Mental Patients' Rights to Refuse Drugs: Involuntary Medication As Cruel and Unusual Punishment

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Introduction

The right of hospitalized mental patients to refuse treatment has been recognized only relatively recently by our judicial system. Although still in its embryonic state, this developing right already has become a major issue in the field of mental patients' civil liberties. Recognizing that the fundamental civil liberties and human dignity of this relatively voiceless segment of the population are at stake, an increasing number of courts and commentators have undertaken a reevaluation of mental health treatment to bring these practices into accord with the more humanistic standards of contemporary society.

Many cases dealing with the right to refuse treatment have concerned highly intrusive medical procedures which have not been proven totally effective and which have the potential to cause grave side effects.[1] In addition, several cases have centered upon the administration of certain medications without the informed consent of the patient. For example, the use of the drugs apomorphine[2] and succinycholine[3] (anectine treatment) when administered without such consent has been prohibited by the courts. These drugs, however, do not represent the standard medication received by the majority of patients in the country's mental institutions; thus, although the cases concerning their use are landmark precedents, they do not directly protect patients

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1. *E.g.*, Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Anderholt, 503 F.2d 1305 (5th Cir. 1974) (patient granted the right to refuse electroshock therapy); New York City Health & Hosp. Corp. v. Stein, 70 Misc. 2d 944, 335 N.Y.S. 2d 461 (Sup. Ct. 1972) (same); Kaimowitz v. Department of Mental Health, Civ. No. 73-19434-AW (Cir. Ct., Wayne County, Mich., filed July 10, 1973) (patient granted the right to refuse experimental psychosurgery).

2. Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973).

3. Mackey v. Procunier, 477 F.2d 877 (9th Cir. 1973).

from the major drug treatment programs to which they are likely to be subjected.

The most common pharmaceuticals used today for mental health treatment are referred to generally as psychotropic medication, or drugs that affect psychic functions and behavior.[4] These drugs, in particular Thorazine, have radicalized the treatment of mental patients in the last thirty years[5] and are usually the primary, and often the sole, form of treatment received by institutionalized patients. It is the often indiscriminate and involuntary use of psychotropic drugs which is coming under increasing judicial scrutiny.[6]

Several constitutional arguments have been raised in support of the theory that the use of psychotropic drugs without informed consent is illegal. Theories based upon the right to privacy,[7] freedom of speech—freedom of thought processes,[8] freedom of religion,[9] and substantive and procedural due process[10] have been proposed by numerous commentators to support the general right to forego treatment, and used successfully in litigation to sustain the right to refuse medication.[11] However, another constitutional provision—the Eighth Amend-

4. 2 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 2601 (2d ed. A. Freedman, H. Kaplan & B. Sadock eds. 1975).

5. Winick, *Psychotropic Medication and Competence to Stand Trial*, 1977 AM. BAR FOUNDATION RESEARCH J. 769, 778 (1977) [hereinafter cited as Winick].

6. *See, e.g.*, Rogers v. Okin, 478 F. Supp. 1342 (D. Mass. 1979) (class action suit by patients resulting in hospital staff being ordered to refrain from forcibly administering psychotropic drugs without first obtaining the consent of the patient or his or her guardian, unless a substantial likelihood of violence, personal injury or attempted suicide); Jamison v. Farraby, Civ. No. 78-0445 WHO (N.D. Cal.) (pending class action against forced use of psychotropics upon mental patients in California).

7. *See, e.g.*, Ferleger, *Loosing the Chains: In-Hospital Civil Liberties of Mental Patients*, 23 SANTA CLARA LAW. 447, 473 (1973) [hereinafter cited as Ferleger]; Wade, *The Right to Refuse Treatment: Mental Patients and the Law*, 1 DET. C. L. REV. 53, 55 (1976) [hereinafter cited as Wade]; Note, *Conditioning and Other Technologies Used to "Treat?" "Rehabilitate?" "Demolish?" Prisoners and Mental Patients*, 45 S. CAL. L. REV. 616, 661-62, (1972) [hereinafter cited as Note]. *See also* Scott v. Plante, 532 F.2d 939 (3d Cir. 1976); Rennie v. Klein, 462 F. Supp. 1131 (D.N.J. 1978).

8. Scott v. Plante, 532 F.2d 939, 946 (3d Cir. 1976); Ferleger, *supra* note 7, at 473; Wade, *supra* note 7, at 55; Note, *supra* note 7, at 661-62.

9. Winters v. Miller, 446 F.2d 65 (2nd Cir. 1971), *cert. denied*, 404 U.S. 985 (1971); Wade, *supra* note 7, at 62.

10. Scott v. Plante, 532 F.2d 939, 946 (3d Cir. 1976); Ferleger, *supra* note 7, at 476; Note, *supra* note 7, at 666.

11. In two critical cases, federal district courts have upheld mental patients' rights to refuse medication. In Rennie v. Klein, 462 F. Supp. 1131 (D.N.J. 1978), the decision was grounded upon both the right to privacy and due process. In a subsequent opinion, Rennie v. Klein, 462 F. Supp. 1294 (D.N.J. 1979), the trial court issued a decree to enforce the constitutional right to refuse medication in certain circumstances. The court required that prior to giving mental patients psychotropic drugs in non-emergency situations, a state hos-

ment right against cruel and unusual punishment inflicted—may be emerging as a powerful weapon in the constitutional arsenal against involuntary drug treatment.[12]

The Eighth Amendment is most often applied in a penal context; its use against involuntary medication has followed suit, being used to defend prisoners' rights to refuse drugs.[13] Yet, it also has been raised successfully in a hospital setting to support mental patients' rights to refuse medication.[14] The potential impact of this Eighth Amendment argument is almost unlimited; if recognized drug treatment, when used without informed consent as therapy for, or control of, institutionalized patients,[15] constitutes cruel and unusual punishment, medication programs affecting both voluntarily and involuntarily committed patients in the nation's mental hospitals will be revolutionized.

Several links in this Eighth Amendment argument must be strengthened before it becomes analytically complete. First, the physiological effects of these drugs must be fully understood. Second, the protection of the Eighth Amendment must be transferred from the setting of a penal institution to a civil mental institution. To accomplish this end, drug treatment must fall under the rubric of punishment as defined in prior cases. Third, the circumstances surrounding the medication procedure, and its detrimental effects, must meet the standards which the courts have set forth to determine what actions constitute cruel and unusual punishment. To complete such an analysis, it will be

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pital must obtain the patient's written consent on a form which explains the potential side effects of the medicine and the right to refuse medication. *Id.* at 1307-08.

Basing its opinion on the right to privacy and the First Amendment, the court in Rogers v. Okin, 478 F. Supp. 1342 (D. Mass. 1979), held that committed mental patients could not be forcibly medicated except in emergency situations. *See also* Jamison v. Farraby, Civ. No. 78-0445 WHO (N.D. Cal.), in which a settlement was reached concerning medication practices for voluntary mental patients. Guidelines put into effect by the California Department of Mental Health in March 1980, require that no voluntary patient receive medication in a non-emergency situation without first giving written consent after being informed of the possible dangers of the drug. A consenting patient who refuses to sign the consent form may receive medication if a doctor notes the patient's consent on the form.

12. The Eighth Amendment prohibition against cruel and unusual punishment is binding on the states through the Fourteenth Amendment. Robinson v. California, 370 U.S. 660 (1962).

13. *See* Nelson v. Heyne, 491 F.2d 352 (7th Cir. 1974), *cert. denied*, 417 U.S. 976 (1974).

14. *E.g.*, Scott v. Plante, 532 F.2d 939 (3d Cir. 1976); Welsch v. Likings, 373 F. Supp. 487 (D. Minn. 1974), *aff'd*, 550 F.2d 1122 (8th Cir. 1977).

15. The Eighth Amendment thesis presented in this note is restricted to involuntary medication in *non-emergency* situations. Adopting the *Rogers v. Okin* analysis, this constitutional argument would apply to patients in all situations except those in which there is a substantial likelihood of physical harm to that patient, other patients, or to staff members of the institution. *See* Rogers v. Okin, 478 F. Supp. 1342, 1365 (D. Mass. 1979).

helpful to compare the intrusiveness and harmful effects of psychotropic drugs with those of psychotherapeutic procedures adjudged unconstitutional under the Eighth Amendment. This commentary will discuss both of the definitional issues in an attempt to create a forceful Eighth Amendment argument for those patients presently subjected to unwanted medication.

I. Uses and Effects of Psychotropics

Psychotropic drugs are the most frequently prescribed class of drugs. Approximately 250 million prescriptions for them are written annually, totalling 25% of all prescriptions in the country.[16] These drugs may be classified in four categories based on the condition they are used to treat: (1) antipsychotic drugs (major tranquilizers), used to treat schizophrenia and related psychoses; (2) antidepressant drugs; (3) lithium, used to treat manic-depressive psychosis; and (4) antianxiety drugs (minor tranquilizers), used to treat situational and neurotic anxiety.

A. Antipsychotics

Antipsychotic drugs are used to control the symptoms of acutely and chronically disturbed psychotic patients.[17] They were a major breakthrough in the treatment of schizophrenia, and are now widely considered the treatment of choice for that condition.[18] Although antipsychotics do not cure schizophrenia, they do control the symptoms, permitting patients to function outside of a hospital setting, thus reducing significantly the number of patients confined to mental hospitals. With the use of antipsychotic drugs, delusions and hallucinations, as well as the often disruptive, belligerent, or extremely withdrawn behavior, of psychotic patients are held in remission.[19] These agents also decrease agitation and hyperactivity, and ameliorate disordered thought and perception, emotional and social withdrawal, paranoid symptoms, and personal neglect.[20] One authority maintains that with proper drug maintenance therapy, relapse and rehospitalization can be prevented for a substantial number of schizophrenic patients.[21]

16. Winick, *supra* note 5, at 778-79.

17. R. SAMPLE, G. DIGREGORIA & R. WICKS, PSYCHOPHARMACOLOGIC DRUGS: A POCKET REFERENCE 9 (1978) [hereinafter cited as SAMPLE].

18. Winick, *supra* note 5, at 780.

19. *Id.* at 781.

20. AMA DEPARTMENT OF DRUGS, AMA DRUG EVALUATIONS 420 (3d ed. 1977).

21. *Id.* at 428. One psychiatric treatise views the advantages of antipsychotic drugs as follows: "The discovery of the antischizophrenic effects of these drugs [chlorpromazine and

Antipsychotic drugs include phenothiazines (the largest and most commonly used class),[22] butyrophenones, thioxanthenes, and rauwolfia alkaloids.[23] Most of the antipsychotics produce a family of autonomic reactions, including blurred vision, dry mouth and throat, constipation, paralytic ileus (non-mechanical obstruction of the bowel due to paralysis of the bowel wall), urinary retention, palpitations, dizziness, faintness, and inhibition of ejaculation.[24] In addition, a particularly troublesome side effect of the drugs in this group is orthostata hypoten-

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reserpine] had profound effects on psychiatric practice. Although chlorpromazine did not usually produce a permanent cure in schizophrenia, it did benefit greatly many patients in a way no treatment had even done before. . . . The therapeutic revolution initiated by chlorpromazine went far beyond the mere pharmacological effects of the drug. Previously, many mental hospitals had been primarily custodial in character. The fact that clinically significant therapeutic effects could be produced by a drug created an atmosphere that emphasized positive treatment and led to the vigorous application of milieu therapy, psychotherapy, group therapy, and occupational therapy. The greater use of these social therapies was made possible by the control, through medication, of the more disruptive and destructive aspects of the patient's illness. The fate of many patients who would otherwise have been permanent residents of the mental hospital was profoundly altered. Some were helped so much that they were able to remain out of the hospital and function in the community. Other patients were discharged to nursing homes or halfway houses. For those remaining in the mental hospital, the hospital became a more humane place. And schizophrenic patients who become ill today can often be treated effectively by antipsychotic medication without hospitalization."

Davis & Cole, *Antipsychotic Drugs*, in COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1921-22 (2d ed. A. FREEDMAN, H. KAPLAN & B. SADOCK 1975) [hereinafter cited as Davis & Cole].

This viewpoint is not uncommon in medical circles. When tempered by elucidation of the harmful effects of psychotropic drugs, and perhaps by a more realistic view of the true availability of "social therapies," the view presents a cost/benefit analysis of the use of these medications, although the effect of the absence of informed consent is lacking. However, the Eighth Amendment test outlined in this note does not take a cost/benefit approach; therefore, despite the drugs' possible advantages, their forced use and deleterious effects may still comprise cruel and unusual punishment. Accordingly, the possible beneficial effects of the drugs perhaps are relevant only in a few limited aspects of an Eighth Amendment inquiry, *e.g.*, defining "punishment" and ascertaining whether the punishment is "unacceptable to contemporary society." *See* notes 118-51 and accompanying text *infra*.

22. Chlorpromazine, commonly known as Thorazine, is a derivative of Phenothiazine and was the first antipsychotic drug. It is still one of the most widely used; the number of patients receiving this drug from 1952 to 1965 was estimated at between 50 million to 150 million. Winick, *supra* note 5, at 780; Note, *supra* note 7, at 625.

23. Winick, *supra* note 5, at 779-80.

24. SAMPLE, note 17, at 16-17; Davis & Cole, *supra* note 21, at 1934; Winick, *supra* note 5, at 782. *See also* THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 164 (5th ed. S. Goodman & A. Gilman eds. 1975) [hereinafter cited as Goodman & Gilman].

Statistics on the incidence of side effects are included in this note where available. Side effects which are "common" are usually so indicated. Other reactions which have been reported are included, but it is not implied that all patients suffer from all of these effects. However, all patients do *risk* negative drug reactions, although the extent of the risk varies with the commonness of the side effect. In addition, the common side effects of phenothi-

sion, a form of low blood pressure that occurs when the subject stands, often resulting in fainting.[25]

Phenothiazines, and, to a lesser extent, other antipsychotic drugs, may produce rather striking side effects on the reproductive system.[26] Amenorrhea (absence of menstruation due to other than natural causes), false-positive pregnancy tests, increased libido, breast engorgement, and lactation have been reported in women,[27] while men have been troubled by decreased libido, synecomastia (excessive development of the male mammary glands, sometimes secreting milk), and sexual impotence.[28] A variety of skin eruptions also have been associated with phenothiazine use, and one long term effect of these drugs is a blue-gray metallic discoloration of skin areas which have been exposed to sunlight.[29] In addition, 1 out of every 1,000 patients treated with chlorpromazine contracts jaundice,[30] which also has been reported with the use of other antipsychotics. There have been reported incidents of sudden death in individuals under treatment with phenothiazines, primarily chlorpromazine,[31] although these incidents are quite rare.[32] Some of these deaths have occurred in otherwise healthy, young adults.[33]

The most common and dramatic side effects produced by the antipsychotic drugs are the neurological syndromes manifested by the extrapyramidal reactions, a family of central nervous system disorders

azines are directly proportional to the dose and to the period of time over which the drug is administered. SAMPLE, *supra* note 17, at 16.

25. Goodman & Gilman, *supra* note 24, at 164; Hollister, *Human Pharmacology of Antipsychotic and Antidepressant Drugs*, 8 ANN. REV. PHARMACOLOGY 491, 501 (1975) [hereinafter cited as Hollister]. For a detailed account of the side effects of the antipsychotic and antidepressant drugs, with detailed tables of drug reactions, see M. SILVERMAN, THE DRUGGING OF THE AMERICAS (1976) [hereinafter cited as SILVERMAN], which documents the multinational drug companies' practice of promoting their medications in Latin America by exaggerating claims for effectiveness and not revealing their hazards. *See also* Crane, *Clinical Psychopharmacology in its 20th Year*, 181 SCIENCE 124 (July 13, 1973), *reprinted in* F. MILLER, R. DAWSON, G. DIX & R. PARNAS, THE MENTAL HEALTH PROCESS 59 (2nd ed. 1976) (thoughtful analysis of the use of antipsychotic medication). *See generally* D. AVIADO, PHARMACOLOGIC PRINCIPLES OF MEDICAL PRACTICE (1972).

26. Hollister, *supra* note 25, at 500.

27. Davis & Cole, *supra* note 21, at 1938; Hollister, *supra* note 25, at 500.

28. Davis & Cole, *supra* note 21, at 1938; Hollister, *supra* note 25, at 500.

29. Davis & Cole, *supra* note 21, at 1937.

30. *Id.* at 1937.

31. R. SHADER & A. DIMASCIO, PSYCHOTROPIC DRUG SIDE EFFECTS: CLINICAL AND THEORETICAL PERSPECTIVES 156 (1970) [hereinafter cited as SHADER].

32. Davis & Cole, *supra* note 21, at 1934.

33. The side effects of the phenothiazines are especially alarming, because traces of these drugs can be found in the body as long as six months after the last dose. SHADER, *supra* note 31, at 97.

characterized by involuntary motor movement, which can be quite stressful.[34] There are four varieties of these disorders: a parkinsonian syndrome,[35] akathesia,[36] dystonia,[37] and dyskinesia.[38] Parkinsonian syndrome, akathesia, and dystonia may be alleviated by lowering the

34. Davis & Cole, *supra* note 21, at 1934; Winick, *supra* note 5, at 782.

35. The parkinsonian syndrome mimics the symptoms of Parkinson's disease: muscular rigidity, tremor at rest, a mask-like face, salivation, motor retardation, shuffling gait, and pill-rolling hand movements. *See* Goodman & Gilman, *supra* note 24, at 169; Davis & Cole, *supra* note 21, at 169; Winick, *supra* note 5, at 782.

36. Akathesia is a feeling of motor restlessness in which the patient cannot remain still but feels compelled to pace. *See* Goodman & Gilman, *supra* note 24, at 169; Davis & Cole, *supra* note 21, at 1934; Winick, *supra* note 5, at 782.

37. Dystonia consists of bizarre muscular spasms, primarily in the head and neck, often combined with facial grimaces, involuntary spasms of the tongue and mouth interfering with speech and swallowing, convulsive movements of the arms and head, bizarre gaits, and difficulty in walking. *See* Goodman & Gilman, *supra* note 24, at 169; Winick, *supra* note 5, at 782.

38. The dyskinesias consist of a broad range of bizarre tongue, face and neck movements. *See* Goodman & Gilman, *supra* note 24, at 169; Winick, *supra* note 5, at 782. Foremost among the antipsychotic drug side effects is tardive dyskinesia. *See* Rogers v. Okin, 478 F. Supp. 1342, 1360 (D. Mass. 1979). This syndrome, which is more common among older persons and women, affects the part of the brain used for control and coordination of muscle movements (the basal ganglia). *See* Goodman & Gilman, *supra* note 24, at 169. *See also* B. ENNIS & B. EMERY, THE RIGHTS OF MENTAL PATIENTS 203 (rev. ed. 1978) [hereinafter cited as ENNIS & EMERY]. Symptoms include certain involuntary motor movements, particularly of the face, lips and tongue, and may also involve involuntary movement of the fingers, hands, legs and pelvic area. *See* Rogers v. Okin, 478 F. Supp. 1342, 1360 (D. Mass. 1979); SILVERMAN, *supra* note 25, at 62; Kobayashi, *Drug Therapy of Tardive Dyskinesia*, 296(5) NEW ENG. J. MED. 257 (1977) [hereinafter cited as Kobayashi]; Winick, *supra* note 5, at 782. The facial movements include tongue protrusion, with licking of the lips, smacking and sucking lip movements, chewing and jaw deviations, grimacing, furrowing of the forehead, and eye blinking. The orofacial dyskinesias may seriously interfere with swallowing, speaking and eating, and in some cases with breathing. *See* Rogers v. Okin, 478 F. Supp. 1342 (D. Mass. 1979); Kobayashi, *supra*, at 257. Other symptoms include overextension of the spine and neck, abnormal posture, shifting of weight from one foot to another and inability to stand still. *See* Winick, *supra* note 5, at 782.

Tardive dyskinesia is usually thought to develop after prolonged treatment. However, many patients, especially the elderly, develop tardive dyskinesia after taking moderate doses of antipsychotic drugs. *See* Clyne & Juhl, *Tardive Dyskinesia*, 33 AM. J. HOSPITAL PHARMACY 481 (1976) [hereinafter cited as Clyne & Juhl]. Tardive dyskinesia may appear at anytime during drug treatment. In addition, one of the most distinctive features of this syndrome is the persistence of dyskinesia even after discontinuation of the antipsychotic drug. SHADER, *supra* note 31, at 96; Davis & Cole, *supra* note 21, at 1936; Kobayashi, *supra*, at 257. One author reported that in 5-40% of asymptomatic patients, dyskinesia developed after discontinuation of the drug. Kobayashi, *supra*, at 257. Symptoms may persist indefinitely after discontinuation, even after a prolonged drug-free period, although in time they will sometimes disappear in younger patients. *See* Goodman & Gilman, *supra* note 24, at 169; Crane, *Persistent Dyskinesia*, 122 BRIT. J. PSYCH. 395, 399 (1973) [hereinafter cited as *Dyskinesia*]. In a large percentage of patients, however, symptoms persist months or years after discontinuation of all psychotropics. *See* Goodman & Gilman, *supra* note 24, at 169; *Dyskinesia*, *supra*, at 399.

dosage of the antipsychotic drugs, taking the patient off the drug completely, or through the use of antiparkinsonian drugs. Tardive dyskinesia, however is frequently irreversible, and it does not respond to treatment with antiparkinsonian drugs. In fact there is currently no effective treatment for tardive dyskinesia.[39]

Extrapyramidals reaction affect a significant proportion of patients taking antipsychotic drugs. One study of 3,775 patients treated with phenothiazine derivatives revealed that 1,472, or 38.9% developed such symptoms.[40] The reported incidence of tardive dyskinesia ranges from 0.5% to 60% of the patients taking these drugs.[41] The high incidence of involuntary movements in drug-treated population and the relative rarity of such symptoms in similar untreated population is compelling evidence that tardive dyskinesia is related to the use of phenothiazines or similar drugs.[42]

B. Antidepressants

Antidepressant drugs were discovered in the late 1950's in an effort to produce more effective antipsychotic medication.[43] Two major classes of these drugs have been developed: the monoamine oxidase (MAO) inhibitors and the tricyclic antidepressants. The efficacy of the

39. Goodman & Gilman, *supra* note 24, at 169-72; Gardes & Cole, *Maintenance Antipsychotic Therapy: Is the Cure Worse Than the Disease?*, 133 AM. J. PSYCH. 32 (1976).

40. Ayd, *A Survey of Drug-Induced Extrapyramidal Reactions*, 175 J. AM. MED. A. 1054 (1961) *reprinted in* SILVERMAN, *supra* note 25, at 62. Approximately 2.3% suffered from dyskinesia, 15.4% from parkinsonism, and 21.2% from akathesia. *Id. See also* Winick, *supra* note 5, at 782.

41. The trial court in Rogers v. Okin, 478 F. Supp. 1342 (D. Mass. 1979), cited two studies which placed the rate of tardive dyskinesia among chronically hospitalized patients at 50% and 56%, and reported another survey which showed the incidence among outpatients at 41%. Winick's research revealed a rate which varied between less than 1% to 40% of patients taking antipsychotic drugs. Winick, *supra* note 8, at 782. Ennis and Emery report that 2-25% of all mental hospital patients who have been taking antipsychotic drugs undetermined periods of time have tardive dyskinesia. ENNIS & EMERY, *supra* note 38, at 203. In populations surveyed by 17 investigations, the tardive dyskinesia rate varied from ½ of 1% to 40%. *Dyskinesia*, *supra* note 38, at 395. One pair of authors, citing the 250 million patients who received antipsychotic drugs prior to 1971, characterized tardive dyskinesia as a potentially common disability, reported in 0.5% to 60% of the patients treated with antipsychotic drugs. Clyne & Juhl, *supra* note 38, at 481. Kobayashi estimated that tardive dyskinesia occurs in 3-6% of a mixed population of pyschiatric patients, and up to 40% of elderly, chronically institutionalized patients. Kobayashi, *supra* note 38, at 257. The discrepancies in incidence rates may be attributed to several factors including the definition of the syndrome, the type of patient population, the methods used in obtaining information, and particularly the clinical assessment of symptoms. *Dyskinesia*, *supra* note 38, at 395.

42. *Id.* at 397.

43. Winick, *supra* note 5, at 785.

MAO inhibitors remains controversial,[44] however, and they are less commonly used than the tricyclic antidepressants. Indeed, one authority has concluded that results with the MAO inhibitors have generally been disappointing, with few studies showing any clear-cut superiority over placebos.[45]

The use of antidepressants in general, and the MAO inhibitors in particular, involves well-documented hazards.[46] The toxic effects of the MAO inhibitors are greater than those of any other group of psychotherapeutic drugs.[47] The most dangerous effects involve the brain, the liver, and the cardiovascular system; autonomic side effects include dry mouth, orthostatic hypotension, constipation, delayed ejaculation and impotence.[48] The MAO inhibitor also may produce serious, or even life-threatening, hypertensive crises (abnormally high blood pressure), acute cardiac failure, and intracranial bleeding, particularly when combined with certain foods such as aged cheeses and wines, and chocolate.[49] Common premonitory symptoms of such a reaction include severe headache, stiff neck, sweating, nausea, and sharply elevated blood pressure. Additional effects may include tremors, insomnia, dizziness, vertigo headache, difficulty in urination, and skin rashes.[50]

Patients using MAO inhibitors may experience confusion, mild mania, convulsion, and occasionally hallucinations; retarded depression may be transformed into an agitated or anxious one, and can occasionally develop into acute schizophrenic psychosis.[51] The risk is especially high when the MAO inhibitors are used with tricyclic antidepressants. Such a combination may result in tremors, fever, generalized chronic convulsion, delirium, or death.[52]

The tricyclic antidepressants are substantially safer and more effective than the MAO inhibitors[53] and are the most valuable and widely used drugs for the pharmacotherapy of depression which is biochemical in origin.[54] Reports on these medications reveal that the percentage of patients using them who show "improvement" ranges from

44. Note, *supra* note 7, at 625.
45. Hollister, *supra* note 25, at 510.
46. SILVERMAN, *supra* note 25, at 77.
47. Goodman & Gilman, *supra* note 24, at 182.
48. Davis & Cole, *supra* note 21, at 1947.
49. AMA DEPARTMENT OF DRUGS, AMA DRUG EVALUATIONS 360 (3d ed. 1977), *reprinted in* SILVERMAN, *supra* note 25, at 77.
50. Goodman & Gilman, *supra* note 24, at 182.
51. Davis & Cole, *supra* note 21, at 1948.
52. *Id. See also* SILVERMAN, *supra* note 25, at 77.
53. SILVERMAN, *supra* note 25, at 76. *See also* SAMPLE, *supra* note 17, at 30.
54. SAMPLE, *supra* note 17, at 33.

30% to 80%, depending on operational definitions used and dosage schedules.[55] However, the tricyclic drugs may produce dry mouth, palpitations, tachycardia (rapid heart beat), postural hypotension, fainting, dizziness, vomiting, constipation, edema (an excessive accumulation of fluid in the tissue spaces), blurred vision, urinary retention, and aggravation of certain types of glaucoma.[56] In addition, skin reactions often occur early in therapy. The drugs may also cause a fine, persistent, rapid tremor, particularly in the upper extremities, but also in the tongue. Other side effects include excessive sweating, weakness, fatigue, headache, cardiovascular problems, and endocrine changes.[57]

C. Lithium

The use of lithium was a breakthrough in the treatment of manic-depressives. When administered properly, it promotes behavioral and emotional stability without requiring institutionalization. While proper therapeutic levels rarely produce adverse side effects, tremors, abdominal cramps, nausea, vomiting, diarrhea, unusual thirst, and polyuria (increased urine excretion), fatigue, and weight gain occasionally may result.[58] Muscular weakness, loss of muscular coordination, and slurred speech also have been documented.[59]

If lithium is administered in excessive doses or is imperfectly eliminated, however, it may produce lithium toxicity. This condition has serious consequences on the central nervous system, including confusion, impairment of consciousness, and even coma.[60] In addition, it may impair cardiac functioning to the point of death.[61]

D. Antianxiety Drugs

Antianxiety drugs have a calming effect without producing a

55. Note, *supra* note 7, at 625.

56. Goodman & Gilman, *supra* note 24, at 178; SAMPLE, *supra* note 17, at 33; Davis & Cole, *supra* note 21, at 194.

57. Goodman & Gilman, *supra* note 24, at 178; Winick, *supra* note 5, at 786.

58. One commentator, however, asserts that the mild side effects of nausea, diarrhea, tremor and polyuria are common during lithium therapy. Peterson, *Organic Brain Syndromes Associated with Drug or Poison Intoxication*, in 2 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1113 (2d ed. A. Freedman, H. Kaplan & B. Sadock 1975).

59. Goodman & Gilman, *supra* note 24, at 185.

60. Goodman & Gilman, *supra* note 24, at 185; Fieve, *Lithium Therapy*, in 2 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1984 (2d ed. A. Freedman, H. Kaplan & B. Sadock 1975) [hereinafter cited as Fieve]; Winick, *supra* note 5, at 787.

61. Fieve, *supra* note 60, at 1984.

marked sedative or hypnotic effect.[62] Their efficacy for relieving symptoms of anxiety is accepted generally by medical practitioners.[63] Even comparatively mild antianxiety drugs, however, may produce unpleasant side effects. These include drowsiness, impairment of performance and judgment (particularly among elderly patients), vertigo, excessive appetite, nausea, headaches, allergic and hematological disorders, impaired visual capability, paradoxical rage reactions, and hangover.[64] Menstrual irregularities and failure to ovulate also have been noted in women taking these drugs. In addition, a major group of antianxiety drugs had been associated with an increase in hostility and psychosis,[65] with sudden suicidal impulses having been reported in patients who received a high dose of these drugs.[66]

The drug treatment programs commonly administered to mental patients thus engender a wide range of potentially deleterious, on occasion life-threatening, physiological and psychological side effects. These side effects will be crucial in applying the judicial tests for cruel and unusual punishment to the forced application of psychotropic medications.

II. Informed Consent

It was suggested at the outset that an Eighth Amendment challenge to the administration of psychotropic medication may be avoided if the drugs are given with the informed consent of the patient. This is a major issue in most right to refuse treatment cases, and its analytic subtleties are beyond the scope of this paper.[67] It is important, however, to note that the concept of informed consent for institutionalized

62. Hollister, *Drugs for Treating Anxiety*, in DRUGS OF CHOICE 1978-1979 264 (W. Modell 1978); AMA DEPARTMENT OF DRUGS, AMA DRUG EVALUATIONS 410 (3d ed. 1977).

63. SAMPLE, *supra* note 19, at 21.

64. Davis & Cole, *Minor Tranquilizers, Sedatives, and Hypnotics*, in 2 COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1966 (2d ed A. Freedman, H. Kaplan & B. Sadock 1975) [hereinafter cited as *Tranquilizers*]; Winick, *supra* note 5, at 788-89. Tolerance to drowsiness usually occurs after several days, and may be combatted by reducing the dosage or discontinuing usage.

65. The major groups of minor antianxiety drugs are the benzodiazepines and the propanediol carbamates. The former group is discussed in the accompanying text. The latter group may cause atoxia (loss of muscular coordination) and hypotension. Allergic reactions also have been reported in from 0.2% to 3.4% of different series of patients, and occur most frequently in patients with a history of dermatological or allergic conditions. Goodman & Gilman, *supra* note 24, at 189, 191.

66. *Id.* at 191.

67. For diverse analyses of informed consent for mental patients, see ENNIS & EMERY, *supra* note 38 at 135-37; AMERICAN ASSOCIATION ON MENTAL DEFICIENCY CONSENT HANDBOOK (1977) (discussing informed consent for the mentally retarded); LEGAL AND

patients is fraught with controversy. Even when a patient gives written consent to a procedure after having been informed of the attendant risks and effects and retains the right to withdraw consent at any time, such consent might still be tainted and inadequate for the purposes of defending a charge of cruel and unusual punishment.

The validity of informed consent is usually based on whether the consent is voluntary, knowledgeable and competent.[68] Certain legal commentators have insisted that although a patient is civilly committed, he or she may still have the competence to give informed consent.[69] One author has asserted that:

> With reference to incompetency, even 'from a medical viewpoint, there is no necessary relationship between commitability and incompetency.' The trend in recent years among legislatures has been toward complete separation of hospitalization and incompetency; it has been recognized that their merger may needlessly deprive persons of essential personal rights.[70]

There are three possible weaknesses in the "informed consent" given by hospitalized patients. First, the effects of a treatment may not be completely known because these drug medication procedures remain largely experimental.[71] Second, as noted in *Kaimowitz v. Department of Mental Health*,[72] an institutional setting may be so inherently coercive as to preclude truly voluntary consent by a patient.[73] The Michigan court recognized that because of the coercive environment of the mental hospital, the physician-patient relationship is on an unequal

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ETHICAL ISSUES IN HUMAN RESEARCH AND TREATMENT: PSYCHOPHARMACOLOGIC CONSIDERATIONS (D. Gallant & R. Force eds. 1978).

68. Kaimowitz v. Department of Mental Health, Civ. No. 73-19434-AW (Cir. Ct., Wayne County, Mich., filed July 10, 1973). *See* Barnhart, Pinkerton & Roth, *Informed Consent to Organic Behavior Control*, 17 SANTA CLARA L. REV. 39, 70-81 (1977), which persuasively argues for the abolition of the competency requirement in informed consent, and against third party consent as an accepted substitute. *See also* Comment, *Informed Consent and the Mental Patient: California Recognizes a Mental Patient's Right to Refuse Psychosurgery and Shock Treatment*, 15 SANTA CLARA LAW. 725, 737 (1975) [hereinafter cited as Santa Clara Comment].

69. Ferleger, *supra* note 7, at 472; Note, *The Right Against Treatment: Behavior Modification and the Involuntary Committed*, 23 CATH. U.L. REV. 774, 784 (1974) [hereinafter cited as Cath. U. Note].

70. Ferleger, *supra* note 7, at 472.

71. Note, *Constitutional Law—Eighth Amendment—Aversion Therapy as Cruel and Unusual Punishment*, 13 DUQ. L. REV. 621, 625 (1975) [hereinafter cited as Duq. Note].

72. Civ. No. 73-19434-AW (Cir. Ct., Wayne County, Mich., filed July 10, 1973).

73. *See* Santa Clara Comment, *supra* note 68, at 737. *See generally* E. GOFFMAN, ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES 3-14 (1962).

footing;[74] a patient will often say what he or she thinks will please the doctor irrespective of his or her true feelings.[75] Hospital officials also may use subtle inducements to obtain consent, further tainting its voluntariness.[76] Patients who refuse treatment may be secluded, restrained, threatened with disciplinary action, or deprived of certain privileges.[77] One commentator's investigation of medication procedures at a state mental hospital revealed the following practices:

> Most of the staff acknowledges that a patient's group or grounds privileges will be withheld while medication is being refused, whether or not the medication is actually received by intramuscular injection. There seems, however, to be some difference in practice among the various wards regarding the use of seclusion in such cases. One nurse denied that seclusion is *ever* used when medication is refused while an aide in another unit freely discussed with me the techniques for forced medication and subsequent seclusion.[78]

At its most insidious, the institutional atmosphere may induce a patient to consent from the fear that a refusal will be viewed as a further indication of mental illness.[79]

Finally, a basic issue in informed consent is the purity of the decision-making process by which the validity of the consent, *i.e.*, whether the consent was voluntary, informed and competent, is judged. When a hospital staff requesting the consent also has the power to decide whether the consent meets the standards for validity, a conflict of interest may arise.[80] Because hospital staff members initiate the decision to administer the drug, they naturally favor its use, either for control purposes or because they believe in its therapeutic qualities. In some instances, use of an experimental procedure may even aid in research and enhance the therapist's career. Staff members are not, therefore, in a position to inform the patient objectively of all the drug's effects, nor to make a final judgment on the adequacy of the patient's consent.[81]

The question of consent thus involves many difficult issues. Nonetheless, it is important in bridging the first analytical hurdle of the Eighth Amendment's applicability to involuntary drug treatment, be-

74. *See* E. GOFFMAN, ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES 29 (1962).

75. *Id.* at 28-29.

76. Duq. Note, *supra* note 71, at 626.

77. Ferleger, *supra* note 7, at 469-70; *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1354 (1974) [hereinafter cited as *Developments*].

78. Ferleger, *supra* note 7, at 469.

79. *Developments*, *supra* note 77, at 1354.

80. Duq. Note, *supra* note 71, at 626-27.

81. *Id.*

cause voluntariness, or more properly the lack of it, may transform "treatment" into "punishment."

III. The Eighth Amendment Right to Refuse Treatment

A. Eighth Amendment History

The history of the Eighth Amendment is especially significant in right to refuse treatment cases, because it can elucidate the important issue of whether the amendment's scope is limited to the criminal context.

The prohibition against cruel and unusual punishment first appeared in the English Bill of Rights of 1869, and subsequently was incorporated into the Virginia Declaration of Rights of 1776.[82] The author of the American constitutional provision appeared principally concerned with the legislative definition of crimes and punishments.[83] Early cases such as *Wilkerson v. Utah*[84] and *In re Kemmler*[85] interpreted the Eighth Amendment as a prohibition on extreme forms of corporal punishment,[86] enumerating as cruel and unusual such punishments as beheadings, public dissection, burning at the stake, and crucifixion.

The early cases defined cruel and unusual by a fixed historical standard used at the time of the adoption of the Bill of Rights.[87] A break from this inflexible criterion was made in the decision of *Weems v. United States*,[88] in which the Court recognized that the proper standard should be flexible and responsive to social norms.[89] Relying on

82. Ingraham v. Wright, 430 U.S. 651, 664 (1977). *See generally* Granucci, *"Nor Cruel and Unusual Punishment Inflicted": The Original Meaning*, 57 CAL. L. REV. 839 (1969).

83. *Id.* at 839-42.

84. 99 U.S. 130, 136 (1879).

85. 136 U.S. 436 (1890).

86. *See* Note, *Constitutional Law—The Eighth Amendment and Prison Reform*, 51 N.C. L. REV. 1539, 1540 (1973).

87. *See, e.g.*, Furman v. Georgia, 408 U.S. 238, 264 (1972).

88. 217 U.S. 349 (1910).

89. "Legislation, both statutory and constitutional, is enacted, it is true, from an experience of evils, but its general language should not, therefore, be necessarily confined to the form that evil had theretofore taken. Time works changes, brings into existence new conditions and purposes. Therefore a principle to be vital must be capable of wider application than the mischief which gave it birth. This is peculiarly true of constitutions. They are not ephemeral enactments, designed to meet passing occasions. They are, to use the words of Chief Justice Marshall, 'designed to approach immortality as nearly as human institutions can approach it.' The future is their care and provision for events of good and bad tendencies of which no prophecy can be made. In the application of a constitution, therefore, our contemplation cannot be only of what has been but of what may be. Under any other rule a constitution would indeed be as easy of application as it would be deficient in efficacy and

the *Weems*, standard, recent cases have broadened the amendment's scope by forbidding conduct which did not reach the point of physically barbarous punishment.[90]

Prior to the case of *Ingraham v. Wright*,[91] every Supreme Court decision based on the issue of cruel and unusual punishment concerned criminal punishment.[92] *Ingraham* presented an Eighth Amendment challenge to the disciplinary corporal punishment of public school students. The case was brought as a class action by the parents of two pupils who were paddled by officials at a junior high school in Dade County, Florida. The majority opinion by Justice Powell described the causes and the effects of the incidents:

> Because he was slow to respond to his teacher's instructions, Ingraham was subjected to more than 20 licks with a paddle while being held over a table in the principal's office. The paddling was so severe that he suffered a hematoma requiring medical attention and keeping him out of school for 11 days. Andrews was paddled several times for minor infractions. On two occasions he was struck on his arms, once depriving him of the full use of his arm for a week.[93]

The district court had found that the plaintiffs had not suffered punishment meeting the constitutional standard of "cruel and unusual," and were thus not deprived of their constitutional rights under 42 U.S.C. §§ 1981-1986. The Supreme Court agreed, holding that the Eighth Amendment proscription was designed to protect persons convicted of

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power. Its general principles would have little value and be converted by precedent into impotent and lifeless formulas. Rights declared in words might be lost in reality. And this has been recognized. The meaning and vitality of the Constitution have developed against narrow and restrictive construction. . . . [The Eighth Amendment] may be therefore progressive, and is not fastened to the obsolete but may acquire meaning as public opinion becomes enlightened by a humane justice." *Id.* at 373, 378.

90. *See, e.g.*, Estelle v. Gamble, 429 U.S. 97 (1976) (deliberate indifference to prisoner's serious medical needs constituted cruel and unusual punishment).

91. 430 U.S. 651 (1977).

92. *Id.* at 666-67 (citing Estelle v. Gamble, 429 U.S. 97 (1976) (incarceration without medical care); Gregg v. Georgia, 428 U.S. 153 (1976) (execution for murder); Furman v. Georgia, 408 U.S. 238 (1972) (execution for murder); Powell v. Texas, 392 U.S. 514 (1968) ($20 fine for public drunkenness); Robinson v. California, 370 U.S. 660 (1962) (incarceration as a criminal for addiction to narcotics); Trop v. Dulles, 356 U.S. 86 (1958) (expatriation for desertion); Louisiana *ex rel.* Francis v. Resweber, 329 U.S. 459 (1947) (execution by electrocution after a failed first attempt); Weems v. United States, 217 U.S. 349 (1910) (15 years imprisonment and other penalties for falsifying an official document); Howard v. Fleming, 191 U.S. 126 (1903) (10 years imprisonment for conspiracy to defraud); *In re* Kemmler, 136 U.S. 436 (1890) (execution by electrocution); Wilkerson v. Utah, 99 U.S. 130 (1879) (execution by firing squad); Pervear v. Commonwealth, 72 U.S. (5 Wall.) 475 (1867) (fine and imprisonment at hard labor for bootlegging)).

93. 430 U.S. at 657 (footnotes omitted).

criminal offenses and did not apply to paddling students for purposes of maintaining discipline in the public schools.[94] Despite the apparently conclusive holding, however, other language in the opinion may furnish a basis for extending Eighth Amendment protection to institutionalized mental patients.

B. The Eighth Amendment Concept of "Punishment"

Eighth Amendment protection can only be accorded mental patients forced to take medication if such conduct is deemed "punishment" within the confines of the amendment. This approach requires a broad leap from the exclusive application of the Eighth Amendment in the criminal arena to its extension into the civil context of the mental institution. The *Ingraham* opinion presents the most recent and extensive Supreme Court articulation of this complex issue. The Court in *Ingraham* declared that the Eighth Amendment was "designed to protect those convicted of crimes,"[95] implying that its application was limited to criminal punishment.[96] However, in a significant and oft-quoted footnote, the Court expressly reserved judgment on the potential application of the Eighth Amendment to health care practices in mental institutions:

> Some punishments, though not labeled "criminal" by the State, may be sufficiently analogous to criminal punishments in the circumstances in which they are administered to justify application of the Eighth Amendment. . . . We have no occasion in this case, for example, to consider whether or under what circumstances persons involuntarily confined in mental or juvenile institutions can claim the protection of the Eighth Amendment.[97]

This statement suggests two criteria for civil application of the amendment: (1) there must be a "punishment," and (2) the circumstances surrounding the punishment must be analogous to those of a criminal punishment.[98] The following discussion will apply these standards to the involuntary medication of hospitalized psychiatric patients.

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94. *Id.* at 664.

95. *Id.*

96. *See* Winick, *supra* note 5, at 806.

97. 430 U.S. at 669 n.37 (citation omitted).

98. Note, *Right to Treatment for the Civilly Committed: A New Eighth Amendment Basis*, 45 U. CHI. L. REV. 731, 741 (1978) [hereinafter cited as Chicago Note].

C. Medical "Treatment" as Punishment

The groundbreaking case of *Estelle v. Gamble*[99] vastly broadened the traditional Eighth Amendment concept of "punishment." In *Estelle* the Supreme Court found that official behavior *not generally considered inherently punitive* was nonetheless cruel and unusual punishment. The case was brought by an inmate of a Texas state prison who claimed that prison officials violated his Eighth Amendment rights by depriving him of adequate medical treatment. The Court held that deliberate indifference to prisoners' serious medical problems violated the Eighth Amendment, because it constituted an "unnecessary and wanton infliction of pain."[100] Deprivation of treatment, or inaction, was characterized as an infliction of pain, and thus, as punishment.[101]

Estelle v. Gamble lends convincing support to the thesis that, in instances of involuntary medication of mental patients, *it is the treatment itself which constitutes punishment*, and is thus deserving of Eighth Amendment protection.[102] The case is significant, because the Court found an Eighth Amendment violation in circumstances which were *not* a *quid pro quo* for misbehavior.[103] Following this reasoning, psychotropic drugs administered without consent for treatment or control purposes should be subject to Eighth Amendment scrutiny, even though they were not dispensed to punish a patient's infraction,[104] because the likelihood of pain and side effects produced by the drugs could characterize their use as "punishment."

The distinction between treatment and punishment is particularly blurred in the area of medical treatment administered to prisoners. One author has vehemently argued that:

> [T]he disinclination of the courts to grapple with the problems of violence by psychiatrists against prisoners represents a blind spot, the logical center of which is the insistence of a distinction between treatment and punishment . . . . it should not be surprising, therefore, if prison adminsitrators have from time to time labeled as 'treatment' acts which, if called 'punishment,' would be

99. 429 U.S. 97 (1976).

100. *Id.* at 103 (quoting Gregg v. Georgia, 428 U.S. 153, 173 (1976) (opinion of Stewart, Powell and Stevens, JJ.)).

101. *Id.* at 104-05. *See* Chicago Note, *supra* note 98, at 747.

102. *See* Cath. U. Note, *supra* note 69, at 786 (calling for application of the Eighth Amendment to all "so-called 'treatments' inflicted upon those involuntary committed to mental institutions").

103. Chicago Note, *supra* note 98, at 749-50.

104. Of course, drugs candidly administered for disciplinary purposes would fit with less difficulty under the punishment classification.

instantly recognized as of dubious morality or legality.[105]

The same commentator cites the administration of mind-altering drugs as the most common instance of "legally sanctioned punitive violence."[106]

A recent case involving the medical treatment of prisoners finally refuted the distinction between treatment and punishment. In *Sawyer v. Sigler*[107] a prisoner challenged Nebraska prison officials who forced him to take emphysema medication in crushed form, which resulted in nausea. The district court found that this constituted cruel and unusual punishment, not simply because of the prison officials' actions, but because of the *result* of such actions, *i.e.*, the nausea.[108] Thus, focusing on the result of medical treatment rather than its form may provide a stronger link between treatment and the "punishment" required to trigger Eighth Amendment protection.

In *Trop v. Dulles*,[109] a case decided well before *Ingraham*, the Supreme Court also propounded a standard which may distinguish treatment from punishment. In *Trop*, an Army private serving in French Morocco escaped from a stockade where he had been incarcerated for an infraction. He was gone for less than a day and willingly surrendered while heading back towards his base. He was subsequently deprived of his citizenship under a statute providing such a sanction for those found guilty of desertion. The Court held that the statute violated the Eighth Amendment, because it was penal in nature and prescribed cruel and unusual punishment.[110] Denaturalization was characterized as cruel and unusual punishment because it constitutes the complete destruction of the individual's status in society, subjecting the victim to increasing fear and distress.

The Court in *Trop* rejected the Government's argument that the statute was not classified as penal and therefore constitutional limits on

105. Opton, *Psychiatric Violence Against Prisoners: When Therapy is Punishment*, 45 MISS. L.J. 605, 607 (1974) [hereinafter cited as Opton].

106. *Id.* at 608.

107. 320 F. Supp. 690 (D. Neb. 1970). *Sawyer* was a civil rights suit brought by three state prisoners who claimed that they had received inadequate medical treatment. The district court sustained the claim of only one of the three prisoners. In addition, it held that the practice of denying statutory good time to prisoners unable to perform work, even when the disability did not result from the prisoner's misconduct, violated the equal protection of the Fourteenth Amendment. *Id.* at 698.

108. *Id.* at 694. *See* Note, *Refusing Medical Care and Behavior Modification*, 10 J. MAR. J. PRAC. & PROC. 173, 184 (1976).

109. 356 U.S. 86 (1958).

110. *Id.* at 99-102 (plurality opinion). *But see* Bassett v. United States Immigration & Naturalization Serv., 581 F.2d 1385, 1387 (10th Cir. 1978) (deportation is a civil proceeding and not cruel and unusual punishment).

the state's power to punish were inapplicable. Rather, the Court insisted that "form cannot provide the answer to this inquiry. . . . The inquiry must be directed to substance."[111] The criterion used by the Court was not whether a particular procedure is labeled treatment or punishment, but whether by its nature it might be considered cruel and unusual.[112] The Court thus declared that "even a clear legislative classification of a statute as 'nonpenal' would not alter the fundamental nature of a plainly penal statute." The court noted: "How simple would be the tasks of constitutional adjudication and of law generally if specific problems could be solved by inspection of the labels posted on them."[113]

Eighteen years later, in his dissent in *Ingraham*, Justice White characterized the *Trop* test as a "purposive approach," which questioned whether "the purpose of the deprivation is among those ordinarily associated with punishment, such as retribution, rehabilitation or deterrence."[114]

Both the *Sawyer* "result" criterion and the *Trop* "purpose" standard may be used to gather involuntary medication within the ambit of the Eighth Amendment. The harmful side effects of many of the psychotropic drugs, particularly the irreversible symptoms of tardive dyskenisia, are *Sawyer*-like "results" upon which many courts might look askance. In *Knecht v. Gillman*[115] the Eighth Circuit used the *Trop* test to find that apomorphine, which induces vomiting spells lasting from fifteen minutes to an hour, when used to punish a mental patient's minor infraction was indeed punishment within the meaning of the Eighth Amendment. Such an analysis may be particularly useful in cases where psychotropic drugs are given to mental patients for puposes of controlling behavior or staff convenience (a widespread practice)[116] with no therapeutic goal in mind.

Knecht was also based in part on the Eighth Circuit's reading of *Inmates of the Boys' Training School v. Affleck*,[117] in which the court

111. 356 U.S. at 95 (plurality opinion).

112. Cath. U. Note, *supra* note 69, at 779. The Court concluded that if a statute had a legitimate governmental purpose besides punishment, it was considered nonpenal. In statutes with both a penal and nonpenal effect, the statute's controlling nature was determined by its legislative purpose. 356 U.S. at 96.

113. 356 U.S. at 94, 95 (plurality opinion).

114. Ingraham v. Wright, 430 U.S. 651, 686-87 (1976) (White, J., dissenting).

115. 488 F.2d 1136, 1139 (8th Cir. 1973).

116. Comment, *Advances in Mental Health: A Case for the Right to Refuse Treatment*, 48 TEMP. L.Q. 354, 362 (1975).

117. 346 F. Supp. 1354 (D.R.I. 1972). *Affleck* was a class action which challenged conditions at a juvenile corrections institution. The trial court reviewed the inadequate feeding

had grappled with a similar question and concluded:

> The fact that juveniles are in theory not punished, but merely confined for rehabilitative purposes, does not preclude operation of the Eighth Amendment. The reality of confinement in Annex B is that it is punishment. It is punishment imposed on obdurate boys by defendant administrators of the Training School.[118]

The court in *Vann v. Scott*[119] considered an Eighth Amendment challenge to the practice of incarcerating runaway juveniles with serious delinquents. Like the Eighth Circuits's approach in *Knecht*, the Seventh Circuit refused to be swayed by a purely semantic distinction:

> Whatever the State does with the child is done is the name of rehabilitiation. Since—the argument runs—by definition the treatment is not "punishment," it obviously cannot be "cruel and unusual punishment." But neither the label which a State places on its own conduct *nor even the legitimacy of its motivation, can avoid the applicability of the Federal Constitution*. We have no doubt that well intentioned attempts to rehabilitate a child could, in extreme circumstances, constitute cruel and unusual punishment proscribed by the Eighth Amendment.[120]

Under this analysis, a hospital's legitimate attempt to "rehabilitate" a patient with psychotropic drugs could constitute punishment.

Nelson v. Heyne[121] continued the erosion of the treatment-punishment distinction, and presents a startlingly close analogy to forced drug administration in mental institutions. In *Nelson*, juveniles in a correctional institution were forced to take the psychotropic drugs Sparine and Thorazine, "not as part of an ongoing psychotherapeutic program, but for the purpose of controlling excited behavior,"[122] a reason also commonly advanced for the administration of psychotropic medicine to numerous institutionalized mental patients. The court held that the involuntary medication of the juveniles constituted cruel and unusual punishment, citing potential harmful side effects of the drugs similar to those previously described: "collapse of the cardiovascular system, the

schedule, deprivation of outdoor exercise, "inhuman solitary confinement cells," *id.* at 1365, and other aspects of the institution and held that the inmates' rights of due process, equal protection, and protection against cruel and unusual punishment were violated. *Id.* at 1366-67.

118. *Id.* at 1366.

119. 467 F.2d 1235 (7th Cir. 1972). Plaintiffs in *Vann* challenged the constitutionality of an Illinois statute which permitted delinquency petitions to be filed against runaways. The appellate court rejected this claim, holding that even if the state incarcerated runaways improperly, the delinquency provisions of the statute simply authorized an adjudication and were distinguishable from possible subsequent unlawful treatment. *Id.* at 1241.

120. *Id.* at 1240 (emphasis added).

121. 491 F.2d 352 (7th Cir. 1974), *cert. denied*, 417 U.S. 976 (1976).

122. 491 F.2d at 356.

closing of a patient's throat with consequent asphyxiation, a depressant effect on the production of bone marrow, jaundice from an affected liver, and drowsiness, hemotological disorders, sore throat and ocular changes."[123]

At least one court, however, has resolutely rejected this "treatment as punishment" theory and refused to uphold a claim that electroshock therapy given to an involuntarily committed patient was cruel and unusual punishment. In *Price v. Sheppard*[124] the Minnesota Supreme Court distinguished the *Knecht* and *Inmates of Boys' Training School* holdings on the grounds that in both of those cases the challenged conduct stemmed from a retributive goal, as it was triggered by infractions perpetrated by the victims. The court in *Price* found that the electroshock treatment was given purely for therapeutic reasons, with no deterrent or retributive objectives, and not as the result of a single behavioral incident.[125] The court also used the *Trop* doctrine not to support, but to defeat the Eighth Amendment challenge, finding that because the treatments served a legitimate purpose, the claim was invalid.[126]

Using the *Sawyer* "result" test, the *Price* analysis would not successfully overcome an Eighth Amendment claim; electroshock therapy may at times produce frightening and painful effects, which could result in a finding of unconstitutionality no matter how well-intentioned the therapeutic goals. Furthermore, the *Price* opinion's narrow reading of *Knecht* and *Inmates* was not mandated by the original wording of those opinions, which might be read in a less restricted manner so as not to preclude "non-retributive" conduct from Eighth Amendment scrutiny. Finally, some experts would claim that electroshock therapy does not in fact serve any legitimate purpose and may well be deleterious,[127] in which case it would fail the purposive standard of the *Trop* test.

123. *Id.* at 357.

124. 307 Minn. 250, 239 N.W.2d 905 (1976). The suit was brought by the mother of a minor who was involuntarily committed to a state mental hospital. The Supreme Court of Minnesota, in addition to rejecting the Eighth Amendment claim, found that the hospital director was immune from tort liability and liability under the Federal Civil Rights Act, but ordered that in future cases, before applying intrusive forms of treatment without the patient's consent, the state must appoint a legal guardian for the patient to represent him or her in an adversary proceeding before a court to determine the necessity and reasonableness of the treatment. *Id.* at 262-63, 239 N.W.2d 913-14.

125. *Id.* at 255, 239 N.W.2d at 909.

126. *Id.*

127. *E.g.*, Giamartino, *Electroconvulsive Therapy and the Illusion of Treatment*, 35 PSYCH. REP. 1127 (1974).

Although it found a right to refuse involuntary medication on other grounds, the trial court in *Rennie v. Klein*[128] rejected the argument that the administration of prolixin (an antipsychotic) to the plaintiff constituted cruel and unusual punishment. The court, citing *Ingraham*, did assume that the Eighth Amendment applies to persons confined in mental hospitals.[129] However, it determined that the prolixin was justifiably administered as treatment, not punishment. The court based this conclusion on its findings that the hospital staff tried to use prolixin in an overall treatment program, that psychotropic drugs have been proven effective, and that the side effects of prolixin, while serious, "are not *unnecessarily* harsh in light of the potential benefits."[130] This cost/benefit analysis, however, is not conclusive in determining the existence of "punishment" for an Eighth Amendment analysis. The cost/benefit considerations are not a major factor in the "result" test under *Sawyer*, which focuses on the deleterious effects of an action, and are only one possible factor in the *Trop* test, which determines the "fundamental nature" of an act in classifying it as punishment. Although potential positive effects from the antipsychotics could be used to show the non-penal purpose of their administration as required by *Trop*, courts have recognized that even legitimate motivations for an action cannot deflect Eighth Amendment inquiry.[131] Furthermore, the court in *Rennie* admitted that if the patient was likely to contract tardive dyskinesia through renewed administration of antipsychotic drugs, the cure would be worse than the illness,[132] thus diluting the court's cost/benefit ratio for Eighth Amendment purposes.

D. The Hospital Setting: An Analogy to Criminal Confinement

In addition to an initial finding of a "punishment," the *Ingraham* Court required that the circumstances surrounding the punishment be analogous to those of a criminal punishment in order to trigger Eighth Amendment protection. The *Ingraham* opinion describes two characteristics of penal confinement which serve as the rationale for such a constitutional requirement. The first, and perhaps more important,[133] characteristic is the prisoner's involuntary confinement. Indeed, the Court based its opinion in large part on the openness of the school, which provided its students public recourse, as opposed to the closed

128. 462 F. Supp. 1131 (1978).
129. *Id.* at 1143.
130. *Id.*
131. *See, e.g.*, Vann v. Scott, 467 F.2d 1235, 1240 (7th Cir. 1972).
132. 462 F. Supp. at 1146.
133. Chicago Note, *supra* note 98, at 741.

community of a jail in which the outside world could not interfere nor serve as advocate.[134] The Court relied heavily on the fact that the public schools are open to public scrutiny, and that students are in less need of Eighth Amendment protection than are prisoners.[135]

Mental institutions, however, are in many ways as closed to outside society as are prisons, which the *Ingraham* Court acknowledged were in such need of constitutional oversight. Just as a prisoner's incarceration "deprives him of the freedom to be with family and friends and 'to form the other enduring attachments of normal life,' "[136] so confinement in a mental institution often cuts off a patient from most contact with society. Mental patients, like prisoners, are totally dependent on the state for food, shelter, medical treatment and other necessities of life. Both mental patients and prisoners are in positions of utter helplessness vis-a-vis the state, with no means of preventing or rectifying abuse or of receiving outside assistance.[137] This condition is aggravated because public scrutiny of mental hospitals is minimal at best. Whereas the Court in *Ingraham* denied Eighth Amendment protection to students because they were not physically confined to school grounds, mental patients are often physically confined and isolated from outside allies who might support them. Even voluntary patients may find that they are not always free to leave the hospital at will.

In effect, the loss of liberty, separation from friends and family, and dependence on state officials for the satisfaction of basic needs puts civilly committed patients in a vulnerable position, remarkably analogous to that of prisoners.[138] In addition, the duration of commitment to a mental institution may be as long or longer than a prison sentence,[139] the physical environment may resemble that of a prison, and the coercive power of the state in controlling patients' behavior parallels the conditions in many prisons.[140]

134. 430 U.S. at 669-70.

135. *Id.*

136. *Id.* (quoting Morrissey v. Brewer, 408 U.S. 471, 482 (1972)).

137. Chicago Note, *supra* note 98, at 741.

138. *Id.* at 741-42.

139. In the landmark case of Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966), a patient's right to treatment as the concomitant compensation for the loss of his or her liberty was first enunciated. In the course of his opinion Judge Bazelon, a noted judicial authority on mental health and the law, had this to say about the indefinite length of a patient's residency: "The purpose of involuntary hospitalization is treatment, not punishment. . . . Absent treatment, the hospital is 'transform[ed] . . . into a penitentiary where one could be held indefinitely for no convicted offense . . ." *Id.* at 452-53 (footnote omitted).

140. Wade, *supra* note 7, at 64.

The second characteristic which identifies an action as punishment is stigmatization. This burden rests heavily on almost all mental patients, as society continues to treat them with amusement, scorn, or fear.[141] For example, the stigma attached to a mentally ill criminal defendant may be even more severe than that imposed on other criminals.[142] In addition, a mental patient's stigmatization may include not only social but legal disabilities, such as restrictions on voting rights, jury service, driving and gun licenses. Finally, a prior commitment may be a crucial factor in a subsequent commitment proceeding.[143]

In holding that proof of mental illness and dangerousness in involuntary civil commitment proceedings must be beyond a reasonable doubt rather than by a preponderance of the evidence, the District of Columbia Circuit Court of Appeals in *In re Ballay*[144] concluded after a thoughtful analysis that civil commitment was analogous to incarceration and that mental patients deserved the safeguard of the strict standard of proof accorded to prisoners. The court's emphasis on the involuntary confinement and stigmatization of mental patients was a precursor of the *Ingraham* opinion, which intimated that these traits, because they were characteristic of criminal incarceration, could generate Eighth Amendment claims if present in other circumstances. The *Ballay* opinion declared:

> As we have highlighted throughout, the loss of liberty—the interest of 'transcending value'—is obviously as great for those civilly committed as for the criminal or juvenile delinquent. Indeed, it may be greater in the former since the statute provides for indefinite commitment. The only question is whether the 'stigma' associated with involuntary civil commitment is as severe as the stigma of finding that an individual committed a crime. Even accepting recent medical advances, current studies clearly indicate the fallacy of contending that most people view mental illness as a disease similar to any physical ailment of the body. At best, an enlightened minority has been persuaded to accept this view.[145]

Several courts have summarily applied the Eighth Amendment to patients in state hospitals without resorting to a tortured analysis. For

141. *See generally* B. ENNIS, PRISONERS OF PSYCHIATRY: MENTAL PATIENTS, PSYCHIATRISTS AND THE LAW 145-78 (1972); Sarbin & Maninso, *Failure of Moral Enterprise: Attitudes of the Public Towards Mental Illness*, 35 J. CONSULT. & CLINICAL PSYCH. 159 (1970).

142. Winick, *supra* note 5, at 807. *See also* Burt, *Of Mad Dogs and Scientists: The Perils of the "Criminal-Insane,"* 123 U. PA. L. REV. 258, 260-63 (1974).

143. Chicago Note, *supra* note 98, at 743.

144. 482 F.2d 648 (D.C. Cir. 1973).

145. *Id.* at 668 (footnotes omitted).

example, *Wheeler v. Glass*,[146] involved a class action by two mentally retarded youths institutionalized in a state hospital. As punishment for an alleged homosexual act, they were bound to their beds in a spread-eagle position for seventy-seven and one-half hours in a public area of the hospital, and several times forced to scrub walls for ten consecutive hours dressed in short, backless hospital gowns. The court decried such sanctions, labeling them cruel and unusual punishment because they were uncommon and did not meet evolving standards of decency in a human society.[147] Similarly, in *United States v. Solomon*,[148] a suit to enjoin certain practices of state mental health officials that allegedly violated the constitutional rights of mentally retarded inmates in a state hospital, the Fourth Circuit declared that "it is too late in the day to deny that in a proper case the protections of the Eighth, Thirteenth and Fourteenth Amendments extend to the mentally retarded who are involuntarily confined."[149]

An Eighth Amendment challenge was also upheld in *Harper v. Cserr*.[150] In *Harper*, a voluntary mental patient had hanged herself after numerous suicide attempts. Her husband sued, claiming that the supervisor of the mental institution's failure to prevent the suicide constituted cruel and unusual punishment. The court agreed that the amendment could apply to voluntary patients who, because of their disabilities, are largely helpless and who may be confined *de facto*, depending on their disabilities and access to relatives, friends, guardians and other resources.[151] The court seemed to assume that there was little question the Eighth Amendment would apply to *involuntary* patients because an "involuntary mental patient has no alternative to enduring whatever conditions the state provides; if his captors allow him to be beaten or consign him to inhuman conditions, it seems rational to speak . . . of . . . an invasion of civil rights by his captors."[152]

146. 473 F.2d 983 (7th Cir. 1973).

147. *Id.* at 987.

148. 563 F.2d 1121 (4th Cir. 1977). The claims were based on violations of the Eighth, Thirteenth and Fourteenth Amendments. The case was never decided on the merits, however, as the complaint was dismissed on the ground that the Attorney General had no right to bring the suit.

149. *Id.* at 1124. *Accord*, Martarella v. Kelley, 349 F. Supp. 575, 597 (S.D.N.Y. 1972): "There is no doubt that the Eighth Amendment's prohibition of cruel and unusual punishment is not restricted to instances of particular punishment inflicted on a given individual but also applies to mere confinement to an institution which is 'characterized by conditions and practices so bad as to be shocking to the conscience of reasonably civilized people'."

150. 544 F.2d 1121 (1st Cir. 1976).

151. *Id.* at 1123.

152. *Id.*

The thesis that involuntary medication may be cruel and unusual punishment should apply to both voluntary and involuntary patients. Superficially an involuntary patient's situation may be more analogous to that of a prisoner, and thus more likely to fulfill the *Ingraham* requirements described above. But a stong argument has been made which demonstrates that patients with "voluntary" status are actually often in institutions against their will.[153] In addition, even truly voluntary patients are often, like prisoners, isolated from outside advocates, and are as subject to the intrusiveness and harmful effects of psychotropics as are their involuntarily committed counterparts.

One recent case has applied the line of reasoning presented above, which distinguishes the openness of the *Ingraham* school setting, with its concomitant safeguards, from the closed, insulated mental institution. *Halderman v. Pennhurst State School and Hospital*[154] was a class action suit brought by residents and former residents of an institution for the retarded. The trial court opinion documented the shocking quality of patient treatment and conditions at the hospital. These included a hazardous and filthy physical environment, abusive use of physical restraints, and inappropriate use of psychotropics. The court found that drugs were often used for control rather than treatment, and that the rate of use in some units was extremely high. Drug effects were inadequately monitored, and in only 29% of the cases in which drugs were administered were the effects on the resident evaluated. After reviewing evidence of some of the harmful effects of psychotropics, such as hypersensitivity to sunlight, ataxia (inability to maintain balance and gait) and gingival hyperplasia (gum tissue condition marked by inflammation, bleeding and increased growth), the court concluded that the use of psychotropics "actually impedes the habilitation of the resident, especially when used as a control rather than a habilitation device."[155]

In response to plaintiffs' Eighth Amendment claim, the *Halderman* defendants argued that *Ingraham* limited the applicability of the Eighth Amendment to those convicted of crimes. The court rejected this reasoning, citing the *Ingraham* footnote which reserved the question of Eighth Amendment applicability to inmates of mental institutions, and insisting that retarded patients do not have the safeguards guaranteed the *Ingraham* plaintiffs' children who were victims of cor-

153. *See* ENNIS & EMERY, *supra* note 38, at 90-95.
154. 446 F. Supp. 1295 (E.D. Pa. 1977).
155. *Id.* at 1308.

poral punishment at school.[156] The court cited the patients' own handicaps, which might prevent them from making effective complaints, and the institution's isolation and segregation from the community as reasons for applying the Eighth Amendment.[157] Few if any of the physically abusive incidents triggering the claim were committed as disciplinary measures,[158] yet, unlike *Price*, the court seemed to find this of little consequence, perhaps because, unlike the electroshock treatment in *Price*, the incidents were blatantly anti-therapeutic.

In sum, the circumstances surrounding an institutionalized mental patient's forced drug treatment may well trigger a claim or cruel and unusual punishment. The administration of drugs is no longer insulated from an Eighth Amendment challenge simply because it is labeled as treatment and not punishment because the treatment/punishment distinction is becoming less arbitrary. Further reason for applying the Eighth Amendment to mental patients is found in the many similarities between institutionalization and criminal confinement. The way is thus cleared to activate the constitutional protection to which the Supreme Court alluded in its *Ingraham* footnote on involuntary mental patients.

E. Judicial Standards for Determining Cruel and Unusual Punishment, and Their Application to Involuntary Medication

The words of the Eighth Amendment are not precise, and their scope is not static.[159] The concept "is not fastened to the obsolete, but may acquire meaning as public opinion becomes enlightened by a humane justice."[160] The Supreme Court has recognized that "the Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society."[161]

This notion of flexibilty is especially pertinent when creating standards for the use of psychotropic drugs. Because they were so recently developed, the extent and severity of their effects still are not completely documented. Judicial decisions concerning the constitutionality of their application must therefore be dependent in part upon the continuing evolution of medical knowledge. In addition, society's attitudes towards mental illness and its treatment are continually changing.

156. *Id.* at 1320-21.
157. *Id.*
158. *Id.* at 1321.
159. Trop v. Dulles, 356 U.S. 86, 100-01 (1958) (plurality opinion).
160. Weems v. United States, 217 U.S. 349, 378 (1910).
161. 356 U.S. at 101 (plurality opinion).

What was once an accepted medical procedure for such patients may now be regarded under contemporary standards of humanism as scandalous or barbaric. For example, performance of lobotomies, once condoned by some medical professionals, is a practice which has since fallen into disfavor. For twenty years, beginning in the late 1930s, frontal lobotomies were considered an important and advanced technique in treating extremely disturbed mental patient; between 1940 and 1960 approxmately 50,000 were performed in the United States. However, the operation often caused patients to become asocial, apathetic and intellectually dulled. Of the operations monitored during one study, 3.6% resulted in the patient's death, and 51.5% caused undesirable side effects such as partial paralysis, bladder control problems, and convulsions. With the appearance of the phenothiazines, the practice of lobotomies fell into disuse.[162] It is possible, therefore, that further medical research coupled with continuing humanistic concern for mental patients might alter the "evolving standards of decency" and render the use of psychotropics unconstitutional.

Although the criteria for determining cruel and unusual punishment remain flexible, judicial decisions have created three separate tests to discern Eighth Amendment violations. The first test is whether the punishment in question is "of such character as to shock the general conscience or to be intolerable to fundamental fairness."[163] As articulated by Chief Justice Warren in *Trop v. Dulles*: "The basic concept underlying the Eighth Amendment is nothing less than the dignity of man. While the State has the power to punish, the Amendment stands to assure that this power be exercised within the limits of civilized standards."[164]

This "fundamental fairness" test has been the most frequently used, perhaps because it was derived from the earliest decisions concerning the scope of the Eighth Amendment.[165] It was further refined by the Supreme Court in *Furman v. Georgia*,[166] which held that imposition of the death penalty under certain circumstances constituted cruel and unusual punishment. Justice Brennan in his *Furman* concurrence declared that "a punishment must not be so severe as to be degrading

162. Santa Clara Comment, *supra* note 68, at 736.

163. Lee v. Tahash, 352 F.2d 970, 972 (8th Cir. 1965).

164. 356 U.S. at 100 (plurality opinion).

165. *See* Note, *Recent Applications of the Ban on Cruel and Unusual Punishments: Judicially Enforced Reform of Nonfederal Penal Institutions*, 23 HASTINGS L.J. 1111, 1125 (1972) [hereinafter cited as Hastings Note].

166. 408 U.S. 238 (1972).

to the dignity of human beings."[167] He acknowledged that severe mental pain as well as physical suffering, could trigger a violation.[168] It is in this context that one commentator's remarks appear particularly appropriate: "Perhaps the most ubiquitous form of violent punishment-as-therapy in prisons is accomplished with tranquilizing drugs. To immobilize a person against his will with drugs is violence for the same reasons that chaining a person to the wall with shackles is violence."[169]

The negative effects of psychotropic medicines can erode the basic core of human dignity that the mental patient must try to preserve. The nausea, Parkinson syndrome, akathesia, dystonia and dyskinesia associated with the use of these drugs attack the fundamental well-being of the patient, producing a degradation which rob the patient of his or her physical integrity. Arguing that electroshock and psychosurgery are prohibited by the *Furman* tests, one author declared that "their result may be degrading. Certainly turning one into a human vegetable demeans one's dignity."[170] A sensitive observer in the wards of many state mental hospitals in which psychotropics are the major and often the only form of "treatment" might agree that this description is also at times applicable to the results of involuntary drug therapy.

Civilized standards of decency also may be viewed in light of the extreme mental and physical intrusiveness of psychotropic drugs. Patients who refuse to take drugs orally are occasionally given medicine intramuscularly, constituting a serious intrusion upon the body of the patient.[171] Similarly, few punishments are more intrusive upon the patient's mind, for the patient is totally vulnerable to the mood changes that the medicine creates, and is usually incapable of resisting them. A *Knecht* medical witness's characterization of apomorphine, which produces severe vomiting spells, may perhaps by analogy apply to many of the effects of the antipsychotics: "its [apomorhine] use is really punishment worse than a controlled beating since the one administering the drug can't control it after it is administered."[172] The standard of "fundamental fairness" articulated in this Eighth Amendment test appears to preclude these drastic, intrusive measures upon an unconsenting patient.

167. *Id.* at 271 (Brennan, J., concurring).

168. *Id.*

169. Opton, *supra* note 105, at 639.

170. Wade, *supra* note 7, at 65-66.

171. Note, *Mental Health—The Right to Refuse Drug Therapy Under "Emergency Restraint Statutes,"* 11 NEW ENG. L. REV. 509, 528-29 (1976).

172. Knecht v. Gillman, 488 F.2d 1136, 1138 (8th Cir. 1973).

Justice Brennan's *Furman* opinion also stated a second principle inherent in the examination of whether a punishment respects human dignity: "the State must not *arbitrarily* inflict a severe punishment."[173] Thousands of mental patients, however, are automatically given Thorazine and other psychotropics with little concern as to the true appropriateness of the prescription for the individual patient. Indeed, for many years the phenothiazines have been used in public mental hospitals on a very large scale to control patients and keep them quiet and docile.[174] This rationale of administrative convenience leads to the arbitrary use of medication for many patients, in violation of Justice Brennan's charge.

Justice Brennan's refinement of this first test also included the principle that a severe punishment "must not be unacceptable to contemporary society. . . . Rejection by society, of course, is a strong indication that a severe punishment does not comport with human dignity."[175] One of the most precise indications of public policy on a given issue is found through an examination of statutory requirements. Although drug treatment does not as yet share the more extensive statutory protection accorded electroshock treatments and psychosurgery, recent statutes are beginning to ban the practice of administering medication without informed consent at least in certain situations. For example, seven states have statutes barring unnecessary or excessive medication.[176] The efficacy of such statutes depends, of course, on the definition of "unnecessary or excessive." South Carolina and Michigan statutes provide even stronger safeguards against involuntary medication. The South Carolina law implies that drugs may be used for restraint only if the doctor indicates that it is required for the patient's medical needs.[177] In Michigan, prior to a commitment adjudication, a patient cannot be given chemotherapy without his or her consent, unless it is necessary to prevent physical injury to the patient or others.[178]

173. 408 U.S. at 274 (emphasis added).

174. Opton, *supra* note 105, at 640.

175. 408 U.S. at 277.

176. *See* Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U.L. REV. 461 (1978) (containing a complete survey of state statutes on the right to refuse treatment). Plotkin cautions, however, that statutory protection actually offers patients little real protection from coerced treatment. *Id.* at 498. For an additional state-by-state survey of right to refuse medication statutes, see 2 MENTAL DISABILITY L. REP. 240 (1977).

177. S.C. CODE § 44-23-1020 (1977).

178. MICH. COMP. LAWS ANN. § 330.1718 (1975) states: "(1) Chemotherapy shall not be administered to an individual who has been hospitalized by medical certification or by petition pursuant to chapter 4 or 5 [civil commitment sections] until after the preliminary court

These legislative judgments that such forced treatment is inappropriate is a strong indication that society no longer tolerates such pharmaceutical punishment. Court decisions from many jurisdictions upholding Eighth Amendment challenges to certain medical procedures are also a harbinger of a change in societal attitudes.

The second Eighth Amendment test is that a punishment is cruel and unusual if greatly disproportionate to the offense for which it is imposed.[179] This standard generally is measured by the severity of the crime for which a prisoner is punished. The court weighs the social and administrative harm caused by the prisoner's conduct against the emotional and physical damage caused the inmate by the particular method of punishment.[180] By analogy, the test can be used to balance the mental patient's "antisocial behavior"—the conduct which has caused the patient to be committed—with the effects of the psychotropics. Until recently, patients could be involuntarily committed under a *parens patriae* rationale in which the patient might possibly have committed no offense whatsoever against society. Although a police power rationale is becoming more popular, it often hinges on a diagnosis of a patient's future dangerousness, a judgment which is questionable at best. The commitment determination also may be founded on the presence of suicidal tendencies, a psychological problem which should not be considered a societal offense. Similarly, past or present dangerousness has been offered as a rationale for forced drug treatment. In those cases, a "least restrictive alternative test" and a narrow, workable definition of dangerousness offer a measure of protection to the patient's constitutional rights.

The above discussion suggests that the painful, frightening, and often irreversible effects of psychotropic drugs which many mental patients must endure are greatly disproportionate to the relative harmful-

hearing has been held unless . . . the administration of such chemotherapy is necessary to prevent physical injury to the individual or others.

(2) Chemotherapy shall not be administered to an individual who has been hospitalized by medical certification or by petition pursuant to chapter 4 or 5 on the day preceding and on the day of his full court hearing unless the individual consents to such chemotherapy or unless the administration of such chemotherapy is necessary to prevent physical injury to the individual or others." In addition, a recent study of the California Assembly has recommended that the right to refuse medication be included in right to refuse treatment legislation. D. CHANDLER & A. SALLYCHILD, CALIFORNIA STATE ASSEMBLY OFFICE OF RESEARCH NO. 31, THE USE AND MISUSE OF PSYCHIATRIC DRUGS IN CALIFORNIA'S MENTAL HEALTH PROGRAMS (1977).

179. *See* Robinson v. California, 370 U.S. 660 (1962); Weems v. United States, 217 U.S. 349 (1910).

180. Hastings Note, *supra* note 165, at 1126-27.

ness of the behavior underlying their commitment. In one case challenging the forced administration of prolixin and Thorazine, for example, the court recognized that "if the patient is likely to contract tardive dyskinesia through renewed administration of antipsychotic drugs, the cure would be worse than the illness, and involuntary medication would not be permitted."[181] Thus, the enormity of the consequences of involuntary psychotropic treatment, when constrasted with what is often nothing more than administrative convenience may be expected to persuade an increasing number of courts that patterns of medication cannot continue to be immune from judicial scrutiny.

The third, final, and perhaps least frequently used,[182] test is the concept that a punishment may be considered cruel and unusual when, although applied in pursuit of a legitimate penal aim, it goes beyond what is necessary to achieve that aim, that is, when a punishment is unnecessarily cruel in view of the purpose for which it is used.[183] As stated by Justice Brennan in *Furman*:

> A punishment is excessive under this principle if it is unnecessary: The infliction of a severe punishment by the State cannot comport with human dignity when it is nothing more than the pointless infliction of suffering. If there is a significantly less severe punishment adequate to achieve the purposes for which the punishment is inflicted the punishment inflicted is unnecessary and therefore excessive.[184]

In many instances involuntary drug treatment might fail to satisfy this standard. Medication often is used to treat and control patients on a widespread basis because it is less expensive and takes much less staff assistance than would psychotherapy.[185] Indeed, many state mental patients see a psychiatrist with startling infrequency. However, psychotherapy is a much less dangerous and intrusive procedure than psychotropics and could in some cases achieve the purposes for which drug therapy is ostensibly administered, *i.e.*, patient rehabilitation. More stringent control of dosages could also be used to partially fulfill this "least restrictive alternative" standard.[186]

181. Rennie v. Klein, 462 F. Supp. 1131, 1146 (D.N.J. 1978).

182. Hastings Note, *supra* note 165, at 1127.

183. Weems v. United States, 217 U.S. 349, 368 (1910).

184. 408 U.S. at 279 (Brennan, J., concurring) (citations omitted).

185. *See* note 116 *supra*. *See also* Halderman v. Pennhurst State School and Hospital, 446 F. Supp. 1295, 1306 (E.D. Pa. 1977) (physical and chemical restraints, *i.e.*, psychotropic drugs, used as control measures in lieu of adequate staffing); Welsch v. Likins, 373 F. Supp. 487 (D. Minn. 1974), *aff'd in part, vacated and remanded in part*, 550 F.2d 1122 (8th Cir. 1977) (insufficient staffing the rationale for excessive use of tranquilizers for behavior control).

186. Covington v. Harris, 419 F.2d 617, 623 (D.C. Cir. 1969); Lake v. Cameron, 364 F.2d

These three tests for determining cruel and unusual punishment are used by some courts in the alternative, by others in combination.[187] The above discussion has demonstrated that in many instances the use of medication without the informed consent of the patient fails to conform to the requirements of these standards, thereby providing the grounds for an Eighth Amendment challege to such forced treatment.

F. Judicial Precedents of Eighth Amendment Claims Against Involuntary Medication

Courts have recently been willing to prohibit the use of certain involuntary drug treatments on the basis of the Eighth Amendment. Perhaps the most well known cases in this area are *Knecht v. Gillman*[188] and *Mackey v. Procunier*.[189] In *Knecht*, mental institution inmates brought suit to enjoin the use of apomorphine. The drug had been used by the hospital staff as an integral part of an "aversion therapy" program based on principles of behavior modification and it was administered to patients who misbehaved as a means of changing their "undesirable behavior patterns." Patient violations leading to the aversion therapy were reported either by staff members or other inmates. Neither a nurse nor a doctor personally witnessed the violation. Applicable infractions included the giving of cigarettes against orders, failure to get up, talking, swearing and lying. For such misconduct, a nurse would administer apomorphine by intramuscular injection, without a doctor present. The apomorphine injection induced vomiting which lasted from fifteen minutes to an hour, and also produced a temporary cardiovascular effect. It is unclear whether the patients always gave initial consent to the procedure, but in any event, they were not permitted to withdraw consent once given.

In its ruling in *Knecht*, the Eighth Circuit, insisting "the mere characterization of an act as 'treatment' does not insulate it from Eighth Amendment scrutiny,"[190] found that the institution's use of apomorphine on nonconsenting patients was cruel and unusual punishment. It ordered the trial court to enjoin the administration of the drug on the institution's inmates unless the patients gave written consent and were adjudged informed and competent enough to do so by a physician. The court also declared that the consent must be reversible at any

657, 659 (D.C. Cir. 1966); Note, *Voluntarily Confined Mental Retardates: The Right to Treatment vs. The Right to Protection from Harm*, 23 CATH. U.L. REV. 787 (1974).

187. Hastings Note, *supra* note 165, at 1125.

188. 488 F.2d 1136 (8th Cir. 1973).

189. 477 F.2d 877 (9th Cir. 1973).

190. 488 F.2d at 1139.

time, and that each injection must be individually authorized by a doctor and based on a violation observed by a professional staff member, not simply a fellow inmate.

The Ninth Circuit in *Mackey v. Procunier*[191] reversed a district court dismissal of a suit brought by a state prisoner at the California Medical Facility at Vacaville who had been administered succinycholine (also known as anectine) without his consent. As in *Knecht*, the drug was used as part of a program of aversion therapy. Succinycholine is not recommended for administration to conscious patients because of its terrifying effects which have earned it its label of "fright drug"; when administered it causes breathing to stop.[192] The court held that if the plaintiffs proved their allegations, serious constitutional questions would be raised, including violation of the right to privacy, caused by impermissible tinkering with the mental processes, and use of cruel and unusual punishment.[193]

Knecht and *Mackey* do not specifically involve the psychotropic drugs whch are main focus of the discussion herein. Nevertheless they are of important precedential value because they can serve as initial standards for determining specific Eighth Amendment criteria in involuntary medication cases. Of particular importance is a comparison between the detrimental side effects of the drugs in question. The *Knecht* court found that continuous vomiting induced by apomorphine constitutes cruel and unusual punishment. It is quite conceivable, however, that the harmful effects of the antipsychotic and antidepressant drugs described above are equally as dangerous and unpleasant, even when the drugs are properly administered and monitored. Thus, by analogy, their administration without patient consent could also entail an Eighth Amendment violation. In fact, one writer sees a direct parallel between the *Knecht* case and the use of antidepressants with respect to the unknown aspects of the drugs and the psychologically debilitating effect of such medication.[194] This writer also contends that "although the effects of anectine may be greater than those accompanying Thorazine, or antidepressants, the degree of intrusiveness upon the mind of the patient seems quite similar."[195]

The comparison between *Knecht* and *Mackey* on the one hand,

191. 477 F.2d 877 (9th Cir. 1973).

192. *Id.* at 877.

193. *Id.* at 878.

194. *See* Note, *Mental Health—The Right to Refuse Drug Therapy Under "Emergency Restraint Statutes,"* 11 NEW. ENG. L. REV. 509, 528-29 (1976).

195. *Id.* at 529.

and the involuntary use of psychotropics on the other, is especially compelling once the treatment/punishment distinction has been removed.[196] Indeed, the irreversible effects of tardive dyskinesia present an especially strong case in favor of Eighth Amendment protection against antipsychotics when viewed in light of the *Knecht* and *Mackey* decisions. The other extrapyramidal symptoms and the questionable effects of the antidepressants also should not be discounted in analyzing an Eighth Amendment claim against such treatment.

Several courts have specifically addressed Eighth Amendment challenges to these widely used psychotropic drugs. Not surprisingly, many of these successful claims have arisen in a penal context. A class action on behalf of children institutionalized in a state training school successfully challenged the institution's practice of punitively administering tranquilizers in *Pena v. New York State Divison for Youth*.[197] Thorazine and other tranquilizing drugs were used by the institution's staff to control "excited behavior" of the boys. Boys were also kept in isolation for over twenty-four hours without permission from appropriate authorities, bound with physical restraints connecting their hands and feet behind their backs, and left lying on their stomachs on the floor. These practices all violated New York regulations, yet the district court found most shocking the violations of the regulations pertaining to drug administration.[198] Holding that the particular conditions under which it was administered violated the Eighth Amendment, the court enjoined the use of Thorazine at the institution as a punitive device, but authorized its use as part of an ongoing treatment program supervised by a doctor. The court also insisted the boys have the option of taking the drug orally, which lessened its physical and psychological dangers.

In *Souder v. McGuire*[199] the forcible use of psychotropic drugs on an inmate at a state hospital for the criminally insane was held sufficient to maintain an action under the Civil Rights Act. The *Souder* court declared that "involuntary administration of drugs which have a painful or frightening effect can amount to cruel and unusual punishment, in violation of the Eighth Amendment."[200]

Nelson v. Heyne[201] concerned the use of Thorazine and Sparine to

196. *See* note 121 and accompanying text *supra*.
197. 419 F. Supp. 203 (S.D.N.Y. 1976).
198. *Id.* at 210.
199. 423 F. Supp. 830 (M.D. Pa. 1976).
200. *Id.* at 832.
201. 491 F.2d 352 (7th Cir. 1974), *cert. denied*, 417 U.S. 976 (1974).

control excited behavior in juveniles at a correctional institution. The court held that the intramuscular administration of the drugs to juveniles by correctional institution staff without first attempting less drastic means of control and without adequate medical guidance or prescription violated the Eighth Amendment. Admittedly the circumstances in *Nelson* involved the improper administration of drugs, whereas the thesis at issue herein also centers on drugs administered according to medical standards. Nevertheless, the acknowledgement of the use of these drugs as punishment in *Nelson* is significant.

In addition to its findings on medication, the *Nelson* court held certain corporal punishment to be in violation of the Eighth Amendment. In the portion of its opinion discussing corporal punishment, the court made some observations that are also applicable to drug treatment. It noted that corporal beatings are "easily subject to abuse in the hands of the sadistic and unscrupulous, and control of the punishment is inadequate."[202] The identical observation may be made about the administration of psychotropics to the thousands of isolated mental patients committed in institutions which rarely come under public scrutiny and which hardly ever have patient advocates.

Two cases have explicitly found that forced medication in a nonpenal hospital setting constituted cruel and unusual punishment. In *Welsch v. Likins*[203] the court found that the excessive use of tranquilizing medication as a means of controlling the behavior of mentally retarded inmates and not for therapeutic purposes might infringe on their Eighth Amendment rights. This could be an important precedent for many patients who are drugged more for purposes of administrative convenience and control than for truly therapeutic reasons. The second case, *Scott v. Plante*,[204] involved the administration of Thorazine, Com-

202. 491 F.2d at 356.

203. 373 F. Supp. 487 (D. Minn. 1974), *aff'd in part, vacated and remanded in part*, 550 F.2d 1122 (8th Cir. 1977). The suit was a class action under the Civil Rights Act brought by mentally retarded inmates of Minnesota mental hospitals. The district court upheld the concept of a constitutional and statutory right to treatment and of patients' right to the least restrictive appropriate treatment. *Id.* at 502. It also found that several specific practices at the institution (including the use of medication) as well as the overall conditions there might constitute cruel and unusual punishment. *Id.* at 503.

204. 532 F.2d 939 (3d Cir. 1976). The suit was brought by a long time resident of a psychiatric hospital who had been charged with murder but had the charges against him dismissed on grounds of insanity. The trial court dismissed the plaintiff's claims of unconstitutional involuntary medication, confinement without right to treatment, unhealthy physical conditions, unconstitutional confinement, procedural inadequacies during inmate hearings, and the plaintiff's request for counsel. The Third Circuit reversed the lower court on each of these issues and remanded the case to the district court. *Id.* at 950.

Constitutional challenges to forced drug treatment of prisoners or juveniles in correc-

pazine, Mellaril, Visprin and Trilafron. In *Scott* the court held that under certain circumstances the inmate of a mental institution subjected to such medication could raise an Eighth Amendment claim.

Conclusion

The right to refuse medication is an essential civil liberty for the thousands of institutionalized mental patients who are obliged, often on a daily basis, to take psychotropic drugs. These drugs are highly intrusive and often cause serious and sometimes irreversible side effects. The Eighth Amendment's prohibiton against cruel and unusual punishment should provide a safeguard against the forced use of such medication even in cases in which it is used for therapeutic purposes and administered in a "medically acceptable" manner.

Although usually applied in a penal context, the Eighth Amendment may extend to a patient's right to refuse such treatment. This theory is supported by the current judicial trend which halts the arbitrary distinction between "treatment" and "punishment." Courts are increasingly disinclined to stand idly by after being exposed to stories of systematic suffering needlessly inflicted upon captive mental patients. Relying on *Estelle v. Gamble*[205] and the *Ingraham* footnote,[206] the courts are treating as punishment official conduct which may not be inherently punitive, but whose effect is the functional equivalent of retributive sanctions. When disinterested malevolence is justified as "administrative convenience," judges are increasingly prone to apply and Eighth Amendment analysis. As judicial understanding of mental illness expands, courts view the promiscuous use of psychotropics as an "unnecessary and wanton infliction of pain."

Eighth Amendment protection may also be triggered when forced druggings of mental patients occurs under circumstances analogous to those of criminal confinement. The reality of confinement is easily interpreted as punishment. Patients are forgotten while institutionalized and shunned upon release. The totality of their helplessness and the

tional institutions have not, however, been uniformly successful. Veals v. Ciccone, 281 F. Supp. 1019 (W.D. Mo. 1968), was one such failure. Veals was a prisoner in a federal penitentiary who sought a writ of habeas corpus to halt the prison staff's administration of medication to him despite his protests. His claim sanctioned by approved medical authority was rejected, in large part because the court found his treatment sanctioned by approved medical authority. *See also* Peek v. Ciccone, 288 F. Supp. 329 (W.D. Mo. 1968) (court rejected claim that Thorazine involuntarily administered to patient by injection constituted cruel and unusual punishment).

205. 429 U.S. 97 (1976).

206. Ingraham v. Wright, 430 U.S. 651, 669 n.37 (1977).

indefiniteness of their confinement should serve to heighten judicial sensitivity.

Many psychotropics cause painful and dangerous side effects; thus, in essence, their use without informed consent constitutes punishment. The negative consequences and their highly intrusive nature are so intolerable that they meet the standards enumerated by the courts as a requisite to sustain a charge of cruel and unusual punishment. The involuntary use of these medications can destroy a patient's self-respect in contravention of the Eighth Amendment mandate of due regard for human dignity. In fact, such use of psychotropics may prove degrading to human dignity in the truest sense, transforming healthy human beings into physically disabled individuals.

The administration of these dangerous and unpredictable drugs arbitrarily inflicts severe punishment on thousands of mental patients. Various statutes and the burgeoning number of hostile court decisions indicate that involuntary drugging is incompatible with the humanistic standards of contemporary society. Its results are greatly disproportionate to the harmfulness of the behavior for which a patients is committed and are often unrelated to the professed goal of rehabilitation. Finally, the involuntary administration of psychotropic drugs violates the Eighth Amendment because it is unnecessarily cruel, as less harmful alternative treatments could replace psychotropics.

Recent decisions have upheld Eighth Amendment challenges to involuntary drugging in both penal and non-penal institutional settings. Future litigation can expand such efforts and take advantage of the broad protective potential of the ban against cruel and unusual punishment in order to ensure committed mental patients the right to refuse medication. The amendment can serve as an important instrument for patients and advocates of mental patients' rights working to restore to such patients the choice of avoiding the inescapable effects of psychotropic drugs. Such a choice is a basic civil liberty and fundamental concept of human integrity that must no longer be denied.