

IN THE
UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 86-5568

UNITED STATES OF AMERICA

Appellee,

v.

MICHAEL F. CHARTERS, JR.,

Appellant.

On Appeal From the United States District Court
For the Eastern District of Virginia
Alexandria Division

BRIEF FOR AMICUS CURIAE AMERICAN PSYCHOLOGICAL
ASSOCIATION IN SUPPORT OF APPELLANT

DONALD N. BERSOFF
DONALD B. VERRILLI, JR.
ENNIS FRIEDMAN & BERSOFF
Suite 400
1200 Seventeenth Street, N.W.
Washington, D.C. 20036
202-775-8100

June 7, 1988

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES.....	i
INTEREST OF AMICUS.....	1
STATEMENT AND SUMMARY OF ARGUMENT.....	3
ARGUMENT.....	5
I. ANTIPSYCHOTIC DRUGS ARE HIGHLY BENEFICIAL FOR MANY PATIENTS, BUT THEY ALSO CAUSE SUBSTANTIAL SIDE EFFECTS THAT IMPLICATE BASIC PRINCIPLES OF INDIVIDUAL AUTONOMY AND DIGNITY.....	5
A. Antipsychotic Drugs Cause A Wide Range of Serious And Potentially Debilitating Physical Side Effects.....	7
B. Antipsychotic Drugs Can Severely Affect Mental Processes.....	16
II. A HOSPITALIZED PATIENT HAS A FEDERAL CONSTITUTIONAL RIGHT TO REFUSE ANTIPSYCHOTIC DRUGS UNLESS THE PATIENT HAS BEEN FOUND INCOMPETENT TO MAKE TREATMENT DECISIONS OR IS IMMINENTLY DANGEROUS TO SELF OR OTHERS.....	18
A. The Constitution Protects An Individual's Right To Refuse Antipsychotic Medication.....	19
B. 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.....	25
C. Absent an Emergency, Antipsychotic Drugs May Be Administered Over The Objections Of An Incompetent Patient Only After A Substituted Judgment Determination Has Been Made.....	33
III. JUDICIAL DETERMINATIONS OF COMPETENCY AND SUBSTITUTED JUDGMENT ARE CONSTITUTIONALLY REQUIRED TO PROTECT AN INDIVIDUAL'S RIGHT TO REFUSE ANTIPSYCHOTIC DRUGS.....	35
CONCLUSION.....	38

TABLE OF AUTHORITIES

CASES:

	Page
<u>Anderson v. Arizona</u> , 663 P.2d 570 (Ariz. App. 1982).....	11, 22
<u>Bee v. Greaves</u> , 744 F.2d 1387 (10th Cir. 1984), <u>cert. denied</u> , 469 U.S. 1214 (1985).....	6, 9, 17, 23, 28
<u>Bell v. Wolfish</u> , 441 U.S. 520 (1979).....	27
<u>Davis v. Hubbard</u> , 506 F. Supp. 915 (N.D. Ohio 1980).....	6, 7, 9, 11, 14, 15, 17, 23
<u>Dautremont v. Broadlawns Hospital</u> , 827 F.2d 291 (8th Cir. 1987).....	31
<u>Goedecke v. State Dep't of Institutions</u> , 603 P.2d 123 (Colo. 1979).....	22
<u>Humphrey v. Cady</u> , 405 U.S. 504 (1972).....	28
<u>In re Boyd</u> , 403 A.2d 744 (D.C.C.A. 1979).....	6, 9, 10, 11
<u>In Re K.K.B.</u> , 609 P.2d 747 (Okla. 1980).....	22, 36
<u>In re the Guardianship of Richard Roe, III</u> , 421 N.E. 2d 40 (Mass. 1981).....	6, 15, 16
<u>Ingraham v. Wright</u> , 430 U.S. 651 (1977).....	19
<u>Jacobson v. Massachusetts</u> , 197 U.S. 11 (1905).....	26
<u>Jarvis v. Levine</u> , 418 N.W.2d 139 (Minn. 1988).....	6, 31
<u>Johnson v. Silvers</u> , 742 F.2d 823 (4th Cir. 1984).....	22
<u>Knecht v. Gillman</u> , 488 F.2d 1136 (8th Cir. 1973).....	22
<u>Mackey v. Procunier</u> , 477 F.2d 877 (9th Cir. 1973).....	22
<u>Mills v. Rogers</u> , 457 U.S. 291 (1982).....	6, 9, 16, 20, 22
<u>Natanson v. Kline</u> , 186 Kan. 393, 350 P.2d 1093 (1960).....	27
<u>O'Connor v. Donaldson</u> , 422 U.S. 563 (1975).....	20

<u>Opinion of the Justices</u> , 465 A.2d 484 (N.H. 1983).....	7, 11, 22
<u>Osgood v. District of Columbia</u> , 567 F.Supp. 1026 (D.D.C. 1983)...	22
<u>Palko v. Connecticut</u> , 302 U.S. 319 (1937).....	19
<u>People v. Medina</u> , 705 P.2d 961 (Colo. 1985).....	7, 9, 10, 23, 32, 34, 35, 37
<u>Project Release v. Prevost</u> , 722 F.2d 960 (2d Cir. 1983).....	21, 22, 31
<u>Rennie v. Klein</u> , 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).....	6, 23
<u>Rivers v. Katz</u> , 67 N.Y.2d, 485 N.E.2d 337 (1986).....	2, 5, 9, 10, 22, 31, 34, 35
<u>Rogers v. Commissioner of Mental Health</u> , 390 Mass. 489 N.E.2d 308 (1983).....	2, 22
<u>Rogers v. Okin</u> , 478 F. Supp. 1342 (D. Mass. 1979).....	22, 36
<u>Rogers v. Okin</u> , 634 F.2d 650 (1st Cir. 1980).....	6
<u>Rogers v. Okin</u> , 738 F.2d 1 (1st Cir. 1984) (on remand).....	22
<u>Schloendorff v. Society of New York Hospital</u> , 211 N.Y. 125 N.E. 92 (1914).....	19
<u>Scott v. Plante</u> , 532 F.2d 939 (3d Cir. 1976).....	7, 23
<u>Superintendent of Belchertown State School v. Saikewicz</u> , 373 Mass. 728, 370 N.E.2d 417 (1977).....	19, 34
<u>United States v. Leatherman</u> , 729 F.2d 863 (D.C. Cir. 1984).....	2
<u>Vitek v. Jones</u> , 445 U.S. 480 (1980).....	19
<u>Whalen v. Roe</u> , 429 U.S. 589 (1977).....	19
<u>Winston v. Lee</u> , 470 U.S. 753 (1985).....	20, 28
<u>Winters v. Miller</u> , 446 F.2d 65 (2d Cir.), cert. denied, 404 U.S. 985 (1971).....	22, 36
<u>Youngberg v. Romeo</u> , 457 U.S. 307 (1982).....	3, 20, 22, 24, 25

STATUTES:

18 U.S.C. § 4241.....	24, 29
18 U.S.C. § 4246.....	24

MISCELLANEOUS:

Addonizio, Susman & Roth, <u>Symptoms of Neuroleptic Malignant Syndrome in 82 Consecutive Inpatients</u> , 143 Am. J. Psychiatry 1587 (1986).....	6
Allen, Ferster & Weihofen, <u>Mental Impairment and Legal Incompetency</u> 49 (1968).....	32
American Psychiatric Association Task Force Report #18, <u>Tardive Dyskinesia</u>	7, 14
Ananth, Edelmuth & Dargan, <u>Meige's Syndrome Associated With Neuroleptic Treatment</u> , 145 Am. J. Psychiatry 513 (1988).....	5, 8
Asnis, et al., <u>A survey of tardive dyskinesia in psychiatric outpatients</u> , 134 Am. J. Psychiatry 1367 (1970).....	13
Ayd, <u>Pre-Treatment Prediction of Responsiveness To Chlorpromazine: Is It Possible?</u> , 10 Int'l. Drug Therapy Newsletter 4 (1975).....	7, 15
Ayd, <u>A Survey of Drug-Induced Extrapyrarnidal Reactions</u> , 175 J.A.M.A. 1054 (1961).....	7
Baldessarini, <u>Clinical and Epidemiological Aspects of Tardive Dyskinesia</u> , 4 J. Clinical Psychiatry 8 (1985).....	11
Beck, <u>The Right To Refuse Antipsychotic Medication: Psychiatric Assessment And Legal Decisionmaking</u> , 11 M.P.D.L.R. 368 (1987).....	30
Brakel, Parry & Weiner, <u>The Mentally Disabled and the Law</u> 71 (3d ed. 1985).....	32
Brooks, <u>The Constitutional Right to Refuse Antipsychotic Medications</u> , 8 Bull. Am. Acad. Psychiatry & Law 179 (1980)...	20, 32, 36
Cole & Davis, <u>Clinical Efficacy of the Phenothiazines as Antipsychotic Drugs</u> , in <u>Public Health Service, Psychopharmacology: A Review of Progress 1957-1967</u> 1057 (1968).....	5
Crane, <u>Clinical Psychopharmacology in its Twentieth Year</u> , 181 Sci. 124 (1973).....	7

Crane, <u>Persistent Dyskinesias</u> , 122 Br. J. Psychiatry 395 (1975).....	15
Davis, <u>Antipsychotic Drugs</u> , in 3 <u>Comprehensive Textbook of Psychiatry/III</u> 2257 (H. Kaplan, A. Freedman & B. Sadock, eds. 1980).....	8
Davis, <u>Overview: Maintenance Therapy in Psychiatry: I. Schizophrenia</u> , 132 Am. J. Psychiatry 1237 (1975).....	5
<u>Dorland's Pocket Medical Dictionary</u>	3
Gardos & Cole, <u>Drug Variables in the Etiology of Tardive Dyskinesia</u> , 1 Prog. Neuro-Psychopharm. 147 (1977).....	13
Gardos, Cole, Salomon & Schniebolz, <u>Clinical Forms of Severe Tardive Diskinesia</u> , 144 Am. J. Psychiatry 895 (1987).....	7, 10, 11
Gardos, Cole & Tarsy, <u>Withdrawal Symptoms Associated With Antipsychotic Drugs</u> , 135 Am. J. Psychiatry 1321 (1978).....	15
Gualtieri, Sprague & Cole, <u>Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic Treatment</u> , 14 J. Psychiatry and Law 187 (1986).....	5, 12, 13, 14, 15, 18
Gutheil & Appelbaum, <u>"Mind Control," "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication</u> , 12 Hofstra L. Rev. 77 (1983).....	11
Helmchen, <u>Schizophrenia: Diagnostic Concepts in the ICD-8, in Studies of Schizophrenia</u> (M. Lader ed.); <u>Developments in the Law - Civil Commitment of the Mentally Ill</u> , 87 Harv. L. Rev. 1190 (1974).....	30
Hogarty, et al., <u>Drug and Sociotherapy in the Aftercare of Schizophrenic Patients</u> , 31 Arch. Gen. Psychiatry 603 (1974).....	6
Hollister, <u>Antipsychotics and Antimanic Drugs, in Review of General Psychiatry</u> 596 (Goldman, ed. 1984).....	7, 8, 13
Jacobson & Baldessarini, <u>Tardive and Withdrawal Dyskinesia Associated With Haloperidol</u> , 131 Am. J. Psychiatry 534 (1975).....	15
Jeste & Wyatt, <u>Changing Epidemiology of Tardive Dyskinesia: An Overview</u> , 138 Am. J. Psychiatry 297 (1981).....	12

Jus, et al., <u>Epidemiology of Tardive Dyskinesia, Part 1, 37</u> <u>Dis. Nerv. Syst. 210 (1976).....</u>	12
Jus, Jus & Fontaine, <u>Long Term Treatment of Tardive</u> <u>Dyskinesia, 40 J. Clin. Psychiatry 72 (1979).....</u>	15
Kane, et al., <u>Incidence of Tardive Dyskinesia: Five Year</u> <u>Data From A Prospective Study, 20 Psychopharmacology</u> <u>Bull. 39 (1984).....</u>	14
Kane, et al., <u>Integrating Incidence and Prevalence of</u> <u>Tardive Dyskinesia, 22 Psychopharmacology Bull.</u> <u>253 (1986).....</u>	14
Kane & Smith, <u>Tardive Diskinesia: Prevalence and Risk</u> <u>Factors, 1959-1979, 39 Arch. Gen. Psychiatry 473 (1982).....</u>	15
H. Kaplan & B. Sadock, <u>Modern Synopsis of Comprehensive</u> <u>Textbook of Psychiatry/III.....</u>	11
Kennedy, Hershon & McGuire, <u>Extrapyramidal Disorders After</u> <u>Prolonged Phenothiazine Therapy, 118 Brit. J.</u> <u>Psychiatry 509 (1971).....</u>	7
Klein, Gittleman, Quitkin & Rifkin, <u>Diagnosis and Drug</u> <u>Treatment of Psychiatric Disorders, 199 (2d ed.</u> <u>1980).....</u>	8
Lazarus & Toglia, <u>Fatal Myoglobinuria Renal Failure in a</u> <u>Patient with Tardive Dyskinesia, 35 Neurology 1055 (1985)....</u>	11
Lehmann, <u>Individual Differences in Response to</u> <u>Pharmacotherapy, in Psychotropic Drug Response: Advances</u> <u>In Prediction 18 (Wittenborn & May, eds., 1969).....</u>	15
M. Lorr, C. Klett & D. McNair, <u>Syndromes of Psychosis 8 (1963)...</u>	29
<u>Modern Synopsis of Comprehensive Textbook of Psychiatry/II</u> <u>943 (A. Freedman, H. Kaplan & B. Sadock, eds. 1976).....</u>	8
National Institute of Mental Health Psychopharmacology Service Center Collaborative Study Group, <u>Phenothiazine</u> <u>Treatment in Acute Schizophrenia, 10 Arch. Gen.</u> <u>Psychiatry 246 (1964).....</u>	5
Neal & Oltmanns, <u>Schizophrenia (1980).....</u>	29
<u>Physicians Desk Reference (1987).....</u>	16
Pope, Keck & McElroy, <u>Frequency of Presentation of</u> <u>Neuroleptic Malignant Syndrome in a Large Psychiatric</u> <u>Hospital, 143 Am. J. Psychiatry 1227 (1986).....</u>	9, 13

Quitkin, Rifkin & Gochfeld, <u>Tardive Dyskinesia: Are First Signs Reversible?</u> , 134 <u>Am. J. Psychiatry</u> 84 (1977).....	16
Rifkin, Quitkin & Klein, <u>Akinesia: A Poorly Recognized Drug-Induced Extrapyrarnidal Behavioral Disorder</u> , 32 <u>Arch. Gen. Psychiatry</u> 672 (1975).....	8
A. Schatzberg & J. Cole, <u>Manual of Clinical Psychopharmacology</u> 99 (1986).....	7, 10, 11, 13, 15, 18
Schooler & Kane, <u>Research diagnoses for tardive diskinesia (RD-TD)</u> , 39 <u>Arch. Gen. Psychiatry</u> 486 (1982).....	12
Sovner, Dimascio, <u>et al.</u> , <u>Tardive Dyskinesia and Informed Consent</u> , 19 <u>Psychosomatics</u> 172 (March 1978).....	14, 15
Spohn, Coyne, Lacoursiere, Mazur & Hayes, <u>Relation of Neuroleptic Dose and Tardive Dyskinesia to Attention, Information-Processing, and Psychophysiology in Medicated Schizophrenics</u> , 42 <u>Arch. Gen. Psychiatry</u> 849 (1985).....	16
Van Putten, <u>Why Do Schizophrenic Patients Refuse to Take Their Drugs?</u> , 31 <u>Arch. Gen. Psychiatry</u> 67 (1974).....	29
Weiden, Mann, Hass, Mattson & Frances, <u>Clinical Nonrecognition of Neuroleptic-Induced Movement Disorders: A Cautionary Study</u> , 144 <u>Am. J. Psychiatry</u> 1148 (1987).....	12
Zander, <u>Prolixin Decanoate: A Review of the Research</u> , reprinted in 2 <u>Mental Disability L. R.</u> 37 (July-Aug. 1977).....	8

IN THE
UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 86-5568

UNITED STATES OF AMERICA

Appellee,

v.

MICHAEL F. CHARTERS, JR.,

Appellant.

On Appeal From the United States District Court
For the Eastern District of Virginia
Alexandria Division

BRIEF FOR AMICUS CURIAE
AMERICAN PSYCHOLOGICAL ASSOCIATION
IN SUPPORT OF APPELLANT

INTEREST OF AMICUS

The American Psychological Association is a voluntary, nonprofit, scientific, and professional organization with more than 70,000 members. It has been the major association of psychologists in the United States since 1892, and includes the vast majority of psychologists holding doctoral degrees from accredited universities in this country. Its purpose, as reflected in its Bylaws, is "to advance psychology as a science and profession, and as a means of promoting human welfare." This case raises questions vital to the interests of both users and providers of psychological services. The circumstances under which antipsychotic 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 involuntarily committed to mental hospitals are provided with treatment that is both effective and consistent with human dignity and autonomy. Association members thus have a direct interest in the questions at issue in this case.^{1/}

The American Psychological Association would like to make this Court aware of the significant differences among the opinions of mental health professionals with respect to the psychopharmacological, ethical and legal propriety of forced medication with psychotropic drugs. Although the American Psychological Association agrees with the American Psychiatric Association that psychotropic medications can provide great benefits to persons suffering from mental illness, the American Psychological Association differs substantially from the American Psychiatric Association in appraising both the risks of side effects posed by psychotropic drugs and the scope of a patient's legitimate right to refuse treatment with the drugs. In light of the risks of

^{1/} 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.

The American Psychological Association has submitted amicus briefs addressing these questions to the United States Supreme Court in Mills v. Rogers, 457 U.S. 291 (1982), to the U.S. Court of Appeals for the District of Columbia in United States v. Leatherman, 729 F.2d 863 (D.C. Cir. 1984), to the New York Court of Appeals in Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337 (1986), to the Supreme Judicial Court of Massachusetts in Rogers v. Commissioner of Mental Health, 390 Mass. 489, 458 N.E.2d 308 (1983), and, most recently to the District of Columbia Court of Appeals in In re Ollie Bryant, Nos. 86-1528 & 87-354, decided March 25, 1988. Additionally, the American Psychological Association participated in oral argument as amicus curiae in Bryant.

severe side effects, and the literal "mind altering" effect of the drugs, the American Psychological Association believes that basic constitutional rights to autonomy and dignity can be fundamentally infringed when the government administers psychotropic drugs against the will of a patient who has not been found by a court to be incompetent to make treatment decisions.

STATEMENT AND SUMMARY OF ARGUMENT

This case presents an important and recurring issue: whether the Due Process Clause of the Fifth Amendment limits the government's ability to administer antipsychotic drugs^{2/} against the will of a patient who has made a competent decision to refuse treatment with the drugs.

The issue arises in the context of a pretrial detainee who has never been found to be incompetent to make basic decisions concerning his medical treatment. Although amicus American Psychological Association has a strong interest in preserving appropriate professional discretion in the treatment of mental illness, this organization does not endorse the relatively unbridled discretion that would be afforded government mental health professionals were the Supreme Court's decision in Youngberg v. Romeo, 457 U.S. 307 (1982), uncritically extended to cover the present case. In the view of amicus, the deference to professional judgment the Supreme Court found appropriate in the

^{2/} 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.

Youngberg context is not appropriate with respect to decisions to administer psychotropic drugs against the will of a patient who has made a competent decision to refuse the treatment. The constitutional interest at stake in this case differs fundamentally from that of Youngberg. Here, unlike Youngberg, the crucial issue is whether an individual's competent decision to refuse unwanted medical treatment may be overridden by a government official seeking to act in the medically-indicated "best interest" of the individual. In the judgment of amicus, the panel in this case correctly held that granting such discretion to override individual treatment decisions affords government too much power to intrude upon individual autonomy and personal security.

Antipsychotic drugs can bring substantial relief from the hallucinations and delusions of psychosis, but also pose a significant risk of potentially debilitating physical and mental side effects. Patients must therefore generally be accorded the right to decide for themselves whether to accept or refuse the risks of treatment with these drugs. (Point I). Because the forced administration of antipsychotic drugs intrudes severely on personal security, bodily integrity, and the sanctity of the mental process, the Constitution protects the individual's right to refuse treatment with these drugs in most circumstances. Absent a life-threatening emergency, antipsychotic drugs may not be constitutionally administered against the will of an individual unless that individual has been found to be incompetent to make treatment decisions. Neither the government's interest in pretrial detention, nor the government's interest in effective law enforcement, nor the government's parens patriae interest provide a sufficiently compelling justification for overriding the decision of a person who has not been found incompetent to make treatment decisions. (Point II). Furthermore, judicial

determinations are required to provide adequate procedural protections for an individual's fundamental right to refuse unwanted medical treatment. Such procedures will measurably increase the accuracy of determinations of incompetency to make medical decisions, and will not unduly burden either the administration of mental health facilities or the courts. (Point III).

ARGUMENT

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

In urging that a patient's competent choice to refuse antipsychotic drugs must be respected, amicus intends no denigration of these medications. When efficacious, antipsychotic drugs reduce the delusions, hallucinations, and thought disorders associated with the most severe psychiatric illness -- the psychoses. See Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337, 339 n.1 (1986) (medical usefulness "stems from their ability to influence thought patterns so as to eliminate psychotic symptoms").^{3/} For many patients, these 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

^{3/} It should be noted, however, that this "treatment is by no means restricted to schizophrenic patients. Surveys of institutions for the mentally retarded reveal that 40-50% of the residents are treated with neuroleptics." Gualtieri, Sprague & Cole, Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic Treatment, 14 J. Psychiatry and Law 187, 204 (1986).

Arch. Gen. Psychiatry 246 (1964); Hogarty, et al., Drug and Sociotherapy in the Aftercare of Schizophrenic Patients, 31 Arch. Gen. Psychiatry 603 (1974). Courts have consistently recognized 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 also, e.g., Davis v. Hubbard, 506 F. Supp. 915, 927 (N.D. Ohio 1980).

Recognition of these potential benefits should not, however, obscure the risks of debilitating side effects posed by antipsychotic drugs. As amicus will show, the panel in this case based its constitutional analysis on scientific assumptions that were accurate -- if somewhat incompletely elaborated. The brief of the American Psychiatric Association in support of rehearing, in contrast, has understated both the severity and the prevalence of the unwanted effects of these drugs. Antipsychotic drugs cause a wide range of unwanted physical and mental effects that can be quite serious -- and occasionally fatal. Because side effects occur in a high percentage of medicated patients, and serious side effects occur in significant numbers, the use of antipsychotic drugs is generally recognized as a "high-risk treatment." In re Guardianship of Richard Roe, III, 421 N.E.2d 40, 54 (Mass. 1981). See also Bee v. Greaves, 744 F.2d 1387, 1390-1391 (10th Cir. 1984), cert. denied 469 U.S. 1214 (1985); Jarvis v. Levine, 418 N.W.2d 139 (Minn. S.Ct. 1988).^{4/} Medical treatises and bulletins -- including those of the American Psychiatric Association -- routinely caution mental health

^{4/} 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

(footnote continued on next page)

professionals to take special care to administer these drugs only when necessary and in the minimum dosage necessary. See, e.g., American Psychiatric Association Task Force Report #18, Tardive Dyskinesia.

A. Antipsychotic Drugs Cause A Wide Range Of Serious And Potentially Debilitating Physical Side Effects.

Far from being "outdated and tendentious," see American Psychiatric Brief at 4, the professional literature documenting the harmful physical side effects of antipsychotic drugs is current, balanced and comprehensive. See, e.g., Ananth, Edelmuth & Dargan, Meige's Syndrome Associated With Neuroleptic Treatment, 145 Am. J. Psychiatry 513 (1988); Gardos, Cole, Salomon & Schniebolk, Clinical Forms of Severe Tardive Diskinesia, 144 Am. J. Psychiatry 895 (1987); Pope, Keck & McElroy, Frequency of Presentation of Neuroleptic Malignant Syndrome in a Large Psychiatric Hospital, 143 Am. J. Psychiatry 1227 (1986); A. Schatzberg & J. Cole, Manual of Clinical Psychopharmacology 99 (1986); Hollister, Antipsychotics and Antimanic Drugs, in Review of General Psychiatry 596 (H. Goldman ed. 1984); 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

4/ Continued

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); People v. Medina, 705 P.2d at 969-970, n.4.; 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).

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 Extrapyrarnidal 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.

The panel opinion correctly identified several side effects caused by antipsychotic drugs, including extrapyramidal symptoms such as: parkinsonian syndrome, which is characterized by mask-like face, drooping, stiffness and rigidity, shuffling gate, and tremors; akathisia, which is characterized by strong subjective feelings of distress and an often irresistible need to be in constant motion; and dystonic reactions, which include muscle spasms, irregular flexing, writhing or grimacing movements, and protrusion of the tongue. 829 F.2d at 483 n.2. See generally Hollister, Antipsychotics and Antimanic Drugs, in Review of General Psychiatry 596 (Goldman, ed. 1984).

Courts have consistently acknowledged -- as did the panel in this case -- that antipsychotic drugs produce these side effects.^{5/} See, e.g.,

^{5/} Meige's Syndrome and Neuroleptic Malignant Syndrome are two other important and more recently identified side effects that must be encompassed in any evaluation of the overall risks of antipsychotic drugs. Meige's syndrome results in uncontrollable contractions of eye muscles; it often severely constricts vision and makes many day-to-day activities impossible. Ananth, Edelmuth & Dargan, Meige's Syndrome Associated With Neuroleptic Treatment, 145 Am. J. Psychiatry 513 (1988). Neuroleptic malignant syndrome is "a continuous spectrum of physiologic reactions," including elevated temperature and blood pressure, incontinence, and extrapyramidal symptoms, "that in some patients takes a severe, potentially lethal form." Addonizio, Susman & Roth, Symptoms of Neuroleptic Malignant Syndrome in 82 Consecutive Inpatients, 143 Am. J. Psychiatry 1587, 1588 (1986); see also Pope, Keck & (footnote continued on next page)

Mills v. Rogers, 457 U.S. 291, 293 n.1 (1982); Bee v. Greaves, 744 F.2d at 1390-1391; Davis v. Hubbard, 506 F. Supp. 915 (N.D. Ohio 1980); Rivers v. Katz, 495 N.E. at 339 n.1; In re Boyd, 403 A.2d 744 (D.C.C.A. 1979). In a recent judicial review of the side effects of antipsychotic drugs, the Supreme Court of Colorado noted that:

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); akathisia (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).

People v. Medina, 705 P.2d 961, 968 n.3 (Colo. 1985) (en banc). In Boyd, the D.C. Court of Appeals 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. 403 A.2d 752 n.13.

Many of the physical side effects described above are both frightening and serious. But the most debilitating effect linked to

5/ Continued

McElroy, Frequency of Presentation of Neuroleptic Malignant Syndrome in a Large Psychiatric Hospital, 143 Am. J. Psychiatry 1227 (1986).

antipsychotic drugs is tardive dyskinesia. See A. Schatzberg & J. Cole, Manual of Clinical Psychopharmacology 99 (1986). A recent professional article acknowledged that "tardive dyskinesia is emerging as one of the dreaded diseases in psychiatry." Gardos, Cole, Salomon & Schniebolk, Clinical Forms of Severe Tardive Dyskinesia, 144 Am. J. Psychiatry at 895. The New York Court of Appeals in Rivers v. Katz described this condition as "potentially devastating," 495 N.E.2d at 339 n.1, and many other courts have recognized its potential severity. See, e.g., In re Boyd, 403 A.2d at 752 n.13. In People v. Medina the Supreme Court of Colorado summarized the effects of 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.

705 P.2d at 968 n.3 (emphasis added) (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)). 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.

Although amicus agrees with the American Psychiatric Association that tardive dyskinesia will more often appear in milder forms, see Brief of American Psychiatric Association at 14, severe manifestations of this condition cannot fairly be described as merely "discomforting and unattractive." Id. To the contrary, as the panel opinion correctly found, 829 F.2d at 483 n.2, and as standard reference manuals make clear, "the severity of tardive dyskinesia ranges from minimal tongue restlessness and finger movements to gross, incapacitating disfiguring movements." A. Schatzberg & J. Cole, Manual of Clinical Psychopharmacology 99 (1986) (emphasis added). In some cases, "self-care, feeding and swallowing, as well as vocationally important dexterity, can be impaired; severe cases, while infrequent, can be as disabling as Huntington's disease." Baldessarini, Clinical and Epidemiological Aspects of Tardive Dyskinesia, 4 J. Clinical Psychiatry 8 (1985). Clinical studies have reported cases of tardive dyskinesia so severe as to "interfere[] even with eating and drinking" or to "prevent driving and reading." Gardos, Cole, Salomon & Schniebolk, Clinical Forms of Severe Tardive Diskinesia, 144 Am. J. Psychiatry at 897. One clinical report of a the death of a patient with tardive dyskinesia, noting that "the potential for serious motor disability is generally underestimated," reported that persistent retching, vomiting, weight loss and dehydration can occur, with respiratory or gastrointestinal involvement. Lazarus & Toglia, Fatal Myoglobinuria Renal Failure in a Patient with Tardive Dyskinesia, 35 Neurology 1055, 1057 (1985).

The best estimates of the rate at which tardive dyskinesia afflicts patients medicated with antipsychotic drugs have been steadily rising since publication of the American Psychiatric Association's Task Force report on

tardive dyskinesia in 1980.^{6/} A study published in 1981 pointed out that the "reported prevalence [of tardive dyskinesia] among neuroleptic-treated psychiatric inpatients has been progressively rising and has reached 25% during the past five years." Jeste & Wyatt, Changing Epidemiology of Tardive Dyskinesia: An Overview, 138 Am. J. Psychiatry 297 (1981). A more recent study noted that "prevalence rates . . . grow year by year." Galtieri, Sprague, and Cole, Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic Treatment, 14 J. Psychiatry and Law at 206. These increases may be due in part to substantial advancement 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).^{7/} In fact, past studies probably underestimate the prevalence of tardive dyskinesia for two reasons: (i) antipsychotic drugs can mask the symptoms even as the drugs cause tardive dyskinesia, see Galtieri, Sprague & Cole, Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic Treatment, 14 J. Psychiatry and Law at 199; and (ii) clinicians may often fail to diagnose the symptoms, see Weiden, Mann, Hass, Mattson & Frances, Clinical Nonrecognition of

^{6/} The numbers exceed the "best estimate" of 10 to 20 percent suggested in the American Psychiatric Association's Brief at 13. The low figure in that brief may be the result of the fact that it is based on somewhat outdated 1980 task force report.

^{7/} The wide range of percentages noted particularly in the earlier 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. Because substantial progress has been made in defining diagnostic criteria, more recent studies measure the prevalence or incidence of tardive dyskinesia with greater precision than has so far been attained.

Neuroleptic-Induced Movement Disorders: A Cautionary Study, 144 Am. J.

Psychiatry 1148, 1153 (1987) (noting "an alarming rate" of underdiagnosis).^{8/}

The best current estimates of prevalence rates are in the range of 20 to 60 percent.⁹ See, e.g., Hollister, Antipsychotics and Antimanic Drugs, in Review of General Psychiatry at 596 ("20-40% of chronically treated patients"); A. Schatzberg & J. Cole, Manual of Clinical Psychopharmacology at 99 (rates in chronically institutionalized patients "on the order of 50-60 percent"). Some studies report consistently high rates. For example, two prevalence studies indicate that the condition affects 50% to 56% of chronically hospitalized schizophrenics,^{10/} 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

^{8/} Studies suggest a similar underdiagnosis of Neuroleptic Malignant Syndrome, another side effect of antipsychotic drugs. One study noted that "neuroleptic malignant syndrome may afflict a larger number of cases than is generally suspected. . . . [E]ven a conservative estimate would place the annual prevalence of neuroleptic malignant syndrome in the United States in the thousands of cases, a significant number of which may have fatal consequences." Pope, Keck & McElroy, Frequency of Presentation of Neuroleptic Malignant Syndrome in a Large Psychiatric Hospital, 143 Am. J. Psychiatry at 1232.

^{9/} Estimates of the prevalence of severe tardive dyskinesia vary widely. One source puts the rate at about 3%. Gualtieri, Sprague, and Cole, Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic Treatment, 14 Am. J. Psychiatry at 198. But the Psychiatric News has stated that tardive dyskinesia is "severe and persistent in about 25% of those affected." TD Court Cases Underscore Importance of APA Report, Psychiatric News, Oct. 7, 1983 at 1.

^{10/} 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).

1367-1370 (1970). The magnitude of the public health issue implicit in these percentages emerges fully when it is recognized that about 3 million Americans are currently medicated with antipsychotic drugs, and that 945,000 new patients receive the drugs each year. Gualtieri, Sprague, and Cole, Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic Treatment, 14 J. Psychiatry and Law 187, 204 (1986).^{11/}

^{11/} A relatively early literature 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 Dyskinesia: Prevalence and Risk Factors, 1959-1979, 39 Arch. Gen. Psychiatry 473 (1982). 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 compare 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, these studies are primarily valuable for determining the likelihood that long-term hospitalized patients will develop the disease. 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 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).

In any event, prevalence studies provide the more appropriate figures for estimating the risks of tardive dyskinesia for the class of persons most likely to be asserting the right to refuse treatment with antipsychotic drugs.

Unlike such extrapyramidal effects as akathisia, parkinsonian syndrome, and dystonic reactions, which typically subside when antipsychotic drugs are discontinued, tardive dyskinesia often persists long after treatment and can be irreversible. See Gualtieri, Sprague & Cole, Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic Treatment, 14 J. Psychiatry and Law at 198; Gardos, Cole & Tarsy, Withdrawal Symptoms Associated With Antipsychotic Drugs, 135 Am. J. Psychiatry 1321 (1978). Reference works acknowledge that "[t]here is no effective or standard treatment for tardive dyskinesia." A. Schatzberg & J. Cole, Manual of Clinical Psychopharmacology at 100.^{12/} Furthermore, accurate predictions as to who will develop the condition are not yet possible. Id. at 99.^{13/} Thus, it cannot be predicted 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

^{12/} Although most authorities consider tardive dyskinesia to be a permanent condition, remission may occur 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.

^{13/} Courts have uniformly recognized that clinicians cannot predict how helpful or harmful an antipsychotic drug will be for a particular patient. 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, Lehmann, Individual Differences in Response to Pharmacotherapy, in Psychotropic Drug Response: Advances In Prediction 18 (Wittenborn & May, eds., 1969); Ayl, Pre-Treatment Prediction of Responsiveness To Chlorpromazine: Is It Possible?, 10 Int'l. Drug Therapy Newsletter 4 (1975).

experience adverse side effects, or will not benefit but will experience adverse side effects. In short; "there is no way to avoid tardive dyskinesia except to avoid using antipsychotics." Id. at 100.

B. Antipsychotic Drugs Can Severely Affect Mental Processes.

Amicus has shown that the panel in this case was correct in concluding that antipsychotic drugs pose a significant risk of producing uncomfortable, debilitating, and sometimes "potentially devastating" physical side effects. The panel opinion was also correct in finding that these drugs are "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." Roe III, 421 N.E. at 53.

Amicus agrees with the American Psychiatric Association that antipsychotic drugs are "mind altering" in the potentially beneficial sense of "ameliorating hallucinations and delusions." American Psychiatric Brief at 16. But this assessment is incomplete. Far from uniformly "enhancing the mentally ill person's ability to concentrate, to learn, and to communicate," id., antipsychotic drugs often diminish these abilities. The Physician's Desk Reference specifically warns that various antipsychotic drugs can impair mental alertness. E.g., Physicians Desk Reference 1779 (1987) (mellaril); id. at 1191 (haldol); id. at 1932 (thorazine). Studies indicate that, at upper levels of prescribed doses, antipsychotic drugs interfere with patients' abilities to concentrate, learn, and react to stimuli by reducing attention span and increasing reaction time. Spohn, Coyne, Lacoursiere, Mazur & Hayes, Relation of Neuroleptic Dose and Tardive Dyskinesia to Attention, Information-Processing, and Psychophysiology in Medicated Schizophrenics, 42

Arch. Gen. Psychiatry 849 (1985). Indeed, one documented effect of antipsychotic drugs is akinesia, a condition in which the patient loses energy and interest in his or her surroundings, and often complains of feeling "dead inside."

Thus, although the administration of antipsychotic drugs should not be considered "thought control" in the sense of facilitating indoctrination or purging particular ideas and values from the minds of those medicated, these drugs can adversely affect mental processes by precipitating docility and diminishing a patient's ability and inclination to interact with environmental stimuli. The panel opinion correctly identified precisely these mental effects in assessing the potential harms of antipsychotic drugs, 829 F.2d at 483 n.2, 489. Recognition of these mental effects has also consistently led other courts to conclude that antipsychotic drugs implicate First Amendment interests by intruding upon a patient's ability to form and communicate ideas. E.g., Bee v. Greaves, 744 F.2d at 1394; Davis v. Hubbard, 506 F. Supp. at 927-929. Furthermore, as the panel correctly observed, the issue of forced medication will arise not only in cases of patients who are profoundly disturbed in all aspects of mental functioning, but also in cases of patients who may be delusional in some aspect but mentally sound in others, 829 F.2d at 489, and patients who are functional but are recovering from short-term emergency treatment for acute psychosis. In such cases, forced administration of antipsychotic drugs precludes a patient's ability to opt for preservation of the "normal" aspects of mental functioning by foregoing the medication.

- II. A HOSPITALIZED PATIENT HAS A FEDERAL CONSTITUTIONAL RIGHT TO REFUSE ANTIPSYCHOTIC DRUGS UNLESS THE PATIENT HAS BEEN FOUND INCOMPETENT TO MAKE TREATMENT DECISIONS OR IS IMMINENTLY DANGEROUS TO SELF OR OTHERS.

Amicus has shown that antipsychotic drugs hold the promise of significant benefits, but also pose the risk of serious discomfort, disability, or disruption of the mental process. Acknowledging both the potential severity of these unwanted effects, and the prevalence of their occurrence, reference manuals and professional articles routinely acknowledge that "[i]t is a hard choice between the danger of prolonged drug treatment and the danger of prolonged, untreated psychosis," even for mental health professionals seeking the patient's best interest. Gualtieri, Sprague & Cole, Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic Treatment, 14 J. Psychiatry and Law at 202; A. Schatzberg & J. Cole, Manual of Clinical Psychopharmacology at 100. This professional consensus alone should be enough to demonstrate that the forced administration of antipsychotic drugs raises grave issues respecting personal security and individual dignity.

Given the severity of the potential intrusion and the difficulty of the calculus respecting the advisability of medication with antipsychotic drugs, a patient's competent decision to refuse the medication is entitled to be respected even if that conclusion differs from the one recommended by the treating physician. Government's failure to respect a patient's competent decision to refuse these drugs threatens fundamental principles of personal security and individual dignity. 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. Under these circumstances, the forced administration of antipsychotic

drugs seriously infringes on the constitutional rights of patients institutionalized as mentally ill.

A. The Constitution Protects An Individual's Right To Refuse Antipsychotic Medication.

The Supreme Court has repeatedly held that "[a]mong the historic liberties protected by the Due Process Clause is the 'right to be free from . . . unjustified intrusions on personal security.'" Vitek v. Jones, 445 U.S. 480, 492 (1980) (quoting Ingraham v. Wright, 430 U.S. 651, 673 (1977)). The individual's firmly embedded common law "right to determine what shall be done with his own body," Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129, 105 N.E. 92 (1914) (Cardozo, J.), is without question one of the "personal rights that can be deemed fundamental or implicit in the concept of ordered liberty" and is therefore protected by the Due Process Clause. See Palko v. Connecticut, 302 U.S. 319, 325 (1937) (Cardozo, J.) (internal quotation omitted). This right to personal security and bodily integrity, the Supreme Court has made clear, encompasses a fundamental interest "in independence in making certain kinds of important decisions" about what will be done to one's body and mind. Whalen v. Roe, 429 U.S. 589, 599-600 (1977). As the Massachusetts Supreme Judicial Court found, the right to refuse unwanted medical treatment 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).

Because the forced administration of antipsychotic drugs intrudes upon not only these interests in personal security and bodily integrity, but

also upon the sanctity of the mental process, see Point I supra, an individual's right to refuse antipsychotic 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). In Mills v. Rogers, 457 U.S. 291 (1982), the Supreme Court, though remanding for a determination whether state law provided a right to refuse antipsychotic medication, proceeded on the assumption that the Due Process Clauses of the federal Constitution encompass such a right:

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).

Similarly, in Winston v. Lee, the Supreme Court specifically refused to permit surgery upon a criminal defendant to remove a bullet that would have provided probative evidence of the defendant's guilt because that surgery would have constituted an "extensive intrusion on . . . personal privacy and bodily integrity." 470 U.S. 753, 764 (1985). Although the case arose under the Fourth Amendment, the analysis in Winston vindicated personal rights

virtually identical to those at stake in the present case. In finding the proposed surgery to be too severe an infringement of personal security and bodily integrity to be permitted under any circumstances, the Court acknowledged that forcing a defendant to undergo a serious nonconsensual medical procedure "involves a virtually total divestment of . . . ordinary control." Id. at 765. The Court also recognized that, despite conflicting evidence about the risks involved in the proposed surgery, "the very uncertainty militates against" forcing the defendant to undergo the operation.

Every lower court that has ruled on the issue in the past decade has reached the conclusion that the right to refuse antipsychotic drugs is a substantive liberty interest protected by the federal Constitution -- although courts have differed in demarking where the right must yield to a compelling governmental interest. See, e.g., 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 government.^{14/}

Of course, recognition of a patient's right to refuse treatment with antipsychotic drugs does not mean that a patient's right is absolute. As the Supreme Court made clear in Youngberg v. Romeo, determination of the appropriate scope of this right requires a weighing of "the individual's interest in liberty against the State's asserted reasons for restraining individual liberty." 457 U.S. at 320. In Youngberg itself the Court held that a profoundly mentally retarded patient in a state hospital had an individual liberty interest in safe conditions, freedom from unnecessary

14/ 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. Greaves, 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).

restraint, and adequate training, but that this interest could be adequately protected by a legal standard requiring that "professional judgment was in fact exercised" in deciding upon the extent of restraint imposed or of training given. Id. at 321-324. Youngberg does not, however, stand for the proposition that government may override an individual's decision to refuse medical treatment whenever the treatment appears medically indicated in the exercise of "professional judgment." Although the government has an interest in the health and well-being of its citizens, this interest has never been held to be sufficient in itself to override a competent individual's right to decide whether to accept or refuse medically indicated treatment. Were the medical treatment at issue an intrusive and risky procedure such as bypass surgery, a mastectomy, or dialysis, it is inconceivable that the Constitution would be held to permit the federal government to force a competent adult to undergo such treatment against his or her will -- even professionals considered the treatment to be in the best medical interest of the patient. Because antipsychotic drugs are similarly intrusive and pose the risk of similarly severe unwanted effects, a competent decision to refuse these drugs must likewise receive constitutional protection.

The particular constitutional balance struck in Youngberg is of little utility in resolving the present case because Youngberg did not involve the individual interest at stake here -- the right to refuse unwanted medical treatment. The patient in Youngberg was a profoundly mentally retarded individual who was utterly unable to care for himself and functioned at the level of an eighteen month-old baby. The patient was not competent to make treatment decisions, and had never in his life been competent to make treatment decisions. He claimed a constitutional entitlement to certain

adequate levels of treatment and standards of care, and not a right to have any choice to refuse treatment respected. In Youngberg, therefore, the government had an obvious interest in caring for a hospitalized individual who was incapable of caring for himself in any way, and the individual was not even seeking to assert any liberty interest in making his own competent decisions about treatment. Given that the individual's constitutional claim was at bottom one for medically adequate conditions and care in Youngberg, the Court struck the balance between the patient's claim of entitlement and the government's interests by applying the "professional judgment" standard.

In Youngberg the patient was at bottom claiming an affirmative right to receive something from the government. Charters is asserting a right to be protected from governmental intrusion and to have his competent treatment decisions respected. Thus, a fundamentally different calculus applies in this case. If Charters were not a pretrial detainee held pursuant to 18 U.S.C. §§ 4241 or 4246, there would be no question that the Constitution would require the government to respect his treatment decision. In general, a competent adult may not constitutionally be forced by government to submit to unwanted, intrusive medical procedures that entail significant risks. The Due Process right at stake in this case is not the right to be free from "arbitrary" administration of antipsychotic drugs -- if "arbitrary" is defined, as in the American Psychiatric Association Brief at 24, as unwise or medically mistaken administration of the drugs. Rather, it is the right of a competent adult to make medical treatment decisions, even if they are in some sense unwise. Forced administration of antipsychotic drugs is constitutionally permissible only if something about Charters' particular character or circumstances provides the government with a compelling

justification for overriding Charters' decision to refuse unwanted medical treatment. Amicus will demonstrate no such justification exists under the circumstances of this case.

- B. 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 government 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.

This case, however, does not involve any such emergency. Only three conceivable bases thus exist for justifying a decision to override Charter's right to refuse medication with antipsychotic drugs: (1) Charter's status as a pretrial detainee; (2) the government's interest in law enforcement and the administration of justice; or (3) the government's parens patriae interest in caring for Charters because he is unable to make treatment decisions for himself. Amicus will demonstrate that none of these purported justifications provides a sufficiently compelling reason for overriding the right to refuse antipsychotic medication in this case.^{15/}

^{15/} No other conceivable government interest would be adequate to justify the intrusion. The state's interest in saving life is not implicated here

(footnote continued on next page)

1. Pretrial Detention. An individual's status as a pretrial detainee does not supply a governmental interest sufficiently compelling to override the individual's right to refuse treatment. Although a pretrial

15/ Continued

because antipsychotic drugs do not save or prolong life. The state's interest in improving the health of the public does not outweigh the patient's constitutionally protected 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 I, supra.) Third, vaccinations are highly effective, but as noted in Point I, antipsychotic drugs may not benefit a given patient. Fourth, although there are no realistic alternatives to vaccinations, other treatment methods (such as group or individual psychotherapy and certain forms of properly developed behavior modification) that are less physically intrusive than antipsychotic drugs may be effective for at least some patients. Nor is the interest in institutional efficiency sufficient. 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. In any event, the threat to these interests is not severe. See Point III infra.

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). 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").

detainee does not possess all the freedoms of an unincarcerated person, Bell v. Wolfish, 441 U.S. 520, 546 (1979), any restrictions placed upon the detainee must be reasonably necessary to effectuate the legitimate purposes of the detention. Id. at 539. As the Tenth Circuit made clear in Bee v. Greaves, pretrial detention in itself does not justify forcible medication with antipsychotic drugs for two reasons. First, treatment with antipsychotic drugs is not necessary to the primary goal of pretrial detention -- ensuring a defendant's presence at trial. Second, although maintaining order and preventing a detainee from injuring himself or others are encompassed within the purposes of pretrial detention, forced administration of antipsychotic drugs is not reasonably necessary to effectuate these ancillary goals absent an emergency. A detainee therefore may not be forcibly administered antipsychotic drugs unless the government can show, at a minimum, some additional compelling interest in forcible treatment. 744 F.2d at 1394-1395.

2. Government Interest In Law Enforcement. Any interest the government might have in returning Charters to competence so that it may then press criminal charges against him is also insufficient to justify the forced administration of antipsychotic drugs. As the Supreme Court made clear in Winston v. Lee, even legitimate law enforcement objectives must give way when fulfillment of those objectives would require a severe intrusion into personal privacy and bodily integrity entailing significant risks of physical harm. See Point II.A. supra. As the Tenth Circuit explicitly held in Bee v. Greaves, the interest in law enforcement should never be itself sufficient to justify the forced administration of antipsychotic drugs. "A state interest unrelated to the well-being of the individual," the court noted, "simply has no relevance to" a determination whether these drugs may be forcibly

administered. 744 F.2d at 1395. Unless the government can justify administration of these drugs under the parens patriae power, the Constitution must forbid forced administration.

3. The Parens Patriae Interest. The government has an indisputable interest in caring for those of its citizens incapable of caring for themselves. But this interest cannot justify every good faith government effort to provide medical care. When the provision of medical treatment involves significant curtailment of liberty or significant intrusion upon personal security and bodily integrity, the government may not forcibly administer treatment to an unwilling recipient unless the government has made a convincing showing that the individual is incapable of making competent decisions about his or her welfare. Humphrey v. Cady, 405 U.S. 504 (1972). Thus, a crucial question in this case is whether Charters has been shown to be incompetent to make treatment decisions. Charters' competency is -- contrary to the suggestions of the American Psychiatric Association -- at the center of this case.

The panel opinion correctly held that no adequate showing of Charters' incompetency has been made. The finding that Charters was incompetent to stand trial cannot serve as a proxy for the necessary finding that Charters was incompetent to make treatment decisions. Under 18 U.S.C. § 4241, a detainee may be hospitalized only after a determination that the individual mentally incompetent "to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense." An individual could meet this standard and yet remain fully competent to make treatment decisions respecting antipsychotic drugs. For example, an individual found to have amnesia might well be unable

to assist properly in his defense, and yet the inability to remember past details would not in any way impair that individual's ability to make competent treatment decisions.

This distinction between competency to stand trial and competency to make treatment decisions also holds true in less obvious cases. 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).

Nor can there be any satisfactory finding of incompetence to make treatment decisions based on the testimony of Dr. Sally Johnson in the trial court. In this testimony, Dr. Johnson revealed that her finding of incompetency was not based on Charters' inability to understand the nature of antipsychotic drugs and their effects, or on Charters' inability to respond in an appropriate way, "and not in non sequiturs." Instead, she found Charters incompetent because he refused treatment that was demonstrably in his interests, 829 F.2d at 484 (quoting testimony), a paternalistic perspective that failed to consider Charters' equally important interests in

self-determination and bodily integrity. As the panel correctly found, incompetence to make treatment decisions cannot be found in a patient's refusal to follow the medically indicated course. Such a standard accords no weight to the autonomy of the individual making the decision. Amicus agrees in general with the standard for competency propounded by the panel. 829 F.2d at 496. A patient should be found competent if the patient has the capacity to assimilate relevant facts and an appreciation of his or her situation as it relates to those facts. Thus, "a person is competent to refuse to take antipsychotic medication if he or she is aware of having a mental disorder; has sufficient knowledge about medication and mental disorder; and does not base the refusal on delusional beliefs." Beck, The Right to Refuse Antipsychotic Medication: Psychiatric Assessment and Legal Decision-making, 11 M.P.D.L.R. 368, 369 (1987). Because these criteria were not applied in the present case, no proper finding of incompetency to make treatment decisions has been made.

Nor could the standards set forth in 18 U.S.C. § 4246 justify forcible medication of Charters. This section authorizes the government to seek alternative placement for detainees who have been found incompetent to stand trial and who are not likely to return to competence, but permits alternative placement only if the detainee has been found to pose "a substantial risk of bodily injury to another or serious damage to property of another" if released. Of course, as the panel opinion held, no finding has ever been made with respect to Charters under this section, 829 F.2d at 487. But even if such a finding had been made, that finding would not suffice to justify forced administration of antipsychotic drugs because the finding entails only a conclusion that the detainee is dangerous, not that the detainee is incompetent.

The American Psychiatric Association seeks to avoid the inadequacy of these statutory findings by suggesting that the findings are the virtual equivalent of the findings necessary for civil involuntary commitment, and thus justify forced administration of antipsychotic drugs as an incident of commitment. See American Psychiatric Association Brief at 7 n.3, 23. Even if this characterization were correct -- and it is not -- amicus believes that involuntary commitment is not alone sufficient to overcome the right to refuse treatment. Although the authorities are split on whether involuntary commitment should justify forced administration of antipsychotic drugs,^{16/} amicus believes that the view best in accord with accepted legal doctrine and professional knowledge is the one that declines to equate involuntary commitment with incompetence to make treatment decisions.

Generally, a civil commitment proceeding establishes only that a person is mentally ill, dangerous to himself or others, and may be in need of treatment. It does not establish that the patient is incapable of making rational decisions about treatment. See, e.g., 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

^{16/} Compare Dautremont v. Broadlawns Hospital, 827 F.2d 291 (8th Cir. 1987); Johnson v. Silvers, 742 F.2d 823 (4th Cir. 1984); and Project Release v. Prevost, 722 F.2d 960 (2d Cir. 1983), with Jarvis v. Levine, 418 N.W.2d 139 (Minn. 1988); Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337 (1986); and People v. Medina, 705 P.2d 961 (Colo. 1985) (en banc).

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, The Constitutional Right to Refuse Antipsychotic Medications, 8 Bull. of Am. Academy of Psychiatry & L. at 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).

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.

Nonetheless, the present record does not reveal any such "borderline" circumstances. Thus, there is no basis for concluding that Charters was incompetent to make treatment decisions.

C. Absent An Emergency, Antipsychotic Drugs May Be Administered Over The Objections Of An Incompetent Patient Only After A Substituted Judgment Determination Has Been Made.

Amicus has demonstrated that -- absent an emergency -- a competent person has an absolute right to refuse antipsychotic medication even if that person has been involuntarily hospitalized pursuant to 18 U.S.C. § 4241 or 4246. Amicus will now show that the panel opinion in this case was correct in holding 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. Respect for the autonomy and dignity of the incompetent requires adoption of the substituted judgment approach for cases in which a person adjudged incompetent refuses treatment with antipsychotic 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.

The rationale for substituted judgment was well expressed by the Massachusetts Supreme Judicial Court:

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.

Superintendent of Belchertown State School v. Saikewicz, 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. See also People v. Medina, 705 P.2d at 971 ("The 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").

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.

People v. Medina, 705 P.2d at 973.¹⁷⁷

III. JUDICIAL DETERMINATIONS OF COMPETENCY AND SUBSTITUTED JUDGMENT ARE CONSTITUTIONALLY REQUIRED TO PROTECT AN INDIVIDUAL'S RIGHT TO REFUSE ANTIPSYCHOTIC DRUGS.

To ensure that a person's substantive rights to refuse antipsychotic 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. These issues are essentially legal in nature. 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. 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."

¹⁷⁷ A patient who refuses antipsychotic medication does not go without treatment. There are a variety of alternative less intrusive, but potentially effective, interventions with severely mentally ill patients. See B. Karon, G. VandenBos, Psychotherapy of Schizophrenia: The Treatment of Choice (1981); Karon & VandenBos, Cost/Benefit Analysis for Schizophrenic Patients Treated by Psychologists, Psychiatrist Psychotherapists, and Medication (without psychotherapy), 7 Professional Psychology 107 (1976).

705 P.2d at 969. Accord Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337 (1986); People v. Medina, 705 P.2d 961; 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. Indeed, that is precisely what happened in the present case. 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. Because the vast majority of patients who are prescribed antipsychotic drugs willingly take them, judicial process would be required only for that small minority of persons who object to treatment with psychotropic drugs. 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. Also, 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). See also Appelbaum & Gutheil, Drug Refusal: A Study of Psychiatric Inpatients, 137 Am. J. Psychiatry 340, 345 (1980). And one study in the District of Columbia found that only 2.4 percent of committed mental patients refused treatment with antipsychotic drugs. Keisling, Characteristics and Outcome of Patients Who Refuse Medication, 34 Hosp. Community Psychiatry 847 (1983).

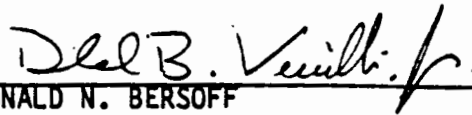
Nor will the courts be unduly burdened with respect to pretrial detainees. The law presently requires federal courts to make determinations respecting a defendant's competency to stand trial. Any additional burden arising from expansion of these hearings to cover the issue of competency to make medical treatment decisions would be minimal. Any delay attendant on the judicial determination will also 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.

CONCLUSION

For all the foregoing reasons, and for the reasons stated in the panel opinion in this case, the judgment of the district court should be reversed.

Respectfully submitted,


DONALD N. BERSOFF
DONALD B. VERRILLI, JR.
ENNIS FRIEDMAN & BERSOFF
Suite 400
1200 Seventeenth Street, N.W.
Washington, D.C. 20036
202-775-8100

June 7, 1988

CERTIFICATE OF SERVICE

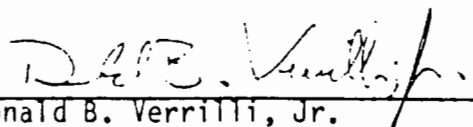
I hereby certify that on this 7th day of June 1988, two copies of the foregoing Brief For Amicus Curiae American Psychological Association in Support of Appellant were served by first-class mail, postage prepaid, to:

Thomas Rawles Jones, Jr.
Cohen, Dunn & Sinclair
221 S. Alfred Street
P.O. Box 117
Alexandria, Virginia 22313-0117

Constance H. Frogale
Assistant United States Attorney
701 Prince Street
Alexandria, Virginia 22314

Victor D. Stone
Attorney
U.S. Department of Justice
P.O. Box 887
Ben Franklin Station
Washington, D.C. 20004

Joel I. Klein
Robert D. Luskin
Onek, Klein & Farr
2550 M Street, N.W.
Washington, D.C. 20037



Donald B. Verrilli, Jr.
ENNIS FRIEDMAN & BERSOFF
1200 17th Street, N.W., Suite 400
Washington, D.C. 20036
Telephone: 202-775-8100