

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 83-2057

UNITED STATES OF AMERICA,

Appellee-Respondent,

v.

JEFFERSON P. LEATHERMAN,

Appellant-Petitioner.

On Appeal from the United States District Court
for the District of Columbia
(D.C. Crim. No. 82-0091)

BRIEF OF AMICI CURIAE
AMERICAN PSYCHOLOGICAL ASSOCIATION
AMERICAN ORTHOPSYCHIATRIC ASSOCIATION

Paul R. Friedman
Donald N. Bersoff
ENNIS, FRIEDMAN, BERSOFF & EWING
1200 17th Street, N.W., Suite 511
Washington, D.C. 20036
(202) 775-8100

Counsel for Amici Curiae

Dated: December 13, 1983

TABLE OF CONTENTS

INTEREST OF <u>AMICI CURIAE</u>	1
QUESTIONS PRESENTED.....	3
INTRODUCTION AND SUMMARY OF ARGUMENT.....	3
I. PSYCHOTROPIC DRUGS ARE HIGHLY BENEFICIAL FOR MANY PATIENTS, BUT THEY ALSO HAVE SUBSTANTIAL SIDE EFFECTS, IMPLICATING BASIC PRINCIPLES OF INDIVIDUAL AUTONOMY.....	7
II. THE LAW OF THE DISTRICT OF COLUMBIA GUARANTEES APPELLANT PERSONAL AUTONOMY AND FREEDOM FROM UNAUTHORIZED BODILY INTRUSIONS SUCH AS THE FORCED ADMINISTRATION OF PSYCHOTROPIC DRUGS.....	11
A. The Common Law of the District of Columbia is Fully Applicable to Appellant.....	11
B. The Law of the District Gives Strong Recognition to the Principle of Individual Autonomy and Guarantees the Right of Competent Adults to Refuse Psychotropic Drugs.....	14
C. Except in Very Unusual Circumstances, the Government's Interests in Forcibly Administering Psychotropic Drugs Do Not Overwhelm the Patient's Basic Right of Autonomy Under the Law of the District.....	16
1. The Government's Interest In Protecting Society From Dangerous Persons Is Not a Sufficient Justification for Forcibly Administering Psychotropic Drugs.....	19
2. The Government's Interest in Improving the Patient's Health is Not a Sufficient Justification for Forcibly Administering Psychotropic Drugs.....	20
3. The Government's Interest in Institutional Order Does Not Justify the Forcible Administration of Psychotropic Drugs.....	21

4. The Government's Interest in Furthering Professional Ethics is Consistent with the Right of Patients to Refuse Administration of Psychotropic Drugs.....	23
III. ABSENT AN EMERGENCY, THE LAW OF THE DISTRICT OF COLUMBIA FORBIDS THE INVOLUNTARY MEDICATION OF APPELLANT WITHOUT A PRIOR JUDICIAL DETERMINATION OF INCOMPETENCY AND JUDICIAL APPLICATION OF THE "SUBSTITUTED JUDGMENT" RULE.....	24
IV. ABSENT AN EMERGENCY, APPELLANT HAS A CONSTITUTIONALLY PROTECTED RIGHT TO BE FREE TO DECIDE WHETHER TO SUBMIT TO THE ADMINISTRATION OF PSYCHOTROPIC DRUGS BY THE GOVERNMENT.....	29
A. When Important State Interests Conflict With Constitutionally Protected Individual Interests, Careful Balancing Is Required.....	30
B. Persons Who Are Able to Make Decisions For Themselves Have Fundamental Constitutional Interests In Being Free to Decide Whether To Submit to the Administration of Psychotropic Drugs.....	31
C. Except In Emergencies Or In Cases of Incompetency, the State Has no Interests That Are Sufficient to Override an Individual's Constitutionally Protected Interests in Being Free to Decide Whether to Submit to the Administration of Psychotropic Drugs.....	33
V. BEFORE APPELLANT'S CONSTITUTIONALLY PROTECTED LIBERTY INTEREST IN CHOOSING WHETHER TO SUBMIT TO ADMINISTRATION OF PSYCHOTROPIC DRUGS MAY BE OVERRIDDEN ON THE BASIS OF THE PARENS PATRIAE POWER, DUE PROCESS REQUIRES A JUDICIAL DETERMINATION OF INCOMPETENCY.....	38
CONCLUSION.....	42

TABLE OF AUTHORITIES

<u>CASES:</u>	<u>Page</u>
<u>Abood v. Detroit Board of Education</u> , 431 U.S. 209 (1977).....	32
<u>Application of President and Directors of Georgetown College, Inc.</u> , 118 U.S. App. D.C. 80, 331 F.2d 1000, <u>cert. denied</u> , 377 U.S. 978 (1964).....	21
<u>Ashwander v. Tennessee Valley Authority</u> , 297 U.S. 288 (1936)....	29
<u>Bell v. Wolfish</u> , 441 U.S. 520 (1979).....	30
<u>Blunt v. United States</u> , 128 U.S. App. D.C. 375, 389 F.2d 545 (D.C. Cir. 1967).....	40
<u>Bolton v. Harris</u> , 130 U.S. App. D.C. 1, 395 F.2d 642 (D.C. Cir. 1968).....	14, 28
<u>Breithaupt v. Abram</u> , 352 U.S. 432 (1957).....	31
<u>Canterbury v. Spence</u> , 150 U.S. App. D.C. 263, 464 F.2d 772 (D.C. Cir.), <u>cert. denied</u> , 409 U.S. 1064 (1972).....	15
<u>Commissioner of Correction v. Myers</u> , 379 Mass. 255, 399 N.E.2d 452 (1979).....	21
<u>Covington v. Harris</u> , 136 U.S. App. D.C. 35, 419 F.2d 617 (D.C. Cir. 1969).....	14
<u>Davis v. Hubbard</u> , 506 F. Supp. 915 (N.D. Ohio 1980).....	9, 32, 36, 37
<u>Eisenstadt v. Baird</u> , 405 U.S. 438 (1972).....	33
<u>Faretta v. California</u> , 422 U.S. 806 (1975).....	32
<u>Green v. United States</u> , 122 U.S. App. D.C. 33, 351 F.2d 198 (D.C. Cir. 1965).....	27
<u>Illinois v. Allen</u> , 397 U.S. 337 (1970).....	32
* <u>In re Boyd</u> , 403 A.2d 744 (D.C. Ct. Apps. 1978).....	passim
<u>In re K.B.B.</u> , 609 P.2d 747 (Okla. 1980).....	37, 39
<u>In the Matter of the Guardianship of Richard Roe, III</u> , 421 N.E.2d 40 (1981).....	9, 11
<u>Ingraham v. Wright</u> , 430 U.S. 651 (1977).....	31, 32

<u>Jacobson v. Massachusetts</u> , 197 U.S. 11 (1905).....	35
* <u>Jones v. United States</u> , 432 A.2d 364, 372 (1981), <u>aff'd</u> , 103 S. Ct. 3043 (1983).....	passim
<u>Jones v. United States</u> , 103 S. Ct. 3043 (1983).....	18
<u>Loving v. Virginia</u> , 388 U.S. 1 (1967).....	33
<u>Mackey v. Procunier</u> , 477 F.2d 877 (9th Cir. 1973).....	32
<u>Mathews v. Eldridge</u> , 424 U.S. 319 (1976).....	38
<u>McCall v. Swain</u> , 166 U.S. App. D.C. 214, 510 F.2d 167 (D.C. Cir. 1975).....	16
<u>Meyer v. Nebraska</u> , 262 U.S. 390 (1923).....	33
<u>Mills v. Rogers</u> , 457 U.S. 291 (1982).....	9, 10, 29
<u>Moore v. City of East Cleveland</u> , 431 U.S. 494 (1977).....	31
<u>Natanson v. Kline</u> , 186 Kan. 393, 406, 350 P.2d 1093 (1960).....	23
<u>O'Connor v. Donaldson</u> , 422 U.S. 563 (1975).....	34
<u>Osgood v. District of Columbia</u> , 567 F. Supp. 1026 (D.D.C. 1983).....	37
<u>Pacific Gas and Electric Co. v. State Energy Resources Conservation and Development Comm'n.</u> , 103 S. Ct. 1713 (1983).....	12
<u>Pierce v. Society of Sisters</u> , 268 U.S. 510 (1925).....	33
<u>Poe v. Ullman</u> , 367 U.S. 497 (1961).....	31
<u>Prince v. Massachusetts</u> , 321 U.S. 158 (1944).....	33
<u>Project Release v. Prevost</u> , No. 82-7943 (2d Cir., Oct. 24, 1983).....	37
<u>Rennie v. Klein</u> , 462 F. Supp. 1131 (D.N.J. 1978), modified and remanded, 653 F.2d 836 (3rd Cir. 1981) (en banc), <u>vacated</u> , 458 U.S. 1119 (1982).....	9
<u>Rennie v. Klein</u> , 653 F.2d 836 (3rd Cir. 1981) (en banc), <u>vacated</u> , 458 U.S. 1119 (1982), on remand No. 79-2576 (3d Cir., Oct. 13, 1983) (en banc).....	9

	<u>Page</u>
<u>Rennie v. Klein</u> , No. 79-2576 (3d Cir., Oct. 13, 1983).....	37
<u>Rochin v. California</u> , 342 U.S. 165 (1952).....	32
<u>Roe v. Wade</u> , 410 U.S. 113 (1973).....	33
* <u>Rogers v. Okin</u> , 478 F. Supp. 1342, 1359-60 (D. Mass. 1979), <u>aff'd in part and rev'd in part</u> , 634 F.2d 650 (1st Cir. 1980).....	9, 10, 20 22, 37
* <u>Rogers v. Okin</u> , 634 F.2d 650 (1st Cir. 1980), <u>vacated sub nom.</u> , <u>Mills v. Rogers</u> , 457 U.S. 291 (1982).....	34, 37
<u>Rouse v. Cameron</u> , 125 U.S. App. D.C. 366, 373 F.2d 451 (D.C. Cir. 1967).....	14
<u>Schmerber v. California</u> , 384 U.S. 757 (1966).....	31
<u>Sibron v. New York</u> , 392 U.S. 40 (1968).....	31
<u>Skinner v. Oklahoma</u> , 316 U.S. 535 (1942).....	33
<u>Sobell v. Reed</u> , 327 F. Supp. 1294 (S.D.N.Y. 1971).....	32
<u>Stanley v. Georgia</u> , 394 U.S. 557 (1969).....	32
<u>Steorts v. American Airlines, Inc.</u> , 207 U.S. App. D.C. 369, 647 F.2d 194 (D.C. Cir. 1981).....	16
<u>Superintendent of Belchertown State School v. Saikewicz</u> , 373 Mass. 728, 370 N.E.2d 417 (1977).....	15, 21, 23, 26
<u>Union Pacific Railway v. Botsford</u> , 141 U.S. 250 (1891).....	31
<u>United States v. (LaVance) Greene</u> , 160 U.S. App. D.C. 21, 489 F.2d 1145 (D.C. Cir. 1974) <u>cert. denied</u> , 419 U.S. 977 (1974).....	13, 14
<u>United States v. Georvassilis</u> , 498 F.2d 883 (6th Cir. 1974).....	31
<u>United States v. Wright</u> , 167 U.S. App. D.C. 309, 511 F.2d 1311 (D.C. Cir. 1975).....	13
<u>Whalen v. Roe</u> , 429 U.S. 589 (1977).....	33
<u>Winn v. United States</u> , 106 U.S. App. D.C. 133, 270 F.2d 326 (D.C. Cir. 1959).....	27
<u>Winters v. Miller</u> , 446 F.2d 65 (2d Cir. 1971), <u>cert. denied</u> , 404 U.S. 985 (1971).....	25, 34, 40

	<u>Page</u>
<u>Wolff v. McDonnell</u> , 418 U.S. 539 (1974).....	30
* <u>Youngberg v. Romeo</u> , 457 U.S. 307 (1982).....	14, 30, 31, 39

CONSTITUTIONAL PROVISIONS:

United States Constitution, Amend. I.....	16, 32
United States Constitution, Amend. IV.....	31
United States Constitution, Amend. V.....	6, 30, 31, 32
United States Constitution, Amend. VIII.....	31
United States Constitution, Amend. XIV	32

STATUTES AND REGULATIONS:

D.C. Code, § 21-545 (1981).....	passim
D.C. Code, § 24-301 (1981).....	passim
D.C. Code, § 21-564.....	39
Ind. Code Ann. § 16-14-9.1-11 (Burns 1983).....	34
S.C. Code § 44-17-580 (Supp. 1982).....	34
Utah Code Ann. § 64-7-36(10)(c) (Supp. 1981).....	34
SEH Policy #4100.4A "Involuntary Administration of Medication"..	18, 39

MISCELLANEOUS:

American Psychological Association, <u>Ethical Principles of Psychologists</u> , 36 <u>Am. Psychol.</u> 633 (1981).....	23
Appelbaum & Gutheil, <u>Drug Refusal: A Study of Psychiatric Inpatients</u> , 137 <u>Am. J. Psych.</u> 340 (1980).....	37
Ayd, <u>A Survey of Drug-Induced Extrapyrarnidal Reactions</u> , 175 <u>J.A.M.A.</u> 1054 (1961).....	8
Brooks, <u>The Constitutional Right to Refuse Antipsychotic Medications</u> , 8 <u>Bull. Am. Acad. Psych. & L.</u> 179 (1980).....	36

Cole & Davis, <u>Clinical Efficacy of the Phenothiazines as Antipsychotic Drugs, in Public Health Service, Psychopharmacology: A Review of Progress 1957-1967</u> <u>1057 (1968)</u>	7
Crane, <u>Clinical Psychopharmacology in Its 20th Year,</u> <u>181 Sci. 124 (1973)</u>	8, 36
Davis, <u>Overview: Maintenance Therapy in Psychiatry:</u> <u>I. Schizophrenia, 132 American Journal of</u> <u>Psychiatry 1237 (1975)</u>	7
<u>Developments in the Law - Civil Commitment of the Mentally</u> <u>III, 87 Harv. L. Rev. 1190 (1974)</u>	19
Helmchen, <u>Schizophrenia: Diagnostic Concepts in the ICD-8,</u> <u>in Studies of Schizophrenia (M. Lader ed. 1975)</u>	19
Hogarty, et al., <u>Drugs and Sociotherapy in the Aftercare</u> <u>of Schizophrenic Patients, 31 Archives of General</u> <u>Psychiatry 603 (1974)</u>	7
Joint Info. Serv. of Am. Psych. Ass'n & Nat'l Ass'n for Mental Health, <u>Psychiatric Points of View</u> <u>Regarding Laws and Procedures Governing Medical</u> <u>Treatment of the Mentally III (Special Info.</u> <u>Bull. No. 1, Sept. 1962)</u>	18
Kane & Smith, <u>Tardive Dyskinesia: Prevalence and Risk</u> <u>Factors, 1959-1979, 39 Archives of General Psychiatry</u> <u>473 (1982)</u>	9
Kennedy, Hershon & McGuire, <u>Extrapyramidal Disorders After</u> <u>Prolonged Phenothiazine Therapy, 118 Brit. J. Psych.</u> <u>509 (1971)</u>	8
M. Lorr, C. Klett & D. McNair, <u>Syndromes of Psychosis 8,</u> <u>1978-80 (1963)</u>	19
<u>Modern Synopsis of Comprehensive Textbook of Psychiatry/II</u> <u>943, 956-61 (A. Freedman, H. Kaplan & B. Sadock</u> <u>eds. 1976)</u>	8
National Comm'n for Protection of Human Subjects of Biomedical and Behavioral Research, <u>Research</u> <u>Involving Those Institutionalized As Mentally Infirm</u> <u>53-56 (H.E.W. Pub. No. 78-006, 1978)</u>	23

National Institute of Mental Health Collaborative Study Group, <u>Phenothiazine Treatment in Acute Schizophrenia</u> , 10 <u>Archives of General Psychiatry</u> 246 (1964).....	7
J. Neale & T. Oltmans, <u>Schizophrenia</u> 24 (1980).....	19
Note, <u>Federal and Local Jurisdiction in the District of Columbia</u> , 92 <u>Yale L. J.</u> 292 (1982).....	12
Shapiro, <u>Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies</u> , 47 <u>So. Cal. L. Rev.</u> 237 (1974).....	32
Stone, <u>Informed Consent: Special Problems for Psychiatry</u> , 30 <u>Hosp. & Comm. Psych.</u> 321 (1979).....	34
Van Putten, <u>Why Do Schizophrenic Patients Refuse to Take Their Drugs?</u> , 31 <u>Arch. Gen. Psych.</u> 67 (1974).....	19

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 83-2057

UNITED STATES OF AMERICA,

Appellee-Respondent,

v.

JEFFERSON P. LEATHERMAN,

Appellant-Petitioner.

On Appeal from the United States District Court
for the District of Columbia
(D.C. Crim. No. 82-0091)

BRIEF OF AMICI CURIAE
AMERICAN PSYCHOLOGICAL ASSOCIATION
AMERICAN ORTHOPSYCHIATRIC ASSOCIATION

INTEREST OF AMICI CURIAE

Amici curiae are two organizations of mental health professionals, many of whose members have direct experience working in state hospitals for the mentally ill. The members of these organizations -- psychiatrists, psychologists, social workers, and psychiatric nurses -- are charged with day-to-day responsibility for providing treatment to residents of state mental institutions, and are familiar with both the problems of institutionalized patients and the use and misuse of antipsychotic drugs in institutional settings.

The American Psychological Association, a voluntary, non-profit, scientific and professional organization with almost 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 Orthopsychiatric Association, founded in 1924, is a national, interdisciplinary, professional, educational organization of over 10,000 members, including psychiatrists, psychologists, social workers, psychiatric nurses, educators, and allied professionals working in the mental health field. Many of its members work in mental hospitals and in out-patient

settings, and are familiar with the problems of institutionalized patients, and the use and misuse of antipsychotic drugs in institutional settings. The Association is concerned not only with the adequacy of the treatment of patients with mental health problems, but also with the rights of those patients.

Amici believe that they have relevant expertise, experience, and perspective which will be of value to the Court in its deliberations.

QUESTIONS PRESENTED

Amici adopt the statement of the questions presented included in Appellant's brief.

INTRODUCTION AND SUMMARY OF ARGUMENT

This case raises the controversial and important issue whether persons involuntarily institutionalized following an acquittal by reason of insanity have either a common law or constitutional right to decide whether to undergo administration of psychotropic drugs in non-emergency situations.¹ The procedural history of the case is fully described in appellant's brief,

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 normally is prescribed for neurotic disorders; the second group for depressive disorders; and the third group for psychotic disorders, especially schizophrenia. The present lawsuit involves only the psychotropic drug Haldol (haloperidol). Other common psychotropic drugs include Thorazine (chlorpromazine), Stelazine (trifluoperazine), Trilafon (perphenazine), Mellaril (thioridazine), Proloxin (fluphenazine), and Navine (thiothexene).

and will not be repeated here. Amici note, however, that the following facts are undisputed: First, the Hospital seeks to medicate appellant with the psychotropic drug Haldol over appellant's clearly expressed objection despite the Hospital's concession that no emergency situation exists and that the administration of Haldol is not necessary to prevent physical harm to appellant or others. Moreover, there is no suggestion in the Medical Director's report that psychotropic drugs are needed to prevent a sudden deterioration in appellant's condition. Second, appellant has not been adjudicated incompetent to choose for himself whether to be medicated with psychotropic drugs. In fact, appellant was adjudicated competent to stand trial for the offense underlying his institutionalization in 1982, and appellant is competent now to participate in judicial proceedings concerning his possible release from the Hospital. Third, the Hospital has unilaterally decided that appellant is factually incompetent to make a rational decision concerning his treatment and that medication with Haldol is in appellant's medical best interest. The District Court allowed these unilateral decisions by the Hospital to override appellant's personal wishes.

Point I. Although psychotropic drugs such as Haldol are highly beneficial for many patients, they are an extremely intrusive form of treatment with severe, sometimes irreversible side effects. Moreover, as the name suggests, psychotropic drugs are literally "mind-altering," implicating the most fundamental of freedoms -- freedom of thought. In light of the serious side affects and harms associated with these drugs, the decision whether to medicate over a patient's objections implicates constitutional and common law rights as well as professional judgments.

Point II. The common law of the District of Columbia gives a right of personal autonomy to persons who, like appellant, have been committed involuntarily following a verdict of not guilty by reason of insanity. In the recent case of In re Boyd, which involved a mental patient who was committed to the Hospital pursuant to the District's basic civil commitment statute, D.C. Code, § 21-545 (1981), the District of Columbia Court of Appeals stated unequivocally that "all competent persons" -- even those involuntarily committed to mental hospitals -- have "the right to refuse medical treatment." 403 A.2d 744, 747, n.5 (1978). Although the instant case deals with civil commitment following an insanity acquittal under a different statutory section, D.C. Code, § 24-301(d) (1981), the substantive standard and objectives of commitment are identical under both statutes. Jones v. United States, 432 A.2d 364, 372, 373 (1981), aff'd, 103 S. Ct. 3043 (1983); see id. at 370, n. 10 (commitment under § 24-301(d) is a "civil, not a criminal" matter). Accordingly, Boyd's logic ineluctably controls this case as well.

Point III. Under the common law of the District, except possibly in emergencies, patients committed pursuant to § 21-545 may not be forcibly administered psychotropic drugs in the absence of two judicial determinations, neither of which has been made in this case: first, that the individual is presently incompetent; and second, that the incompetent individual would consent to the treatment if competent. In the absence of relevant differences between them, courts in the District have extended to § 24-301 committees the same procedural safeguards afforded § 21-545 committees. Analysis shows that nothing in § 24-301 precludes application of the safeguards established in Boyd and that, to the contrary, there are even stronger justifications for requiring a judicial determination of incompetency before allowing forced

medication of § 24-301 committees than there are in the case of § 21-545 committees. Accordingly, the Hospital should not be allowed to administer psychotropic drugs over appellant's objections in the absence of an emergency until it has obtained a judicial determination of incompetency.

Point IV. Although a proper resolution of appellant's claims under District of Columbia law will end this controversy, making it unnecessary to base a decision on federal constitutional grounds, the Due Process Clause of the Fifth Amendment also requires reversal of the District Court. As the District Court in this case assumed, and as virtually every court to rule on the issue has found, forced administration of psychotropic drugs infringes a variety of liberty interests protected by the Constitution, including the interest in bodily integrity and personal security, the interest in being able to think and communicate freely, and the interest in being free to make decisions about one's own body and mind. The District Court properly questioned the Government's contention that forced administration of Haldol does not implicate Federal Constitutional rights. Absent an emergency, there are no state interests sufficient to outweigh the fundamental liberty interests of a competent committed person in being free to decide whether to submit to the administration of psychotropic drugs.

Point V. It is a complex and unresolved issue whether the Constitution would be satisfied if the decision to medicate an incompetent patient were based solely on professional judgment and an orderly administrative process. But the District Court erred in finding that Due Process is provided when the crucial threshold question of competency itself is decided conclusively by medical or administrative personnel. Only a court

of law can provide the requisite process when competency -- quintessentially a legal determination, not a medical one -- is at issue.²

I. PSYCHOTROPIC DRUGS ARE HIGHLY BENEFICIAL FOR MANY PATIENTS, BUT THEY ALSO HAVE SUBSTANTIAL SIDE EFFECTS, IMPLICATING BASIC PRINCIPLES OF INDIVIDUAL AUTONOMY

Psychotropic drugs have a major beneficial impact on, and are considered the treatment of choice for, many patients. 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); Davis, Overview: Maintenance Therapy in Psychiatry:

I. Schizophrenia, 132 American Journal of Psychiatry 1237 (1975); National Institute of Mental Health Collaborative Study Group, Phenothiazine Treatment in Acute Schizophrenia, 10 Archives of General Psychiatry 246 (1964); Hogarty, et al., Drugs and Sociotherapy in the Aftercare of Schizophrenic Patients, 31 Archives of General Psychiatry 603 (1974). Based upon such evidence, the District of Columbia Court of Appeals found that "[p]sychotropic drugs are considered more effective than any other form of treatment in reducing thought disorder in schizophrenics." In re Boyd, supra, 403 A.2d at 752, n.13.

As discussed below, however, the efficacy of a procedure does not provide a sufficient predicate for involuntary treatment. What was lost in

² Amici are aware that this case involves the review of the denial of a preliminary injunction. Amici address only the merits determination, seeking to establish that appellant will succeed on the merits of his common law and constitutional claims. Amici do not address the other elements appropriate to the issuance of preliminary relief. Nor do amici address the merits of appellant's constitutional claim based on his pending D.C. Code, § 24-301(k) proceeding.

Respondent-Appellee's District Court discussion of the effectiveness of psychotropic medication is that efficacy is not the primary -- or, for that matter, even a highly relevant -- issue in this case. Even if it could be demonstrated that psychotropic drugs were always effective in reducing symptoms associated with schizophrenia, the law still would not permit forcible treatment with these drugs, except in highly unusual situations.

Efficacious psychotropic drugs also can have severe side effects. The District of Columbia Court of Appeals, in the Boyd case, catalogued a series 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 (akathisia), and mask-like face, drooping, stiffness and rigidity, shuffling gait, and tremors (pseudo-parkinsonian syndrome). See In re Boyd, supra, 403 A.2d at 752, n.13.³ The Boyd court also noted nonmuscular physical 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.⁴

³ See, e.g., Ayd, A Survey of Drug-Induced Extrapyrarnidal Reactions, 175 J.A.M.A. 1054 (1961); Crane, Clinical Psychopharmacology in Its 20th Year, 181 Sci. 124 (1973); Kennedy, Hershon & McGuire, Extrapyrarnidal Disorders After Prolonged Phenothiazine Therapy, 118 Brit. J. Psych. 509 (1971).

⁴ See, e.g., id.; Modern Synopsis of Comprehensive Textbook of Psychiatry/II 943, 956-61 (A. Freedman, H. Kaplan & B. Sadock eds. 1976).

Although the side effects described above are both frightening and serious, the most debilitating effect linked to psychotropic drugs is a condition known as tardive dyskinesia. See In re Boyd, supra, 403 A.2d at 752, n.13. This side effect is characterized by involuntary muscle movements of the lips and tongue which often mimick normal chewing, blowing, or licking motions. To date, tardive dyskinesia has resisted curative efforts, and its disabling manifestations may persist for years. Ibid. A major recently published literature review found an average prevalence of tardive dyskinesia of twenty percent in patients who had been treated with psychotropic medication. Kane & Smith, Tardive Dyskinesia: Prevalence and Risk Factors, 1959-1979, 39 Archives of General Psychiatry 473 (1982).⁵ In the light of these serious side effects, the Supreme Judicial Court of Massachusetts appropriately adopted the findings of other courts,⁶ including the Boyd court, and researchers, that "antipsychotic drugs are high-risk treatment." In the Matter of the Guardianship of Richard Roe, III, 421 N.E.2d 40, 54 (1981).

⁵ According to the authors, however, "there are relatively few data supporting the assumption that the risk of Tardive Dyskinesia development continues to increase with increasing neuroleptic exposure." Id.

⁶ Among the many cases reaching a similar conclusion are Mills v. Rogers, 457 U.S. 291, 293, n.1 (1982), Rennie v. Klein, 653 F.2d 836, 843 and n.8 (3rd Cir. 1981) (en banc), vacated, 458 U.S. 1119 (1982), on remand No. 79-2576 (3d Cir., Oct. 13, 1983) (en banc), Rogers v. Okin, 634 F.2d 650, 653 and 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), Rogers v. Okin, 478 F. Supp. 1342, 1359-60 (D. Mass. 1979), aff'd in part and rev'd in part, 634 F.2d 650 (1st Cir. 1980), Rennie v. Klein, 462 F. Supp. 1131, 1137-38 (D.N.J. 1978), modified and remanded, 653 F.2d 836 (3rd Cir. 1981) (en banc).

Thus, psychotropic drugs offer great benefit to many patients, but also pose a risk of serious side effects. Moreover, it is impossible to predict at the outset whether a given individual will benefit from the treatment and have no adverse side effects; will benefit but will experience adverse side effects; will not benefit but will also not experience adverse side effects; or will not benefit but will have adverse side effects. Clinicians have great difficulty in predicting a particular individual's response to a particular drug. See id., at 53.

Because psychotropic medication holds the promise of dramatically alleviating the patient's suffering or controlling his symptoms, but also involves a risk of serious side effects, the decision whether to take such medication implicates the basic common law and constitutional principles, discussed below, favoring personal autonomy and freedom from unauthorized bodily intrusions. The Government may have greater freedom to impose its will where the costs and benefits of a decision are known. But the Government's power to act is most restricted where, as here, the decision involved raises the possibility of major risks to individual health and has no clear and predictable outcome in a particular case.

Finally, the purpose of psychotropic drugs is to affect the patient's consciousness in order to reduce psychosis and enhance rational thought and behavior. There can be no question that such drugs are "mind-altering." See Mills v. Rogers, supra, 457 U.S. at 293, n.1. One district court appropriately found that psychotropic drugs have the potential "to affect and change a patient's mood, attitude, and capacity to think." Rogers v. Okin, supra, 478 F. Supp. at 1366. As the Supreme Judicial Court of Massachusetts

observed, psychotropic drugs such as Haldol have a "profound effect ... on the thought processes of an individual..... [T]he impact of the chemicals upon the brain is sufficient to undermine the foundations of personality." Roe, III, supra, 421 N.E.2d at 53.

The basic principle of protecting individual autonomy is fundamentally threatened when the Government seeks forcibly to change an individual's consciousness and thought processes by administering powerful mind-altering drugs against his will. Accordingly, this Court should ensure that such drugs are forcibly administered only where the justification is overwhelmingly strong.

II. THE LAW OF THE DISTRICT OF COLUMBIA GUARANTEES APPELLANT PERSONAL AUTONOMY AND FREEDOM FROM UNAUTHORIZED BODILY INTRUSIONS SUCH AS THE FORCED ADMINISTRATION OF PSYCHOTROPIC DRUGS

A. The Common Law of the District of Columbia is Fully Applicable to Appellant

In a cryptic footnote, the District Court dismissed appellant's claim that he has an absolute right under District of Columbia law -- absent an emergency -- to refuse psychotropic medication until adjudicated incompetent. Memorandum and Order Denying Interim Relief, p. 3, n.*. Amici agree with appellant that the District Court erred in refusing to rule on appellant's common law claim before denying relief.

For the reasons stated in appellant's brief and those added herein, amici also agree with appellant that District law is fully applicable to appellant, and is not preempted. A local law may be preempted when it conflicts with the terms or objectives of a federal statute, or when it is

clear that through legislation Congress intended to occupy the field to the exclusion of state or local laws. See Pacific Gas and Electric Co. v. State Energy Resources Conservation and Development Comm'n., 103 S. Ct. 1713, 1722 (1983). Neither the District Court -- which purported not to decide the question -- nor the Government has suggested how either type of preemptive intent is discernible here. Indeed, the only tenable conclusion is that Congress intended that the law of the District control.

Congress always has considered the commitment of those acquitted of federal offenses by reason of insanity to be a local, not a federal, matter. Congress has not passed legislation of a national scope providing for the commitment of federal insanity acquittees. Outside this federal district, where Congress acts as the local legislature, see Note, Federal and Local Jurisdiction in the District of Columbia, 92 Yale L. J. 292, 294 (1982), Congress has left entirely to the fifty states whether, and on what terms, federal insanity acquittees are to be committed. There is no reason to suppose that in the District of Columbia alone Congress determined that commitment of federal insanity acquittees is a matter of national concern. In fact, in the District of Columbia, Congress has chosen to regulate the commitment of federal insanity acquittees in the D.C. Code provision that governs commitment of local insanity acquittees, making clear its intent that the same, local law governs both types of acquittees in this jurisdiction.

To be sure, § 24-301 does distinguish among insanity acquittees -- but the distinction is according to whether the acquittee, local or federal, raised the insanity defense, not whether the underlying crime was local or federal. Subsection 24-301(d) provides only for the commitment of those

acquittees who successfully raised the defense at the criminal trial. Federal defendants, like local defendants, acquitted by reason of insanity on the prosecutor's or judge's motion may be committed in the District, as elsewhere, only pursuant to local civil commitment law -- in the District under § 21-545. See United States v. Wright, 167 U.S. App. D.C. 309, 511 F.2d 1311 (D.C. Cir. 1975). The terms of commitment of all such federal defendants acquitted on the grounds of insanity by prosecutors' or judges' motions have been left by Congress entirely to the law of the District. That such acquittees have violated the U.S., rather than the D.C., Code has not moved Congress to view their commitment as a matter of federal concern. There is no evidence to suggest, and it is inherently implausible, that Congress would view the commitment of one group of federal insanity acquittees as a matter of local law, and commitment of another group as a matter of federal law, based solely on whether the insanity defense was raised by the defendant himself or by others. In amici's view, Congress intended the conditions of commitment of federal insanity acquittees who themselves raised the defense to be governed as are the conditions of commitment of federal insanity acquittees elsewhere in the country, and as those of other federal insanity acquittees here are governed -- by local law.⁷

⁷ Despite the language of § 24-301, which clearly applies D.C. law to both federal and local defendants and insanity acquittees in the District, see United States v. (LaVance) Greene, 160 U.S. App. D.C. 21, 489 F.2d 1145, 1170-1172 (D.C. Cir. 1974) (Bazelon, C.J., dissenting from denial of rehearing en banc), cert. denied, 419 U.S. 977 (1974), this Court on occasion has expressed some doubt as to whether § 24-301 was intended to, or could, apply to federal defendants. E.g., United States v. Wright, supra, 511 F.2d at

B. The Law of the District Gives Strong Recognition to the Principle of Individual Autonomy and Guarantees the Right of Competent Adults to Refuse Psychotropic Drugs

The laws of the District provide independent and often greater protection to involuntarily committed mental patients than does the Federal Constitution. Compare, e.g., Rouse v. Cameron, 125 U.S. App. D.C. 366, 373 F.2d 451, 456 (D.C. Cir. 1967) (involuntary committees under both § 21-545 and § 24-301 in the District have right to "treatment which is adequate in light of present knowledge") and Covington v. Harris, 136 U.S. App. D.C. 35, 419 F.2d 617, 623 (D.C. Cir. 1969) (District law provides right not only to treatment but to treatment in least restrictive alternative consistent with the purposes of commitment) with Youngberg v. Romeo, 457 U.S. 307, 319 (1982) (involuntarily committed mentally retarded individuals have constitutional right to "minimally adequate or reasonable training to ensure safety and freedom from undue restraint"). See Bolton v. Harris, 130 U.S. App. D.C. 1, 395 F.2d 642, 649 (D.C. Cir. 1968).

In the Boyd case, the District of Columbia Court of Appeals made clear that the District recognizes "the traditional rule against imposing

7 Continued

1312-1313; United States v. Greene, *supra*, 489 F.2d at 1153 (panel opinion). The applicability of local law to appellant is no less clear if § 24-301(d) applies only to local defendants. In that event, appellant could not lawfully be committed under that section, and the Hospital would not have lawful custody over him. The only way in which appellant lawfully could be committed to the Hospital -- as in every other jurisdiction in the United States -- would be via local civil commitment proceedings, pursuant to D.C. Code, § 21-545. Local law obviously would control the terms of commitment. Thus, even if § 24-301(d) does not apply to those acquitted by reason of insanity of federal offenses in the District, Congress intended that local law control.

medical treatment on a competent person who rejects it, for whatever reason -- absent a compelling state interest." 403 A.2d at 750. The Court grounded this rule on the fundamental concept of American jurisprudence, "that every competent adult has the "right to determine what shall be done with his own body."" Boyd, supra, 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)). The Boyd Court also relied heavily, see 403 A.2d at 748, n.8, 749, 750-753, on a Massachusetts Supreme Judicial Court decision 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).

Indeed, the importance of personal autonomy in the law of the District permeates the Boyd case. The Court of Appeals there adopted a "substituted judgment" standard for determining whether an incompetent person should receive medical treatment. Under that standard the decisionmaker must look not to the best interests of the patient in an objective sense, but instead must ask what the patient, subjectively, would consider in his best

interests were he competent to decide. As the Boyd court stated, the "substituted judgment" standard reflects the principle of personal autonomy 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 750.⁸

C. Except in Very Unusual Circumstances, the Government's Interests in Forcibly Administering Psychotropic Drugs Do Not Overwhelm the Patient's Basic Right of Autonomy Under the Law of the District

Boyd establishes⁹ that the common law principle of personal autonomy prohibits the Government from administering psychotropic drugs to nonconsenting patients "absent a compelling state interest." 403 A.2d at

⁸ While the Boyd Court was applying the "substituted judgment" standard in the context of a First Amendment free exercise of religion claim, it stated that

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, but no longer has the capacity to decide.

403 A.2d at 750 (emphasis supplied). The application of the "substituted judgment" rule outside the religious context is based on the District's common law rule respecting personal autonomy, which, together with the First Amendment, comprised the "two premises" from which the "substituted judgment" rule was derived in Boyd. Ibid.

⁹ Since the early 1970's, the District of Columbia courts have had "full responsibility for the development of the District's own law." Steorts v. American Airlines, Inc., 207 U.S. App. D.C. 369, 647 F.2d 194, 196 (D.C. Cir. 1981). This Court must accord "the greatest deference" to local court decisions, McCall v. Swain, 166 U.S. App. D.C. 214, 510 F.2d 167, 173 (D.C. Cir. 1975), much as federal courts elsewhere defer to the decisions of state courts on state law.

750. Amici believe that the Government may forcibly administer such drugs in only two limited and unusual situations. The first situation -- which the Government concedes does not exist in this case -- involves patients who are actively violent toward themselves or others, or who pose an immediate and substantial threat of becoming violent. In this situation, the Government's interest in preserving order and protecting patients and staff within the institution may well be sufficient to override the patient's autonomy interest if -- but only if -- other less intrusive approaches would be ineffective in quelling the patient's violent behavior. The second situation involves incompetent patients who resist administration of the drugs and who, if competent, would consent to the treatment. Analytically, this second situation does not involve an infringement of the patient's right of autonomy because under Boyd's "substituted judgment" standard, it would further the patient's autonomy interest to administer the medication despite his objections. Accordingly, the Government's interest in improving the health of individuals in its care justifies treatment of such incompetent patients with psychotropic drugs.

Implicit in Boyd is the conclusion that, except in these unusual circumstances, the Government's interests in forcibly administering psychotropic drugs are not sufficiently compelling to overwhelm the right to choose possessed by patients involuntarily committed under D.C. Code, § 21-545. The same plainly is true with respect to patients involuntarily committed after successfully raising the insanity defense pursuant to D.C. Code, § 24-301. Both types of commitment are civil in nature, Jones v. United States, supra, 432 A.2d at 370, n.10, and are based on an "identical" substantive standard of commitment, id. at 373. Moreover, in the District,

"[t]he purpose of commitment following an insanity acquittal, like that of civil commitment, is to treat the individual's mental illness and protect him and society from his potential dangerousness," Jones v. United States, 103 S. Ct. 3043, 3051 (1983); see Jones v. United States, supra, 432 A.2d at 373 ("[i]n either case, the only concern is a determination as to sanity and dangerousness, with a view to rehabilitation")(quoting from the first panel opinion). Thus, as the Government concedes, under neither statute does a commitment determination "mean that the committee is legally incompetent." Boyd, supra, 403 A.2d at 747, n.5.

As the Hospital's own regulations demonstrate, this legal distinction reflects clinical reality; SEH Policy #4100.4A "Involuntary Administration of Medication," at the top of page 6, sets forth procedures governing "Involuntary Patients Having the Capacity to Consent to Medication Treatment." As early as 1962, amicus American Psychiatric Association acknowledged that hospitalization is not necessarily related to competence to make decisions:

It must be clearly understood that the establishment of a mental illness does not, ipso facto, warrant a finding of incompetency From a medical point of view, there is not, necessarily, any connection between the two [A]ll laws governing mental illness should recognize that many hospital patients are perfectly capable of handling their own affairs and that any automatic tie-up of incompetency and commitment is harmful.

Joint Info. Serv. of Am. Psych. Ass'n & Nat'l Ass'n for Mental Health,
Psychiatric Points of View Regarding Laws and Procedures Governing Medical

Treatment of the Mentally Ill (Special Info. Bull. No. 1, Sept. 1962)
(emphasis added).¹⁰

1. The Government's Interest In Protecting
Society From Dangerous Persons Is Not a
Sufficient Justification for Forcibly
Administering Psychotropic Drugs.

Civil commitment in the context of § 24-301 does not involve a determination that the Government's interests in forcibly administering psychotropic drugs overwhelm the right of the patient, whether competent or not, to refuse such drugs. While one purpose of commitment under § 24-301 is protecting society from dangerous individuals, that is equally true under § 21-545. Section 24-301 committees differ from some § 21-545 committees in that they have committed a crime, showing that they were dangerous at some point in the past. But a finding of past criminal conduct under § 24-301 merely creates a "presumption of continuing dangerousness," Jones v. United States, supra, 432 A.2d at 371, that substitutes, in effect, for the finding required under § 21-545 that committees are presently dangerous by "clear and convincing evidence." Jones v. United States, supra, 432 A.2d at 375; Jones

¹⁰ 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, 1978-80 (1963) (cognitive disorientation is absent in hostile paranoid schizophrenia); see J. Neale & T. Oltmans, Schizophrenia 24 (1980); Helmchen, Schizophrenia: Diagnostic Concepts in the ICD-8, in Studies of Schizophrenia (M. Lader ed. 1975) (disturbances of comprehension, memory and awareness absent among as many as two-thirds of schizophrenics); Developments in the Law - Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190, 1214 (1974). In fact, patients often have good reasons 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. Psych. 67, 68 (1974).

v. United States, supra, 103 S. Ct. at 3049-3050.¹¹ Moreover, as noted above, some § 21-545 committees may be insanity acquittees who did not themselves raise the defense at the criminal trial. Whether an acquittee himself raised the defense is wholly irrelevant to the level of the Government's interest in involuntary treatment with psychotropic drugs. Thus, as with § 21-545 committees, the Government's interest in protecting society is satisfied when an individual committed pursuant to § 24-301 is removed from the community and cannot justify the forcible administration of psychotropic drugs to the patient once he is committed.¹²

2. The Government's Interest in Improving the Patient's Health is Not a Sufficient Justification for Forcibly Administering Psychotropic Drugs.

The Government's interest in improving the patient's health provides no more sufficient justification for forcibly administering psychotropic drugs to § 24-301 committees than does its interest in protecting against harm. As Boyd makes clear, even in a life-or-death situation, the law of the District

¹¹ By contrast, an insanity acquittee committed under § 24-301(d) has not been shown to be presently dangerous, even by a preponderance of the evidence. See n.19, infra.

¹² Amici do not contend that, once the patient has been committed, the Government's interests in administering psychotropic drugs can never outweigh the patient's right to refuse treatment. Amici already have identified situations when the Government's interests overwhelm the patient's autonomy right. The interest in preventing patients from engaging in violent conduct harmful to themselves or others justifies involuntary medication if less intrusive approaches are not effective. But only a relatively small percentage of involuntarily committed patients are even potentially violent in an institutional setting. See Rogers v. Okin, supra, 478 F. Supp. at 1356. This interest, then, cannot justify a general regime in which the Government may forcibly medicate the entire patient population.

may require a finding of present incompetency and application of the "substituted judgment" standard before medication may forcibly be administered. 403 A.2d at 750. But even if the Government's interest in saving life, characterized by the Saikewicz Court as the "most significant of ... State interests," 370 N.E.2d at 425, can in some situations override the autonomy right,¹³ this interest is not implicated here because psychotropic drugs do not prolong life. When the treatment in question is the administration of psychotropic drugs, Boyd makes clear that the interest in enhancing or preserving health, as opposed to that of saving life, is never sufficiently compelling to override the patient's fundamental right to autonomy and freedom from unconsented bodily intrusions.¹⁴

3. The Government's Interest in Institutional Order Does Not Justify the Forcible Administration of Psychotropic Drugs.

Boyd also makes clear that under D.C. common law the Government's interests in institutional order, relied upon by the District Court in its constitutional analysis, are not a sufficient justification for forcibly administering psychotropic drugs. Any governmental institution can function more efficiently and effectively if individual freedom of action is limited.

¹³ See, e.g., Commissioner of Correction v. Myers, 379 Mass. 255, 399 N.E.2d 452 (1979), Application of President and Directors of Georgetown College, Inc., 118 U.S. App. D.C. 80, 331 F.2d 1000, cert. denied, 377 U.S. 978 (1964).

¹⁴ In this respect, of course, § 24-301 committees are situated identically to § 21-545 committees. Under § 24-301, "the crime is relevant only insofar as it indicates dangerousness." Jones v. United States, *supra*, 432 A.2d at 371. Accordingly, the fact that the acquittee committed a crime cannot raise the Government's interest in treatment.

However, this Nation -- and the District of Columbia -- have made the basic choice that individual freedom is a higher value that should be preferred even at the expense of some loss of governmental efficiency and order.

Accordingly, even assuming arguendo that patient refusals to take psychotropic drugs adversely affect institutional order, the Government could justify forcibly administering the medication only by demonstrating that the interference with institutional order was so severe that it overrides the preferred interest in personal autonomy and freedom from unauthorized bodily intrusions. With due respect, amici submit that the Government has not come close to meeting that evidentiary burden.

In balancing the Government's interest in orderly administration of the Hospital against the autonomy interests of patients, one must remember that the vast majority of patients who are prescribed psychotropic 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 psychotropic drugs in nonemergency situations, a witness for the State was able to identify only 12 patients out of approximately 1000 who refused medication for prolonged periods. And most of those patients changed their minds within a few days and agreed to take the medication. Rogers v. Okin, supra, 478 F. Supp. at 1369. Moreover, there are far fewer patients committed to the Hospital pursuant to § 24-301 than are committed under § 21-545. As of September 30, 1983, for example, there were almost three times as many patients in the Hospital by way of civil commitment than were there by way of an insanity acquittal. The Boyd Court found that for this larger group of persons committed under § 21-545, the burden upon the government's interest in preserving institutional order

was not sufficiently great to override that group's common law right to refuse psychotropic drugs. This same reasoning holds true for the far smaller group of § 24-301 committees of which appellant is a member.

4. The Government's Interest in Furthering Professional Ethics is Consistent with the Right of Patients to Refuse Administration of Psychotropic Drugs.

Finally, recognition of the right of competent patients to refuse psychotropic drugs is wholly consistent with the Government's interest in furthering professional ethics. It is a universally accepted, though not always honored principle, that persons must give their 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 53-56 (H.E.W. Pub. No. 78-006, 1978) (Nat'l Comm'n). The underlying legal and ethical premise of the informed consent doctrine is the notion of "thoroughgoing 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, see Nat'l Comm'n, supra, at 53, 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. See Saikewicz, supra, 370 N.E.2d at 426-27. In fact, recognition of this common law right would accord with the highest ethical and professional standards of professional psychology. See American Psychological Association, Ethical Principles of Psychologists, 36 Am. Psychol. 633, 633, 634, 636 (1981) (psychologists must strive to protect

fundamental human rights, fully inform clients of the purpose and nature of treatment, and recognize that clients "have freedom of choice with regard to participation"). The ethical demands of all mental health professionals are best served by recognizing, to the maximum extent possible, the autonomy of the patients they serve.

To sum up, as a matter of law and ethics, the decision to treat is not one that resides solely within the discretion of the hospital staff; nor is the status of competency a mere legal technicality. The presumption of competency and the attendant principle of autonomy are foundations both of Anglo-American jurisprudence and of professional ethics, providing barriers to well-intentioned but improper state intervention. The proper role of the treating professional is to respect the patient's autonomy and to honor the presumption of competency.

III. ABSENT AN EMERGENCY, THE LAW OF THE DISTRICT OF
COLUMBIA FORBIDS THE INVOLUNTARY MEDICATION OF
APPELLANT WITHOUT A PRIOR JUDICIAL DETERMINATION
OF INCOMPETENCY AND JUDICIAL APPLICATION OF THE
"SUBSTITUTED JUDGMENT" RULE

Even when the Government has the substantive power forcibly to administer psychotropic medication, District law imposes stringent and vitally important procedural safeguards with respect to how that decision is made. The question of competency obviously lies at the heart of appellant's traditional and fundamental common law right to refuse medication. Moreover, a determination of incompetency is the sine qua non of the Government's parens

patriae power to choose "for" the incompetent individual.¹⁵ In light of the competency determination's centrality to the competent individual's right to choose for himself, and its centrality to the Government's parens patriae power, it is not surprising that, in the District, "a trial court cannot override the treatment decision of a mentally ill adult unless he or she has been adjudicated presently incompetent," Boyd, supra, 403 A.2d at 747, n.5 (emphasis supplied). Further, as Boyd makes clear, the treatment decision itself, involving medically unpredictable potential benefits and equally unpredictable severe side effects, is at bottom a question of "subjective" individual values and preferences¹⁶ that also is best decided by an

¹⁵ See Boyd, supra, 403 A.2d at 748, n.8 ("once an individual becomes incompetent, the state must act as parens patriae"); Winters v. Miller, 446 F.2d 65, -71 (2d Cir. 1971), cert. denied, 404 U.S. 985 (1971) (parens patriae relationship created "if and when a person is found legally incompetent") (emphasis in original).

¹⁶ The Boyd court observed:

"Implicit here is the recognition that competent persons occasionally decide that their best interest requires rejection of medical care on religious grounds, and that courts should respect their wishes. Accordingly, it begs the question to say that the trial court can determine an incompetent's 'best interest' without considering that person's religious opposition to medical treatment. As the Jehovah's Witness cases make clear, even in a life-or-death situation one's religion can dictate a 'best interest' antithetical to getting well. ...

"The court, as surrogate for the incompetent, is to determine as best it can what choice that individual, if competent, would make with respect to medical procedures. ... We believe this approach is sound, whether religious preference or other factors are

impartial judge using the substitute judgment standard.¹⁷ The potential for inappropriate use of psychotropic drugs by those claiming to act in the patient's best interests provides an additional reason for requiring a judicial determination of incompetency, and judicial application of the "substituted judgment" rule, before such drugs are forcibly administered.¹⁸

16 Continued

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, but no longer has the capacity to decide."

403 A.2d at 750. The Court of Appeals then quoted the following passage from Saikewicz:

"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. ... Nor do statistical factors indicating that a majority of competent persons similarly situated choose treatment resolve the issue. The significant decisions of life are more complex than statistical determinations. Individual choice is determined not by the vote of the majority but by the complexities of the singular situation viewed from the unique perspective of the person called on to make the decision. 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."

Id. (quoting Saikewicz, supra, 370 N.E.2d at 428) (emphasis supplied).

¹⁷ 403 A.2d at 747, n.5 ("a trial court cannot override ...") (emphasis supplied), 750-51 ("[t]he court, as surrogate for the incompetent, is to determine as best it can what choice that individual, if competent, would make....").

¹⁸ Although it is undisputed that no emergency situation exists in this case, amici note that in an emergency posing imminent danger to the patient

Continued

Boyd's requirement of a judicial determination of incompetency before the Government may forcibly medicate an involuntarily committed mental patient, announced there in connection with those civilly committed pursuant to D.C. Code § 21-545, see 403 A.2d at 747, n.5, necessarily applies to those, like appellant, committed following an insanity acquittal pursuant to § 24-301. Commitment under § 24-301, like commitment under § 21-545, "demonstrates only that a committee is mentally ill and likely to injure [him]self or others." Boyd, 403 A.2d at 747, n.5; see Jones v. United States, supra, 432 A.2d at 373 ("the substantive standard of commitment is identical" under § 21-545 and § 24-301). This Court has often observed that "commitment pursuant to § 24-301(d) after a verdict of not guilty by reason of insanity is not an adjudication of ... incompetency." Green v. United States, 122 U.S. App. D.C. 33, 351 F.2d 198, 200 (D.C. Cir. 1965); see Winn v. United States, 106 U.S. App. D.C. 133, 270 F.2d 326, 328 (D.C. Cir. 1959). As noted above, pp. 17-18, supra, this legal distinction is based on clinical fact.

18 Continued

or others, or a sudden crisis in the patient's condition, requiring immediate treatment to prevent further deterioration, there are sound reasons to dispose with the requirements of judicial determination of incompetency and judicial application of the "substituted judgment" standard. The Government's interests in protecting patients against physical violence and in treating the patient's illness are highest in emergencies of these sorts. In such circumstances, the patient's autonomy interest in refusing treatment is at a minimum. The patient is likely to lack ability to make considered choices in an emergency situation. The patient's interests are also safeguarded because of the inherently short duration of emergency situations. The intrusion, if any, on the patient's right of autonomy will last no longer than the period of the emergency. Hospital staff may need to determine whether the patient has become incompetent, and if so, whether the patient would accept psychotropic drugs if he were competent. In these special situations, and possibly in other emergencies, it is reasonable for the law to give the treating professional authority to override the patient's wishes if in his professional judgment such treatment is appropriate.

In the absence of relevant differences between them, courts in the District have extended to § 24-301 committees the same procedural safeguards and substantive rights afforded § 21-545 committees. Where nothing unique to § 24-301 precludes application of § 21-545 safeguards in such circumstances, they have been found "necessarily implicit" in § 24-301. Bolton v. Harris, supra, 395 F.2d at 651-652. Certainly, nothing in § 24-301 precludes application here of the safeguards established in Boyd. To the contrary, there are even stronger justifications for a judicial determination of incompetency before permitting forced medication of § 24-301 committees than there are in the case of § 24-545 committees. Although no finding of competency is part of § 21-545 proceedings, a person acquitted by reason of insanity necessarily has been adjudicated competent to stand trial and to assist in preparing his defense, see D.C. Code, § 24-301(a), notwithstanding his mental illness at the time of the offense. Furthermore, even the determination of mental illness and dangerousness made at the criminal trial -- which, of course, is vastly different from a competency determination -- relates only to a past mental state. See Bolton v. Harris, supra, 395 F.2d at 646. While commitment proceedings under § 21-545 require the Government to establish by clear and convincing evidence that the potential committee is presently mentally ill and dangerous, a § 24-301(d) committee need never be found, even by a preponderance of the evidence, to be presently mentally ill.¹⁹ Accordingly, there is less reason to presume incompetency from an

¹⁹ D.C. Code § 24-301(j) provides that, in the District of Columbia, a criminal defendant may be acquitted by reason of insanity if he is shown, by a preponderance of the evidence, to have been mentally ill at the time of the offense. If the defendant successfully invokes the insanity defense, he is

insanity acquittal, and a greater need to provide persons committed under § 24-301 the fundamental procedural safeguard of a judicial determination of incompetency before their common law right to refuse intrusive medication is extinguished.

Because the Hospital has not obtained a judicial determination of incompetency, and because it has even refused to apply a "substituted judgment" standard, it may not administer psychotropic drugs to appellant over his objections in the absence of an emergency.

IV. ABSENT AN EMERGENCY, APPELLANT HAS A CONSTITUTIONALLY PROTECTED RIGHT TO BE FREE TO DECIDE WHETHER TO SUBMIT TO THE ADMINISTRATION OF PSYCHOTROPIC DRUGS BY THE GOVERNMENT

Because appellant is clearly entitled to an injunction under the law of the District of Columbia, this Court should avoid the unnecessary adjudication of appellant's constitutional claims. Mills v. Rogers, supra, 457 U.S. at 305, Ashwander v. Tennessee Valley Authority, 297 U.S. 288, 341, 347-48 (1936) (Brandeis, J., concurring). Should the Court reach the issue, however, amici submit that appellant also is entitled to relief under the Federal Constitution.

19 Continued

committed to a mental hospital. Within 50 days of commitment the acquittee is entitled to a judicial hearing to determine his eligibility for release, at which point he has the burden of proving by a preponderance of the evidence that he is no longer mentally ill or dangerous. § 24-301(d)(2). Thereafter, the acquittee is entitled to a judicial hearing every six months at which he may establish by a preponderance of the evidence that he is entitled to release. § 24-301(k). Thus, if a defendant successfully invokes the insanity defense, there never has been a judicial determination that he has been shown presently mentally ill by a preponderance of the evidence.

A. When Important State Interests Conflict With
Constitutionally Protected Individual Interests,
Careful Balancing Is Required

Although certain liberty interests of persons involuntarily committed to mental institutions are necessarily diminished, they are by no means extinguished entirely. "The mere fact that [an individual] has been committed under proper procedures does not deprive him of his substantive liberty interests under the [Fifth] Amendment." Youngberg v. Romeo, supra, 457 U.S. at 315. As Youngberg makes clear, when evaluating the rights of involuntarily committed persons, the due process balancing test requires a court to take into account the particular individual and public interests involved in the unique environment of a government mental institution. To determine the extent to which the constitutionally protected interests of mental patients remain intact in government mental institutions, courts must first identify the particular liberty interests that are affected and then balance those interests against the competing interests of the Government in operating such facilities. Id. at 34. The stronger the individual interest potentially affected, the greater is the burden imposed upon the Government to justify any intrusion on that interest.²⁰

²⁰ Analogy to the method of analysis used in cases examining the constitutional rights of convicted prisoners is instructive. Wolff v. McDonnell, 418 U.S. 539, 556 (1974). See also Bell v. Wolfish, 441 U.S. 520 (1979). It goes without saying, of course, that a mental institution is not a prison. As a general rule, involuntarily committed mental patients retain substantive liberty interests that are at least as great as those of prisoners. See Youngberg, supra, 457 U.S. at 315-316 ("[i]f it is cruel and unusual punishment to hold convicted criminals in unsafe conditions, it must be unconstitutional to confine the involuntarily committed -- who may not be punished at all -- in unsafe conditions"); see Jones v. United States, supra, 432 A.2d at 369 ("a punitive rationale has no part in the commitment of persons acquitted by reason of insanity").

B. Persons Who Are Able to Make Decisions For Themselves Have Fundamental Constitutional Interests In Being Free to Decide Whether To Submit to the Administration of Psychotropic Drugs.

Like the liberty interests in safety and freedom of movement which were discussed in the Youngberg case, supra, 457 U.S. at 315-316, the fundamental constitutional liberty interests implicated in this case also survive involuntarily commitment. In identifying the individual's interests to be balanced, this Court must look to "[t]he full scope of the liberty guaranteed by the Due Process Clause [which] cannot be ... limited by the precise terms of the specific guarantees elsewhere provided in the Constitution." Moore v. City of East Cleveland, 431 U.S. 494, 502 (1977) (quoting Poe v. Ullman, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting)). The Supreme Court has recognized that "[a]mong the historic liberties [protected by the due process clause] was a right to be free from ... unjustified intrusions on personal security." Ingraham v. Wright, 430 U.S. 651, 672-73 (1977); see Breithaupt v. Abram, 352 U.S. 432, 439 (1957). As the Court has stated, "[n]o right is held more sacred, or is more carefully guarded ... than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." Union Pacific Railway v. Botsford, 141 U.S. 250, 251 (1891). A respect for each individual's bodily integrity underlies the specific guarantees of the fourth amendment, e.g., Sibron v. New York, 392 U.S. 40, 65-66 (1968); Schmerber v. California, 384 U.S. 757, 772 (1966); the eighth amendment, e.g., United States v. Georvassilis, 498 F.2d 883 (6th Cir. 1974); and the due process clauses of the

fifth and fourteenth amendments, e.g., Ingraham v. Wright, supra, 430 U.S. at 672-675; Rochin v. California, 342 U.S. 165, 172, 174 (1952).

The Constitution protects not only one's interest in bodily integrity and personal security, but also the inviolability of one's mind. Every person has a right to think his own thoughts, free of state intervention or manipulation. Government control of a competent individual's mind through the use of psychotropic drugs would be wholly inconsistent not only with the philosophy of the first amendment, but with virtually any concept of liberty. See, e.g., Stanley v. Georgia, 394 U.S. 557, 565-66 (1969). The Court has recognized that "in a free society one's beliefs should be shaped by his mind and his conscience rather than coerced by the State." Aboud v. Detroit Board of Education, 431 U.S. 209, 235 (1977). "Indeed, the State's power to control the minds of its subjects is the hallmark of those 'totalitarian ideologies we profess to hate....'" Davis v. Hubbard, supra, 506 F. Supp. at 933 (quoting Sobell v. Reed, 327 F. Supp. 1294, 1305 (S.D.N.Y. 1971)). See also Mackey v. Procunier, 477 F.2d 877, 878 (9th Cir. 1973); Shapiro, Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies, 47 So. Cal. L. Rev. 237, 253-76 (1974).

Closely related to the individual's interests in bodily integrity and the freedom to think and communicate freely is the interest in being free to make important decisions about one's own body and mind. This interest in self-determination is grounded in respect for individual choices, "which is the lifeblood of the law." Faretta v. California, 422 U.S. 806, 834 (1975) (quoting Illinois v. Allen, 397 U.S. 337, 350-51 (1970)). The Supreme Court consistently has held that individuals have a constitutionally protected interest in making particularly personal or intimate decisions. See, e.g.,

Roe v. Wade, 410 U.S. 113 (1973) (pregnancy); Eisenstadt v. Baird, 405 U.S. 438 (1972) (contraception); Loving v. Virginia, 388 U.S. 1 (1967) (marriage); Prince v. Massachusetts, 321 U.S. 158 (1944) (family relationships); Skinner v. Oklahoma, 316 U.S. 535 (1942) (procreation); Pierce v. Society of Sisters, 268 U.S. 510 (1925), and Meyer v. Nebraska, 262 U.S. 390 (1923) (child rearing). See also Whalen v. Roe, 429 U.S. 589, 599-600 (1977).

C. Except In Emergencies Or In Cases of Incompetency, the State Has no Interests That Are Sufficient to Override an Individual's Constitutionally Protected Interests in Being Free to Decide Whether to Submit to the Administration of Psychotropic Drugs.

The state interests that might be thought to justify forcing an individual to take psychotropic drugs are: (1) the interest in the treatment and care of incompetents, under the parens patriae power; (2) the interest in protecting the general health of society, under the police power; (3) the interest in protecting society from imminent danger, also under the police power; and (4) the interest in the secure and efficient administration of mental institutions. These, of course, are the same interests that were considered above in the context of the common law of the District. For essentially the same reasons, they are insufficient to outweigh the constitutionally protected interests of a committed person who is able to decide for himself whether to take psychotropic drugs.

While amici do not challenge the Government's parens patriae interest in making treatment decisions for those who are not able to make decisions or to act for themselves, the Government has no valid parens patriae interest with respect to persons who are able to make decisions and act for

themselves. See, e.g., O'Connor v. Donaldson, 422 U.S. 563, 583 (1975) (Burger, C. J., concurring). Thus, the First Circuit correctly recognized that "the sine qua non for the state's use of its parens patriae power as justification for the forceful administration of mind-affecting drugs is a determination that the individual to whom the drugs are to be administered lacks the capacity to decide for himself whether he should take the drugs." Rogers v. Okin, supra, 634 F.2d at 657. Accord, Winters v. Miller, supra, 446 F.2d at 70-71. As noted above, see pp. 23-24 and n.15, the same rule pertains in the District of Columbia.

As a former president of the American Psychiatric Association has noted, many committed persons "may be fully capable of weighing the risks and benefits of a proposed treatment." Stone, Informed Consent: Special Problems for Psychiatry, 30 Hosp. & Comm. Psych. 321, 326 (1979). Consistent with this modern realization, the District of Columbia, like most states presumes the competency of committed persons. Boyd, supra, 403 A.2d at 747, n.5. Because the determination of incapacity is not part of the commitment decision, under the law of the District a committed individual is presumed capable of making his own decisions about treatment unless adjudicated incompetent. The commitment decision, therefore, is no justification for assertion of the parens patriae power.²¹

²¹ Of course, Congress could statutorily require a determination of incompetency as a necessary criterion for involuntary civil commitment, and thereby assert its parens patriae power over all subsequently committed individuals. See, e.g., S. C. Code § 44-17-580 (Supp. 1982); Utah Code Ann. § 64-7-36(10)(c) (Supp. 1981). Or it could merge a competency determination with the commitment proceedings in order to clarify such matters one way or the other prior to the individual's commitment. See, e.g., Ind. Code Ann. § 16-14-9.1-11 (Burns 1983). Congress has chosen neither of these statutory schemes.

The Government's police power interest in improving the health of individuals for the benefit of society (as opposed to its parens patriae interest in preserving health for the benefit of the incompetent individual) also does not outweigh a competent individual's constitutionally protected interests. The courts have strictly limited the power of the state to act to further general societal interests at the expense of the individual's constitutional liberty interests. While in Jacobson v. Massachusetts, 197 U.S. 11 (1905), the Supreme Court held that the state's interest in compulsory vaccination outweighed the individual's right to bodily integrity, the balance of government and individual interests is far different in the case of psychotropic drugs. First, the state's interests in treatment are not as compelling as the need to prevent life-threatening epidemics. Second, far more than vaccinations, psychotropic drugs dramatically affect the body and mind of the individual and have dangerous and often permanent side effects. Third, as noted above, p. 9, supra, although sometimes the treatment of choice, psychotropic drugs may prove to be of no benefit to any given patient. Fourth, treatment methods such as psychotherapy and certain forms of behavior modification, that are less physically intrusive than psychotropic medication, are also highly effective for at least some patients. Given the extent of the intrusion involved here, the possibility that harmful side effects may last months or years beyond the period of commitment itself, the inability to predict whether some drugs will benefit a particular patient, the availability of other effective and less physically intrusive forms of treatment, and the well-documented tendency of government hospitals to misuse

and overuse drugs for the convenience of staff and for punishment,²² the Government's interest in the general welfare does not justify imposition of psychotropic medication over a patient's objections.

For the reasons discussed, supra, in Part II of this brief, the Government's interest in taking emergency action to ensure security in the institution is not at issue here, and is adequately protected if forcible medication is allowed when, in the judgment of a staff physician, a patient is an imminent threat to harm himself or others.

Finally, recognition of committed patients' right to refuse medication will not so seriously disrupt the efficient operation of the institution as to require that, in the interest of efficiency, the right must be discarded. Putting to one side the debate about how best to implement the right to refuse treatment (see Part V, below), the evidence suggests that recognizing such a right has not interfered with either the daily 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 psychotropic drugs. The psychiatrists and hospital staff experienced little disruption in treating patients. In fact, substantial savings in medication costs were realized, fewer side effects occurred, and most significantly, "[t]reatment itself ... improved ... [without] substantial additional burdens ... placed on treatment personnel." Brooks, The Constitutional Right to Refuse Antipsychotic Medications, 8 Bull. Am. Acad. Psych. & L. 179, 213 (1980). Similarly, in Ohio, where the patients' right to

²² See, e.g., Davis v. Hubbard, supra, 506 F. Supp. at 926 & n.7 (quoting Crane, Clinical Psychopharmacology in its 20th Year, 181 Sci. 124, 125 (1973)).

refuse treatment was implemented after litigation, the district court found no evidence suggesting that the "recognition of the right has had any adverse effects on the operation of the institution or on its treatment goals." Davis v. Hubbard, supra, 506 F. Supp. at 937, n.31. And, as noted above, during the period that the Boston State Hospital operated under the stringent requirements imposed by one district court, treatment continued without substantial disruption. See Rogers v. Okin, supra, 478 F. Supp. at 1369; Appelbaum & Gutheil, Drug Refusal: A Study of Psychiatric Inpatients, 137 Am. J. Psych. 340, 345 (1980).

For the foregoing reasons, amici agree with the conclusion of virtually every court to address the subject.²³ The Constitution protects the right of an individual capable of making his own decision to be "left free by the state to decide for himself whether to submit to the serious and potentially harmful medical treatment that is represented by the administration of antipsychotic drugs." Rogers v. Okin, supra, 634 F.2d at 653.

²³ In addition to the First Circuit's decision in Rogers v. Okin, supra, the following cases are among those recognizing the substantive constitutional right to refuse psychotropic drugs in an institutional setting: Project Release v. Prevost, No. 82-7943 (2d Cir., Oct. 24, 1983), Rennie v. Klein, No. 79-2576 (3d Cir., Oct. 13, 1983), Osgood v. District of Columbia, 567 F. Supp. 1026 (D.D.C. 1983); Davis v. Hubbard, supra; In re K.B.B., 609 P.2d 747 (Okla. 1980). Although the courts have split on the procedures required by the Constitution to protect that right, compare, e.g., Rogers v. Okin, supra (judicial finding of incompetency required) with, e.g., Project Release v. Prevost, supra (three levels of review by medical personnel sufficient to satisfy due process), the existence of the constitutional right itself is virtually unquestioned.

V. BEFORE APPELLANT'S CONSTITUTIONALLY PROTECTED LIBERTY INTEREST IN CHOOSING WHETHER TO SUBMIT TO ADMINISTRATION OF PSYCHOTROPIC DRUGS MAY BE OVERRIDDEN ON THE BASIS OF THE PARENS PATRIAE POWER, DUE PROCESS REQUIRES A JUDICIAL DETERMINATION OF INCOMPETENCY

If a patient is an imminent threat violently to harm himself or others, and psychotropic medications are the least intrusive means of averting the imminent harm, the Government's interest in protecting patients and staff justifies forcible administration, even to a competent patient, of psychotropic drugs without recourse to a court. See p. 16, supra. Absent an emergency, however, the only justification sufficient to overcome a patient's refusal to submit to administration of these drugs is pursuant to the parens patriae power, that is, if the patient is unable to choose for himself.

The individual's ability or inability to choose is the fulcrum in the balance of constitutional right and government interest; competency is the sine qua non of the right to autonomy, and incompetency the sine qua non of the parens patriae power. At stake for the patient in this determination is his very right to control his own destiny with respect to his own bodily integrity and thought processes. In determining the procedures required by due process in rendering a determination of competency, this very weighty personal interest must be considered, along with the risk of an erroneous decision through the procedures currently used, and the governmental interests at stake, including possible fiscal and administrative burdens other procedural requirements might impose. Mathews v. Eldridge, 424 U.S. 319, 335 (1976).

There is little question that the procedures currently employed by the Hospital to determine competency pose an intolerable risk in making this

vital determination. The District Court uncritically relied on the Supreme Court's statement in Youngberg that, with respect to determining what treatment or training is reasonable to ensure a mentally retarded individual's safety and freedom from unreasonable restraints, "there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions." 457 U.S. at 322-23, quoted in Memorandum and Order Denying Interim Relief, p. 6. But this reasoning is simply inapplicable to the incompetency determination. Unlike the essentially non-legal, treatment decision addressed in Youngberg, an adjudication of incompetency does not require the courts to render substantive judgments with respect to treatment. The patient's ability to make a decision is the only issue decided at a competency hearing, and such determinations traditionally have been handled by the courts.²⁴ Competency is a legal, not a medical determination, see In re K.B.B., 609 P.2d 747, 749 (Okla. 1980), and consequently the courts are far better qualified than mental health professionals to render such a judgment. It is not true, then, that requiring a judicial competency decision will "embroil [the courts] in a never-ending controversy concerning medical

²⁴ In the District, for example, a court must find that a person civilly committed pursuant to § 21-545 is incompetent before such a person may be denied "the right to dispose of property, execute instruments, make purchases, enter into contractual relationships, vote, and hold a driver's license." D.C. Code, § 21-564. Pursuant to Boyd, as explained above, a court must adjudicate such a person incompetent before he may be denied his right to refuse psychotropic medication. Even the Hospital's own regulations require a court order before any patient may be forcibly medicated over a religious objection. SEH Policy #4100.4A, p. 2. And, of course, courts routinely rule on the question of competency to stand trial.

judgments." Memorandum and Order Denying Interim Relief, p. 5. Instead, the Hospital's current approach entrusts to mental health professionals application of legal standards.

Moreover, leaving the competency determination to Hospital personnel creates a significant risk that, simply because a professional believes the patient has made the "wrong" decision, he will conclude the patient is incapable of making a rational choice. 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, supra, 446 F.2d at 71.

Nor will requiring a judicial determination of competency compromise governmental interests in institutional efficiency and treatment as feared by the District Court. Memorandum and Order Denying Interim Relief, p. 5. While it may be true that "competency to participate in treatment decisions may change over time," id., due process does not require, as the District Court apparently assumed, a separate adjudication of incompetency for each refusal to submit to psychotropic medication.²⁵ Instead, a single adjudication of incompetency would be sufficient to extinguish the presumption of competency. Subject, perhaps, to periodic judicial review, hospital personnel may constitutionally determine whether an individual once adjudicated incompetent

²⁵ The District Court's memorandum suggests that by contrast with competency to make treatment decisions, competency to stand trial is not subject to change over time. In amici's opinion, that assumption is factually mistaken. See Blunt v. United States, 128 U.S. App. D.C. 375, 389 F.2d 545, 549 and n.15 (D.C. Cir. 1967).

has regained the ability to choose for himself.²⁶ Moreover, as noted above, p. 21, supra, few committed patients refuse psychotropic medication, and most who do soon change their minds and agree to submit. Thus, there is no reason to expect a "continuous shuttle of doctors and patients back and forth from treatment rooms to courtrooms." Memorandum and Order Denying Interim Relief, p. 5. Nor, under a proper legal standard, need the delay entailed in obtaining a judicial determination of incompetency "have grave consequences to the patient." Ibid. For the reasons noted above, see pp. 25-26, n.18, supra, if a sudden crisis develops in the patient's condition, requiring immediate treatment to prevent further deterioration, the Constitution may allow the staff to determine whether the patient has become incompetent, and if so, whether administration of psychotropic drugs is appropriate. In most cases, however, there will be ample time to get a judicial ruling without creating an undue risk of deterioration. Appellant's clearly is such a case.

²⁶ In fact, pursuant to D.C. Code § 24-301(k)(1), a person adjudicated incompetent to stand trial and subsequently committed under § 24-301(a) may petition a court for release from custody on the ground that he has regained his competency, but under § 24-301(k)(5) "[a] court shall not be required to entertain a 2nd or successive motion for relief . . . more often than once every 6 months." The same rule applies to § 24-301(k) petitions of those acquitted by reason of insanity claiming a right to release or a change in conditions of confinement based on an improved mental condition. A single adjudication of incompetency or a continuing need for commitment extinguishes for six months the right to challenge that determination in the courts. Of course, notwithstanding the limitations of § 24-301(k)(5), the Hospital superintendent is required to monitor the patient's mental condition to determine whether he is "restored to mental competency," § 24-301(b), or whether he no longer meets the criteria for commitment, § 24-301(e). If the superintendent determines that such a change in the patient's mental status has occurred, the superintendent must certify this fact to the appropriate court, whereupon trial or release may follow. This statutory scheme is not unworkable, and, in amici's view, is not unconstitutional. A similar workable approach could be implemented with respect to competency to choose whether to submit to psychotropic medication.

Finally, it should be noted that the Hospital itself requires a court order before medicating a patient objecting on religious grounds, and, after Boyd, a judicial determination of incompetency is required before the Hospital may forcibly medicate any patients civilly committed under § 21-545. Because this latter group far outnumbers those committed under § 24-301(d), any additional administrative burden imposed by a similar requirement for § 24-301(d) committees would be de minimus.

CONCLUSION

As noted above, amici have addressed only the merits component of the district court's ruling on appellant's motion for preliminary relief. In the absence of an emergency, the Hospital may not forcibly administer psychotropic drugs to appellant without a judicial determination that appellant is unable to make the choice for himself. In amici's view, appellant should succeed on the merits of his suit on either common law or constitutional grounds.

Respectfully, submitted,

Paul R. Friedman
Donald N. Bersoff
ENNIS, FRIEDMAN, BERSOFF & EWING*
1200 17th Street, N.W., Suite 511
Washington, D.C. 20036
(202) 775-8100

Counsel for Amici Curiae

Dated:

*Counsel gratefully acknowledges the assistance of David Ogden in the preparation of this brief.

CERTIFICATE OF SERVICE

The undersigned attorney for the American Psychological Association and the American Orthopsychiatric Association certifies that on December __, 1983 he mailed two copies of the attached Motion Of The American Orthopsychiatric Association For Leave To Join The American Psychological Association In Its Brief Amicus Curiae, and the attached Brief of Amici Curiae, by first-class mail, postage prepaid, to John D. Aldock, Shea & Gardner, 1800 Massachusetts Avenue, N.W., Washington, D.C. 20036, Counsel for Appellant; John C. Martin, Assistant United States Attorney, United States Courthouse, Washington, D.C. 20001, Counsel for Appellee; and Joel I. Klein, Onk, Klein & Farr, Suite 425, 2550 M Street, N.W., Washington, D.C. 20037, Counsel for Amicus American Psychiatric Association.

PAUL R. FRIEDMAN