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Ethics and the Use of Coercion in the Treatment of Psychiatric Patients

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Ethics and the Use of Coercion in the Treatment of Psychiatric Patients

Abstract

Involuntary psychiatric treatment occurs under such conditions as the medicating or placing in treatment facilities of patients without their consent. Such involuntary treatment has been litigated in the Supreme Court; however, the Court's rulings have been applied to incarcerated persons, with the notable exception of the 1975 ruling in *O'Connor v. Donaldson*, a case argued as a civil rights violation. Using *O'Connor v. Donaldson* as a framework, this paper argues that forcing non-violent psychiatric patients to take medication, or be otherwise treated against their will, is an unethical practice and must be discontinued. This practice of forcible treatment violates the due process rights of patients, and is a violation of accepted medical ethics.

Keywords

psychiatry, involuntary treatment, ethics

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Involuntary psychiatric treatment occurs under such conditions as the medicating or placing in treatment facilities of patients without their consent. Such involuntary treatment has been litigated in the Supreme Court; however, the Court's rulings have been applied to incarcerated persons, with the notable exception of the 1975 ruling in *O'Connor v. Donaldson*, a case argued as a civil rights violation. Using *O'Connor v. Donaldson* as a framework, this paper argues that forcing non-violent psychiatric patients to take medication, or be otherwise treated against their will, is an unethical practice and must be discontinued. This practice of forcible treatment violates the due process rights of patients, and is a violation of accepted medical ethics.

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Introduction

Involuntary psychiatric treatment occurs when patients are medicated, or placed in a treatment facility without their consent. While involuntary treatment has been litigated before the Supreme Court, with the exception of *O'Connor v. Donaldson* (1975), which was argued as a civil rights violation, the Court's rulings have been applied to incarcerated persons (*Washington v. Harper*, 1990; *Riggins v. Nevada*, 1992; *Sell v. United States*, 2003). Forcing non-violent psychiatric patients to take medication against their will is an unethical practice and should be discontinued.

Historical Overview of Mental Health and Involuntary Treatment of Psychiatric Patients

For much of history, the treatments for mental illness have been coercive and inhumane. For centuries, those who were different, or socially unacceptable, were often accused of being witches or possessed by demons. The most innocuous of treatments was exorcism, in which priests attempted to vacate evil spirits that had invaded the body, which was supposed to cure the afflicted person. Trepanning, a practice in which a hole was drilled into the skull, exposing the outermost layer of the brain, was believed to release demons and cure various mental illnesses, including schizophrenia. When shock was discovered to alleviate symptoms, hydrotherapy—submerging patients in ice water—was implemented as a treatment. A more advanced technique, electroconvulsive therapy, consists of passing large amounts of electric current through a person's brain in an attempt to effect structural changes in the brain conducive to curing certain psychological problems (Barlow & Durand, 2009).

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In the early twentieth century in the United States, forced sexual sterilization was performed on those deemed unsuitable to reproduce (*Buck v. Bell*, 1927). Carrie Buck was a patient at the State Colony for Epileptics and Feeble Minded in Virginia. Based on a state law passed in 1924, Buck was deemed feeble-minded by heredity, and was ordered to undergo sterilization. Buck appealed to the Supreme Court on the basis that the forced sterilization order violated the due process clause of the Fifth Amendment and the equal protection clause of the Fourteenth Amendment.¹ The Court determined that Buck's due process rights had not been violated, and that not extending the sterilization statute to those outside state institutions did not violate the equal protection clause. The Court upheld the judgment forcing Buck to be sterilized, and ended with Justice Holmes' famous rejoinder: "Three generations of imbeciles are enough" (*Buck v. Bell*, 1927, p. 207). The right to procreate, despite the ruling in *Buck v. Bell*, is one of the fundamental rights, even though it is not written specifically in the text of the Constitution (Chemerinsky, 2001).

Arguments in Favor of Ceasing Involuntary Treatment of Psychiatric Patients

Case Law and Constitutional Rights

As citizens, certain rights and privileges are guaranteed by the Constitution. Those pertinent to this topic include the Fifth, Sixth, and Fourteenth Amendments. The due process clause of the Fifth Amendment, which states "[n]o person

¹ Perhaps a more appropriate constitutional argument would have been to assert that forced sterilization violated the protection against cruel and unusual punishment laid out in the Eighth Amendment.

shall...be deprived of life, liberty, or property, without due process of the law” (U.S. Const., amend. V), has been used in several cases to argue violations of due process in forcing treatment upon patients. The Sixth Amendment arguments generally used in the following cases relate to confronting witnesses and having counsel. The right used to argue against involuntary treatment in the Fourteenth Amendment is the equal protection clause, which states that no state may “deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws” (U.S. Const., amend. XIV, § 1). Practically speaking, the equal protection clause in the Fourteenth Amendment is essentially the same as the due process clause in the Fifth Amendment, but protects persons specifically from the states.

Since *Buck v. Bell* and the end of forced sterilization, there have been several landmark cases relating to involuntary treatment. The first such case was *O'Connor v. Donaldson* (1975). Using the provisions set forth in the United States Code for civil rights violations (42 U.S.C. § 1983), Kenneth Donaldson brought the action against Dr. O'Connor, the superintendent of the state mental facility in Florida in which he had been civilly committed for fifteen years. Donaldson claimed that O'Connor and his staff had intentionally deprived him of his constitutionally guaranteed right to liberty. Donaldson proved he had at no time been a danger to himself or to others, nor had he received any treatment for any perceived mental illnesses. O'Connor claimed that Florida state law allowed for the indefinite confinement of the mentally ill, without necessarily treating them or even allowing for their return to the community if deemed to not be dangerous. The Supreme Court held that

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confining a harmless individual, who is able to survive freely in the community on his own, or with the help of private persons, on the basis of mental illness alone, is unconstitutional. Justice Potter Stewart asserted that the state had an interest in “providing care and assistance to the unfortunate,” but that mental illness itself did not necessarily “disqualify a person from preferring his home to the comforts of an institution” (*O'Connor v. Donaldson*, 1975, p. 575).

The first case dealing with the rights of prisoners was *Washington v. Harper* (1990). Harper was serving a sentence in Washington for a robbery of which he was convicted in 1976. During his incarceration, Harper consented to the administration of anti-psychotic drugs. While not medicated, he was often violent, had been transferred to Washington's psychiatric prison on multiple occasions, and he was finally diagnosed as suffering from manic-depressive disorder. While there, Harper was forced to take anti-psychotic drugs based on a policy that stated that an inmate may be medicated against his will when ordered by a psychiatrist, if he met the following criteria: “suffer[ing] from a 'mental disorder' and... 'gravely disabled' or poses a 'likelihood of serious harm' to himself or others” (*Washington v. Harper*, 1990, p. 210). Harper filed a petition claiming that his forced medication regime violated the equal protection clause of the Fourteenth Amendment. The trial court denied the claim; however, the State Supreme Court reversed the lower court's decision, concluding that medication could only be forced upon an inmate if the treatment was deemed medically necessary and such treatment furthered a compelling state interest. During litigation, the state ceased medicating Harper, but the Supreme Court decided that the issue at hand was still relevant. The Court held that an inmate who suffered from a severe mental illness

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and posed a danger to himself or others could be medicated against his will if the treatment was in the inmate's best medical interests. In such cases, this was not a violation of the due process clause of the Fifth Amendment (*Harper v. Washington*, 1990).

The basis for *Riggins v. Nevada* (1992) was similar to that of *Harper*. While awaiting trial for robbery and homicide, Riggins began suffering from auditory hallucinations and insomnia. A psychiatrist prescribed a powerful anti-psychotic and Riggins was later found to be competent to stand trial. Riggins moved to cease the administration of his anti-psychotic regime for the duration of the trial so that he could present an insanity defense. Riggins' argument was that the medication hid his mental state, denying him his due process rights. His request was denied and he was tried while still medicated. He still presented an insanity defense, but was convicted and sentenced to death. On appeal, the State Supreme Court held that expert testimony was sufficient in describing the effects of anti-psychotic drugs on Riggins and his conviction was upheld. However, the Supreme Court maintained that for the state to satisfy Riggins' due process concerns, they had to prove that continuing his treatment was necessary and medically appropriate. Since this was not done, and the Court could find no compelling state interest in continuing to medicate Riggins, the Court held that Nevada's treatment of Riggins violated his Sixth and Fourteenth Amendment rights. The decision of the Supreme Court of Nevada was reversed, and Riggins' case was sent back to a lower trial court to be retried in a way not inconsistent with their findings (*Riggins v. Nevada*, 1992).

In *Sell v. United States* (2003), the petitioner, Sell, who had a non-violent history of delusional disorders, was on trial in

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federal court for fraud and attempted murder. A Magistrate judge found him competent to stand trial and released him on bail. However, the Magistrate revoked Sell's bail when his condition worsened. After his bail was revoked, Sell requested that his competency to stand trial be reevaluated. Sell was examined by psychiatrists at the United States Medical Center for Federal Prisoners, was found incompetent to stand trial, and was ordered to be hospitalized to determine when, or if, he would be capable of standing trial. While hospitalized, Sell refused to take the anti-psychotic drugs prescribed to him, and Medical Center officials sought to have him forcibly medicated, a decision Sell appealed. The Magistrate determined that Sell was a danger to himself and others, and that medicating him was the only way to diminish his dangerousness. The Magistrate also determined that the benefits of medicating Sell outweighed the risks of any potential side effects, and the regime of drug therapy proposed would likely have the effect of returning Sell's competency, making it possible for him to stand trial. Sell appealed to the District Court, who found the Magistrate's determination of dangerousness inaccurate, but affirmed his stance on drug therapy as an attempt to return Sell's competency. The Supreme Court, as laid out in prior cases (*Washington v. Harper*, 1990; *Riggins v. Nevada*, 1992), stated that the Constitution permits involuntary administration of medication aimed at “render[ing] a mentally ill defendant competent to stand trial on serious...charges if...medically appropriate...substantially unlikely to have side effects...undermin[ing] the trial's fairness, and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests” (*Sell v. United States*, 2003, p. 167). However, this standard was rather high and infrequently applied because of several stringent criteria required

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to meet the test. Using a strict scrutiny test, it must be determined that forcing a defendant to take medication against his will for the express purposes of making him competent to stand trial achieves a vital and compelling government interest, under which national security and similar interests would fall. Other considerations must also be taken into account, such as a defendant's confinement in an institution during the period of time in which he is incompetent to stand trial, which would protect the community from the defendant as well as depriving the defendant of the same types of liberties normally lost during incarceration (*Sell v. United States*, 2003).

As pointed out by mental health professionals who have studied the *Sell* decision, the Court found itself weighing the autonomy and liberties of the accused with that of the safety of the community at large (Heilbrun & Kramer, 2005; Hunter, Ritchie, & Spaulding, 2005), which is what trial courts are often asked to balance. Hunter et al. (2005) pointed out two main responses for mental health professionals in dealing with the *Sell* decision: the consideration by clinicians of factors such as context and environment when determining dangerousness, and “the importance of providing [the] least restrictive services prior to such interventions that violate patients' liberty interests” (Hunter et al., 2005, p. 467). *Sell*, like *Harper* and *Riggins*, related only to competency issues and the coercive treatment of mentally ill defendants (Heilbrun & Kramer, 2005). However, those who have analyzed *Sell* agreed that, as with non-psychiatric defendants and inmates, violating the laws does rescind some civil liberties, most notably freedom (Heilbrun & Kramer, 2005; Hunter et al., 2005).

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Medical Ethics and the Freedom of Choice

Outside the realm of criminality, there appeared to be multiple schools of thought on the use of coercion in treating the mentally ill. Some stressed that patients need to be treated respectfully and be allowed to make their own decisions regarding their treatments with absolutely no coercion involved (Heilbrun & Kramer, 2005). Others, however, found that coercion was sometimes a necessity in dealing with certain types of patients, and without the help of the judiciary, these patients would never get the treatment they needed (Heilbrun & Kramer, 2005).

Civil liberties were not the only obstacles in the way of coercive treatments. Connor (1996) explained that the therapeutic value of psychiatric treatments, especially psychotherapy, was negated when coercion was involved. Successful psychotherapy required a high level of trust between patient and therapist, and this trust cannot be garnered through a forced relationship. According to Connor (1996), the outcome of a patient's therapy was directly proportional to the relationship that developed between patient and therapist.

Medical ethics naturally do not lend themselves to the use of coercive treatment. The basic tenets of medical ethics generally fall under the following four principles: patient autonomy, beneficence, non-maleficence, and justice (Gillon, 1994). Patient autonomy essentially means respecting a patient's right to choose which, if any, treatment option is best considering the circumstances in which one finds oneself. The foundation for patient autonomy is based on Emmanuel Kant's ideal of respecting the person. The concepts of beneficence and non-maleficence can be best explained to mean that healthcare professionals, in this case psychiatrists, must do what is in the

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best interests of their patients, and they must also avoid harming patients. Justice, the final of the four principles, includes distributive justice, which relates to the allocation of healthcare funding for various programs in a way that is as fair to as many persons as possible (Gillon, 1994).

Chemerinsky (2001) explained that the right to make one's own medical decisions is fundamental, including the right to refuse treatment. Bassman (2005) posed the question “[a]re there indisputable benefits to the individual and the community that justify forcing people to relinquish their right to choice because of assessments of mental illness and its often associated implication of global incapacity?” (p. 488). This question was philosophical, ethical, and political in nature. Bassman asserted, much as Connor (1996) did before him, that coercion, and the threat of force, is contrary to the nature of medicine and healing. The threat of force will dissuade the mentally ill from seeking treatment that may actually be beneficial to them (Bassman, 2005).

Arguments in Favor of Continued Coercive Treatments for Psychiatric Patients

Assisted Outpatient Treatment Laws

According to the Treatment Advocacy Center, a non-profit organization based in Virginia, there are currently forty-five states that have some version of an assisted outpatient treatment law (Treatment Advocacy Center, 2011). The only states that have no such laws are Connecticut, Maryland, Massachusetts, New Mexico, and Tennessee (Treatment Advocacy Center, 2011).

New York's outpatient treatment law is known as Kendra's Law. Passed in 1999, the law lists four criteria by

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which a person can be placed into an assisted treatment program: the patient must be at least eighteen years of age; suffering from a mental illness; based on a clinician's assessment, be unable, or unlikely to be able, to live in the community without some form of non-private assistance; and have a history of refusing psychiatric treatment. The patient must also be likely to benefit from an assisted treatment program (New York Mental Hygiene Law ch. 27 title B § 9.60).

While at first it may appear as though assisted treatment laws are at odds with the various Supreme Court rulings related to forcible treatments, such as *Washington*, *Riggins*, and *Sell*, that is not the case. Each of the aforementioned cases are specifically related to defendants awaiting trial, in the case of *Harper* and *Sell*, or a specific due process violation during the trial phase of a convicted prisoner in the case of *Riggins*. The closest to the case law these treatment laws come is the *O'Connor* case, in which Donaldson was civilly committed to a mental institution for nearly fifteen years. However, there are significant differences between assisted treatment laws and the *O'Connor* case. Donaldson was not actually treated in any way for a mental illness, whereas the purpose of Kendra's Law is to treat severely mentally ill persons.

However, as Chemerinsky (2001) stated, freedom and liberty are fundamental rights, as is control over one's medical decisions, including refusal of treatment. Perlin (2003), in his study of Kendra's Law, determined that it violates the rights of individuals who have committed no crime. Kendra's Law violates the due process clause of the Fifth Amendment protecting against the deprivation of "life, liberty, or property" (U.S. Const., amend. V).

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The Necessity of Coercion in the Treatment of Certain Psychiatric Patients

As noted in Heilbrun and Kramer (2005), a segment of mental health professionals have claimed that a certain degree of coercion is necessary in treating certain patients, who, without the assistance of the judiciary, would likely attempt to remain untreated. However, coercion in the absence of proof of dangerousness and criminality is antithetical to the very nature of a free society and the fundamental rights therein. The therapeutic value of psychiatric treatments, especially psychotherapy, are negated when coercion is involved (Connor, 1996). Successful psychotherapy requires a high level of trust between patient and therapist, and this trust cannot be garnered through a forced relationship (Connor, 1996). Therefore, coercion is not a valid, reliable, or ethical technique to employ in the pursuit of treating any patients.

Conclusion

Coercive treatments for mental illnesses did not cease as the modern era dawned. The topic of coercive and involuntary treatment of psychiatric patients remains relevant today. The fundamental rights relating to personal autonomy in medical decisions are not absolute in all circumstances, as recent case law makes clear (*Washington v. Harper*, 1990; *Riggins v. Nevada*, 1992; *Sell v. United States*, 2003). In relation to criminal defendants and prisoners, the distinction of being a danger to oneself or to others is an important factor in determining the constitutionality of medicating a patient against one's will (*Washington v. Harper*, 1990; *Sell v. United States*, 2003). The prevalence of assisted outpatient treatment laws, such as Kendra's Law in New York, suggests this is a problem that

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will continue for some time. Given the opinions of the Supreme Court on the matter, and the assertion by many mental health professionals that coercion and the threat of force actually hamper the possibility of recovery in relation to mental illnesses (Connor, 1996; Bassman, 2005), as well as the fundamental rights that live on in the Constitution (Chemerinsky, 2001), it is clear that, without the presence of violence or dangerousness, patients should not be forced to be treated without their consent.

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