IN THE

United States Court of Appeals

FOR THE FIRST CIRCUIT

No. 79-1648

RUBIE ROGERS, *et al., Appellants,*

v.

ROBERT OKIN, M.D., *et al., Appellees.*

On Appeal From The United States District Court
For The District of Massachusetts

BRIEF OF THE AMERICAN PSYCHIATRIC ASSOCIATION AS AMICUS CURIAE

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INTEREST OF AMICUS CURIAE

The American Psychiatric Association, founded in 1844, is the nation's largest organization of qualified doctors of medicine specializing in psychiatry. Almost 26,000 of the nation's approximately 33,000 psychiatrists are members. Psychiatrists have the principal responsibility for providing expert testimony in civil commitment proceedings and for providing treatment to those who suffer from mental

illness. The Association has participated as amicus curiae in numerous cases involving mental health issues, including *O'Connor* v. *Donaldson,* 422 U.S. 563 (1975), *Addington* v. *Texas,* 99 S.Ct. 1804 (1979), and *Parham* v. *J.R.,* 99 S.Ct. 2493 (1979). The instant case, which presents the question of whether civilly committed patients have a constitutional right to refuse psychiatric medication, will have important implications for the treatment of serious mental illness and, consequently, will greatly affect the concerns and the work of the Association and its members.

The parties have consented to the filing of this brief. Copies of their consenting letters have been filed with the Clerk.

STATEMENT OF THE CASE

This class action was brought by several voluntary and involuntary psychiatric patients at Boston State Hospital, alleging constitutional deprivations in violation of 42 U.S.C. § 1983. In particular, plaintiffs challenged the medication and seclusion policies used on the May and Austin units of the hospital, seeking injunctive relief and monetary damages. The essence of plaintiffs' claims was that defendants, the Commissioner of Mental Health and the psychiatrists responsible for providing care at May and Austin, used seclusion and forced psychiatric medication in nonemergency situations.

The case was filed on April 27, 1975, and on April 30, 1975, upon the *ex parte* representations of plaintiffs, the district court (Tauro, J.) issued a temporary restraining order ("TRO") barring nonemergency seclusion or forced medication of both voluntary and involuntary patients. The case came on for hearing in November 1975. After several days of testimony, the court adjourned the hearing, urging the parties to settle the issues in dispute. Settlement discussions proved unavailing and, ultimately, on March 25, 1977, the court denied defendants' motion for partial

summary judgment on the seclusion and damages claims. In addition, in its March 25 order, the court denied defendants' motion to dissolve the TRO it had issued almost two years earlier.

The decision refusing to dissolve the TRO was appealed to this Court, which expressed concern because "the appeal unfortunately does not come to us with the statement of reasons and findings that should accompany a trial court's ruling on a temporary restraining order or a preliminary injunction." Slip op. at 8. The Court also recognized that plaintiffs had made a "lesser showing of the likelihood of success on the merits" than usually required for a TRO, and that "the many complexities make it hard to predict the outcome of the case . . . ." Slip op. at 11. Nevertheless, "in view of the significant harm plaintiffs alleged would befall them," *ibid,* the Court affirmed the TRO on December 8, 1977.

Trial on the merits began in the district court in early December 1977, and continued intermittently through late January 1979. On October 29, 1979, the court issued a permanent injunction prohibiting defendants from "forcibly secluding or medicating the plaintiffs and all other inpatients of the Austin and May Units . . . without the patient's consent or the consent of the patient's guardian, if any, except where there is a substantial likelihood of, or as a result of, extreme violence, personal injury or attempted suicide." The court rejected plaintiffs' claims for damages, however, finding that defendants' behavior fell within the "good faith" exemption under § 1983, and that plaintiffs' state law tort claims had not been proved.

In reaching its decision on the issue of involuntary medication,[1] the court recognized that "[t]he prime purpose

[1] The court's ruling concerning seclusion is not being appealed, and therefore will not be addressed by amicus. Nor will amicus discuss the court's rejection of plaintiffs' claims for damages other than to note that the decision with respect to the federal causes

of any hospital is to treat. . . . In the case of an involuntarily committed patient, Boston State has a duty to provide treatment." 478 F.Supp. at 1365. It also found that the psychiatrists "desired only to help plaintiffs," *id.* at 1382, and that the specific use of forced medication constituted "reasonable medical practice." *Id.* at 1386. In fact, as a result of the medication "most [plaintiffs] showed eventual improvement" without suffering serious side effects. *Ibid.* The court further stressed "plaintiffs' helplessness and dependency" and noted that the patient population generally "was extremely demanding, both in terms of numbers and their potential for disruptive behavior." *Id.* at 1382-83.

These factors notwithstanding, the court held that civilly committed patients in Massachusetts have a constitutionally protected privacy right to refuse all psychiatric medication in nonemergency situations. To overcome this right the patient must be declared incompetent at a judicial hearing, a guardian must be appointed, and the guardian must consent to the medication. The basis for this decision was the court's conclusion that "[t]he committed patient . . . is in need of treatment, yet is presumed to be competent." *Id.* at 1366. Since he can, therefore, lawfully make decisions about his life, it must follow, according to the court, that he maintain his right to decide "whether to accept or refuse psychotropic medication." *Ibid.*

The court elaborated its privacy analysis by asserting that the "concept of a right of privacy also embodies First Amendment concerns." *Ibid.* (footnote omitted). It then found that psychiatric medication was "mind-altering" and "mind control[ling]," and, therefore, that it impinged on

of action rests on a finding of good faith by defendants, a factual finding that is plainly not "clearly erroneous" under the standards of Rule 52(a), F.R.C.P. Likewise, the court's rejection of plaintiffs' state law claims for damages rests on plaintiffs' failure to prove certain key elements of their causes of action. These are also factual findings that should not be disturbed on appeal.

the committed patients' "right to produce a thought—or refuse to do so . . ." *Id.* at 1367.

The court went on to rule that voluntary patients likewise have a constitutional right to refuse medication and that this right is not waived by their signing an application upon admission stating "I understand that during my hospitalization and any after care, I will be given care and treatment which may include the injection of medicines." *Ibid.* Moreover, if a voluntary patient refuses appropriate medication, he may remain at the hospital nonetheless.

SUMMARY OF ARGUMENT

In fundamental disregard of the Massachusetts statutory and regulatory scheme governing civil commitment of the mentally ill, the district court has created a constitutional right to refuse effective and necessary psychiatric medication. This new right is purportedly based on the constitutional right to privacy, including the "right to produce a thought" inherent in the First Amendment right to communicate ideas. In amicus' view, the court's constitutional analysis is unfounded and its result is unwise.

Massachusetts law provides that the decision to commit a seriously mentally ill person is a decision to treat that person's illness, even if the person objects. *See* D.M.H. Reg. § 220.02. Civil commitment must, of course, satisfy substantive constitutional norms, *see, e.g., O'Connor* v. *Donaldson,* 422 U.S. 563 (1975), and be attended by appropriate due process protections, *see, e.g., Addington* v. *Texas,* 99 S.Ct. 1804 (1979). But once those requirements are met, whatever right to reject psychiatric medication that an individual might otherwise possess has been lawfully overcome by the state's legitimate parens patriae interest in treating his serious illness. *See Addington* v. *Texas, supra,* 99 S.Ct. at 1809. By viewing "the safety of the general public" as the sole justification for commitment, 478 F.

Supp. at 1368, the court below misperceived not only state law, but also the constitutional basis for civil commitment. Without the authority—and indeed the obligation—to treat, the state, in civilly committing someone, engages in nothing more than unlawful preventive confinement. *See Rouse* v. *Cameron,* 373 F.2d 451 (D.C. Cir. 1966); *Gary W.* v. *Louisiana,* 437 F.Supp. 1209, 1216 (E.D. La. 1976).

Moreover, even assuming, contrary to amicus' position, that a committed patient has a right to refuse psychiatric medication, the court below, by improperly confusing state law with constitutional principles, erred in holding that the right could only be overcome through a judicial competency hearing and the appointment of a guardian. The Supreme Court in *Parham* v. *J.R.,* 99 S.Ct. 2493 (1979), made plain that this type of medical determination—*i.e.* the patient's competency to reject medication—is precisely the kind of due process decision that should be made by a psychiatrist, rather than a court. *See Rennie* v. *Klein,* 476 F.Supp. 1294, 1307-09 (D.N.J. 1979).

The policy implications of the district court's decision are especially troubling. The new right created by the court will undermine proper treatment, causing patients needless suffering and extended hospitalization as their illnesses deteriorate. Other patients will suffer as well, as the treatment milieu of a psychiatric ward will be converted into the security milieu of a prison. And significant state's resources will be diverted into providing custodial care for people who could otherwise be treated effectively and returned home quickly. Insofar as the district court foresaw the answer to these problems in allowing a competency hearing for objecting patients, its efforts are unavailing. The delays involved before hearings can be concluded will often destroy effective treatment. Moreover, doubling the number of hearings will only result in a needless drain of judicial and treatment resources as the initial commitment hearing is ritualistically reenacted in a so-called competency hearing. And the need to appoint a guardian—who may not even know the patient—will only further frustrate matters.

Finally, the district court also ruled that voluntary patients in Massachusetts have a right to refuse medication. While amicus takes no exception to this statement of principle, we believe the court's application is misguided. The court held that even when a voluntary patient refuses proper treatment the state is required to continue his hospitalization. There is no constitutional basis for such a holding. *See Parham* v. *J.R., supra,* 99 S.Ct. at 2505. A citizen who does not want a state-offered benefit (psychiatric treatment) cannot transform it to another benefit (custodial care) not being offered by the state. *See United States* v. *George,* 239 F.Supp. 752, 754 (D. Conn. 1965). Thus, if a voluntary patient rejects proper treatment the state can either discharge him or; if it can satisfy the governing standards, it can commit him. At that point, as shown above, the state can then lawfully treat him even in the face of his stated rejection.

ARGUMENT

I. THE CONSTITUTION DOES NOT REQUIRE THAT CIVILLY COMMITTED PATIENTS CAN BE INVOLUNTARILY MEDICATED IN NONEMERGENCIES ONLY IF THEY HAVE BEEN DECLARED INCOMPETENT AT A JUDICIAL HEARING AND A GUARDIAN CONSENTS FOR THEM.

The court below ruled that, before civilly committed patients can be involuntarily medicated in situations not involving violence, the Constitution requires a state to hold a full-blown competency hearing and appoint a guardian who consents to the medication. An initial problem with the decision is that, while the result is clear, the *constitutional* basis for reaching the result is difficult to discern. The court starts by examining state law and concludes that a civilly committed patient is presumed competent, and,

therefore, *on that basis alone,* cannot be medicated in non-emergencies unless he consents or has been declared incompetent and a guardian consents for him. *See* 478 F.Supp. at 1361-65. The court then invokes the constitutional right to privacy—including the "First Amendment concerns" found to be embodied in that right—apparently to reach the same conclusion. *See id.* at 1365-71. The court never explains the relationship between the state law holding and its purported constitutional analysis. If the federal constitution provides the right at issue, state law analysis would appear to be irrelevant.[2] Alternatively, if it is state law that mandates the relief granted, the district court lacked jurisdiction to impose it in this case.[3]

Amicus believes that the court's constitutional approach —as well as its holding—is fundamentally flawed. The court should have inquired whether Massachusetts law authorizes forced medication of committed patients and, if so, whether it violates the federal constitution. If the

[2] It is true that state law analysis could be relevant under the due process approach articulated in *Meachum* v. *Fano*, 427 U.S. 215 (1976), which held that whether a change in the conditions of confinement requires a due process hearing depends on whether state law creates a liberty interest with respect to the contemplated change. *See Rennie* v. *Klein*, 462 F.Supp. 1131, 1147-48 (D.N.J. 1978). But the district court in this case plainly did not engage in such a constitutional analysis. Indeed, if it had, it would have concluded that the patient's objection to medication could be overridden after a hearing by a psychiatrist. *See* pp. 18-22 *infra*.

[3] Absent a claim of pendent jurisdiction, which was not present here, federal courts are not charged with remedying violations of state law in § 1983 cases. *See Paul* v. *Davis*, 424 U.S. 693, 700-01 (1976); *cf. Evans* v. *Abney*, 396 U.S. 435 (1970). Moreover, in a case involving intricate questions of state commitment law and informed consent, and leading to a decree that will necessitate costly hearings and the appointment of guardians, the district court would have been well-advised to abstain if it believed the result was mandated by state law. *See, e.g., Babbitt* v. *United Farm Workers Nat'l Union*, 99 S.Ct. 2301, 2313 (1979). There is no claim that Massachusetts courts cannot enforce state laws.

court answered these questions in the affirmative, it then should have considered what relief would be appropriate to remedy the constitutional deficiencies.

Amicus will show that Massachusetts law does in fact authorize forced medication of committed patients; that, as such, it does not violate the Constitution; and that, in any event, the Constitution does not require a judicial hearing and the appointment of guardian to overcome the committed patients' objection to medication.

A. The Massachusetts Statutory Scheme For Civil Commitment Contemplates That Patients May Be Medicated Involuntarily.

Civil commitment of the mentally ill in Massachusetts may be accomplished only after an individual has been accorded full due process protections including a judicial hearing at which the individual is represented by counsel. M.G.L. Ch. 123 §§ 5-8.[4] At the hearing the state must prove beyond a reasonable doubt that the individual is mentally ill and that the failure to commit would create a likelihood of serious harm. *Id.* at § 8; *Superintendent of Worcester State Hospital* v. *Hagberg*, —— Mass ——, 372 N.E.2d

[4] For a period of up to 10 days, an individual can be hospitalized on an emergency basis upon the petition of a licensed physician who has determined, after examination, that "failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness." M.G.L. Ch. 123 § 12. If a physician is not available, a police officer may make the application for admittance but the individual must be examined by a designated physician immediately upon his reception at the hospital. *Ibid.* The patient must be released within 10 days unless the superintendent applies for commitment, entitling the patient to a judicial hearing. *Id.* at §§ 7, 8, 12. In addition, any other individual can apply for an emergency 10-day commitment of a mentally ill person, but such commitments require a judicial hearing. *Id.* at § 12. These procedures plainly accord with due process. *See Logan* v. *Arafeh*, 346 F.Supp. 1265 (D. Conn. 1972), *aff'd sub nom. Briggs* v. *Arafeh*, 411 U.S. 911 (1973); *Coll* v. *Hyland*, 411 F.Supp. 905 (D.N.J. 1976) (three judge, per curiam).

242 (1978). For purposes of commitment a "likelihood of serious harm" requires a showing that the individual is either self-assaultive, or violent to others, or so incapable of caring for himself that physical harm will result. M.G.L. Ch. 123 § 1.

Massachusetts law further provides that the purpose of commitment is treatment. To be committed, "the mentally ill person [must be] in need of further care and treatment." *Id.* at § 4. State courts have also stressed this fact. Thus, the Massachusetts Appeals Court recently made plain that "the State has a legal obligation to provide needed medical care to a person involuntarily committed to a State institution." *In the Matter of Spring,* 1979 Mass. App. Ct. Adv. Sh. 2469, 2481 n.10 (citations omitted). *See also Nason* v. *Superintendent of Bridgewater State Hospital,* 353 Mass. 604, 233 N.E.2d 908, 912-13 (1968).

Although the Massachusetts commitment scheme affords a committed individual a series of rights and protections, it does not provide a right to refuse psychiatric medication. The statutes specifically delineate which legal and civil rights are retained by a committed patient. Those rights include the right

> to wear his own clothes, keep and use his own personal possessions including toilet articles, to keep and be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases, to have access to individual storage space for his private use, reasonable access to telephones to make and receive confidential calls, to refuse shock treatment, to refuse lobotomy, and any rights specified in the regulations of the department.

M.G.L. Ch. 123 § 23. Nowhere in the statutory listing or in the regulations implementing the statute is a right to refuse medication provided. To the contrary, the State Department of Mental Health, charged with promulgating "standards for the reception, examination, treatment, restraint, transfer and discharge of mentally ill" persons in

departmental facilities, *id.* at § 2, specifically adopted regulation § 220.02, which provides that a committed person "shall receive treatment and rehabilitation in accordance with accepted therapeutic practice, including oral, subcutaneous and intramuscular medication when appropriate and when ordered by a physician." Thus, consistent with the treatment purposes of civil commitment in Massachusetts, state law specifically denies patients the right to refuse appropriate psychiatric medication.[5]

That Massachusetts guards against having the commitment determination turned into a full-blown adjudication of legal incompetence, *see* M.G.L. Ch. 123 § 25, is in no way inconsistent with the decision not to authorize committed patients to reject medication. The decision to civilly commit in Massachusetts is a particularistic one. The individual is hospitalized in order to be treated with routine psychiatric treatments, including proper medication. His legal rights are limited only to the extent necessary for the state to achieve its legitimate purposes in civil commitment. The patients' other rights—such as his right to vote or to marry —need not be sacrificed to achieve this goal.[6]

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[5] The fact that Massachusetts, like most states, distinguishes between medication, on the one hand, and electroshock and lobotomy, on the other, *see* M.G.L. Ch. 123 § 23, is not surprising. Unlike medication—which is routine and essential to the effective treatment of committed patients, *see* pp. 25-27 *infra*—these other medical procedures, especially lobotomy, are used much less frequently. The legislature is plainly empowered to decide that, since they present more serious risks to the patient, they require greater scrutiny before utilization.

[6] The district court erroneously asserted that "defendants' position would permit the [state hospital] alone to decide whether [a pregnant committed] patient would give birth or abort." 478 F. Supp. at 1362 n.14. On the contrary, state law would leave that decision to the patient, unless a guardian was appointed. M.G.L. Ch. 123 § 25. Such an approach, moreover, is entirely consistent with a sensible commitment scheme, which is concerned only with treatment of the patient's mental illness, not with his other medical problems.

The district court found that this statutory scheme, which provides that "a committed mental patient would be presumed competent to deed his home to his doctor, [but] would not be presumed competent to decide whether to follow that doctor's advice concerning taking of medication . . . would make a doubter of even the most credulous." 478 F.Supp. at 1361, n.12. The *wisdom* of this statutory scheme, of course, is not for review by a federal district court. Surely the Constitution does not demand that, when the state displaces an individual's decisionmaking capacity for a limited purpose, it must displace such capacity for all purposes.[7] It seems plain, moreover, that the state law presumption of competence notwithstanding, no court would enforce an unfair contract entered into by a psychotic patient. *See, e.g., Commonwealth* v. *Wiseman,* 356 Mass. 251, 249 N.E.2d 610 (1969) (signed release by committed patients not presumed valid). In short, the presumption of competence, far from straining credulity, sensibly promotes the *responsible* exercise of those rights that do not interfere with the fundamental purposes of civil commitment.

In any event, the question of which rights are sacrificed by the decision to commit is, as an initial matter, a question of state law. In Massachusetts the law plainly establishes

[7] It is well-recognized that an individual can be competent for some purposes but not for others. *See, e.g.,* Developmental Disabilities Model Legislation Series, 3 Mental Disability L.Rptr. 264-90 (1979); Ford, *The Psychiatrists' Double Bind: The Right to Refuse Medication,* 137 Am. J. Psychiat. 332, 333-34 (1980). In fact, many states formerly equated commitment with full-scale incompetence; the separation of those legal statuses was a desirable humanitarian reform promotive of patients' rights. *See* Roth, *Involuntary Civil Commitment: The Right to Treatment and The Right to Refuse Treatment in* Psychiatrists and the Legal Process: Diagnosis & Debate 332, 343 (1977). The district court in this case would reverse that reform by insisting that a committed patient who objects to medication be declared legally incompetent and have a guardian appointed for all purposes.

that committed patients have no right to refuse medication. D.M.H. § 220.02. The only question for a federal court is whether this state scheme violates the Constitution.

B. Civilly Committed Patients Do Not Have A Constitutional Right To Refuse Appropriate Psychiatric Medication.

This district court held that committed patients have an absolute right to refuse medication in nonemergencies, which can only be overridden by a court-appointed guardian. The essence of the court's constitutional ruling is found in its conclusion that the "decision as to whether to accept or refuse psychotropic medication . . . is basic to any right of privacy." 478 F.Supp. at 1366. In addition, or perhaps in elaboration,[8] the court also found that psychiatric medication is "mind-altering" and, therefore, its forcible administration interferes with the patient's "right to think and decide . . . [and] to produce a thought—or refuse to do so . . ." *Id.* at 1367. The court brushed aside the fact that the medication was proven effective in treating patients, asserting "a basic premise of the right to privacy is the freedom to decide whether we want to be helped, or whether we want to be left alone." 478 F.Supp. at 1369. Amicus submits that the freedom invoked by the court was lawfully overcome by the decision to commit the patient. The fatal flaw in the district court's analysis is its failure to explain why the decision to commit a person against his will is not a sufficient constitutional predicate to justify the provision of that treatment for which the person was committed to receive.

It is well established that the state may commit mentally ill patients for involuntary treatment. "The state has

[8] While referring to "First Amendment concerns," the court makes clear that those concerns are a part of the "right to privacy." 478 F.Supp. at 1366. Hence it appears that there is a single constitutional basis for the decision rather than alternative constitutional rulings.

a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves." *Addington* v. *Texas, supra,* 99 S.Ct. at 1809. *See also O'Conner* v. *Donaldson, supra; French* v. *Blackburn,* 428 F.Supp. 1351, 1354 (M.D.N.C. 1977), *aff'd summarily,* 99 S.Ct. 3091 (1979). It must follow, therefore, that once a patient is properly committed, the state may treat his mental illness even if he objects:

> The question in the case before us is whether the state, consistent with [plaintiffs'] right of privacy, can assume the decision of whether [plaintiff], an involuntarily committed mental patient, will undergo psychiatric treatment. We observe that the more fundamental decision, whether he was to undergo hospitalization, was assumed by the state at the commitment proceeding, the validity of which is not contested.
>
> . . . If th[e] interest of the state is sufficiently important to deprive an individual of his physical liberty, it would seem to follow that it would be sufficiently important for the state to assume the treatment decision. We hold that it is. *Price* v. *Sheppard,* 307 Minn. 250, 239 N.W.2d 905, 911 (1976).

See also, Rachlin, *Civil Commitment, Parens Patriae, and the Right to Refuse Treatment,* 1 Am. J. Forensic Psychiat. 174 (1979).

The district court in this case nevertheless attempted to unhinge the decision to commit from the decision to treat by asserting that "the state's interest in protecting the safety of the general public is the justification for commitment of mental patients." 478 F.Supp. at 1368. As an initial matter, this rationale is totally inapplicable to the many people committed solely on the ground that they are likely to harm themselves, not others. Moreover, the court mistakenly assumed that in committing potentially harmful patients, Massachusetts acts with a unitary purpose—

the protection of the public. On the contrary, as shown above, Massachusetts acts both to protect the public and to aid the mentally ill patient. The court here implicitly recognized this fact when it stated, "[i]n the case of an involuntarily committed patient, Boston State has a duty to provide treatment. Stated another way, the involuntarily committed patient has a right to receive treatment." 478 F.Supp. at 1365. This "duty to treat" would not exist, we submit, if protection of the public were the sole justification for civil commitment. Rather, the "duty" is created by the fact that commitment serves the dual function of protecting the public and helping the patient. *See Rouse* v. *Cameron, supra; Bowring* v. *Godwin,* 551 F.2d 44, 48 (4th Cir. 1977); *Wyatt* v. *Aderholt,* 503 F.2d 1305, 1312-14 (5th Cir. 1974); *Rone* v. *Fireman,* 473 F.Supp. 92, 118 (N.D. Ohio 1979); *Stuebig* v. *Hammel,* 446 F.Supp. 31, 34 (M.D. Pa. 1977).

By separating treatment from commitment, and concluding that protection of the public is the sole basis for commitment, the district court not only misunderstood Massachusetts law, but it also undermined the constitutional basis for commitment itself. The Supreme Court has made clear that "[i]n a civil commitment state power is not exercised in a punitive sense." *Addington* v. *Texas, supra,* 99 S.Ct. at 1810 (footnote omitted). Yet, this is precisely what the district court would allow here by its decision to authorize continued commitment of a patient who rejects treatment. In such circumstances, psychiatric hospitalization impermissibly becomes "equivalent to placement in a penitentiary where one could be held indefinitely for no convicted offense.' " *Gary W.* v. *Louisiana, supra,* 437 F.Supp. at 1216 quoting *Ragsdale* v. *Overholser,* 281 F.2d 943, 950 (D.C.Cir. 1960) (Fahy, J., concurring). *See also Donaldson* v. *O'Connor,* 493 F.2d 507, 522 n.22 (5th Cir. 1974), *vacated* and *remanded,* 422 U.S. 563 (1975); *Welsch* v. *Likins,* 373 F. Supp. 487, 497 (D. Minn. 1974). In short, treatment is an essential ingredient in commitment, and the decision to

commit properly overcomes any right to refuse appropriate medication that a person might otherwise possess.[9]

For the same reasons, the decision to commit overcomes any "First Amendment concerns" noted by the court. Amicus believes, moreover, that the court's invocation of such concerns is particularly inappropriate in this case. According to the court:

> The First Amendment protects the communication of ideas. That protected right of communication presupposes a capacity to produce ideas. As a practical matter, therefore, the power to produce ideas is fundamental to our cherished right to communicate and is entitled to comparable constitutional protection. Whatever powers the Constitution has granted our government, involuntary mind control is not one of them, absent extraordinary circumstances. The fact that mind control takes place in a mental institution in the form of medically sound treatment of mental disease is not, itself, an extraordinary circumstance warranting an unsanctioned intrusion on the integrity of a human being. 478 F.Supp. at 1367.

This analysis stands the world on its head. Far from being "mind controlling," antipsychotic medication is mind-

[9] The two cases relied on by the district court, *see* 478 F.Supp. at 1371 n.38, are essentially inapposite. While *Rennie* v. *Klein*, *supra*, recognized a "qualified" right to refuse medication, the court there made plain that the right could be overridden by a psychiatrist. *See* p. 20, *infra*. The other case cited by the court below, *In re Boyd*, 403 A.2d 744, 746 (D.C.Ct.App. 1979), plainly states that it is limited to "one question: whether—in a non-emergency situation—the court may authorize a hospital to administer psychotropic drugs to a patient adjudicated mentally ill and incompetent, when that patient, before her illness and incompetency, had rejected any use of medication on religious grounds." *See also Winters* v. *Miller*, 446 F.2d 65 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971). The instant case, by contrast, involves no issue of religious objection to medication.

liberating by freeing the mind from the destructive and imprisoning bind of a serious mental illness. And it enhances the "capacity to think" by eliminating the gross distortions created by psychotic thought disorders.[10] The court commits a serious error by cloaking the disturbed thoughts of a sick mind in First Amendment protections. *See Rennie* v. *Klein*, *supra*, 462 F.Supp. at 1143-44. The right to be psychotic should hardly be enshrined among the pantheon of "preferred freedoms."

In rejecting the decision below, amicus does not claim that forced medication could never violate a patient's constitutional rights.[11] When medication is administered not

[10] See Appelbaum & Gutheil, *"Rotting With Their Rights On": Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients*, 7 Bull. Am. Acad. Psychiat. & Law 308, 310 (1979) (footnote omitted):

> In fact, properly used, psychotropic medications are chemically normative in their mechanism of action: that is, they restore existing imbalance toward the balanced norm. They are generally incapable of creating thoughts, views, ideas or opinions *de novo*, or of permanently inhibiting the process of thought generation. Thus, the psychotic conformist, cured of his psychosis with medications, remains the conformist; the depressed rebel, cured of his depression, remains the rebel still.

See also Spohn, *et al.*, *Phenothiazine Effects on Psychological and Psychophysiological Dysfunction in Chronic Schizophrenics*, 34 Arch. Gen. Psychiat. 633 (1977); Meadow, *et al.*, *Effects of Phenothiazines on Anxiety and Cognition in Schizophrenia*, 36 Diseases of the Nervous System 203, 207 (1975).

[11] It should be noted, however, that the contours of the constitutional right to privacy are ill-defined, and it is not at all clear what, if any, constitutional right to refuse state-imposed treatment generally exists. *See Jacobson* v. *Massachusetts*, 197 U.S. 11 (1905); *cf. Whalen* v. *Roe*, 429 U.S. 589 (1977).

for purposes of treatment but for punitive reasons or in violation of religious rights, a constitutional violation may be found. *See, e.g., Knecht* v. *Gillman,* 488 F.2d 1136 (8th Cir. 1973) (vomit-inducing drug administered to prisoner as punishment); *Mackey* v. *Procunier,* 477 F.2d 877 (9th Cir. 1973) (breath-stopping and paralyzing "fright drug" administered to prisoner); *Nelson* v. *Heyne,* 355 F.Supp. 451 (N.D. Ind. 1972) *aff'd,* 491 F.2d 352 (7th Cir.), *cert. denied,* 417 U.S. 976 (1974) (transquilizers administered to juveniles in correctional facility without medical evaluation and not as part of treatment program); *Winters* v. *Miller, supra,* (forced psychiatric medication of Christian Scientist). But where, as in this case, medication is given "as part of an ongoing treatment program authorized and supervised by a physician," *Pena* v. *New York State Division For Youth,* 419 F.Supp. 203, 211 (S.D.N.Y. 1976), no constitutional violation can be established. *See also Welsch* v. *Likins, supra,* 373 F.Supp. at 503.

C. Even Assuming Arguendo That Committed Patients Have A Right To Refuse Medication, There Is No Constitutional Basis For Requiring Competency Hearings And The Appointment Of Guardians To Overcome Patients' Refusals.

Even assuming the validity of the district court's central premise that civilly committed patients have a constitutional right to reject psychiatric medication in nonemergencies unless they have been found incompetent after an additional hearing, there is no justification for holding that the Constitution requires this competency decision to be made by a court and that, if the court finds the patient incompetent, a guardian must be appointed. As indicated above, *see* pp. 8-13, *supra,* amicus believes the court fastened on these requirements because it engaged in an impermissible and erroneous analysis of state law, finding that Massachusetts generally requires that the exercise of civil rights cannot be restricted unless a person is declared

incompetent and a guardian appointed.[12] But, even if the court were correct in its analysis of state law, it is the federal constitution—not state law—that defines the appropriate scope of constitutional relief. Had the court limited itself to the proper inquiry, it would have found—assuming, contrary to amicus' position, that there is a constitutional right for committed patients to reject medication—that the Constitution allows a psychiatrist to decide when a patient is incompetent to exercise that right.

This conclusion flows directly from the Supreme Court's recent decision in *Parham* v. *J.R., supra.* In that case, the Court held that an objecting child has a due process liberty interest at stake when his parents attempt to place him in a psychiatric hospital. The Court made clear, however, that "[d]ue process has never been thought to require that the neutral and detached trier of fact be law-trained or a judicial or administrative officer. . . . Surely, this is the case as to medical decisions for 'neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments.' " *Id.* at 2505-07, quoting *In re Roger S.,* 19 Cal.3d 921, 941, 569 P.2d 1286, 1299 (1977) (Clark, J., dissenting). While recognizing the fallibility of medical and psychiatric decisionmaking, the Court nevertheless explained:

> [W]e do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing. Even after a hearing, the nonspecialist decision-

[12] The court was incorrect not only in its view of what Massachusetts requires for forcibly medicating a committed patient, *see* pp. 8-13, *supra,* but also in its general understanding of state law. Even with respect to electroshock, which specifically requires the consent of a committed patient, the hospital can overcome the objection, without a competency hearing, if the patient's nearest relative consents. M.G.L. Ch. 123 § 23; D.M.H. Reg. § 220.06(c).

> maker must make a medical-psychiatric decision. Common human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real. 99 S.Ct. at 2507-08.

Accordingly, the Court concluded, due process is satisfied when the decision to hospitalize the objecting child is made by "a staff physician . . . so long as he or she is free to evaluate independently the child's mental and emotional condition and need for treatment." *Id.* at 2507.

Likewise, in this case, it is clear that the due process determination of whether a committed patient is competent to refuse medication is exactly the kind of "medical decision that must be left to the judgment of physicians in each case." *Id.* at 2507.[13] A federal district court in New Jersey recently applied these principles in an identical situation. *See Rennie* v. *Klein,* 462 F.Supp. 1131 (D.N.J. 1978) and 476 F.Supp. 1294 (D.N.J. 1979). In its 1978 ruling, before *Parham* had been decided, the *Rennie* court, recognizing a committed patient's right to refuse medication, held that the decision to override that right had to be made at an adversary hearing where the patient was represented by counsel. 462 F.Supp. at 1147-48. In its second decision, however, the *Rennie* court acknowledged that the Supreme Court's intervening decision in *Parham* mandated a different result. 476 F.Supp. at 1307-08. Accordingly, it ruled that the decision regarding a patient's competence to reject medication could be made by a staff psychiatrist. *Id.* at 1314.[14]

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[13] It should be reiterated in this regard that the competency determination need only be focused on the patient's competence to refuse treatment, and not on his competence to exercise other rights. *See* n. 5, *supra.*

[14] In fact, the *Rennie* court went on to rule that even if the staff psychiatrist found the patient competent, the decision to override the patient's objection could be made after a hearing before an "independent psychiatrist," who was not a member of the hospital staff. 476 F.Supp. at 1314-15.

Moreover, even assuming, contrary to the ruling in *Parham,* that the decision as to the patient's competence to reject medication must be made at a judicial hearing, there plainly is no constitutional basis for then requiring imposition of a guardian to decide whether the patient should accept or reject medication. Since many patients do not have family members ready and willing to assume this role,[15] the appointment of guardians will be difficult and costly. *See* Ford, *The Psychiatrist's Double Bind: The Right to Refuse Medication,* 137 Am. J. Psychiat. 332, 336-37 (1980). Moreover, "it would be unrealistic to rely on legal guardians to protect the rights of incompetent patients in this respect." *Rennie* v. *Klein, supra,* 476 F.Supp. at 1311. *See also* Morris, *Conservatorship for the "Gravely Disabled": California's Nondeclaration of Nonindependence,* 15 San Diego L.Rev. 201 (1978). And, while not protecting patients' rights, guardians often impede their effective care. *See* Gutheil, *et al., Legal Guardianship in Drug Refusal: An Illusory Solution,* 137 Am. J. Psychiat. 347, 350 (1980) ("the use of the guardianship process [has] made it very difficult or impossible to deliver good medical care, to protect the patient's right to treatment, *and* to protect the patient's right to refuse medication") (emphasis in original).[16]

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[15] Even as to family members, it could be argued that they have a conflict of interest since typically they have been involved in committing the patient in the first place. *See Parham* v. *J.R., supra,* 99 S.Ct. at 2504.

[16] Even if guardians can be found, there is no way to assure that they will be available to make substitute decisions for the patient, or that they will not leave the jurisdiction, thereby necessitating appointment of a new guardian. Moreover, if a guardian has a philosophical or political objection to forced treatment, why should that position take precedence over the state's legitimate exercise of its parens patriae power?

The court below failed to explain why the constitution requires that a guardian—rather than the treating psychiatrist—must approve medication even after a judicial declaration of incompetence. Amicus submits that there is no basis. In any event, this kind of constitutional relief, which intrudes into the interstices of the state's mental health care delivery scheme, and which will require the state to expend significant resources to pay guardians, is contrary to established notions of federalism. *See Bell* v. *Wolfish,* 99 S.Ct. 1861 (1979); *Rizzo* v. *Goode,* 423 U.S. 362, 378-80 (1976).

II. THE DISTRICT COURT'S RULING WILL DESTROY THE EFFECTIVE OPERATION OF THE STATE PSYCHIATRIC HOSPITAL SYSTEM IN MASSACHUSETTS.

The district court acknowledged that the medication practices on the May and Austin units of Boston State Hospital—both teaching units of distinguished medical schools—were consistent with good medical practices, and beneficial to patients. 478 F.Supp. at 1356, 1382, 1386. It also recognized that "it is important to bear in mind that in this case we are dealing with a hospital setting, not a jail." 478 F.Supp. at 1365. But once having articulated this salutory principle, the court immediately proceeded to ignore it by imposing a uniform rule that would grant patients (or their guardians) an absolute right to refuse medication unless violence occurs or is imminent. Amicus believes that the district court did not pay sufficient attention to the likely effect of its decision. By replacing a system premised on sound medical discretion with one that relies on ineffective legal safeguards, the court did much to assure the transformation of psychiatric hospitals into antitherapeutic prison-like facilities.

A. The System Of Medical Discretion Outlawed By The Court Is Efficacious And Sensitive To Patients' Needs As Well As Rights.

While it is obviously preferable that psychiatric treatment be made available on a voluntary basis, the simple fact is that many people, precisely *because* they suffer from a serious mental illness, will not or cannot seek such treatment. Thus, in contrast to the delivery of most care for physical illnesses, treatment of mental illness must sometimes be imposed on patients. But this fact notwithstanding, the evidence shows that civil commitment can and does work effectively and in the patient's best interest. For example, one recent study specifically comparing the effects of hospitalization on voluntary and involuntary patients found that, although "committed patients tended to have a much more severe disorder than the voluntary patients," in the year following their release from the hospital, both groups—the involuntary as well as the voluntary patients—experienced "a very discernible improvement in their interpersonal roles" as a result of hospitalization. Gove & Fain, *A Comparison of Voluntary and Committed Psychiatric Patients,* 34 Arch. Gen. Psychiat. 669, 671 (1977).[17]

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[17] Similarly, another study of involuntary hospitalization concluded that certification for a brief period of involuntary treatment was sufficiently beneficial to the people involved to warrant its continued use, despite the authors *a priori* belief that only *voluntary* treatment was successful in the long run. Spensley, *et al., Involuntary Hospitalization: What For and How Long?* 131 Am. J. Psychiat. 219, 222 (1974). The researchers found that, within a three-day period following the involuntary commitment, all but 19 percent of the initially involuntary patients had either converted themselves to voluntary status or were discharged. Of this small remaining group, over half later accepted voluntary treatment. *Id.* at 221. *See also* Sata & Goldenberg, *A Study of Involuntary Patients in Seattle,* 28 Hosp. & Comm. Psychiat. 834 (1977).

Moreover, by most available accounts, involuntary patients themselves retrospectively view their hospitalization as beneficial. For example, in the Gove and Fain study referred to above, a substantial majority of both the committed patients (75.3 percent) and the voluntary patients (81.4 percent) believed that they had been helped by the hospitalization, whereas only a very small number—9.5 percent of the voluntary and only 5.5 percent of the committed patients—believed they were harmed. *Id.* at 675. Likewise, another recent study found that in 30 of 38 different samples, former patients espoused generally favorable attitudes toward their hospitalization. Weinstein, *Patient Attitudes Toward Mental Hospitalization: A Review of Quantitative Research,* 20 J. Health and Soc. Behavior 237 (1979).

Thus, even though civil commitment involves a serious disruption in a person's life, it is legitimate and desirable. "When the choice is between a loss of life or health and a loss of liberty for a brief period of time, the preferable alternative is apparent." *Coll* v. *Hyland,* 411 F.Supp. 905, 910 (D.N.J. 1976) (three judge, per curiam). Equally apparent is the fact that if the benevolent purpose of civil commitment is to be realized, patients invariably will have to be treated at least for a time with the major psychiatric medications at issue in this case.[18] Indeed, before the advent of these medications in the 1950's, seriously mentally ill patients were often the subject to long-term

[18] There are three major categories of medication commonly used in the treatment of committed patients: the antipsychotics, lithium, and the antidepressants. The antipsychotics are used in treating psychoses, particularly schizophrenia. They work by reducing thought disorders, such as hallucinations and delusions. *See generally* R. Baldessarini, Chemotherapy in Psychiatry, Ch. 2 (1977). Lithium operates primarily on mood, rather than thought, disorders. It is generally used to reduce the grandiosity, elation and aggressiveness that characterize the manic phase of manic-depressive psychosis. *See id.* at Ch. 3. The antidepressants are also used to remedy mood disorders, particularly the sense of helplessness and despondency that characterizes a psychotic depression. *See id.* at Ch. 4.

Collectively, these medications are called "psychotropic medication." Although the district court made plain that its only concern was the antipsychotics, 478 F.Supp. at 1359-60, it incorrectly used the designation interchangeably with "psychotropic," *id.* at 1365, and the terms of its order appear to apply to all three forms of psychiatric medication.

custodial warehousing in facilities marked by violence and known best for the repeated use of seclusion and restraints.[19]

The development of the psychiatric medications, particularly the antipsychotics, has had the kind of dramatic effect on the treatment of mental illness that antibiotics have had in the treatment of general illness. *See R. Baldessarini,* Chemotherapy in Psychiatry 36 (1977). Psychiatric hospital populations have declined drastically, from 512,501 in 1950 to 170,619 in 1976, and the decline has continued. *See* Ozarin, *et al., A Quarter Century of Psychiatric Care 1950-1974: A Statistical Review,* 27 Hosp. & Comm. Psychiat. 515, 516 (1976); Witkin, Mental Health Statistical Note #153: Provisional Patient Movement and Selective Administrative Data, State and County Mental Hospitals,

[19] The following description conveys a vivid picture of what hospitalization was like before these medications were available:

> Hallucinating patients paced the floor or rocked in chairs, and talked to their "voices"; paranoid patients scanned the rooms, ever vigilant and ever fearful; catatonic patients remained in fixed positions for days at a time developing swollen limbs and pressure sores; withdrawn patients sat on wooden chairs, year after year, doing nothing, while their physical health deteriorated; manic patients joked, laughed and moved about rapidly for days at a time until they collapsed exhausted; violent or agitated patients attacked other patients or staff members in response to idiosyncractic beliefs. Berger, *Medical Treatment of Mental Illness,* 200 Science 974 (May 20, 1978).

See also Romano, *On the Nature of Schizophrenia: Changes in the Observer as Well as the Observed (1932-77),* 3 Schizophrenia Bull. 532 (1977).

Inpatient Services by State (D.HEW Aug. 1979). The use of medications has also enabled patients to be hospitalized for far shorter periods of time—from a median hospital stay of 44 days in 1971 to 26 days in 1975—and has shifted the primary locus of care from the hospital to community treatment programs. *See* Klerman, *National Trends in Hospitalization,* 30 Hosp. & Comm. Psychiat. 110, 111-12 (1979). *See also Rennie* v. *Klein, supra,* 462 F.Supp. at 1137.[20]

[20] Although there is virtual unanimity concerning the efficacy of the antipsychotics, these medications have recently come under serious attack in the legal literature because of their side effects. *See, e.g.,* Dubose, *Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do The Benefits To The Patient Justify Involuntary Treatment,* 60 Minn. L.Rev. 1149 (1976); Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment,* 72 Northwestern U.L.Rev. 461 (1977). It is neither surprising nor uncommon that medications that are sufficiently potent to treat a powerful illness also produce side effects. As the district court recognized, however, 478 F.Supp. at 1360, most of the side effects are reversible. These effects, known as extrapyramidal effects, include primarily akinesia—involuntary weakness and diminished spontaneity—and akathisia—an inability to be still. Besides subsiding when the medication is discontinued, these side effects can often be alleviated or reduced by changing medications and by treatment with an anti-Parksonian medication. *See* R. Baldessarini, Chemotherapy in Psychiatry, *supra* at 43-44.

The most serious side effect of antipsychotic medication is tardive dyskinesia, which involves involuntary or semi-involuntary tic-like movements generally of the tongue, facial and neck muscles. *Id.* at 46. None of the plaintiffs in this case was found to suffer from tardive dyskinesia. 478 F.Supp. at 1360. Nevertheless, the problems posed by tardive dyskinesia are admittedly serious, and much careful examination has to be given to its incidence, effects and reversibility. Amicus has appointed a task force of eminent psychiatrists and neurologists to study the problem, and its report will soon issue. *See also* Dorsey, *et al., Psychopharmacological Screening Criteria Development Project,* 241 J. Amer. Med. Ass'n 1021 (1979).

Despite these serious concerns, it is important to point out that some of the more tendentious legal literature has exaggerated the evidence on the incidence and effects of tardive dyskinesia. Since its symptoms are similar to some of the involuntary movements suffered by many persons with schizophrenia, differentiating between tardive dyskinesia and schizophrenic mannerisms is often quite difficult. *See* Jeste & Wyatt, *Tardive Dyskinesia: The Syndrome,* 10 Psychiat. Annals 16, 19 (1980). Abnormal involuntary movements were reported in chronic patients many years before the antipsychotic medications were used. *Ibid.*

It is also true that tardive dyskinesia almost always occurs after prolonged usage of high doses of antipsychotic medication, and is not necessarily irreversible. Jeste, *et al., Tardive Dyskinesia —Reversible and Persistent,* 36 Arch. Gen. Psychiat. 585 (1979). Increasingly, new ways to treat or manage tardive dyskinesia are being found. *See* Gelenberg, *et al., Choline and Lecithin in the Treatment of Tardive Dyskinesia: Preliminary Results from a Pilot Study,* 136 Am. J. Psychiat. 772 (1979); Jus, *et al., Long-Term Treatment of Tardive Dyskinesia,* 40 J. Clin. Psychiat. 72

The district court was willing to neglect this history, perhaps because it thought that "[t]here are alternative methods of treating mental patients, though some may be slower and less effective than psychotropic medication." 478 F.Supp. at 1369. The court simply was mistaken. Although it never identified these "alternative" treatments, presumably the court was referring to psychotherapy and milieu therapy. But the plain medical fact is that for those patients so seriously ill to require commitment, medication is invariably an indispensable treatment. *See* P. May, Treatment of Schizophrenia: A Comparative Study of Five Treatment Methods (1968); Group for the Advancement of Psychiatry, Pharmacotherapy and Psychotherapy: Paradoxes, Problems and Progress (1975). In fact, medication acts as an "enabler," reducing the patient's grossly disordered thinking so that he can derive long-term benefits from the psychotherapy and milieu therapy being provided. *See Rennie* v. *Klein, supra,* 462 F.Supp. at 1137; Note, *The Use of Psychotropic Drugs in State Hospitals: A Legal or Medical Decision,* 29 Hosp. & Comm. Psychiat. 118, 121 (1978).

It is also clear that the most effective utilization of these medications occurs when the psychiatrist and patient work together in a therapeutic alliance. Thus, amicus fully supports the notion that the medication and its effects should be discussed with the patient and his cooperation in taking the medication should be enlisted. *See* D. Klein & J. Davis, Diagnosis and Drug Treatment of Psychiatric Disorders, 17-23 (1969); Roth, *Clinical and Legal Considerations in the Therapy of Violence-prone Patients, in* 18 Current Psychiatric Therapies 55, 61 (Masserman ed. 1978).[21] Similarly, there are occasions when it is clinically sensible to delay medication in the face of a patient objection. *See* Appelbaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients,* 137 Am. J. Psychiat. 340, 345 (1980) ("Permitting both situational and stereotypic refusers in our study to decline medication, not as a 'right' but as a

(1979); Jeste & Wyatt, *In Search of Treatment for Tardive Dyskinesia: Review of the Literature,* 5 Schizophrenia Bull. 25 (1979).

It is obvious that more research is needed in this area, and that more clinical sensitivity to tardive dyskinesia is necessary. But the fact remains that, the side effects notwithstanding, "the overwhelming preponderance of data supports a high benefit/risk ratio for [antipsychotic] medications and a safety record commensurate with other powerful pharmacologic agents." *See* Appelbaum & Gutheil, *"Rotting With Their Rights On," supra,* 7 Bull. Am. Acad. Psychiat. & Law at 309.

[21] The issue of informed consent, however, is a complicated one requiring sensitive clinical judgments. *See* Stone, *Informed Consent: Special Problems for Psychiatry,* 30 Hosp. & Comm. Psychiat. 321 (1979). Meisel, *et al., Toward a Model of the Legal Doctrine of Informed Consent,* 134 Am. J. of Psychiat. 285 (1977). The law itself has had a difficult time adjusting to the various subtleties and nuances presented, including the physician's right to delay disclosure when to do otherwise would be harmful or traumatic to the patient. *See* Meisel, *The "Exceptions" To the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking,* 1979 Wisc.L.Rev. 413; Gauvey, *et al., Informed and Substitute Consent to Health Care Procedures: A Proposal for State Legislation,* 15 Harv.J.Legis. 431 (1978).

matter of clinical policy, did not seriously impair their overall treatment and yielded some positive advantages"); J. Lion, The Art of Medicating Psychiatric Patients 28 (1978).

Ultimately, however, effective clinical care demands that the physician be allowed to override the committed patient's objection in certain situations. At times, for example, the patient's verbal objection will be patently senseless or will be accompanied by behavior demonstrating ambivalence about treatment and the loss of the psychotic illness. *See* Hoffman, *The Right to Refuse Psychiatric Treatment: A Clinical Perspective,* 4 Bull. Am. Acad. Psychiat. & Law 269, 271-73 (1976); Appelbaum & Gutheil, *"Rotting With Their Rights On", supra,* 7 Bull. Am. Acad. Psychiat. & Law at 315 (1979).[22] Failure to impose treatment in such circumstances is irresponsible. Thus, the Massachusetts Supreme Judicial Court specifically criticized a psychiatric hospital because "[d]rugs were not . . . administered involuntarily where patients refused medication."

[22] The authors report a study of 23 patients who accounted for 72 discrete episodes of drug refusal. The stated reasons—sometimes more than one reason was given—for these refusals were as follows: no reason offered (nine patients); angry or seemingly irrelevant responses (seven patients); side effects (10 patients); overt delusions (nine patients); privacy (eight patients); legal rights (three patients). Appelbaum & Gutheil, *"Rotting With Their Rights On": Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients,* 7 Bull. Am. Acad. Psychiat. & Law 308, 312-13 (1979). In another article, the authors divided these 23 patients into three groups: "(1) situational refusers [13 patients]—a diverse group of patients who on occasion refused medication for a short period of time and for one of a variety of reasons; (2) stereotypic refusers [five patients]—chronically ill patients with paranoid traits who habitually and predictably responded to a variety of stresses with brief medication refusal; and (3) symptomatic refusers [five patients]—young, relatively acutely ill patients whose refusal, often based on delusional premises, was sustained over a long period and successfully stymied treatment efforts." Appelbaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients,* 137 Am. J. Psychiat. 340, 342-44 (1980).

Nason v. *Superintendent of the Bridgewater State Hospital, supra,* 233 N.E.2d at 912 n.7. *See also Whitree* v. *State,* 56 Misc.2d 693, 290 N.Y.S.2d 486, 501 (1968):

> We find [plaintiff] was not treated with any of the modern [psychiatric] drugs or any of their less effective antecedents during his entire stay in the hospital. It was not until 1959 . . . that such drugs were prescribed. We find that the reason for not using such drugs was that Whitree refused them. We consider such reason to be illogical, unprofessional and not consonant with prevailing medical standards.

In short, it is only the physician, charged with monitoring the patient's day-to-day care, who can make the delicate and subtle clinical judgment of when best to ignore the patient's objection. As the court below recognized:

> the patient population was extremely demanding, both in terms of numbers and their potential for disruptive behavior. Defendants did not have the luxury of detached, leisurely reflection as they faced the innumerable crises that characterized daily living on the Austin and May wards. They met those crises decisively, with the purpose of restoring plaintiffs to self control. 478 F.Supp. at 1383.

Admittedly, in such circumstances, medical judgments will not be infallible. *See Parham* v. *J.R., supra,* 99 S.Ct. at 2506-07. But reliance on such judgments—rather than the invocation of a hollow constitutional rule [23]—is the best

[23] This is especially true where, as here, the court sought to tie its constitutional ruling to the legal definition of competency. Even the objective legal standards in this area are very confused. *See* Roth, *et al., Tests of Competency to Consent to Treatment,* 134 Am. J. Psychiat. 279 (1977). As a subjective matter, of course, "patient competency is continually changing, even as a result of treatment." Roth, *Involuntary Civil Commitment: The Right to Treatment and the Right to Refuse Treatment, supra,* at 343; *see Rennie* v. *Klein, supra,* 462 F.Supp. at 1141 ("[plaintiff's] capacity to participate in the refusal of medicine or the choice of medicine is somewhat limited, depending on the day").

way to protect the patient's dignity as well as his interest in receiving proper care for a serious illness.

B. The Decision Below Will Transform The Treatment Milieu Of A Psychiatric Hospital Into The Security Milieu Of A Prison.

Amicus further believes that the district court failed to pay sufficient attention to the likely implications of its decision. Had it done so, it would have realized that it was setting into play a series of self-fulfilling prophecies likely to destroy the psychiatric hospital.

First, the court seemed to believe that its decision would not cause many patients to reject treatment. *See* 478 F. Supp. at 1369. While it would hardly appear that the "nonexercise" of a right should be cited as a justification for its creation, we think the court misjudged the effect of its ruling. The data suggest that, even without a constitutional right to refuse, there are significant numbers of patient refusals. *See Rennie* v. *Klein,* 476 F.Supp. 1294, 1304 (D.N.J. 1979).[24] Moreover, the articulation of the right will surely lead other patients to exercise it.[25] Thus, in *Rennie,* almost immediately after the district court announced a right to refuse treatment the evidence showed

[24] In a recent study it was found that 23 patients refused medication in a three-month period when there were 56 admissions, 52 discharges, and an average daily census of 40 patients. Appelbaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients, supra,* 137 Am. J. Psychiat. at 342.

[25] The district court failed to indicate how the psychiatrist was to assure that the patient knowingly waived his new right. *See Johnson* v. *Zerbst,* 304 U.S. 458 (1938). Must he advise the patient of the right each time that medication is being administered? Can he urge the patient to take medication? Deny him ward privileges if he does not? In this regard it is instructive to note that the court rejected a claim that voluntary patients had waived their rights to refuse medication by signing an application stating, "I understand that during my hospitalization and any after care, I will be given care and treatment which may include the injection of medicines." 478 F.Supp. at 1367.

that the plaintiff's "discussion of the opinion in a hospital ward for the criminally insane encouraged other patients in that ward to refuse medication." 462 F.Supp. at 1152, n.1.

In addition, it is reasonable to assume that if the psychiatrist has any doubt about whether the patient wants to reject the medication, he will decline to provide medication rather than risk violating the patient's rights. This is particularly true when such a violation may result in a successful damages action under 42 U.S.C. § 1983.[26] The district court responded to this concern by stating:

> Doctors, like judges, are in a decision making profession. Some decisions are clear and others are less certain. Neither profession has room for those unwilling or unable to make the tough ones. 478 F.Supp. at 1369, n.36.

What the court failed to indicate, however, is that doctors, unlike judges, are not granted absolute immunity if their "tough" decisions turn out to be wrong.

Nor is the district court's solution of a competency hearing resulting in the appointment of a guardian a sensible response to the problems created by its decision. Even assuming that such a procedure would satisfy legitimate treatment needs—an assumption we will dispute shortly—the procedure is needlessly costly and wasteful. Since typically the patient will only recently have had a commitment hearing, the competency hearing will be largely duplicative with the patient's attorney again arguing that the patient should not be treated involuntarily. The costs of such hearings—in terms of treatment staff diverted from the hospital, as well as the costs of lawyers and court time—will be significant. "Behavioral experts in courtrooms

[26] Unlike in this case, in future cases the psychiatrist-defendant will not be able to claim that he should not be held responsible for failure "to anticipate then uncharted constitutional developments." 478 F.Supp. at 1382.

and hearings are of little help to patients." *Parham* v. *J.R.*, *supra*, 99 S.Ct. at 2506.[27]

More significantly, these competency hearings will not assure on-going effective treatment. Under the best of circumstances it will take time—weeks, if not months—before notice is provided, an attorney appointed, and the hearing completed.[28] During this period, absent an emergency, the patient's refusal cannot be overridden except during episodes of violence. This hiatus in treatment, which will often occur at the beginning of a commitment when the patient's illness is likely to be most acute, can have serious consequences, including significant deterioration of an illness that might have been treated quickly and effectively.[29] *See* Gutheil, *et al.*, *Legal Guardianship in Drug Refusal: An Illusory Solution*. 137 Am. J. Psychiat. 347 (1980). In an

[27] The Supreme Court went on to explain:

> The *amicus* brief of the American Psychiatric Association points out at page 20 that the average staff psychiatrist in a hospital presently is able to devote only 47% of his time to direct patient care. One consequence of increasing the procedures the state must provide prior to a child's voluntary admission will be that mental health professionals will be diverted even more from the treatment of patients in order to travel to and participate in—and wait for—what could be hundreds—or even thousands—of hearings each year. Obviously the cost of these procedures would come from the public monies the legislature intended for mental health care. *Parham* v. *J.R.*, 99 S.Ct. 2493, 2506 (1979).

[28] In view of the well-known aversion that psychiatrists have to judicial hearings, *see, e.g.*, Kumasaka, *et al.*, *Criteria for Involuntary Hospitalization*, 26 Arch. Gen. Psychiat. 399 (1972), it is also reasonable to assume that many will reject or delay the decision to move for a competency hearing hoping that the patient will change his mind and agree to accept medication. This deterrent against seeking a competency hearing is strengthened by the fact that a "successful" outcome may mean only the appointment of a disinterested guardian.

[29] Indeed, that these results are probable is made clear by the fact that the district court explicitly rejected defendants' argu-

analogous situation, the Supreme Court recently stated, "[t]he State also has a genuine interest in allocating priority to the diagnosis and treatment of patients as soon as they are admitted to a hospital rather than to time-consuming procedural minuets before the admission." *Parham* v. *J.R., supra*, 99 S.Ct. at 2506. The district court here, by contrast, has established a procedure whereby the state will have to expend significant resources to warehouse a patient who might have been released before the time for his competency hearing arrives.

The failure to provide proper medication will work to the detriment of nonobjecting patients as well because it will increase patient violence thereby leading to the restoration of the prison-like atmosphere that marked state mental hospitals before the 1950's. The district court's order allows forced medication only when there is a "substantial likelihood, or as a result of, extreme violence, personal injury or attempted suicide." In effect, then, absent an actual violent episode a patient cannot be forcibly medicated because psychiatrists cannot otherwise predict when physical harm is likely to result.[30] *See* A. Stone, Mental Health and Law: A System in Transition, 27-36 (1975); Amer. Psychiat. Ass'n., Task Force Report No. 8: *Clinical Aspects of the Violent Individual,* 23-24 (1974). Once the

ment that the emergency exception to the patient's right to refuse medication should be defined as follows:

> (1) suicidal behavior, whether seriously meant or a gesture, (2) assaultiveness, (3) property destruction, (4) extreme anxiety and panic, (5) bizarre behavior, (6) acute or chronic emotional disturbance having the potential to seriously interfere with the patient's ability to function on a daily basis, (7) the necessity for immediate medical response in order to prevent or decrease the likelihood of further severe suffering or the rapid worsening of the patient's clinical state. 478 F.Supp. at 1364. *See also id.* at 1353.

[30] In view of a possible suit for damages if his judgment is wrong, *see* n. 26, *supra*, it can be expected that a psychiatrist will be especially reluctant to make such predictive assessments.

violence occurs, it is, unfortunately, too late to treat; at that point, seclusion is necessary. If medication is administered, it is essentially used as a "restraint" until the patient is calmed, at which point he can then presumably refuse medication again.

This assessment of the likely effect of the district court's opinion is not mere speculation. A recent report documents life at the Austin and May units as they operated under the temporary restraining order issued in this case:

> "Tension seems to fill the air at the Austin Unit twenty-four hours a day." One wing has been destroyed by fire, set by a patient. One female patient attempted to burn a staff member, to choke a patient, and to strangle herself with a ripped dress. She smashed a window, threatened to kill several staff members, attacked, kicked and spat at them. At another time, she was "screaming, threatening, deluded, beat staff, grabs them, incited another disturbed patient to violence by inviting him to her bed and defying staff to deal with him. This other patient becomes so threatening that the night staff sent Dr. G a letter signed by all informing him that they could not and would not work under these conditions."
>
> Another female Austin Unit patient punched a social worker and several patients, cut herself with flip-tops, and "gouged her face with her fingernails until she bled; this continued almost daily throughout the month of June." A schizophrenic male patient who has refused medication since the grant of the temporary restraining order has had sexual intercourse with at least three different patients who are either retarded or are severely and chronically regressed. He has also broken a window, kicked a patient, and grabbed and threatened two female staff members. The incidence of assaultive behavior by other Austin patients has also increased as the administration of medication has declined in deference to their wishes.
>
> Patients in the May Unit have experienced similar problems. One woman, while refusing medication, became psychotic and left the hospital in anger, lived

> on a doorstep without changing her clothes for two weeks, was twice returned to the hospital by police, and twice set herself on fire in her room. In the May, as in Austin Unit, "since the issuance of the temporary restraining order, tensions, threats, agitation and acts of violence have increased." (16, pp. 22, 23; statements in quotation marks are taken from hospital records.) Stone, *Recent Mental Health Litigation: A Critical Perspective,* 134 Am. J. Psychiat., 273, 278 (1977).

The court chose to ignore the evidence of violence, suggesting that medication can be used when violence is imminent and thus the violence can be avoided under its ruling. *See* 478 F.Supp. at 1369, n.36. The error in the court's logic is that, certainly in most instances, it will be impossible to predict when violence will result. *See* n. —, *supra.* After the violence occurs, it is hardly comforting to suggest that it *should* have been anticipated. In the meantime, the court's decision will destroy the therapeutic potential of the hospital, thereby denying all patients their rights, including particularly their constitutional right to treatment.[31] *See* cases cited at p. 15, *supra.*

In sum, this is a case where the use of forced medication was found to be in the best interests of the patients—indeed, that it helped many for whom "Boston State was the end of the treatment line." 478 F.Supp. at 1384. Yet,

[31] In fact, the quality of care and treatment can be expected to worsen as these conditions deter competent physicians from seeking employment in state psychiatric hospitals. *See* Roth, *Involuntary Civil Commitment: The Right to Treatment and the Right to Refuse Treatment, supra,* at 342-43. It is, to say the least, demoralizing for a psychiatrist, who is trained to treat mental illness, to stand helplessly by and watch patients deteriorate, knowing that there are treatments available that will alleviate the suffering. It is already difficult to get good psychiatrists to work in state hospitals, as the court below recognized. *See* 478 F.Supp. at 1384-85. *See generally* Note, *Psychiatry in the Public Sector,* 30 Hosp. & Comm. Psychiat. 749 *et seq.* (1979). Yet, it went on to announce a rule that will only make matters worse.

the court below strained to create a constitutional rule that replaces psychiatric discretion with a court hearing and a disinterested guardian. Presumably the court believed that anyone but the psychiatrists could be trusted to act as a substitute decisionmaker for committed patients. But "[t]o structure a system with the assumption that sadism is the norm may smother benevolent intent in legalistic controls and thereby create a self-fulfilling prophecy." Appelbaum & Gutheil, *"Rotting With Their Rights On", supra,* 7 Bull. Am. Acad. Psychiat. & Law at 311.

III. VOLUNTARY PATIENTS HAVE NO CONSTITUTIONAL RIGHT TO REFUSE MEDICATION AND REMAIN AT THE HOSPITAL.

In addition to considering the constitutional rights of committed patients, the district court also ruled that voluntary patients have a constitutional right to refuse medication in nonemergencies "and still remain at the Hospital." 478 F.Supp. at 1367. The court recognized that upon admission such patients sign an application stating "I understand that during my hospitalization and any after care, I will be given care and treatment which may include the injection of medicines," *ibid.,* but found this waiver to be constitutionally insufficient. Amicus believes that the court's basic premise—that voluntary patients have a right to refuse medication—is unobjectionable.[32] But its holding

[32] It could be argued that such patients, by agreeing to undertake a course of treatment that is paid for by the state, waive their right to refuse until treatment is completed. *See O'Donoghue* v. *Riggs,* 734 Wash.2d 814, 440 P.2d 823, 828, n.2 (1968); *cf. Belger* v. *Arnot,* 344 Mass. 679, 684, 183 N.E.2d 866, 870 (1962). Obviously, the state has an interest in assuring that its resources are spent prudently and, therefore, it is not unreasonable to suggest that patients should not be allowed to abort their treatment before it is concluded. We think the better approach, however, is to allow voluntary patients to terminate treatment in nonemergencies, unless they are properly committed.

that such patients can refuse medication and not be discharged from the hospital has no constitutional foundation and is senseless.

It is undisputed that the state has no constitutional obligation to provide psychiatric services to voluntary patients; rather, in so doing, it undertakes a "voluntarily assumed mission." *Parham* v. *J.R., supra,* 99 S.Ct. at 2505. If the individual refuses to accept the benefit provided, which, by the district court's own terms, is proper psychiatric treatment, it defies common sense to suggest that the state must then waste its resources by warehousing him. The court below cited no principle or authority that would suggest a different result. The law is to the contrary:

> In the present case the patient voluntarily submitted himself to and insisted upon medical care. Simultaneously he sought to dictate to treating physicians a course of treatment amounting to medical malpractice. To require these doctors to ignore the mandates of their own conscience, even in the name of free religious exercise, cannot be justified under these circumstances. The patient may knowingly decline treatment, but he may not demand mistreatment. *United States* v. *George, supra,* 239 F.Supp. at 754.

Similarly, the Supreme Court recently noted that "[t]he state obviously has a significant interest in confining the use of its costly mental health facilities to cases of genuine need." *Parham* v. *J.R., supra,* 99 S.Ct. at 2505. The patient who refuses medication plainly forfeits the "genuineness" of his claim.

If a voluntary patient is willing to accept appropriate treatment that is being freely provided by the state he may remain at the hospital. If, by refusing to accept appropriate treatment, he destroys the purpose for which he came to the hospital, the state must be free to discharge him unless, of course, the patient is appropriately civilly committed. At that point, for the reasons given above, the state can lawfully treat him with proper medication.

CONCLUSION

For the foregoing reasons, amicus curiae, the American Psychiatric Association, urges this Court to reverse the decision below insofar as it holds that committed patients have a constitutional right to refuse medication and that voluntary patients have a right to remain in the hospital if they refuse medication.

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