

Involuntary Non-emergent Psychotropic Medication

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Administration of Non-emergency Psychotropic Medication to a Nonconsenting Patient Who Is Involuntarily Committed

In *Myers v. Alaska Psychiatric Institute*, 138 P.3d 238 (Alaska 2006), the Supreme Court of Alaska considered whether the state can administer non-emergent psychotropic medications to a nonconsenting patient involuntarily committed to a state hospital without judicial determination regarding the appropriateness of the treatment.

Facts of the Case

Faith Myers had a 20-year history of recurring psychotic illness episodically and successfully treated with antipsychotic medications. In 2001, Ms. Myers stopped her medications based on her belief that the medications worsened her condition. In February 2003, she was involuntarily committed to the Alaska Psychiatric Institute (API) based on a petition filed by her family. She refused to participate in treatment plans offered by her physicians, who filed a petition with the superior court requesting authorization to medicate her without her consent.

Citing guarantees to liberty and privacy found in Alaska's constitution, she challenged the physicians' bypassing her consent to treatment. Ms. Myers argued that the state may only abridge these rights while advancing a compelling state interest. She argued that API had not made this requisite showing and failed to show that involuntary administration of medications is the least restrictive means to advance any state interest. Ms. Myers challenged the statutory limitations on the court's authority to modify or restrict a treatment plan, arguing that the court cannot take into account whether a treatment plan is in the patient's best interests.

After testimony from opposing psychiatrists regarding the safety and efficacy of antipsychotic med-

ications, the superior court found that Ms. Myers lacked insight, and although she presented a reasonable objection to her medications, she lacked the capacity to make informed decisions regarding treatment. The court authorized API to administer psychotropic medications based on API's assessment of Ms. Myers's best interests. However, the court expressed concern that Alaska's statutes did not allow the court to consider the merits of API's treatment plan or weigh the objections of Ms. Myers' experts, limiting their jurisdiction to whether Ms. Myers had the capacity to give informed consent. The court emphasized this limitation as follows:

Where a patient, such as Ms. Myers, has a history of undergoing a medical treatment that she has found to be harmful, where she is found to lack capacity to make her own medical decisions and a valid debate exists in the medical/psychiatric community as to the safety and effectiveness of the proposed treatment plan, it is troubling that the statutory scheme apparently does not provide a mechanism for presenting scientific evidence challenging the proposed treatment plan [*Myers*, p 240].

Ruling and Reasoning

The Alaska Supreme Court made the following holding: "In the absence of emergency, a court may not authorize the state to administer psychotropic drugs to a nonconsenting mental patient unless the court determines that the medication is in the best interests of the patient and that no less intrusive alternative treatment is available" (*Myers*, p 239).

At the time of the ruling, Alaska had two separate statutory provisions governing non-emergent administration of antipsychotic medications against a patient's consent. Under Alaska law, the administration of antipsychotic medications without the patient's consent required first that the patient be committed to an institution based on clear and convincing evidence that, as the result of a mental illness, the patient was likely to harm himself or herself or someone else or was gravely disabled. For commitment longer than 72 hours, statutes required a signed statement by two mental health professionals that the treatment staff considered and rejected less restrictive alternatives and that the proposed treatment was likely to improve the person's condition.

Informed consent must be obtained for the treatment of each patient, regardless of commitment status. Alaskan law requires that the physician or treating staff provide information related to proposed treatments; risks and benefits of and alternatives to the proposed treatment; and a statement describing

the patient's right to give or withhold consent. If a patient refuses consent for medication and the treatment team wishes to override the refusal, the physician must petition the court a second time. First, the physician must show by clear and convincing evidence that the committed patient currently lacks capacity to give informed consent with regard to the proposed treatment. If the court finds a lack of capacity, it appoints an uninvolved "visitor" who is charged with the duty of investigating the capacity of the patient and conducting a search for previously expressed opposition to treatment with psychotropic medications while competent. The patient may have expressed these wishes in the form of an advanced directive, power of attorney, or oral or written communication with significant relatives or family members. If the court finds the patient presently incapable of consenting and without prior expressed desire not to be medicated, then the statute requires the court to authorize administration of psychotropic medications.

Ms. Myers challenged the ruling based on Alaska's constitutional guarantees of liberty and privacy, which are much broader than the protections of the federal constitution. Alaska's constitution declares that "all persons have natural right to life, liberty, the pursuit of happiness and the enjoyment of rewards of their own industry" (Constitution of the State of Alaska, Article 1: Declaration of Rights § 1 Inherent Rights). Later, the Constitution protects liberty ("No person shall be deprived of life, liberty, or property, without due process of law") and privacy ("The right of the people to privacy is guaranteed and shall not be infringed"). The court noted, "When a law places substantial burdens on the exercise of a fundamental right, we require the state to articulate a compelling interest and to demonstrate the absence of a less restrictive means to advance [that] interest" (*Myers*, p 238). When the right is not fundamental, however, the state should show a legitimate interest and show a close relationship between the interest and means of advancing that interest.

The court ruled that these constitutional protections entail a right to be free from involuntary ingestion of medicines, especially psychotropic medications, given the risk of early and late harm. The court cited similar rulings in other states (including *Rogers v. Commissioner of the Department of Mental Health*, 458 N.E.2d 308 (Mass. 1983), *Rivers v. Katz*, 495 N.E.2d 337 (N.Y. 1986), *Jarvis v. Levine*, 418 N.W.2d 139 (Minn. 1988), and *Steele v. Hamilton*

County Mental Health Board, 736 N.E.2d 10 (Ohio 2000). Based on these cases, the court held that, given no emergency situation, the state may override the fundamental right to refuse medications only when necessary to advance a compelling state interest and only when no less intrusive alternative exists.

API argued that treating Ms. Myers advanced two compelling state interests: protection against self-harm or harm to others (police power) and improvement of Ms. Myers' medical condition (*parens patriae* duty). A state's police power has its roots in the state's interest in preserving the physical safety of its citizens. Although this might hold true in an emergency, as the Ohio Supreme Court held in *Steele*, the facts of this case centered on non-emergent administration of medications. The court rejected the police power interest argument because of the lack of emergency and also noted that the existing statute for involuntary administration of medications that applies to this case makes no mention of police power or dangerousness. With regard to its *parens patriae* duty, API argued that since Ms. Myers was found to lack capacity to make mental health treatment decisions, the state had a compelling interest in protecting her. The court agreed with this argument but held that the existing statutory scheme was overly intrusive in its advancement of the state's interest. The court reasoned that there should be judicial determination as to which treatments are in the best interest of the patient.

API argued that the applicable statutory scheme had already taken into account the patient's best interest by allowing her treatment team to make mental health care decisions for committed patients. The current statute reflected the legislative belief that doctors were the best arbiters of the patient's interests. Thus judicial determination of the best interests of the patient was not necessary. The court disagreed, arguing that judicial determination is constitutionally necessary to ensure that the least intrusive means are used to advance the *parens patriae* duty of the state. The court argued that medical competence and expertise were not at issue, but rather the constitutional protection of the rights of liberty and privacy, which are protected by the courts. Although medical decision-making and expertise must be taken into account, the final decision regarding protection of constitutional rights must rest with the courts. In addition, physicians may have competing interests of institutional stability or economic considerations

which could conflict with a patient's desire not to take medications. The principle of making decisions from the standpoint of medical necessity may often conflict with decisions made by personal choice. This is a conflict between the autonomy of a patient to determine his or her own treatment and the physician's principle of beneficence.

The court then described an additional criterion not previously found in the statutes for involuntary administration of medications: the best-interests criteria. The court acknowledged that this remains a fact-specific, case-by-case endeavor. At the minimum, the court should hear the statutorily required information provided to patients for their own determination of medical decision-making. Specifically, the court should consider:

- (A) An explanation of the patient's diagnosis and prognosis or their predominant symptoms, with and without the medication;
- (B) Information about the proposed medication, its purpose, the method of its administration, the recommended ranges of dosages, possible side effects and benefits, ways to treat side effects, and risks of other conditions, such as tardive dyskinesia;
- (C) A review of the patient's history, including medication history and previous side effects from medication;
- (D) An explanation of interactions with other drugs, including over-the-counter drugs, street drugs, and alcohol; and
- (E) Information about alternative treatments and their risks, side effects, and benefits (*Myers*, p 252).

The court held that the order granting involuntary administration of medication by the superior court be vacated, since that court did not take into account Ms. Myers' best interests. The court also held that, in future cases of non-emergent medication of unwilling patients, the treating team must continue to show that the patient lacks capacity and never previously expressed a desire to take psychotropic medications. In addition, the court must find clearly and convincingly that the proposed treatment is in the patient's best interest and that no less intrusive alternative is available under the new guidelines.

Discussion

In the involuntary treatment of nonconsenting patients, the courts have held various opinions on what counts as a compelling state interest to over-

come a patient's right to liberty and privacy. In *Rennie v. Klein*, 476 F.Supp. 1294 (D. N.J. 1979), the U.S. District Court held that an informal review by an independent physician is sufficient to override a patient's refusal to take medications. This model is treatment driven and gives the physician control over medical decision-making. The Utah model gives even more rights to physicians, by arguing that a committed patient is involuntary at the time of commitment. Once this adjudication takes place, then the physician may make any treatment decision he or she sees fit. Contrast this with *Rogers v. Commissioner of Dept. of Mental Health*, 458 N.E.2d 308 (1983), in which the Massachusetts Supreme Judicial Court held that only a judge is sufficient to make substituted decisions for patients who have been adjudicated incompetent. The reasoning in this case is that due process is necessary to override the liberty interests that are at odds with involuntary administration of medications.

In this case, the Alaska Supreme Court has placed additional restrictions on the ability of physicians to treat patients without consent, above and beyond the holding in *Rogers v. Commissioner*. The model proposed requires the finding of incapacity, but also requires that the treatment team give information associated with informed consent to a judge who then decides if this treatment is in the patient's best interest. This ruling is confusing, in that the statute as written assumes a substituted-judgment model. The visitor from the court must investigate whether the patient reliably expressed a choice not to have psychiatric medication, and if so, the judge must rule that the medication may not be given. In the new ruling by the Supreme Court of Alaska, the judge makes consideration of the best interest of the patient based on a judicial evaluation of the risks, benefits, side effects, and alternatives to the proposed treatment. Since best interest does not equal substituted judgment, this ruling must be further clarified with a separate opinion.

As it stands, the *Myers v. Alaska Psychiatric Institute* standard is the most restrictive standard for overcoming refusal of treatment in case law. It remains to be seen whether other states will adopt similar rulings.