Steele v. Hamilton County Community Mental Health Board

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Before October 2000, psychiatric hospitals in Ohio were free to implement their own policies for overriding medication refusals. Then in October, the Ohio Supreme Court decided *Steele v. Hamilton County* (90 Ohio St.3d 176), the first case to reach the state's highest court involving the right to refuse antipsychotic medication. The issue facing the Court was whether a finding of dangerousness was required to override a patient's refusal of antipsychotic medication. The Court decided that dangerousness was not required. However, the Court moved Ohio in a distinctly rights-driven direction by requiring a judicial decision-maker.

Question

Must a mentally ill person be imminently dangerous in order for a court to order the forcible administration of antipsychotic medication?

Facts

On July 26, 1997, Jeffrey Steele was brought to the University of Cincinnati Hospital by police officers due to "seeing things and trying to fight imaginary foes." He was involuntarily admitted to University Hospital. Two days later an affidavit was filed in probate court by his treating psychiatrist, stating that Mr. Steele was mentally ill and unable to provide for his basic physical needs due to paranoid schizophrenia. The probate court subsequently civilly committed Mr. Steele and ordered his transfer to the Lewis Center (a state psychiatric hospital) for long-term treatment.

Two months later, the Hamilton County Mental Health Board sought a court order to administer antipsychotic medication to Mr. Steele without his informed consent. At a probate court hearing, three psychiatrists testified that Mr. Steele suffered from schizophrenia but he was not dangerous to himself or others while in the hospital. However, all three psychiatrists testified that:

1. Mr. Steele lacked the capacity to give or withhold informed consent;
2. Antipsychotic medication was the only effective treatment for his mental illness;
3. The benefits of antipsychotic medication outweighed the side effects;
4. Mr. Steele's illness, without treatment, prevented his release.

The probate court magistrate concluded that Mr. Steele was mentally ill due to schizophrenia, required hospitalization, and lacked the capacity to give informed consent for treatment. However, because Mr. Steele was not imminently dangerous, the magistrate concluded that Mr. Steele should not be medicated forcibly.

On appeal, the probate court upheld the magistrate's finding that forced psychotropic medications may only be given to a severely mentally ill person who is dangerous within the institution, and only when the treatment is in the patient's medical interest.

On further appeal, an Ohio court of appeals reversed the judgment of the probate court and held that dangerousness to self or others is not required to

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order forced psychotropic medications when it has been shown that the patient lacks the capacity to give informed consent and medication is in the patient's best interests. The case was then appealed to the Ohio Supreme Court.

Holding

In a unanimous decision written by Justice Douglas, the Ohio Supreme Court affirmed and ruled that a court may authorize the administration of antipsychotic medication against a patient's wishes without a finding of dangerousness when clear and convincing evidence exists that:

1. The patient lacks the capacity to give or withhold informed consent regarding treatment;
2. The proposed medication is in the patient's best interest;
3. No less intrusive treatment will be as effective in treating the mental illness.

Rationale

The Court noted that the right to refuse medical treatment is a fundamental right and is guaranteed by the Ohio constitution and the (substantive) due process clause of the 14th Amendment of the United States Constitution. The Court held that the right to refuse medication is not an absolute right and must yield when outweighed by a compelling governmental interest.

The Court acknowledged that significant liberty interests are infringed on with forced medication, including the liberty interests of personal security, bodily integrity, and autonomy. Forced antipsychotic medications were described as a "particularly severe" intrusion because of the chemical changes produced in the brain by antipsychotic medications and resultant alteration of cognitive processes. The liberty interest infringement is further magnified by the negative side effects of antipsychotic medications, including Parkinsonism, akathisia, dystonic reactions, tardive dyskinesia, and risk of neuroleptic malignant syndrome. The Court also considered the therapeutic benefits of antipsychotic medications and their substantial impact on deinstitutionalization.

There are two compelling government interests that may override an individual's right to refuse antipsychotic medications—the state's police powers interest in preventing mentally ill persons from harming themselves or others, and the state's *parens patriae* authority.

The Court held that when an involuntarily committed mentally ill patient poses an imminent threat of harm to himself or others, the state's police powers interest in protecting its citizens outweighs the patient's interests in refusing antipsychotic medication. This is uniquely a medical (rather than judicial) determination to be made by a qualified physician, because this issue arises only when there is an imminent threat of harm. The decision of whether to medicate the patient in an emergency must be made promptly before an injury occurs. There is not time for a judicial hearing, and medical personnel must make the determination whether the patient is dangerous to self or others. Therefore, a physician may order the forced medication of an involuntarily committed mentally ill patient with antipsychotic medications when the physician determines that:

1. The patient presents an imminent danger of harm to himself or others;
2. There are no less intrusive means of avoiding the threatened harm;
3. The medication to be administered is medically appropriate for the patient.

The Court emphasized that "imminent" dangerousness must be present to medicate forcibly a patient in an emergency, and that emergency medication may only be administered as long as the emergency persists. The Court acknowledged that this places substantial power and authority in the hands of physicians but was confident that properly trained, competent, and compassionate physicians will not abuse such power.

The second compelling governmental interest that may override a mentally ill person's treatment refusal is the state's *parens patriae* authority, which allows the state to care for citizens who are unable to care for themselves. This *parens patriae* authority is invoked when a patient lacks the capacity to make an informed decision regarding treatment. Modifying its earlier decision in *In re Milton*, the Ohio Supreme Court found that an individual need not be ruled generally incompetent before receiving forced medication, which would unnecessarily stigmatize the patient. Rather, the Court endorsed the concept of specific competencies, that is, examining whether the patient lacks the capacity to give or withhold informed consent. The Court also found that civil commitment is not equivalent to incompetence to

give informed consent for treatment decisions—they are separate liberty interests and must be adjudicated separately. However, failure to recognize the state's *parens patriae* authority could result in the warehousing of mentally ill persons who incompetently refuse medication; this would be inhumane.

Whether an involuntarily committed mentally ill patient who does not pose an imminent threat of harm to himself or others lacks the capacity to give informed consent is uniquely a judicial (rather than a medical) determination. Accordingly, the Court held that a court might issue an order to administer antipsychotic medications against the wishes of a mentally ill person if it finds, by clear and convincing evidence, that:

1. The patient lacks the capacity to give or withhold informed consent regarding treatment;
2. It is in the patient's best interest to take the medication; that is, the benefits of the medication outweigh the side effects;
3. No less intrusive treatment will be as effective in treating the mental illness.

In the case of Mr. Steele, the Court did not rule whether he had to take medications, because by the time this decision was written he was voluntarily taking medications.

The issue of "procedural due process" was not raised by the appellant. However, the Court stated *in dicta* that procedures required when determining whether the state's *parens patriae* authority outweighs the individual's right to refuse antipsychotic medication include:

1. Representation by an attorney;
2. An independent psychiatrist or a licensed clinical psychologist and a licensed physician must be appointed to examine the patient's capacity to give or withhold informed consent and the appropriateness of the proposed treatment;
3. The patient, attorney, and treating physicians must receive notice of all hearings;
4. The patient must have the opportunity to be present at all hearings and to present and cross-examine witnesses.

Periodic hearings to review the patient's capacity for consent and efficacy of treatment should take place, but specific guidelines on the frequency of these hearings were not given. The need for continued forced medication should be substantiated by competent medical evidence. A motion to continue forced medication is subject to the same procedural safeguards as an original motion for forced medication.

Commentary

This is the first case on the issue of the right to refuse antipsychotic medication to reach the Ohio Supreme Court (a case of first impression). The decision moves Ohio in a distinctly "rights-driven" direction, approximating the requirements laid out in the Massachusetts Supreme Court decision *Rogers v. Commissioner* (1983).

Before the *Steele* decision, psychiatric hospitals in Ohio were free to develop and implement policies of their own design with regard to attempting to override the medication refusals of involuntarily committed psychiatric patients; no case law or statute directly addressed the issue. Practically, some private facilities used a second doctor as the decision-maker in medication refusal cases, similar to the treatment-driven model, which first entered case law with the *Rennie v. Klein* (1983) decision. Other Ohio facilities used variants of the treatment-driven model that gave decision-making authority to an internal oversight committee. Still others voluntarily sought a court order to override medication refusals. For the last several years, the Ohio Department of Mental Health had required its state-run inpatient facilities to seek formal adjudication of medication refusal issues at the probate court level, an internal policy that went beyond legal requirements.

Although the *Steele* decision approximates a strict *Rogers* model, there are important differences. Most importantly, the Ohio decision does not require that a guardian be appointed. However, an Ohio court must now find a patient incompetent to give or withhold informed consent on the specific issue of antipsychotic treatment before a refusal can be overridden. When a treatment refusal is to be overridden, the *Rogers* decision requires that a guardian be assigned to the patient. The guardian then provides oversight of the implementation of the forced medication process. Like Ohio, the court in Massachusetts is the ultimate decision-maker on the treatment refusal issue.

Another important difference between *Steele* and *Rogers* is the surrogate decision-making model used in each. In Ohio, like New York, under *Rivers v. Katz*, courts are now directed to apply a "best interests" model to the treatment refusal override decision. In Massachusetts, a "substituted judgment"

model is used, which involves an effort to determine what the patient would have decided if he or she were competent.

Although the Ohio Supreme Court included, *in dicta*, the specific procedural due process requirements for overriding medication refusals in nonemergencies, uncertainty remains as to exactly how these procedures will be implemented. In particular, the opinion specifies that an "independent psychiatrist. . . must be appointed to examine the patient. . . " as part of the refusal override process. After conducting an informal telephone survey of several magistrates and probate judges in Ohio, it became clear that there was no unified interpretation of this aspect of the decision yet. In one county, the magistrate handling mental health issues stated unequivocally that it was her understanding that the independent medical evaluation was an absolute requirement (that is, it could not be waived by a patient or his counsel). Further, she stated that her county ensured that the evaluation was truly independent by requiring it to be done by a physician, uninvolved in the patient's care, who practices in an entirely different facility. Another county's probate judge indicated that a patient could waive the independent medical evaluation requirement and that any doctor, even one in the same facility, who is uninvolved in the patient's care would suffice for this purpose. Another county's magistrate indicated that, before *Steele*, a patient's counsel typically accepted any second doctor's opinion to satisfy the requirement for an independent medical evaluation and he expected that not to change under the new decision.

From the perspective of some probate courts, the *Steele* decision will not significantly change their procedures; they had nearly identical requirements, which predated *Steele*. Clearly, the biggest impact of this decision is going to be on private inpatient facilities, some of which previously used an internal review procedure for overriding medication refusals. Now, these facilities must seek a formal adjudication on each patient for whom forced medication is sought. This will require an additional expenditure of staff time and resources. The need for a formal adjudication also may significantly delay beginning effective therapy for patients, lengthening costly hospital stays. This may result in more patient transfers from private to public facilities or more refusals to admit patients predicted to refuse medication.

The Ohio Psychiatric Association (OPA) and Ohio Department of Mental Health (ODMH) did not file amicus briefs in this case. The inclusion of the specific procedural requirements surprised some state mental health officials. Some observers expected a narrow ruling on the specific issue of whether or not dangerousness was a required element to override a medication refusal. Had such a broad decision been anticipated, it is possible that *amicus* briefs by OPA, ODMH, or other interested organizations could have persuaded the court to take a more moderate, treatment-driven view of the issue.