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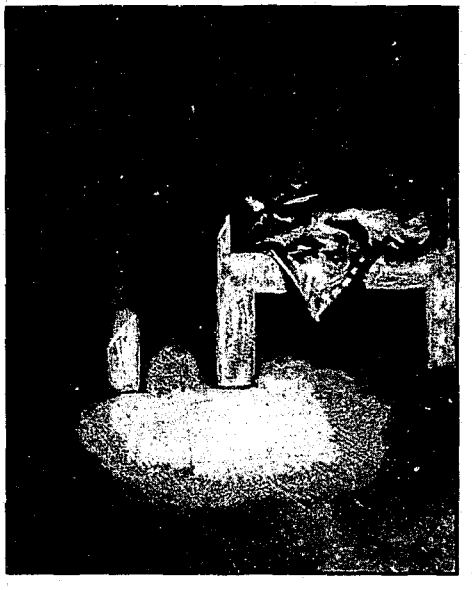

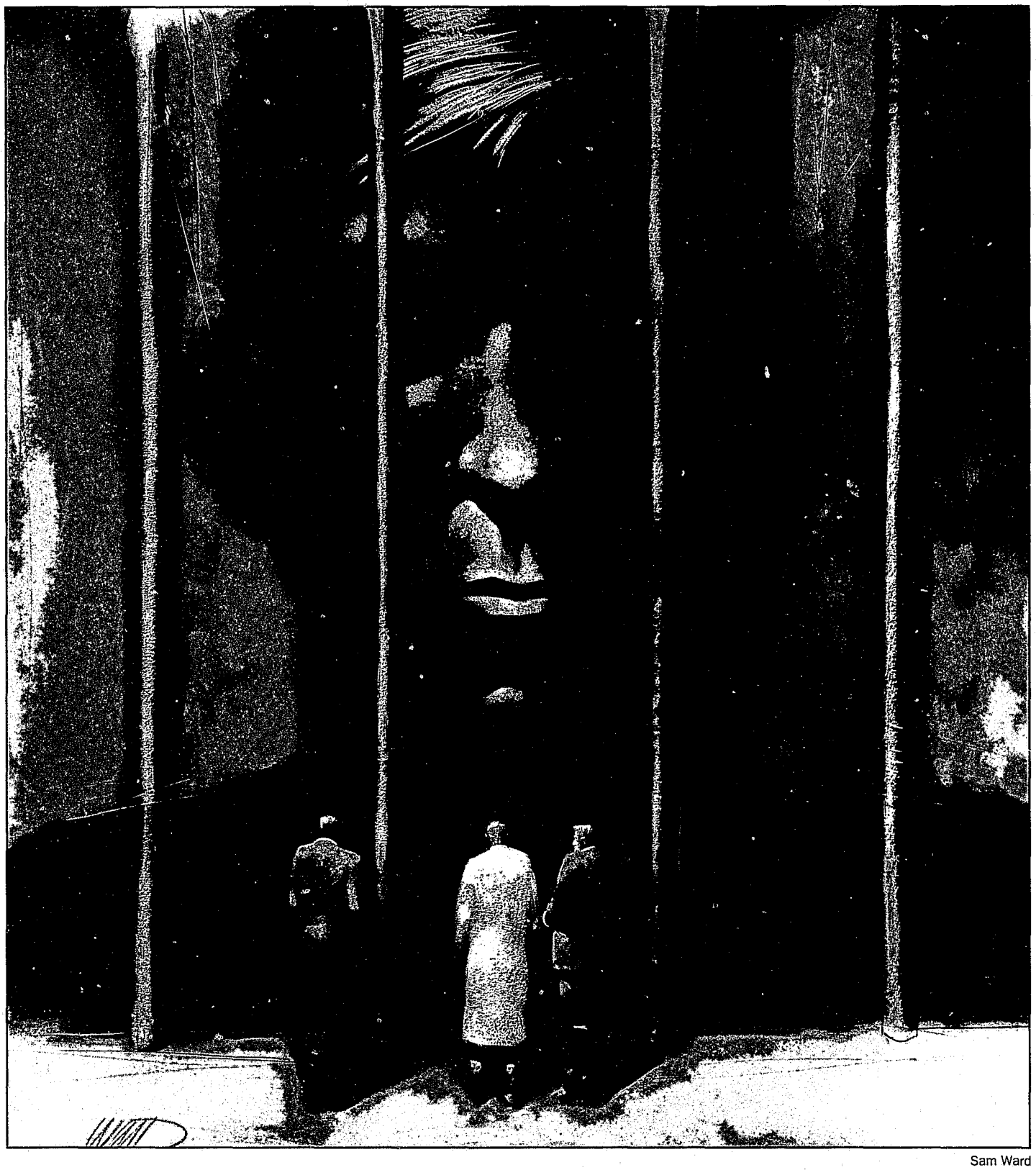

Sam Ward

Involuntary Treatment

When can mentally ill inmates be medicated against their will?

Bill Burlington

For those involved with caring for the mentally ill, the 1990 Supreme Court term was a banner year, as the Court in one decision answered a question that has divided mental health professionals for more than 35 years—under what circumstances can mentally ill patients be given antipsychotic medications against their will?

On the same day, in a separate case, the Court provided guidance on a related question: what is the obligation of mental health professionals to ensure that a mentally ill person has the capacity to provide an informed consent for admission to the hospital, or to be medicated voluntarily? These issues affect both the quality of mental health care and the potential legal liability of those who treat the mentally ill, whether in a prison or a civilian psychiatric hospital. This article will examine these two decisions in detail, and will attempt to show how they may affect both mental health patients and staff.

Involuntary medication of a dangerous psychiatric hospital patient

Washington v Walter Harper[1]—In 1976, Walter Harper began serving a 20-year sentence for robbery in the Washington State Penitentiary. Mr. Harper was diagnosed by staff as suffering from schizophrenia, schizoaffective disorder, and manic depression, and consequently spent much of his sentence in the prison's mental health unit. He had a history of assaultive behavior, having received at least 29 disciplinary reports for offenses such as fighting, assault, setting fires, threatening bodily harm, destroying property, possessing narcotics, and theft. Mr. Harper's treating physicians attributed his assaultive behavior to his mental illness. In 1980, he was paroled on the condition that he receive outpatient psychiatric treatment. While on parole he was committed on two occasions to a psychiatric hospital for treatment. In 1981, his parole was revoked when he assaulted two nurses at the hospital.

This debate generally divided those who stress the benefits of such treatment from those who fear the serious side effects that may accompany some of the medications used.

When he returned to prison, Mr. Harper was sent to the Special Offender Center, where convicted felons are diagnosed and treated for mental illness. Here, after initially consenting to medication, Mr. Harper refused further treatment. Following center procedures, physicians medicated Mr. Harper. Mr. Harper remained at the center off and on until February 1985, when he filed suit, claiming that his constitutional rights were violated when he was involuntarily medicated without a prior judicial finding that he was medically incompetent.[2]

While Mr. Harper prevailed before the Washington State Supreme Court, the United States Supreme Court ruled against him. The Court held that a prior judicial finding of incompetence was not necessary, and that prison officials can treat an inmate who has a serious mental illness involuntarily with antipsychotic drugs—where that illness makes him a danger to himself or others, and when treatment is found to be in the inmate's medical interests.

The *Harper* decision resolved an issue that on two previous occasions had been before the Court—under what circumstances can psychiatric patients be medicated against their will?[3] In each previous instance, the Court decided the case without answering this controversial question. In the meantime, the issue divided both the lower Federal courts and professionals engaged in caring for the mentally ill.[4]

This debate generally divided those who stress the benefits of such treatment from those who fear the serious side effects that may accompany some of the medications used. This same division may explain the decision in *Harper*, as the six-justice majority stressed that "the proper administration of antipsychotic drugs is one of the most effective means of treating certain mental illnesses," while the three dissenting justices stressed the adverse side effects that may accompany such medications, and quote Mr. Harper as saying, "Haldol paralyzed

my right side of my body...you are burning me out of my life...you are burning me out of my freedom."

In *Harper*, the two parties, as well as seven other interested groups, filed briefs with the Supreme Court. These groups were hotly divided over the desirability of using antipsychotic medication. As Justice Blackmun observed in his concurring opinion, "The difficult and controversial character of this case is illustrated by the simple fact that the American Psychiatric Association and the American Psychological Association, which are respected, knowledgeable, and informed professional organizations, and which are here as amici curiae, pull the Court in opposite directions." The American Psychiatric Association had stressed that the benefits from cautious use of these medications outweigh the potential side effects, while the American Psychological Association had urged the opposite.

Implications of *Harper*— Procedural and substantive

The narrow holding of the *Harper* decision is that a dangerous inmate may be medicated against his will when such treatment is found by mental health professionals to be in his or her best medical interests. However, the decision contains both a procedural and a substantive component, and by looking at each component individually, it appears that there may be other circumstances under which medication may be involuntarily administered to a hospitalized inmate.

■ ***Administrative procedures.*** The Court rejected Mr. Harper's contention that he was entitled to a judicial hearing before the State could treat him over his objection. Finding the real debate to be over the benefits and risks of antipsychotic medication, the Court found this was the type of question that should be decided by mental health professionals during an administrative hearing, rather than by a judge. The Court stressed that the hearing official should be independent, and approved the Washington State regulations, which guaranteed that the mental health professionals who presided at the hearing must not be personally involved in the current diagnosis and treatment of the inmate.

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The Court in *Harper* was concerned that the inmate has an opportunity to adequately prepare and be heard at the hearing. The Court approved of Washington's procedures, which required:

1. At least 24 hours prior notice of a hearing that will determine whether the inmate should be involuntarily medicated, during which time the inmate may not be medicated.

2. The notice must state the tentative diagnosis, the factual basis for the diagnosis, and why the staff believes medication is necessary.

3. At the hearing, the inmate has the right to attend, to present evidence, including witnesses, and to cross-examine staff witnesses.

4. The inmate can have the assistance of a lay adviser who has not been involved in his case and who understands the psychiatric issues involved. There is no right to have an attorney present at the hearing.

5. Minutes of the hearing are kept, with a copy given to the inmate.

6. The inmate may appeal the decision to the Superintendent within 24 hours of the decision, and the Superintendent must act on the appeal within 24 hours of its receipt. If still dissatisfied, the inmate may seek judicial review of the decision.

7. Once authorized, the involuntary medication decision must be reviewed

after 7 days and, if approved again, reviewed (with a report prepared) every 14 days while treatment continues. At the end of 180 days, a new hearing is held to consider the need for continued treatment.

■ ***Conditions that must be found at the hearing to justify involuntary medication.***

The second aspect of the *Harper* decision focused on the substantive component of the hearing—what factors must the hearing officials find before they can authorize medication against the patient's will? Because the record contained numerous instances of assaultive behavior by Mr. Harper, the Washington State hearing panel authorized his involuntary medication due to its belief that he was a danger to others as a result of his disease. Given that Mr. Harper's lawsuit challenged this decision, the holding of the Supreme Court was a narrow one—that an inmate with a serious mental illness can be involuntarily treated with antipsychotic medication if the inmate is dangerous to himself or others, and the treatment is in the inmate's medical interest.[5] However, in its opinion, the Supreme Court spoke approvingly of regulations that authorized medication where the following conditions were found:

1. The person suffers from a "mental disorder," defined as any organic, mental, or emotional impairment that has a substantial adverse effect on an individual's cognitive volitional functioning, and

2. As a result of disorder, the person is "gravely disabled," defined as either

a. being in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety, or

An argument can be made that involuntary medication may be authorized in certain circumstances to help even a nonviolent inmate regain competence to stand trial.

b. manifesting severe deterioration in routine functioning, evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions *and* is not receiving such care as is essential for his or her health or safety.

Thus, the narrow holding of the Court should not be read as defining the entire spectrum of situations in which involuntary treatment of a prison inmate may be allowed. In fact, shortly after the Court handed down the *Harper* decision, it denied certiorari in *U.S. v Charters* 863 F.2d 3D2, (4th Cir. 1988) (en banc), a case the Court previously agreed to hear, where the Fourth Circuit Court of Appeals approved of medicating an inmate who was not currently dangerous, so he could regain competence to stand trial. By the Supreme Court's declining to hear the case instead of remanding it for further proceedings in light of the *Harper* decision, an argument can be made that involuntary medication may be authorized in certain circumstances to help even a nonviolent inmate regain competence to stand trial.

In addition, it is likely that additional light will soon be shed on the question, as the Supreme Court has agreed to hear this year a case involving the question of whether the State of Louisiana can involuntarily medicate an inmate to help him regain his competence, after which the inmate will be executed.[6]

Competence to consent to admission or medication

Zinermon v Burch[7]—On December 7, 1981, Darrell Burch was found wandering along a Florida highway, appearing disoriented and injured. He was taken to a private mental health facility, and after 3 days was transferred to a public hospital operated by the State of Florida, as he was felt to need long-term treatment.

Dr. Zinermon, the attending physician, wrote upon admission that Mr. Burch was "disoriented, semi-mute, confused and bizarre in appearance and thought...not cooperative to the initial interview," and "extremely psychotic, appeared to be paranoid and hallucinating." A day after his admission, a nurse noted that Mr. Burch was confused and unable to state the reason for his hospi-

talization and believed "this is heaven." At the time of his admission, Mr. Burch signed forms for voluntary admission and treatment. Mr. Burch remained an inpatient for 5 months, during which time he received antipsychotic medication.

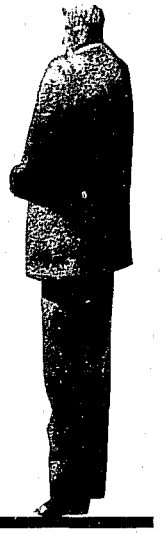
Upon his release, Mr. Burch initiated a Federal lawsuit seeking to hold personally liable 11 staff members at the hospital. Mr. Burch claimed staff knew, or should have known, that he was "incapable of voluntary, knowing, understanding and informed consent to admission and treatment...," and that such conduct deprived him of his liberty without adequate procedural due process. Before the Supreme Court, the narrow question presented was whether these allegations stated a valid claim of violation of Mr. Burch's constitutional rights.

The Supreme Court held if Mr. Burch could prove the above facts at trial, he would prove that Florida hospital staff had violated his constitutional liberty interest by improperly admitting him to the hospital, and by subsequently treating him without a valid informed consent. While the State of Florida had regulations that required that a valid voluntary consent to admission and informed consent to treatment be obtained, they had failed to develop procedures that would ensure that the patient was competent to make such decisions. In so holding, the Court left open the possibility that staff at the hospital could be personally liable for failing to ensure that Mr. Burch was competent when he admitted himself, and when he agreed to treatment. The case was remanded to the District Court for a trial on the merits of Mr. Burch's allegations.

Implications of *Burch v Zinermon*

Staff who work in psychiatric hospitals have long been troubled by the fact that their patient's mental condition may preclude obtaining a valid informed consent. A need for informed consent arises in a variety of situations with psychiatric patients, aside from decisions regarding admission to the hospital or treatment. Virtually all States require mental capacity to make a will, to get married, to transfer property, and to manage one's affairs. In *Burch*, the Court required staff specifically to assess whether Mr. Burch was competent to consent either to admission or treatment. If they determined he was not competent, involuntary admission or treatment procedures should have been implemented. After *Burch*, it appears that mental health staff will run the risk of personal liability if they fail to consider whether the patient is competent to make certain decisions.

Thus, a patient who voices a desire for admission and treatment, yet is found incompetent to consent to such treatment, may not be treated.



While both the *Harper* and *Burch* decisions seem fairly straightforward when read together and when seen in the context of the Federal statutes governing the treatment of Federal prison inmates (Title 18, United States Code, Section 4241-4247), these cases raise the potential of temporarily placing a legal straitjacket upon treatment staff, and of relegating certain categories of patients who may desire help to little or no treatment.

After Burch, the effect of finding a person incompetent to consent to voluntary admission to a psychiatric hospital is that staff will be forced to initiate the State involuntary commitment procedures. In most States, such procedures can be accomplished in a matter of weeks, if not days. However, involuntary commitments under the Federal statute, 18 United States Code, Section 4245, have taken on average several months, and in one case as long as 10 months.[8] Thus, a patient who voices a desire for admission and treatment, yet is found incompetent to consent to such treatment, may not be treated for several months. This possible scenario is extremely upsetting to Federal mental health staff, who feel an obligation to provide needed treatment.

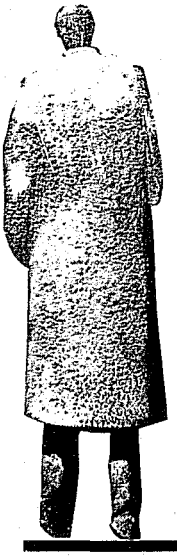
An even more upsetting dilemma for some is seen in the case of the patient who expresses a desire for treatment, is not competent to consent either to admission to the hospital or to treatment, yet is not dangerous or gravely disabled.

After *Burch*, it is clear that this patient must be involuntarily committed. However, it is conceivable that after *Harper*, even though the patient could be involuntarily committed under Federal law, where dangerousness or a finding that the patient is gravely disabled is not necessary for commitment, staff could not legally treat this person. While the patient is too sick to give valid consent to admission or treatment, he or she may not be sick or dangerous enough to treat involuntarily.

The above scenarios will be frustrating for mental health staff and others who believe in the patient's need for treatment, and that antipsychotic medication offers the only form of meaningful treatment for some mental illnesses. In the case of delays in the commitment process, there is a clear need to explore—with the judiciary and the inmate's counsel—means to streamline the commitment process. The *Burch* decision exacerbates the problem, as there could now be substantial delays in the treatment of a person who is not openly opposing treatment.

Mental health staff may find it difficult to legally treat, under the *Harper* and *Burch* decisions, a person who is incompetent to give an informed consent, yet is not ill enough to treat involuntarily. An argument can be made that the Court in *Burch* recognized this dilemma when they noted that some persons who are not competent to consent to admission would not necessarily be involuntarily commitable, as most States require a finding of "dangerous to self or others" before such commitment can take place.

However, in making this statement, the Court was stressing that a person who was not dangerous to others, and who posed no danger to him- or herself, has a constitutional right to live free in society. This rationale does not seem to apply to the prison context, where the inmate's liberty has already been substantially curtailed, where the Federal commitment statute does not require a finding of "dangerous to self or others," and where bizarre behavior by a mentally ill prisoner places that individual at risk of being victimized. To simply warehouse mentally ill inmates may subject them to danger at the hands of other inmates, who may not tolerate what they see as "crazy" behavior.



Mental health staff will run the risk of personal liability if they fail to consider whether the patient is competent to make certain decisions.

This author believes that this consequence was not anticipated or intended by the Court; unfortunately, however, its resolution will come only through the long and often uncertain course of future litigation. ■

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Notes

1. 494 U.S.___, 110 S.Ct.1028, 108 L.Ed.2d 178 (1990).

2. Mr. Harper filed suit under Title 42 U.S.C. Section 1983, claiming violation of the Equal Protection, Due Process, and Free Speech clauses of the Federal and State constitutions; he also claimed that State tort law had been violated.

3. See *Hills v Rodgers*, 457 U.S. 291, 299 (1982); and *Rennie v Klein*, 720 F.2d 266 (3rd Cir. 1983), vacated and remanded at 458 U.S. 1119 (1982).

4. See *Bee v Greaves*, 744 F.2d 1387 (10th Cir. 1984) and *Walters v Western State Hosp.*, 864 F.2d 695 (10th Cir. 1988), adopting a very restrictive approach to involuntary treatment, versus *Dautremont v Broadlawns Hospital*, 827 F.2d 291 (8th Cir. 1987); *Johnson v Silvers*, 742 F.2d 823 (4th Cir. 1984); *Project Release v Prevost*, 722 F.2d 960 (2nd Cir. 1983); and *United States v Charters*, 863 F.2d 302 (4th Cir. 1988) (en Banc), which adopt the more liberal "professional judgment" standard for involuntary treatment.

5. In defining what amounts to a danger to self or others, the Washington regulations included the concept of harm to the property of another, stating, "Likelihood of serious harm means either,

a. a substantial risk that physical harm will be inflicted by an individual upon his own person, as evidenced by threats of attempts to commit suicide or inflict physical harm on one's self,

b. a substantial risk that physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm, or

c. a substantial risk that physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others."

6. *Perry v State of Louisiana*, 502 Sc.2d 543 (1986), cert. granted March 5, 1990, No. 89-5120.

7. 494 U.S.___, 110 S.Ct.975, 108 L.Ed.2d 100 (1990).

8. At one Bureau psychiatric hospital, the average time from the filing of the commitment petition until the final judicial decision was: 1988—3 months, 24 days; 1989—4 months, 10 days; 1990—2 months, 22 days.