

STATE OF NEW YORK
COURT OF APPEALS

-----X
MARK RIVERS and FLORENCE ZATZ,

Plaintiffs-Appellants,

-against-

DR. STEVEN KATZ, in his official capacity
of Commissioner of the New York State
Office of Mental Health, WENDY ACRISH, in
her official capacity of Executive Director
of Harlem Valley Psychiatric Center, and
DR. GIRISH SHAH, in his official capacity of
Clinical Director of Harlem Valley Psychiatric
Center,

Index #: 2558/84

Defendants-Respondents.
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FLORENCE GRASSI,

Petitioner-Appellant,

-against-

WENDY ACRISH, in her official capacity of
Executive Director of Harlem Valley Psychiatric
Center, and DR. GIRISH SHAH, in his official
capacity of Clinical Director of Harlem Valley
Psychiatric Center,

BRIEF OF AMICUS CURIAE
AMERICAN PSYCHOLOGICAL
ASSOCIATION IN SUPPORT
OF APPELLANTS

Index #: 4665/84

Respondents.
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Dated: Washington, D.C.
February 27, 1986

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TABLE OF CONTENTS

	<u>Page</u>
INTEREST OF <u>AMICUS CURIAE</u>	1
<u>INTRODUCTION</u>	1
<u>SUMMARY OF ARGUMENT</u>	4
<u>ARGUMENT</u>	6
I. THE DECISIONS BELOW ARE SO FACTUALLY AND LEGALLY FLAWED THAT A REMAND FOR FURTHER CONSIDERATION IS APPROPRIATE.....	6
A. The Judicial Retention Orders Cannot Justify The Decisions To Administer Antipsychotic Drugs To Appellants Over Their Objections Because Those Decisions Were Made Before The Retention Orders Were Signed.....	6
B. Under The Plain Meaning Of The Mental Hygiene Law, A Judicial Determination That A Patient Requires Involuntary Care And Treatment In A Hospital Is Not A Determination That The Patient Is Incompetent Or Otherwise Unable To Form An Opinion Concerning Antipsychotic Drugs.....	8
II. HOSPITALIZED PATIENTS HAVE A FEDERAL CONSTITUTIONAL RIGHT TO REFUSE ANTIPSYCHOTIC DRUGS UNLESS THEY HAVE BEEN FOUND INCOMPETENT OR ARE IMMINENTLY DANGEROUS TO SELF OR OTHERS.....	16
A. Antipsychotic Drugs Are Highly Beneficial For Many Patients, But They Also Have Substantial Side Effects, Implicating Basic Principles Of Individual Autonomy.....	16
B. Involuntarily Hospitalized Patients Have A Federal Constitutional Right To Refuse Antipsychotic Drugs.....	24
C. Only When The Patient Is Incompetent Or Is Imminently Dangerous To Self Or Others Do State Interests Become Sufficiently Compelling To Overcome The Patient's Federal Constitutional Right To Refuse Antipsychotic Drugs.....	28

-ii-

D. No Other State Interests Are Sufficiently Compelling To Justify The Forcible Administration Of Antipsychotic Drugs Over A Patient's Objection.....	32
1. The state's interest in improving the patient's health is not a sufficient justification for forcibly administering antipsychotic drugs.....	32
2. The state's interest in improving public health is not a sufficient justification for forcibly administering antipsychotic drugs.....	33
3. The state's interest in institutional order and efficiency is not a sufficient justification for forcibly administering antipsychotic drugs.....	34
4. The state's interest in furthering professional ethics is not a sufficient justification for forcibly administering antipsychotic drugs.....	35
III. THE FINAL DECISION WHETHER TO AUTHORIZE LONG-TERM ADMINISTRATION OF ANTIPSYCHOTIC DRUGS OVER A PATIENT'S OBJECTION SHOULD BE MADE BY A COURT.....	36
<u>CONCLUSION</u>	39

TABLE OF AUTHORITIES

CASES:

	<u>Page</u>
<u>Anderson v. Arizona</u> , 663 P.2d 570 (Ct. App. Ariz. 1982).....	14, 20, 27
<u>Bee v. Greaves</u> , 744 F.2d 1387 (10th Cir. 1984), cert. denied, 105 S.Ct. 1187 (1985).....	23, 27, 32
<u>Davis v. Hubbard</u> , 506 F. Supp. 915 (N.D. Ohio 1980).....	<u>passim</u>
<u>Goedecke v. State Dept. of Institutions</u> , 603 P.2d 123 (Colo. 1979)...	27
<u>In Re Boyd</u> , 403 A.2d 744 (D.C. Ct. App. 1979).....	<u>passim</u>
<u>In Re K.K.B.</u> , 609 P.2d 747 (Okla. 1980).....	<u>passim</u>
<u>In the Matter of the Guardianship of Richard Roe, III</u> , 421 N.E.2d 40 (Mass. 1981).....	17, 22-23
<u>Jacobson v. Massachusetts</u> , 197 U.S. 11 (1905).....	33
<u>Jamison v. Farabee</u> , ____ F. Supp. ____, No. C78-445 WHO (N.D. Cal. April 26, 1983).....	27
<u>Johnson v. Silvers</u> , 742 F.2d 823 (4th Cir. 1984).....	25, 27
<u>Knecht v. Gillman</u> , 488 F.2d 1136 (8th Cir. 1973).....	27
<u>Mackey v. Procunier</u> , 477 F.2d 877 (9th Cir. 1973).....	27
<u>Mills v. Rogers</u> , 457 U.S. 291 (1982).....	<u>passim</u>
<u>Natanson v. Kline</u> , 186 Kan. 393, 350 P.2d 1093 (1960).....	36
<u>O'Connor v Donaldson</u> , 422 U.S. 563 (1975).....	24, 25
<u>Opinion of the Justices</u> , 465 A.2d 484 (N.H. 1983).....	<u>passim</u>
<u>Osgood v. District of Columbia</u> , 567 F. Supp. 1026 (D.D.C. 1983).....	27
<u>People v. Medina</u> , 705 P.2d 961 (Colo. 1985) (<u>en banc</u>).....	<u>passim</u>
<u>Project Release v. Prevost</u> , 722 F.2d 960 (2nd Cir. 1983).....	<u>passim</u>
<u>Rennie v. Klein</u> , 653 F.2d 836 (3rd Cir. 1981) (<u>en banc</u>), cert. granted and judgment vacated and remanded, 458 U.S. 1119 (1982), <u>on remand</u> , 720 F.2d 266 (3rd Cir. 1983).....	23, 27

	<u>Page</u>
<u>Rogers v. Commissioner of Mental Health</u> , 390 Mass. 489, 458 N.E.2d 308 (1983).....	<u>passim</u>
<u>Rogers v. Okin</u> , 478 F. Supp. 1342 (D. Mass. 1979).....	27, 30, 34
<u>Rogers v. Okin</u> , 634 F.2d 650 (1st Cir. 1980), <u>vacated sub</u> <u>nom. Mills v. Rogers</u> , 457 U.S. 291 (1982).....	23, 27
<u>Rogers v. Okin</u> , 738 F.2d 1 (1st Cir. 1984) (<u>on remand</u>).....	27
<u>Scott v. Plante</u> , 532 F.2d 939 (3rd Cir. 1976).....	23, 27
<u>Superintendent of Belchertown State School v. Saikewicz</u> , 370 N.E.2d 417 (Mass. 1977).....	30
<u>Winters v. Miller</u> , 446 F.2d 65 (2nd Cir.), <u>cert. denied</u> , 404 U.S. 985 (1971).....	27, 38
<u>Youngberg v. Romeo</u> , 457 U.S. 307 (1982).....	25

STATUTES:

New York Codes, Rules and Regulations, Title 14:

§27.8.....	<u>passim</u>
§27.9.....	10, 29

New York Mental Hygiene Law:

§9.01.....	<u>passim</u>
§9.03.....	8, 13
§9.21(b).....	12, 13
§9.27.....	13
§9.31.....	<u>passim</u>
§29.03.....	11
§33.01.....	12, 29
§33.03.....	29
§43.03.....	13
§77.01.....	13
§77.25(a).....	13
§77.25(b).....	13
§77.25(c).....	14

UNITED STATES CONSTITUTION:

Amendment XIV.....	28
--------------------	----

MISCELLANEOUS:

<u>ABA Standards for Criminal Justice</u> , Commentary to §7-4.10.....	26
<u>ABA Standards for Criminal Justice</u> , Standard 7-9.12.....	26
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American Psychiatric Association Task Force Report #18, <u>Tardive Dyskinesia</u>	21, 22
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Brooks, <u>The Constitutional Right to Refuse Antipsychotic Medications</u> , 8 Bull. Am. Acad. Psychiatry & L. 179 (1980).....	24, 35
Callahan & Longmire, <u>Psychiatric Patients' Right to Refuse Psychotropic Medication: A National Survey</u> , 7 Mental Disability L. R. 494 (Nov.-Dec., 1983).....	5
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	<u>Page</u>
Crane, <u>Persistent dyskinesias</u> , 122 Br. J. Psychiatry 395 (1975).....	20
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<u>Dorland's Medical Dictionary</u>	1
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	<u>Page</u>
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<u>Physicians' Desk Reference</u> (38th ed. 1984).....	20

	<u>Page</u>
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BRIEF OF AMICUS CURIAE
AMERICAN PSYCHOLOGICAL ASSOCIATION
IN SUPPORT OF APPELLANTS

INTEREST OF AMICUS CURIAE

The interest of amicus American Psychological Association ("amicus"), a voluntary, non-profit, scientific and professional organization with over 60,000 members, has been described in amicus' motion for leave to file a brief amicus curiae, which was granted by this Court's Order of February 11, 1986.

INTRODUCTION

This case raises the important issue whether persons involuntarily hospitalized for treatment of mental illness have the right under the federal Constitution or state law to decide for themselves whether to undergo administration of antipsychotic drugs in non-emergency situations.¹

Because these consolidated cases reach this Court on appellees' successful motions to dismiss and for summary judgment, the following critical and undisputed facts must be taken as true:

1. Appellants have not been found mentally incompetent by any court.
2. Appellants have not been found dangerous to self or others by any court.

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. 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).

3. The mental health professionals who reviewed appellants' objections to antipsychotic drugs did not find that appellants were incompetent or dangerous to self or others, or that drugs were necessary to prevent serious deterioration of their mental condition.²

4. The mental health professionals who reviewed appellants' objections to antipsychotic drugs did not find that appellants were unable to understand the potential benefits or the potential risks of the proposed drugs.

5. The mental health professionals who reviewed appellants' objections to antipsychotic drugs did not find that drugs were the only available form of treatment, or that less intrusive forms of treatment had been tried and had failed.

6. The initial decisions to treat appellants with antipsychotic drugs were made by the Head of Service and confirmed by the Hospital Director (and for appellants Rivers and Zatz were confirmed by the Regional Director) before the entry of any judicial order finding that appellants met the statutory criteria for involuntary hospitalization.³

² In this brief we will frequently use the term "mental health professional." In fact, however, it appears that the individual who made the initial decision to administer drugs to appellants was a psychiatrist, and the individuals who reviewed and approved those decisions were either psychiatrists or social workers.

³ Appellants' complaint, amended complaint, affidavits and other papers submitted in opposition to appellees' motion for summary judgment contained the following undisputed facts:

The Head of Service made the initial decision to treat appellant Rivers with antipsychotic drugs, over his objection, on March 23, 1984. That decision was reviewed and confirmed by the Hospital Director on March 30, 1984, and by the Regional Director on May 16, 1984. The original complaint was filed on May 25, 1984 and alleged that as of then appellant Rivers was being forcibly drugged over his objection. (Although the precise date is not specified in the court record, the hospital chart reveals that his drugs began on May 24, 1984.) The judicial

7. Appellees had actually subjected appellants Rivers and Zatz to the administration of antipsychotic drugs before any judge had signed an order authorizing their retention for involuntary care and treatment in a hospital.⁴

Given these undisputed facts, it is clear that the psychiatrists and social workers who refused to honor appellants' objections to drugs did so (a) even though appellants had not been found by them or by any court to be incompetent or incapable of deciding their own interests, and (b) even though

³ Footnote continued:

retention order for appellant Rivers was not signed until June 8, 1984. (That retention order was submitted as Ex. A to the Affirmation of Robert L. Schonfeld in support of appellees' motion for summary judgment. Although Mr. Schonfeld incorrectly stated in his Affirmation that the Rivers' retention order was "entered on May 21, 1984," the exhibit clearly shows that 5/21/84 was only the date of the hearing, and shows further that the retention order was not signed until 6/8/84, and was not "entered" until 6/13/84).

The Head of Service made the initial decision to treat appellant Zatz with antipsychotic drugs, over her objection, on April 24, 1984. That decision was reviewed and confirmed by the Hospital Director on May 1, 1984, and by the Regional Director on May 16, 1984. The original complaint was filed on May 25, 1984 and alleged that as of then appellant Zatz was being forcibly drugged over her objection. (Although the precise date is not specified in the court record, the hospital chart reveals that her drugs began on May 21, 1984.) The judicial retention order for appellant Zatz was not signed until June 25, 1984.

The Head of Service made the initial decision to treat appellant Grassi with antipsychotic drugs, over her objection, on August 15, 1984. That decision was reviewed and confirmed by the Hospital Director on August 31, 1984. The judicial retention order for appellant Grassi was signed on September 24, 1984, two days before the Regional Director confirmed the initial decision.

⁴ See supra note 3. It is unclear from the record whether appellees had actually subjected appellant Grassi to forced drugs before the signing of a judicial retention order. The experience of appellants Rivers and Zatz demonstrates, in any event, that such an order, if it preexisted the forced medication in appellant Grassi's case, played little or no part in the decision to forcibly medicate appellant Grassi.

the psychiatrists and social workers had not determined that respecting appellants' wishes would result in danger to appellants or others, or would make it impossible to treat appellants with less intrusive types of treatment.

SUMMARY OF ARGUMENT

The lower court agreed with appellants that competent and non-dangerous patients cannot be subjected to the forcible administration of antipsychotic drugs. It ruled, however, that the judicial orders authorizing appellants' retention in the hospital meant that appellants were incompetent. That ruling was based on the incorrect factual assumption that the retention orders had been signed before the decisions to administer antipsychotic drugs were made. In fact, however, the retention orders could not possibly have justified those decisions, because the retention orders were not signed until after those decisions were made, and after antipsychotic drugs had already been administered to appellants Rivers and Zatz. Point I-A.

The lower court's ruling was also legally flawed because under the plain meaning of the Mental Hygiene Law, a retention order is not a determination that the patient is incompetent or otherwise unable to form judgments concerning antipsychotic drugs. Point I-B.

Because of these factual and legal errors, the lower court did not even reach the questions that are presented by the facts of this case -- whether competent and non-dangerous patients have a constitutional or state law right to refuse antipsychotic drugs. Accordingly, instead of resolving these important questions, it would be appropriate for this Court to vacate the judgments below and remand for further consideration.

If the Court nevertheless reaches the merits, it should rule that hospitalized patients have a federal constitutional right to refuse

antipsychotic drugs unless they have been found incompetent or are imminently dangerous to self or others.⁵

As amicus will show, for many patients, antipsychotic drugs have a major beneficial impact and are considered the treatment of choice. It is nevertheless true that antipsychotic drugs commonly cause various side effects, some of which are very serious. Point II-A.

Because antipsychotic drugs directly affect fundamental interests of privacy, personal security and personal autonomy, every court that has reached the issue has correctly ruled that hospitalized patients have a federal constitutional right to refuse such drugs, except in narrowly defined circumstances. Point II-B.

In amicus' view, which is shared by nearly every court to rule on the issue, the patient's federal constitutional right to refuse antipsychotic drugs must be respected by the state unless the patient is incompetent or imminently dangerous to self or others. Point II-C. No other state interests are sufficiently compelling to justify the forcible administration of antipsychotic drugs. Point II-D.

Finally, as many but not all courts have ruled, the decision to authorize long-term administration of antipsychotic drugs over a patient's

⁵ Amicus also believes that the patient's right to refuse antipsychotic drugs is presumptively protected by New York common law. Amicus adopts appellants' arguments on that point. The vast majority of the states agree that hospitalized patients cannot be forced to accept antipsychotic drugs simply because the hospital staff thinks those drugs would be good for them. Either on constitutional or state law grounds, at least "[f]orty-five states . . . recognize a 'qualified right to refuse medication.'" Callahan & Longmire, Psychiatric Patients' Right to Refuse Psychotropic Medication: A National Survey, 7 Mental Disability L. R. 494, 495 (Nov.-Dec., 1983).

objection is essentially a legal decision, not a psychological or medical decision, and should be made by a court. Point III.

If the Court reaches the merits, therefore, it should reverse the judgment below.

ARGUMENT

I. THE DECISIONS BELOW ARE SO FACTUALLY AND LEGALLY FLAWED THAT A REMAND FOR FURTHER CONSIDERATION IS APPROPRIATE.

- A. The Judicial Retention Orders Cannot Justify The Decisions To Administer Antipsychotic Drugs To Appellants Over Their Objections Because Those Decisions Were Made Before The Retention Orders Were Signed.

An erroneous factual assumption underlies and undermines the opinions below. The lower court's decisions to grant summary judgment to appellees in the Rivers and Zatz cases, and to dismiss the petition in the Grassi case, were based upon its belief that a judicial retention order "necessarily calls for the conclusion" that patients subject to such an order "were so impaired that they were unable to understand the need for their care, treatment, and medication, or to competently make a choice of their treatment. . . . Such a determination is in fact a predicate for commitment of these individuals." November 4, 1984 Opinion of Justice Ralph Beisner granting summary judgment to appellees, at 3 (hereafter, 11/4/84 Opinion).⁶ Implicit in the lower court's rulings was the factual assumption that the retention orders were

⁶ See, to the same effect, Justice Beisner's Opinion of 11/7/84 (hereafter, 11/7/84 Opinion), dismissing appellant Grassi's Article 78 Proceeding, at 3: "Pursuant to Mental Health [sic] Law Section 9.01, the predicate for an order of retention as an involuntary patient is that the patient does not understand the need for such care and treatment. This precise determination was made before petitioner [Grassi] was committed following a hearing before Dutchess County Court Judge King."

signed before the decisions to administer drugs were made (and before appellants were actually subjected to drugs). But for that assumption, Justice Beisner might have ruled in favor of appellants, not appellees, because he had accepted appellants' argument, based on New York case law, "that a person of sound body and mind is in a position to determine for his or herself which medication, if any, should be administered." 11/4/84 Opinion, at 3. See, to the same effect, 11/7/84 Opinion, at 3 [citing New York cases]: "This court has no quarrel and wholly agrees that a competent person has the right to determine his or her own course of treatment. This concept is well entrenched within our system of jurisprudence, and is a crucial cornerstone in a free society."

As amicus will show, infra, the lower court's view of the legal effect of a judicial retention order was erroneous. But even assuming, arguendo, that a judicial retention order does have that legal effect, the retention orders involved in this case could not possibly have justified the decisions to treat appellants with forced drugs because those decisions were made approximately one and one-half to three months before the retention orders were signed.⁷ It is also clear from the undisputed record that

⁷ With respect to appellants Rivers and Zatz, the initial decisions to administer drugs, and both administrative reviews of that decision, were made before any judicial retention order was signed. Supra note 3. With respect to appellant Grassi, the initial decision to drug, and the first administrative review, were made before any judicial retention order; the second administrative review was made two days after issuance of a judicial retention order. Supra note 3. The fact that in appellant Grassi's case the second review was made after the judicial retention order issued does not justify treating appellant Grassi differently from appellants Rivers and Zatz because in each case the final review was not a de novo determination, based on all of the relevant information then available, but only, as 14 NYCRR §27.8

antipsychotic drugs were being administered to appellants Rivers and Zatz over their objections before the signing of judicial retention orders in their cases.⁸

In these circumstances, involving an incorrect factual assumption by the lower court that was central to its decision, it would be appropriate for this Court to vacate the judgments below and remand for reconsideration in light of the true factual record, rather than to resolve the important issues presented by this appeal without the benefit of the properly informed views of the lower courts.

- B. Under The Plain Meaning Of The Mental Hygiene Law, A Judicial Determination That A Patient Requires Involuntary Care And Treatment In A Hospital Is Not A Determination That The Patient Is Incompetent Or Otherwise Unable To Form An Opinion Concerning Antipsychotic Drugs.

The lower court's conclusion that patients subject to retention orders are necessarily incompetent to form opinions concerning antipsychotic drugs was legally incorrect and contrary to legislative intent. Under the plain meaning of §§9.03 and 9.31 of the Mental Hygiene Law, and indeed under the Department of Mental Hygiene's own regulations, a judicial retention order

⁷ Footnote continued:

makes clear, a "review" of the "decision" of the Hospital Director, which was, in turn, only a "review" of the initial "decision" to medicate. Appellant Grassi's Article 78 Proceeding challenged that initial decision. Moreover, it is clear from the Rivers and Zatz cases that the Grassi retention order probably played no role in the second administrative review. Accordingly, the legality of that initial decision must be determined on the basis of the facts and circumstances existing when that initial decision was made.

⁸ See supra note 3.

is not a finding that the patient is incompetent or otherwise unable to form an opinion concerning antipsychotic drugs.

Section 9.31 authorizes judges to order the retention in a hospital of a patient, such as each appellant, who was initially hospitalized through non-judicial procedures if the judge determines that the patient "is in need of retention." Section 9.01, the definitions section, explains that "in need of retention" means "in need of involuntary care and treatment in a hospital for a further period" (emphasis added). The same section further provides that "in need of involuntary care and treatment" means "that a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment" (emphasis added).

Under the plain meaning of these sections, the factual predicate for a retention order is not a finding that the patient is unable to understand the need for care and treatment. The predicate for a retention order is, instead, a finding that the patient is unable to understand the need for care and treatment in a hospital. That straightforward interpretation of the relevant sections furthers the legislative purpose underlying these sections, which is to distinguish between those mentally ill persons for whom involuntary hospitalization would be authorized, and for whom it would not. Under this statutory scheme, individuals who understand the need for care and treatment with antipsychotic drugs, and even agree to be treated with antipsychotic drugs on an out-patient basis, would still meet the statutory criteria for a retention order if they were unable to understand that it was essential to their welfare that care and treatment be provided in a hospital.

The Department of Mental Hygiene's regulations authorizing patients to object to the administration of antipsychotic drugs are premised on the same straightforward interpretation of the Mental Hygiene Law urged here by amicus. The Department's elaborate mechanism for reviewing such objections, embodied in 14 NYCRR §27.8, applies to all patients, including those subject to retention orders. Providing counsel to such patients and holding out to them the possibility that their objections to antipsychotic drugs might be found worthy of respect would be a sham if the predicate for retention orders is a judicial determination that patients subject to such orders are necessarily incapable of forming judgments concerning drugs. At least one court has cited those regulations as evidence that hospitalized patients do have a right to refuse drugs. Project Release v. Prevost, 722 F.2d 960, 979 (2nd Cir. 1983) ("the existence in New York state of a right to refuse medication may be gleaned from the regulations providing for objection to treatment. See 14 NYCRR §§27.8, 27.9").⁹

This interpretation of §§9.01 and 9.31 is also consistent with the other sections of the Mental Hygiene Law, which uniformly reflect the legislative judgment, shared by amicus, that an individual's judgment may be mentally impaired with respect to one subject or issue, but not with respect

⁹ The decisions below in the cases at bar have the curious effect that patients subject to retention orders remain presumptively competent to consent, but are presumptively incompetent to refuse. If patients subject to retention orders were also deemed incompetent to consent to treatment, the state would then be obligated to review not only patient decisions to refuse treatment, but also patient decisions to consent to treatment. The fact that the Department of Mental Hygiene does not have a mechanism for reviewing consent decisions is additional evidence that retention orders are not findings of incompetence.

to other subjects or issues. The Mental Hygiene Law carefully -- and properly -- provides that a determination of mental impairment in one area shall not be deemed a determination of mental impairment in others. For example, §29.03 explicitly provides as follows:

No order or determination under this article that a person is in need of involuntary care and treatment or that there was a need for retention of such person shall be construed or deemed to be a determination or finding that such person is incompetent or is unable adequately to conduct his personal or business affairs.

§29.03 (emphasis added).

By using the disjunctive "or," the legislature made clear its intent that a retention order is not a determination either that the individual was incompetent, or that the individual was unable adequately to conduct his personal or business affairs because of mental impairment less severe than incompetence.¹⁰

This provision, enacted in 1972, placed New York in the mainstream of a nationwide trend towards separating determinations of the need for involuntary hospitalization and incompetency. As a major study published in 1968 noted:

The trend in legislation during the last 15 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

¹⁰ Of course, under New York common law, competent persons may refuse unwanted treatment. Appellees urge, in effect, that §9.31 has the effect of changing the common law. But statutes in derogation of the common law must be strictly, not broadly, construed. Thus, unless the legislative intent to change the common law is clear and unambiguous, the common law rule should govern.

between a person's need to be cared for in a mental hospital and his capacity to handle his own affairs.¹¹

Similarly, Section 33.01 provides, in even broader terms, as follows:

Notwithstanding any other provision of law, no person shall be deprived of any civil right, if in all other respects qualified and eligible, solely by reason of receipt of services for a mental disability nor shall the receipt of such services modify or vary any civil right of any such person, including but not limited to civil service ranking and appointment, the right to register for and to vote at elections, or rights relating to the granting, forfeiture, or denial of a license, permit, privilege, or benefit pursuant to any law.

Moreover, in a broad range of circumstances, New York's Mental Hygiene Law consistently recognizes that a ruling of incompetence or incapacity for one purpose should not be deemed a ruling of incompetence or incapacity for any other purpose. For example, under §9.21(b), even if individuals do not have "the legal capacity to contract," they can have the

¹¹ Allen, Ferster & Weihofen, Mental Impairment And Legal Incompetency 49-50 (1968) (footnotes omitted). The study formally recommended that states adopt the following provision: "A determination that a person needs care and treatment in a mental hospital . . . should never be deemed an adjudication of incompetency; nor should a hospitalization order constitute of itself sufficient ground for appointment of a guardian in a subsequent guardianship proceeding." *Id.* at 229. As early as 1962, the American Psychiatric Association and the National Association For Mental Health urged states to distinguish between hospitalization and 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 [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. Psychiatric 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) at 5 (emphasis added). As a former president of the American Psychiatric Association once 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. Psychiatry* 321, 326 (1979).

capacity to apply for voluntary admission to a hospital, which is a form of contract since patients, if able, must pay for the costs of hospitalization (see §43.03). §9.21(b). Conversely, even if an individual has been found to be incompetent and thus subject to the control of a "committee," the committee does not have the unilateral authority to authorize the hospitalization of that individual. Instead, the committee must obtain a further court order or certificates from "two examining physicians" willing to certify that the individual meets the criteria for "involuntary care and treatment." §9.27. Obviously, a judicial determination that an individual is "incompetent" is not a determination that the individual "has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment." §9.03.

Similarly, under the Mental Hygiene Law a court can subject an individual to the control of a "conservator" if it finds that the individual "by reason of . . . mental weakness . . . has suffered substantial impairment of his ability to care for his property or has become unable to provide for himself or others dependent upon him for support." §77.01. Nevertheless, the Mental Hygiene Law provides not only that appointment of a conservator shall not be deemed a determination of incompetence, but also that appointment of a conservator shall not even be relied upon as "evidence" of the "incompetency of the conservatee." §77.25(b). The law provides, further, that a "conservatee shall not be deprived of any civil right solely by reason of the appointment of a conservator, nor shall such appointment modify or vary any civil right of a conservatee, including [specified rights]." §77.25(a). And the law explicitly provides that even though, by definition, a conservatee

suffers from substantial impairment of his ability to care for his property, the conservatee nevertheless retains the power "to dispose of property by will, if he possesses the requisite testamentary capacity." §77.25(c). This provision reflects the legislative judgment that even though a conservatee has impaired capacity to "care for" his property, he may nevertheless have the requisite capacity to understand what his property is, and to understand the natural objects of his beneficence, and thus the capacity to dispose of, by will, property he could not care for himself.

These and many other provisions in the Mental Hygiene Law consistently reflect the legislative judgment that incapacity for one purpose should not be deemed incapacity for any other purpose, even if the second purpose is closely related to the first. This interpretation of the New York Mental Hygiene Law is consistent with the interpretation of other state commitment laws by other courts.¹² As the Supreme Court of Colorado has noted en banc, "the fact that the patient has been involuntarily certified for

¹² Other state courts have relied on similar or even less protective statutory language in concluding that involuntarily hospitalized mental patients are not incompetent simply because of their commitment, and that they retain the right to refuse antipsychotic drugs unless they are specifically found to be incompetent. E.g., People v. Medina, 705 P.2d 961, 969 (Colo. 1985) (en banc) (construing statute providing that patients certified for mental health care and treatment do not "forfeit any legal right or suffer legal disability" by reason of certification); Rogers v. Commissioner of Mental Health, 390 Mass. 489, 458 N.E.2d 308, 313 (1983) ("We think it clear that the right to make treatment decisions is an essential element of the patient's general right 'to manage his affairs.'"). See also Opinion of the Justices, 465 A.2d 484, 488 (N.H. 1983); Anderson v. Arizona, 663 P.2d 570, 573, and n.1 (Ct. App. Ariz. 1982); In Re K.K.B., 609 P.2d 747, 749 (Okla. 1980) ("Commitment in an institution does not necessarily mean a person is incapable of appropriately deciding whether or not he prefers to be treated with antipsychotic drugs.").

mental health treatment does not by itself establish the patient's incompetency to make treatment decisions."¹³

These legislative and judicial judgments are supported by the experience of mental health professionals. It is now generally accepted that many forms of mental illness have a specific impact on the individual, leaving decisionmaking capacity and reasoning ability largely unimpaired. M. Lorr, C. Klett & D. McNair, Syndromes of Psychosis 8 (1963) (cognitive disorientation is absent in hostile paranoid schizophrenia); see Neale & Oltmanns, Schizophrenia 24 (1980); Helmchen, Schizophrenia: Diagnostic Concepts in the ICD-8, in Studies of Schizophrenia (M. Lader ed.), British Journal of Psychiatry, Special Publication No. 10 (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. Psychiatry 67, 68-70 (1974).

The decisions below, holding that persons subject to retention orders necessarily lack the capacity to form judgments concerning antipsychotic drugs, are therefore contrary to the plain meaning of §§9.01 and 9.31, and are also inconsistent with the legislative judgment, reflected throughout the

¹³ People v. Medina, 705 P.2d 961, 973 (Colo. 1985). See also, id. at 970, n.6. See H. Davidson, Forensic Psychiatry 196 (1952); Plotkin, Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment, 72 Nw. U.L. Rev. 461, 489-90 (1977).

Mental Hygiene Law, that determinations of incapacity for one purpose are not determinations of incapacity for any other purpose.

Because the lower court erred in its interpretation of the legal effect of retention orders, and erroneously concluded that retained patients are necessarily unable to understand the need for treatment with antipsychotic drugs, it did not discuss, or even consider, the circumstances in which a competent patient can or cannot refuse such drugs. Rather than address those issues ab initio, it would be appropriate for this Court to vacate the judgments below and remand for further consideration. Amicus urges the Court to adopt that course.

II. HOSPITALIZED PATIENTS HAVE A FEDERAL CONSTITUTIONAL RIGHT TO REFUSE ANTIPSYCHOTIC DRUGS UNLESS THEY HAVE BEEN FOUND INCOMPETENT OR ARE IMMINENTLY DANGEROUS TO SELF OR OTHERS.

A. Antipsychotic Drugs Are Highly Beneficial For Many Patients, But They Also Have Substantial Side Effects, Implicating Basic Principles Of Individual Autonomy.

For many patients, antipsychotic drugs have a major beneficial impact and are considered the treatment of choice. See, e.g., Cole & Davis, Clinical Efficacy of the Phenothiazines as Antipsychotic Drugs, in Public Health Service, Psychopharmacology: A Review of Progress 1957-1967 1057 (1968) at 1057-1063; Davis, Overview: Maintenance Therapy in Psychiatry: I. Schizophrenia, 132 Am. J. Psychiatry 1237 (1975); National Institute of Mental Health Psychopharmacology Service Center Collaborative Study Group, Phenothiazine Treatment in Acute Schizophrenia, 10 Arch. Gen. Psychiatry 246 (1964); Hogarty, et al., Drug and Sociotherapy in the Aftercare of Schizophrenic Patients, 31 Arch. Gen. Psychiatry 603 (1974). 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, 403 A.2d 744, 752, n.13 (D.C. Ct. App. 1979). See Davis v. Hubbard, 506 F. Supp. 915, 927 (N.D. Ohio 1980) ("it can at least be said that psychotropic drugs are an effective method of treating schizophrenic symptoms, and may thus enable patients to benefit from other types of therapy").

But despite their potential benefits, antipsychotic drugs also cause side effects, some of which are very serious. See Gaughan & LaRue, The Right of a Mental Patient to Refuse Antipsychotic Drugs in an Institution, 4 L. & Psychology Rev. 43, 51-52 (1978). Furthermore, the courts have uniformly recognized that it is impossible for clinicians to predict how helpful or harmful an antipsychotic drug will be for a particular patient.¹⁴ Thus, it is impossible to predict at the outset whether a particular patient will benefit from antipsychotic drugs and will experience no adverse side effects; will benefit but will experience adverse side effects; will not benefit but will not experience adverse side effects; or will not benefit but will experience adverse side effects.

The side effects caused by antipsychotic drugs are well documented in the professional literature. See, e.g., Ayd, A Survey of Drug-Induced

¹⁴ E.g., Davis v. Hubbard, 506 F. Supp. at 927, 928, 934 n.23; In the Matter of the Guardianship of Richard Roe, III, 421 N.E.2d 40, 53 (Mass. 1981). See generally, Plotkin, Limiting The Therapeutic Urgy: Mental Patients' Right To Refuse Treatment, 72 Nw. U. L. Rev. 461, 474-475 (1977); Lehmann, Individual Differences in Response to Pharmacotherapy, in Psychotropic Drug Response: Advances In Prediction 18 (Wittenborn & May, eds., 1969); Ayd, Pre-Treatment Prediction of Responsiveness To Chlorpromazine: Is It Possible?, 10 Int'l. Drug Therapy Newsletter 4 (1975).

Extrapyramidal Reactions, 175 J.A.M.A. 1054 (1961); Crane, Clinical Psychopharmacology in Its 20th 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, 956-61 (A. Freedman, H. Kaplan & B. Sadock eds. 1976); Zander, Prolixin Decanoate: A Review of the Research, reprinted in 2 Mental Disability L. R. 37 (July-Aug. 1977); Klein, Gittelman, Quitkin & Rifkin, Diagnosis and Drug Treatment of Psychiatric Disorders 199-203 (2d ed. 1980); Rifkin, Quitkin & Klein, Akinesia: A Poorly Recognized Drug-Induced Extrapyramidal Behavioral Disorder, 32 Arch. Gen. Psychiatry 672 (1975); Davis, Antipsychotic Drugs, in Vol. 3 Comprehensive Textbook of Psychiatry/III 2257, 2281 (H. Kaplan, A. Freedman & B. Sadock eds. 1980); and the authorities cited therein. Those side effects have also been recognized by the courts. For example, in the most recent judicial review of the side effects caused by antipsychotic drugs, the Supreme Court of Colorado noted the following:

Several types of side effects are associated with antipsychotic medications. Autonomic 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 to 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).¹⁵

Although many of the side effects described above are very serious, the most debilitating effect linked to antipsychotic drugs is tardive dyskinesia. The seriousness of that condition has been noted by many courts, including the Supreme Court of Colorado:

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

People v. Medina, 705 P.2d 961, 968, n.3 (Colo. 1985) (en banc) (citing Gutheil & Appelbaum, "Mind Control," "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication, 12 Hofstra L. Rev. 77, 109 (1983); Davis v. Hubbard, 506 F. Supp. 915, 928-29 (N.D. Ohio 1980) (collecting authorities); H. Kaplan & B. Sadock,

¹⁵ People v. Medina, 705 P.2d 961, 968, n.3 (Colo. 1985) (en banc).

Modern Synopsis of Comprehensive Textbook of Psychiatry/III 771-89 (3d ed. 1981); Physicians' Desk Reference 1896-99 (38th ed. 1984)) (emphasis added).¹⁶

To date, tardive dyskinesia has resisted curative efforts, and its disabling manifestations may persist for years.¹⁷ A major recently published 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). Some prevalence studies report much higher rates. For example, two prevalence studies indicate that the condition affects 50% to 56% of chronically hospitalized schizophrenics,¹⁸ and a third prevalence study indicates that the condition affects 41% of all outpatients. Asnis, et al., A survey of tardive dyskinesia in psychiatric outpatients, 134 Am. J. Psychiatry 1367-1370 (1970). See

¹⁶ See, to the same effect, In Re Boyd, 403 A.2d at 752, n.13; Opinion of the Justices, 465 A.2d 484, 489 (N.H. 1983); and Anderson v. Arizona, 663 P.2d 570, 572 (Ct. App. Ariz. 1982).

¹⁷ Although most authorities consider tardive dyskinesia to be a permanent condition, it may regress to some extent after discontinuation of treatment. Moreover, some studies have suggested that it can be treated in certain cases, particularly if it is a mild case or is detected early. Sovner, Dimascio, et al., Tardive Dyskinesia and Informed Consent, 19 Psychosomatics 172 (March 1978); Crane, Persistent dyskinesias, 122 Br. J. Psychiatry 395-405 (1975); Jacobson & Baldessarini, Tardive and withdrawal dyskinesia associated with haloperidol, 131 Am. J. Psychiatry 534-535 (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.

¹⁸ Gardos & Cole, Drug variables in the etiology of tardive dyskinesia, 1 Prog. Neuro-Psychopharm. 147-154 (1977); Jus, et al., Epidemiology of tardive dyskinesia. Part 1., 37 Dis. Nerv. Syst. 210-214 (1976).

Sovner, Dimascio, et al., Tardive Dyskinesia and Informed Consent, 19 Psychosomatics 172, 173 (March 1978); and Davis v. Hubbard, 506 F. Supp. at 929. However, prevalence studies of hospitalized patients may overstate the risk that a given patient will develop tardive dyskinesia. They 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 antipsychotic drugs in that population at that time. Because patients who do have tardive dyskinesia may be more likely to remain hospitalized, and patients who have not developed tardive dyskinesia may be more likely to have been discharged, such prevalence studies may overstate the risk that a newly admitted patient will develop tardive dyskinesia.

Incidence studies, on the other hand, study 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 4 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). (The same study 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); and American Psychiatric Association Task Force Report #18, Tardive Dyskinesia, at 57 (estimating incidence of 10-40% in patients receiving long-term treatment).

The wide range of percentages, in both prevalence and incidence studies, is attributable in large part to the fact that, until recently, there have been "no 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 upon the "symptom severity" required by the researcher to identify a "case." Id. Substantial progress has been made in defining the criteria for a diagnosis of tardive dyskinesia. See Schooler & Kane, Research diagnoses for tardive dyskinesia (RD-TD), 39 Arch. Gen. Psychiatry 486 (1982). It can be expected, therefore, that future studies will be able to establish the prevalence or incidence of tardive dyskinesia more precisely.

Unfortunately, despite science's increasing knowledge about tardive dyskinesia, it is still impossible to predict which patients will develop that condition. As the American Psychiatric Association's Task Force on Tardive Dyskinesia reported in a July 1985 letter to the entire membership of that Association, "it is impossible at present to identify which patients are at risk," the "course of the condition is difficult to predict in individual patients," and there is "no established treatment for tardive dyskinesia." Accordingly, the Task Force recommended that the "benefits and risks of long-term neuroleptic treatment should be discussed with patients and families and their informed consent to treatment documented." Id. (emphasis added).

Because antipsychotic drugs cause tardive dyskinesia (and other less serious but nevertheless unpleasant side effects) in a very substantial percentage of patients, the Supreme Judicial Court of Massachusetts appropriately found that "antipsychotic drugs are high-risk treatment." In

the Matter of the Guardianship of Richard Roe, III, 421 N.E.2d 40, 54 (Mass. 1981). Similarly, the Supreme Court of Colorado, en banc, has found that "the administration of antipsychotic medication is within this high risk category of treatment that requires consent or some other legal justification before it may be properly administered to a patient." People v. Medina, 705 P.2d at 969-970, n.4. As that court found:

Antipsychotic medications, either alone or in combination, can cause numerous and varied side effects and carry with them the risk of serious and possibly permanent disabilities in the patient. . . . The effects of these drugs can be far more debilitating to the patient than the physical restraint incident to the involuntary commitment process.¹⁹

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

¹⁹ Id. at 968 (footnote omitted). Among the many cases concluding that antipsychotic drugs are high risk treatment are Mills v. Rogers, 457 U.S. 291, 293, n.1 (1982); Rennie v. Klein, 653 F.2d 836, 843 and n.8 (3rd Cir. 1981) (en banc), vacated, 458 U.S. 1119 (1982), on remand, 720 F.2d 266 (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); Bee v. Greaves, 744 F.2d 1387, 1390-91, 1394 (10th Cir. 1984), cert. den., 105 S.Ct. 1187 (1985); and Opinion of the Justices, 465 A.2d 484, 488 (N.H. 1983). See Scott v. Plante, 532 F.2d 939, 945 n.8 (3rd Cir. 1976) (describing side effects).

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

B. Involuntarily Hospitalized Patients Have A
Federal Constitutional Right To Refuse
Antipsychotic Drugs.

Although courts have differed on the precise circumstances in which a hospitalized patient's right to refuse antipsychotic drugs can be overridden by more compelling state interests, every court that has ruled on the issue has ruled that the right to refuse such drugs is protected by the United States Constitution. Amicus agrees.²⁰

The starting point is the United States Supreme Court's decision in Mills v. Rogers, 457 U.S. 291 (1982). The Court had granted plenary review "to determine whether involuntarily committed mental patients have a constitutional right to refuse treatment with antipsychotic drugs." Id. at 293. But because of an intervening state court decision, on state law grounds, the Court decided that resolution of that constitutional question would be premature. Id. at 305. The Court nevertheless noted that the "parties agree that the Constitution recognizes a liberty interest in avoiding the unwanted administration of antipsychotic drugs." Id. at 299. And the Court's opinion proceeded on the assumption that there is such a constitutional 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, 45 L.Ed.2d 396, 95 S.Ct. 2486 (1975), and that these interests are implicated by the involuntary administration of antipsychotic drugs. Id. at 299, n.16.

²⁰ See generally, Brooks, The Constitutional Right to Refuse Antipsychotic Medications, 8 Bull. Am. Acad. Psychiatry & L. 179 (1980).

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 he was involuntarily committed by court order to a state mental hospital, and even though he had been found by the court to be not only mentally ill, but also mentally "incompetent." O'Connor, 422 U.S. at 566, n.2. It follows, a fortiori, that patients such as appellants, who have not been found by any court to be incompetent, retain constitutionally protected liberty interests following involuntary hospitalization.

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. 307, 315 (1982).²¹

Thus, although the question has not been squarely resolved by the Supreme Court, its opinions in Mills v. Rogers, Youngberg v. Romeo, and O'Connor v. Donaldson, read together, strongly suggest that the Court would rule that the right of competent patients to refuse antipsychotic drugs is a liberty interest that is protected by the federal Constitution.²²

²¹ Other courts have read Youngberg as support for a constitutional right to refuse antipsychotic drugs. E.g., Johnson v. Silvers, 742 F.2d 823, 825 (4th Cir. 1984).

²² That is the way the Supreme Court's opinion in Mills v. Rogers has been read by lower courts. See, for example, Project Release v. Prevost, 722 F.2d 960, 979 (2d Cir. 1983): "Although Mills did not definitively resolve the question of whether a liberty interest in refusing antipsychotic medication exists as a federal constitutional matter, the case appears to indicate that there is such an interest."

So far as amicus is aware, every lower court that has ruled on the issue has reached that conclusion.²³ 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 constitutional source for the right to refuse antipsychotic drugs is not an argument against recognition of such a right by this Court. To the contrary, the breadth of constitutionally protected interests those courts have cited indicates that forcible administration of antipsychotic drugs implicates a panoply of fundamental liberty interests. But regardless of the specific constitutional source of the right, those courts all hold that involuntarily hospitalized mental patients have a constitutionally protected right to refuse antipsychotic drugs that must be respected by the state except in narrowly

²³ The Commentary to §7-4.10 of the American Bar Association's recently adopted Criminal Justice Mental Health Standards, adopted by the ABA House of Delegates on August 7, 1984 and published as Chapter 7 of the second edition of the ABA Standards for Criminal Justice, notes that "[i]t seems the prevailing view at present that there exists valid constitutional objections to forced treatment, at least by civilly committed mental patients in at least some situations." The commentaries are not official ABA policy, but the standards are. Standard 7-9.12 provides that mentally ill convicts should have "the same right to decline habilitation or mental health treatment as a civilly committed person in that jurisdiction." Similarly, a recent survey of this issue, published by the ABA's Mental and Physical Disability Law Reporter ("MPDLR"), concluded as follows: "The recent court decisions discussed above all acknowledge the existence of a qualified constitutional right to refuse antipsychotic or antipsychotic medication, but, at the same time, all allow mental hospital personnel to compel medication in a legitimate emergency. In nonemergency situations, the courts generally hold that there is an absolute right to refuse treatment for nondangerous, competent individuals, even involuntary psychiatric hospital patients." 8 MPDLR 85 (March-April, 1984). For a discussion of the effects of antipsychotic drugs on competence to stand trial, see Tomashefsky, Antipsychotic Drugs and Fitness to Stand Trial: The Right of the Unfit Accused to Refuse Treatment, 52 U. Chi. L. Rev. 773 (1985).

defined circumstances. As discussed in the next section, most courts have ruled, and amicus submits, that the state must respect a patient's decision to refuse such drugs unless forced medication is necessary to avoid immediate danger to self or others, or the patient is incompetent.²⁴

²⁴ 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 (2nd 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 (3rd Cir. 1981) (en banc), cert. granted and judgment vacated and remanded, 458 U.S. 1119 (1982), on remand, 720 F.2d 266 (3rd 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 Project Release v. Prevost, 722 F.2d 960 (2nd 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 (3rd Cir. 1976) (complaint alleging forced administration of antipsychotic 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 antipsychotic 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 antipsychotic 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 medical 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 antipsychotic drugs. E.g., Goedecke v. State Dept. 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). See also Jamison v. Farabee, F. Supp. ___, No. C78-445 WHO (N.D. Cal. April 26, 1983), 7 Mental Disability L. R. 436 (consent decree).

- C. Only When The Patient Is Incompetent Or Is Imminently Dangerous To Self Or Others Do State Interests Become Sufficiently Compelling To Overcome The Patient's Federal Constitutional Right To Refuse Antipsychotic Drugs.

In this section, amicus will analyze the substantive grounds we believe are sufficient to override a patient's refusal of antipsychotic drugs. In Point III amicus will analyze the procedures we believe should be employed for determining whether there is a substantive justification for overriding such a refusal.

First, however, we must address a misconception entertained by the lower court. That court seemed to feel that the Second Circuit's decision in Project Release v. Prevost, 722 F.2d 960 (2nd Cir. 1983), "held that the administrative procedures for reviewing determinations to administer [drugs] pursuant to 14 NYCRR Section 27.8 complied with the procedural and substantive due process requirements of the Fourteenth Amendment."²⁵

Project Release did hold that 14 NYCRR §27.8 satisfies the procedural requirements of the Fourteenth Amendment, but it did not hold that §27.8 satisfies the substantive requirements of the Fourteenth Amendment. Nor could it. Section 27.8 is a procedural mechanism. With the exception of one clause authorizing involuntary treatment if treatment "appears necessary to avoid serious harm to life or limb of the patients themselves," it contains no substantive standards. It is obvious from the structure of §27.8 that it permits involuntary treatment in circumstances other than "serious harm to life or limb of the patients themselves," but §27.8 does not itself specify the substantive standards for deciding in which other circumstances forced treatment can be authorized.

²⁵ 11/7/84 Opinion, at 2 (emphasis added). See also, 11/4/84 Opinion, at 2.

The court in Project Release carefully and repeatedly distinguished between the substantive grounds for refusing antipsychotic drugs and the procedures for determining whether those substantive grounds are present in a given case. Immediately after noting that the right to refuse drugs "has both substantive and procedural aspects," 722 F.2d at 977 (quoting Mills v. Rogers), the court said it had to determine "first, as a substantive matter," whether such a liberty interest exists, and "second, whether the procedures embodied in 14 N.Y.C.R.R. §27 . . . satisfy minimum due process requirements." Id. (emphasis added). After concluding that hospitalized patients do have a substantive right in at least some circumstances to refuse antipsychotic drugs, but without attempting to specify what those circumstances would be, the court then inquired whether the "patient's right to refuse treatment with antipsychotic medication is sufficiently protected by New York State procedures. . . . In our view, the New York regulations, 14 N.Y.C.R.R. §§27.8, 27.9, on their face, meet minimum due process standards." Id. at 979. (emphasis added). The court then held that "these procedures, on their face, satisfy due process." Id. at 980-981 (emphasis added).

Immediately after ruling that New York's procedures satisfied due process requirements, the court expressly noted that its opinion intimated "no view as to whether" those procedures sufficiently protected various substantive rights, including "patient rights set forth in M.H.L. §§33.01, 33.03." Id. at 981 n. 25.

It is not surprising that the court did not attempt to define the circumstances in which patients would or would not have a substantive due process right to refuse antipsychotic drugs because the court had before it no concrete circumstances to consider. As the court repeatedly noted, it

was reviewing "a purely facial challenge to the statute," and "whether the statute is applied constitutionally remains an open question. . . ." Id. at 970, 971 (emphasis in original). See also id. at 963, 964, 965, 979 and 981. Thus, Project Release did not resolve the substantive due process issues presented by this appeal.

Amicus believes the state may forcibly administer antipsychotic drugs only in two situations. The first involves patients who are actively dangerous to themselves or others, or who pose an immediate and substantial threat of becoming violent. In this situation, the state's 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.²⁶ The second situation involves incompetent patients who refuse drugs but who, in the judgment of the substitute decisionmaker, would consent if competent. This "substituted judgment" standard is consistent with the patient's autonomy interest because it authorizes the state to do only what the patient would do if competent.²⁷

²⁶ Only a relatively small percentage of involuntarily committed patients are even potentially violent in an institutional setting. See Rogers v. Ukin, 478 F. Supp. at 1356.

²⁷ E.g., In Re Boyd, 403 A.2d at 753; In Re K.K.B., 609 P.2d 747, 752 n.16 (Okla. 1980); Rogers v. Commissioner of Mental Health, 390 Mass. 489, 458 N.E.2d 308, 316 (1983); Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417, 431 (Mass. 1977). Under the "substituted judgment" standard, the substitute decisionmaker is not free to do whatever he or she thinks would be best for the incompetent patient. Rather, the substitute decisionmaker must first make a good faith effort to determine what the incompetent patient would do if competent. If the incompetent patient would refuse antipsychotic drugs even if competent, that is the decision the substitute decisionmaker must make.

Except in these two circumstances, the state's interests in forcibly administering antipsychotic drugs are not sufficiently compelling to override the constitutional rights of involuntarily hospitalized patients.

To state these general principles is relatively easy, but to apply them in borderline circumstances is more difficult. For example, although it is clear that a serious risk of physical violence to self or others would satisfy the first principle, 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.

Similarly, 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.²⁸

D. No Other State Interests Are Sufficiently Compelling To Justify The Forcible Administration Of Antipsychotic Drugs Over A Patient's Objection.

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

The state's interest in saving life is not implicated here because antipsychotic drugs do not save or prolong life. The state's lesser interest in improving the patient's health is not sufficiently compelling to justify the forcible administration of antipsychotic drugs. That conclusion is implicit in each of the decisions cited above holding that patients do have the right to refuse antipsychotic drugs.²⁹

²⁸ People v. Medina, 705 P.2d 961, 973 (Colo. 1985) (emphasis added). Unlike amicus, the Colorado Supreme Court would apparently apply this test in the case of all incompetent patients, including those whose wishes, if competent, could be determined.

²⁹ See also, Bee v. Greaves, 744 F.2d 1387, 1395 (10th Cir. 1984), cert. denied, 105 S.Ct. 1187 (1985), in which the court held that even though a state had a "constitutional duty to treat" a pre-trial detainee, the detainee nevertheless had a constitutional right to refuse antipsychotic drugs.

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

The state's interest in improving the health of the public does not outweigh the patient's constitutionally protected interests. Courts have strictly limited the power of the state to further general societal interests at the expense of the individual's constitutional liberty interests. Although the Supreme Court held, in Jacobson v. Massachusetts, 197 U.S. 11 (1905), that the state's interest in compulsory vaccination outweighed the individual's right to bodily integrity, the balance of governmental and individual interests is far different in the case of antipsychotic drugs. First, the state's interest in administering antipsychotic drugs in the hope that they will help individuals is not as compelling as its interest in administering vaccinations to prevent highly predictable and life-threatening epidemics. Second, far more than vaccinations, antipsychotic drugs dramatically affect the body and mind of the individual and have dangerous and often permanent side effects. (See Point II-A, supra.) Third, vaccinations are highly effective, but as noted in Point II-A, antipsychotic drugs may not benefit a given patient. Fourth, although there are no realistic alternatives to vaccinations, other treatment methods (such as psychotherapy and certain forms of behavior modification) that are less physically intrusive than antipsychotic drugs may be effective for at least some patients. Given the extent of the intrusion involved, the possibility that harmful side effects may last months or years beyond the period of hospitalization, the inability to predict whether antipsychotic drugs will benefit a particular patient, the availability of other and less physically intrusive forms of treatment, and the tendency of some hospitals to misuse drugs for the convenience of staff

and for punishment,³⁰ the state's generalized interest in improving the health of the public does not justify the forcible administration of antipsychotic drugs.

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

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

First, the vast majority of patients who are prescribed antipsychotic drugs willingly take them. The example of the Rogers' case is instructive. In a more than two-year period after the district court issued its injunction generally prohibiting forced administration of antipsychotic drugs in nonemergency situations, a witness for the state was able to identify only 12 patients out of approximately 1000 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.

³⁰ See, e.g., Davis v. Hubbard, 506 F. Supp. at 926 & n.7 (quoting Crane, Clinical Psychopharmacology in its 20th Year, 181 Sci. 124, 125 (1973)).

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

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

Finally, recognition of the right of competent patients to refuse antipsychotic drugs is wholly consistent with the government's interest in furthering professional ethics. Among treating professionals, it is an almost universally accepted principle that patients must give informed consent before they are subjected to medical treatment. See National Comm'n for Protection of Human Subjects of Biomedical and Behavioral Research, Research Involving

Those Institutionalized As Mentally Infirm (5-3)-(5-6) (H.E.W. Pub. No. 78-0007, 1978) (Nat'l Comm'n). The underlying legal and ethical premise of the informed consent doctrine is the notion of "thorough-going self determination." Natanson v. Kline, 186 Kan. 393, 406, 350 P.2d 1093, 1104 (1960). This doctrine, grounded in the respect society has for patients as persons, emerged as a rule of law in the context of physician-patient malpractice suits. Accordingly, the patient's rights to autonomy and self-determination do not conflict with the professional's ethical duties. To the contrary, respecting the patient's rights would accord with the ethical and professional standards of professional psychology. See American Psychological Association, Ethical Principles of Psychologists, 36 Am. Psychologist 633, at 633, 636 (1981) (psychologists strive to protect fundamental human rights, they fully inform clients of the purpose and nature of treatment, and they recognize that clients "have freedom of choice with regard to participation"). The ethical demands of all mental health professionals are best served by respecting the autonomy of the patients they serve, to the maximum extent possible.

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

In Project Release, the Second Circuit apparently held that the decision to authorize long-term administration of antipsychotic drugs over a patient's objection can be made by mental health professionals, and need not be made by a court.³¹ Some other courts have also thought a judicial

³¹ Project Release v. Prevost, 722 F.2d 960, 981 (2nd Cir. 1983).

determination might be unnecessary.³² Amicus respectfully disagrees. The determination is essentially a legal determination, not a psychological or medical determination, and should be made by a court. Several courts have so ruled.³³

For example, in People v. Medina, the Supreme Court of Colorado, en banc, required a judicial hearing because the issues to be resolved are essentially legal in nature:

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

Courts have traditionally been considered the appropriate forum for resolving issues of competency or danger to self or others, and there is no persuasive reason why courts should not resolve those same issues in the context of forced medication.

Moreover, leaving competency determinations to hospital personnel creates a significant risk that, simply because a professional believes the patient has made the "wrong" decision, he or she will conclude the patient is incapable of making a rational decision. 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

³² E.g., Davis v. Hubbard, 506 F. Supp. 915, 939 (N.D. Ohio 1980); Opinion of the Justices, 465 A.2d 484 (N.H. 1983).

³³ People v. Medina, 705 P.2d 961 (Colo. 1985) (en banc); Rogers v. Commissioner of Mental Health, 390 Mass. 489, 458 N.E.2d 308 (1983); In Re K.K.B., 609 P.2d 747 (Okla. 1980); and In Re Boyd, 403 A.2d 744, 747, n.5 (D.C. Ct. App. 1979).

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 (2nd Cir.), cert. denied, 404 U.S. 985 (1971).

Requiring a judicial determination of incompetence would not unduly burden governmental interests in institutional efficiency and treatment. Due process does not require a separate adjudication of incompetency for each refusal to submit to antipsychotic drugs. A single adjudication of incompetency would be sufficient to extinguish the presumption of competency. The delay required to obtain a judicial determination of incompetency will be minimal. And if a sudden crisis develops in the patient's condition, requiring immediate treatment to prevent substantial deterioration, the Constitution may allow the hospital staff to determine whether the patient has become incompetent, and if so, whether the temporary administration of antipsychotic 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.³⁴

³⁴ E.g., People v. Medina, 705 P.2d 961, 974-975 (Colo. 1985) (en banc) (emphasis supplied):

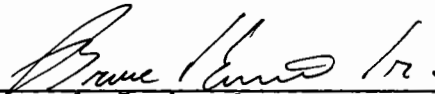
The state's legitimate interest in protecting those mentally ill patients committed to its custody will support immediate medical intervention when the delay occasioned by ordinary recourse to the judicial process would itself place the physical well-being of the patient or others in immediate jeopardy. In these emergency situations, however, judicial authorization for continued treatment must be obtained as soon as practicable after the emergency in the event that continued treatment with antipsychotic medication is contemplated.

But even if the determination of incompetence, or of danger to self or others, need not be made by a court, it must be made by someone before antipsychotic drugs may be forcibly administered. The undisputed facts in this case show that no court and no mental health professional has ever found that the forcible administration of antipsychotic drugs was necessary to prevent appellants from being dangerous to self or others, and no court and no mental health professional has ever found that appellants were incompetent. Accordingly, they should not have been subjected to forced medication.

CONCLUSION

The judgments below should either be vacated and remanded, or reversed.

Respectfully submitted,



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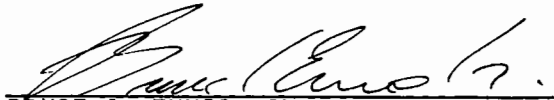
CERTIFICATE OF SERVICE

I, BRUCE J. ENNIS, JR., do hereby certify that I caused to be served three copies of the Brief of Amicus Curiae American Psychological Association In Support Of Appellants on this 27th day of February, 1986, by depositing said copies in the United States mail, first-class postage prepaid to:

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