STATE OF WISCONSIN

SUPREME COURT

Appeal No. 2007AP2767-CR

STATE OF WISCONSIN,

Plaintiff-Respondent,

V.

JOHN A. WOOD,

Defendant-Appellant.

APPEAL FROM ORDERS OF THE CIRCUIT COURT FOR LACROSSE COUNTY, THE HONORABLE MICHAEL J. MULROY AND THE HONORABLE RAMONA A. GONZALES PRESIDING

AMICUS BRIEF OF DISABILITY RIGHTS WISCONSIN, THE NATIONAL DISABILITY RIGHTS NETWORK, AND THE JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW

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Disability Rights Wisconsin, the National Disability Rights Network, and the Judge David L. Bazelon Center for Mental Health Law (collectively "*amici*") submit the following, pursuant to Wis. Stat. § 809.19(7) and this Court's November 18, 2008 Order, as their brief *amicus curiae*.

INTEREST OF *AMICI*

Amici, who represent many thousands of individuals with disabilities, have an interest in ensuring that the State does not forcibly medicate persons who are incompetent to refuse medication without showings of

dangerousness and without adequate safeguards to protect the right to bodily autonomy.[1]

STATEMENT OF THE CASE

Amici adopt the statement of the case in the Brief of Appellant.

QUESTIONS PRESENTED

Amici address three issues regarding due process rights under section 1 of article 1 of Wisconsin's Constitution and amendment XIV of the Constitution of the United States and the judicial[2] and non-judicial[3] mechanisms for forcibly medicating a person subject to psychiatric commitment under chapter 971 of the Wisconsin Statutes.

First, does the forcible administration of psychoactive drugs that will not cure Appellant's mental disability, but may cause serious side effects, violate Appellant's right to bodily integrity?

Second, does Wisconsin law permit forcible medication without clear and convincing evidence that a person is actually dangerous and that no less restrictive means could prevent harm?

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1 *Amici* incorporate by reference their Motion for Leave to File a Non-Party Brief, which contains a more detailed statement of their interests.

2 Wis. Stat. Ann. § 971.17(3)(c) (West Supp. 2008).

3 Department of Health and Family Services, *Administrative Directive Re: Decisions Whether to Involuntarily Medicate a Forensic Patient under an Order to Treat*, Apr. 22, 1997 ("AD-11-97" or the "Directive").

Third, even if dangerousness were not required for forcible medication, do existing mechanisms adequately protect the rights of persons who have regained their competence to refuse medication?

ARGUMENT

I. PERSONS WITH MENTAL DISABILITIES HAVE THE RIGHT TO REFUSE PSYCHOACTIVE MEDICATION

A. Appellant has the right to bodily integrity

Individuals have a fundamental right to make decisions about their health care, including decisions about what treatments to use, if any, to address chronic mental disabilities. Appellant's fundamental rights to bodily integrity[4] and to refuse psychoactive medication[5] were not extinguished by an acquittal by reason of mental disease or defect,[6] by a disagreement about whether a drug is appropriate,[7] or by a finding that he could not exercise informed consent.[8] Yet Wisconsin law permits forcible medication that impermissibly invades personal liberty. This violation of rights is particularly troubling because the medication at issue poses substantial and often permanent

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4 *Ingraham v. Wright*, 430 U.S. 651, 673 (1977) ("Among the historic liberties" protected by the Due Process Clause is the "right to be free from, and to obtain judicial relief for, unjustified intrusions on personal security").

5 *Jones v. Gerhardstein*, 141 Wis. 2d 710, 728 (1987); *Sell v. United States*, 539 U.S. 166, 178 (2003).

6 *Enis v. DHSS*, 962 F. Supp. 1192, 1194 (W.D. Wis. 1996).

7 *In re Virgil D*, 189 Wis. 2d 1, 15-16 (1994) ("Simply because Virgil disagrees with the recommendation of the examining psychiatrist, he does not lose his right to refuse administration of the drug.").

8 *In re L.W.*, 167 Wis. 2d 53, 73-74 (1992) (incompetence does not extinguish "long-established" right to refuse treatment).

health risks, and forcible medication itself undermines the effectiveness of treatment.

B. Psychoactive drugs like Risperidone have severe physiological and psychological side effects

The State seeks to forcibly administer psychoactive drugs that do not cure schizophrenia or guarantee normal social and vocational functioning,[9] but do cause debilitating and sometimes fatal side effects.

By taking Risperidone, an "atypical antipsychotic," Appellant risks severe weight gain[10] and is nearly eight times more likely than a comparable general population group to contract diabetes mellitus.[11] Severe weight gain and obesity increase the risk "of hypertension, coronary artery disease, stroke, osteoarthritis, sleep apnea, type II diabetes mellitus and several cancers including endometrial, breast, prostate and colon cancer."[12]

Atypical antipsychotics also increase the risk of pancreatitis[13] and metabolic abnormalities.[14] They reduce life

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[9] *See* Ann M. King et al., *Abnormal Psychology* 344 (9th ed. 2004); Jeffrey A. Lieberman et al., *Textbook of Schizophrenia* 327 (2006).

[10] N.R. Kleinfield, *In Diabetes, One More Burden for the Mentally Ill*, N.Y. Times, June 12, 2006, at A1.

[11] Michael J. Sernyak et al., *Association of Diabetes Mellitus with Use of Atypical Neuroleptics in the Treatment of Schizophrenia*, 159 Am. J. Psychiatry 561, 561, 565 (2002).

[12] Peter Haddad, *Weight Change with Atypical Antipsychotics in the Treatment of Schizophrenia*, 19 J. Psychopharmacology 16, 17 (Supp. 2005).

[13] Elizabeth A. Koller et al., *Pancreatitis associated with atypical antipsychotics: From the Food and Drug administration's MedWatch surveillance system and published reports*, 23(9) Pharmacotherapy 1123 (2003).

[14] George M. Simpson, *Atypical Antipsychotics and the Burden of Disease*, 11 Am. J. Managed Care S235, S236 (Supp. 2005).

expectancy because of increased cardiovascular risk factors[15] and increase the risk of death among elderly persons with dementia.[16]

Appellant also risks contracting two muscular and neurological disorders called "extrapyramidal side effects." First, neuroleptic malignant syndrome is characterized by severe muscular rigidity, high fever, tachycardia, hypertension, and changing levels of consciousness. Although rare, the condition kills between 10 and 30 percent of those it afflicts. [17] Second, tardive dyskinesia is a potentially irreversible disorder "characterized by involuntary, rhythmic, and often grotesque movements of the face, lips, tongue, fingers, hands, legs, and pelvis." [18] Because the convulsions are so severe, and because they impose a significant social handicap on persons attempting to assimilate into the community, courts and caregivers should give great weight to them before ordering the administration of antipsychotics.[19]

Risperidone's less severe side effects include fever, muscle stiffness, confusion, fast or irregular pulse, sweating, seizures, slow movements or shuffling walk, rash,

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[15] J. Cordes et al., *Therapeutic Options for Weight Management in Patients Treated with Atypical Antipsychotics*, Fortschr. Neurol. Psychiatr. (Oct. 2008).

[16] U.S. Food & Drug Admin. Public Health Advisory, *Deaths with Antipsychotics in Elderly Patients with Behavioral Disturbances* (2005), *available at* http://www.fda.gov/cder//advisory/antipsychotics.htm.

[17] Gerard Addonizio, *Neuroleptic Malignant Syndrome*, in *Drug-Induced Dysfunction in Psychiatry*, ch. 11 at 148 (Matcheri S. Keshavan & John S. Kennedy eds., 1992).

[18] Rafael A. Rivas-Vasquez et al., *Atypical Antipsychotic Medications: Pharmacological Profiles and Psychological Implications*, 31 Prof. Psychol.: Res. & Prac. 628, 630 (2000).

[19] John Wilkaitis et al., *Classic Antipsychotic Medications*, in *The American Psychiatric Publishing Textbook of Psychopharmacology* 437 (Alan F. Schatzberg & Charles B. Nemeroff, eds., 3d ed., 2004).

hives, itching, difficulty breathing or swallowing, and prolonged, painful erection of the penis. Others include drowsiness, dizziness, nausea, vomiting, diarrhea, constipation, heartburn, dry mouth, increased saliva, stomach pain, anxiety, agitation, restlessness, difficulty falling asleep or staying asleep, sexual dysfunction, vision problems, muscle or joint pain, dry or discolored skin, and difficulty urinating.[20] These side effects considerably affect the daily lives of patients and "can be a source of acute distress to patients who are struggling to feel wide awake and think more clearly" while learning to cope with their mental disabilities.[21]

The development of a newer class of drugs—atypical antipsychotic drugs—has not eliminated the specter of dangerous side effects. These newer drugs, while causing a lower incidence of certain side effects than older drugs, trade one set of problems for another. Atypical antipsychotics are more likely than conventional antipsychotics to cause diabetes[22] and to cause intolerable side effects,[23] and may even be less effective than the older drugs.[24]

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[20] American Society of Health-System Pharmacists, *Risperidone*, *Consumer Medication Information* (updated May 1, 2008), *available at* http://www.ncbi.nlm.nih.gov/books/bv.fcgi?log$=drug_bottom_one&rid=medmaster.chapter.a694015.

[21] *See* Robert M. Levy & Leonard S. Rubenstein, *The Rights of People with Mental Disabilities* 112 (1996).

[22] Sernyak, *supra* note 11.

[23] *See* John Geddes et al., *Atypical Antipsychotics in the Treatment of Schizophrenia: Systematic Overview and Meta-Regression Analysis*, 321 Brit. Med. J. 1371, 1371 (2000) (review of 12,649 patients showed "no clear evidence that atypical antipsychotics are more effective or are better tolerated than conventional antipsychotics").

[24] *See, e.g.*, Jeffrey Mattes, *Risperidone: How Good is the Evidence for Efficacy?*, 23 Schizophrenia Bulletin 155, 157 (1997) (Risperidone may not be "as effective as standard neuroleptics for typical positive symptoms").

C. Forcible medication harms prospects for successful treatment

Treatment that prioritizes respect for the autonomy of persons with mental disabilities has better outcomes. The absence of coercion encourages relationships of trust and cooperation to develop between patients and caregivers.[25] A person's adherence to treatment depends not only on his mental condition, but also on the treating physician's conduct[26] and the prescribed drug's side effects.[27] Adherence increases when caregivers take the time to develop stronger therapeutic alliances with their patients.[28] By contrast, the experience of being drugged against one's will causes severe psychological injuries—including feelings of violation, anger, pain, panic, fear and helplessness—that make coping with mental disability even harder.[29]

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[25] *See* Elyn R. Saks, *Refusing Care: Forced Treatment and the Rights of the Mentally Ill* 88 (2004).

[26] *See* Prakash S. Masand & Meera Narasimhan, *Improving Adherence to Antipsychotic Pharmacotherapy*, 1(1) Curr. Clinical Pharmacology 47, 48 (2006) ("Physician-related risk factors for nonadherence are related primarily to poor relationships with patients, poor discharge planning, or lack of follow-up care.").

[27] J.A. Lieberman et al., *Effectiveness of antipsychotic drugs in patients with chronic schizophrenia*, 353(12) New England J. of Med. 1209, 1218 (2005) (high rates of discontinuation indicate "substantial limitations in the effectiveness of the drugs," usually intolerable side effects and therapeutic inefficacy).

[28] J.P. Lacro et al., *Prevalence and risk factors for medication nonadherence in patients with schizophrenia: a comprehensive review of recent literature*, 63(10) J. Clin. Psychiatry 892 (2002); M. Olfson et al., *Predicting medication noncompliance after hospital discharge among patients with schizophrenia*, 51(2) Psychiatr. Serv. 216 (2000).

[29] *See* K. Haglund, L. von Knorring et al., *Forced Medication in psychiatric care: patient experiences and nurse perceptions*, 10 J. of Psychiatric and Mental Health Nursing 65 (2003); W.M. Greenberg, L. Duncan-Moore, et al., *Patients' Attitudes Toward Having Been Forcibly Medicated*, 24(4) Bull. Am. Acad. Psychiatry Law 513 (1996).

II. STRONGER SAFEGUARDS ARE NECESSARY TO PREVENT IMPERMISSIBLE ADMINISTRATION OF PSYCHOACTIVE DRUGS

The showing of dangerousness required under the Directive—a "current risk of harm"[30]—is insufficient to justify forcible medication. The statute and the Directive are unconstitutional because they deprive a person subject to post-acquittal commitment of his right to be free from bodily restraint without clear and convincing evidence that he is dangerous.[31]

A. The Directive incorrectly presumes that people with mental illness are dangerous

The Directive violates Appellant's right to autonomy because its overbroad definition of "danger" permits forcible medication of persons who have mental disabilities and have refused treatment, but are not actually dangerous. Under the Directive, a person is considered dangerous, and thus subject to forcible medication, if he might "suffer significant deterioration to his health or safety", [32] or if "there may be harm to the prospects for successful treatment"[33] if medication were not administered. Thus, the Directive improperly allows forcible medication not because medication is necessary to prevent danger, but because it might help "treat" a person's mental disability.

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30 AD-11-97, *supra* note 3, § II(A)(3).

31 *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992) (requiring clear and convincing evidence that an individual acquitted of a crime is mentally ill and dangerous before permitting confinement); *Washington v. Harper*, 494 U.S. 210, 229 (1990) (forcible medication "represents a substantial interference with that person's liberty").

32 AD-11-97, *supra* note 3, § II(A)(3)(e).

33 AD-11-97, *supra* note 3, § II(A)(3)(c).

Under the Directive, a person is also "dangerous" if his refusal to take medication may result in "significant psychological harm" including "mental anguish, pain, suffering, fear, anxiety or desperation". These symptoms are subjective, often characteristic of serious mental disabilities,[34] and resemble both the side effects of medication[35] and the experience of forcible medication.[36] Forcibly medicating a person who might otherwise suffer "psychological harm" does not cure mental illness, but does replace the potential pain of mental disability with the certain side effects of psychoactive drugs.

B. The Directive unconstitutionally permits an inference of current dangerousness from past acquittals

It is unconstitutional to restrict a person's liberty on the basis of offenses for which he was not criminally responsible.[37] It is also unacceptable for a facility to use medication as an instrument of institutional control over a patient whose behavior is difficult and challenging but not dangerous.[38] Yet the Directive allows a treatment team to infer from Appellant's "history of physical violence"—acquittals eleven and thirty years ago—that he might "cause physical harm to others in the facility", even absent present threats of harm.[39]

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[34] Features associated with paranoid schizophrenia include "anxiety, anger, aloofness and argumentativeness." *Diagnostic and Statistical Manual of Mental Disorders* 314 (4th ed. 2000).

[35] *See* § I(B), above.

[36] *See* Haglund, *supra* note 29.

[37] *See Foucha*, 504 U.S. at 80 (State lacks punitive interest in restricting the liberty of a person acquitted by reason of insanity).

[38] *See* Robert Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 Nw. U. L. Rev. 461, 478 (1977); *Rivers v. Katz*, 495 N.E.2d 337, 343 n.6 (N.Y. 1986) (interests in providing a therapeutic environment and ensuring staff efficiency do not outweigh right to refuse medication).

[39] AD-11-97, *supra* note 3, § II(A)(3)(b).

C. The absence of frequent independent review violates procedural due process

This court has held that forcible treatment orders must either expire or undergo periodic judicial review.[40] The danger justifying forcible medication may be short-lived[41] and forcible medication may even increase a risk of harm,[42] so frequent independent review[43] of dangerousness and of less restrictive means[44] is essential to protect the right to be free of unnecessary[45] psychoactive drugs.[46] Yet under

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[40] *State v. Anthony D.B.*, 2000 WI 94, ¶¶ 30-34 (forcible medication order for a sexually violent person must be subject to review at a judicial hearing with the "'essentials of due process and fair treatment'") (citation omitted).

[41] *See* Dora W. Klein, *Autonomy and Acute Psychosis: When Choices Collide*, 15 Va. J. Soc. Pol'y & L. 355, 372-73 (2008) (forcible medication may be necessary only during psychotic breaks).

[42] *See Harper*, 494 U.S. at 249 n.18 (Stevens, J. concurring in part and dissenting in part) (prison psychiatrist believed Harper's violent acts occurred "'in the context of his complaining about medication side effects'") (quoting the psychiatrist's report).

[43] *See, e.g.*, 405 Ill. Comp. Stat. Ann. 5/2-107.1(a-5)(5) (West Supp. 2009) (Illinois limits first and second medication orders to 90 days and subsequent orders to 180 days).

[44] Appellant is a patient, not a prisoner, so *Sell v. United States*, 539 U.S. 166, 178 (2003), not *Harper*, 494 U.S. at 226-27, applies: Respondent has the burden of showing that less intrusive means are unlikely to achieve substantially the same results as forcible medication. *See Sell*, 539 U.S. at 180-182.

[45] *See* Klein, *supra* note 41, at 370 ("[B]ecause schizophrenia tends to be an episodic illness; because long-term use of a particular medication sometimes diminishes its effectiveness, or causes new side effects to develop, or old side effects to intensify—questions concerning antipsychotic medication rarely can be addressed and answered once and for all.").

[46] *See Enis v. DHSS*, 962 F. Supp. 1192, 1202 (W.D. Wis. 1996) ("Without regular review of these decisions, there is no guarantee that the medication decision has any currency, without which it is questionable whether the inmate's liberty interest actually is outweighed in the particular instance.").

the Directive, reviews occur after six months, and only annually thereafter,[47] while judicial review occurs only if a patient petitions the court.[48] The Directive allows facility staff,[49] who have an obvious interest in prolonging forcible medication orders, to determine whether "danger" persists and whether less restrictive means exist to prevent it.[50] Due process requires frequent judicial review to ensure that forcible medication will cease once danger has abated.

III. IN THE ALTERNATIVE, EXISTING MECHANISMS VIOLATE DUE PROCESS BY ALLOWING FORCIBLE MEDICATION OF PERSONS WHO ARE COMPETENT TO REFUSE MEDICATION

Even if the court holds that individuals who have been found incompetent may be medicated without a finding of actual dangerousness, existing procedural mechanisms improperly allow competent refusals to be ignored. Three measures are constitutionally necessary to safeguard the right to refuse.[51]

First, the statute specifies that determination of incompetence is a judicial function,[52] but the Directive empowers facility staff to make subsequent incompetence

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47 AD-11-97, *supra* note 3, §§ III(A)-III(E).

48 *Id.* § V(D)(5).

49 *Id.* § I(C)(2) and (3).

50 *Id.* § III(D) and (E).

51 A court evaluating due process claims weighs "the private interest affected by the official action, the risk of an erroneous deprivation of this interest through the procedures used, the probable value of additional procedural safeguards and the government's interests." *Enis*, 962 F. Supp. at 1202 (citing *Matthews v. Eldridge*, 424 U.S. 319, 335 (1976)).

52 Wis. Stat. Ann. § 971.16(3) (West 2007).

determinations.[53] Due process forbids such deference: a psychiatric facility may not adjudicate its own patient's legal capacity to exercise a constitutional right.

Second, although the statute requires clear and convincing evidence that a person is incompetent to refuse a "particular medication or treatment"[54], under the Directive, a treatment team may forcibly administer medications a person *is* competent to refuse.[55] A defect of reasoning that vitiates a person's refusal of one medication may not affect his competence to reject another.[56] Hence, judicial medication orders should only permit forcible administration of drugs a person is incompetent to refuse.[57]

Third, under the Directive, a person who is *competent* to refuse medication may be forcibly drugged if "[d]iscontinuance of the medications would result in the patient again becoming" incompetent.[58] A person who has regained his competence and is not actually dangerous clearly has the right to refuse psychoactive medication.

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[53] AD-11-97, *supra* note 3, § IV(C)(1).

[54] Wis. Stat. Ann. § 971.16(3) (West 2007).

[55] AD-11-97, *supra* note 3, § III(A) (authorizing involuntary administration of medications").

[56] Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. Rev. 945, 955, 992 (1990).

[57] *See, e.g.*, 405 Ill. Comp. Stat. Ann. 5/2-107.1(a-5)(6) (West Supp. 2009) (Illinois statute requiring medication order to "specify the medications and the anticipated range of dosages that have been authorized").

[58] AD-11-97, *supra* note 3, § IV(C)(1)(b).

CONCLUSION

For the foregoing reasons, *amici* urge that this Court reverse the decision of the circuit court.

Dated this 12th day of August, 2009.

Respectfully submitted,

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FORM AND LENGTH CERTIFICATION

I hereby certify that this brief conforms to the rules contained in Wis. Stat. § 809.19(8)(b) and (c) for a brief produced with a proportional serif font. The length of this brief is 2979 words.

Dated this 12th day of August, 2009.

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CERTIFICATION OF COMPLIANCE

WITH WIS. STAT. § 809.19(12)

I hereby certify that:

I have submitted an electronic copy of this brief, which complies with the requirements of Wis. Stat. § 809.19(12).

I further certify that:

The electronic brief is identical in content and format to the printed form of the brief filed as of this date.

A copy of this certificate has been served with the paper copies of this brief filed with the court and served on all opposing parties.

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Kristin Kerschensteiner, an attorney, certifies that she caused three (3) copies of Amicus Brief of Disability Rights Wisconsin, the National Disability Rights Network, and the Judge David L. Bazelon Center for Mental Health Law to be served on counsel contained in the attached service list by depositing same in a United States mail depository located at [] in a properly addressed envelope, first class postage prepaid, on this 12th day of August, 2009, on or before the hour of 5:00 pm.

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