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# ETHICAL DILEMMAS FOR THE MENTAL HEALTH PROFESSIONAL: ISSUES RAISED BY RECENT SUPREME COURT DECISIONS

DAVID L. SHAPIRO\*

For many years, there has been a perception in the mental health community that the laws and codes of professional ethics are light years apart. In fact, when one surveys many legal decisions, the similarities are often greater than the discrepancies. The discrepancies tend to be overly dramatized and polarize members of the mental health and legal communities. For example, the very concept of "standard of care" in malpractice litigation refers back to the level of practice exercised by the average or relatively prudent practitioner. Quite frequently, this level of practice is defined by the ethics code of the relevant mental health community.

In recent years, there have been many attempts to open dialogues between mental health professionals and legal and judicial professionals, and to teach mental health professionals the importance of legal constraints in their work. As an example, there are now many joint degree programs across the country where the school awards both a Ph.D. in psychology and a J.D. degree. There are also a variety of organizations which promote such interchange (Division of Psychology and Law, American Psychological Association; American Academy of Psychiatry and Law; American Academy of Forensic Psychology). In addition, joint workshops are now being presented that are sponsored by several organizations. For example, a recent conference on family law was sponsored by the American Psychological Association and the American Bar Association, and a conference is being planned by the same two organizations on issues raised in criminal law.

Nevertheless, there are areas of the law with which many mental health professionals are unfamiliar, yet which may have a significant and profound impact on their daily practice. This survey reviews recent Supreme Court cases which raise ethical issues for mental health professionals.

Two documents referred to frequently within the course of this essay are *Ethical Principles of Psychologists and Code of Conduct*<sup>1</sup> ("*Ethical*

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1. American Psychological Ass'n, *Ethical Principles of Psychologists and Code of Con-*

*Principles*") and the *Specialty Guidelines for Forensic Psychologists*<sup>2</sup> ("*Specialty Guidelines*"). The general format of the essay will be a discussion of the highlights of certain Supreme Court decisions and an assessment of the ethical issues involved in each for mental health professionals.

### I. ONE COMPETENCY FITS ALL: *GODINEZ V. MORAN*<sup>3</sup>

In *Godinez v. Moran*, the defendant, Richard Moran, was charged with a capital offense, first degree murder. Following a plea of not guilty, he was examined by two psychiatrists who agreed that he was competent to stand trial.<sup>4</sup> Following this, Moran expressed a desire to change his plea to guilty, to discharge his attorney, and to represent himself.<sup>5</sup> After Moran did so, he was sentenced to death.<sup>6</sup> When he made these decisions, Moran was taking several medications including Dilantin, Inderal, Phenobarbital, and Vistaril.<sup>7</sup> Moran was quite depressed and had tried to commit suicide shortly before his arrest.<sup>8</sup> The dissent in *Godinez* noted, among other things, that the drugs may have caused disorientation, confusion, depression, short-term memory loss and drowsiness.<sup>9</sup>

The legal issue was whether or not the finding that Moran was competent to stand trial was also sufficient to render Moran competent to represent himself. The United States Supreme Court, in the majority opinion, held that the mental capacity involved in competency for pleading guilty or waiving the right to counsel is the same as competency to stand trial.<sup>10</sup> This appears to fly in the face of a number of other cases that suggest that different levels of competency are involved.<sup>11</sup> The *Godinez* Court, in essence, re-

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duct, 47 AM. PSYCHOLOGIST 1597-1611 (1992) [hereinafter *Ethical Principles*].

2. Committee on Ethical Guidelines for Forensic Psychologists, *Specialty Guidelines for Forensic Psychologists*, 15 LAW & HUM. BEHAV. 655-65 (1991) [hereinafter *Specialty Guidelines*].

3. *Godinez v. Moran*, 509 U.S. 389 (1993).

4. *See id.* at 391.

5. *See id.* at 392.

6. *See id.* at 393.

7. *See id.* at 410. Dilantin is an anti-epileptic drug which may cause confusion. Inderal is a beta-blocker which may cause "light-headedness, mental depression, hallucinations, disorientation, and short-term memory loss; and Vistaril, a depressant that may cause drowsiness, tremors, and convulsions." *Id.* at n.1.

8. *See id.* at 416.

9. *See id.* at 417 (Blackmun, J., dissenting) ("such drugs often possess side effects that may 'compromise the right of a medicated criminal defendant to receive a fair trial' . . .") (quoting *Riggins v. Nevada*, 514 U.S. 127, 142 (Kennedy, J., concurring)).

10. *See id.* at 391.

11. *See Sieling v. Eyman*, 478 F.2d 211, 214 (9th Cir. 1973) (holding that when defendant's mental capacity is at issue, the court must "look further than to the usual 'objective' criteria in determining the adequacy of a constitutional waiver" [of the right to a trial]); *Westbrook v. Arizona*, 384 U.S. 150 (1966) (holding that defendant has a right to a hearing to determine his competency to waive his right to trial); *Faretta v. California*, 422 U.S. 806

jected the claim that a higher competency standard is necessary when a defendant decides to represent himself/herself.<sup>12</sup> The Court essentially suggested a very low standard of competency to plead guilty or to waive the assistance of counsel. The majority opinion made a very essential distinction between the *decision* to waive counsel and the ability to act in one's defense.<sup>13</sup> In other words, the Court stated that the decision to waive counsel, isolated and by itself, is no more complicated than the decisions that need to be made by a defendant in the course of a criminal trial. The majority opinion insisted that how well a defendant represents himself/herself is not an issue.<sup>14</sup>

In a strong dissent, Justice Blackmun argued that equating competency to stand trial with competency to waive counsel is inappropriate. He noted that one cannot isolate the term "competency" and apply it in a vacuum.<sup>15</sup> Blackmun described the majority's opinion as "monolithic" and noted that "[c]ompetency for one purpose does not necessarily translate to competency for another purpose."<sup>16</sup> Blackmun rejected the claim that there can be any meaningful distinction between competency to waive the right to counsel and competency to represent oneself.<sup>17</sup>

In fact, Justice Blackmun's very eloquent dissent reflected and mirrored what many forensic psychologists have been stating for years. For example, Thomas Grisso argues very strongly that there are different functional capacities involved in different competencies, and that being competent for one purpose in no way implies competency for another.<sup>18</sup> Richard Bonnie advocates the same point when he notes the distinction between functional competency and decisional competency, a factor largely overlooked by the majority opinion.<sup>19</sup>

Alan Felthous argues quite persuasively that the *Godinez* decision will result in "a right to represent oneself incompetently."<sup>20</sup> Felthous notes that clinicians are rarely asked to evaluate a defendant for competency to waive counsel, and this practice will probably become even rarer following this decision.<sup>21</sup> Felthous believes that a separate inquiry into competency to waive counsel is superfluous once a finding of competency to stand trial is

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(1975) (holding that a defendant has a constitutional right to represent himself at trial).

12. See *Godinez*, 509 U.S. at 399.

13. See *id.* at 399-400.

14. See *id.* at 400.

15. *Id.* at 413 (Blackmun, J., dissenting).

16. *Id.*

17. See *id.* at 416.

18. See THOMAS GRISSO, *EVALUATING COMPETENCIES* (1986).

19. See Richard Bonnie, *The Competence of Criminal Defendants: A Theoretical Perspective*, 10 *BEHAV. SCI. & L.* 291-316 (1992).

20. Alan R. Felthous, *The Right to Represent Oneself Incompetently: Competency to Waive Counsel and Conduct One's Own Defense Before and After Godinez*, 18 *MENTAL & PHYSICAL DISABILITIES L. REP.* 105 (1994).

21. See *id.* at 110.

made.<sup>22</sup>

An even more striking discussion of the implications of *Godinez* may be found in a contribution by Michael Perlin, who analyzes the Colin Ferguson trial in light of *Godinez v. Moran*.<sup>23</sup> The ludicrous display of Colin Ferguson attempting to represent himself in the Long Island Railroad shooting raised many questions in the public's mind about how such an obviously mentally ill individual could represent himself. The simple answer is that the trial judge followed the standard set forth in *Godinez*.<sup>24</sup> Of course, *Godinez* dealt with the minimum competency required by the Constitution for the waiver of important Constitutional rights. Any state is allowed to adopt higher standards than that minimum.

In fact, in *Illinois v. Lego*, the Illinois Supreme Court recognized the need to adopt this higher standard.<sup>25</sup> The *Lego* court noted that the defendant did not need to possess the skills of an attorney but had to be aware of the pitfalls in self-representation, knowing what he/she is doing, and making a choice rationally.<sup>26</sup> *Lego* had made comments to the trial court about his legal abilities, and remarked that he was probably "the best attorney in the United States," manifesting his delusional thinking.<sup>27</sup> The court noted:

If by virtue of delusion occasioned by mental illness a defendant believes falsely that his legal skills equal or exceed those of virtually any attorney who might represent him, he can hardly be said to be aware of the dangers and disadvantages of self-representation or to know what he is doing and to be making his choice with eyes open. To disregard the cause of a defendant's misperceptions and to take the position that delusion borne of mental illness has no bearing on the knowing and intelligent choice to waive the assistance of counsel would do violence to the most fundamental principles associated with waiver.<sup>28</sup>

The *Godinez* decision was quite unusual in that the majority rejected the concept, described above and reflected in the works of Grisso and Bonnie, that competence is tied to specific functions to be performed (functional abilities). In fact, the *Godinez* Court noted and rejected this in a rather "cheap shot" at mental health professionals: "While psychiatrists and scholars may find it useful to classify the various kinds and degrees of competence . . . the Due Process Clause does not impose these additional requirements."<sup>29</sup> Psychologists and other mental health professionals who have

22. *See id.*

23. Michael L. Perlin, *Dignity was the First to Leave: Godinez v. Moran, Colin Ferguson, and the Trial of Mentally Disabled Criminal Defendants*, 14 BEHAV. SCI. & L. 61 (1996). Colin Ferguson was the African-American man who opened fire on "white targets" on a New York commuter train in December 1993. *See id.*

24. *See id.*

25. *Illinois v. Lego*, 660 N.E. 2d 971 (Ill. 1995).

26. *See id.* at 973.

27. *Id.* at 975.

28. *Id.* at 979.

29. *Godinez v. Moran*, 509 U.S. 389, 402 (1993).

performed competency to stand trial evaluations over the years virtually always, in such evaluations, tailor them to the specific functional abilities necessary to understand and participate in proceedings with the assistance of counsel. The consensus, indeed, what may be described as the standard of care for mental health professionals, is that competence is situationally based and needs to be evaluated in terms of the specific functions that have to be performed by the defendant.<sup>30</sup> That is, different functional capacities are involved in competency to stand trial, competency to represent oneself, competency to plead guilty or, for that matter, competency to consent to or refuse treatment.

The *Ethical Principles* has several sections relevant to the issues raised by *Godinez v. Moran*. Most notably, Standards 2.01 and 7.02 are highly relevant.<sup>31</sup> These sections speak about the fact that assessments, recommendations, reports, and diagnostic and evaluative statements "are based on information and techniques . . . sufficient to provide appropriate substantiation for their findings."<sup>32</sup> Within this context, reference is made once again to the widely held belief and, in fact, standard of care of mental health professionals, of the need to assess different functional capacities. If a mental health professional made a blanket statement that because a person is competent to stand trial, he/she is also competent to plead guilty, to waive counsel, to consent to or resist treatment, or is competent to be executed, the professional would certainly not be operating in accord with this particular ethical principle. The "information and techniques" clearly are not sufficient to provide appropriate substantiation for the findings. In a similar manner, Standard 2.04(c) speaks of the need to "identify situations in which particular interventions or assessment techniques or norms may not be applicable or may require adjustment in administration or interpretation."<sup>33</sup> Here again, this principle would be consistent with the functional abilities approach and totally inconsistent with a blanket "one competency fits all" approach.

Sections of the *Ethical Principles* that deal with informed consent,<sup>34</sup> along with Section 4(E) of the *Specialty Guidelines*<sup>35</sup> which talk about a "thorough notification of the purposes, methods and intended uses of the forensic evaluation," raise serious problems from an ethical point of view. That is, if one follows the logic of *Godinez v. Moran*, then one would need to conclude that at the time of obtaining informed consent for a competency to stand trial evaluation, one would also need to inform the defendant that the results of this evaluation, for example, could also be used to determine whether he/she could represent himself or whether he/she was competent to

30. See GRISSE, *supra* note 18.

31. See *Ethical Principles*, *supra* note 1, §§ 2.01, 7.02.

32. *Id.* (emphasis added).

33. *Id.* § 2.04.

34. *Ethical Principles*, *supra* note 1, § 4.02 (Informed Consent to Therapy).

35. *Specialty Guidelines*, *supra* note 2, § 4(E).

be executed. Finally, Standard 2.02(a) of the *Ethical Principles* speaks to the issue that psychologists use assessment techniques only for “purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the technique.”<sup>36</sup> Because the “techniques” used in competency evaluations are based on the assessment of given functional capacities, it would be a clear violation of this standard to use such assessment techniques to render statements regarding other competencies.

In summary, rather than adopting the “one competency fits all” approach suggested by the majority opinion in *Godinez v. Moran*, the practitioner will need to continue regarding each competency as representing a different functional capacity in order to practice ethically. In other words, the minimal competency standard enunciated by the Supreme Court to satisfy due process concerns is not high enough to enable a psychologist to practice in accordance with the *Ethical Principles*. In fact, following the Supreme Court decision of “one competency fits all” would not only violate the *Ethical Principles* but would also represent a substantial deviation from the accepted standard of care in conducting such evaluations.

## II. USE OF EXPERT TESTIMONY: *DAUBERT V. MERRELL DOW PHARMACEUTICALS*<sup>37</sup>

In *Daubert v. Merrell Dow Pharmaceuticals*, the Supreme Court of the United States indicated that the “general acceptability theory” enunciated in *Frye v. United States*<sup>38</sup> was too austere a standard to be used for the admissibility of expert testimony.<sup>39</sup> The *Daubert* Court, in the majority opinion written by Justice Blackmun, suggested that the more liberalized version consistent with the Federal Rules of Evidence be adopted.<sup>40</sup> Unfortunately, several questions remain unanswered after *Daubert* with respect to the adoption of the Federal Rules of Evidence.

The new standard was believed to be more flexible and liberal than *Frye*, in that it might allow the admission of innovative or “cutting edge” material that would not pass muster under the more restrictive *Frye* standard. On the other hand, *Daubert* appoints the individual trial judge as a “gatekeeper.” Thus, according to the language of the decision, the trial judge is required to evaluate proposed expert testimony in light of whether it is “reliable.”<sup>41</sup> (These criteria actually refer more to validity in a psychologi-

36. *Ethical Principles*, *supra* note 1, § 2.02.

37. *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993).

38. *Frye v. U.S.*, 293 F. 1013 (D.C. Cir. 1923). In *Frye*, the court held “while courts will go a long way in admitting expert testimony deduced from a well-recognized scientific principle or discovery, the thing from which the deduction is made must be sufficiently established to have gained general acceptance in the particular field. . . .” *Id.* at 1014.

39. *See Daubert*, 509 U.S. at 589.

40. The Court agreed with the defendant’s argument that the *Frye* test had been superseded by the Federal Rules of Evidence. *See id.*

41. *See id.* at 597.

cal sense than to reliability.) In this assessment, the trial judge is called upon to determine: whether the proposed methodology and opinion are based on hypotheses that are testable, whether they have been tested, whether they have been peer reviewed, whether they have been published, whether they have a known error rate, and whether they have general acceptability in the field.<sup>42</sup>

Many mental health scholars have shown a good deal of consternation because these criteria appear to make admissibility far more narrow than under *Frye*, rather than more flexible. In fact, many assessment instruments and interview techniques do not fall under the rigorous scientific methodology suggested by these standards. For instance, while a given practitioner may perform a criminal responsibility evaluation by conducting extensive clinical interviews, utilizing psychological testing, reviewing police reports, witness reports, hospital records, and interviewing witnesses and police officers, and although this represents the standard of care in doing such assessments, one could raise the issues of whether this methodology is testable, what exactly is being tested, whether it has been tested, whether it has a known error rate and therefore whether it would satisfy these criteria.

Mental health professionals who perform child custody evaluations are quick to note that most of their techniques, such as interviewing teachers, family, extended family and obtaining school records, as well as assessing the children and the parents, do not have a known error rate and do not contain hypotheses that can be easily tested. Are such evaluations, therefore, inadmissible in a court of law that uses *Daubert* as the criterion for admission? Some mental health professionals have pointed to Footnote 8 in *Daubert v. Merrell Dow*, which states that "Rule 702 also applies to 'technical or other specialized knowledge.' Our discussion is limited to the scientific context because that is the nature of the expertise offered here."<sup>43</sup> In other words, should mental health professionals not be concerned that their forensic evaluations will be excluded in court because they represent "technical or other specialized knowledge" rather than scientific knowledge? On one hand, this would provide some degree of comfort, but on the other hand, this would contribute to a "watering down" of whatever gains psychology has made as a scientific enterprise. A recent federal district court ruling, however, suggests otherwise.<sup>44</sup>

In *United States v. Scholl*, an expert was called to testify about whether a defendant did or did not have the mental state to willfully falsify tax forms.<sup>45</sup> The expert, who was subpoenaed to present scientific literature to support his conclusion that the defendant did not have such a mental state, admitted that no such studies existed.<sup>46</sup> The expert's opinion was "not based

42. *See id.* at 593-94.

43. *Id.* at 590 n.8.

44. *See United States v. Scholl*, 959 F. Supp. 1189 (D. Ariz. 1997).

45. *Id.*

46. *See id.* at 1194-95.



on highly controlled studies but on personal perceptions not subject to verification or evaluation."<sup>47</sup> Therefore, the court denied the expert's cumulative opinion testimony on the disorder's effect on the defendant's alleged mental state of denial.<sup>48</sup> The decision was, in fact, even more restrictive. The expert was allowed to testify about his diagnosis of the defendant as a compulsive gambler, relating the diagnosis only to the criteria listed in DSM-IV.<sup>49</sup> Testimony about "associated features" was excluded because, according to the court, those "associated features" did not meet the *Daubert* criteria.<sup>50</sup>

It is too early to tell what the long range implications of this finding will be. Perhaps it will have little impact because testimony of one's mental state regarding ability to tell the truth is probably not admissible under other rules of evidence.<sup>51</sup> On the other hand, if a broader interpretation of this case is taken, that the expert could not testify because his opinion was based on personal perception not subject to verification or evaluation, the implications could be quite ominous for mental health professionals involved in forensic work.

The *Ethical Principles* contain several sections that are relevant to the issues raised by the *Daubert* case. Standard 1.06 (Basis for Scientific and Professional Judgments) states that "[p]sychologists rely on scientifically and professionally derived knowledge when making scientific or professional judgments or when engaging in scholarly or professional endeavors."<sup>52</sup> Does this suggest that the scientifically and professionally derived knowledge needs to abide by the *Daubert* criteria in order to be admitted into a court of law? Standard 1.23 of the *Ethical Principles* (Documentation of Professional and Scientific Work) speaks of the fact that when psychologists have reason to believe that records of their professional services will be used in legal proceedings, "they have a responsibility to create and maintain documentation in the kind of detail and quality that would be consistent with reasonable scrutiny in an adjudicative form."<sup>53</sup> Once again, if this "reasonable scrutiny" refers to the "gatekeeping criteria" outlined in *Daubert*, it is unlikely that any psychologist performing clinical/forensic evaluations could satisfy that requirement. Does this require us to "bow out" of the legal arena entirely?

Again, reference is made to the sections dealing with *Godinez v. Moran*, Standards 2.01(b) and 7.02(a)—whether the conclusions are based in

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47. *Id.* at 1194-97.

48. *See id.*

49. *See id.* "DSM-IV" refers to the AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC & STATISTICAL MANUAL (4th ed. 1994).

50. *See United States v. Scholl*, 959 F. Supp. 1189 (D. Ariz. 1997).

51. *See* FED. R. EVID. 704 ("ultimate issue testimony").

52. *Ethical Principles*, *supra* note 1, § 1.06.

53. *Id.* § 1.23.

data sufficient to provide appropriate substantiation.<sup>54</sup> Will this be judged according to the "scientific criteria" or according to the clinical criteria that are often used? Standard 2.02(a), discussed earlier in reference to *Godinez*, is also relevant here.<sup>55</sup> This section deals with the use of assessment techniques that are appropriate in light of the research on, or evidence of, the usefulness and proper application of the technique.<sup>56</sup> While it is certainly reasonable for an ethical clinician to very narrowly utilize the various forensic assessment instruments, if one follows the *Daubert* criteria, then there are many instruments being utilized (i.e., the majority of projective and objective tests) that could not be shown to be appropriately related to certain legal criteria or that have known error rates in reference to these legal criteria.

Finally, the *Specialty Guidelines* speaks about the need, during initial consultation with the legal representative of the party seeking services, for the forensic psychologist to discuss "the known scientific bases and limitations of the methods and procedures that they employ . . ."<sup>57</sup> It is highly questionable whether a legal representative would even contract with a psychologist if that psychologist, for example, were to tell an attorney that under the *Daubert* criteria none of the psychological tests used would be admissible in court.

The ethical implications of this whole area are somewhat vague and ambiguous at best. In a recent presentation regarding *Daubert* and forensic mental health assessment, Kirk Heilbrun suggested essentially that, despite the vastly different wordings of the two decisions, in the majority of cases techniques found admissible under *Frye* would also be found admissible under *Daubert*.<sup>58</sup> Moreover, Heilbrun suggests the opposite is also true; those techniques and methods that would not be found admissible under *Frye* are not admissible under *Daubert*.<sup>59</sup> None of the cases surveyed by Heilbrun, however, spoke to the issue raised in the *Scholl* case: whether a clinical interview could pass muster under the *Daubert* criteria. Mental health professionals essentially will have to continue to do carefully documented, well-validated work and present to courts in expert testimony only those conclusions that have appropriate substantiation, without going beyond the limits of their data or making unwarranted inferences. This will certainly keep psychologists in line with any ethical constraints. Whether it will amount to admissibility under the *Daubert* criteria remains to be seen.

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54. *Id.* §§ 2.01(b), 7.02(a).

55. *Id.* § 2.02(a).

56. *See id.*

57. *Specialty Guidelines*, *supra* note 2, § 4(A).

58. Kirk S. Heilbrun, *Daubert and Forensic Mental Health Assessment Uses and Implications*, presented at Biennial Meeting of American Psychology Law Society (Hilton Head, S.C. March, 1996) (unpublished manuscript on file with author).

59. *See id.*

### III. PSYCHOTHERAPIST-PATIENT PRIVILEGE: *PENNSYLVANIA V. RITCHIE*<sup>60</sup>

*Ritchie* illustrates a growing trend that encroaches on psychotherapist-patient privilege. Traditionally, the exceptions to psychotherapist-patient privilege are relatively straightforward and somewhat limited. The most widely recognized exceptions are: (1) the patient-litigant exception when a patient puts his/her mental state into litigation; (2) court-ordered evaluations; (3) involuntary commitment procedures; (4) as defenses against malpractice claims; (5) child abuse reporting laws; and (6) duty to protect third parties laws.<sup>61</sup>

As illustrated in *Ritchie*, there is an additional area of encroachment—the criminal defense exception. In a large number of cases, defense attorneys in a criminal proceeding will attempt to obtain the treatment records of an individual who is either the victim of or a witness to the criminal offense. The attorneys do so in an attempt to impeach the individual by suggesting that the individual's psychiatric/psychological symptoms would render him/her not credible as a witness. This clearly poses serious ethical dilemmas for the psychologist trying to provide mental health services to the individual, often as the result of the very trauma the individual experienced or witnessed. The psychologist is then placed in the position of having treatment records subpoenaed in a criminal proceeding, with a predictably adverse impact on the therapeutic relationship and on the patient's mental health. States vary in the way they have approached this problem.

Some early decisions suggested that the psychotherapist-patient privilege must yield to the rights of the defendant in a criminal proceeding because the latter is seen to be Constitutionally based and is regarded as more compelling than a privilege, which is granted in an individual state by statute.<sup>62</sup> Another related case in Arkansas suggested that not all of the record need be revealed but only the diagnosis and the fact that the patient was in treatment.<sup>63</sup> While this was a commendable "balancing act" on the part of

60. *Pennsylvania v. Ritchie*, 480 U.S. 39 (1987).

61. See CLIFFORD C. STROMBERG, *THE PSYCHOLOGIST'S LEGAL HANDBOOK* 371-424 (1988).

62. See *People v. Reber*, 233 Cal. Rptr. 139 (Cal. Ct. App. 1986). In *Reber*, the defendant had been charged with false imprisonment, assault with a deadly weapon and sodomy, as well as various other charges, against two separate victims. See *id.* at 142. Defense counsel attempted to obtain the victims' psychiatric records arguing the Sixth Amendment right to confront witnesses against him. See *id.* at 143. The defendant wanted to show, for the purpose of impeaching their credibility as witnesses, that both victims had histories of paranoid schizophrenia. See *id.* The trial court denied their request. See *id.* at 144. The appellate court held the trial court erred in merely identifying and protecting the privilege because it failed to weigh the defendant's need for access to privileged information. See *id.* at 146. However, the appellate court ultimately concluded there was no probability that the records could have "materially assisted the defense in such a way as to undermine confidence in the outcome of the trial." *Id.* at 147. Therefore, it affirmed the lower court's denial of the request. See *id.* at 149.

63. See *Horne v. Arkansas*, 677 S.W.2d. 856 (Ark. Ct. App. 1984).

the Arkansas court, it also raised the possibility of attorney misuse and misrepresentation. An attorney could use this very limited data to influence jurors in rejecting the testimony of a given witness, causing that witness/patient great distress and potential harm. A Massachusetts court illustrated the extreme to which this could be taken.<sup>64</sup> The court in *Commonwealth v. Stockhammer* stated essentially that treatment records can be turned over directly to the defense attorney who has issued the subpoena.<sup>65</sup> This, of course, would be the most certain way for any privileged information to be revealed and used against the patient.

In *Ritchie*, the defendant was charged with sexually assaulting his daughter.<sup>66</sup> In preparing his defense, he sought to obtain records maintained by the Department of Protective Services in that state.<sup>67</sup> However, statutory regulations made the records privileged, and the agency refused to release them.<sup>68</sup> The issue presented to the court was essentially the balancing act between permitting the defendant in a criminal case to have all evidence necessary to put on an adequate defense and the desire to protect the confidentiality of the therapeutic relationship. The court tried to strike a balance, stating that if there were a showing that the privileged file might contain relevant information, the judge should require that the holder of the confidential information provide the file to the court (not directly to counsel, in contrast to *Stockhammer*).<sup>69</sup> The court would then review the file in camera to determine whether the probative value outweighed the prejudicial impact. If nothing of material importance was found by the judge, the material would be returned to the agency; but if something of material relevance was found, *only that information* would be revealed to the defendant.<sup>70</sup> Essentially, *Ritchie* illustrates that there is a Constitutionally-required criminal defense exception to privilege statutes. While most state privilege statutes do not contain criminal defense exceptions, there is a growing encroachment on privilege through a variety of case law decisions.

A number of unanswered questions remained following the *Ritchie* case. Since the case involved the records of a state agency, the question arose whether the result would be the same if the records of someone in private practice or in a private mental health center were the subject of the

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64. *Commonwealth v. Stockhammer*, 570 N.E.2d. 992 (Mass. 1991).

65. *See id.* Note that this case was decided after the Supreme Court decided *Ritchie* in 1987. Basically, the *Stockhammer* court dismissed *Ritchie* as non-binding. *See id.* at 1001. The court held that the Massachusetts constitution afforded the defendant greater rights than the Sixth Amendment to the U.S. Constitution regarding the right of confrontation. *See id.* at 1002. The court further found that in camera review does not necessarily protect defendant's rights, and that a protective order would better serve the interests of the state, the victim and the defendant. *See id.*

66. *Ritchie*, 480 U.S. at 43.

67. *See id.*

68. *See id.*

69. *See id.* at 58, 60.

70. *See id.*

subpoena. Generally, because courts may not always know what may be relevant to a criminal defense, there may be a tendency by trial courts to permit broad disclosures of information from therapy.

More recently, a somewhat reassuring case that addressed this issue as it applied to private practitioners emerged from Maryland.<sup>71</sup> In *Goldsmith v. Maryland*, the defense attorney had to overcome a very high threshold before the court would even consider reviewing the material in camera. That is, the court forbade a “fishing expedition” sojourn into the records.<sup>72</sup> The court required the defense attorney to state the specific material, which was either expected to be found in the records or known to be in the records, that would be relevant to the defense and to the impeachment of the credibility of a given witness.<sup>73</sup> In other words, a defense attorney’s assertion that someone was in treatment and therefore that person’s mental state was questionable, would be insufficient to require an in camera review by the trial court. If, on the other hand, the defense attorney could make a compelling enough argument (for example, that the patient/witness/victim in question experienced auditory hallucinations and had serious distortions in reality testing), then the court would review the record in camera because such issues could potentially be relevant to witness credibility. The *Goldsmith* case made it very clear that the court would review only cases in which there was this prima facie showing of relevance and even then, upon review, the trial court would have to be convinced that the probative value outweighed the prejudicial impact.

As an example, the following is an illustration of inappropriate behavior on the part of a therapist in such a situation. A psychologist had been treating a woman who stated that she had been sexually assaulted by a man she had dated. She had, in fact, brought criminal charges against this man. When the defense attorney became aware of the fact that the woman was in treatment, the attorney subpoenaed the therapist and the treatment records. The psychologist essentially panicked and came to court the next morning with records in hand and allowed himself to be sworn in as a witness, revealing material from the clinical record that was very damaging to the patient and to the therapeutic relationship. The psychologist testified that the woman had been diagnosed with Borderline Personality Disorder and had, in the past, brought a fraudulent charge of rape against a boyfriend who had abandoned her. When the material was presented to the jury, more than a reasonable doubt was raised in the jurors’ mind that the woman may have fabricated the rape charge in the current case, and the jury acquitted the defendant.

Several *Ethical Principles*, of course, come into play here. At the very outset, Standard 1.02 (Relationship of Ethics and Law) notes that if ethical

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71. See *Goldsmith v. Maryland*, 651 A.2d 866 (Md. 1995).

72. *Id.* at 888.

73. See *id.*

responsibilities conflict with the law, psychologists should make known their commitment to the *Ethical Principles* and attempt to resolve the conflict in a responsible manner.<sup>74</sup> This would suggest that upon receipt of the subpoena the psychologist, rather than undergoing a panic reaction, should have filed a Motion to Quash the subpoena, noting an inability to comply with the subpoena because of the possible destruction of the relationship and the potential harm to the patient. Then, an evidentiary hearing would be held where the judge determines whether the records needed to be released. The filing of the Motion to Quash or of a Motion for Protective Order would certainly fulfill the psychologist's need to "take steps to resolve the conflict in a responsible manner."<sup>75</sup> If, of course, the judge ordered the psychologist to release the records, then the psychologist could do so, having documented the attempt to comply with the *Ethical Principles*. Merely "knee-jerking" in response to the subpoena, as the psychologist did here, represents a clear violation of the *Ethical Principles*.

Standard 1.14 (Avoiding Harm) is also relevant in that it exhorts psychologists to "take reasonable steps to avoid harming their patients or clients" and to "minimize harm where it is foreseeable and unavoidable."<sup>76</sup> Once again, a Motion to Quash would be consistent with, and in the spirit of, the *Ethical Principles*. Standards 1.15 (Misuse of Psychologist's Influence)<sup>77</sup> and 1.16 (Misuse of Psychologist's Work)<sup>78</sup> are relevant and again urge the psychologist to "take reasonable steps to correct or minimize the misuse or misrepresentation." Certainly, the Motion for Protective Order described above would be seen as a "reasonable step," but if and when, in the worst possible case scenario, the psychologist learns that the records which have been court-ordered to be released have been misused, he/she would need to contact opposing counsel in order to present some testimony that would rebut the misrepresentation.

Standard 2.02(b) speaks of the ethical constraint against the "misuse of assessment techniques, interventions, results, and interpretations" and the need for the psychologist to "take reasonable steps to prevent others from misusing the information these techniques provide."<sup>79</sup> This includes refraining from releasing raw test results or raw data to persons, other than to patients or clients as appropriate, who are not qualified to use such information.<sup>80</sup> This would be another basis for the Motion to Quash, especially if there is psychological test material in the record that clearly could be misused by an attorney intent on cross-examining a witness who is also in therapy. Clearly, if psychological test data or interpretations, especially com-

74. See *Ethical Principles*, *supra* note 1, § 1.02.

75. *Id.*

76. *Id.* § 1.14.

77. *Id.* § 1.15.

78. *Id.* § 1.16.

79. *Id.* § 2.02(b).

80. See *id.*

puter-generated interpretations, are part of the file, these could be quite injurious when used in cross-examination. These computer program statements are actuarial statements and may or may not be applicable to the patient at a given point in time. Nevertheless, such test results in the hands of an ardent advocate, using this data for cross-examination purposes, could be extremely destructive. Thus, access to test data must be guarded with utmost care.

Closely related to this is a principle, referred to several times in different parts of the *Ethical Principles*, about psychologists' need to indicate "any significant reservations they have about the accuracy or limitations of their interpretations,"<sup>81</sup> and "[w]hen necessary to avoid misleading, psychologists acknowledge the limits of their data or conclusions."<sup>82</sup> An advocate attempting to utilize the records for purposes of cross-examination would not comment on qualifications about the validity or reliability of the data. But, Standard 3.02(c) encourages the psychologist, if he/she learns of deceptive statements about their work made by others, to "make reasonable efforts to correct such statements."<sup>83</sup>

Section 5 of the *Ethical Principles* (Privacy and Confidentiality) is central to this entire discussion.<sup>84</sup> Standard 5.01(a) requires psychologists to discuss "the relevant limitations on confidentiality" and "the foreseeable uses of the information generated through their services" and that this discussion of confidentiality and its limits occur "at the outset of the relationship."<sup>85</sup> This suggests that if a psychologist enters into a treatment contract with an individual who has been either a victim of or a witness to a criminal offense, then the psychologist must, as part of the Informed Consent to Treatment, discuss the fact that under certain limited circumstances the psychologist may be required to reveal part or all of the records of treatment. Of course, the client should also be made aware of the fact that the psychologist will make every effort to protect such an intrusion into the privilege from occurring. Nevertheless, the client must be made aware of it and never be given the assurance that "everything you say is confidential."

In summary, the trend in case law illustrated by *Pennsylvania v. Ritchie* raises a number of ethical dilemmas for the psychologist. While the phrase, "taking reasonable steps," is admittedly vague, the suggestions enumerated above would go a long way toward a psychologist remaining in compliance with the *Ethical Principles*, even when the psychologist's records are subpoenaed under these circumstances.

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81. *Id.* § 2.05.

82. *Id.* § 7.04(b).

83. *Id.* § 3.02.

84. *Id.* § 5.00.

85. *Id.* § 5.01.

IV. COMPETENCY TO BE EXECUTED: *FORD V. WAINWRIGHT*<sup>86</sup>

In June of 1986, the United States Supreme Court issued a decision in *Ford v. Wainwright* involving a habeas corpus petition filed on behalf of a death row prisoner.<sup>87</sup> The Supreme Court held that the Eighth Amendment prohibited the state from inflicting the death penalty upon a prisoner who is insane.<sup>88</sup> The Court further held that Florida's procedures for determining the sanity of a death row prisoner were not "adequate to afford a full and fair hearing" and therefore the habeas petitioner was entitled to an evidentiary hearing in the district court on the question of his competence to be executed.<sup>89</sup> The Court ruled that the Florida scheme for determination of competency to be executed was deficient in that it precluded a prisoner or his counsel from presenting material relevant to the prisoner's sanity, denied the opportunity to challenge or impeach state-appointed psychiatric opinion, and placed the decision wholly within the Executive Branch.<sup>90</sup>

The petitioner, Alvin Ford, was convicted of murder in a Florida state court in 1974 and sentenced to death.<sup>91</sup> There was no evidence that he demonstrated a mental disorder at the time of the offense, at trial or at sentencing.<sup>92</sup> However, while in prison he demonstrated behavioral changes, indicating a mental disorder.<sup>93</sup> At his defense attorney's request, this led to extensive separate examinations by two psychiatrists, one of whom concluded that Ford was incompetent to be executed.<sup>94</sup> Defense counsel then invoked the Florida statute governing the determination of a condemned prisoner's competency.<sup>95</sup>

The governor, following statutory procedures, appointed three psychiatrists who together interviewed Ford for thirty minutes in the presence of eight other people, including petitioner's counsel, state attorneys and correctional officials.<sup>96</sup> The governor ordered that the attorney should not participate in the examination in any adversarial manner.<sup>97</sup> Each of the psychiatrists then filed a separate report with the governor, to whom the statute delegated the final decision.<sup>98</sup> Of some interest is that the reports reached conflicting diagnoses but were in accord on the question of Ford's compe-

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86. *Ford v. Wainwright*, 477 U.S. 399 (1986).

87. *Id.*

88. *See id.* at 399.

89. *Id.* at 417-18.

90. *See id.* at 413-18.

91. *See id.* at 402.

92. *See id.*

93. *See id.*

94. *See id.* at 402-03.

95. *See id.* at 403.

96. *See id.* at 403-04.

97. *See id.* at 412-13.

98. *See id.* at 404.



tency to be executed.<sup>99</sup> Counsel for Ford then attempted to submit to the governor other written materials, including the reports of the two psychiatrists who had previously examined Ford, but the governor's office refused to inform counsel whether the submission would be considered.<sup>100</sup> The governor subsequently signed a death warrant without explanation or statement.<sup>101</sup> Following an unsuccessful attempt to obtain a hearing in state court to determine Ford's competency, counsel filed a habeas corpus proceeding in federal district court seeking an evidentiary hearing, but the court denied the petition without a hearing and the Court of Appeals affirmed.<sup>102</sup> Upon writ of certiorari to the United States Supreme Court, the judgment was reversed and the case remanded.<sup>103</sup>

In addition to the defects the Court found in the Florida statute, questions were also raised as to the adequacy of the examinations with several witnesses present, as well as the brief nature of the evaluations, considering the enormity of the conclusions. The Court concluded that Florida's procedures for determining sanity were inadequate to preclude federal redetermination of the Constitutional issue.<sup>104</sup> At the same time, the Court did not suggest that a full trial on the issue of sanity was necessary to protect federal interests, and the Court left it to the state to develop appropriate ways to enforce the Constitutional restriction upon the execution of sentences.<sup>105</sup>

Whereas *Ford* was a 1986 case and *Godinez v. Moran* was a 1993 case, one may certainly raise the issue of whether, in light of *Godinez*, *Ford* will be reinterpreted. That is, if "one competency fits all," then Ford, or anyone like him who deteriorates into psychosis following incarceration, could conceivably be executed because he had originally been found competent to stand trial. Of course, the length of time of incarceration and change in mental condition would be raised as countervailing issues.

Several bothersome ethical issues are raised by the *Ford* case. The whole issue of conducting an evaluation of an individual's competence for execution can have a profound impact on subsequent proceedings. Psychologists are enjoined by Standard 1.14 of the *Ethical Principles* to "avoid harm."<sup>106</sup> That standard states, "Psychologists take reasonable steps to avoid harming their patients or clients, research participants, students, and others with whom they work, and to minimize harm where it is foreseeable and

99. *See id.*

100. *See id.*

101. *See id.*

102. *See id.*

103. *See id.* at 418.

104. *See id.* at 417-18. The Court held that in a federal habeas corpus proceeding, an evidentiary hearing is required unless the state court, after full hearing, found the relevant facts. *See id.* at 410. Because the Court found the state's procedures lacking, the Court held that it was proper to remand for an evidentiary hearing. *See id.* at 417-18.

105. *See id.* at 416.

106. *Ethical Principles*, *supra* note 1, § 1.14.

unavoidable."<sup>107</sup> If one believes that executing another human being is harm, then participating in such evaluations at all could be seen as a violation of Standard 1.14. It is beyond the scope of this paper to debate this issue but it has certainly been raised in a variety of paper presentations since the Supreme Court's decision in *Ford*.<sup>108</sup> Some have stated that the psychologist's proper response to such a request would be to "just say no."<sup>109</sup> Unfortunately, working within a correctional setting does not make such a simple response very feasible. Even more troubling is the situation in which an individual has been determined incompetent to be executed yet the psychologist's role, as part of the treatment team, is to restore him/her to competence, so that the state may take his/her life. While such "treatment" would likely consist of medication management, if the individual is psychotic, it could easily be seen that a psychologist would be called on to provide some degree of supportive counseling along with the medication program.

Standard 1.02 of the *Ethical Principles* speaks about the procedure of making known a commitment to the *Ethical Principles* when ethical responsibilities conflict with the law.<sup>110</sup> "Tak[ing] steps to resolve the conflict in a responsible manner" might include documenting one's resistance to the procedure which is about to be undertaken.<sup>111</sup> Standard 1.06 (Basis for Scientific and Professional Judgments) would be highly relevant, assuming that the psychologist is willing to perform a competence for execution evaluation.<sup>112</sup> With so much at stake, the statement that a psychologist will rely on "scientifically and professionally derived knowledge when making scientific or professional judgments" is clearly of great import.<sup>113</sup> The issue of informed consent referred to by Standard 1.07 (Describing the Nature and Results of Psychological Services) and Standard 2.09 (Explaining Assessment Results) clearly suggests that a psychologist needs to provide the defendant with "appropriate information about the nature of the service and appropriate information about results and conclusions"<sup>114</sup> prior to the evaluation. This would indicate the necessity for any psychologist engaging in such an evaluation to let the defendant know the purpose of the evaluation. While psychologists understandably may feel very squeamish about such an informed consent procedure, it may provide some degree of protection in that the defendant, knowing the nature of the evaluation, may well refuse to participate in it. That refusal, in turn, would preclude the potential

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107. *Id.*

108. See Kirk S. Heilbrun, *Death Penalty*, 5 BEHAV. SCI & L. 383-95 (1987).

109. See *id.*

110. *Ethical Principles*, *supra* note 1, § 1.02.

111. *Id.*

112. Standard 1.06 states that "psychologists rely on scientifically and professionally derived knowledge when making scientific or professional judgments." *Id.* § 1.06.

113. *Id.*

114. See *id.* §§ 1.07, 2.09.

for violations of Standards 1.15 (Misuse of Psychologist's Influence)<sup>115</sup> and 1.16 (Misuse of Psychologist's Work).<sup>116</sup> Standard 1.17, which urges psychologists to avoid multiple relationships, would preclude the psychologist from conducting an evaluation of competency to be executed and subsequently providing the treatment to restore that individual to competence.<sup>117</sup>

Standard 1.23, regarding the documentation of professional and scientific work, indicates that if a psychologist becomes involved in such an evaluation, there is a clear responsibility for very careful documentation, considering the stakes that are involved.<sup>118</sup>

Standards 2.01(b) and 7.02(a), which require information and techniques sufficient to provide appropriate substantiation for the findings, are very important here and, given the ultimate use of the conclusions, require little further comment.<sup>119</sup> The appropriate use of assessments and interventions<sup>120</sup> and the necessity to avoid obsolete tests and outdated test results<sup>121</sup> are also highly relevant to the present situation. Of course, Standard 5.01, regarding the necessity of discussing the limits of confidentiality, is highly relevant in that one needs to very clearly state to the defendant not only the fact that the examination results are not confidential, but also how they may, and most likely will, be used.<sup>122</sup>

Standards 7.02(c) and 7.04(b) speak to the issue of limiting the nature and extent of conclusions or recommendations when there are questions about reliability and validity.<sup>123</sup> Once again, the chances are that if a defendant has given informed consent to such an evaluation procedure, it is unlikely the defendant will be totally forthcoming in her/his statements, therefore allowing the psychologist to qualify conclusions in light of these two Standards. In addition, if the defendant is so mentally ill as to have the question of competence for execution raised in the first place, it is possible that informed consent could not be obtained at all. Under those circumstances the psychologist would have to decline further participation.

Looking now at the *Specialty Guidelines*,<sup>124</sup> Guideline 3(E) suggests declining participation or limiting assistance in any situation where personal values, moral beliefs or personal and professional relationships may interfere with an ability to practice competently.<sup>125</sup> Therefore, the clear implication is that if an individual psychologist has strong feelings one way or an-

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115. *See id.* § 1.15.

116. *See id.* § 1.16.

117. *See id.* § 1.17.

118. *See id.* § 1.23.

119. *See id.* §§ 2.01(b), 7.02(a).

120. *See id.* § 2.02.

121. *See id.* § 2.07.

122. *See id.* § 5.01.

123. *See id.* §§ 7.02(c), 7.04(b).

124. Note that while the *Specialty Guidelines* are not enforceable as part of the *Ethical Principles*, they do provide some guidance.

125. *See Specialty Guidelines, supra* note 2, § 3(E).

other (i.e., either pro or con) regarding the death penalty, then participation should be declined.

#### V. DETENTION AFTER DEFENDANT IS NO LONGER MENTALLY ILL: *FOUCHA v. LOUISIANA*<sup>126</sup>

In 1992, the United States Supreme Court issued an opinion in *Foucha v. Louisiana* regarding the length of time that a defendant who is acquitted by reason of insanity may remain within a mental hospital.<sup>127</sup> In *Foucha*, the Court's analysis focused on the defendant's mental illness, or rather, his lack thereof.<sup>128</sup>

Under the law in the State of Louisiana, defendants who are found not guilty by reason of insanity (hereinafter "NGRI") are committed to a mental hospital until it can determine that they are not dangerous to themselves or to others.<sup>129</sup> Psychiatrists and psychologists may provide reports on defendants' mental conditions and whether defendants are dangerous to themselves or others, but the ultimate decision on dangerousness and release is up to a judge following a hearing.<sup>130</sup> The burden of proof rests with the defendant to demonstrate that he/she is no longer dangerous.<sup>131</sup> The important issue, which gave rise to this case, was that even if defendants were no longer mentally ill, they could be kept in the mental hospital until able to prove themselves no longer dangerous.<sup>132</sup>

*Foucha* had been adjudicated NGRI in 1984 on charges of aggravated burglary and a firearms offense.<sup>133</sup> Four years later, doctors examined him and recommended that he be released, finding that he had an antisocial personality but stating that this was not a mental disease and noting the condition was untreatable.<sup>134</sup> The evidence suggested that at the time of the offense, *Foucha* was suffering from a drug-induced psychosis.<sup>135</sup> On the basis of the evidence, the trial court ruled that *Foucha* was no longer mentally ill,

126. *Foucha v. Louisiana*, 504 U.S. 71 (1992).

127. *Id.*

128. *Id.* An earlier decision by the Court in 1983 tackled the same issue but did not consider the mental illness. *See Jones v. U.S.*, 463 U.S. 354 (1983). In *Jones*, the Court ruled that there was a continuing presumption of dangerousness and that the length of time that a person may serve if he/she had been convicted was not relevant to the length of time he/she would be in a mental hospital if found Not Guilty by Reason of Insanity ("NGRI"). *See id.* at 369. However, in *Jones*, the doctors who evaluated the defendant found the defendant to have a continued mental illness. *See id.* at 360.

129. *See Foucha*, 504 U.S. at 73. The dissenting opinion of Justice Thomas provides expanded discussion of the relevant Louisiana statutes. *See id.* at 104 & nn. 2-6 (Thomas, J., dissenting).

130. *See id.* at 73.

131. *See id.*

132. *See id.*

133. *See id.*

134. *See id.* at 74-75 & n.2.

135. *See id.* at 75.

but he had not proved that he was no longer dangerous and therefore the court refused to release him.<sup>136</sup>

In *Foucha*, the Supreme Court ruled that a state could not constitutionally confine an insanity acquittee<sup>137</sup> who is no longer mentally ill even though he may still be dangerous.<sup>138</sup> The Court emphasized that the combination of mental illness *and* dangerousness permitted the confinement and allowing the continued detention of those who could not prove they were non-dangerous would permit the indefinite confinement of someone found NGRI.<sup>139</sup> The Court noted, "It would also be only a step away from substituting confinements for dangerousness for our present system which, with only narrow exceptions and aside from permissible confinements for mental illness, incarcerates only those who are proved beyond reasonable doubt to have violated a criminal law."<sup>140</sup>

Justice O'Connor noted in her concurring opinion that the state might be permitted to confine an insanity *acquittee* who is no longer mentally ill if "unlike the situation in this case, the nature and duration of detention were tailored to reflect pressing public safety concerns related to the *acquittee's* continuing dangerousness."<sup>141</sup> As will be seen, this concurring opinion has had reverberations in several subsequent opinions.<sup>142</sup> The dissent noted that the state should be given considerable latitude to confine defendants until defendants could prove that they were no longer dangerous, and that there was sufficient basis to permit the state to detain someone who was dangerous but not mentally ill.<sup>143</sup>

An issue that was not discussed in the *Foucha* opinion was exactly what constitutes a mental illness. This is of note because *Foucha* reportedly had an antisocial personality disorder but did not suffer from mental illness.<sup>144</sup>

State courts reacted in a variety of ways to the Court's decision in *Foucha*. In *Wisconsin v. Randall*, Wisconsin followed Justice O'Connor's concurring opinion, distinguishing its statutory scheme from that in Louisiana.<sup>145</sup> The *Randall* court talked about the reflection of public safety concerns and the fact that the treatment program was designed to address the

136. *See id.*

137. "Insanity acquittee" is someone who has been convicted of a crime, but not held criminally responsible due to proof of mental illness. *Wisconsin v. Randall*, 532 N.W.2d 94, 96 n.2 (Wisc. 1995).

138. *Foucha*, 504 U.S. at 75-83.

139. *See id.* at 77, 82-83.

140. *Id.* at 83.

141. *Id.* at 87-88 (O'Connor, J., concurring).

142. *See Randall*, 532 N.W.2d at 94; *Colorado v. Hilton*, 902 P.2d 883 (Colo. Ct. App. 1995).

143. *See Foucha*, 504 U.S. at 91 (Kennedy, J., dissenting); *id.* at 111 (Thomas, J., dissenting).

144. *See id.* at 75.

145. *Randall*, 532 N.W.2d at 94.

person's propensity for violence.<sup>146</sup> Ultimately, the court held that an insanity *acquittee* may be held in an institution as long as he/she is still dangerous, to the extent the time does not exceed the maximum time that could have been imposed if the *acquittee* had been sentenced to prison.<sup>147</sup>

Cases from both Colorado<sup>148</sup> and California<sup>149</sup> essentially included antisocial personality as a mental disorder. The courts, therefore, could justify the continuing detention of individuals based on the fact that their personality disorder rendered them a danger to society. This raises serious questions about what disorders fall under the purview of an insanity defense, but this was not discussed in these cases.

Ethical implications here mirror a large number of the earlier discussions having to do with the basis for scientific and professional judgment<sup>150</sup> and the misuse of psychologists' influence and work.<sup>151</sup> However, most critical from an ethical point of view are Standards 2.01(b) and 7.02(a)-(c).<sup>152</sup> That is, the entire area of assessment of violent behavior and the appropriate use of assessment tools for that purpose come into play here.

In the past two decades, there have been dramatic advances in the methodology used to assess the potential for violent behavior. It is clearly beyond the scope of this paper to review this voluminous literature, but a summary statement indicates that enough research has now developed to help delineate the various risk factors associated with violent behavior. This has largely been accomplished under the auspices of the MacArthur Foundation.<sup>153</sup> Never before have there been such carefully controlled studies.

146. *Id.* at 106.

147. *See id.* at 96.

148. *See Hilton*, 902 P.2d at 883. In *Hilton*, psychiatrists evaluated defendant and determined that he had "'antisocial personality disorder, severe' which he characterized as being an abnormal mental condition." *Id.* at 885. The doctor further concluded that the "condition is associated with instances of dangerous criminal behavior." *Id.* The defendant argued that his condition did not come within the statutory definition of "abnormal mental condition" and therefore the state must release him. *Id.* Ultimately, the court construed "'abnormal mental condition' . . . to include a severe antisocial personality disorder . . . [regardless of how] such a disorder is manifested." *Id.*

149. *See People v. Superior Court (Williams)*, 284 Cal. Rptr. 601 (Cal. Ct. App. 1991). In *Williams*, four different psychotherapists testified that defendant "suffered from a mental disorder which caused [defendant] to present a substantial danger of physical harm to others." *Id.* at 604. They diagnosed defendant with "antisocial personality disorder" using the criteria stated in DSM-III-R. *Id.* The appellate court pointed out that the criteria for extending commitment includes mental disorder and is not limited to "mental disease or defect" which is the test for insanity. *Id.* at 609. The court ultimately concluded that antisocial personality disorder may be evidence of mental disorder, so long as the diagnosis is based on more than just repeated criminal or other antisocial behavior. *See id.* at 609-10.

150. *See Ethical Principles*, *supra* note 1, § 1.06.

151. *Id.* §§ 1.15, 1.16.

152. *See id.* §§ 2.01(b), 7.02(a)-(c).

153. The MacArthur Foundation has been funding research in mental health law for approximately the last decade. In addition to the Risk Assessment Project, it currently funds work on competency and a variety of other psycho-legal areas.

Many books and monographs, as well as articles, have emerged from this research, most notably the volume by Monahan and Steadman entitled *Violence and Mental Disorder*.<sup>154</sup> Essentially this creates a "standard of care" for the assessment of violent behavior. In other words, in order to comply with the *Ethical Principles* requiring the grounding of opinions in established scientific principles and research,<sup>155</sup> and having opinions based in techniques sufficient to provide adequate substantiation for the conclusions,<sup>156</sup> one would need to look to this research to determine the risk factors that need to be assessed before undertaking an evaluation of potential for violent behavior.<sup>157</sup>

Clearly, the other half of the standard, the mental illness aspect, requires equally careful documentation, though this has been far more adequately explicated in the past. In essence, in order to determine whether an individual suffers from a mental illness and whether that mental illness in any way contributes to the person's potential for violence, one must carefully review all of the recent literature surrounding risk assessment and tailor her/his conclusions in light of those findings. According to this research, certain mental disorders, but by no means all, represent a moderate risk factor.

Psychologists who are called upon to render such conclusions must avail themselves of the many training opportunities in these areas. Guideline 3(A) of the *Specialty Guidelines* talks about the provision of services "only in areas of psychology in which they have specialized knowledge, skill, experience, and education."<sup>158</sup> In addition, prior to contracting with a legal representative of the party seeking services, the psychologist has to inform parties of "the known scientific bases and limitations of the methods and procedures that they employ and their qualifications to employ such methods and procedures."<sup>159</sup> In many circumstances, psychologists will be asked to render opinions for which they are not qualified by virtue of their experience and training, or will be asked to render opinions in areas in which scientific literature does not exist. Ethically, the psychologist must decline participation in such proceedings. Guideline 6(A) speaks about the

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154. JOHN MONAHAN AND HENRY J. STEADMAN, *VIOLENCE AND MENTAL DISORDER* (1994). In their book, Monahan and Steadman identify four "domains" of risk factors: (1) Dispositional (2) Clinical (3) Historical and (4) Contextual. *See id.* at vii. Dispositional risk factors include "anger, impulsiveness, psychopathy and personality disorders." *Id.* Clinical risk factors include "mental disorders, substance abuse . . . delusions and hallucinations." *Id.* Historical risk factors include events in the past which "predispose" defendant to violence. *Id.* at 227. Contextual risk factors refer to "aspects of [defendants'] current environment that may be conducive to . . . violent behavior." *Id.*

155. *Ethical Principles*, *supra* note 1, § 1.06.

156. *See Ethical Principles*, *supra* note 1, §§ 2.01(b), 7.02(a).

157. Note also that Standard 1.05 also requires psychologists to stay current on scientific and professional information in their fields of activity. *See id.* § 1.05.

158. *Specialty Guidelines*, *supra* note 2, § 3(A).

159. *See id.* § 4(A).

psychologist's obligation to use acquired knowledge "consistent with accepted clinical and scientific standards, in selecting data collection methods and procedures for an evaluation, treatment, consultation or scholarly/empirical investigation."<sup>160</sup> Finally, because assessment of violent behavior so often becomes a "high profile" issue in the media, psychologists must act in accordance with Guideline 7(C), which prescribes avoiding out-of-court statements, but "[w]hen there is a strong justification to do so, such public statements are designed to assure accurate representation of their role or their evidence, not to advocate the positions of parties in the legal proceeding."<sup>161</sup> In other words, if there are misstatements regarding the psychologist's role or testimony, the psychologist must make statements in order to ensure that his/her role or scientific evidence is accurately presented.

## VI. MENTAL DISORDER V. MENTAL ILLNESS: *KANSAS V. HENDRICKS*<sup>162</sup>

In June 1997, the Supreme Court upheld a Kansas law providing for the involuntary civil commitment of "sexual predators" following the completion of their prison sentences in *Kansas v. Hendricks*.<sup>163</sup>

Hendricks had served ten years in a state prison facility and was scheduled to be released to a halfway house in 1994.<sup>164</sup> He originally had been convicted of sexual molestation of minors.<sup>165</sup> Kansas had recently enacted a Sexually Violent Predator Act, and instead of releasing Hendricks sought to apply this Act.<sup>166</sup> The Act established an involuntary commitment procedure for "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."<sup>167</sup>

What distinguishes this from a typical civil commitment statute is that the typical statute requires "mental illness"; but the new statute refers to "mental abnormality or personality disorder" and essentially opens the floodgates to every conceivable diagnosis, including conditions which are largely regarded as untreatable. "Mental abnormality" was defined in the Kansas statute as "[a] congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to commit sexually violent offenses in a degree constituting such a person a menace to the health and safety of others."<sup>168</sup> At the time that a "sexually violent offender"

160. *Id.* § 6(A).

161. *Id.* § 7(C).

162. *Kansas v. Hendricks*, 117 S. Ct. 2072 (1997).

163. *Id.* at 2086.

164. *See id.* at 2078.

165. *See id.*

166. KAN. STAT. ANN. § 59-29a02(a) (1996).

167. *Id.* at 2077 (quoting KAN. STAT. ANN. § 59-29a02(a)).

168. *Id.* (quoting KAN. STAT. ANN. § 59-29a02(b)).



is to be released from prison, a petition is filed requesting an evaluation, and a mental health professional conducts the evaluation to determine whether the person is a violent sexual offender.<sup>169</sup> The level of proof in these cases is the most extreme one: "beyond a reasonable doubt."<sup>170</sup> If there is a finding at a subsequent trial that the person is a violent sexual offender, he/she can then be committed until such time as the mental abnormality or personality disorder has been so altered that the person can be released safely.<sup>171</sup>

The Supreme Court rejected Hendricks' claims that the statute violated due process and that he was being punished twice for the same crime.<sup>172</sup> In rejecting these claims, the Court held that the "mental abnormality" definition met due process requirements for a civil commitment procedure.<sup>173</sup> Whether the Sexually Violent Predator Act constituted double jeopardy hinged on the issue of whether the procedures provided in the Act constituted a civil commitment procedure. If so, there would be no double jeopardy. However, if the Act was a punitive or criminal statute, there would be double jeopardy.<sup>174</sup> A very close split of the Court (5-4) indicated the majority believed that it was a civil procedure.<sup>175</sup>

As noted in Justice Burger's dissenting opinion, a disturbing aspect of the Kansas statute was that Kansas, and other states who might enact similar statutes, could fail to provide the necessary treatment.<sup>176</sup> In other words, this form of involuntary commitment could be pursued even if no treatment for the condition were available. The purpose of the confinement, in other words, would be the prevention of antisocial behavior, rather than any treatment of the individual concerned. Justice Kennedy, in fact, cautioned about the misuse of civil commitment, especially when the purpose of the confinement is unrelated to the provision of treatment but rather is only for the protection of the public from a potentially dangerous person.<sup>177</sup> Notably, many earlier "sexual psychopath laws" had been found unconstitutional and this appears to be a new way of reinstating the old laws. Again, from an ethical point of view, the Court assumes that mental health professionals possess the expertise to predict future violent behavior and violent sexually predatory behavior.

Also of some interest is the extension of this statute to allow for the civil commitment of individuals with personality disorders, where, as noted

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169. *Id.*

170. *Id.*

171. *See id.*

172. *See id.* at 2081. The 5th Amendment of the U.S. Constitution protects defendants from being prosecuted twice for the same crime. This is known as "double jeopardy." BLACK'S LAW DICTIONARY 491 (6th ed. 1990).

173. *Kansas v. Hendricks*, 117 S. Ct. 2072, 2081 (1997).

174. *See id.* at 2081-82.

175. *See id.* at 2082.

176. *See id.* at 2088 (Burger, J., dissenting).

177. *See id.* at 2087 (Kennedy, J. concurring).

above in *Foucha*, the same Court suggested that a personality disorder was not an adequate basis for involuntary commitment.<sup>178</sup> Essentially, what the Kansas statute amounts to, and the Supreme Court has essentially sanctioned, is the continuing confinement of these individuals following service of their prison time, based on an assessment of future violent behavior.

Clearly, many ethical issues are involved here. As noted above, the need to be very precise in one's definitions following appropriate procedures in accord with the relevant standards of care and documenting procedures in terms of established scientific procedures are, as in *Foucha*, quite central. The ethical principle that appears to be most central here is Standard 1.04 (Boundaries of Competence) which urges psychologists to "provide services, teach, and conduct research only within the boundaries of their competence, based on their education, training, supervised experience or appropriate professional experience."<sup>179</sup> Additionally, in new areas, or in new techniques, psychologists can provide services only after first undertaking appropriate study, training, supervision, and consultation from people competent in these areas and techniques. In areas in which generally recognized standards do not yet exist, psychologists must "nevertheless take reasonable steps to ensure the competence of their work and to protect patients, clients, students, research participants and others from harm."<sup>180</sup>

In addition, Standard 1.06, which addresses a psychologist's need to "rely on scientifically and professionally derived knowledge when making scientific or professional judgments or when in engaging in scholarly or professional endeavors," becomes quite central here.<sup>181</sup> For example, the area of assessment of the potential for sexual acting-out is very much in its infancy and there is little consensus. Conceivably, a psychologist who is called upon to provide services in such a setting would be practicing out of the bounds of her/his competence when attempting to provide treatment for a condition for which there is no consensus as to its appropriate treatment.

Standard 4.02 (Informed Consent to Therapy) is also clearly relevant as the individual's right to refuse treatment can become a very troubling issue.<sup>182</sup> Finally, once again, the issue of informed consent in the assessment procedure can pose many thorny dilemmas for a psychologist who is asked to perform the evaluation to determine whether a given individual is a violent sexual predator.<sup>183</sup> Part of the informed consent would need to include information to the effect that the purpose of the evaluation is to help determine whether the individual needs to be involuntarily confined following the expiration of the prison term. It is unlikely under such circumstances that an inmate would consent to a full psychological evaluation. In a sense,

178. *Foucha v. Louisiana*, 504 U.S. 71, 77, 82-83.

179. *Ethical Principles*, *supra* note 1, § 1.04.

180. *Id.*

181. *Id.* § 1.06.

182. *Id.* § 4.02.

183. *See id.* § 1.07.

this may provide a “self-limiting mechanism” very similar to that discussed in the previous analysis of *Ford v. Wainwright*.<sup>184</sup> In essence, when provided a fully informed consent, the inmate may well refuse to participate in the evaluation and the psychologist can then ethically state that he/she cannot render any final opinion due to the inmate’s lack of cooperation. Under such circumstances, it may well be that only individuals with extreme and repetitive violent sexually predatory behavior could be committed under the scheme. It remains an open question whether, if the psychologist cannot provide an opinion due to limitations regarding the validity and reliability of the data, the commitment trial could proceed at all.

## VII. CONCLUSION

In summary, I have outlined some major ethical issues raised by recent Supreme Court decisions. This analysis, of course, has not exhausted all decisions of the Supreme Court involving mental health professionals. There are several where the issues are fairly straightforward and do not raise troubling ethical concerns. This analysis and summary has restricted itself to only those cases where such issues are of concern.

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184. *See supra* Part IV.