

IN THE
Supreme Court of the United States
OCTOBER TERM, 1988

STATE OF WASHINGTON, *et al.*,
Petitioners,

v.

WALTER HARPER,
Respondent.

On Writ of Certiorari to the
Washington Supreme Court

AMICUS CURIAE BRIEF OF
THE AMERICAN PSYCHOLOGICAL ASSOCIATION
IN SUPPORT OF RESPONDENT

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STATEMENT OF INTEREST OF AMICUS CURIAE

The American Psychological Association (APA) has been the principal professional association of psychologists in the United States since 1892. It now has more than 70,000 members, including the vast majority of psychologists with doctorates from accredited universities. APA has Divisions devoted to Psychopharmacology, Clinical Psychology, and other subjects germane to this case. APA members serve many patients who have been or may be incarcerated. APA members have a substantial interest in the effects of antipsychotic drugs on such persons, as well as a broader ethical and professional interest in ensuring that mentally ill persons are treated in an appropriate manner.¹

¹ Letters from all parties consenting to the filing of this *amicus curiae* brief have been filed with the Clerk of the Court.

SUMMARY OF ARGUMENT

This case raises the issue of whether due process requires that a prisoner receive an impartial hearing before he can be forced to take potent, mind-altering drugs that themselves cause disabling and potentially incurable disorders. The answer clearly is yes. Because antipsychotic drugs have grave effects, inherent potential for abuse, and an actual history of indiscriminate use by the psychiatric profession, forcible administration of these drugs requires review by an independent decisionmaker in a manner comporting with due process.

The antipsychotic drugs at issue have powerful effects on a person's ability to think and feel, and on his sense of self. These drugs also cause disabling, incurable, and often unpredictable disorders,² including akathisia (repetitive, irresistible tapping-type movements), dystonia (severe rigidity or spasms of the upper body, writhing and grimacing), and neuroleptic malignant syndrome, a condition that can be fatal.³ In about one-fourth of the cases, these drugs cause tardive dyskinesia, a condition that can disfigure and disable a prisoner long after his penal debt has been paid. See Section I.A., *infra*.

² See *Mills v. Rogers*, 457 U.S. 291, 293 n.1 (1982); *Rennie v. Klein*, 462 F. Supp. 1131, 1138 (D. N.J. 1978), *supplemented*, 476 F. Supp. 1294 (D. N.J. 1979), *modified and remanded*, 653 F.2d 836 (3d Cir. 1981) (*en banc*), *vacated and remanded*, 458 U.S. 1119 (1982), *on remand, aff'd and remanded*, 720 F.2d 266 (3d Cir. 1983) (*en banc*); *In Re Boyd*, 403 A.2d 744, 752 n.13 (D.C. 1979). See also A. Schatzberg and J. Cole, *Manual of Clinical Psychopharmacology* 87-102 (1986); Jeste, Iager, and Wyatt, "The Biology and Experimental Treatment of Tardive Dyskinesia and Other Related Movement Disorders," in 8 *American Handbook of Psychiatry* 536, 537-539 (Berger and Brodie, eds. 2d ed. 1986).

³ See generally Addonizio, *et al.*, "Neuroleptic Malignant Syndrome: Review and Analyses of 115 Cases," 22 *Biological Psychiatry* 1004 (1987); Pearlman, "Neuroleptic Malignant Syndrome: A Review of the Literature," 6 *Journal of Clinical Psychopharmacology* 257 (1986); Hollister, "Antipsychotics and Antimanic Drugs," in *Review of General Psychiatry* 596 (Goldman ed. 1984).

Respondent Harper already has developed some of these disorders, including dystonia and akathisia. Petitioner's Appendix ("Pet. App.") B-8. No one can know whether he will develop additional side effects of antipsychotic drugs; but if he does, they are likely to be incurable. See Section I.A, *infra*. Unless there is a formal determination that he is incompetent to make decisions about his own treatment, or unless he is imminently dangerous, Mr. Harper should have the right to refuse drug treatments that jeopardize his current and long-term health.

Involuntary medication is usually accomplished by restraining the inmate while he is given an intra-muscular or subcutaneous injection with a hypodermic needle. Sometimes there are repeated, ineffective needlesticks, bruises, and other injuries. As noted, the medications used can cause severe disorders. These disorders can be life-long, constituting a deprivation of liberty far beyond simple custodial confinement for the term of the criminal sentence. Accordingly, the American Psychological Association submits that involuntary medication is a "major change in the conditions of confinement,"⁴ and is "qualitatively different from the punishment characteristically suffered by a person convicted of a crime."⁵ As this Court held in *Vitek v. Jones*, "the stigmatizing consequences of a transfer to a mental hospital . . . [and] subjection of the prisoner to mandatory behavior modification as a treatment for mental illness, constitute the kind of deprivations of liberty that requires procedural protections." 445 U.S. at 494. Surely forcible drugging requires no less.

Given that a competent and objecting prisoner has a constitutional right not to be drugged without due process, the issue becomes what process is due. Under this Court's rulings, such action requires a hearing before a truly independent, unbiased decisionmaker—either a court or a properly constituted administrative body.

⁴ *Wolff v. McDonnell*, 418 U.S. 539, 571-572 n.19 (1974).

⁵ *Vitek v. Jones*, 445 U.S. 480, 493 (1980).

The State and its associated amici essentially argue⁶ that prisoners are incompetent to decide whether to accept drugs and that even if they are competent, "the concept of patient preference . . . is essentially irrelevant";⁷ that psychiatrists always make benevolent and wise decisions; and that courts should write psychiatrists a blank check to force these drugs upon patients. But each of these arguments is unsupportable.

First, most prisoners—including Mr. Harper—have never been found to be legally, medically, or psychologically incompetent to consent (or refuse to consent) to treatment. The psychiatrists' callous declaration that patients' consent to treatment is "irrelevant" flouts long-settled ethical and legal rules on the treatment of prisoners. Second, the scientific literature, as well as scores of pending lawsuits, show that psychiatrists, far from acting wisely, often prescribe antipsychotic drugs indiscriminately, risking serious and irreparable harm to patients.⁸ As a psychiatrist has written, "[l]itigation from patients suffering from TD [tardive dyskinesia] is expected to explode within the next five years. Some psychiatrists and other physicians continue to minimize the seriousness of TD . . . [despite] continual warnings."⁹

⁶ See Brief of Petitioners ("Pet. Br.") at 24, 29, 30; Brief of the United States as Amicus Curiae Supporting Petitioners ("U.S. Br.") at 3-5; Brief for the American Psychiatric Association and the Washington State Psychiatric Association as Amici Curiae ("APA/WSPA Br.") at 21; Brief Amici Curiae of Washington Community Mental Health Council, *et al.* ("WCMHC Br.") at 18-20.

⁷ APA/WSPA Br. at 21.

⁸ The findings in the scientific literature, discussed in Sections I.A and I.B, *infra*, are confirmed by a growing number of malpractice suits against psychiatrists for harm due to abuse of antipsychotic drugs. See, e.g., Joseph T. Smith, *Medical Malpractice: Psychiatric Care* § 5.17 (1986 and Supp. 1988, App. 5-1); R. Simon, *Clinical Psychiatry and the Law* 60-74 (1986); Gualtieri, Sprague, and Cole, "Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic Treatment," 14 *J. Psychiatry and Law* 187 (1986).

⁹ Simon, *supra* n.8, at 74.

Third, this Court and the lower courts repeatedly have noted the unreliability of psychiatric judgments, and have rejected the psychiatric profession's demands for unlimited discretion.¹⁰ Finally, determining whether anti-psychotic drugs should be forced on a patient requires a weighing not only of medical factors (such as the anticipated benefit and the medical risk to the prisoner), but also of correctional needs (the degree of risk to others and possible alternative precautions) and the prisoner's liberty interest—which are *not* medical determinations.

We do not assert that the entity weighing these varied factors must be a court. It might also be a properly constituted administrative body, following fair procedures, and calling upon unbiased expertise.

But such a fair process surely did not occur in this case. The review panel was comprised of one administrator from the prison Special Offender Center ("SOC") and two SOC professional staff—all of whom presumably would tend to do what their institutional colleagues desired. Mr. Harper was told the basis of the medication order twenty-four hours in advance and advised to "prepare" for a hearing. He had no right to assistance of counsel, even though the staff believed he was seriously mentally ill. Rules of evidence did not apply. The panel of "unbiased" decisionmakers consulted with SOC staff about the case outside the hearing room, depriving Mr. Harper of the opportunity to respond adequately and giving him reason to believe the decision was predetermined. Subsequent SOC review panels (which authorized continued forced medication) could include the very physician who ordered medication in the first place. These features taken together clearly establish that the hearing process was not fundamentally fair and unbiased.

Forced drugging should occur only if a reasonably independent and unbiased decisionmaker concludes that it

¹⁰ See, e.g., *Estelle v. Smith*, 451 U.S. 454 (1981); *O'Connor v. Donaldson*, 422 U.S. 563 (1975); *Jackson v. Indiana*, 406 U.S. 715 (1972); *Rennie v. Klein*, *supra*.

is warranted, based upon evidence from diverse professionals (such as internists and psychologists) who have no vested interest in using antipsychotic drugs. Forced drugging is warranted only if the prisoner is incompetent or imminently dangerous, if the medication is likely to be effective, if non-drug therapies have been objectively explored, and if forced medication is truly needed for the welfare of the prisoner or others.

ARGUMENT

I. THE STATE AND ITS AMICI IGNORE WARNINGS ABOUT ANTIPSYCHOTIC DRUGS IN CURRENT MEDICAL LITERATURE.

Recent research reveals that previous reports significantly underestimated the prevalence, permanence, and severity of the disabling disorders caused by antipsychotic (neuroleptic) drugs. Although these drugs appear to be effective in alleviating the symptoms of certain mental disorders, primarily schizophrenia, they should not be used indiscriminately. It is alarming that both the State and its amici ignore the dangers of antipsychotic drugs. The persistent disregard of factual evidence by both the State and the psychiatric profession discredits their contention that they can unquestioningly be trusted to use unbiased clinical judgment in prescribing such drugs for prisoners.

A. Antipsychotic Drugs Often Cause Dangerous and Largely Incurable Disorders.

The disorders caused by antipsychotic drugs range in severity from mildly disturbing to lethal. The less severe ones include nausea, skin rashes, restlessness, muscle stiffness, dry mouth and congestion, diminished energy, and suppression of personality. More serious disorders include vomiting, diarrhea, blurred vision, nocturnal confusion, tremors and spasms, shuffling walk, and inability to sit still.¹¹ The truly grave risks presented by these

¹¹ The major antipsychotic drugs include Haldol, Mellaril, Navane, Compazine, Prolixin, and Thorazine. For a description of side effects

drugs include liver damage, changes in heart rate (possibly resulting in cardiac arrest), convulsions, acute dystonia (fixed, involuntary rigidity due to muscle spasms), neuroleptic malignant syndrome (which can lead to death from cardiac dysfunction)¹²—and tardive dyskinesia.

Tardive dyskinesia is characterized by bizarre, uncontrollable movements of the face (lip smacking, chewing, protruding tongue, grimacing) and similar rhythmic, involuntary movements of the trunk, arms and legs.¹³ At times it occurs in a mild form, but its more serious form can include severe physical and other effects:

Physical complications range from severe respiratory disturbances, characterized by irregularities in respiratory rate, depth, and rhythm accompanied by involuntary grunting, snorting, and gasping noises; or severe gastrointestinal dyskinesia with persistent vomiting, aerophagia, retching, and paroxysmal contraction and distention of the abdominal wall; to less severe but more frequent and still disturbing swallowing disorders, hyperkinetic dysarthria, loosening of teeth, and traumatic ulcerations of the oral mucosa, which may become infected.

Psychosocial sequelae may range from embarrassment, anxiety, guilt, shame, and anger, to severe, full-blown reactive depression, decompensation of psychosis, and even suicide. Dyskinesia can result in

they can cause, see generally *Physician's Desk Reference* (43d ed. 1989) ("PDR"), at 1236 (Haldol), 1882 (Mellaril), 1785 (Navane), 2042 (Compazine), 1639 (Prolixin), and 2071 (Thorazine).

¹² See generally PDR, *supra* n.11, at 1968 ("a potentially fatal symptom complex sometimes referred to as Neuroleptic Malignant Syndrome (NMS) has been reported in association with antipsychotic drugs. Clinical manifestations of NMS are hyperpyrexia [feverishness], muscle rigidity, altered mental status and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis [profuse perspiration] and cardiac dysrhythmias").

¹³ See generally Jeste, Iager, and Wyatt, *supra* n.2, at 537-538.

a social and/or occupational handicap and stigmatization.¹⁴

As devastating to a patient as these disorders are, even more disturbing is the fact that once symptoms become manifest, it is unlikely that they will disappear—even if medication is discontinued. While the State and its amici rely principally on the American Psychiatric Association's Task Force Report on Tardive Dyskinesia,¹⁵ that report is based on data developed between the 1950s and 1970s, which no longer represent the best scientific judgment. More recent published reports, which include analysis of all of the prior studies, show that the prevalence of tardive dyskinesia ("TD") among patients treated with neuroleptics is increasing at an alarming rate, as shown in the chart below:

*Increasing Prevalence of Tardive Dyskinesia Among Chronically Ill Psychiatric Inpatients Treated With Neuroleptics*¹⁶

Period	1960-1965	1966-1970	1971-1975	1976-1980
No. of Studies	3	16	6	12
No. of Patients	821	6800	2211	3048
Prevalence of TD (%)	5.5%	14.6%	20.2%	25.6%

Thus, an impressive body of recent research shows that tardive dyskinesia is far from the minimal risk that the State and its amici suggest. For long-term patients such as Mr. Harper, the chance of suffering this potentially devastating disorder is greater than one in four.¹⁷ The

¹⁴ *Id.* at 541.

¹⁵ American Psychiatric Association Task Force on Late Neurological Effects of Antipsychotic Drugs, Report 18 *Tardive Dyskinesia* (1980). (See, e.g., Table 6 at 26 at Table 14 at 102-103.)

¹⁶ Jeste, Iager and Wyatt, *supra* n.2, at 539. Richard Jed Wyatt, M.D., is Chief of the Neuropsychiatry Branch and also Chief of the Psychopharmacology Section of the National Institute of Mental Health.

¹⁷ *Id.* See also Gualtieri, Sprague, and Cole, *supra* n.8, at 187; Baldessarini, "Clinical and Epidemiologic Aspects of Tardive Dyskinesia," 46(4) *J. Clin. Psychiatry* 8 (1985).

consistent escalation of the reported incidence of tardive dyskinesia suggests that when studies are performed in the coming years, the incidence may well be still higher. Other troubling aspects of tardive dyskinesia are that it is impossible to predict which patients will develop the disorder, and that the disorder is reversible in only one-third of the patients who suffer its consequences.¹⁸

B. Indiscriminate and Incorrect Use of Antipsychotic Drugs Exacerbates the Problem.

A patient's risk of suffering from tardive dyskinesia is further heightened by several disturbing features of the disorder and psychiatric practice. First, onset of the disorder often is masked by the very drugs that cause it, so that symptoms do not appear until the medication is stopped, and the disorder is so advanced that it cannot be cured.¹⁹ Second, psychiatrists often fail to recognize the incipient symptoms of harm. A 1987 study found that attending psychiatrists failed to recognize symptoms of tardive dyskinesia in about 90% of the cases.²⁰ Still worse, neurologic side effects—particularly akathisia—are sometimes misdiagnosed as agitation or psychosis, with the result that the psychiatrists then *increase* the dosage of the very drugs that cause the disorders.²¹

¹⁸ Jeste, Iager, and Wyatt, *supra* n.2, at 560:

We estimate that in approximately one-third of these patients in whom neuroleptics are stopped, TD will disappear. The remaining two-thirds of these patients will have persistent TD. . . . *To date, there is no proven specific curative treatment for persistent TD.* [Emphasis added.]

Accord Baldessarini, *supra* n.17.

¹⁹ Jeste, Iager, and Wyatt, *supra* n.2, at 560.

²⁰ Weiden, *et al.*, "Clinical Nonrecognition of Neuroleptic-Induced Disorders: A Cautionary Study," 144(9) *Am. J. Psychiatry* 1148, 1150 (1987). A similar study found a 75% rate of nonrecognition of tardive dyskinesia in a Veterans Administration teaching hospital. Hansen, Casey, and Weigel, "TD Prevalence: Research and Clinical Differences," *New Research Abstracts*, 139th Annual Meeting of the American Psychiatric Association (1986).

²¹ Weiden, *et al.*, *supra* n.20, at 1151-52.

Although antipsychotic medications can and do ameliorate the symptoms of *certain* mental illnesses, the seriousness of their adverse effects dictates that they be used only for conditions for which they have proven effective. The 1986 *Manual of Clinical Psychopharmacology* warns:

Maintenance antipsychotic therapy in non-schizophrenic patients is not, generally, a good idea The risk of dyskinesia is real, and the burden is on the clinician to prove that maintenance therapy was, in fact, necessary and effective.

* * * *

In conditions such as depression, anxiety, personality disorder, or organic brain syndromes where efficacy is not firmly established, other drug therapies or no drug therapy may be preferable.²²

The use of these neuroleptic drugs may be appropriate to treat schizophrenia, paranoia, childhood psychosis, and certain neuropsychiatric disorders such as Tourette syndrome and Huntington's chorea.²³ The vast majority of mentally ill prisoners, however, *do not suffer from such disorders*. Instead, most of these inmates have a personality disorder or a history of alcohol or drug abuse, as shown in the table below:

*Percent of Mentally Ill Prisoners With Specific Diagnoses*²⁴

Prison Site	Schizophrenia or Schizophreniform	Depression or Manic Depression	Antisocial Personality or Personality Disorder	Substance Abuse
Washington	6.6%	14.6%	44%	66%
Oklahoma	5.0%	unreported	35%	25%
Michigan	2.8%	8.9%	50%	47%

²² Schatzberg and Cole, *supra* n.2, at 86, 87.

²³ Jeste, Iager and Wyatt, *supra* n.2, at 559. Even with such disorders, periods of nonmedication and low continuous dosages are advisable.

²⁴ Source: Jemelka, Trupin and Chiles, "The Mentally Ill in Prisons: A Review," 40(5) *Hosp. and Community Psychiatry* 481, 482-483 (1989).

Thus, since most mentally ill prisoners have precisely the kind of disorders that "*have not been found to respond to psychopharmacologic treatment*,"²⁵ there should be little need for chronic use of antipsychotic drugs in penal institutions. If psychiatrists are using these drugs for the wrong disorders, the practice should not be sanctioned.²⁶

An antipsychotic drug should be administered only after a thorough diagnostic and psychological workup and "only when it is the drug of choice for a well-specified clinical condition."²⁷ Although Mr. Harper reportedly suffered at times from manic-depression, and the record mentions many drugs he was forced to take, it does not show that he ever was treated with lithium, which psychopharmacologists and psychiatrists view as the "overwhelming treatment of choice for patients suffering from manic-depression."²⁸ While a patient exhibiting manic excitement properly may be given both lithium and an antipsychotic drug for a brief period until the mania subsides, "the effectiveness of long-term treatment of manic-depression with an antipsychotic remains questionable at best."²⁹

The indiscriminate approach to treatment, in which individuals like Mr. Harper are forced to take a variety of potent drugs without any clear diagnosis of their mental

²⁵ Schatzberg and Cole, *supra* n.2, at 21-22 (emphasis supplied).

²⁶ Cf. *Davis v. Hubbard*, 506 F. Supp. 915, 926 (N.D. Ohio 1980) ("Psychotropic drugs are not only overprescribed; they are also freely prescribed. . . . Such widespread use of psychotropic drugs, both in terms of the number of patients using drugs and the dosages that they receive is not . . . however, necessarily supported by any sound medical course of treatment. [I]t is countertherapeutic and can be justified only for . . . the convenience of the staff or for punishment").

²⁷ Jeste, Iager, and Wyatt, *supra* n.2, at 559; see also Schatzberg and Cole, *supra* n.2, at 86-87.

²⁸ Smith, *supra* n.8, § 5.15 at 128. See also *Rennie v. Klein*, 462 F. Supp. at 1138 ("Lithium carbonate is now established as the most effective treatment available for mania").

²⁹ Smith, *supra* n.8, § 5.13 at 123-124.

disorder, is bad medicine. Encouraging it would be bad law. As one court observed:

[A]t various times during plaintiff's prior hospitalizations, diagnoses of both schizophrenia and manic depression were offered. . . . [The] lack of certainty about causation and physiopathology demonstrates the tentativeness of much psychiatric diagnosis as compared to the usual physical diagnosis.

* * * *

[T]he testimony in this case underscores the fact that psychiatric diagnosis and therapy is uncertain, with great divergence of opinion in any given case. . . . This also weighs toward leaving the final decision with the patient rather than deferring to the doctors. [*Rennie v. Klein*, 462 F. Supp. at 1145 (citations omitted).]

Given their potency and serious adverse consequences, antipsychotic drugs should be administered (even to consenting patients) with care and restraint. This requires, at a minimum, a thorough evaluation to identify any alternative treatable basis for the behavioral symptoms and to ensure that the use of antipsychotic drugs is not inadvisable due to the presence of other complications. Equally important, the prescribing psychiatrist should be required to document evidence supporting a diagnosis for which the proposed drug regimen is recognized as effective. Forcing drugs that are likely to be ineffective for the condition at issue is destructive and pointless.³⁰

Finally, the dose of the prescribed drug should be the lowest dose that is effective. Unfortunately, the literature reveals that in the decade from 1973 to 1982, the average dose of neuroleptic drugs approximately *doubled* in many psychiatric facilities, although it "has not been documented . . . whether patients need or benefit from such high doses of neuroleptics."³¹ In fact, psychiatrists some-

³⁰ Smith, *supra* n.8, § 5.20 at 140.

³¹ Reardon, *et al.*, "Changing Patterns of Neuroleptic Dosage Over a Decade," 146 *Am. J. Psychiatry* 726, 727, 729 (1989).

times prescribe five to ten times the necessary dose of antipsychotic drugs.³² This results in no increase in effectiveness, but a significant increase in risks. As one expert warns:

Given that there is no satisfactory treatment for tardive dyskinesia, it is reasonable . . . to try to minimize risks of tardive dyskinesia by thoughtful and conservative long-term use of neuroleptic medications for clear indications (chronic psychotic illness that *responds* to treatment), and in the lowest effective doses, which may be as low as 10%-20% of those now in common use in this country.³³

We have searched the record of this case in vain for evidence that these basic precautions were taken before Mr. Harper was forced to risk his long-term health by taking antipsychotic drugs. The record reveals no discussion of specific diagnoses, lower drug dosages, less risky medications, or the benefits of drug-free respite periods, all of which are standard medical considerations. The minutes of the SOC review committee's meetings apparently include only the conclusory statement that "the committee found that, as a result of mental disease or disorder, Mr. Harper was a danger to others." Pet. App. A-3, B-3. Although periodic review of each case is required, it does not appear that periodic examinations and laboratory tests are either required or presented during such reviews. *Id.* Nor is there evidence that psychological or behavioral therapies were tried—or even considered.

In sum, antipsychotic drugs have both an inherent potential for abuse and an actual history of indiscriminate use by the psychiatric profession. In this respect they

³² Baldessarini, *supra* n.17, at 10 ("there is growing evidence that typical maintenance (or even short-term) regimens involve doses of neuroleptics that are much greater than necessary for many patients, perhaps by a factor of 5-10").

³³ Baldessarini, *supra* n.17, at 10-11 (emphasis in original). See also Reardon, *et al.*, *supra* n.31, at 728-729.

are similar to psychosurgery and electroshock therapy, highly invasive treatments which psychiatrists embraced enthusiastically and used indiscriminately—until their tragic effects became publicized and their use was curtailed by legislative, judicial, and scientific pressure.³⁴ Because many psychiatrists will not heed the warnings in the scientific literature as to the dangers and misuse of neuroleptic drugs, independent and unbiased decisionmakers should decide whether orders for forced medication are justified. Even some psychiatrists acknowledge that:

Placing unbridled discretion in the hands of a single clinician has often led to unskillful and at times unfortunate use of medications. This is particularly true in some of our public facilities, which historically have had difficulties recruiting and supporting competent clinicians.³⁵

Moreover, as many courts have found, prisons present unique possibilities for distortion of clinical judgment by punitive, retaliatory, or other improper motivations.³⁶ Thus, even more than patients in private hospitals, prisoners need the protection of unbiased decisionmakers.

³⁴ See generally E. Valenstein, *Great and Desperate Cures: The Rise and Decline of Psychosurgery and Other Radical Treatments for Mental Illness* (1986); P. Breggin, *Electroshock: Its Brain-Disabling Effects* (1979).

³⁵ Appelbaum, "The Right to Refuse Treatment with Antipsychotic Medications: Retrospect and Prospect," 145(4) *Am. J. Psychiatry* 413, 418 (1988).

³⁶ "In *Nelson, Pena, and Mackey*, the courts found that the drugs were used improperly and for punishment rather than as part of an ongoing psychotherapeutic program." *Rennie v. Klein*, 462 F. Supp. at 1143, citing *Nelson v. Heyne*, 355 F. Supp. 451, 455 (N.D. Ind. 1972), *aff'd* 491 F.2d 352 (7th Cir.), *cert. denied*, 417 U.S. 976 (1974); *Pena v. New York State Div. for Youth*, 419 F. Supp. 203, 207 (S.D.N.Y. 1976); and *Mackey v. Procunier*, 477 F.2d 877 (9th Cir. 1973). See also *Bee v. Greaves*, 744 F.2d 1387, 1390 (10th Cir. 1984) ("jail officers administered Bee's medication forcibly by injection for the express purpose of intimidat[ing] him so he wouldn't refuse the oral medication anymore"), *cert. denied*, 469

II. Forcible Administration of Antipsychotic Drugs Implicates Basic Liberty Interests.

A. Prisoners Usually Have a Right to Refuse Invasive and Dangerous Therapies.

It is beyond reasoned dispute that forcing drugs on an unwilling prisoner at least impinges upon constitutionally protected liberty interests. Administering drugs to an individual who is actively resisting is usually accomplished by physically restraining the prisoner while a hypodermic needle is forced beneath the skin (subcutaneous injection) or into a large muscle (intramuscular injection). Often the process results in repeated needlesticks, bruises, pools of medication in tissue, and further efforts to insert the needle.

Moreover, the psychotropic drugs that are administered have a powerful effect on the prisoner's mental state, awareness, and sense of self. For some patients, these drugs may be helpful—even essential—in restoring mental function. Unfortunately, they cause serious, incurable, and sometimes fatal side effects and it is impossible to predict which patients will suffer these effects. As one court concluded, "[w]e can identify few legitimate medical procedures which are more intrusive than the forcible

U.S. 1214 (1985); *Knecht v. Gillman*, 488 F.2d 1136 (8th Cir. 1973).

A national commission "noted and [could] not ignore serious deficiencies in living conditions and health care that generally prevail in prisons. Nor [could] the Commission ignore the potential for arbitrary exercise of authority by prison officials." National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *Report and Recommendations: Research Involving Prisoners*, 42 *Fed. Reg.* 3076, 3078 (1977). The Commission also recommended court review of any psychosurgery to be performed on a prisoner or involuntarily confined mental patient because "such individuals are vulnerable to coercion and . . . psychosurgery may be proposed in attempts to modify behavior for social or institutional purposes not coinciding with the patient's own interests or desires." *Report and Recommendations: Psychosurgery*, 42 *Fed. Reg.* 26318, 26330 (1977).

injection of antipsychotic medication." *In re Guardianship of Roe*, 421 N.E.2d 40, 52 (Mass. 1981).

For these and other reasons, the courts have recognized that psychotropic medications are a "high-risk treatment" that "has potentially devastating effects."³⁷ Thus "a person has a constitutionally protected interest in being left free by the state to decide for himself whether to submit to the serious and potentially harmful . . . administration of antipsychotic drugs."³⁸ Indeed, in remanding *Rogers* in light of *In re Guardianship of Roe*, this Court "assum[ed] for purposes of this discussion that involuntarily committed mental patients do retain liberty interests protected directly by the Constitution . . . and that these interests are implicated by the involuntary administration of antipsychotic drugs."³⁹ A number of courts have agreed with the conclusion of the Washington Supreme Court in this case, that "antipsychotic drug treatment is no less intrusive than ECT [electroconvulsive or electroshock therapy]," for which it is well established that an unwilling patient is entitled to a judicial hearing.⁴⁰

³⁷ *In re Guardianship of Roe*, 421 N.E.2d at 54; *Jarvis v. Levine*, 418 N.W.2d 139, 147 (Minn. 1988). Other courts have noted that these drugs "carry a significant risk," see *Mills v. Rogers*, 457 U.S. at 293 n.1 and "can inflict serious, permanent injury," see *Bee v. Greaves*, 744 F.2d at 1390. See also *Rennie v. Klein*, 653 F.2d at 843 n.8; *Davis v. Hubbard*, 506 F. Supp. at 927-929; *Opinion of the Justices*, 465 A.2d 484, 488 (N.H. 1983).

³⁸ *Rogers v. Okin*, 634 F.2d 650, 653 (1st Cir. 1980), vacated and remanded sub nom. *Mills v. Rogers*, 457 U.S. 291 (1982).

³⁹ *Mills v. Rogers*, 457 U.S. at 299 n.16. Cf. *Vitek v. Jones*, 445 U.S. at 494; *Mackey v. Procunier*, 477 F.2d at 878.

⁴⁰ Pet. App. A-6. See, e.g., *Riese v. St. Mary's Hosp. & Med. Center*, 196 Cal. App. 3d 1388, 243 Cal. Rptr. 241 (Cal. Ct. App. 1987); *People v. Medina*, 705 P.2d 961, 967 (Colo. 1985) (*en banc*); *Gundy v. Pauley*, 619 S.W.2d 730, 731-732 (Ky. 1981) (involuntary patient has right to refuse electroshock therapy "in the absence of a judicial declaration of incompetence, or an emergency"); *In re Guardianship of Roe*, 421 N.E.2d at 51-52.

Forced antipsychotic drugging involves many of the same risks which caused the Court to reject forced surgical intrusions in *Winston v. Lee*, 470 U.S. 753 (1984). There, the Court ruled, without dissent, that even a small incision to remove a bullet from a criminal suspect "implicates expectations of privacy and security of such magnitude that the intrusion may be 'unreasonable' even if likely to produce evidence of a crime." The Court stressed "the extent to which the procedure may threaten the safety or health of the individual," and "the uncertainty about the medical risks." *Id.* at 761, 764. These same factors are present here, in contrast to the "minor intrusion" to extract a blood sample which involved "virtually no risk, trauma or pain," and hence was permitted in *Schmerber v. California*, 384 U.S. 757, 771 (1966).

Despite the obvious liberty interest at issue in this case, the State persists in denying that any such interest exists. Pet. Br. at 19-20. Yet it is alone in this assertion. Its position was rejected by both the trial court and the Washington Supreme Court. As amicus United States acknowledges, "even if state law did not create a liberty interest, we believe that a prison inmate ordinarily retains a liberty interest in not receiving antipsychotic medication against his will." U.S. Br. at 15. *See also* APA/WPSA Br. at 16.

B. Significant Changes in Conditions of Confinement Implicate Basic Liberty Interests.

As this Court ruled in *Wolff v. McDonnell*, 418 U.S. at 571-572, a "major change in the conditions of confinement" requires that a person receive due process. Forced drugging constitutes a change in the conditions of confinement at least as significant as transfer from a prison to a psychiatric facility, which this Court found to trigger due process protection in *Vitek v. Jones*. Indeed, while transfer to a psychiatric facility may improve care, is always reversible, and normally will not extend beyond the prison term, forced medication can be worse than simple incarceration, and its effects may last a lifetime or

shorten a lifetime. As the Washington Supreme Court found, "the highly intrusive nature of anti-psychotic drug treatment warrants greater protections than . . . those necessary to protect the interests at issue in *Vitek*." Pet. App. A-18. Cf. *Jarvis v. Levine*, 418 N.W.2d 139 (Minn. 1988).

In *Vitek*, the Court cited another criterion for deciding whether due process protections are triggered: whether "the conditions or degree of confinement to which the prisoner is subjected is within the sentence imposed upon him." 445 U.S. at 493, quoting *Montanye v. Haymes*, 427 U.S. 236, 242 (1976). A prisoner's transfer from one penal institution to another is "within the sentence imposed upon him," because his sentence makes no assumption as to prison location. But this is not true of transfer to a mental hospital (*Vitek*), and it is not true of forced medication. On the contrary, as this Court noted in *Vitek*:

[I]nvuntary commitment to a mental hospital is not within the range of conditions of confinement to which a prison sentence subjects an individual. . . . [A] criminal conviction and sentence of imprisonment extinguish an individual's right to freedom from confinement for the term of his sentence, but they do not authorize the State to classify him as mentally ill and to subject him to involuntary psychiatric treatment, without affording him additional due process protections. [445 U.S. at 493-494.]

A criminal sentence does not itself authorize forced drugging of any inmate.⁴¹ Given that an important lib-

⁴¹ In contesting this conclusion, the State relies principally on *Turner v. Safley*, 482 U.S. 78 (1987), and *Youngberg v. Romeo*, 457 U.S. 307 (1982). Both cases are readily distinguishable. In *Turner*, the Court found that it is important to inquire whether "a prison regulation that burdens fundamental rights is 'reasonably related' to legitimate penological objectives or whether it represents an 'exaggerated response' to those concerns." 482 U.S. at 87. The State mistakenly believes that this general formula means that any infringement on inmates' rights need only meet the same, low

erty interest of inmates is at stake, the real issue is what due process procedures are required to balance that interest with the legitimate interests of the State.

III. ABRIDGEMENT OF CONSTITUTIONAL RIGHTS REQUIRES DUE PROCESS.

Determining whether a change in an inmate's conditions of confinement is justified by particular behavior "becomes critical, and the minimum requirements of procedural due process appropriate for the circumstances must be observed." *Wolff v. McDonnell*, 418 U.S. at 558. Moreover, a state's "reliance on the opinion of a designated physician or psychologist for determining whether the conditions warranting a transfer exist neither removes the prisoner's interest from due process protection nor answers the question of what process is due under the Constitution."⁴²

"reasonably related" standard of justification. On the contrary, as the Court ruled in *Turner*, restrictions on less essential prisoner rights (such as exchange of mail among inmates) might be justified by a lesser "penal interest" than a restriction on core rights, such as the right to marry. Under *Turner*, a major intrusion on a person's privacy, dignity and health through forced drugging should require a very substantial justification.

Nor does *Youngberg* support the State's position. In that case, the Court ruled that a retarded person, involuntarily committed to a state institution, retains constitutional rights to reasonably safe conditions, minimally adequate training, and freedom from unreasonable bodily restraints. *Youngberg* thus confirms that confinement itself does not divest a person of rights. The State invokes *Youngberg* for the proposition that "the Constitution only requires that the courts make certain that professional judgment was in fact exercised." Pet. Br. at 19. In *Youngberg*, however, the physical restraint had no lasting effects, while antipsychotic drugs can have permanently disabling and disfiguring effects, warranting an independent judgment on their use. In addition, deference to professional judgment may have been reasonable in *Youngberg*, since the patient was retarded and functioned at the mental age of an infant. By contrast, Mr. Harper is an adult who has *never* been found—judicially or otherwise—incompetent to make decisions about his own medical treatment.

⁴² *Vitek v. Jones*, 445 U.S. at 491. The State's reliance on *Parham v. J.R.*, 442 U.S. 584 (1979), is misplaced because *Parham* involved

It is important to stress that the issue in this case is not whether legitimate penal interests require administering drugs to certain inmates against their will, but whether they require that it be done *without a fair hearing*. We submit there is no legitimate institutional benefit to dispensing with impartiality and basic fairness. Prisons can operate effectively if the predicate for involuntary medication is established at a hearing either at the time of incarceration, at the time of transfer to a medical facility, or as the need arises. See *Large v. Superior Court of County of Maricopa*, 714 P.2d 399 (Ariz. 1986).

Once it is established that *some* hearing is required before a competent prisoner can be drugged against his will, the correctional system has no legitimate interest in requiring that the prisoner be denied counsel, that the fact-finder be biased, or that less intrusive and less risky treatments not be considered. A sham hearing might be swifter and surer of result, but this is not a legitimate penal interest.⁴³

The State and its amici warn of dire results if prisoners are afforded a fair hearing. We will briefly answer each warning. First, fair hearing requirements will not interfere with the facility's right to treat inmates who threaten imminent violence. It is well established that even civilly committed mental patients (who *have* a right to refuse treatment) nevertheless can be medicated against their will in emergencies, *i.e.*, when necessary to

a child who could not give or withhold consent, and because in *Parham*, unlike this case, "the [appropriate] questions are essentially medical in character: whether the child is mentally or emotionally ill and whether he can benefit from the treatment." *Id.* at 609.

⁴³ See *Turner v. Safley*, 482 U.S. at 89 ("when a prison regulation impinges an inmate's constitutional rights, the regulation is valid if it is reasonably related to *legitimate* penological interests") (emphasis added).

prevent immediate harm to themselves or others.⁴⁴ The same is true in jails and prisons, and we support the principle that involuntary medication can be administered if truly necessary in order to prevent instant harm to inmates or staff. But there is no suggestion that an instant "emergency" was present here; Mr. Harper was medicated year after year, and the inadequate protections afforded him were *standard operating procedure* at the facility.

Second, the State defends its procedures on the basis of "the state's *parens patriae* interest in providing Mr. Harper with necessary mental health care." Pet. Br. at 29. However, Mr. Harper has not been found incompetent to make his *own* decisions about treatment. Unless a patient has been found incompetent, any *parens patriae* argument is limited. *Bee v. Greaves*, 744 F.2d at 1395 ("the state may not deliberately fail to provide necessary medical treatment *where it is desired by the detainee*. . . . This Constitutional requirement cannot be turned on its head to mean that if a competent individual chooses not to undertake the risk or pains of a potentially dangerous treatment the jail may force him to accept it").

Third, the State and amici APA/WSPA voice apocalyptic fears that a fair review of forced medication orders will paralyze the correctional system. On the contrary, history has shown that hearings on involuntary treatment are manageable. For example, the trial court in *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980), enjoined forcible drugging of mental patients in non-emergencies. In the decade following that order, only about one out of ten patients appealed medication orders.⁴⁵ One study found that only 16 out of 677 hos-

⁴⁴ See, e.g., *Bee v. Greaves*, 744 F.2d at 1393-96; *Rennie v. Klein*, 720 F.2d at 269; *Rivers v. Katz*, 495 N.E.2d 337 (N.Y. 1986); *Colorado v. Smith*, 720 P.2d 629 (Colo. Ct. App. 1986).

⁴⁵ Appelbaum, *supra* n.35, and studies cited therein.

pitalized prisoners in New York (approximately 2.5%) pursued court review of medication orders.⁴⁶

A. Constitutional Rights of Prisoners May Be Limited Only As Required For Correctional Operations.

As this Court noted in *Addington v. Texas*, 441 U.S. 418, 426 (1979), involuntary hospitalization can be justified only on two bases: police power (dangerousness) or parens patriae (for the good of the patient). If the first rationale applies, then under well-established law in the civil commitment context, a patient can be medicated without consent if he is imminently dangerous.⁴⁷ If he is *not* dangerous, so that the "good of the patient" is the only rationale for hospitalization, then before the State can make treatment decisions for the prisoner, there must first be a determination that he is incompetent to decide for himself. "Thus, medication cannot be forcibly administered solely for treatment purposes absent a finding of incompetency." *Rogers v. Okin*, 634 F.2d at 656. Accord *Jarvis v. Levine*, 418 N.W.2d at 144.

It is critical to recognize that a finding of incompetence is not implicit in a finding that a patient is mentally ill. On the contrary, all but a handful of states have statutory provisions to the effect that involuntary commitment does *not* create a presumption of incompetency.⁴⁸ In this case, Mr. Harper accepted medication voluntarily for a period of years and the State accepted his consent as

⁴⁶ L.D. Smith, "Medication Refusal and the Rehospitalized Mentally Ill Inmate," 40(5) *Hosp. & Community Psychiatry* 491 (1989).

⁴⁷ *Rennie v. Klein*, 720 F.2d at 269; *People v. Medina*, 705 P.2d at 971-975; *Riese v. St. Mary's Hosp. and Med. Center*, 243 Cal. Rptr. at 252.

⁴⁸ Brakel, *et al.*, *The Mentally Disabled and the Law*, Table 7.2 at 405-407 (3d ed. 1985). See also *Nolen v. Peterson*, No. 87-446 (Ala. Jan. 13, 1989) ("without exception, every case has repeated the proposition that absent a finding of incompetency of the patient or an emergency situation, . . . a mental patient confined involuntarily to a mental facility retains a constitutionally protected right to reject potentially harmful antipsychotic medications").

valid; only his subsequent refusal was regarded as invalid. This is contrary to established law that competency depends on the reasoning process itself, and not on which choice is made.⁴⁹

The State argues, citing *Parham*, that "[I]f the state, acting for a ward, can constitutionally make . . . an admission decision . . . certainly it is appropriate to allow the state, acting for a felon, to make the treatment decision." Pet. Br. at 30. This reasoning ignores the critical distinction between a child who is legally incompetent to give or withhold consent, and an adult felon who is presumed competent unless a court rules otherwise. Amici APA/WSPA dismiss even a competent prisoner's objection to potent drugs as a mere "preference", adding the remarkable contention that "the concept of patient preference . . . is essentially irrelevant to a due process inquiry." APA/WSPA Br. at 21. Similarly, the State argues that "for most patients, refusing psychotropic medication reflects the patient's illness rather than autonomous functioning or consistent beliefs," and it declares invalid various reasons for refusal, such as "anger" and "whim." Pet. Br. at 24.

An objection asserted year after year hardly constitutes a "whim," and forced drugging surely would provoke anger in most people. To dismiss another's reasons simply because one disagrees with them is not permissible either in health care or in law. But there is nothing in the record to suggest that Mr. Harper was *ever* incom-

⁴⁹ As former Chief Justice Burger has written, regarding Justice Brandeis' formulation of the right to be let alone:

Nothing in this utterance suggests that Justice Brandeis thought an individual possessed these rights only as to *sensible* beliefs, *valid* thoughts, *reasonable* emotions, or *well-founded* sensations. I suggest he intended to include a great many foolish, unreasonable and even absurd ideas which do not conform, such as refusing medical treatment even at great risk. [*Application of the President & Directors of Georgetown College, Inc.*, 331 F.2d 1010, 1017 (D.C. Cir.) (Burger, J., dissenting from denial of rehearing), *cert. denied*, 377 U.S. 978 (1964) (emphasis in original).]

petent to make a treatment decision during the three years he was involuntarily medicated, or that the State ever sought to have him declared incompetent. In the absence of an adjudication of incompetence, Mr. Harper has the right to refuse medication based on his own weighing of risks and benefits.⁵⁰

The State and its amici also take the position that while transfer from a prison to a mental hospital is a major change in the conditions of confinement requiring due process, the change from confinement in a special unit to forced neuroleptic medication is not such a change. This is false for the reasons described in Section II.B. Both decisions can have major consequences. In light of the risks of error, abuse, and punitive motives in the transfer of an inmate to a mental hospital,⁵¹ this Court has assured judicial review of such decisions in *Vitek v. Jones*. There should be analogous review of the decision to force an inmate to take mind-altering drugs which can cause permanent disability.

⁵⁰ "[O]nly the patient can really know the discomfort associated with side effects of particular drugs. . . . It is also difficult for any person, even a doctor, to balance for another the possibility of a cure of his schizophrenia with the risks of permanent disability in the form of tardive dyskinesia. Whether the potential benefits are worth the risks is a uniquely personal decision which, in the absence of a strong state interest, should be free from state coercion. . . . [There is also] the fact that psychiatric diagnosis and therapy is uncertain, with great divergence of opinion in any given case. . . . This also weighs toward leaving the final decision with the patient rather than deferring to doctors." *Rennie v. Klein*, 462 F. Supp. at 1145. *Accord Davis v. Hubbard*, 506 F. Supp. at 936.

⁵¹ Similar concerns about the treatment of inmates were cited recently by researchers at the University of Washington:

The behavior of mentally ill offenders promotes ambiguity for correctional staff. . . . Because infractions are taken as a primary indicator of prison adjustment, which may ultimately affect classification and release decisions, judgments about what behaviors are tolerable or are allowed as manifestations of illness are important ones. This question raises issues about the training and qualifications of correctional officers. . . . [Jemelka, Trupin, and Chiles, *supra* n.24, at 485.]

B. Involuntary Administration of Antipsychotic Drugs Is Proper Only If An Unbiased Decisionmaker Concludes That the Prisoner Is Either Dangerous or Incompetent and That Alternative Treatments Have Failed.

The State presents the Court with a daunting—but false—dichotomy: either prisoners have no right to meaningful review of medication decisions or prisons will be paralyzed by endless hearings and a total displacement of clinical judgment. But this Court can achieve a reasonable accommodation of both liberty and penal interests by rejecting these polar positions, in favor of a reasonable alternative.

The American Psychological Association represents psychologists who seek primarily what is best for mentally ill patients. Therefore, we reject both the unrealistic view that no patient—even if dangerous—should ever be forcibly medicated, and the paternalistic view that practitioners always know best and that patients should just do as they are told. Instead, we recognize that forcible administration of drugs sometimes is necessary, but we urge that such action be taken (except in emergencies) only if an unbiased decisionmaker finds, on the basis of due process procedures, that:

- The prisoner either is imminently dangerous or is not competent to make a treatment decision;
- Behavioral and psychological alternatives to medication have been objectively explored;
- The prisoner has a diagnosed mental illness for which the proposed drug is effective;
- Medical examinations as well as psychological, neuropsychological, and laboratory evaluations reveal no other basis for the abnormal behavior, and no condition for which the proposed drug regimen is contraindicated; and
- Forcible medication is necessary or best for the patient and others.

Standards similar to these have been adopted by many courts.⁵²

In considering what process is due, it is important to note that the procedures available for review of the medication decisions in this case were hardly as substantial as suggested by the State and its amici. Pet. Br. at 16-18; *see also* APA/WSPA Br. at 3-5. For example, the inmate had no right to counsel, although the very premise of forced medication is that the prisoner has a serious mental illness. The right to know the issues in dispute and the right to cross-examine witnesses were compromised by permitting the panel to question the facility's staff *outside* the hearing room, thus denying the prisoner an effective "opportunity to challenge the contemplated action and to understand the nature of what is happening to him."⁵³

In addition, the SOC panel was hardly unbiased, since it consisted of an administrator of the facility whose principal interest is order, and other treatment staff employed by the same facility. Although the physician proposing medication in a particular case could not be on the panel during a review of his own orders, he could participate in subsequent inquiries into whether his orders should stand or be changed. Moreover, *all* panel members were staff employees, and thus susceptible to implicit or explicit pressure for cooperation ("If you support my orders, I'll support yours"). It is instructive that month after month, year after year, this "review" panel *always* voted for more medication⁵⁴—despite the scientific literature showing that periodic respites from drugs are ad-

⁵² *See, e.g., Project Release v. Prevost*, 722 F.2d 960, 980-981 (2d Cir. 1983); *Rennie v. Klein*, 720 F.2d at 274 (Becker, J. concurring); *Rogers v. Okin*, 634 F.2d at 660; *Davis v. Hubbard*, 506 F. Supp. at 938-939; *People v. Medina*, 705 P.2d at 973.

⁵³ *Vitek v. Jones*, 445 U.S. at 496, citing *Wolff v. McDonnell*, 418 U.S. at 564.

⁵⁴ *See, e.g., Pet. App. A-3, B-5, B-6.*

visible and that prolonged use of antipsychotic drugs is proper only when the medical need is clear and compelling. *See* Section II.B, *supra*.

The record also discloses no active consideration of alternative therapies to drugs. Before a constitutional liberty interest is abrogated, reasonable alternatives must be explored. This does not necessarily mean exhaustion of every possible alternative. But it does mean that an impartial decisionmaker has reviewed the question *with* benefit of input by professionals such as psychologists who are expert in non-drug treatment alternatives, and *without* an invariable bias in favor of medication. Unfortunately, since some psychiatrists have a persistent bias in favor of drugs, often this is the only treatment option presented. The State and its amici reflect this bias by referring repeatedly to the existence of two options: drug therapy or no therapy.⁵⁵

It is unfortunate that the available alternatives to drugs often are not explored. As one District Court declared, after an exhaustive inquiry into conditions at Texas prisons:

"Treatment" there consists almost exclusively of the administration of medications, usually psychotropic drugs, to establish control over disturbed inmates. Other options, such as counseling, group therapy, individual psychotherapy, or assignment to constructive, therapeutic activities are rarely, if ever, available on the units. Essentially, an inmate with a mental disorder is ignored by unit officers until his condition becomes serious. When this occurs, he is medicated excessively. . . . With constructive psy-

⁵⁵ *See, e.g.*, the statement of amici APA/WSPA that there is an "absence in the majority of cases of *any* feasible therapeutic alternatives." (APA/WSPA Br. at 14.) (emphasis in original). They also stress that Mr. Harper deteriorated without medication—but of course he received no alternative therapy. Indeed, they refer to the prisoner who is not on drugs as "untreated." *Id.* at 20. *See also* Pet. Br. at 31; WCMHC Br. at 13.

chotherapy virtually non-existent on the units, a large number of inmates resort to self-mutilations and suicide attempts, as dramatic cries for help.⁵⁶

Ignoring the alternatives is particularly tragic because "the therapeutic value of antipsychotic medication depends upon the existence of a trusting relationship," *People v. Medina*, 705 P.2d at 970, and "if the patient is unwilling to accept it, the positive effects are greatly lessened." *Rennie v. Klein*, 462 F. Supp. at 1141. *Accord Davis v. Hubbard*, 506 F. Supp. at 936. Moreover, behavioral and psychological therapies often are effective in treating assaultive behavior and psychosis.⁵⁷ To be optimally effective, the choice of drug therapy should be informed by neuropsychological and psychological assessments, and often must be accompanied by behavioral and other therapy.⁵⁸

Because the State and its employees persist in ignoring the scientific risks of antipsychotic drugs, and in viewing them as the only treatment for behavioral problems, their demands for forcible medication should be subject to review by either a court or an unbiased administrative

⁵⁶ *Ruiz v. Estelle*, 503 F. Supp. 1265, 1332, 1334 (S.D. Tex. 1980), *aff'd in part and vacated in part, modified* 679 F.2d 1115 (5th Cir. 1982), *cert. denied*, 460 U.S. 1042 (1983).

⁵⁷ See, e.g., Glynn, *et al.*, "Compliance with Less Restrictive Aggression-Control Procedures," 40(1) *Hosp. and Community Psychiatry* 82 (1989); Karon & VandenBos, *Psychotherapy of Schizophrenia: The Treatment of Choice* (1981); Paul and Lentz, *Psychosocial Treatment of Chronic Mental Patients: Milieu vs. Social Learning Programs* (1977); Karon & VandenBos, "Cost/Benefit Analysis for Schizophrenia Patients Treated by Psychologists, Psychiatric Psychotherapists, and Medication without Psychotherapy," 7 *Prof. Psychology* 107 (1976).

⁵⁸ "[I]t becomes increasingly clear that both modalities will continue to be necessary: psychotropic drugs to reduce vulnerability and psychological treatments to enhance coping skills. . . . Biological approaches should no longer be competitive but, rather, cooperative in the interest of the mentally ill." Meltzer and Lipton, "Introduction" in *Psychopharmacology: The Third Generation of Progress* (Meltzer, ed. 1987) at xii.

body. This body should include professionals who are not employees of the prison, and who represent a variety of disciplines (e.g., psychologists, psychiatrists, psychiatric social workers, internists and others) whose views concerning antipsychotic medication may balance one another.

CONCLUSION

Except in an emergency, before a prisoner is forced to take potentially disabling antipsychotic drugs, he should receive a fair hearing before an unbiased, independent body, to determine that:

- The prisoner either is imminently dangerous or is not competent to decide about his own treatment;
- Medical, psychological, neuropsychological and laboratory evaluations reveal no other cause of the abnormal behavior and confirm that the prisoner has no condition for which the proposed drug is contraindicated;
- The proposed drug is effective for the prisoner's diagnosed mental illness;
- Alternative approaches (behavioral and psychological as well as drugs) have been objectively explored; and
- Forcible medication is necessary or best for the prisoner and others.

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