

DISTRICT OF COLUMBIA COURT OF APPEALS

In the Matter of OLLIE BRYANT

86-1528
87-354

BRIEF AMICUS CURIAE OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION
ON BEHALF OF APPELLANT OLLIE BRYANT

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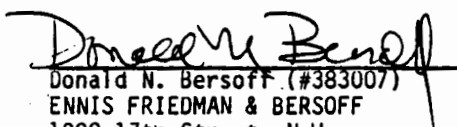
Dated: June 24, 1987

CERTIFICATE REQUIRED BY RULE 28 (a) (1)
OF THE RULES OF THE DISTRICT OF
COLUMBIA COURT OF APPEALS

The undersigned, counsel for amicus American Psychological Association, certifies that the following listed parties appeared below: Ollie Bryant, appellant in the proceedings before this court, and St. Elizabeth's Hospital, appellee in the proceedings before this court.

These representations are made in order that judges of this court, inter alia, may evaluate possible disqualification or recusal.

Respectfully Submitted,


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INTEREST OF AMICUS CURIAE

The American Psychological Association, a voluntary, non-profit, scientific and professional organization with more than 60,000 members, has been the major association of psychologists in the United States since 1892. Its purpose, as reflected in its Bylaws, is "to advance psychology as a science and profession, and as a means of promoting human welfare."

Association members have a direct interest in the questions at issue in this case. The Division of Clinical Psychology is comprised of nearly 5,000 psychologists, many of whom provide professional services at in-patient mental institutions. The Division of Psychopharmacology, with over 1,000 members, concerns itself with research into the uses of psychotropic drugs such as those at issue in this case. Other Divisions with a direct interest in the case include the Society for the Psychological Study of Social Issues, with over 2,500 members, and the Division of Psychology and Law, with over 500 members.

This case raises questions vital to the interests of both users and providers of psychological services. The circumstances under which psychotropic drugs can be administered to institutionalized patients over their objections are matters of serious concern to both research and clinical psychologists. Psychologists also have an ethical and therapeutic interest in ensuring that persons who are involuntarily committed to mental hospitals are provided with treatment that is both effective and consistent with human dignity and autonomy. The American Psychological Association has submitted amicus briefs addressing the issues these questions to the United States Supreme Court in Mills v. Rogers, 457 U.S. 291 (1982), to the New York Court of Appeals in Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337 (1986), and the Supreme Judicial Court of Massachusetts in Rogers v. Commissioner of Mental Health, 390 Mass. 489, 458 N.E.2d 308 (1983).

The parties have consented to the filing of this brief amicus curiae. Letters of consent have been obtained and are on file with the Clerk of this Court.

STATEMENT OF ISSUE PRESENTED

This case squarely presents the important and controversial issue whether common law principles and the federal constitution prohibit a hospital or other treatment facility -- in the absence of an emergency -- from forcibly administering psychotropic drugs^{1/} to persons involuntarily hospitalized for treatment of mental illness.

STATEMENT OF THE CASE

Appellant Ollie Bryant is an older woman with a long history of mental illness, diagnosed as paranoid schizophrenia. This condition has required repeated periods of treatment at Saint Elizabeth's Hospital ("St. Elizabeth's") since 1957, some voluntary and some involuntary. But Bryant has also lived much of her life in the community. During hospitalizations, Bryant was usually treated with psychotropic medications such as thorazine. The need for frequent readmission was apparently occasioned by Bryant's refusal to take prescribed psychotropic drugs when she was not under hospital supervision, although she apparently took such medication without objection during some periods of her life. The record in this case contains no evidence that Bryant was ever adjudged mentally incompetent during this period. Superior Court Opinion ("Sup.Ct. Op.") at 1-4.

On December 6, 1985, Bryant was involuntarily brought to St. Elizabeth's pursuant to an emergency application submitted by the D.C. Department of Human Services under the terms of D.C. Code § 21-521. Involuntary hospitalization proceedings before the D.C. Commission on Mental Health were commenced pursuant to the terms of D.C. Code §§ 21-541 to 21-544.

^{1/} Three groups of drugs are principally used to treat patients with mental disorders: (1) sedative agents; (2) antidepressants; and (3) psychotropic agents. The first group is normally prescribed for neurotic disorders; the second group for depressive disorders; and the third group for psychotic disorders, especially schizophrenia. Psychotropic simply means "exerting an effect on the mind." Dorland's Pocket Medical Dictionary. The types of psychotropic drugs at issue in this case are known as "antipsychotic" or "neuroleptic" drugs. Common antipsychotic drugs include Thorazine (chlorpromazine), Stelazine (trifluoperazine), Trilafon (perphenazine), Mellaril (thioridazine), Prolixin (fluphenazine), Navine (thiothexene), and Haldol (haloperidol). This brief refers to this class of medications as "psychotropic" or "antipsychotic" drugs.

After a hearing, the Commission recommended on February 27, 1986, that Bryant be hospitalized because she was a danger to herself and others and needed psychotropic medication to function in the community. The Superior Court reviewed this determination pursuant to D.C. Code § 21-545. On May 9, 1986, the Court found Bryant to be mentally ill and dangerous to herself and others if allowed to remain at liberty, and ordered her committed for an indefinite period. Sup.Ct. Op. at 4. On April 1, 1986, in a separate proceeding, the Superior Court appointed a conservator to manage Bryant's property pursuant to D.C. Code § 21-1501.

While Bryant was hospitalized pursuant to the emergency application, but before any finding that she was incompetent or mentally ill, attending physicians prescribed psychotropic medication. Bryant refused the medication. Upon approval from the medical director of the hospital division charged with Bryant's treatment, the drugs were administered to her against her will during the periods December 12, 1985 to January 12, 1986, February 26, 1986 to March 26, 1986, and on April 1, 1986. Bryant's attorney moved for a protective order prohibiting the involuntary administration of the drugs. An order of the Superior Court temporarily enjoined administration of the drugs after April 1st.

On April 9, 1986, after a hearing, the Superior Court found Bryant incompetent to make treatment decisions, but declined to lift the prohibition of administration of psychotropic medication pending final resolution of the case. On October 13, 1986, the Superior Court rendered a final decision denying the motion for a protective order. Although the court had previously found Bryant incompetent to make treatment decisions, the court believed that this Court's decision in In re Boyd, 403 A.2d 744 (1979), required further analysis. Boyd holds that if an incompetent, involuntarily committed patient refuses medication on the basis of religious belief -- and an emergency is not present -- the First Amendment guarantee of free exercise of religion prohibits forcible administration unless a reviewing court determines that the patient would not have refused the treatment for religious reasons if competent. Boyd thus requires courts to undertake a "substituted judgment"

analysis to determine whether a patient has a valid First Amendment right to refuse treatment. See Point III. infra. In the present case, the court found that Bryant's refusal to take medication was based not on bona fide religious belief, but on delusions that she was God. Sup.Ct. Op. at 18-19.

Because Boyd had instructed courts in "less clear situations" to look to "the nature, intensity and longevity of the patient's objection . . . , the intrusiveness and side effects of the proposed treatment, and the likelihood of cure or improvement with or without such treatment," 403 A.2d at 751, the court went on to conduct what superficially appeared to be a broad a "substituted judgment" determination. Although Bryant had often objected to psychotropic medications, the court dismissed the significance of this pattern of conduct on the ground that Bryant had been incompetent for her entire adult life; this finding was made notwithstanding the court's prior recognition that Bryant had never been found incompetent prior to 1986. The court then accepted psychiatric testimony suggesting that psychotropic medication might significantly improve Bryant's condition and enable her to live in the community. After recognizing that Bryant was at a particularly high risk of developing a painful and disabling side effect of psychotropic drugs -- tardive dyskinesia, see Point II.A. infra -- the court nonetheless concluded that Bryant, if competent, would have accepted treatment with psychotropic drugs. See Sup.Ct. Op. at 15-18.^{2/}

But the court was careful to take back with one hand the substituted judgment determination which it appeared to have granted Bryant with the

^{2/} In no respect does the court's purported "substituted judgment" analysis eliminate the need to decide the issues presented on this appeal. See Point V infra. First, that analysis was directed only toward the narrow issue whether Bryant had a valid religious objection to treatment and not to the broader question whether Bryant had a valid nonreligious objection. Second, Appellant has demonstrated factual errors and procedural flaws that fatally undermine the accuracy of the trial court's conclusion. Third, the trial court made a crucial error in discounting Bryant's lifelong pattern of objection to psychotropic drugs; the court simply presumed Bryant to have been incompetent during virtually her entire adult life despite the facts that she lived most of that life in the community, she had never been adjudged incompetent prior to 1986, and the court had received no evidence whatsoever concerning Bryant's mental state during prior periods in which she had refused psychotropic medication.

other. Seeking to truncate any right Bryant might have to refuse psychotropic drugs, and rendering superfluous the entirety of the purported "substituted judgment" analysis, the court stated that "its ruling in this case does not constitute a determination . . . that a committed patient's objection to psychotropic medication requires a judicial determination of competency and 'substituted judgment' when non-religious objections are the basis for a patient's refusal." Id. at 19. Having refused to recognize Bryant's substantive right to refuse psychotropic drugs, the court went on to hold that neither "the common law of our jurisdiction [n]or the United States Constitution requires judicial proceedings . . . to resolve a committed patient's nonreligious refusal of psychiatric treatment." Id. at 22. Accordingly, the court denied the motion for a protective order.

The court refused to recognize Bryant's common law and constitutional claims of right, notwithstanding: (i) this Court's clear statement in Boyd that the substituted judgment "approach is sound, whether religious or other factors are involved, for it is the only way to pay full respect to the individuality and dignity of a person," 403 A.2d at 750 (emphasis added); (ii) the Supreme Court's assumption that such a right exists, Mills v. Rogers, 457 U.S. 291 (1982); and (iii) the explicit recognition of such a right in the lower courts of most jurisdictions, see Point II infra, including the District of Columbia Superior Court, see In the Matter of J.O.J., 108 D.W.L.R. 1017 (Feb. 29, 1980) (cited in Sup.Ct. Op. at 20 n.10).

The court thus held that, apart from a religious-based objection, an involuntarily committed mental patient -- whether competent or incompetent -- has no substantive or procedural rights with respect to the forced administration of psychotropic medication. Under this ruling, the government's parens patriae power permits hospital officials to administer psychotropic or other medications -- or presumably to apply any psychosurgical or other medical procedure -- whenever those officials believed the medication or procedure to be in the best interest of the patient. And under this ruling, a competent person who executed a living will expressing the desire never to be medicated with psychotropic drugs -- or to undergo other intrusive

procedures -- would, upon involuntary commitment, have no substantive or procedural right to have that living will respected if hospital officials decided to override it.

SUMMARY OF ARGUMENT

At issue in this case are the principles of individual autonomy and dignity -- the right of each individual to decide how to live and what types of intrusions to permit upon bodily integrity. If these principles mean anything, they mean that our society is committed to allowing each individual to choose his or her own fate -- even if choices the individual makes are not, in some objective sense, in his or her best interests.

The forcible administration of psychotropic drugs threatens these principles. Although psychotropic drugs can provide great benefits to persons suffering from mental illness, these medications also pose the risk of side effects some of which are severe. The most dangerous and debilitating of these side effects is tardive dyskinesia, a condition characterized by involuntary movements of the tongue, lips, jaw, hands, legs, back, neck, pelvis, and -- in severe form -- interference with all motor activity, including breathing, swallowing and speaking. (Point I.A.). In light of the risks of such side effects, and the literal "mind altering" effect of the drugs, basic principles of autonomy and dignity can be fundamentally infringed when the government administers psychotropic drugs against the will of a patient. (Point I.B).

These basic rights to personal autonomy and dignity are protected under the common law of the District of Columbia (Point II.A.) and under the Constitution of the United States (Point II.B.). Amicus will show that, absent an emergency, these rights absolutely prohibit the government from forcibly administering psychotropic drugs to an involuntarily committed patient unless the patient is incompetent to make treatment decisions. The decision to commit a patient involuntarily is by no means equivalent to either a determination that the patient is incompetent to make the treatment decision, or to a finding that the government's interests in treatment are so

compelling as to justify the forcible administration of psychotropic drugs whenever an attending physician thinks such treatment is warranted. (Point II.C.).

Amicus will also show that even if a patient has been adjudged incompetent, common law and constitutional rights to personal dignity and autonomy still prohibit the forcible administration of psychotropic drugs unless the patient would have consented to treatment if competent. Persons adjudged incompetent do not thereby forfeit their rights. O'Connor v. Donaldson, 422 U.S. 563 (1975). The "substituted judgment" standard looks not to the best interest of the patient in some objective sense, but rather asks what the patient would consider in his or her best interests if competent to decide. This approach reflects and implements the principles of personal autonomy and dignity because it attempts to approximate as closely as possible the individual's own values and preferences: it "commends itself simply because of its straightforward respect for the integrity and autonomy of the individual." Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 751, 370 N.E.2d 417, 431 (1977). (Point III.). No other governmental interest justifies forcible medication. (Point IV.). Furthermore, adequate protection of the patient's rights requires the procedural safeguard of a judicial determination of both competency and substituted judgment. These decisions are fundamentally legal -- and not medical -- in nature, and cannot safely be left to the judgment of the treating physician, however well-intentioned that physician might be. (Point V.).

The Superior Court wholly failed to acknowledge these common law and constitutional rights in the present case. In its opinion, the court explicitly declined to recognize Bryant's common law and constitutional right to refuse treatment. The court also sanctioned the forcible administration of psychotropic drugs to Bryant during the period prior to any judicial determination that Bryant was incompetent to make treatment decisions. And the court's purported "substituted judgment" determination cannot justify the forced medication of Bryant after the finding of incompetency. This finding

-- a necessary predicate for any order permitting forced medication absent an emergency -- was wholly inadequate. In any event, the purported "substituted judgment" determination was directed only toward determining whether Bryant would have refused psychotropic drugs for religious reasons. The court specifically disavowed any intention to extend the "substituted judgment" test to protect Bryant's common law and constitutional rights to be free of forcible administration of psychotropic drugs. The court's opinion should therefore be reversed and remanded for further proceedings consistent with properly applicable substantive and procedural protections guaranteed to the involuntarily hospitalized. (Point VI).

ARGUMENT

I. ANTIPSYCHOTIC DRUGS ARE HIGHLY BENEFICIAL FOR MANY PATIENTS, BUT THEY ALSO HAVE SUBSTANTIAL SIDE EFFECTS THAT IMPLICATE BASIC PRINCIPLES OF INDIVIDUAL AUTONOMY AND DIGNITY

A. Antipsychotic Drugs Benefit Many Patients But Also Pose Risks Of Substantial Side Effects.

For many patients, antipsychotic drugs provide significant benefits and are considered the treatment of choice. See, e.g., Cole & Davis, Clinical Efficacy of the Phenothiazines as Antipsychotic Drugs, in Public Health Service, Psychopharmacology: A Review of Progress 1957-1967 1057 (1968) at 1057-1063; Davis, Overview: Maintenance Therapy in Psychiatry: I. Schizophrenia, 132 Am. J. Psychiatry 1237 (1975); National Institute of Mental Health Psychopharmacology Service Center Collaborative Study Group, Phenothiazine Treatment in Acute Schizophrenia, 10 Arch. Gen. Psychiatry 246 (1964); Hogarty, et al., Drug and Sociotherapy in the Aftercare of Schizophrenic Patients, 31 Arch. Gen. Psychiatry 603 (1974). This Court -- after reviewing such evidence -- found that "[p]sychotropic drugs are considered more effective than any other form of treatment in reducing thought disorder in schizophrenics." In re Boyd, 403 A.2d at 752, n.13. See Davis v. Hubbard, 506 F. Supp. 915, 927 (N.D. Ohio 1980) ("it can at least be said that psychotropic drugs are an effective method of treating schizophrenic symptoms, and may thus enable patients to benefit from other types of therapy"). As the New York Court of Appeals recognized in Rivers v. Katz, the medical usefulness

of these drugs "stems from their ability to influence thought patterns so as to eliminate psychotic symptoms." 495 N.E. at 339 n.1.

Efficacious antipsychotic drugs also cause side effects, some of which are very serious. See Gaughan & LaRue, The Right of a Mental Patient to Refuse Antipsychotic Drugs in an Institution, 4 L. & Psychology Rev. 43, 51-52 (1978). Furthermore, the courts have uniformly recognized that clinicians cannot predict how helpful or harmful an antipsychotic drug will be for a particular patient.^{3/} Thus, it is difficult to predict with any certainty at the outset whether a particular patient will benefit from antipsychotic drugs and experience no adverse side effects, will benefit but will experience adverse side effects, will not benefit but will not experience adverse side effects, or will not benefit but will experience adverse side effects.

The side effects caused by antipsychotic drugs are well documented in the professional literature. See, e.g., Ayd, A Survey of Drug-Induced Extrapyramidal Reactions, 175 J.A.M.A. 1054 (1961); Crane, Clinical Psychopharmacology in its Twentieth Year, 181 Sci. 124 (1973); Kennedy, Hershon & McGuire, Extrapyramidal Disorders After Prolonged Phenothiazine Therapy, 118 Brit. J. Psychiatry 509 (1971); Modern Synopsis of Comprehensive Textbook of Psychiatry/II 943, 956-961 (A. Freedman, H. Kaplan & B. Sadock, eds. 1976); Zander, Prolixin Decanoate: A Review of the Research, reprinted in 2 Mental Disability L. R. 37 (July-Aug. 1977); Klein, Gittleman, Quitkin & Rifkin, Diagnosis and Drug Treatment of Psychiatric Disorders, 199-203 (2d ed. 1980); Rifkin, Quitkin & Klein, Akinesia: A Poorly Recognized Drug-Induced Extrapyramidal Behavioral Disorder, 32 Arch. Gen. Psychiatry 672 (1975); Davis, Antipsychotic Drugs, in 3 Comprehensive Textbook of Psychiatry/III 2257, 2281 (H. Kaplan, A. Freedman & B. Sadock, eds. 1980); and the authorities cited therein.

^{3/} E.g., Davis v. Hubbard, 506 F. Supp. at 927, 928, 934 n.23; In the Matter of the Guardianship of Richard Roe, III, 421 N.E.2d 40, 53 (Mass. 1981). See generally, Plotkin, Limiting The Therapeutic Orgy: Mental Patients' Right To Refuse Treatment, 72 Nw. U. L. Rev. 461, 474-475 (1977); Lehmann, Individual Differences in Response to Pharmacotherapy, in Psychotropic Drug Response: Advances In Prediction 18 (Wittenborn & May, eds., 1969); Ayd, Pre-treatment Prediction of Responsiveness To Chlorpromazine: Is It Possible?, 10 Int'l. Drug Therapy Newsletter 4 (1975).

The courts have also taken cognizance of these side effects. In Boyd, this Court catalogued a host of adverse side effects, including extra-pyramidal symptoms such as muscle spasms, irregular flexing, writhing or grimacing movements, and protrusion of the tongue (dystonic reactions), motor restlessness and inability to stay still (akathesia), and mask-like face, drooping, stiffness and rigidity, shuffling gait, and tremors (pseudo-parkinsonian syndrome). 403 A.2d at 752, n.13. The Boyd court also noted nonmuscular side effects that regularly result from psychotropic drugs, including drowsiness, dizziness, blurred vision, dry mouth and throat, "torn up" stomach, low blood pressure, skin rashes, constipation, and loss of sexual desire.

In a recent judicial review of the side effects of antipsychotic drugs, the Supreme Court of Colorado similarly noted:

Several types of side effects are associated with antipsychotic medications. Automatic nervous system effects include dryness of the mouth and throat, blurred vision, weight gain, dizziness, fainting, low blood pressure, urinary retention and constipation. A central nervous system effect associated with the medication is sedation, which may cause distress in patients who desire to feel alert and think clearly. Other effects include adverse behavioral problems, allergic reactions such as jaundice, agranulocytosis (a rarely occurring serious infection), skin discoloration, eye lesions, endocrine effects such as lactation and impotence, and, on rare occasions, sudden death. The most significant group of side effects, however, is the extrapyramidal effects. These are neuromuscular reactions of three types: parkinsonian syndrome (mask-like face, tremors, drooling, rigidity, shuffling gait, motor retardation, and an "ill-rilling" motion with one or both hands); akathesia (an inability to sit still or an irresistible desire to keep walking or tapping the feet); and dyskinesia (bizarre movements of the tongue, face, and neck).

See also Rivers v. Katz, 495 N.E. at 339 n.1; People v. Medina, 705 P.2d 961, 968 n.3 (Colo. 1985) (en banc).

Many of the side effects described above are both frightening and serious. But the most debilitating effect linked to antipsychotic drugs is tardive dyskinesia. The New York Court of Appeals in Rivers v. Katz described this condition as "potentially devastating." Id. Many other courts, including this Court in Boyd, have recognized its severity. In re Boyd, 403

A.2d at 752 n.13. The Supreme Court of Colorado, provided a detailed summary of tardive dyskinesia in People v. Medina:

With one exception, all of the common side effects of antipsychotic medications are short-lived, disappear if the dosage is lowered or the type of medication altered, or are treatable through the use of other medications, although these medications have their own associated side effects. The exception is a form of dyskinesia known as tardive dyskinesia. This condition produces involuntary movements of the tongue, lips, and jaw, which may include continual chewing and lip smacking motions and facial contortions. It may also be accompanied by involuntary movement of the fingers, hands, legs, back, neck, and pelvic area. In its most severe form, it may interfere with all motor activity, making speech, swallowing, and breathing extremely difficult. Tardive dyskinesia is of special concern for several reasons. First, its symptoms often do not appear until late in the course of treatment and sometimes not until after treatment is discontinued. Second, there is no known cure for the condition. Third, it is impossible to predict who will become a victim, aside from the tendency of the condition to affect patients on long-term high dosages of antipsychotic medications. Finally, the condition is fairly widespread, as studies have indicated that the condition occurs in 10-40% of patients receiving long-term, high-dosage treatment.

People v. Medina, 705 P.2d 961, 968, n.3 (Colo. 1985) (en banc) (citing Gutheil & Appelbaum, "Mind Control, "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication, 12 Hofstra L. Rev. 77, 109 (1983) (emphasis added)). See also Davis v. Hubbard, 506 F. Supp. at 928-929 (collecting authorities); H. Kaplan & B. Sadock, Modern Synopsis of Comprehensive Textbook of Psychiatry/III, supra, at 771-789.^{4/}

To date, tardive dyskinesia has resisted curative efforts, and its disabling manifestations may persist for years.^{5/} A recent literature

^{4/} See, to the same effect, In re Boyd, 403 A.2d at 752 n.13; Opinion of the Justices, 465 A.2d 484, 489 (N.H. 1983); and Anderson v. Arizona, 663 P.2d 570, 572 (Ariz. Ct. App. 1982).

^{5/} Although most authorities consider tardive dyskinesia to be a permanent condition, it may regress to some extent after discontinuation of treatment. Moreover, some studies have suggested that it can be treated in certain cases, particularly if it is a mild case or is detected early. Sovner, Dimascio, et al., Tardive Dyskinesia and Informed Consent, 19 Psychosomatics 172 (March 1978); Crane, Persistent Dyskinesias, 122 Br. J. Psychiatry 395-405 (1975); Jacobson & Baldessarini, Tardive and Withdrawal Dyskinesia Associated With Haloperidol, 131 Am. J. Psychiatry 534-35 (1975); Jus, Jus & Fontaine, Long Term Treatment of Tardive Dyskinesia, 40 J. Clin. Psychiatry 72 (1979); Quitkin, Rifkin & Gochfeld, Tardive Dyskinesia: Are First Signs Reversible?, 134 Am. J. Psychiatry 84-86 (1977). See Davis v. Hubbard, 506 F. Supp. at 929 n.16.

review, analyzing 56 studies, found an average prevalence of tardive dyskinesia of twenty percent in patients who had been treated with antipsychotic medication. Kane & Smith, Tardive Diskinesia: Prevalence and Risk Factors, 1959-1979, 39 Arch. Gen. Psychiatry 473 (1982). Some prevalence studies report much higher rates. For example, two prevalence studies indicate that the condition affects 50% to 56% of chronically hospitalized schizophrenics,^{6/} and a third prevalence study indicates that the condition affects 41% of all outpatients. Asnis, et al., A survey of tardive dyskinesia in psychiatric outpatients, 134 Am. J. Psychiatry 1367-1370 (1970). See Sovner, Dimascio, et al., Tardive Dyskinesia and Informed Consent, 19 Psychosomatics 172, 173 (March 1978); Davis v. Hubbard, 506 F. Supp. at 929.

Prevalence studies of hospitalized patients may, however, overstate the risk that a given patient will develop tardive dyskinesia. This type of study compares the number of patients treated with antipsychotic drugs in a hospital population who have developed tardive dyskinesia with the total number of patients treated with psychotropic drugs in that population at that time. Because patients who do have tardive dyskinesia may be more likely to remain hospitalized, and patients who have not developed tardive dyskinesia may be more likely to have been discharged, such prevalence studies may overestimate the risk that a newly admitted patient will develop tardive dyskinesia.

Incidence studies, by contrast, measure how many patients out of every 100 patients treated with antipsychotic drugs will develop tardive dyskinesia within a given time period. The incidence of tardive dyskinesia apparently increases with cumulative exposure to antipsychotic drugs. A major on-going study of the incidence of tardive dyskinesia has reported that the "overall TD [tardive dyskinesia] incidence . . . is 18.5% . . . following four

^{6/} Gardos & Cole, Drug Variables in the Etiology of Tardive Dyskinesia, 1 Prog. Neuro-Psychopharm. 147-54 (1977); Jus, et al., Epidemiology of Tardive Dyskinesia, Part 1, 37 Dis. Nerv. Syst. 210-14 (1976).

years of cumulative exposure . . . and 40% . . . following 7 years of exposure." Kane, et al., "Integrating Incidence and Prevalence of Tardive Dyskinesia", 22 Psychopharmacology Bull. 253, 254 (1986) (this study also reported that the "incidence of TD which persists for at least 3 months is 13% . . . at 4 years and 29% . . . at 8 years." Id.). See generally Kane, et al., "Incidence of Tardive Dyskinesia: Five Year Data From A Prospective Study", 20 Psychopharmacology Bull. 39 (1984); American Psychiatric Association Task Force Report #18, Tardive Dyskinesia, at 57 (estimating incidence of 10-40% in patients receiving long-term treatment).

The wide range of percentages, in both prevalence and incidence studies, is attributable in large part to the lack of "established or universally accepted criteria for the diagnosis" of tardive dyskinesia. Kane & Smith, supra, at 473. In addition, "many other neuromedical disorders produce a similar clinical picture," and prevalence and incidence vary markedly depending on the "symptom severity" required by the researcher to identify a "case." Id. Substantial progress has been made in defining the criteria for a diagnosis of tardive dyskinesia. See Schooler & Kane, "Research diagnoses for tardive dyskinesia (RD-TD)", 39 Arch. Gen. Psychiatry 486 (1982). It can be expected, therefore, that future studies will be able to establish the prevalence or incidence of tardive dyskinesia with greater precision than has so far been attained.

Unfortunately, despite increasing knowledge about tardive dyskinesia, accurate predictions as to who will develop the condition are not yet possible. As the American Psychiatric Association's Task Force on Tardive Dyskinesia reported in a July 1985 letter to the entire membership of that Association, "it is impossible at present to identify which patients are at risk," the "course of the condition is difficult to predict in individual patients," and there is "no established treatment for tardive dyskinesia." Accordingly, the Task Force recommended that the "benefits and risks of long-term neuroleptic treatment should be discussed with patients and families and their informed consent to treatment documented." Id. (emphasis added).

Because psychotropic drugs cause tardive dyskinesia (and other less severe but nevertheless serious and unpleasant side effects) in a very substantial percentage of patients treated with those drugs, the Supreme Judicial Court of Massachusetts found that "antipsychotic drugs are a high-risk treatment." In the Matter of the Guardianship of Richard Roe, III, 421 N.E.2d 40, 54 (Mass. 1981). Similarly, the Supreme Court of Colorado has found that "the administration of psychotropic medication is within the high risk category of treatment that requires consent or some other legal justification before it may be properly administered to a patient." People v. Medina, 705 P.2d at 969-970, n.4. As the court in Medina found:

Antipsychotic medications, either alone or in combination, can cause numerous and varied side effects and carry with them the risk of serious and possibly permanent disabilities in the patient. . . . The effects of these drugs can be far more debilitating to the patient than the physical restraint incident to the involuntary commitment process.^{7/}

Thus, antipsychotic drugs offer great benefit to many patients, but also pose a serious risk of debilitating side effects. Many researchers, including members of the Division of Psychopharmacology of the American Psychological Association, are studying ways to reduce the risks posed by antipsychotic drugs. But for now, the risks remain.

B. The Administration of Psychotropic Drugs Implicates Fundamental Interests In Human Dignity and Autonomy

Amicus has shown that psychotropic drugs pose a significant risk of producing uncomfortable, debilitating, and sometimes "potentially devastating"

^{7/} Id. at 968 (footnote omitted). Among the many cases concluding that antipsychotic drugs are high risk treatment are: Mills v. Rogers, 457 U.S. 291, 293 n.1 (1982); Rennie v. Klein, 653 F.2d 836, 843 & n.8 (3d Cir. 1981) (en banc), vacated, 458 U.S. 1119 (1982), on remand, 720 F.2d 266 (3d Cir. 1983) (en banc); Rogers v. Okin, 634 F.2d 650, 653 & n.1 (1st Cir. 1980), vacated sub nom. Mills v. Rogers, 457 U.S. 291 (1982); Davis v. Hubbard, 506 F. Supp. 915, 927-29 (N.D. Ohio 1980); Bee v. Greaves, 744 F.2d 1387, 1390-91, 1394 (10th Cir. 1984), cert. denied, 105 S. Ct. 1187 (1985); and Opinion of the Justices, 465 A.2d 484, 488 (N.H. 1983). See Scott v. Plante, 532 F.2d 939, 945 n.8 (3d Cir. 1976) (describing side effects).

Antipsychotic drugs are the only known cause of tardive dyskinesia. Indeed, a diagnosis of tardive dyskinesia is not permissible unless the patient has been given antipsychotic drugs.

physical side effects. Psychotropic drugs are also "mind altering." See Mills v. Rogers, 457 U.S. at 293 n.1. As the Supreme Judicial Court of Massachusetts observed, psychotropic drugs have a "profound effect . . . on the thought process of an individual. . . . [T]he impact of the chemicals upon the brain is sufficient to undermine the foundations of personality." Roe III, 421 N.E. at 53. Because psychotropic drugs hold the promise of dramatically alleviating the patient's suffering or controlling his symptoms, but also involve a risk of serious side effects, the decision whether to take such medication implicates core common law and constitutional principles protecting personal autonomy, physical and mental integrity, and human dignity.

Basic principles of personal autonomy and dignity are fundamentally threatened when the government seeks forcibly to invade an individual's bodily integrity and to change an individual's thought processes by administering powerful mind-altering drugs. The extreme difficulty of predicting when administration of the drugs will cause adverse side effects exacerbates the threat to fundamental interests; government's power to act is most restricted where, as here, the decision involved raises the possibility of serious risks to individual health and has no clear and predictable outcome in a particular case. Accordingly, this Court should ensure that such drugs are forcibly administered only when the government can meet a stringent burden of justification.

II. THE COMMON LAW OF THE DISTRICT OF COLUMBIA AND THE UNITED STATES CONSTITUTION RECOGNIZE THE RIGHT TO REFUSE PSYCHOTROPIC DRUGS.

As far as amicus is aware, every court to have considered the issue in the past decade has found that persons involuntarily hospitalized for mental illness have a right under certain circumstances to refuse psychotropic medication. Some courts have grounded this right in the common law doctrine of informed consent whereas others have grounded the right in various constitutional principles protecting personal autonomy and dignity. Both the common law of the District of Columbia and the United States Constitution guarantee the right to refuse psychotropic medication.

A. The Common Law Of The District Of Columbia Recognizes A Right To Refuse Psychotropic Drugs.

In re Boyd, 403 A.2d 744, makes clear that the District recognizes the common law's "traditional rule against imposing medical treatment on a competent person who rejects it, for whatever reason -- absent a compelling state interest." Id. at 750. In Boyd, the court grounded this rule in the fundamental concept of American jurisprudence, "that every competent adult has the 'right to determine what shall be done with his own body.'" Id. at 748 n.8 (quoting Canterbury v. Spence, 150 U.S. App. D.C. 263, 464 F.2d 772, 780 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972)). In Boyd, the court also relied heavily, see 403 A.2d at 748 n.8, 749, 750-753, on a decision of the Massachusetts Supreme Judicial Court that stated that the patient's right to be free from unauthorized bodily intrusion is

an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.

Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 742, 370 N.E.2d 417, 426 (1977). In a passage cited in Boyd in connection with the District's common law rule, see 403 A.2d at 748 n.8, the Supreme Judicial Court stated, "[t]here is implicit recognition in the law of the commonwealth, as elsewhere, that a person has a strong interest in being free from nonconsensual invasion of his bodily integrity. . . . In short, the law recognizes the individual interest in preserving the 'inviolability of his person.'" 370 N.E.2d at 424 (citations omitted).

The common law rights of personal autonomy and bodily integrity adumbrated in Boyd compel this Court to recognize the right to refuse psychotropic drugs. The principles recognized in Boyd have provided the foundation for rulings by the high courts of several states that the common law encompasses a right to refuse the forcible administration of psychotropic drugs. In People v. Medina, 705 P.2d 961 (Colo. 1985) (en banc), the Colorado Supreme Court held that "the decision to forcibly medicate a patient with psychotropic drugs . . . directly implicates the patient's legal interests in

personal autonomy and bodily integrity." Id. at 968. The court recognized that "an involuntarily committed mental patient has a qualified common law right to refuse antipsychotic medication." Id. at 969. Similarly, the New York Court of Appeals in Rivers v. Katz, 495 N.E.2d 337, recognized a co-extensive common law and state constitutional right to refuse psychotropic medication. The court recognized that under our fundamental "notions of individual autonomy and free choice . . . it is the individual who must have the final say in respect to decisions regarding his medical treatment." Id. at 341. Accordingly, under Boyd all competent persons have a common law right to refuse treatment with psychotropic drugs, absent an emergency.^{8/}

B. The United States Constitution Protects The Right To Refuse Psychotropic Drugs.

Because the common law of the District supports the right appellant Bryant asserts, this Court need not reach the question whether the Constitution also prohibits the forced administration of psychotropic drugs under certain circumstances. See Ashwander v. Tennessee Valley Authority, 297 U.S. 288, 347-348 (1936) (Brandeis, J. concurring). But should resolution of the constitutional question be thought necessary, this Court should find that the Constitution protects the right Bryant asserts in this case. Although courts have differed on the precise circumstances in which a hospitalized patient's right to refuse psychotropic drugs can be overridden by more compelling state interests, every court that has ruled on the issue in the past decade has held that the right to refuse such drugs is protected by the United States Constitution. See generally Brooks, The Constitutional Right to Refuse Antipsychotic Medications, 8 Bull. Am. Acad. Psychiatry & Law 179 (1980).

^{8/} The holding that District common law grants a right to refuse psychotropic drugs is equivalent to a holding that forced administration of these drugs constitutes a tort. Accordingly, just as the District -- subject to applicable sovereign immunity limitations -- would be liable to any citizen for a tort committed against that citizen by an official of the District, so too the District is bound to respect the common law right to refuse psychotropic medication.

The starting point for the constitutional analysis is the United State's Supreme Court's decision in Mills v. Rogers, 457 U.S. 291. The Court had granted plenary review to "determine whether involuntarily committed mental patients have a constitutional right to refuse treatment with antipsychotic drugs." Id. at 293. But because of an intervening state court decision on state law grounds the Court decided that resolution of the federal constitutional question would be premature. The Court nevertheless noted that the "parties agree that the Constitution recognizes a liberty interest in avoiding the unwanted administration of antipsychotic drugs." Id. at 299. And the opinion proceeded on the assumption that such a right exists:

As do the parties, we assume for purposes of this discussion that involuntarily committed mental patients do retain liberty interests protected directly by the Constitution, cf. O'Connor v. Donaldson, 422 U.S. 563, and that these interests are implicated by the involuntary administration of psychotropic drugs. Id. at 299, n.16.

The Court's reliance on O'Connor v. Donaldson is significant. There the Court unanimously held that an individual retained liberty interests that were protected by the federal constitution even after the individual was involuntarily committed by court order to a state mental hospital, and even though the individual had been found incompetent. 422 U.S. at 566 n.2. And the same day the Court decided Mills v. Rogers it explicitly and unanimously held that involuntarily hospitalized patients do retain at least some liberty interests that are protected by the federal constitution. Youngberg v. Romeo, 457 U.S. 315 (1982).

Thus, although the question has not been squarely resolved by the Supreme Court, its opinions in Mills, Youngberg, and O'Connor, read together, strongly suggest that the Court would rule that the right of competent patients to refuse psychotropic drugs is a liberty interest that is protected by the federal constitution.

Every lower court that has ruled on the issue in the past decade has reached this conclusion. See, e.g., Johnson v. Silvers, 742 F.2d 823, 825 (4th Cir. 1984); Project Release v. Prevost, 722 F.2d 960, 979 (2d Cir. 1983). Some have based their conclusion on the constitutional right to form

and express ideas, others on the constitutional right to privacy, to personal integrity, to personal security, or to substantive due process. That other courts have not agreed on a single rationale for the right is not an argument against recognition by this Court. To the contrary, the breadth of constitutionally protected interests those courts have cited demonstrates that forcible administration of antipsychotic drugs implicates a panoply of fundamental liberty interests. But regardless of the specific source of the right, those courts have all held that involuntarily hospitalized mental patients have a constitutionally protected right to refuse antipsychotic drugs that must be respected by the state except in narrowly defined circumstances.^{9/}

^{9/} In addition to the district court and circuit court opinions in *Mills v. Rogers*, both of which found a federal constitutional right to refuse antipsychotic drugs (see *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980), and *Rogers v. Okin*, 738 F.2d 1 (1st Cir. 1984) (on remand)), see *Winters v. Miller*, 446 F.2d 65 (2d Cir.), cert. denied, 404 U.S. 985 (1971); *Davis v. Hubbard*, 506 F. Supp. 915 (N.D. Ohio 1980); *Rennie v. Klein*, 653 F.2d 836 (3d Cir. 1981) (en banc), cert. granted and judgment vacated and remanded, 458 U.S. 1119 (1982), on remand, 720 F.2d 266 (3d Cir. 1983); *In Re K.K.B.*, 609 P.2d 747 (Okla. 1980); *Johnson v. Silvers*, 742 F.2d 823 (4th Cir. 1984); and *Rogers v. Commissioner of Mental Health*, 390 Mass. 489, 458 N.E.2d 308 (1983). See also *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983), and *Anderson v. Arizona*, 663 P.2d 570 (Ct. App. Ariz. 1982), both of which hold that patients have a right to refuse antipsychotic drugs and appear to ground that right in both the federal Constitution and state law. And see, *Knecht v. Gillman*, 488 F.2d 1136 (8th Cir. 1973) (mental patients have a constitutional right to refuse the drug apomorphine); *Scott v. Plante*, 532 F.2d 939 (3d Cir. 1976) (complaint alleging forced administration of psychotropic drugs states a claim under the federal Constitution); *Bee v. Graves*, 744 F.2d 1387 (10th Cir. 1984), cert. denied, 105 S.Ct. 1187 (1985) (pre-trial detainees have a constitutional right to refuse psychotropic drugs); *Osgood v. District of Columbia*, 567 F.Supp. 1026 (D.D.C. 1983) (former mental patient has a constitutional right, in jail, to refuse psychotropic drugs); and *Mackey v. Procunier*, 477 F.2d 877 (9th Cir. 1973) (complaint alleging forcible administration of the drug succinylcholine to a prisoner in a state mental facility states a claim under the federal Constitution). Furthermore, although sympathetic to a federal constitutional right, many other courts have found it unnecessary to reach that question and have ruled, instead, that involuntarily hospitalized mental patients have a common law right, a state statutory right, or a state constitutional right, to refuse psychotropic drugs. E.g., *Rivers v. Katz*, 67 N.Y.2d 485, 495 N.E.2d 337 (1986); *Goedecke v. State Dep't of Institutions*, 603 P.2d 123 (Colo. 1979); *People v. Medina*, 705 P.2d 961 (Colo. 1985) (en banc); *Opinion of the Justices*, 465 A.2d 484 (N.H. 1983).

- C. Absent An Emergency, A Competent Person Has An Absolute Right To Refuse Psychotropic Medication Even If That Person Has Been Involuntarily Hospitalized For Treatment Of Mental Illness.
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Amicus has demonstrated that common law and constitutional principles protect the right to refuse psychotropic drugs. The precise contours of this right may differ according to the circumstances of the person asserting it. Amicus will show that -- absent an emergency -- a competent person has an absolute right to refuse psychotropic medication even if that person has been involuntarily hospitalized for treatment of mental illness.

Amicus recognizes that the state has a legitimate interest in forcibly medicating patients who are actively dangerous to themselves or others, or who pose an immediate and substantial threat of becoming violent. Under these circumstances, the state's police power interest in preserving order and protecting patients and staff within the institution will be sufficient to override the patient's refusal of antipsychotic drugs if -- but only if -- other less intrusive approaches would be ineffective in preventing violent behavior. In this situation, the government has a compelling interest sufficient to overcome the right. Short of an emergency, however, every competent person retains the right to refuse psychotropic medication.

The fact of involuntary commitment does not in itself deprive a person of this right. In Boyd, this Court made absolutely clear that "civil commitment to St. Elizabeth's under D.C. Code 1973 § 21-545 demonstrates only that a committee is mentally ill and likely to injure herself or others. It does not, at the same time, mean, that the committee is legally incompetent. . . . Thus, even after a civil commitment proceeding, a trial court cannot override the treatment decision of a mentally ill adult unless he or she has been adjudged presently incompetent." 403 A.2d at 747 n.5. The civil commitment proceeding establishes only that a person is mentally ill and in need of treatment. It does not establish that the patient is incapable of making rational decisions about treatment. See D.C. Code § 21-564 (establishing that involuntary commitment does not create even a presumption of incompetency).

The New York Court of Appeals explained the basis for this distinction in Rivers v. Katz:

[T]he nearly unanimous modern trend in the courts, and among psychiatric and legal commentators is to recognize that there is no significant relationship between the need for hospitalization of mentally ill patients and their ability to make treatment decisions. Indeed there is considerable authority within the psychiatric community that from a medical point of view no relationship necessarily exists between the need for commitment and the capacity to make treatment decisions . . . since the presence of mental illness does not ipso facto warrant a finding of incompetency.

495 N.E.2d at 342. Accord Brooks, Constitutional Right to Refuse Antipsychotic Medications, 8 Bull. of Am. Academy of Psychiatry & L. 179, 191.

There is also now an almost universal legislative recognition of the separation between determinations of the need for involuntary hospitalization and incompetency. As a major study published in 1968 noted:

The trend in legislation during the last fifteen years has been toward a complete separation of hospitalization and incompetency. This trend appears to be a reflection of the belief held by an increasing number in both the medical and legal professions that there is no necessary relationship between a person's need to be cared for in a mental hospital and his capacity to handle his own affairs.

Allen, Ferster & Weihofen, Mental Impairment and Legal Incompetency 49-50 (1968) (footnotes omitted). "Today, virtually every state has an explicit provision to the effect that institutionalization does not affect competency or even create a presumption of incompetency." Brakel, Parry & Weiner, The Mentally Disabled and the Law 71, 184-185, 405-407 (3d ed. 1985).

These judicial and legislative judgments are supported by the experience of mental health professionals. It is now generally accepted that many forms of mental illness have a specific impact on the individual, leaving decisionmaking capacity and reasoning ability largely unimpaired. M. Lorr, C. Klett & D. McNair, Syndromes of Psychosis 8 (1963) (cognitive disorientation is absent in hostile paranoid schizophrenia); see Neal & Oltmanns, Schizophrenia 24 (1980); Helmchen, Schizophrenia: Diagnostic Concepts in the ICD-8, in Studies of Schizophrenia (M. Lader ed.); Developments in the Law - Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190, 1214 (1974). In

fact, patients-often have good reason for refusing drugs; for example, in one study a high percentage of those who objected to drugs had experienced serious side effects from previous drug treatment. Van Putten, Why Do Schizophrenic Patients Refuse to Take Their Drugs?, 31 Arch. Gen. Psychiatry 67, 68-70 (1974).

Accordingly, under the law of the District of Columbia, involuntary hospitalization does not deprive a person of the right to refuse psychotropic drugs. Such persons presumptively retain the ability to make decisions about treatment. District common law and federal constitutional law both require that the right to make treatment decisions be respected under these circumstances.

Application of this principle in borderline circumstances may raise some difficult issues. For example, although it is clear that a serious risk of physical violence to self or others would justify forcible medication as an exercise of the police power, would a serious risk of substantial deterioration in the patient's mental health also justify forced drugging under that rubric? In amicus' view, that kind of harm might justify the temporary administration of antipsychotic drugs pending a court hearing on the patient's competency, but would not justify the long-term administration of such drugs without a judicial finding of incompetence, and the court's substituted judgment that the patient, if competent, would authorize administration of the drugs.

III. ABSENT AN EMERGENCY, PSYCHOTROPIC DRUGS MAY BE ADMINISTERED OVER THE OBJECTIONS OF AN INCOMPETENT PATIENT ONLY WHEN A SUBSTITUTE DECISIONMAKER DETERMINES THAT THE PATIENT WOULD NOT HAVE REFUSED TREATMENT IF COMPETENT

Amicus has demonstrated that -- absent an emergency -- a competent person has an absolute right to refuse psychotropic medication even if that person has been involuntarily hospitalized for treatment of mental illness. Amicus will now show that persons adjudged incompetent retain the right to refuse psychotropic medication if, in the judgment of a substitute decisionmaker, the patient would have decided to refuse the drugs when competent.

Under Boyd, the substantive right to be free of the forcible administration of psychotropic drugs extends to patients adjudged incompetent. The precise holding in Boyd was that when an incompetent patient refuses medication for religious reasons the court must "determine as best it can what choice that individual, if competent, would make." 403 A.2d at 750. But the Court went on to state: "We believe this approach is sound, whether religious preference or other factors are involved, for it is the only way to pay full respect to the individuality and dignity of a person who has expressed clear, deeply felt, even sacred preferences while competent." Id. (emphasis added). Thus, in Boyd this Court acknowledged that the principles set forth therein demanded a wider application, and invited that application.

In Boyd, this Court quoted and endorsed the following passage from Saikewicz, supra:

The 'best interests' of an incompetent person are not necessarily served by imposing on such persons results not mandated as to competent persons similarly situated. It does not advance the interest of the State or the ward to treat the ward as a person of lesser status or dignity than others. . . . To presume that the incompetent person must always be subjected to what many rational and intelligent persons may decline is to downgrade the status of the incompetent person by placing a lesser value on his intrinsic human worth and vitality. 403 A.2d at 750 (citation omitted)

Similarly, in Rivers v. Katz the New York Court of Appeals explained that "the right extends equally to mentally ill persons who are not to be treated as persons of lesser status or dignity because of their illness." 495 N.E.2d at 341. As the Colorado Supreme Court explained, "[t]he disruption of bodily integrity is no less real in the case of an incompetent patient; nor for that matter, are the risks from the antipsychotic medication any less for a patient who is unable to give an informed consent to the proposed treatment." People v. Medina, 705 P.2d at 971.

Respect for the autonomy and dignity of the incompetent requires adoption of the substituted judgment approach set forth in Boyd for cases in which a person adjudged incompetent refuses treatment with psychotropic medication. Under that standard, the decisionmaker does not look to the best

interests of the patient in an objective sense, but instead must ask what the patient, subjectively, would consider in his or her best interest if competent to decide. As Boyd recognized, the substituted judgment approach respects the principles of autonomy and bodily integrity because, by attempting to approximate as closely as possible the individual's own values and preferences, "it is the only way to pay full respect to the individuality and dignity of a person." 403 A.2d at 750.

This approach may raise difficult questions in some cases. For example, although it would be permissible to administer antipsychotic drugs to an incompetent patient who, if competent, would consent, is forced drugging permissible when, despite a good faith effort, it is impossible to determine what the incompetent patient would do if competent? In amicus' view, it would be permissible to administer antipsychotic drugs in that circumstance if certain additional standards were satisfied. A recent thoughtful opinion of the Supreme Court of Colorado, en banc, summarizes the standards amicus would consider appropriate for determining whether to medicate an incompetent patient when it cannot be determined what the patient would decide if competent:

We are satisfied that the interest of both the patient and the state will be adequately served if the physician or professional person desiring to administer antipsychotic medication satisfies the court by clear and convincing evidence of the following four propositions: (1) that the patient is incompetent to effectively participate in the treatment decision; (2) that treatment by antipsychotic medication is necessary to prevent a significant and likely long-term deterioration in the patient's mental condition or to prevent the likelihood of the patient's causing serious harm to himself or others in the institution; (3) that a less intrusive treatment alternative is not available; and (4) that the patient's need for treatment by antipsychotic medication is sufficiently compelling to override any bona fide and legitimate interest of the patient in refusing treatment.

IV. NO OTHER GOVERNMENTAL INTEREST IS SUFFICIENTLY
COMPELLING TO OVERRIDE A PATIENT'S RIGHT TO REFUSE
PSYCHOTROPIC MEDICATION

Absent an emergency or -- in the case of an incompetent person -- a substituted judgment determination that the patient would consent to medication if competent, no governmental interest is sufficiently compelling

to override a person's right to refuse treatment with psychotropic medication. In Boyd, this Court identified four possible claims that might be asserted by a government as reasons for overcoming the right to refuse psychotropic drugs: (1) the preservation of life; (2) the protection of third parties; (3) the prevention of suicide and maintenance of institutional order; and (4) maintaining the ethical integrity of the medical profession. 403 A.2d at 748 n.9. Amicus will demonstrate that none of these interests justifies forcible medication absent an emergency.

1. The state's interest in improving the patient's health is not a sufficient justification for forcibly administering antipsychotic drugs.

The state's interest in saving life is not implicated here because antipsychotic drugs do not save or prolong life. The state's lesser interest in improving the patient's health is not sufficiently compelling to justify the forcible administration of antipsychotic drugs. That conclusion is implicit in each of the decisions cited above holding that patients do have the right to refuse antipsychotic drugs.

2. The state's interest in improving public health is not a sufficient justification for forcibly administering antipsychotic drugs.

The state's interest in improving the health of the public does not outweigh the patient's constitutionally protected interests. Courts have strictly limited the power of the state to further general societal interests at the expense of the individual's constitutional liberty interests. Although the Supreme Court held, in Jacobson v. Massachusetts, 197 U.S. 11 (1905), that the state's interest in compulsory vaccination outweighed the individual's right to bodily integrity, the balance of governmental and individual interests is far different in the case of antipsychotic drugs. First the state's interest in administering antipsychotic drugs in the hope that they will help individuals is not as compelling as its interest in administering vaccinations to prevent highly predictable and life-threatening epidemics. Second, far more than vaccinations, antipsychotic drugs dramatically affect

the body and mind of the individual and have dangerous and often permanent side effects. (See Point II-A, supra.) Third, vaccinations are highly effective, but as noted in Point II-A, antipsychotic drugs may not benefit a given patient. Fourth, although there are no realistic alternatives to vaccinations, other treatment methods (such as psychotherapy and certain forms of behavior modification) that are less physically intrusive than antipsychotic drugs may be effective for at least some patients. Given the extent of the intrusion involved, the possibility that harmful side effects may last months or years beyond the period of hospitalization, the inability to predict whether antipsychotic drugs will benefit a particular patient, the availability of other and less physically intrusive forms of treatment, and the tendency of some hospitals to misuse drugs for the convenience of staff and for punishment, the state's generalized interest in improving the health of the public does not justify the forcible administration of antipsychotic drugs.

3. The state's interest in institutional order and efficiency is not a sufficient justification for forcibly administering antipsychotic drugs.

Any governmental institution might function more efficiently and effectively if individual freedom could be curtailed. But our constitutional system of government is based on the premise that individual freedom should be protected even at the expense of some loss of governmental efficiency and order. Accordingly, even assuming arguendo that patients' refusals to take antipsychotic drugs could have some adverse effect on institutional order, the state could justify forcibly administering such drugs on these grounds, if at all, only if such refusals caused very substantial interference with institutional order. They do not.

First the vast majority of patients who are prescribed antipsychotic drugs willingly take them. The example of the Rogers' case is instructive. In a more than two-year period after the district court issued its injunction generally prohibiting forced administration of antipsychotic drugs in nonemergency situations, a witness for the state was able to identify only 12 patients out of approximately 1,000 who refused such drugs. And most of them

changed their minds within a few days and agreed to take the drugs. Rogers v. Okin, 478 F. Supp. at 1369.

Second, the evidence suggests that recognizing a right to refuse antipsychotic drugs has not interfered with the operation of institutions or with treatment programs. In New Jersey, for example, a state institution operated for a year under a court order enforcing patients' right to refuse antipsychotic drugs. The hospital staff experienced little disruption in treating patients. In fact, substantial savings in medication costs were realized, fewer side effects occurred, and most significantly, "treatment itself . . . improved . . . [without] substantial additional burdens . . . placed on treatment personnel." Brooks, The Constitutional Right to Refuse Antipsychotic Medications, 8 Bull. Am. Acad. Psychiatry & L. 179, 213 (1980). Similarly, in Ohio, where the right to refuse treatment was recognized after litigation, the district court found no evidence suggesting that "recognition of the right has had any adverse effects on the operation of the institution or on its treatment goals." Davis v. Hubbard, 506 F. Supp. at 937 n.31. See also Appelbaum & Gutheil, Drug Refusal: A Study of Psychiatric Inpatients, 137 Am. J. Psychiatry 340, 345 (1980).

4. The state's interest in furthering professional ethics is not a sufficient justification for forcibly administering antipsychotic drugs.

Finally, recognition of the right of competent patients to refuse antipsychotic drugs is wholly consistent with the government's interest in furthering professional ethics. Among treating professionals, it is an almost universally accepted principle that patients must give informed consent before they are subjected to medical treatment. See National Comm'n for Protection of Human Subjects of Biomedical and Behavioral Research, Research Involving Those Institutionalized As Mentally Infirm (5-3)-(5-6) (H.E.W. Pub. No. 78-0007, 1978) (Nat'l Comm'n). The underlying legal and ethical premise of the informed consent doctrine is the notion of "thorough-going self determination." Natanson v. Kline, 186 Kan. 393, 406, 350 P.2d 1093, 1104 (1960). This doctrine, grounded in the respect society has for patients as

persons, emerged as a rule of law in the context of physician-patient malpractice suits. Accordingly, the patient's rights to autonomy and self-determination do not conflict with the professional's ethical duties. To the contrary, respecting the patient's rights would accord with the ethical and professional standards of professional psychology. See American Psychological Association, Ethical Principles of Psychologists, 36 Am. Psychologist 633, at 633, 636 (1981) (psychologists strive to protect fundamental human rights, they fully inform clients of the purpose and nature of treatment, and they recognize that clients "have freedom of choice with regard to participation"). The ethical demands of all mental health professionals are best served by respecting the autonomy of the patients they serve, to the maximum extent possible.

V. THE FINAL DECISION WHETHER TO AUTHORIZE LONG-TERM ADMINISTRATION OF PSYCHOTROPIC DRUGS OVER A PATIENT'S OBJECTION SHOULD BE MADE BY A COURT.

To ensure that a person's substantive rights to refuse psychotropic drugs are adequately protected, the determination of competency and -- in the case of an incompetent person -- the substituted judgment determination must be made by a court. The issues to be resolved in such cases are essentially legal in nature. For example, in People v. Medina, the Supreme Court of Colorado, en banc, held that a court must conduct the substituted judgment evaluation because the issues to be resolved are primarily legal in nature:

Although the decision to forcibly medicate a patient with antipsychotic drugs undoubtedly involves an aspect of professional medical judgment in connection with psychiatric diagnosis and treatment alternatives, the fact remains that the decision itself directly implicates the patient's legal interests in personal autonomy and bodily integrity. 705 P.2d at 968.

Courts have traditionally been considered the appropriate forum for resolving issues of competency or danger to self or others, Rivers v. Katz, 495 N.E.2d at 343 ("[s]uch a determination is uniquely a judicial, not a medical function"), and there is no persuasive reason why courts should not resolve those same issues in the context of forced medication.

Similarly, as this Court made clear in In re Boyd, the substituted judgment test is at bottom a legal determination, not a psychological or medical determination, and should be made by a court. 403 A.2d at 750-753. Accord Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337 (1986); People v. Medina, 705 P.2d 961 (Colo. 1985) (en banc); Rogers v. Commissioner of Mental Health, 390 Mass. 489, 458 N.E.2d 308 (1983); In re K.K.B., 609 P.2d 747 (Okla. 1980).

Leaving competency and substituted judgment determinations to hospital personnel creates a significant risk that, simply because a professional believes the patient has made the "wrong" decision, the professional will conclude that the patient is incapable of rational thought. Hospital personnel are simply not in the position to make the kind of neutral and detached judgment necessary to respect the patient's rights. It is because of the dangers posed by such well-intentioned but potentially biased judgments that "[u]nder our Constitution there is no procedural right more fundamental than the right of the citizen, except in extraordinary circumstances, to tell his side of the story to an impartial tribunal." Winters v. Miller, 446 F.2d 65, 71 (2d Cir.), cert. denied, 404 U.S. 985 (1971).

Requiring judicial competency and substituted judgment determinations will not unduly burden governmental interests in institutional efficiency and treatment. Judicial process would be required only for that small minority of persons who object to treatment with psychotropic drugs. Any delay attendant on the judicial determination will be minimal. And if the patient faces a crisis that requires immediate treatment to prevent substantial deterioration, the Constitution may allow the hospital staff to determine whether the temporary administration of psychotropic drugs pending a judicial determination is appropriate. In most cases, however, there will be ample

time to obtain a judicial ruling without creating an undue risk of deterioration. See People v. Medina, 705 P.2d at 974-975.^{10/}

VI. THE LOWER COURT ERRED IN REFUSING TO RECOGNIZE BRYANT'S COMMON LAW AND CONSTITUTIONAL RIGHTS AND A REMAND IS NECESSARY TO CORRECT THE ERROR

The judgment of the Superior Court in the present case must be reversed and remanded. The undisputed facts make clear that the Court sanctioned forced medication with psychotropic drugs prior to a judicial determination of incompetency. The trial court wholly failed to acknowledge this clear violation of common law and constitutional rights. At this point, moreover, Bryant cannot properly be held to be incompetent to make treatment decisions. Appellants brief to this Court makes clear that the Superior Court's finding of incompetency was so flawed that it cannot justify depriving Bryant of the right to make treatment decisions; amicus will not repeat those arguments here. The alleged determination of incompetency by hospital staff cannot in itself justify forced medication because, as amicus demonstrated in Point IV. supra, a court must make the determination of incompetency. And the finding that Bryant could be involuntarily committed pursuant to D.C. Code § 21-545 is not a finding that Bryant is incompetent to make treatment decisions. In re Boyd, 403 A.2d at 747 n.5.

But even if Bryant had properly been found to be incompetent to make treatment decisions, the Superior Court's decision permitting forced medication was fatally flawed. The court's purported "substituted judgment" determination cannot justify the forced medication of Bryant. Appellant has pointed out the numerous respects in which that determination fell short.

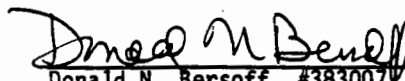
^{10/} The Supreme Court's decision in Youngberg v. Romero, 457 U.S. 307 (1982), does not suggest a different result. In Youngberg the Court recognized that involuntarily committed patients have a right to adequate treatment. But the Court left the primary determination as to what constitutes adequate treatment to the professional discretion of treating physicians. The decision to leave the primary determination to professional discretion in that case makes sense because the determination is essentially medical in nature: what form of treatment best suits the patient. In the present case, by contrast, the "substituted judgment" determination is not primarily medical in nature. Rather, it is primarily a legal determination intended to protect the right to autonomy and dignity of the patient.

Amicus will stress two additional points. First, the court was seeking to answer the narrow question whether Bryant would have raised a religious objection to treatment if competent. The court simply was not addressing itself to the proper inquiry: whether Bryant would have refused psychotropic drugs for any reason if competent. A remand is therefore necessary to ensure that the proper inquiry has been conducted. Second, the court's decision to ignore Bryant's consistent history of refusing psychotropic drugs was in itself reversible error. The court simply assumed that Bryant had been incompetent during her entire adult life and that her decisions to refuse medication thus could be ignored. But the record contains no evidence that Bryant was incompetent at any time prior to the court's determination of incompetency in April 1986. Indeed, Bryant lived most of her life in the community. Therefore the court had no warrant for failing to consider Bryant's history of refusing medication.

CONCLUSION

For the foregoing reasons, the judgment of the Superior Court in this case should be reversed and remanded.

Respectfully Submitted,


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Dated: June 24, 1987
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-- AFFIRMATION OF SERVICE

I, DONALD B. VERRILLI, JR., do hereby affirm under penalty of perjury that I caused to be served a copy of the Brief of Amicus Curiae American Psychological Association In Support Of Appellant on this 24th day of June, 1987, by depositing said copy in the United States mail, first-class postage prepaid to:

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