Supreme Court Decision Ends Juvenile Executions

The U.S., Iran, and the Democratic Republic of the Congo were the only countries to execute juveniles.

BY DAVID STERNBERG
Contributing Writer

Psychiatrists across the country, having argued for years that adolescents' brains function differently from those of adults, applauded last month's Supreme Court ruling that abolished juvenile executions.

In a 5-4 vote, the court concluded that the death penalty for minors—those under 18 at the time they committed the crime—was unconstitutional and represented cruel and unusual punishment.

"I am pleased and quite happy with the court's decision," said David Fassler, M.D., a child and adolescent psychiatrist in Burlington, Vt. "The decision is a reinforcement of what we all know in the psychiatric community—that the brains of adolescents function differently [from those of] adults."

Cynthia Pfeffer, M.D., a child psychiatrist at New York–Presbyterian Hospital, agreed.

"I think the court took a developmental view, which was very appropriate. From the perspective of development, children and adolescents are not the same as adults regarding neurobiological development," she said.

Brain-development differences between adolescents and adults, say many child and adolescent psychiatrists, affect judgment, behavior, impulse control, and decision-making ability. Teens, with their still-maturing brains, rely more on impulsivity than rational and goal-oriented thought.

"Adolescents are still capable of change; their future behaviors are not yet fixed," Dr. Fassler said. "It's important to remember that adolescents know the difference between right and wrong. But when it comes to capital punishment, it should be reserved for fully functioning and developed adults with a greater capacity to control and modify their behavior."

Dr. Fassler, also of the University of Vermont, said he was pleased the medical community spoke with a unified voice on the issue.

Last October, Dr. Fassler was one of many attending the oral arguments on this case in front of the Supreme Court.

Several organizations, including the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the American Society of Adolescent Psychiatry, and the National Mental Health Association, have long opposed the death penalty for juvenile offenders.

The United States had been one of only three countries to maintain the practice of executing juvenile offenders; Iran and the Democratic Republic of the Congo are the others.

Last month's decision means 72 juvenile offenders on death rows in 12 states will be resentenced. Prior to last month, 20 states allowed executions of juvenile offenders. Since 1973, 22 juvenile offenders have been executed.

The ruling will also prohibit execution of defendants in pending cases, including then–17-year-old Lee Boyd Malvo, who, along with John Allen Muhammad, is responsible for killing 10 people in the Washington, D.C., area in October 2002. He will spend the remainder of his life in prison.

The high court decision overturned a 1989 ruling upholding the death penalty for 16- and 17-year-old offenders.

The impetus for the Supreme Court's new ruling was the case of *Roper v. Simmons*. In 1993, Christopher Simmons, then 17, and two younger accomplices broke into a neighbor's home, intending to burglarize it. When the neighbor, Shirley Crook, awoke and recognized him, Mr. Simmons tied her up, put duct tape over her eyes and mouth, put her in a minivan and threw her off a railroad bridge south of St. Louis. Crook drowned in the waters below.

The medical community spoke with a unified voice on the issue.

DR. FASSLER

Prosecutors described the crime as "wantonly vile, horrible, and inhuman," and the jury sentenced Mr. Simmons to die. Two years ago, Missouri's highest court overturned that sentence because of Mr. Simmons' age at the time of the crime, forcing the Supreme Court to revisit the issue.

"From a moral standpoint, it would be misguided to equate the failings of a minor with those of an adult, for a greater possibility exists that a minor's character deficiencies will be reformed," wrote Justice Anthony A. Kennedy.

Justices John Paul Stevens, David H. Souter, Ruth Bader Ginsburg, and Stephen G. Breyer joined Justice Anthony A. Kennedy's opinion setting 18 years as the minimum age for capital punishment. In addition to their arguments about brain development, they noted that in nearly every state, 18 is the minimum age for voting, serving on juries, and obtaining marriage licenses without parental permission.

Texas' juvenile offenders may be the biggest beneficiary of the court's ruling. Of the 72 juvenile defenders on death row, by far the largest number (29) is in Texas, a fact not lost on Christopher R. Thomas, M.D., professor of child and adolescent psychiatry at the University of Texas, Galveston. He said a lot of people think the ruling will spark an increase in juvenile violence. But states that have decided to abolish juvenile executions have not seen an increase in violent crimes among juveniles, said Dr. Thomas, who is also the chair of the rights and legal matters committee at the American Academy of Child and Adolescent Psychiatrists.

Lee Haller, M.D., who teaches forensic psychiatry at Children's Hospital in Washington and maintains a private practice in Potomac, Md., noted that "there is simply no evidence that executing juveniles does anything to act as a deterrent to crime."

Early intervention and greater access to mental health services, not the death penalty, say psychiatrists, are what's needed for juvenile offenders.

Dr. Haller suggests comprehensive or "wraparound" services—psychotropic medication, behavioral therapy, and case management—as an early intervention for children and adolescents. Specifically, he noted the importance of groups that teach social skills, anger management, and impulse control. Dr. Thomas acknowledged the importance of gang prevention and substance abuse counseling. ■

Medicare Part D Benefit May Facilitate Formulary Appeals

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

WASHINGTON — Patients may find it easier to appeal denials of payment for medications under Medicare's new Part D prescription drug benefit than they do under other health programs, an analyst said during a meeting of the Medicare Payment Advisory Commission.

Specifically, the new benefit offers quicker alternatives to getting formulary exceptions for nonpreferred drugs than private plans or Medicaid, said Joan Sokolovsky, Ph.D., a MedPAC senior analyst. The new prescription drug benefit, a part of the Medicare Modernization Act of 2003, goes into effect in January.

MedPAC analysts reviewed the appeals processes in several private plans and in Medicaid to see how they compare with the upcoming Part D prescription drug benefit. The commission queried a number of stakeholders in these markets, including physicians, pharmacists, consumer advocates, health plan representatives, and pharmacy benefit manager representatives.

While Medicare's regulations on appeals generally support the processes of Medicaid and private health plans, MedPAC did find some fundamental differences, Dr. Sokolovsky said.

More situations are considered "coverage determinations" under the Part D benefit and may be appealed, she said. For example, Medicare beneficiaries will be able to appeal an increased copayment if they are prescribed a nonpreferred drug as opposed to a preferred drug. Dr. Sokolovsky said that private plans reported having little experience with this kind of adjustment.

'If under an urgent request for an exception, a [Medicare Part D] plan must handle these determinations within 24 hours.'

The time frame for handling exception requests is also shorter under Part D, Dr. Sokolovsky continued. "If under an urgent request for an exception, a [Medicare Part D] plan must handle these determinations within 24 hours. That's typically faster than required for most [private insurers] now."

Shorter, expedited time frames and the ability to appeal copays, however, may lead to an increased volume of appeals, and possibly higher premiums, she said.

To minimize appeals, Medicare Part D plans may put fewer restrictions on separate, tiered cost sharing on nonpreferred drugs. "Good communication is important to prevent an excessive increase in appeals," she said.

In some cases, physicians under Part D must get prior approval or authorization before nonpreferred drugs are covered.

From its interviews with stakeholders, MedPAC learned that prior authorization often creates burdens for both beneficiaries and providers in commercial and Medicaid plans.

Prior authorization should ideally take place before the prescription is written—but often doesn't, Dr. Sokolovsky said.

"Physicians frequently don't know what the drugs are on their patients' formularies, or which ones require prior authorization." Patients often become aware of the need for prior authorization when the pharmacist tries to process the prescription and gets a notice that the drug is not covered, but lists other drugs that would be covered.

Private health plans tend to keep detailed information on the disposition of exception requests; however, some information never comes back to a plan, she said.

For example, the private plans MedPAC surveyed didn't seem to know how often a beneficiary paid out of pocket for a drug when the drug was not covered, how often pharmacists contact physicians or the plan member when a drug isn't covered, or if the physician even had time to respond to the situation.

One physician whom MedPAC analysts surveyed reported that his practice spends several hours a day trying to resolve prior authorization matters.

Private plans have tried to minimize this burden by educating their members and physicians about their formularies.

"Some plans deal with the burden by simply placing fewer drugs on prior authorization," she said. ■