

# Oregon Supreme Court Ruling Prohibits Hospital from Refusing a *Sell* Order

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In a recent decision involving a capital murder case, *Oregon State Hospital v. Butts*, the Oregon Supreme Court conducted a *mandamus* hearing to ascertain whether Oregon State Hospital (OSH) had a legal duty to comply with a *Sell* order from a county trial court to provide antipsychotic medications to an incompetent defendant, despite its belief, as an institution, that medication was not clinically indicated. The case is reviewed and important implications, including the court's being granted the ability to circumvent the medical decision-making process, are discussed.

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The 2003 United States Supreme Court case *Sell v. United States*<sup>1</sup> established the framework by which courts could order that incompetent, nondangerous defendants be given psychotropic medication for the sole purpose of restoring their competency to stand trial. This case established that compelling medication in such situations is constitutionally allowable, provided that important state interests are involved, that medications are “substantially likely” to restore the defendant to competency, that less intrusive methods are unlikely to achieve the same results, and that the administration of the drugs is medically appropriate.

From the standpoint of expert witnesses in *Sell* hearings, there is little dispute that psychotropic medications are effective as the primary means of restoring trial competency in defendants with psychosis. The question of what constitutes medically appropriate treatment, however, is dependent on

several variables that reasonable clinicians may disagree on, including the patient's diagnosis and severity of illness.

In Oregon, as of October 2015, there have been 10 *Sell* hearings resulting in commitment of defendants to OSH with court orders enabling the use of medications against the wishes of the defendants for the purpose of competency restoration. Competency to stand trial in Oregon is addressed by Oregon Revised Statutes (ORS) 161.360–370,<sup>2</sup> which outline that a defendant found incompetent to stand trial is sent for either inpatient or outpatient restoration for a period not to exceed the lesser of three years or the time of the maximum sentence the court could impose if the defendant were convicted. Once committed, the defendant must have a competency evaluation within the first 60 days and every 180 days thereafter.<sup>3</sup> The process by which a *Sell* hearing occurs typically begins with a finding that a defendant is not competent to stand trial and a court referral to the state hospital for restoration, where it is determined by the treating psychiatrist that the patient does not meet the criteria for involuntary medication (i.e., the defendant is dangerous or gravely disabled), and the defendant refuses to consent to take the medication. At that point, a competency evaluation is undertaken that indicates that the defendant is unlikely to be restored to competency within the statutory time frame allowed without medication. It is then left to the trial court to decide whether the

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state's interests are sufficient to have the defendant medicated expressly for the purpose of competency restoration.

Specific procedures governing *Sell* hearings have yet to be codified in the Oregon statutes. In the 2013 case of *State of Oregon v. James Michael Francis Lopes*,<sup>2</sup> the Oregon Supreme Court first explored the application of *Sell*. In this case, the defendant, Mr. Lopes, challenged a *Sell* order issued by a trial court, arguing that the court did not have the authority to issue such an order and that the constitutional limitations articulated in *Sell* were not proven by the state. On the first point, the Oregon Supreme Court ruled that the Oregon Revised Statutes governing incompetence to stand trial conferred on Oregon trial courts the authority to enter a *Sell* order. On the second point, the court ruled that the trial court had erred and the state had not met all four *Sell* criteria, while establishing that *Sell* criteria require "factual determinations supported by clear and convincing evidence."<sup>3</sup>

Mr. Lopes argued that "a court has no role in prescribing treatment; a court's role is limited to ordering a defendant's commitment to or release from a hospital" (Ref. 3, p 520). In response, the Oregon Supreme Court pointed out that the hospital had determined that medications were the only treatment that would be likely to restore Mr. Lopes to trial competence, that such medications would be medically appropriate, and therefore that "this case does not present the question whether a trial court has the authority to order a defendant to be involuntarily medicated when a hospital opposes such treatment" (Ref. 3, p 520). In a recent case, however, the court addressed this question.

### **Oregon State Hospital v. Butts**

In January 2011, Police Chief Ralph Painter responded to a reported attempted car theft at a local audio store in Rainier, Oregon. On Chief Painter's arrival, Daniel Butts allegedly became involved in a physical struggle with him. During the struggle, Mr. Butts allegedly wrestled the officer's gun away from him and killed him by shooting him in the head. Mr. Butts was charged with 21 felonies, including 9 counts of the capital offense of aggravated murder.<sup>4</sup> After his indictment, Mr. Butts' legal team raised concerns related to his competency to stand trial (termed "aid and assist" in Oregon, ORS 161.370).<sup>2</sup>

### **History of Evaluations**

Mr. Butts' legal team initially retained a psychiatrist to complete a capacity-to-stand-trial evaluation, and he concluded that Mr. Butts had a "psychosis and possibly schizophrenia, and recommended that defendant be treated with antipsychotic medication" (Ref. 4, p 51). The trial court first ordered a competency evaluation to be completed in the custody of OSH. Mr. Butts was admitted for three weeks in July 2011 under an ORS 161.365 order, which specified that, although he was at the hospital for several weeks, the sole purpose of his hospitalization was evaluation of trial competency.<sup>3</sup> He was evaluated by a hospital psychologist who concluded that Mr. Butts was not mentally ill and had the substantial capacity to stand trial.

The trial court held its first competency hearing in December 2012 and adjudicated Mr. Butts fit to proceed. The court noted that Mr. Butts exhibited "disturbing" behavior but believed that he was "gaming the system" (Ref. 4, p 52). However, the trial court also opined that it did "not see any reason why defendant should not be provided with the antipsychotic medication that [the defense psychiatrist] had prescribed" [*sic*] (Ref. 4, p 52). As a result the court, "ordered that such medication be provided to the defendant if requested by him or his counsel" (Ref. 4, p 52).

The trial court ordered Mr. Butts to OSH for a second time, and he was admitted from April to May 2012. He underwent another competency evaluation by an OSH psychiatrist who noted that Mr. Butts did not participate in a "detailed interview," but opined that Mr. Butts did not have a mental illness and was fit to proceed. He noted that Mr. Butts expressed an understanding that he potentially faced the death penalty and referred to himself as being "clinically insane" (Ref. 4, p 52).

A second competency hearing was held in February 2013. The court noted that it remained unclear whether Mr. Butts' failure to cooperate with counsel or participate in his defense was a "rational and calculated strategy or the product of a mental disorder," but ultimately found him "currently unable . . . and that such inability is the result of his current mental deficiencies, possibly schizophrenia" (Ref. 4, p 523).

For a third time, in March 2013, Mr. Butts was ordered to OSH and for a second time the "involuntary administration of antipsychotic medication" was ordered (Ref. 4, p 53). A forced-medication petition

was initiated by OSH under the provisions of ORS 426.385(3) and Oregon Administrative Rules 309-114-0020(1)(e), and approved by an Administrative Law Judge (ALJ). Oregon Administrative Rules 309-114-0020(1)(e) outlines that forced medications cannot be used solely to restore competency and may be approved to address dangerousness and grave disability related to symptoms of mental illness. At that time the treating hospital psychiatrist, an independent physician, and the hospital's Chief Medical Officer all agreed that Mr. Butts was psychotic and in need of treatment based on "dangerousness or to treat grave disability" (Ref. 4, p 53).

Mr. Butts initially contested the petition for forced medication but later withdrew his objections, leading to the approval of the petition in May 2013, allowing OSH "to immediately administer [antipsychotic medication to Mr. Butts without informed consent" (Ref. 4, p 54). The treating psychiatrist who had initiated the forced-medication petition later concluded that Mr. Butts was not psychotic, but that he was depressed and "possibly" had a personality disorder (Ref. 4, p 53), and no forced antipsychotics were prescribed. Another OSH psychologist conducted a second competency evaluation of Mr. Butts and opined that he was fit to proceed and was malingering.

A month after the ALJ's forced-medication petition was adjudicated, OSH still had not administered antipsychotic medication to Mr. Butts. His counsel returned to the trial court, stating that although the ALJ and trial court had both ordered OSH to administer antipsychotics to Mr. Butts, OSH still had not done so. The prosecution noted that, for the court to force medications under *Sell*, it first had to ascertain that Mr. Butts was mentally ill. The court took the "matter under advisement" (Ref. 4, p 54).

A year later, in September 2014, the trial court entered a *Sell* order, basing its decision on the evidence from the February 2013 hearing where Mr. Butts was found not fit to proceed. The defense team added evidence from another defense expert whose affidavit suggested that antipsychotics should be used in Mr. Butts' treatment and restoration. The trial court found that:

[t]he recommended treatment is substantially likely to enable Defendant to gain or regain his capacity to stand trial, because administration of the medication to the defendant is medically appropriate, i.e., in the defendant's best medical interest in light of his medical condition [Ref. 4, p 54].

On the basis of the *Sell* order, Mr. Butts was admitted to OSH for a fourth time in September 2014. The trial court denied OSH's attempt to vacate the *Sell* order. In January 2015, the *Sell* order was reissued to reaffirm the prior court orders. OSH then filed for a *mandamus* proceeding and the Oregon Supreme Court issued its own writ of *mandamus* (Ref. 4, p 55). As the court noted, "Mandamus is an extraordinary remedy and serves a limited function. . . . It is a statutory remedy aimed at correcting errors of law for which there is no other plain, speedy and adequate remedy in the ordinary course of the law" (Ref. 4, p 56; internal quotations omitted).

Thus, over 3 years and 10 months, Mr. Butts was admitted to OSH on four separate occasions. He was evaluated by two defense experts, three state forensic evaluators, and three separate professionals, who evaluated him for a forced-medication petition. Mr. Butts was the subject of two competency hearings, a forced-medication hearing in front of an ALJ, and finally a *Sell* hearing. The petition for forced medication at OSH was not implemented, despite the ALJ's approval, as the initiating and treating physician later determined that Mr. Butts was not psychotic. The trial court ordered that Mr. Butts be administered antipsychotics on three separate occasions; however, at no time during this process did OSH physicians prescribe antipsychotics. As of October 2015, Mr. Butts had been ordered back to OSH, but no further information on his treatment has been made public.

### Arguments and Ruling

In contrast to *Lopes*, in *Butts*, OSH and not the defendant, objected to the "validity of the trial court's *Sell* order" (Ref. 4, p 55). The hospital argued that the trial court lacked authority under the competency-restoration statute (ORS 161.370) to order them to medicate a patient involuntarily when the hospital providers deemed the treatment medically unnecessary:

While the trial court has the ultimate authority to determine whether an individual has the capacity to aid and assist at trial [under ORS 161.370], it is within the exclusive province of the hospital to determine whether, and what, medication is necessary to treat mental illness [Ref. 4, p 55].

The state hospital further argued that "ORS 161.370 should be interpreted to leave all treatment decisions to OSH, notwithstanding the authority that statute confers on a trial court to issue a *Sell* order when it

determines that a defendant is unfit to stand trial” (Ref. 4, p 55).

Defense counsel, in contrast, argued that ORS 161.370 allows the court, “the authority to order that a defendant be medicated—whether or not an OSH doctor agrees with that determination” (Ref. 4, p 55). The defense noted that there was no explicit provision in the statute to do so, but that, “by implication, relying on *Lopes*,” trial courts are allowed to issue *Sell* orders “to enable” hospitals to treat (Ref. 4, p 56). They further argued that if that is not the case, then anytime OSH disagrees with a trial court’s order, “criminal proceedings could be brought to a standstill” (Ref. 4, p 56).

As noted earlier, the *Lopes* holding granted trial courts the right to issue *Sell* orders. In the *Lopes* case, however, OSH and the courts agreed about the appropriateness of treatment. It was noted that the statutes governing competence to stand trial in Oregon (ORS 161.360–370) were initiated in 1971, long before *Sell* was settled in 2003. Nevertheless, the court held that “courts have implicit authority to issue *Sell* orders under ORS.161.370 to order hospitals to involuntarily medicate defendants for the purpose of restoring their fitness to stand trial” (Ref. 4, p 57). In contrast to *Lopes*, the treating institution advocated not to treat, creating a dispute not previously answered in Oregon: can a trial court order OSH to comply with an order for involuntary medication when hospital personnel do not believe it is indicated? The trial court adjudicated that Mr. Butts was not fit to proceed after “resolving disputed factual issues” (Ref. 4, p 58) around his competency and thus that he was in need of treatment.

Oregon case law has determined that *mandamus* hearings should be considered an “extraordinary remedy” and should not “control judicial discretion.” In other words, “mandamus relief is not available to OSH solely based on its disagreement with the trial court’s findings of fact” (Ref. 4, p 59).

First, OSH argued for *mandamus* relief because the trial court based the need for a *Sell* order for forced medication in large part on the opinions of two defense psychiatrists, stressing that this evidence did not meet the clear-and-convincing evidentiary threshold required in *Sell* cases and therefore represented an error of fact.

Second, OSH argued that ORS 161.370 did not confer on the trial court the authority to order OSH to administer medications that the institution

deemed were not medically necessary. OSH argued that it is “within the exclusive province of the superintendent or director to determine what treatment, if any, is necessary for a defendant to regain the capacity to stand trial” (Ref. 4, p 59).

OSH based their argument on two provisions in the competency-to-stand-trial statute (ORS 161.370). First, ORS 161.370(5) specifies that the superintendent’s duty is to deem patients competent to stand trial by way of an evaluation and to notify the court of how OSH arrived at its decision. Second, ORS 161.370(5)(b)(c), outlines the hospital’s duty to notify, “when there is a substantial probability that the defendant, in the foreseeable future, will gain or regain the capacity to stand trial” (Ref. 4, p 59). A third provision, outlined in the brief, ORS 161.370(6)(a), further establishes that OSH can retain a defendant for treatment based on the assessment of likely restoration:

... [i]f the superintendent or director determines that there is a substantial probability that, in the foreseeable future, the defendant will gain or regain the capacity to stand trial, unless the court otherwise orders, the defendant shall remain in the superintendent’s or director’s custody where the defendant shall receive treatment designed for the purpose of enabling the defendant to gain or regain capacity [Ref. 4, pp 59–60].

However, the court outlined that these provisions provide only partial support for OSH’s contention of their exclusive role in determining treatment, noting that ORS 161.370(6)(a) outlines that the patient must receive treatment but does not specify who should select the treatment. Likewise, ORS 161.370(5)(b)(c), notes that an estimate by the institution of a time frame for restoration, “with appropriate treatment” (Ref. 4, p 60), does not elucidate who determines treatment appropriateness.

Further evidence cited to support the court’s authority included its ability to suspend proceedings if fitness is in question, commit defendants to OSH, dismiss charges, require OSH to report on progress to the court, and determine the likelihood of restoration in the foreseeable future. Alongside procedural authority to hold hearings related to competency, the court also has the authority to call any witness for the purpose of determining fitness. This includes psychologists and psychiatrists who may provide treatment recommendations. If fitness is contested, it is the court that has the authority to determine the weight of evidence. Thus, the court reasoned that

OSH's "veto" power is not supported in statutory analysis.

The criminal proceedings in this case were frozen because of the disagreements between the court and the hospital about Mr. Butts' competency and the role of antipsychotic treatment in resolving the matter. If the trial court did not have implicit authority to order involuntary medication, there would be only two options: to conduct serial evaluations of competency or to dismiss "criminal prosecution without prejudice" (Ref. 4, p 64). The court did not believe that this was the legislative intent of ORS 161.370.

The final argument against the order was that providers at OSH would ethically object to the administering of medications that "no OSH doctor has determined" (Ref. 4, p 64) to be medically necessary. The court contended that the Chief Medical Officer and two providers at OSH had earlier agreed to the necessary treatment and the court felt that there was no explanation of why the ALJ's decision to force medications was not enacted in May 2013. They concluded that OSH did not demonstrate that it is "unable to comply" or "that compliance would pose an ethical conflict for any OSH doctor." (Ref. 4, p 64–5).

In conclusion, *mandamus* relief was deemed inappropriate, the alternate writ of *mandamus* was dismissed, and it was determined that the *Sell* order, "directing OSH to involuntary medicate defendant was authorized by ORS 161.370" (Ref. 4, p 66). The court ruled that provisions in ORS 161.370 do not provide exclusive treatment authority to OSH and that no ethics-related conflicts for OSH providers were identified.

## Discussion

To our knowledge, this is the first instance in which a state supreme court decided that a hospital cannot refuse to medicate a defendant in opposition to a *Sell* order. Given that medication treatment is traditionally initiated and managed by an individual practitioner, this decision potentially creates an ethical/professional dilemma. What happens if a prescriber designated to restore an individual to competence does not believe that the defendant has a treatable mental illness?

In Oregon, *Sell* hearings typically occur after a period of hospital assessment, and it is during this time that a judgment is made on the patient's diagnosis and whether his symptoms would be responsive

to medication. Moreover, the defendant must be evaluated for his capacity to consent to medication, and if he refuses, it must be determined whether he meets dangerousness or grave disability criteria for being involuntarily medicated. *Sell* hearings therefore typically involve a defendant who is deemed incompetent to stand trial, is nondangerous, and refuses medication that a treating provider thinks has a substantial chance of restoring his competence. The defendant in this case was considered dangerous by the hospital, but it was not thought that the danger he presented was a result of a treatable mental illness.

In *Butts*, the defendant (and his defense team), not the hospital, wanted involuntary medication for restoration, and it appears that the Oregon Supreme Court ruled that the defendant met *Sell* criteria, based not on the opinions provided by treating providers, but on those expressed by the defense experts (presuming one accepts that the initiator of forced medications under the dangerousness and grave disability criterion later modified her assessment and concluded that he was not psychotic). This ruling creates a precedent where medical decisions are decided by expert witnesses in the courtroom rather than treating providers in the hospital.

As the *Butts* case was shuttled back and forth from the courts to the hospital, the original issue in *Sell* may have been lost (i.e., the weight of the government's interest in bringing a defendant to trial versus the defendant's constitutional right to refuse psychotropic medication). Consequently, the *Sell* holdings aimed to set limits on the state by tightly demarcating the rare circumstances under which a defendant's right to refuse medication could be overruled. Instead of checking the power of the government, the current case tips the scales in favor of government interests by enabling the courts, under the guise of a *Sell* hearing, to overrule, not just the defendant's rights but the ethics-based obligation of the psychiatrist to treat a patient in a manner that the psychiatrist believes is in the patient's best interest.

In its decision, the Oregon Supreme Court disregarded all three of the state hospital forensic evaluations that opined that the defendant was competent to stand trial. From the court's standpoint, it may have appeared that OSH evaluators and clinicians were divided in their opinions after the treating psychiatrist's petition to medicate the defendant involuntarily, whereas, in contrast, the defense experts

were unified in their opinions. While expressing divided and changing opinions, the OSH did not appear to present a robust clinical opinion to buttress the position ultimately taken. Given the gravity of the charges in this case, there is significant interest in the resolution of the matter of competency to stand trial. Perhaps this decision also aims to give the benefit of the doubt to a capital defendant.

In the current case, the essential role of the individual treating provider in diagnosing and selecting a course of treatment has been circumvented in a manner antithetical to how medicine is routinely practiced. It would be unethical for a physician to prescribe a medication with no medical purpose for the treatment, and, according to Oregon law, such action could result in disciplinary action against the physician. From the court's perspective, the "medical necessity" of treatment for Mr. Butts had already been determined during the hearing, but should this be a point decided in the courtroom? The process of diagnosing and treating illness is dynamic and subject to temporal changes and individual idiosyncrasies (i.e., genetic differences affecting symptom presentation and reactions to medications), and diagnoses sometimes change over time with more observational data. Medication that is appropriate at one moment in time might not be at another. In their decision, the Oregon Supreme Court seems to gloss over the complexities of psychiatric medicine. The *Butts* decision also appears to contradict the sentiment expressed by the U.S. Supreme Court in *Washington v. Harper*, where they found that the defendant's interests were "perhaps better served, by allowing the decision to medicate be made by medical professionals rather than a judge" (Ref. 5, p 211).

In general practice, one clinician's recommendation, based on one interview or less, would routinely

have no authority over another independent provider. In the current scenario, the court is taking the recommendation of a defense expert and making another independent practitioner (and institution) follow the expert witness's direction; in essence, the court is practicing medicine by proxy without a license, potentially leading attorneys and courts toward expert and institution shopping.

The Oregon Supreme Court stated that their ruling in *Butts* serves, in part, to prevent the Oregon State Hospital from having "the authority to bring the criminal proceeding to a standstill if it disagrees with the court's fitness and treatment determination" (Ref. 4, p 1194). A treating provider who disagrees with a *Sell* order, however, has the primary responsibility and goal of treating an individual's mental illness and is unlikely to have any intention of disrupting criminal proceedings.

Given the benefits to the defense in the current decision, this case raises another question. Should a defense team advocating for their client to be medicated be allowed a *Sell* hearing in contradiction to the original intent of *Sell*, which is to determine whether a defendant's right to remain unmedicated can be overruled? This case appears to open the door for courts to make decisions to medicate without regard for the opinions of treating providers, certainly an unwelcome development for psychiatrists. It is likely that future cases will be heard in Oregon and around the country that address the questions raised by this controversial ruling.

## References

1. *Sell v. United States*, 539 U.S. 166 (2003)
2. Or. Rev. Stat. § 161.360 (1983), Or. Rev. Stat. § 161.365 (2011), Or. Rev. Stat. § 161.370 (2014)
3. *State v. Lopes*, 322 P. 3d 512 (Or. 2014)
4. *Oregon State Hospital v. Butts*, 359 P.3d 1187 (Or. 2015)
5. *Washington v. Harper*, 494 U.S. 210 (1990)