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Gerald J. Schaefer, Drug-Induced Alteration of Psychotic Behavior: Who Benefits?, 9 J.L. & Health 43 (1994-1995)

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DRUG-INDUCED ALTERATION OF PSYCHOTIC BEHAVIOR: WHO BENEFITS?

GERALD J. SCHAEFER¹

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I. INTRODUCTION

Defining mental health and mental illness remains a difficult task, even in the Decade of the Brain.² Criteria used to determine mental illness depend to

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²Lewis L. Judd, 1990 *Made Decade of the Brain*, 20 NEUROSCIENCE NEWSL. 2 (1989). President Bush signed into law a joint resolution of Congress (H.J. Res. 174) declaring January 1, 1990, the start of the Decade of the Brain. The purpose of this resolution was

some extent on the culture or society, and tend to change over time.³ For example, psychosis is currently defined as a severe mental disorder in which there is a marked impairment of behavior as well as a manifest inability to think coherently, to comprehend reality, or to gain insight into one's own abnormal condition.⁴ Because psychosis is so devastating Western society usually intervenes to prevent self-harm and harm to others, as well as to prevent abuse of the psychotic individual by others. Important questions arise regarding the type of intervention that is appropriate and when the psychotic may refuse the proffered treatment.

While Freud suggested early in this century that psychosis might result from a biochemical abnormality,⁵ it was a chance discovery in 1952 that ushered in the era of modern psychopharmacology.⁶ Delay and Deniker reported that the drug chlorpromazine (Thorazine ^R, an aliphatic phenothiazine) reduced psychotic symptoms in affected patients.⁷ Since then a class of drugs called neuroleptics or antipsychotics has been the mainstay of treatment for inpatients and has also advanced the public policy of deinstitutionalizing patients whenever possible.

Given the debilitating nature of psychosis, those affected are often unable to give informed consent about taking the medication. A crucial question is whether civil or criminal authorities can force the individual to take antipsychotic medication and under what circumstances this should be permitted. This review will focus on the current legal status of involuntary treatment with antipsychotics in various patient populations. The constitutional issues involved will be considered in light of both the patient's

to increase recognition of and federal funding for neuroscience research, including studies on schizophrenia.

³Nancy C. Andreasen, *Schizophrenia: Diagnosis and Assessment*, in *PSYCHOPHARMACOLOGY: THE THIRD GENERATION OF PROGRESS* 1087 (Herbert Y. Meltzer ed., 1987).

⁴Ross J. Baldessarini, *Drugs and the Treatment of Psychiatric Disorders*, in *THE PHARMACOLOGICAL BASIS OF THERAPEUTICS* 383 (Alfred G. Gilman et al. eds., 8th ed. 1990).

⁵Joseph T. Coyle & S.J. Enna, *Neuroleptics*, in *NEUROLEPTICS: NEUROCHEMICAL, BEHAVIORAL, AND CLINICAL PERSPECTIVES* 1 (Joseph T. Coyle & S.J. Enna eds., 1983).

⁶Frank J. Ayd, *The Early History of Modern Psychopharmacology*, 5 *NEUROPSYCHOPHARMACOLOGY* 71 (1991).

⁷Jean R. Delay et al., *The Treatment of Excitement and Agitation States By a Method of Medication Derived from Hibernotherapy*, 110 *ANNALS MED. PSYCHOL.* 267 (1952). The term "neuroleptic" was coined by Delay and Deniker, and literally means "that which takes the neuron." It should be noted, however, that prior to the introduction of the phenothiazines, reserpine was used to treat schizophrenia in India. See G. Sen & K.C. Bose, *Rauwolfia Serpentina: A New Indian Drug For Insanity and High Blood Pressure*, 2 *INDIAN MED. WORLD* 194 (1931), as cited in Elliot Richelson, *Pharmacology and Clinical Considerations of the Neuroleptics*, in *NEUROPHARMACOLOGY OF CENTRAL NERVOUS SYSTEM AND BEHAVIORAL DISORDERS* 123 (Gene C. Palmer ed., 1981).

and the civil or criminal institution's rights and duties. A review of the literature suggests there is a critical need for a balanced position on this controversial medical and legal issue. Before attempting to negotiate the legal landscape, however, it is necessary to describe the drugs themselves. No intelligent decision can be made without an understanding of what these chemicals do.

II. THE PHARMACOLOGY OF ANTIPSYCHOTIC DRUGS

An antipsychotic is a drug used to treat a psychosis such as schizophrenia, a condition characterized by emotional withdrawal, apathy, disordered thinking and lack of interpersonal relationships.⁸ Sometimes "schizophrenia" and "psychosis" are used interchangeably, but this is incorrect because the term "psychosis" embraces a wide range of mental diseases.⁹ Broad subdivisions include the affective disorders (major depression and mania), organic psychoses (resulting from definable toxic, metabolic or neurological causes) and idiopathic ("functional") psychoses. It is the idiopathic psychoses, for which the underlying cause remains obscure, that more closely correspond to the term schizophrenia. The term "neuroleptic" is used synonymously with "antipsychotic", and refers to the "syndrome neuroleptique" described in the original paper on chlorpromazine.¹⁰ To be consistent with both the legal and the medical literature, the terms "neuroleptic" and "antipsychotic" will be used interchangeably in this article.

Contemporary biological research is based mainly on the so-called dopamine hypothesis of schizophrenia in which it is theorized that schizophrenia is due to an over-activity or relative excess of the neurotransmitter dopamine in the brain.¹¹ The hypothesis derives from the demonstration that clinically effective antipsychotic drugs block dopamine receptor sites in the brain and reduce dopaminergic transmission. In contrast, high doses of dopamine-releasing drugs, such as amphetamine, produce symptoms resembling paranoid schizophrenia.¹² However, *in vivo* studies measuring dopamine metabolites such as homovanillic acid (HVA) have failed to demonstrate differences between normals and unmedicated schizophrenics,¹³ as has an examination of autopsied brain material from the

⁸Andreasen, *supra* note 3, at 1087.

⁹See generally AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed. rev. 1987).

¹⁰Sven Ove Ögren & Thomas Höglberg, *Novel Dopamine D-2 Antagonists for the Treatment of Schizophrenia*, 2 ISI ATLAS SCI.: PHARMACOLOGY 141 (1988).

¹¹P.J. McKenna, *Pathology, Phenomenology and the Dopamine Hypothesis of Schizophrenia*, 151 BRIT. J. PSYCHIATRY 288 (1987).

¹²Yousry Sayed & John M. Garrison, *The Dopamine Hypothesis of Schizophrenia and the Antagonistic Action of Neuroleptic Drugs-A Review*, 19 PSYCHOPHARMACOLOGY BULL. 283 (1983).

¹³JACK R. COOPER ET AL., THE BIOCHEMICAL BASIS OF NEUROPHARMACOLOGY 309 (5th ed. 1986).

two populations.¹⁴ More recently, non-invasive brain imaging techniques such as positron emission tomography (PET scans) and magnetic resonance imaging (MRI) have begun to show promise as reliable and sensitive techniques for ascertaining central nervous system differences between control and schizophrenic populations.¹⁵

Since the initial report of the antipsychotic properties of chlorpromazine in 1952, there has been a major research effort to develop more effective drugs with fewer or less severe side effects. Although no compound has been found to be clinically more effective than chlorpromazine,¹⁶ the antipsychotics differ in their degrees of various side effects, the most troublesome of which are the neurological symptoms.

A. Behavioral Characteristics of Antipsychotic Drugs

Antipsychotics often produce sedation.¹⁷ However, they should not be, although they often are, regarded as sedatives. Unfortunately, antipsychotics are sometimes referred to incorrectly as "major tranquilizers."¹⁸ In fact, antipsychotics produce a normalizing effect.¹⁹ The drugs may slow down excited patients and, in particular, may reduce hostile or aggressive behavior. However, the drugs can also speed up retarded patients who are withdrawn or autistic, thus rendering them more accessible, responsive and communicative. It was recently demonstrated, for example, that neuroleptics improve attentional processes and the ability to concentrate in schizophrenics.²⁰ In addition, these compounds reduce such symptoms as auditory hallucinations, delusions and indifference to the environment. The behavioral effects, however, are time-dependent. During the first few weeks of antipsychotic medication, aggression is decreased and cooperation and socialization are increased.²¹ Thought disorders, auditory hallucinations and

¹⁴*Id.* at 309-310.

¹⁵Göran Sedvali, *PET Imaging of Dopamine Receptors in Human Basal Ganglia: Relevance to Mental Illness*, 13 TRENDS IN NEUROSCIENCES 302 (1990).

¹⁶Arthur Rifkin & Samuel Siris, *Drug Treatment of Active Schizophrenia*, in PSYCHOPHARMACOLOGY: THE THIRD GENERATION OF PROGRESS, *supra* note 3, at 1095; John M. Kane, *Treatment of Schizophrenia*, 13 SCHIZOPHRENIA BULL. 133 (1987).

¹⁷Baldessarini, *supra* note 4, at 388.

¹⁸*Id.*

¹⁹John Davis et al., *Neuroleptics and Psychotic Disorders*, in NEUROLEPTICS: NEUROCHEMICAL, BEHAVIORAL, AND CLINICAL PERSPECTIVES, *supra* note 5, at 15.

²⁰Paul C. Nestor et al., *Neuroleptics Improve Sustained Attention in Schizophrenia: A Study Using Signal Detection Theory*, 4 NEUROPSYCHOPHARMACOLOGY 145 (1991).

²¹See John M. Davis et al., *Important Issues in the Drug Treatment of Schizophrenia*, in SCHIZOPHRENIA 1980, 109 (1980).

delusions are not altered until after approximately two weeks, a phenomenon referred to as the "neuroleptic lag-time".²²

Studies in animals suggest that antipsychotics reduce the rewarding value of natural (food and water) and artificial (drugs such as cocaine and intracranial self-stimulation) stimuli.²³ Hence, the neuroleptics are said to produce anhedonia by blocking an overly active dopamine system in the brain's "reward sites" such as the nucleus accumbens, olfactory tubercle and the prefrontal cortex.²⁴

The normalizing effect of antipsychotics described in schizophrenic patients stands in marked contrast to the effects reported in controls, an issue that is seldom addressed. A single 0.75 mg dose of haloperidol (Haldol R, a butyrophenone) reduced spontaneous locomotor activity in healthy male volunteers.²⁵ This is consistent with their reported effects in animals.²⁶ However, not only is movement slowed, but thinking is slowed as well, and subjects report an "inner restlessness" or akathisia along with severe anxiety and dysphoria that may occur within hours after drug administration.²⁷ As discussed below, it is highly probable that some of these effects are also produced in schizophrenics.

B. Toxic Side Effects of Antipsychotic Drugs

While the antipsychotics have proven effective in the treatment of schizophrenia, they are notorious for a wide range of undesirable side effects, including neurological, cardiovascular, and endocrinological abnormalities.²⁸ The most disturbing and the most apparent of the side effects are the neurological symptoms.

²²Baldessarini, *supra* note 4, at 402.

²³Roy A. Wise, *Neuroleptics and Operant Behavior: The Anhedonia Hypothesis*, 5 BEHAVIORAL & BRAIN SCI. 39 (1982).

²⁴Baldessarini, *supra* note 4, at 384.

²⁵S. Frey et al., *Spontaneous Motor Activity in Healthy Volunteers after Single Doses of Haloperidol*, 4 INT'L CLINICAL PSYCHOPHARMACOLOGY 39 (1989).

²⁶Gerald J. Schaefer & Richard P. Michael, *Drug Interactions on Spontaneous Locomotor Activity in Rats: Neuroleptics and Amphetamine-Induced Hyperactivity*, 23 NEUROPHARMACOLOGY 909 (1984).

²⁷Brian G. Anderson et al., *Prolonged Adverse Effects of Haloperidol in Normal Subjects*, 305 NEW ENG. J. MED. 643 (1981); Robert H. Belmaker & David Wald, *Haloperidol in Normals*, 131 BRIT. J. PSYCHIATRY 222 (1977); Kenneth S. Kendler, *A Medical Student's Experience with Akathisia*, 133 AM. J. PSYCHIATRY 454 (1976).

²⁸Baldessarini, *supra* note 4, at 389-92; George M. Simpson et al., *Adverse Effects of Antipsychotic Agents*, 21 DRUGS 138 (1981).

1. Neurological Side Effects

According to the dopamine hypothesis of schizophrenia, the manifestation of the disease results from an overactivity of dopamine in the limbic (nucleus accumbens and olfactory tubercle) and prefrontal areas of the brain.²⁹ These are the therapeutic target sites for the neuroleptics. However, dopamine also plays a prominent role in areas that control movement, the so-called extrapyramidal sites which include the striatum, caudate putamen and globus pallidus.³⁰ Most neuroleptics block dopamine in the extrapyramidal areas and this blockade produces the neurological side effects. A new generation of neuroleptics exemplified by clozapine (Clozaril[®], a dibenzodiazepine) appears to have few or no extrapyramidal side effects, and hence produces antipsychotic results without pronounced neurological symptoms.³¹ To the author's knowledge, all court cases to date have dealt with the classical antipsychotics such as chlorpromazine, haloperidol, thioridazine and mesoridazine (Mellaril[®] and Serentil[®], respectively, piperidine phenothiazines), fluphenazine (Prolixin[®], a piperazine phenothiazine), thiothixene (Navane[®], a thioxanthene) and molindone (Moban[®], a dihydroindolone). Neurological side effects are prominent features of therapy and some knowledge of them is essential.

a. Akathisia:

Akathisia refers to a pattern of restless motor activity. Patients complain of a lack of ability to tolerate inactivity along with internal discomfort, a drive or urge to move or an inability to sit, stand or lie still. Akathisia usually does not begin within the first forty-eight hours of neuroleptic treatment, but when given to normals it may begin much sooner. The incidence of akathisia may increase over the course of drug treatment up to three months from the start of administration, and the overall incidence rate is considered to be about twenty percent.³²

b. Acute dyskinesia:

Sometimes called dystonia, this side effect usually occurs immediately after the start of treatment and consists of intermittent or sustained muscular spasms and abnormal postures of the eyes, face, neck and throat.³³ The effects are often painful, and may be frightening and disturbing both to the patient and to those around him.³⁴ These signs are the first to appear, sometimes occurring within

²⁹COOPER, *supra* note 13, at 309.

³⁰*Id.* at 281.

³¹Ögren & Högberg, *supra* note 10, at 141.

³²Daniel Tarsy, *Neuroleptic-Induced Extrapyramidal Reactions: Classification, Description, and Diagnosis*, 6 (Supp. 1) CLINICAL NEUROPHARMACOLOGY S9, S16-S17 (1983).

³³*Id.* at S9.

hours after the first dose, and the incidence rate is about five percent.³⁵ The symptoms can be readily treated by the concomitant administration of an anti-cholinergic agent such as benztropine (Cogentin R).

c. Parkinsonism:

In some instances, the administration of neuroleptics produces the neurological signs of Parkinson's disease, including akinesia (lack of voluntary movement), bradykinesia (slowness of movements), rigidity, tremor and postural abnormalities.³⁶ There may be reduced facial expression and an absence of the normal arm swing. These signs may begin within several days of the onset of drug administration and most cases occur within three months of original treatment.³⁷ The overall incidence rate is reported to fall between ten and fifteen percent.³⁸ In addition, there is some evidence that tolerance occurs to the parkinsonian effect.³⁹ That is, with continued drug administration, the severity of these side effects decreases.

d. Tardive dyskinesia:

When the dyskinetic signs occur late (i.e., tardive, after at least three months) in the course of treatment, the phenomenon is referred to as tardive dyskinesia. The effect is characterized by stereotyped, involuntary movements of the face, tongue and mouth, and sometimes involve movements of the trunk and limbs.⁴⁰ The patient displays tics and facial grimacing which are socially disabling. It is important to note that tardive dyskinesia is drug induced rather than part of the natural progress of schizophrenia. It is estimated that between five and twenty percent of all patients administered neuroleptics for more than one year will show signs of tardive dyskinesia,⁴¹ although some authors report a higher incidence.⁴²

³⁴Paolo Decina et al., *Painful Sensory Symptoms in Neuroleptic-Induced Extrapyramidal Syndromes*, 149 AM. J. PSYCHIATRY 1075 (1992).

³⁵Tarsy, *supra* note 32, at S10.

³⁶*Id.* at S12.

³⁷*Id.* at S13.

³⁸*Id.*

³⁹Tarsy, *supra* note 32, at S15.

⁴⁰Ögren & Högborg, *supra* note 10, at 141; Sheila Taub, *Tardive Dyskinesia: Medical Facts and Legal Fictions*, 30 ST. LOUIS U. L.J. 833 (1986).

⁴¹Hal Morgenstern, *The Impact of Neuroleptic Medication on Tardive Dyskinesia: A Meta-Analysis of Published Studies*, 77 AM. J. PUB. HEALTH 717 (1987); John M. Kane et al., *The Prevalence of Tardive Dyskinesia*, 21 PSYCHOPHARMACOLOGY BULL. 136 (1985); Tarsy, *supra* note 32, at S21.

⁴²Taub, *supra* note 40, at 836.

There are certain risk factors which predict tardive dyskinesia and, therefore, may be helpful in its prevention.⁴³ As noted above, the longer the duration of neuroleptic administration, the greater is the chance of tardive dyskinesia.⁴⁴ Similarly, the higher the relative dose of the neuroleptic, the greater is the incidence of tardive dyskinesia.⁴⁵ The very young and the very old are at a disproportionately higher risk for tardive dyskinesia than are those in between.⁴⁶ Females develop it more often than males, but males develop it more severely.⁴⁷ The administration of anti-parkinson drugs along with neuroleptics increases the risk of tardive dyskinesia.⁴⁸ Perhaps the most predictive risk factor, however, is the incidence of acute extrapyramidal symptoms.⁴⁹ Hence, the physician should be wary of continuing the neuroleptic treatment in patients that display acute extrapyramidal signs. She can either lower the dose or switch to a different antipsychotic drug.

2. Cardiovascular Side Effects

The most prominent cardiovascular side effect of antipsychotics is postural or orthostatic hypotension, a form of low blood pressure that occurs when the patient stands.⁵⁰ This side effect occurs quite often following initial treatment with the drug. Tolerance develops to this effect, so that after several weeks blood pressure returns to normal.⁵¹

A potentially fatal, but rare, side effect of antipsychotics is the neuroleptic malignant syndrome. This effect is characterized by hyperthermia, rigidity and respiratory distress.⁵² This syndrome can occur anytime during drug treatment, but generally occurs within two weeks of the initial administration when the patient may be "loaded up" with high doses resulting in cardiac dysfunction.⁵³ At the first indication of this syndrome, immediate cessation of neuroleptic treatment is required and supportive care is essential.

⁴³Richard L. Borison, Lecture presented at the Georgia Mental Health Institute (Oct. 28, 1981).

⁴⁴*Id.*

⁴⁵*Id.*

⁴⁶*Id.*

⁴⁷Lecture from Richard L. Borison, *supra* note 43.

⁴⁸*Id.*

⁴⁹*Id.*

⁵⁰Simpson, *supra* note 28, at 138.

⁵¹*Id.*

⁵²Stanley N. Caroff, *The Neuroleptic Malignant Syndrome*, 41 J. CLINICAL PSYCHIATRY 79 (1980); Charles A. Kaufmann & Richard J. Wyatt, *Neuroleptic Malignant Syndrome*, in PSYCHOPHARMACOLOGY: THE THIRD GENERATION OF PROGRESS, *supra* note 3, at 1421.

⁵³Kaufman & Wyatt, *supra* note 52, at 1421.

3. Endocrine Side Effects

In addition to blocking dopamine receptor sites in the presumed target areas and in the motor areas, the neuroleptics block dopamine in the hypothalamus and pituitary. This produces endocrine changes, the most prominent of which is an increased secretion of the hormone prolactin.⁵⁴ The administration of the neuroleptics and the consequent prolactin surge have been demonstrated to produce breast enlargement and galactorrhea (a continued discharge of milk from the breasts) in both male and female patients.⁵⁵ The results can be extremely disconcerting and embarrassing to the patient, regardless of his or her mental condition.

C. Patient Compliance

When a diagnosis is made and a prescription order is written, it is assumed that the patient will take her medicine as directed. Empirical evidence suggests that a significant proportion of non-institutionalized, voluntary patients do not fully comply.⁵⁶ This also appears to be an issue for psychiatric inpatients.⁵⁷ In order to derive therapeutic value, the patient must take the correct dose at the proper time and continue the regimen as directed without taking unprescribed medicines which may produce adverse drug interaction effects. A further complication arises in institutions where patients or inmates have been found to obtain a neuroleptic illicitly, mistaking it for another drug such as diazepam (Valium[®]).⁵⁸ Ingestion of the neuroleptic may produce the side effects described above and require medical intervention.⁵⁹ These are important issues which must also be considered by institutional authorities (and courts) when making treatment decisions.

III. THE LAW AND ANTIPSYCHOTIC DRUGS

The description of the antipsychotic drugs reveals a marked ability to restore normal behavior as well as a tendency to produce serious side effects. Unfortunately, those who would potentially benefit from them may not be competent to give informed consent to their administration and may not appreciate the risks and discomfort associated with neuroleptic

⁵⁴Robert T. Rubin, *Prolactin and Schizophrenia*, in *PSYCHOPHARMACOLOGY: THE THIRD GENERATION OF PROGRESS*, *supra* note 3, at 803.

⁵⁵Baldessarini, *supra* note 4, at 392.

⁵⁶Leslie Z. Benet, *Principles of Prescription Order Writing and Patient Compliance Instructions*, in *THE PHARMACOLOGICAL BASIS OF THERAPEUTICS*, *supra* note 4, at 1640.

⁵⁷E.H. Hare & D.R.C. Willcox, *Do Psychiatric Inpatients Take Their Pills?*, 113 *BRIT. J. PSYCHIATRY* 1435 (1967).

⁵⁸*Id.*

⁵⁹William W. Weddington, Jr. & Bennett L. Leventhal, *Malicious Use of Haloperidol*, 43 *J. CLINICAL PSYCHIATRY* 434 (1982).

administration. In determining society's right and duty to administer neuroleptics, three populations of patients can be identified: those patients that have been civilly committed to a psychiatric institution, those convicted of a crime and serving prison terms, and pretrial detainees. The issues are somewhat different for each population and, therefore, they will be discussed separately. For each population the issues involved, the current status based on case law, and proposed guidelines will be addressed.

A. The Involuntary Administration of Antipsychotic Drugs to Civilly Committed Patients

The right of incompetent civilly committed patients to refuse medication has been dealt with at the state and federal court levels, but has not yet been ruled on by the United States Supreme Court. While there is a trend for increased judicial review when the patient refuses medication, in practice the patient usually receives medication.⁶⁰ In an early and complex class action suit, *Rogers v. Okin*,⁶¹ a federal district court in Massachusetts found that the Fourteenth Amendment Due Process Clause was a basis for an incompetent patient's right to refuse medication (Thorazine, Mellaril, Prolixin and Haldol) in non-emergency situations.⁶² The plaintiffs also raised a First Amendment right to privacy issue. They argued that antipsychotic administration produced a form of "mind control" that amounted to an unsanctioned intrusion upon the individual's psychological integrity.⁶³ The defendants argued that once admitted, patients were *per se* incompetent to make medication decisions and, therefore, the best clinical judgment of the professional staff was the proper standard for determining appropriate therapy.⁶⁴ The district court disagreed, as did the Court of Appeals for the First Circuit.⁶⁵ Unless adjudicated to be incompetent, patients could not be forcibly medicated, and even if found incompetent patients could not be forcibly medicated absent an emergency, as defined by the prevention of either imminent physical harm or further deterioration in the patient's mental state.⁶⁶

The *Rogers* decision was controversial.⁶⁷ Some hailed it as a victory for patients' rights and as a judicial guarantee of their proper treatment. In

⁶⁰Paul S. Appelbaum, *The Right to Refuse Treatment with Antipsychotic Medications: Retrospect and Prospect*, 145 AM. J. PSYCHIATRY 413 (1988).

⁶¹478 F. Supp. 1342 (D. Mass. 1979).

⁶²*Id.* at 1360.

⁶³*Id.* at 1366-67.

⁶⁴*Id.* at 1360-67.

⁶⁵*Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980).

⁶⁶478 F. Supp. at 1361-62.

contrast, the psychiatric community predicted the collapse of the public mental health system.⁶⁸ Both sides, however, exaggerated the consequences of *Rogers*, and some good has resulted from this decision. It has recently been reported, for example, that the court-ordered administration of antipsychotics can be useful as a device to help assure that outpatients will comply with their medication regimen.⁶⁹ This compliance means that patients remain functional outside the hospital, saving scarce Massachusetts resources and preventing a serious side effect of psychosis itself, namely removal from community life.

In contrast to the *Rogers* decision in Massachusetts, the Court of Appeals for the Third Circuit in *Rennie v. Klein*⁷⁰ held that antipsychotic medication could be administered to an involuntarily committed patient in New Jersey without his consent when necessary to prevent the patient from harming himself or others. The court abandoned its earlier "least intrusive means" standard for permitting antipsychotic treatment, and instead held that the standard for determining whether or not to administer neuroleptics was the exercise of professional judgment of the medical staff.⁷¹ That is, if in the expert opinion of the psychiatrist it was best for the patient and the institution, then the patient could be forced to take antipsychotic drugs. The obvious problem with this decision is that no effective counterbalance existed against the biases of "professional judgment" and hence this deference could be misused, an issue later raised in *Jarvis v. Levine*.⁷²

In *Jarvis*, a psychiatrist's request for involuntary treatment was denied by the institution's Treatment Review Panel.⁷³ Nonetheless, the patient was administered the neuroleptic when the panel's decision was overruled by the medical director. The constitutional issue of due process was apparent in *Jarvis*, as was the patient's right to privacy.⁷⁴ The Minnesota Supreme Court ruled that before neuroleptic medication (Navane, Prolixin and Serentil) could be forced on an involuntary but competent patient in a non-emergency situation, a judicial review procedure had to approve it.⁷⁵

⁶⁷Paul S. Appelbaum & Thomas G. Gutheil, *The Boston State Hospital Case: "Involuntary Mind Control," the Constitution, and the "Right to Rot"*, 137 AM. J. PSYCHIATRY 720 (1980).

⁶⁸Appelbaum, *supra* note 60, at 413.

⁶⁹Marilyn J. Schmidt & Jeffrey L. Geller, *Involuntary Administration of Medication in the Community: The Judicial Opportunity*, 17 BULL. AM. ACAD. PSYCHIATRY & L. 283 (1989).

⁷⁰720 F.2d 266, 269 (3d Cir. 1983).

⁷¹*Id.* at 268-69.

⁷²418 N.W.2d 139 (Minn. 1988).

⁷³*Id.* at 141-43.

⁷⁴*Id.* at 147-49.

⁷⁵*Id.* at 150.

There may be a conflict between the institution's professional review apparatus and an adversarial judicial review that wishes to preserve a patient's right to refuse. Empirical evidence has shown that while agreement can be reached between these two bodies, imposing both layers of review significantly increased time to treatment, increased costs of treatment, and diverted the limited time of physicians from patient care to judicial review.⁷⁶ In fact, the judicial review process was seen by the psychiatric staff as a hindrance rather than a help in patient treatment because of the increased time and costs.⁷⁷ As is often the case, however, patients in public health facilities are largely from the lower socioeconomic class and unless there is a strong advocate system protecting their welfare, the institution's agenda may take precedence over the patient's best interests.

For example, the United States Public Health Service has recently been accused of pursuing its own interests, at the expense of patient welfare, in its long-running study (1932-1972) of syphilis among poor black men in rural Alabama.⁷⁸ In the now infamous Tuskegee Study, physicians working on the federal project observed but did not treat syphilis patients, even though penicillin was available as early as 1941 and its administration might have saved the lives of some of the study's participants. Those in charge of the project made the decision not to inform the patients about the new therapy and not to treat them with an effective drug.

In *People in the Interest of Medina*,⁷⁹ the Colorado Court of Appeals also required a judicial hearing before antipsychotics (Thorazine and Prolixin) could be administered in a non-emergency situation.⁸⁰ The court established criteria for determining when the judiciary should permit involuntary administration of neuroleptics. These criteria included (1) the patient's incompetence; (2) the danger he posed to himself and others; (3) the availability of less intrusive alternatives; (4) the probable outcome with and without the drug; (5) the effect on the operation of the mental institution; and (6) the patient's need for the drug.⁸¹ Commentators have noted, however, that these

⁷⁶Michael C. Farnsworth, *The Impact of Judicial Review of Patients' Refusal to Accept Antipsychotic Medications at the Minnesota Security Hospital*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 33 (1991).

⁷⁷*Id.*

⁷⁸Jim Auchmuty, *Ghosts of Tuskegee: The Government is Still Living Down Its Infamous Study of Untreated Syphilis in Alabama, But to Doctors Who Took Part, There's Nothing to Apologize For*, ATLANTA JOURNAL/ATLANTA CONSTITUTION, Sept. 6, 1992, at M1. Dr. Louis Sullivan, Secretary of U.S. Department of Health and Human Services, referred to the Tuskegee study as "an outrage." Physicians at the Centers for Disease Control (CDC) worry that the legacy of Tuskegee is hampering its efforts to control AIDS, particularly among blacks.

⁷⁹662 P.2d 184 (Colo.App. 1982).

⁸⁰*Id.* at 187.

⁸¹*Id.* at 187-88.

criteria differ little from those used by the institution's professional staff and, instead, remove the decision-making process one step away from those who are closest and best qualified to decide.⁸²

In *State ex rel. Jones v. Gerhardstein*,⁸³ the Wisconsin Supreme Court also held that involuntarily hospitalized patients have a right to refuse neuroleptic (Mellaril, Haldol and Prolixin) medication when there has been no judicial determination of their incompetence.⁸⁴ It is of interest that the plaintiff patients here were a nurse⁸⁵ and a psychiatrist.⁸⁶ Both were apparently familiar with the drugs and both refused this treatment. The court was sensitive to abuses in the system in which a patient's right to refuse medication could be ignored⁸⁷ and wanted to permit forced medication only when the patient was found incompetent.

Again, available data do not support this judicial fear.⁸⁸ During a six-month study of involuntarily committed patients in Wisconsin, twenty-nine percent of the patients on neuroleptics refused to continue treatment following the *Jones* decision.⁸⁹ Of those who refused, thirty-two percent resumed taking their medication voluntarily, and courts overturned the refusals of the remaining fifty-one percent who maintained their objections to further treatment.⁹⁰ While patients may have felt some control over their condition, this came at the expense of valuable clinical and judicial time. The authors further noted that patients who did refuse were no more willing to take their medication after going to court.⁹¹

In California involuntarily hospitalized patients must also be found judicially incompetent to refuse treatment before they can be given neuroleptics (Mellaril, Navane, Moban, Serentil) against their will when no emergency exists.⁹² The *Riese* court wanted to be sure that the issue of competence was determined judicially and not by the hospital administration. The judicial determination of competence was based on such criteria as

⁸²Jeffrey L. Metzner, *The Right to Refuse Treatment in Colorado: People v. Medina*, 10 NEWSL.: AM. ACAD. PSYCHIATRY & L. 17 (1985).

⁸³416 N.W.2d 883 (Wis. 1987).

⁸⁴*Id.* at 896.

⁸⁵*Id.* at 891.

⁸⁶*Id.* at 889.

⁸⁷416 N.W.2d at 890-91.

⁸⁸Robert D. Miller et al., *The Impact of the Right to Refuse Treatment in a Forensic Patient Population: Six-Month Review*, 17 BULL. AM. ACAD. PSYCHIATRY & L. 107 (1989).

⁸⁹*Id.*

⁹⁰*Id.*

⁹¹*Id.* at 118.

⁹²*Riese v. St. Mary's Hosp. & Medical Ctr.*, 243 Cal. App. 3d 241 (Cal.App. 1 Dist. 1987).

whether the patient was aware of his situation, whether the patient understood the benefits and risks of the intervention, and whether the patient was able to understand and knowingly and intelligently to evaluate the information required for her informed consent.⁹³ If competent, the patient could refuse the drugs.⁹⁴

Such hearings may not provide any additional protection. In a recent study of California involuntary patients, only seven percent refused neuroleptic administration and only one percent were judged competent to refuse medication.⁹⁵ Furthermore, judicial hearings sometimes produce their own problems, such as allowing the court to make decisions about the type of treatment. This should not happen. One way to avoid this would be to appoint a conservator with power to decide medication issues during the pendency of any judicial hearing to determine competence.

Levin and her colleagues⁹⁶ compared the status of patients who successfully refused medication with the status of those who did not. These investigators found that the refusers functioned poorly in the ward, tended to be disruptive of the hospital environment and stayed twice as long in the hospital, even though the refusing patients received the medication as a judicial requirement. These findings suggest that it is better for the patient and the institution if compliance can be obtained voluntarily rather than by judicial decree.

Following the *Rivers v. Katz*⁹⁷ decision in New York, there was a marked change in dealing with patients who refused antipsychotic medication (Mellaril, Navane, Prolixin). Prior to *Rivers*, involuntarily hospitalized patients who refused medication could appeal to a clinical administrative review board. If this review panel agreed with the patient's psychiatrist, medication could be administered over the patient's objection.⁹⁸ The *Rivers* court, however, rejected the "presumption of incompetence" for involuntarily admitted patients.⁹⁹ After *Rivers*, the clinical review process was the first step to appeal, followed by a judicial review of the patient's competence. If the patient was found incompetent, based on clear and convincing evidence, the judge could make a substitute treatment decision, prescribing antipsychotic drugs if she determined that their utility outweighed the risks.¹⁰⁰ Fewer patients refused

⁹³*Id.* at 253-54.

⁹⁴*Id.* at 254.

⁹⁵Renée L. Binder & Dale E. McNiel, *Involuntary Patients' Right to Refuse Medication: Impact of the Riese Decision on a California Inpatient Unit*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 351 (1991).

⁹⁶Shelley Levin et al., *A Controlled Comparison of Involuntarily Hospitalized Medication Refusers and Acceptors*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 161 (1991).

⁹⁷495 N.E.2d 337 (N.Y. 1986).

⁹⁸*Id.* at 339-40.

⁹⁹*Id.* at 341-42.

¹⁰⁰*Id.* at 343-44.

medication after the *Rivers* decision, but for those who did, the review process was lengthy and the patients were not better served by the added expense and time.¹⁰¹

When a patient is incompetent to consent to hospitalization itself, but is nonetheless hospitalized without an involuntary placement hearing, he may sue for a violation of his due process rights under 42 U.S.C. Sec. 1983,¹⁰² as occurred in *Zinerman v. Burch*,¹⁰³ unless he is considered dangerous. Such emphasis on informed consent, however, may deprive many potential psychiatric patients of the very treatment they need. The due process argument was recently raised in *Williams v. Wilzack*.¹⁰⁴ The Maryland Court of Appeals reviewed the procedural protections which must be applied to patients, such as Williams, who face forced medication (Mellaril).¹⁰⁵ Involuntarily admitted patients were not presumed to be incompetent to refuse medication. Before the medication was administered, the court wanted to allow the patient or his representative to be given sufficient notice and the right to present their case at a hearing.¹⁰⁶ The court implied that, absent an emergency, it might allow the professional judgment approach to prevail when medication is an issue, provided the patient's right to be heard is not violated.¹⁰⁷

The fundamental issue revolves around establishing a balance between the medical-scientific duty to treat and the judicial duty to safeguard the individual rights of patients. Constitutional issues of the First (privacy, freedom of thought and speech), Eighth (cruel and unusual punishment), Fifth and Fourteenth (due process) Amendments have been raised to limit or control the involuntary use of antipsychotics.¹⁰⁸ These issues are important and deserve further comment.

¹⁰¹J. Richard Ciccone et al., *Right to Refuse Treatment: Impact of Rivers v. Katz*, 18 BULL. AM. ACAD. PSYCHIATRY & L. 203 (1990).

¹⁰²42 U.S.C. § 1983 (1994), part of the Civil Rights Act, provides in relevant part:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

¹⁰³494 U.S. 113 (1990).

¹⁰⁴573 A.2d 809 (1990).

¹⁰⁵*Id.* at 809-12.

¹⁰⁶*Id.* at 820-21.

¹⁰⁷*Id.*

¹⁰⁸Amicus Brief, *Okin v. Rogers* (No. 77-1201), cited in 2 MENTAL DISABILITY L. REP. 43 (1977).

The history of the neuroleptics reveals that the drugs have helped reduce the resident population in mental institutions since 1952.¹⁰⁹ Former inpatients are able to live with their families or in less-restrictive halfway houses.¹¹⁰ These changes in patient populations argue against the issues concerning both invasion of privacy and bodily integrity, and cruel and unusual punishment. For inpatients and outpatients, the antipsychotics increase rather than decrease freedom of speech and thought. They do not produce mind control, nor are they a form of chemical brainwashing. Rather, the drugs normalize incoherent thought, improve attention, reduce inappropriate behavior, and allow the patient to communicate with others in an intelligible manner.¹¹¹ Often the administration of neuroleptics is the least intrusive means of shortening a hospital stay and returning the patient to a community setting, as well as of alleviating the psychological pain of racing thoughts and distressing hallucinations.¹¹²

Due process may be an issue in some circumstances. If the patient, family member or another professional disagrees with the prescribing physician about the appropriateness of drug treatment, a review mechanism should be available prior to drug treatment or when continued treatment is at issue. To ensure due process, the patient, her guardian, attorney and other interested parties must be given sufficient notice of the time and place of the hearing as well as of the issues to be decided. The form of review procedure will depend upon whether the patient has been admitted voluntarily or involuntarily, and whether the patient is competent. Competence itself is an elusive term whose meaning depends upon a specific fact situation. As used in the present context, competence means that the patient understands and appreciates the information provided and that she realizes the information applies to her condition.¹¹³ The patient should be able to process the information and reach conclusions that logically follow from the information offered. If voluntary and competent, the patient has a right to refuse medication. If the patient is incompetent, a legal guardian or conservator may make the decision, unless there is an emergency, in which case the professional judgment of the staff should prevail. When admitted involuntarily but competent, the patient should be allowed to refuse treatment unless there is an emergency or she is

¹⁰⁹SAMUEL BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* 46 (3d ed. 1985).

¹¹⁰Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, 42 U.S.C. § 2689 (1963).

¹¹¹David J. King, *The Effect of Neuroleptics on Cognitive and Psychomotor Function*, 157 BRIT. J. PSYCHIATRY 799 (1990).

¹¹²Paul S. Appelbaum & Thomas G. Gutheil, "Rotting With Their Rights On": *Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients*, 7 BULL. AM. ACAD. PSYCHIATRY & L., 306, 312 (1979).

¹¹³Greg Smith, *Depression and Competence to Refuse Medical Treatment*, ETHICS CENTER NEWS (Emory Univ./Center for Ethics in Pub. Policy & Professions, Atlanta, Ga.), Sept. 1992, at 6.

considered dangerous. Finally, for the involuntarily admitted patient who is found incompetent, treatment decisions should be determined by the professional staff. If agreement cannot be reached after in-house review, a judicial hearing could be invoked to determine issues of competence and drug administration.

Many issues are now dealt with statutorily. For example, in Georgia, the spirit and the letter of the law demand respect for the patient as well as his access to the most appropriate treatment, and if necessary, a judicial hearing.¹¹⁴ However, according to its Medical Director, at least at his institution the threshold test for administering antipsychotics in an emergency is the dangerousness standard.¹¹⁵ The institution takes the view that it does not have a right to withhold medication when the patient presents a danger to himself or to others. To prevent medical staff bias when the patient refuses medication, a second physician must concur with the opinion of the first psychiatrist, and the patient has a right to a court hearing on the issues. Furthermore, published "Rules and Regulations for Patients' Rights" ensure that the patient is fully informed about the medication, including its side effects, and emphasize that the drugs are not used as punishment or for the convenience of the staff. In addition, time limits are set. In an emergency, an admitting physician can prescribe the drug for seventy-two hours. If such an emergency exists after seventy-two hours, a second physician must concur with the admitting physician and the two physicians' determination will remain valid for thirty days.¹¹⁶

While side effects of antipsychotic medication cannot be ignored, the ratio of benefits to risks must be emphasized. It is for this reason that informed consent is obtained whenever possible. However, it is sometimes forgotten that all drugs have side effects,¹¹⁷ and the voluntary patient is free to accept or refuse treatment. While constitutional issues are raised concerning neuroleptic treatment, the same could be done, for example, for cancer. The discovery of a foreign mass generally results in emergency surgery, with its attending risks. This is followed by a course of chemotherapy which produces severe nausea, weight loss or gain, and extreme weakness. The chemotherapy is often followed by radiation therapy with its additional side effects that can be painful and disfiguring. Yet issues about the humaneness of treatment and bodily integrity are seldom raised in this regard. The benefits are said to far outweigh the risks.

This approach is equally valid for the use of antipsychotics in incompetent patients. The release from impaired thinking and hallucinations, and the ability

¹¹⁴GA. CODE ANN. §§ 37-3-162, 37-3-163 (1988).

¹¹⁵Interview with John Gustin, M.D., Medical Director of the Georgia Mental Health Institute (Sept. 18, 1992).

¹¹⁶*Id.*

¹¹⁷Alan S. Nies, *Principles of Therapeutics*, in THE PHARMACOLOGICAL BASIS OF THERAPEUTICS, *supra* note 4, at 62.

to return to society are often worth the risks of drug administration. Withholding of the drug may mean that the patient becomes locked into his own world and locked out of the community, including his family.¹¹⁸ The argument has been considered that the patient should have the right to refuse neuroleptic administration.¹¹⁹ However, commentators have noted that by exercising the right to refuse treatment, the patient may be forfeiting his right to eventual freedom from the illness and hospitalization, and the very waiver of this right might be an incompetent one.¹²⁰

Probably the most notorious side effect of the neuroleptics is tardive dyskinesia, a syndrome which has resulted in much malpractice litigation.¹²¹ Causes of action in tardive dyskinesia cases are grounded either in negligence for failure to follow the proper standard of care in the diagnosis and treatment of the behavioral disorder, or in failure to obtain informed consent.¹²² The risk of tardive dyskinesia is real, but its prevalence is often over-rated. For example, Bursztajn and his colleagues¹²³ presented a hypothetical case involving a potentially psychotic patient that might require antipsychotic medication to a group of psychiatrists and a group of judges. Both groups were asked the degree of risks they would accept in order to obtain clinical benefits and also the percentage of patients they expected to develop tardive dyskinesia.¹²⁴ Either group was willing to accept a fifty percent rate of tardive dyskinesia in order to obtain the antipsychotic response.¹²⁵ However, the psychiatrists predicted that twenty-five percent of the patients would actually develop tardive dyskinesia, while the judges predicted that sixty-two percent would develop this syndrome.¹²⁶ These different perceptions suggest that psychiatrists would be more willing to use neuroleptics than would judges, who would probably forgo treatment. Indeed, the judges might well consider psychiatrists who administer the drugs as behaving recklessly.

As described above, tardive dyskinesia can occur when antipsychotics are administered on a long-term basis and there is insufficient follow-up to monitor the slow onset of the symptoms. Both to protect her patient and to prevent a

¹¹⁸Appelbaum & Gutheil, *supra* note 112, at 306.

¹¹⁹*Id.* at 308.

¹²⁰Appelbaum & Gutheil, *supra* note 67, at 722.

¹²¹Harold Bursztajn et al., *Medical and Judicial Perceptions of the Risks Associated with Use of Antipsychotic Medication*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 271 (1991); Robert M. Wettstein & Paul S. Appelbaum, *Legal Liability for Tardive Dyskinesia*, 35 HOSP. & COMMUNITY PSYCHIATRY 992 (1984); Taub, *supra* note 40, at 833.

¹²²*Clites v. State*, 322 N.W.2d 917 (Iowa App. 1982); Wettstein & Appelbaum, *supra* note 121, at 993.

¹²³Bursztajn, *supra* note 121, at 271.

¹²⁴*Id.* at 271-72.

¹²⁵*Id.* at 272-73.

¹²⁶*Id.*

negligence action, the psychiatrist must provide for regular check-ups and consultation with other specialists, particularly neurologists.¹²⁷ Lowering the maintenance dose or switching to a different neuroleptic should be considered when early signs of tardive dyskinesia appear. In addition, temporary interruptions of drug therapy (drug holidays) are often used to monitor the patient's progress while not under the effects of the neuroleptic.

For long-term maintenance, the psychiatrist should now consider administering clozapine because of its negligible risks of tardive dyskinesia.¹²⁸ However, patients on clozapine require careful hematologic monitoring, because it is associated with a one to two percent risk of agranulocytosis (a potentially fatal disease of the blood in which a marked drop in white blood cells occurs).¹²⁹ Clozapine is also very expensive (in 1992 \$4,160 per year for the drug alone),¹³⁰ precluding its use in many public mental health facilities. Regardless of whether the psychiatrist administers a traditional neuroleptic or an "atypical" compound such as clozapine, the patient must be monitored on a regular basis. In addition, updating the informed consent, particularly when switching to new medication, affords good protection should a malpractice action subsequently arise.

In sum, the patient's right to treatment or his refusal must be given respect by way of procedural due process at both the institutional level and, if necessary, at the judicial level. Once the decision to medicate with antipsychotics is affirmed, the psychiatrist must provide non-negligent care in selecting and monitoring the drug therapy and obtaining informed consent from the patient, his family or legal guardian. Although risks of medication will remain, they can be minimized and the benefits to the patient realized.

B. The Involuntary Administration of Antipsychotic Drugs to Criminally Committed Patients

When the issue of antipsychotic drug administration arises in a prison environment, a different analysis may be required. A criminal conviction and sentencing *per se* amount to involuntary institutionalization. Requiring the inmate to take neuroleptics is based on a determination of mental illness and competence as well as a determination that drug treatment furthers a compelling state interest, namely maintaining prisoners in a secure environment. Unlike cases of neuroleptic administration in civil commitment, the criminal side has been reviewed by the United States Supreme Court.

¹²⁷John E. Kalachnik et al., *A Tardive Dyskinesia Monitoring Policy for Applied Facilities*, 19 PSYCHOPHARMACOLOGY BULL. 277 (1983).

¹²⁸Stephen R. Marder & Theodore Van Putten, *Who Should Receive Clozapine?*, 45 ARCHIVES GEN. PSYCHIATRY 865 (1988).

¹²⁹*Id.*

¹³⁰Claudia Wallis & James Willwerth, *Awakenings; Schizophrenia; A New Drug Brings Patients Back to Life*, TIME, July 6, 1992, at 52, 54.

The leading case of forced administration of neuroleptics in a prison setting is *Washington v. Harper*.¹³¹ In *Washington*, the Court had to decide whether Washington State Penitentiary could treat a mentally ill person with neuroleptics (Prolixin) against his will. While recognizing that the inmate had a liberty interest based on the Fourteenth Amendment Due Process grounds, the Court was required to determine both what substantive and what procedural due process safeguards were necessary before antipsychotics could be forcibly administered.

To decide the substantive due process issue, the Court found it necessary to scrutinize the circumstances when neuroleptics were appropriately administered in spite of an inmate's liberty interest in not being forcibly medicated.¹³² If an inmate was found to have a serious mental illness, was dangerous to himself or to others, and if the administration of neuroleptics was a reasonable way to ensure prison safety and security, the State could require the administration of antipsychotic drugs.¹³³

On the procedural due process side, the Court held that a judicial hearing is not necessary for involuntary neuroleptic administration. Rather, an in-house committee procedure is sufficient due process if the inmate is given notice of the hearing and of the tentative diagnosis, has a right to be represented by a disinterested state employee as a lay advisor, and is allowed to present evidence.¹³⁴ The inmate was allowed to appeal the decision to the superintendent of the institution and to secure a timely (twenty-four hours) decision. Furthermore, the treatment was allowed to continue only with periodic review.¹³⁵ Thus, the pivotal issue was whether the State could administer antipsychotics without an adversarial, judicial hearing. The Court answered in the affirmative.¹³⁶

Much of the Court's reasoning was based on *Vitek v. Jones*.¹³⁷ In *Vitek*, the Court considered a related due process issue of whether or not a prisoner could be transferred to a state mental hospital without adequate notice, a judicial hearing and presence of counsel. The *Vitek* Court determined that, indeed, a prisoner could not be involuntarily transferred to a psychiatric facility without adequate procedural protections.¹³⁸ The interest of the state in segregating and treating mentally ill prisoners was strong, but even stronger was the right of the inmate not to be classified as mentally ill and segregated in a facility known

¹³¹494 U.S. 210 (1990).

¹³²*Id.* at 221-27.

¹³³*Id.*

¹³⁴*Id.* at 228-36.

¹³⁵494 U.S. at 216.

¹³⁶*Id.* at 211-12.

¹³⁷445 U.S. 480 (1980).

¹³⁸*Id.*

for housing such individuals.¹³⁹ Thus, the Court wanted to err on the side of the inmate's liberty interest, which it considered fundamental.¹⁴⁰

Why did the Court in *Washington* reach its decision? One reason may be that the plaintiff in *Washington* was already in a psychiatric facility. It can be argued that a greater liberty interest exists in not being sent to a psychiatric facility than in not being medicated once there. In *Vitek*, the prisoner's concern was being labelled a psychiatric patient through his admission to a medical facility. That issue was moot in *Washington* since the inmate was already a patient in a psychiatric ward. Rather, the purpose of drug treatment in *Washington* was to restore an inmate to a level of functioning where he could be returned to a normal prison environment.

The dissent in *Washington* presented a parade of horrors about the uses and effects of the neuroleptics, and then argued that Harper had a fundamental liberty interest in remaining unmedicated. The dissenters also rebuked the majority for not considering less intrusive methods of treating the patient.¹⁴¹ In distinguishing between the short-term (medical emergency) and long-term (rehabilitation) condition, the dissent correctly raised the concern about allowing prisoners to remain on these drugs without proper monitoring over long periods of time.¹⁴² The issue of long-term administration of neuroleptics is the same whether in a civil commitment or in a prison setting. The decision to continue medication should focus on whether it is in the best interest of the individual, but since the individual may do harm to others as well as to himself, it may also involve the best interest of the institution. Such interests are separate and probably in conflict. Furthermore, the dissenters implied that an in-house psychiatrist would be biased toward the interest of the State rather than the individual patient, and that the ethical principles of the physicians would receive short shrift.¹⁴³

The majority might have based its argument on the Eighth Amendment prohibition against cruel and unusual punishment. The Eighth Amendment, however, has also been interpreted as to place an affirmative duty upon prison officials to provide inmates with medical care and protection from harm. These rights have been articulated in *Estelle v. Gamble*¹⁴⁴ and are two-pronged. Prison officials are guilty of cruel and unusual punishment if they show indifference to inmates' medical needs, and these medical needs are serious.¹⁴⁵ When an inmate has been diagnosed as seriously ill, the prison officials have an affirma-

¹³⁹*Id.* at 495.

¹⁴⁰*Id.*

¹⁴¹494 U.S. at 255.

¹⁴²*Id.* at 251-52.

¹⁴³*Id.* at 253.

¹⁴⁴429 U.S. 97 (1976).

¹⁴⁵*Id.* at 104-05.

tive duty to treat.¹⁴⁶ In addition, prison officials must be given deference in maintaining security in an environment where the potential for violence is always present. With the limited resources available, prison officials must make decisions about prison security and the safety of staff and inmates. Allowing courts to second-guess the judgment of hospital staff would, in effect, mandate that the courts become involved in the day-to-day decisions of each institution. Courts will not engage in such conduct. Prison officials must have broad discretion in making decisions about the good order and security of their institutions.¹⁴⁷ Furthermore, an inmate loses some of his liberty interests by virtue of his conviction; he can not expect to live in an environment that is free of all tribulation following his conviction.¹⁴⁸

The issue of involuntary administration of antipsychotics is best left to the professional staff. As noted in *Glick v. Henderson*:¹⁴⁹ "[i]t is the rare case in which a court should venture forth to establish medical procedures and guidelines in an area where the medical profession has not yet been able to ascertain what they should be." Although the *Glick* court dealt with the controversial issue of AIDS testing in prisons, the argument also applies to the administration of antipsychotics to prison inmates.

While prison inmates do not lose all constitutional rights, their liberty interests are not as broad and unrestricted as those of non-inmates. Prison officials face difficult decisions in attempting to maintain order and security within the prison as well as in providing for the medical needs of inmates. Sometimes these needs conflict and the professional staff of the institution must be given deference to make choices that affect the rights and safety of all patients. Except in rare instances, requiring a judicial hearing to review the medical decisions amounts to adding a layer of bureaucracy. More of the already scarce prison resources are thereby allocated to reviewing medical decisions. Furthermore, the empirical evidence suggests that the courts usually concur with the professional prison staff.¹⁵⁰

Although the Supreme Court in *Washington* limited its ruling to a prison setting, one can speculate about how the Court would decide in the case of a civil commitment. Based upon its holdings, it appears that when a patient had a serious mental disease, was dangerous to himself or others, and treatment was in the patient's best medical interest, then civil authorities would be permitted to forcibly administer neuroleptics. Furthermore, the decision to medicate would best be made by professional psychiatric judgment without the intervention of a judicial decision maker. The *Washington* Court assumed that physicians in a prison setting prescribe drugs only to meet the medical

¹⁴⁶*Id.* at 103.

¹⁴⁷*O'Lone v. Estate of Shabazz*, 482 U.S. 342 (1987); *Turner v. Safley*, 482 U.S. 78 (1987).

¹⁴⁸*Atiyeh v. Capps*, 449 U.S. 1312, 1315-16 (1981).

¹⁴⁹855 F.2d 536, 541 (8th Cir. 1988).

¹⁵⁰*Miller, supra* note 88, at 107.

needs of their patients and that this conduct is grounded in their professional ethics. Presumably, physicians in a civil setting would behave similarly.

C. The Involuntary Administration of Antipsychotic Drugs to Pretrial Detainees

The final category of institutionalized patients consists of those who have been incarcerated and are awaiting trial, but have not yet been convicted of a current crime. The issue often focuses on the pretrial detainee's right to refuse antipsychotic medication in the context of determining competency to stand trial. What rights to refuse medication do these patients have?

In *United States v. Charters*,¹⁵¹ the Court of Appeals for the Fourth Circuit had to decide whether the government's "duty" to treat pretrial detainees overcame the defendant's liberty and due process interests. The court first determined that a professional judgment standard as articulated in *Youngberg v. Romeo*¹⁵² was insufficient where the patient had strong liberty and due process interests. In contrast, the government claimed that it had a duty to prevent violence in the institution, to produce an individual competent to stand trial, and to protect the inmate's health and well-being.¹⁵³

Of particular concern was the issue of producing trial competence. First, the court realized that there was "no way of knowing" whether Charters would be rendered competent by administering the neuroleptics.¹⁵⁴ Second, the court worried that when administered antipsychotic medication, the defendant might not get a fair trial. The jury could get a "false impression" of the defendant under the influence of the drug and the neurological side-effects might create "important misimpressions about the defendant's mental state."¹⁵⁵ Third, the government's forcible administration of neuroleptics was considered a "draconian invasion" of the individual's freedom and bodily integrity.¹⁵⁶ On rehearing, however, the circuit court decided *en banc* that Charters' interests were adequately protected by exercise of the professional judgment standard in deciding whether to medicate him.¹⁵⁷

The recent Supreme Court decision in *Riggins v. Nevada*¹⁵⁸ stands for the proposition that forcible administration of antipsychotics (Mellaril) during a trial violates the individual's due process rights. In *Riggins*, the defendant was administered a neuroleptic prior to trial. When he requested suspension of the

¹⁵¹1829 F.2d 479 (4th Cir. 1987).

¹⁵²457 U.S. 307 (1982).

¹⁵³829 F.2d at 492.

¹⁵⁴*Id.* at 493.

¹⁵⁵*Id.* at 493-94.

¹⁵⁶*Id.* at 494.

¹⁵⁷*United States v. Charters*, 863 F.2d 302 (4th Cir. 1988).

¹⁵⁸504 U.S. 127 (1992).

drug during trial, his request was denied.¹⁵⁹ He was convicted of murder and sentenced to death. The defendant argued that administering the neuroleptic during trial camouflaged his true mental state thereby limiting his ability to present an insanity defense.¹⁶⁰ The Court overturned his conviction on due process grounds acknowledging that the trial court made no determination of either a medical need for the drug or the existence of a less intrusive alternative.¹⁶¹ The Supreme Court recognized that Riggins' defense may have been impaired under the drug. Thus, the use of Mellaril denied defendant "a full and fair trial."¹⁶²

Justice Kennedy, in a concurring opinion, likened the forcible administration of neuroleptics, which can modify behavior, to manipulating material evidence.¹⁶³ His concern was about medicating an individual for the express purpose of bringing the defendant to trial, rather than of rehabilitating him.¹⁶⁴ Justice Kennedy argued that if the only method of rendering the defendant competent to stand trial was forcible administration of antipsychotics, then the trial court must resort to civil commitment.¹⁶⁵ There is little doubt that the defendant's behavior was observed throughout the trial and that his behavior would have a powerful influence on its outcome. This is particularly the case where, as here, the defendant took the stand, since his credibility and persuasiveness would be assessed. Thus, there was particular concern with how the neurological side effects might produce a negative demeanor on the stand or at the defense table.¹⁶⁶ Furthermore, use of these drugs could interfere with the defendant's ability to interact with counsel if neurological side effects were prominent.

The Court appears to have correctly decided *Riggins*. Although Justice Thomas, in his dissent,¹⁶⁷ denied that the defendant had an unfair trial because of his medication, it appears highly likely that the drugs produced behavioral changes. This, in turn, negatively affected the outcome for the defendant. The dissent focused on whether the defendant might have feigned or exaggerated his psychotic condition while un-medicated. If a psychotic condition is feigned and the defendant is normal then neuroleptics, which severely impair the behavior of normal individuals, should never be administered. An overriding

¹⁵⁹*Id.* at 130.

¹⁶⁰*Id.*

¹⁶¹*Id.* at 127.

¹⁶²504 U.S. at 133.

¹⁶³*Id.* at 139.

¹⁶⁴*Id.* at 140-41.

¹⁶⁵*Id.* at 145.

¹⁶⁶504 U.S. at 142.

¹⁶⁷*Id.* at 146.

concern should be that, to the extent possible, the jury observe the defendant's behavior as it was during the alleged criminal event.

The determination of forcible medication turns on the patient's medical and legal status. Pretrial detainees are involuntary patients. Although charged with a crime, they have not yet been found guilty and, therefore, retain fundamental liberty interests. These patients have a right to develop the best possible case for acquittal at trial, provided it is substantively and procedurally correct. Forcing antipsychotic drug administration is not permissible unless an overriding medical justification exists, and none was present in *Riggins*. This does not deny the State's legitimate interest in bringing an accused to trial. It only requires the State to demonstrate that the medication is necessary to render the accused competent and that the drug would not impair his trial rights. The State, in effect, misused a powerful chemical to increase its chances of getting a conviction. A drug that in the past was used to deinstitutionalize civilly committed patients was used here to provide a candidate for capital punishment.

IV. SUMMARY

The antipsychotic drugs or neuroleptics were serendipitously discovered in the early 1950's as a treatment for schizophrenia. Although not a cure for this complex disease, the neuroleptics have restored normal functioning to countless institutionalized patients. Unfortunately the drugs also possess debilitating side effects, the most serious of which are the neurological symptoms. Because of the nature of schizophrenia, patients are often unable to give informed consent about accepting neuroleptic treatment. When this occurs in a civil commitment, the professional judgment of the medical staff should determine the issue of competence; when the patient is found incompetent, the psychiatrist should also establish the treatment protocol, including the administration of antipsychotics. If an objection to drug administration is raised by either the patient or his representative, the issue should first be dealt with by an in-house treatment review board. Only when no agreement can be reached, should the issue be adjudicated in a court of law.

The issue of competence in a criminal setting should be handled in a manner similar to that of a civil commitment environment. If the professional judgment of the psychiatrist indicates that the patient has a serious mental disease and neuroleptic medication is in his best interest, then medication should be instituted. This should not require judicial review.

A different situation exists for pretrial detainees. Here, the issue is generally one of producing competence to stand trial. The State must demonstrate that neuroleptics are necessary to accomplish this goal without also impairing the accused's trial rights. It is in the sphere of pretrial detainee rights that neuroleptics appear most subject to abuse.

Regardless of the environment, however, it must be remembered that these drugs are intended to restore normal behavior and free the patient from disordered thinking and bizarre conduct. Under no circumstances should they be used as a form of punishment or for the convenience of the institutional staff. In weighing the risks and benefits of the neuroleptic treatment, the physician should be guided by the words of the Hippocratic oath:

I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone.