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Howard Berger

University at Buffalo School of Law (Student)

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Injection or Rejection

The Right to Refuse Psychotropic Drugs

By Howard Berger

In the early 1950's, a group of scientists discovered that tranquilizing compounds such as thiorazine, could be highly effective in controlling psychiatric disorders. The immediate effect of this discovery was the addition of a new weapon to the medical arsenal combatting mental illness. Yet, in the course of the next three decades, as the use of pharmacotherapy increased dramatically, so, too, did suspicion that beneath the track-marked surface lay neglected fundamental liberties and human dignity reeling in a chemically-induced darkness. Law and psychiatry soon found themselves moving inevitably on a collision course.

One of the issues that has helped to draw battle lines is the question of whether civilly committed mental patients have a constitutional right to refuse treatment, and more specifically, the right to refuse psychotropic medication. The clash continues today, and though the trend appears to be toward recognition of such a right, it is by no means the law of the land. The issue pits judicial rationality against clinical reality, and presents two diametrically distinct conceptions of "freedom."

The legal arguments derive, for the most part, from the individual's right to be free from unnecessary and unwarranted governmental intrusions upon one's person, including freedom from any kind of "mind control" via medication. But this argument is at loggerheads with the view of much of the psychiatric profession, who consider this notion "a cruel joke unwittingly perpetrated by clinically untutored persons." To the psychiatrist, those who suffer from mental illness are human beings "whose action and thinking are significantly governed by irrational, seemingly illogical, and inconsistent forces." Such "irrational forces" render meaningless the legal concept of "freedom." Instead, the medical profession argues that the real "freedom" they are attempting to bequeath upon their mentally ill patients is the "freedom from the fetters of unconscious conflicts, self-doubts, unrealistic phobias, incapacitating anger, anxiety, delusions, and hallucinatory experiences" — what they call the "unique and individual prisons rarely discussed in debates on constitutional law in regard to mental health." (Shewd, Protecting the Rights of the Mentally Ill, 64 A.B.A.J. 564 (1978).

Much of one's perspective in this matter seems to depend on how one views the psychiatric profession. Either it is seen as a group of truly dedicated, sensitive individuals with the best interests of their patients always their first priority, or as "hot-so-benign jail keepers" assuming the role of society's agent for social control. Perhaps the truth lies somewhere in between. Clearly, though, some observers do believe that the

question of the right to refuse treatment ultimately reveals a growing lack of credibility in the methodology and practices of the psychiatric profession.

The controversy also reflects some hard thinking about the nature of the risks involved in pharmacotherapy, and about who, in fact, should be bearing them. A treatment program without drugs, for instance, may result in longer institutionalization, creating a greater financial burden upon the state. But what of the risk of permanent disability associated with the administration, over extended periods of time, of drugs such as the major tranquilizers, known to produce the condition referred to as "tardive dyskinesia?" (See below) Who should bear the risk of such treatment — the patient? the psychiatrist? society? These critical questions are only now being addressed, and at present, the answers remain embryonic.

A fundamental concern which pervades any consideration of the right to refuse treatment lies in the definition of 'treatment' itself. A major objective of all recent litigation in this area has been to expose the institutional abuse of the concept of 'treatment' — an abuse which has often enlarged the scope of the term to include punishment and behavior control. The cases, as a whole, have sought to accomplish three things: first, to prohibit the use of intrusive treatment as a means of punishment under any circumstances; second, to prohibit treatment as a means of behavior control except in clearly warranted exigent situations; and third, to establish, in non-emergency circumstances, a constitutional right to refuse treatment for competent as well as incompetent mental patients, the latter's protection safeguarded by concepts closely resembling the doctrine of substituted consent.

The Drugs

Of the six general categories of psychotropic (mind-altering) medications, the most intrusive drugs are considered to be the Major Tranquilizers (also known as antipsychotics or neuroleptics). This group of drugs is the most frequently prescribed for treatment of mental disorder, and produces the most profound neurological reaction when administered. Drugs included in this class are Thorazine, Mellaril, Stelazine, Trilafon, Prolixin, Haldol, and Navane. The major tranquilizers are regularly used in the treatment of schizophrenia and have the effect of significantly influencing chemical signals to the brain. The net result is a dramatic decrease in both mental and physical activity.

The possible side effects caused by this class of drugs fall into two groups: those that are temporary and reversible, and those that are presently considered permanently disabling. Of the

first group, "extrapyramidal" effects are the most common. These are neurological reactions including spasms of the neck, back, face and eye muscles known as dystonia; excessive tension, insomnia and general restlessness called akathisia; and tremors, drooling, shuffling walk and muscle stiffness termed Parkinsonisms. Other side effects can include lowered sex drive, dizziness, incoherency, reduction in white blood cell count, constipation, blurred vision, depression, false positive pregnancy tests, and urinary complications. In addition, grand mal seizures can occur, leading to loss of consciousness. Severe reaction to antipsychotic drug therapy has resulted in the deaths of several patients.

Their complaint centered. . .around defendants' policy of forced medication. . .

The prolonged use of antipsychotic drug treatment can lead to the irreversible condition known as tardive dyskinesia. The symptoms of this condition, caused by damage to the basal ganglia in the brain, include bizarre involuntary motor movements of the tongue, face, lips, fingers, hands, legs, and pelvis. Patients suffering from this chronic condition also face the possibility of developing non-tumorous enlargement of the tongue and ulcerations of the mouth, as well as extreme difficulty in breathing and swallowing, in the disease's most advanced stages.

The incidence of tardive dyskinesia among institutionalized schizophrenics is not limited to a relative few. Conservative estimates suggest that thirty to fifty per cent of all patients treated with antipsychotic drugs over a several year period suffer from the disease. Other studies have put that figure at fifty to sixty per cent. Science has yet to perfect a cure for tardive dyskinesia. However, there is an evolving school of psychiatric thought which believes that the risk of permanent impairment may be significantly lessened where a regimen of strict monitoring of the beneficial and adverse effects of the drugs, plus a systematic dosage reduction is implemented.

The other categories of psychotropic medications include: 1) the Antiparkinsonian drugs (employed to neutralize the profound effects of the major tranquilizers); 2) Lithium Carbonate; 3) the antidepressant drugs (including amphetamines and tricyclics); 4) the minor tranquilizers (anti-anxiety drugs such as Librium and Valium); and 5) sleeping pills. Although the risk of permanent side effects is generally not associated with the administration of the drugs in these groups, a vast array of serious temporary side effects for each class of drugs has been documented.

Two Recent Decisions

Though the Supreme Court has yet to speak in this area, two federal district courts have considered on the merits the question whether there exists a constitutional right to refuse psychotropic medication. Rogers v. Okin, 478 F. Supp. 1342 (D. Mass. 1979), and Rennie v. Klein, 462 F. Supp. 1131 (D.N.J. 1978) represent the first serious attempts to carve out this new constitutional right.

Rogers v. Okin

Rubie Rogers and the five other named plaintiffs in this class action were all at one time either voluntarily or involuntarily committed inpatients at the May and Austin Units of the Boston State Hospital, a Massachusetts institution for the mentally ill. The action was brought pursuant to the Civil Rights Act (42 U.S.C. §1983) alleging, among other things, deprivation of plaintiffs' constitutional rights resulting from defendant institution supervisors' policies of forced medication with powerful drugs. Seeking permanent injunctive relief and money damages, plaintiffs asserted a constitutional right to refuse treatment based on the first, fourth, eighth, and ninth amendments, as guaranteed by the Due Process Clause of the fourteenth amendment.

The plaintiffs in Rogers were not disputing the institution's right to forcibly administer powerful drugs in an emergency. Their complaint centered squarely around defendants' policy of forced medication absent these compelling circumstances. Underlying the complaint, then, was the tacit recognition of the qualified nature of the right being asserted.

Narrowing the scope of its analysis, the Rogers court examined only those claims based on the right of privacy and the first amendment.

The Privacy Right: It was the defendants' contention that plaintiffs' "interest" in refusing psychotropic medication was not a cognizable right fundamental to the concept of ordered liberty, and was, therefore, unprotected. Declaring that "common sense dictate(d) a contrary conclusion," the court rejected this argument. The court could not accept the assertion that while the right to protect or dispose of one's property was considered a fundamental liberty, the right to refuse intrusive medication was not. In its findings of fact, the court had recognized the potentially dangerous and mind-altering nature of psychotropic medication. Reiterating the essence of its findings, the court then stated emphatically:

"Such rights (in the protection and disposition of property) pale in comparison to the ultimate decision as to whether to accept or refuse psychotropic medication—medication that may or may not cause unpleasant and unwarranted side effects. The right to make such a decision is basic to any right of privacy."

Defendants argued further that the voluntarily committed mental patient, having institutionalized himself of his own free will, had implicitly agreed to accept the Hospital's treatment program, whatever that might entail. In other words, that such individuals had waived any right to refuse treatment based on the contract/application they had signed prior to admission. The application stated: "I understand that during my hospitalization and any after care, I will be given treatment which may include the injection of medicines."

Again, the court rejected the argument, proclaiming that there could be no distinction between the rights of involuntary or voluntary mental patients in refusing psychotropic medication in non-emergencies. The language of the application, said the court, failed to satisfy the standard of "knowing and intelligent waiver" set forth in Johnson v. Zerbst, 304 U.S. 458 (1938). The court called the language "ambiguous, at best," and stated that "it could even be interpreted as mere statement of expectation or entitlement by the patient."

The First Amendment: The court recognized, initially, the intimate association between the first amendment and the right of privacy in the deprivation of the fundamental right to generate ideas. The court stated: "The power to produce ideas is fundamental to our cherished right to communicate and is entitled to comparable constitutional protection." The court also said that despite the fact that mind control in mental institutions was an accepted medical practice, that such practice could not, of itself, warrant "an unsanctioned intrusion on the integrity of a human being." It declared that the public interest was served by the fact of commitment of mentally disturbed persons, but that such commitment did not deprive such individuals of the right to be wrong about treatment decisions, or of "the right to be unwise," as long as "the consequences of such error do not pose a danger of physical harm to himself, fellow patients or hospital staff." The Rogers court thus found "...a fundamental right to decide to be left alone, absent an emergency situation."

The court then turned to an examination of the state's interest in forced medication in non-emergencies. The court began its analysis by citing the litany that no constitutional right is absolute; that it is subject to and may be subordinated by a compelling state interest. But the court found no such compelling state interest in the forced medication of patients in non-emergency situations. Unlike in an emergency, said the court, the hospital community is in no danger. And since the patient has already been quarantined by commitment, forcible injection is unnecessary to protect the general public. Therefore, the police power of the state provides no rationale for forced treatment in non-emergencies.

The alternative rationale left to the state, then, is its parens patriae power—enabling it to take those actions needed to help those who are incapable of caring for themselves. But the privacy right, said the court, guarantees "...the freedom to decide whether we want to be helped, or whether we want to be left alone." The court called forcible medication in non-emergencies a "classic" intrusion which was not justified under the circumstances.

An amicus brief filed by the Massachusetts

**“ . . . the freedom to
decide whether we
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helped . . . ”**

Psychiatric Society argued that the prohibition on forced medication would leave hospital staffs "caught in a situation of having a legal obligation which they cannot carry out." But the court dispelled this assertion, declaring that: "The state has a duty to make treatment available. It has no duty to impose treatment on a competent involuntary patient who prefers to refuse medication, regardless of its potential benefit." The court thus disavowed the parens patriae rationale as a justification for forced medication in non-emergencies.

The state argued further that their legitimate interest in decreasing both the number of hospitalized patients, and their respective lengths of stay was sufficiently compelling to stand up against plaintiffs' claims. While acknowledging this interest as important, the court, nonetheless, refused to accept factors such as cost and convenience as legitimate justifications for the denial of constitutional rights. The court then issued an order enjoining defendants from forcibly medicating voluntary or involuntary mental patients in all non-emergency circumstances.

How then, did the Rogers court define an "emergency?" Defendants urged the court to recognize the term "psychiatric emergency" as the appropriate standard to be employed. Such a term was seen to include any behavior ranging from mock or real suicide gestures to "acute or chronic emotional disturbance having the potential to seriously interfere with the patient's ability to function on a daily basis." The court rejected this definition out of hand as being "...too broad, subjective, and unwieldy." It held instead, that circumstances constituting an emergency existed only where the failure to forcibly medicate a patient "would result in a substantial likelihood of physical harm to that patient, other patients, or to staff members of the institution."

Rennie v. Klein

John Rennie, a "highly intelligent" forty year old former pilot and flight instructor, began exhibiting symptoms of mental illness in 1971. With the death of his brother in 1973, his mental health worsened and he was involuntarily admitted to Ancora Psychiatric Hospital in New Jersey in April of that year. He was "depressed and suicidal, and diagnosed as a paranoid schizophrenic." Rennie was treated with the antipsychotic drug Mellaril, and was then released to a private facility within four days. A "revolving door series of readmissions and releases" ensued thereafter, and continued for a period of approximately three and one half years, resulting in twelve separate admissions to Ancora. Rennie's behavior was characterized as "erratic, alternating between depressed and suicidal to manic and homicidal." There was a suicide attempt on December 14, 1976. Throughout this period, Rennie was subjected to a variety of psychotropic drugs—among them, haldol, mellaril, and prolixin decanoate. Rennie often vacillated in taking the medication. Often he took it without challenge. At other times, he refused.

In August 1976, Rennie was once more committed involuntarily to the Ancora facility. Throughout 1977, he was "shifted" between several medications, including thorazine, prolixin, etrafon, haldol, elaril, and lithium. Assaultive behavior with other patients and hospital attendants was coupled with further periods of delusion and suicidal outbursts.

In December 1977, the underlying events of the lawsuit took place. By this time, the hospital staff had grown to believe that Rennie's general condition was deteriorating to the point where compelled medication was essential "...to prevent plaintiff from harming other patients, staff, and himself and to ameliorate his delusional thinking pattern." A hospital physician received permission from the state Attorney-General's office to administer medication without consent and shortly thereafter, Rennie was forcibly administered the drug prolixin hydrochloride, a long-acting drug requiring injection only every two weeks. A motion for preliminary injunction, pursuant to the Civil Rights Act was then filed on Rennie's behalf to prohibit the administration of drugs without his consent in non-emergency circumstances.

The District Court found that Rennie did, in fact, suffer from many of the side effects associated with the use of major tranquilizing drugs. Rennie's condition, as a result of the prolixin regimen, included blurred vision, dry mouth, decreased blood pressure, and akathisia (uncontrollable tremors). The court also noted that the danger of tardive dyskinesia was real in Rennie's case, evidenced by preliminary symptoms including "wormlike movements of the tongue."

Rennie's §1983 claim asserted that the New Jersey statutory scheme, which denied the right of an involuntarily committed patient to refuse medication, was unconstitutional as violative of the first, eight, and fourteenth amendments, and the right of privacy.

Cruel and Unusual Punishment: Though the court assumed, *arguendo*, that the Supreme Court's decision in *Ingraham v. Wright*, 430 U.S. 651 (1977), did not preclude the application of the eighth amendment to persons confined in mental institutions, it found no eighth amendment violation in the forced administration of prolixin in Rennie's case. (In *Ingraham v. Wright*, the Court narrowed the scope of afforded protection under the eight amendment to exclude corporal punishment in public schools, declaring that the ban on cruel and unusual punishment was meant to apply only to persons who had been convicted of criminal acts. The question of the applicability of the eight amendment to mental institutions was expressly reserved.) The *Rennie* court's conclusion was premised primarily on its belief that the prolixin regimen was "an integral component of an overall treatment program," and was therefore, "justifiably administered as treatment, not punishment." The court distinguished the facts in Rennie's case from those of other cases which had found eighth amendment violations despite claims of the therapeutic value of drug use. The court noted that, unlike Rennie's case, each of those cases had set forth findings that either "...the drugs were used improperly and for punishment rather than as part of an ongoing psychotherapeutic program," or that the drug utilized was not recognized as acceptable medical practice. Nor did the adverse effects of prolixin appear to the court "unnecessarily harsh" when balanced against the benefits of the drug.

The First Amendment: The court also rejected plaintiff's contention that the first amendment guarantee of the right to "mentation" (freedom to generate ideas) compelled prohibition of the non-consensual prolixin treatment. Citing plaintiff's expressed desire to be "cured, not warehoused," along with testimony, first, that his ability to perform on intelligence tests was not impaired as a result of the treatment, and second, that any dulling of his senses, was at most, temporary, the court distinguished the case from *Kaimowitz v. Dept. of Mental Health*, No. 73-19434-AW (Cir. Ct., Wayne County, Mich., July 10, 1973). In *Kaimowitz*, a Michigan county court held that experimental psychosurgery could not be legally consented to by the proposed patient, an involuntarily committed individual confined for seventeen years under a criminal sexual psychopath statute. Finding such

intrusive treatment violative of both the first amendment and the right of privacy, the Kaimowitz court had declared:

"A person's mental processes, the communication of ideas, and the generation of ideas come within the ambit of the First Amendment. To the extent that the First Amendment protects the dissemination of ideas and the expression of thoughts, it equally must protect the individual's right to generate ideas."

. . .the court. . . underscored the need to leave the final decision to the patient. . .

The Rennie court distinguished Kaimowitz, stating that in Kaimowitz: "the effects (of proposed psychosurgery) would be irreversible and unpredictable, the dangers to the patient substantial, and the benefits uncertain, with no scientifically established therapeutic effect." Rennie's drug regimen, the court concluded, did not "rise to the level" of the first amendment violations found in Kaimowitz.

The Right of Privacy: The Rennie court did, however, find a qualified constitutional right to refuse psychotropic medication based on what it called the "emerging" right of privacy, extending its protection to encompass a mental patient's decision to refuse such treatment in non-emergency circumstances. To the court, recognition of such a right was foremost a "practical" consideration, pointing as it did to the greater effectiveness of a voluntary, as opposed to involuntary, treatment program.

The court added further that balancing the risks with the potential benefits of the treatment was a "uniquely personal decision, which in the absence of a strong state interest, should be free from state coercion." Finally, the court noted that the uncertainty and great divergence in psychiatric opinion in any given case underscored the need to leave the final decision to the patient "rather than deferring to doctors."

Due Process: Recognizing forced medication as involving "a major change in the conditions of confinement," the court held that, in the absence of emergency, some due process hearing is required prior to the forced administration of drugs. And in its conclusion, the court presented four factors to be considered in any future proceedings for preliminary injunction: 1) plaintiff's physical threat to patients and staff at the institution, 2) plaintiff's capacity to decide on his particular treatment, 3) whether any less restrictive treatment exists, and 4) the risk of permanent side effects from the proposed treatment.

Though it refused to issue the injunction both in the instant complaint and again on renewed motion for preliminary injunction one month later, the court did finally enjoin the forced administration of psychotropic drugs in September 1979. 476 F. Supp. 1294 (D.N.J. 1979) In this class action, the court granted injunctive relief to Rennie as well as to all adult patients both voluntarily and involuntarily committed to five New Jersey state hospitals. Citing a "widespread failure" on the defendants' part to implement the court's formerly expressed guidelines, the court issued a new order setting forth minimum due process guarantees and mandating compliance by January 1980.

The essence of that order provided that in all non-emergency situations, the hospital may not proceed to medicate without the patient's written formal consent. Nor is the hospital excused from this procedure where a patient is either legally or "functionally" incompetent. Under such circumstances, the order requires that "patient advocates" be notified, and an independent evaluation made by a psychiatrist from outside the institution. The consent form must apprise all parties of the nature of the proposed treatment, including any possible consequences. In addition, the form must state the patient's full legal rights in refusing the proposed medication. Where the refusal is made by a voluntary patient, either orally or by a failure to sign the consent form, the hospital is precluded from forcibly medicating, except in emergency situations. Where the refusal is from an involuntary patient, there must be an informal review by an independent psychiatrist, prior to any forced medication, at which the patient must be represented by a patient advocate (or by counsel, if permitted). The patient does not have the right to call witnesses. However, the independent psychiatrist must "issue a written decision in each case, basing any decision to override the patient's privacy right on the four factors" set forth in the court's earlier opinions.

In addition, the court defined the context of an "emergency," the existence of which empowers the institution to forcibly medicate for a maximum of seventy-two hours, unless the attending physician recertifies the emergency. The court defined "emergency" as a certified "sudden, significant change in the patient's condition which creates danger to the patient himself or to others in the hospital." The court added that no medication may be prescribed "under any circumstances" where commitment procedures have been improperly completed.

Implications for the Future

While the Rennie court adopted a limited due process approach to the question whether there exists a constitutional right to refuse psychotropic medication, the Rogers court appeared content to

(continued on page twenty)