

“I Refuse to Take My Meds!”

Psychotropic Medication Treatment
over Objection

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DISCLOSURES

We do not have any relevant financial relationships
with any commercial interests

DISCLAIMER

This informational presentation was developed by independent experts. The information provided in this presentation is not the official positions or recommendations of NCCHC but rather expert opinion. This information is not intended to be appropriate for every clinical situation nor does it replace clinical judgment.

Objectives

- Explore setting-specific approaches to compelled medications in the jail, prison, or community setting
- Describe relevant legal landmark cases and risk management issues
- Discuss how NCCHC standards can be applied when developing policies, procedures, and practices to implement these interventions in a safe and judicious manner

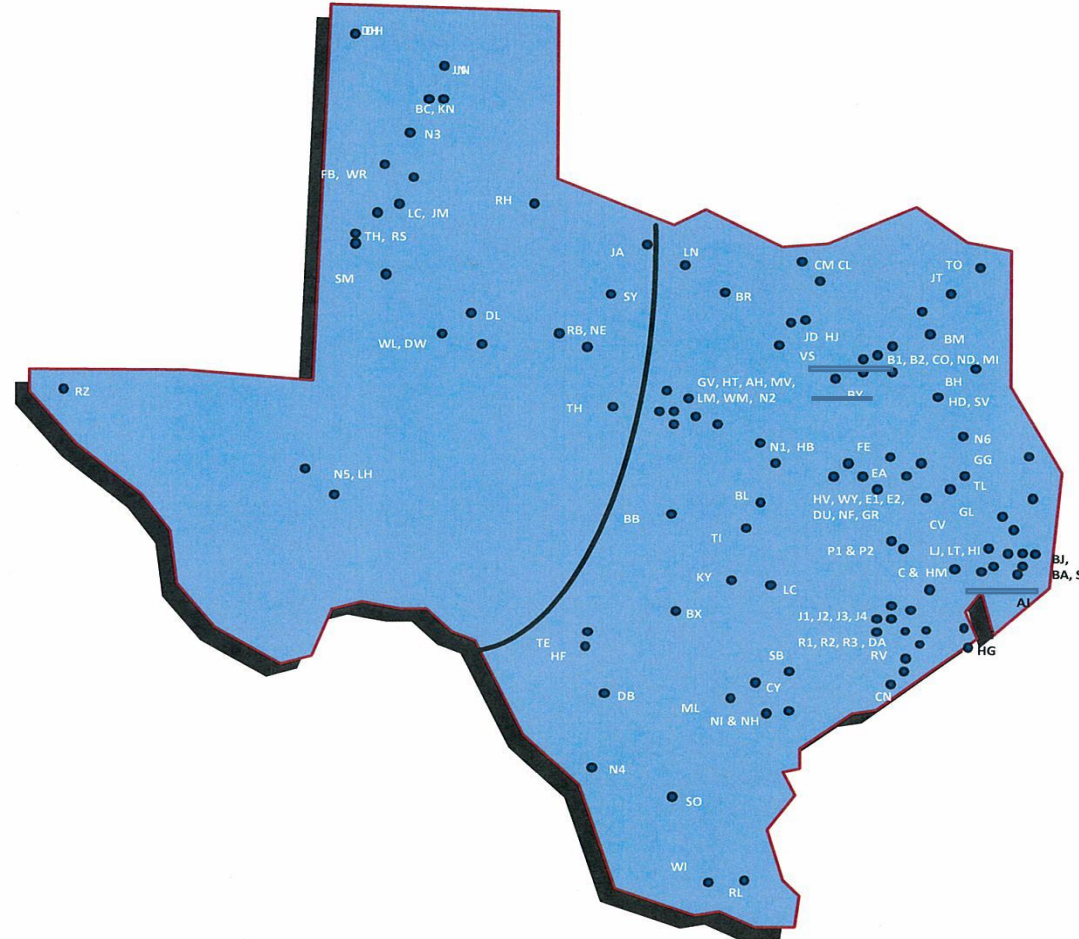
UTMB and Texas Tech Facilities

Geographic Areas of Responsibilities



FACILITIES

BC-Clements
DH-Dalhart
DL-Daniel
DW-Ware
FB-Formby
JA-Allred
JN-Jordan
KN-Neal
LH-Lynaugh
N2-San Saba
N3-Tulia
N5-Ft. Stockton
RB-Robertson
RD-Rudd
RH-Roach
RZ-Sanchez
SM-Smith
SY-Sayle
JM-Montford
TH-Havins
WL-Wallace
WR-Wheeler



FACILITIES

AH- Hughes
AJ- Luther
AJ -Lynchner
B2- Powlledge
BA- Leblanc
BB-Halbert
BH- Bradshaw
BJ- Gist
BL-Bartlett
B1- Beto
BM- B. Moore
BR- Bridgeport
BX- Dominguez
BY- Boyd
C- Central
CL-Cole
CM- C Moore
CN- Clemens
CO-Coffield
CV-Cleveland
CY-Connally
DA-Darrington
DB-Briscoe
Do-Diboll
DU-Byrd
E2-Estelle
EA-Eastham
E1- Ellis
EN-Segovia
FE-Ferguson
GC-Young
GG-Goodman
GL-Lewis
GR-Gorree
GV-Gatesville
HB-Hobby
HD-Hodge
HF-Ney
HG-Hospital
Galveston
HI-Hightower
HJ- Hutchins
HM-Kegans
HT-Hilltop
HV-Huntsville
J1- Jester 1
J2- Vance
J3- Jester 3
J4- Jester 4
JD-Dawson
JH- Hamilton
JT-Johnston
KY-Kyle
LC- Lockhart
LJ- Plane
LM-Murray
LN- Lindsey
LT- Henley
MI-Michael
ML-McConnell
MV-Mountain View
N1-Martin
N4-Cottulla
N6-Duncan
ND-Gurney
NE-Middleton
NF- Holliday
N1-Garza E
N4-Garza W
P1-Pack1
R1-Ramsey
R2-Stringfellow
R3-Terrell
R1-Travis County
RV-Scott
SB-Stevenson
SO-Glossbrenner
ST- Stiles
SV-Skyview
T3- Torres
T1-Bridgeport
TL-Polunsky
To-Telford
VS-Estes
WI-Willacy Co
WM-Woodman
WY-Wynne

USA and Corrections

- The US currently imprisons a higher percentage of its population than any other developed country
- > 2.3 million people are incarcerated in the US
- Focus is on punishment and “keeping them off the streets,” beginning in the juvenile system
- Sentences are getting longer and parole more difficult to attain and maintain
- Privatization of corrections/custody and correctional health care services

Psychiatric Disorders in US Corrections

- The current **epidemic** of psychiatric disorders in the United States prison system represents a **national public health crisis**.
- Between **15%** and **24%** of state prison inmates have a **severe mental illness**.
- Half of US inmates— over 1 million— have **at least 1 mental health condition**
 - *Bureau of Justice Statistics Report, 2006*
- A number of **legal, social** and **political** factors over the last **40 years** have led to this current excess.

Causes of Psychiatric Disease **Epidemic in Corrections**

1. **Mass downsizing** of public mental health hospitals (beginning in the late 1960's)
2. Inadequate **community-based** mental health services
3. **Legal systems** with limited capacity to discern mental illness among lawbreakers
4. **Laws** that have made it difficult to **commit** mentally ill patients to psychiatric hospitals
5. Private hospitals' **limited** enrollment of **psychotic** patients
6. **Economic pressures** resulting in reduced mental health coverage
7. Lack of psychiatric **continuity of care/community re-entry** programs following release from prison

Psychiatric Disorders and Repeat Incarcerations: The Revolving Prison Door

Jacques Baillargeon, Ph.D.

Ingrid A. Binswanger, M.D.,
M.P.H.

Joseph V. Penn, M.D.

Brie A. Williams, M.D., M.S.

Owen J. Murray, D.O.

Objective: A number of legal, social, and political factors over the past 40 years have led to the current epidemic of psychiatric disorders in the U.S. prison system. Although numerous investigations have reported substantially elevated rates of psychiatric disorders among prison inmates compared with the general population, it is unclear whether mental illness is a risk factor for multiple episodes of incarceration. The authors examined this association in a retrospective cohort study of the nation's largest state prison system.

Method: The study population included 79,211 inmates who began serving a sentence between September 1, 2006, and August 31, 2007. Data on psychiatric disorders, demographic characteristics, and history of incarceration for the preceding 6-year period were obtained from statewide medical information systems and analyzed.

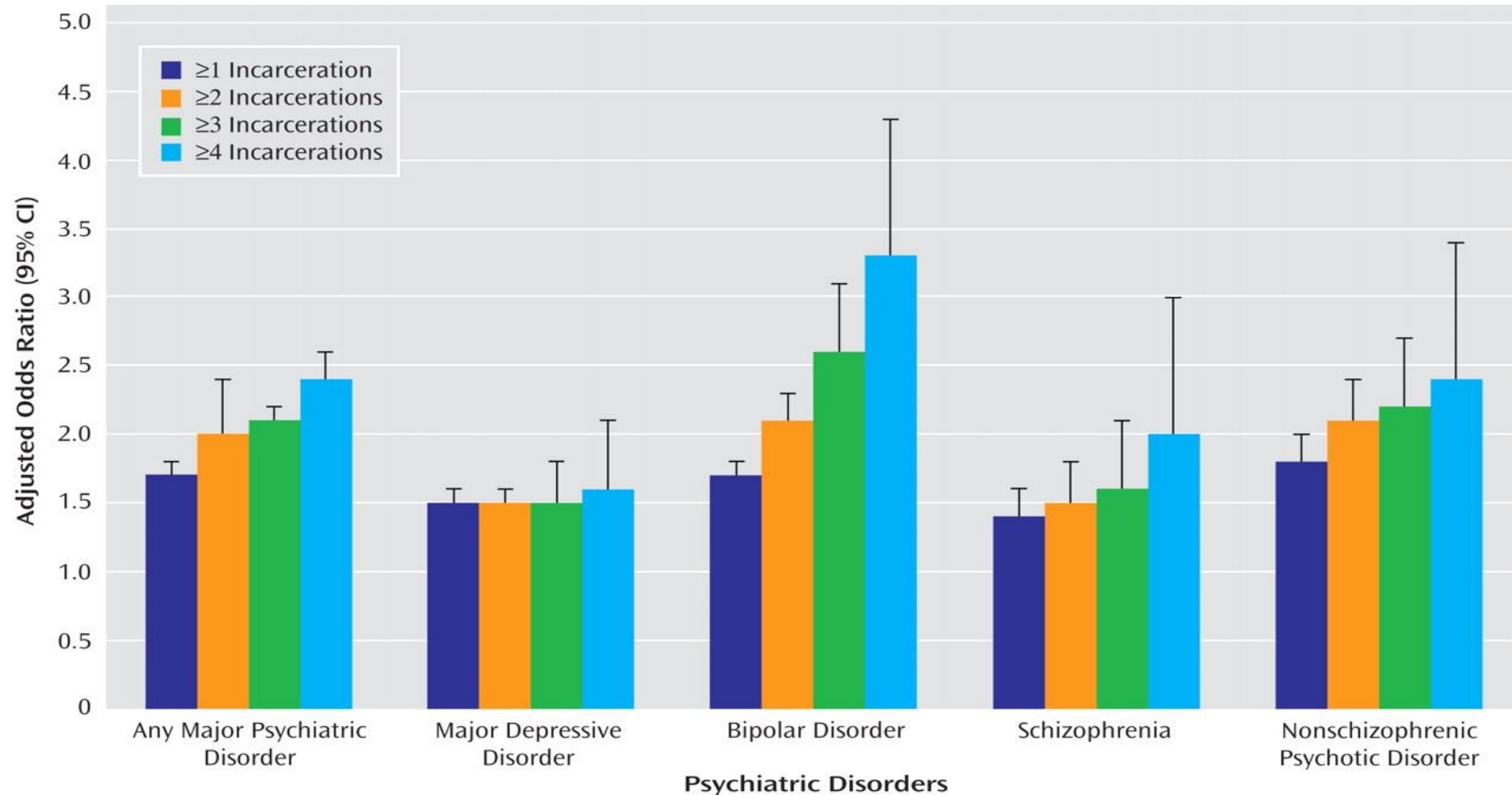
Results: Inmates with major psychiatric disorders (major depressive disorder, bi-

polar disorders, schizophrenia, and non-schizophrenic psychotic disorders) had substantially increased risks of multiple incarcerations over the 6-year study period. The greatest increase in risk was observed among inmates with bipolar disorders, who were 3.3 times more likely to have had four or more previous incarcerations compared with inmates who had no major psychiatric disorder.

Conclusions: Prison inmates with major psychiatric disorders are more likely than those without to have had previous incarcerations. The authors recommend expanding interventions to reduce recidivism among mentally ill inmates. They discuss the potential benefits of continuity of care reentry programs to help mentally ill inmates connect with community-based mental health programs at the time of their release, as well as a greater role for mental health courts and other diversion strategies.

Risk of Previous Incarcerations Among Texas Inmates - by Presence of Psychiatric Disorder

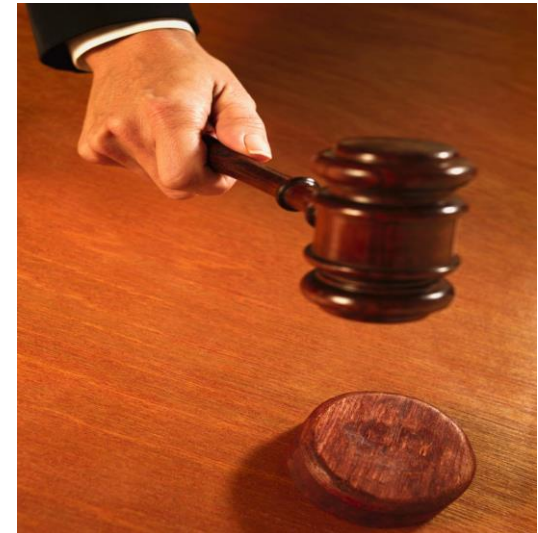
(Baillargeon, et al. *Am J Psychiatry* 2009. 166:103-109)

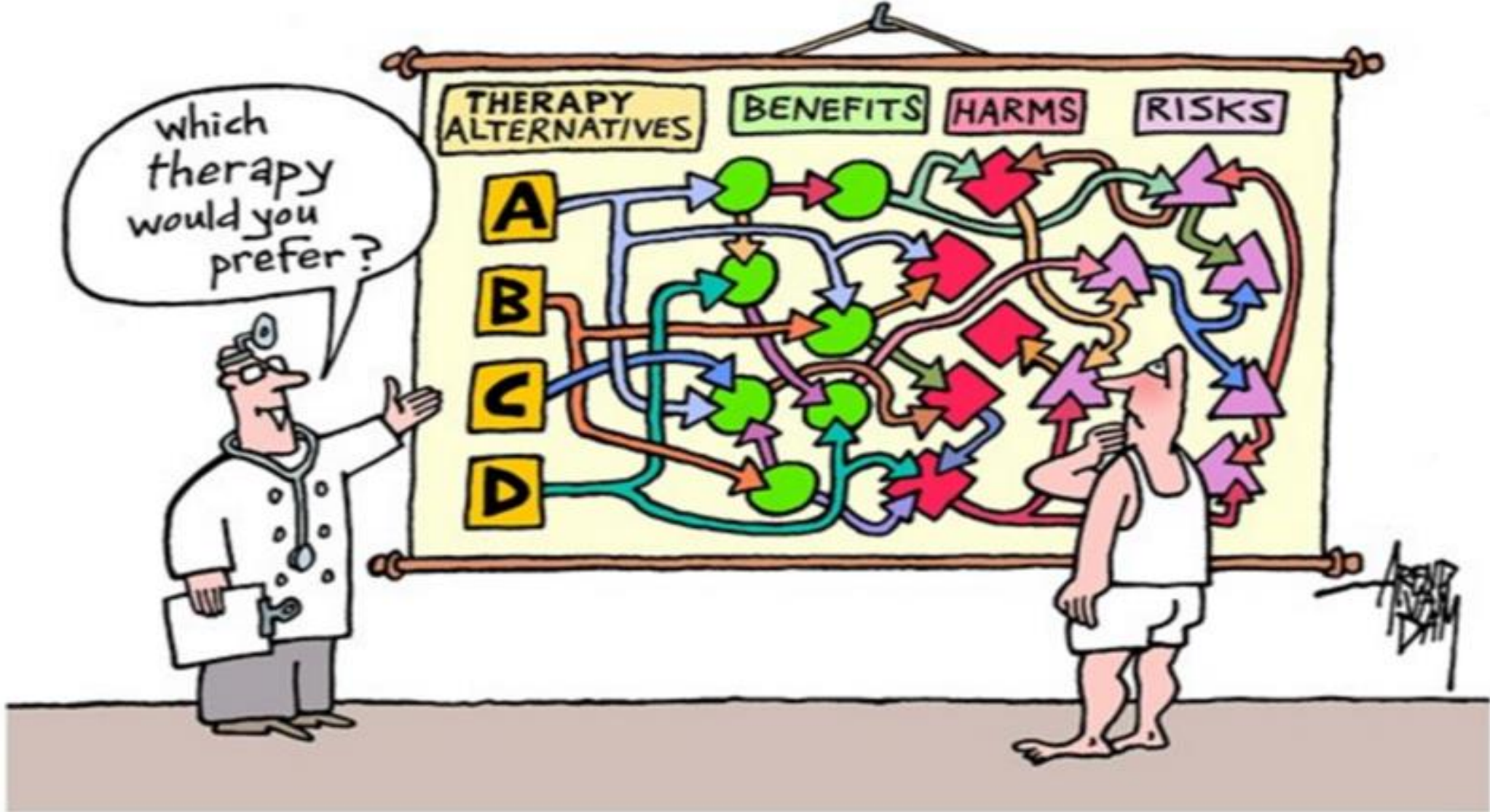




Constitutional Level of Care

- Prisoners have a constitutional right to health care services
- *Estelle v. Gamble* (1976) – medical treatment needs met
- *Ruiz v. Estelle* (1980)- mental health focused
- Landmark Texas cases which became basis for federal court action to set higher national standard for correctional medical and psychiatric health care





Capacity/Competency

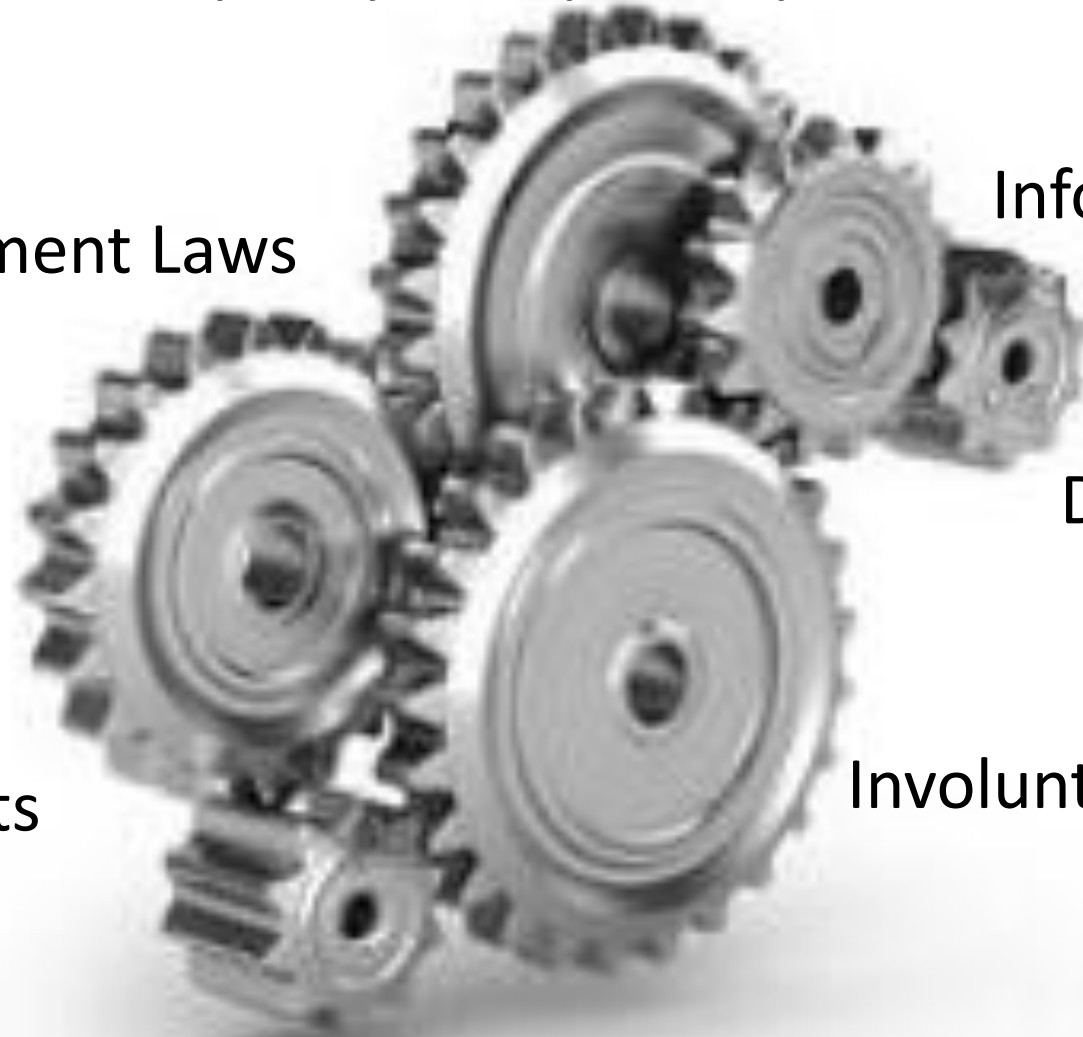
Informed Consent laws

Involuntary Commitment Laws

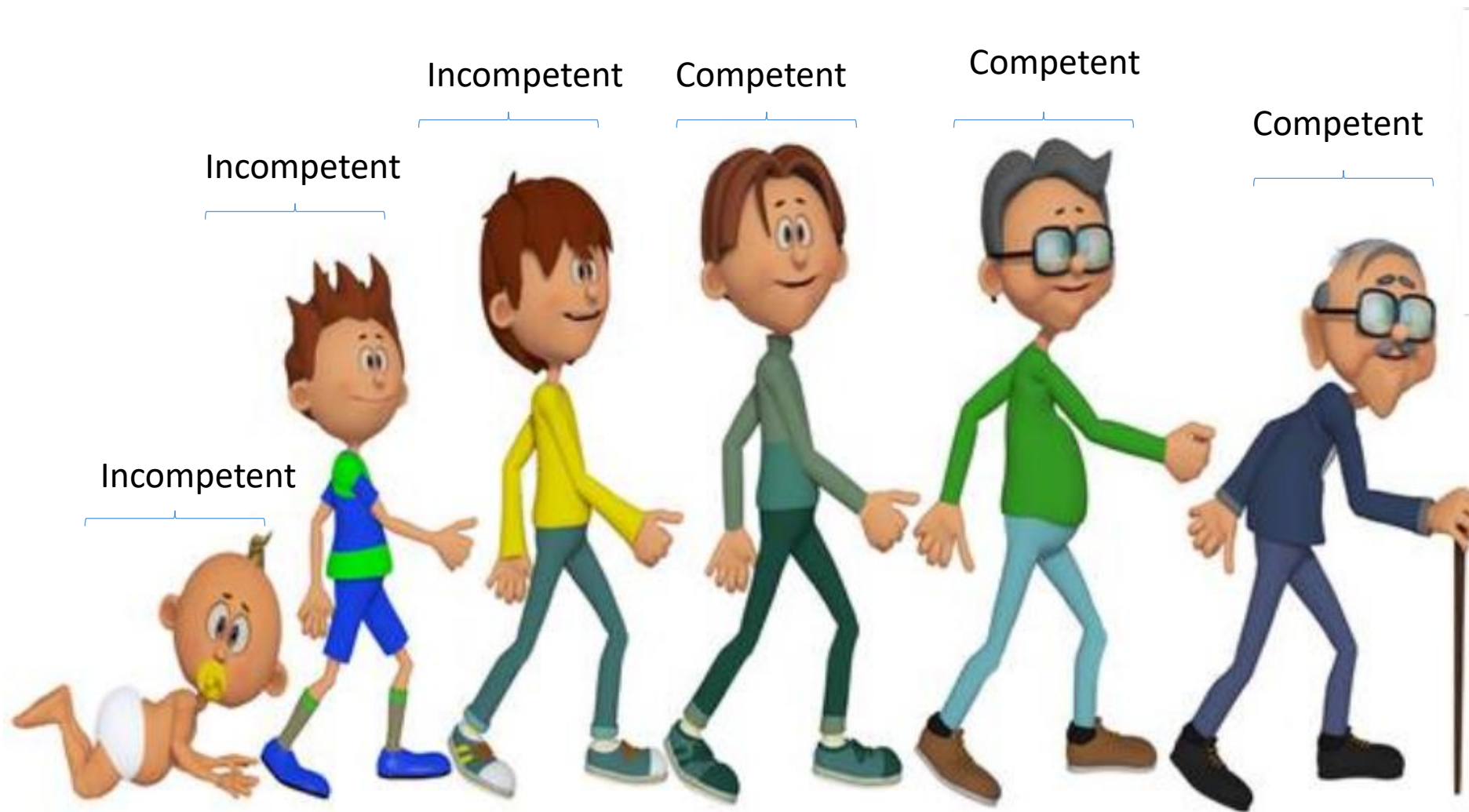
Duty to Protect

Constitutional Rights

Involuntary Medication Laws



PRESUMPTION OF COMPETENCE



AMENDMENTS

- ✓ I: Freedom of Speech.
- ✓ II: Right to keep/bear arms
- ✓ IV: Prohibits unreasonable search and seizures
- ✓ V: protects right to due process and prohibits self-incrimination.
- ✓ VIII: prohibits cruel and unusual punishment.
- ✓ XIV: Due Process and Equal Protection



**Preamble and Articles
of the Constitution**

Preamble

II • III • IV • V • VI • VII

Amendments to the Constitution

of Rights

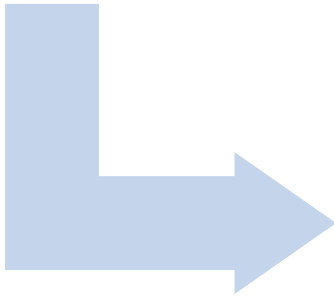
VII • VIII • IX • X

Core Principles of Medical Ethics:

- Non-maleficence (to do no harm)
- Beneficence (to do something good)
- Autonomy (freedom to choose)
- Justice (ensuring fairness)

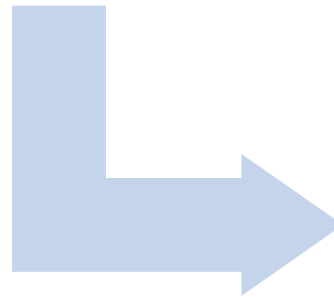
Medication
offer

- The provider gives information to educate the patient



Patient
verbalize
understanding

- Patient expresses a preference and asks questions



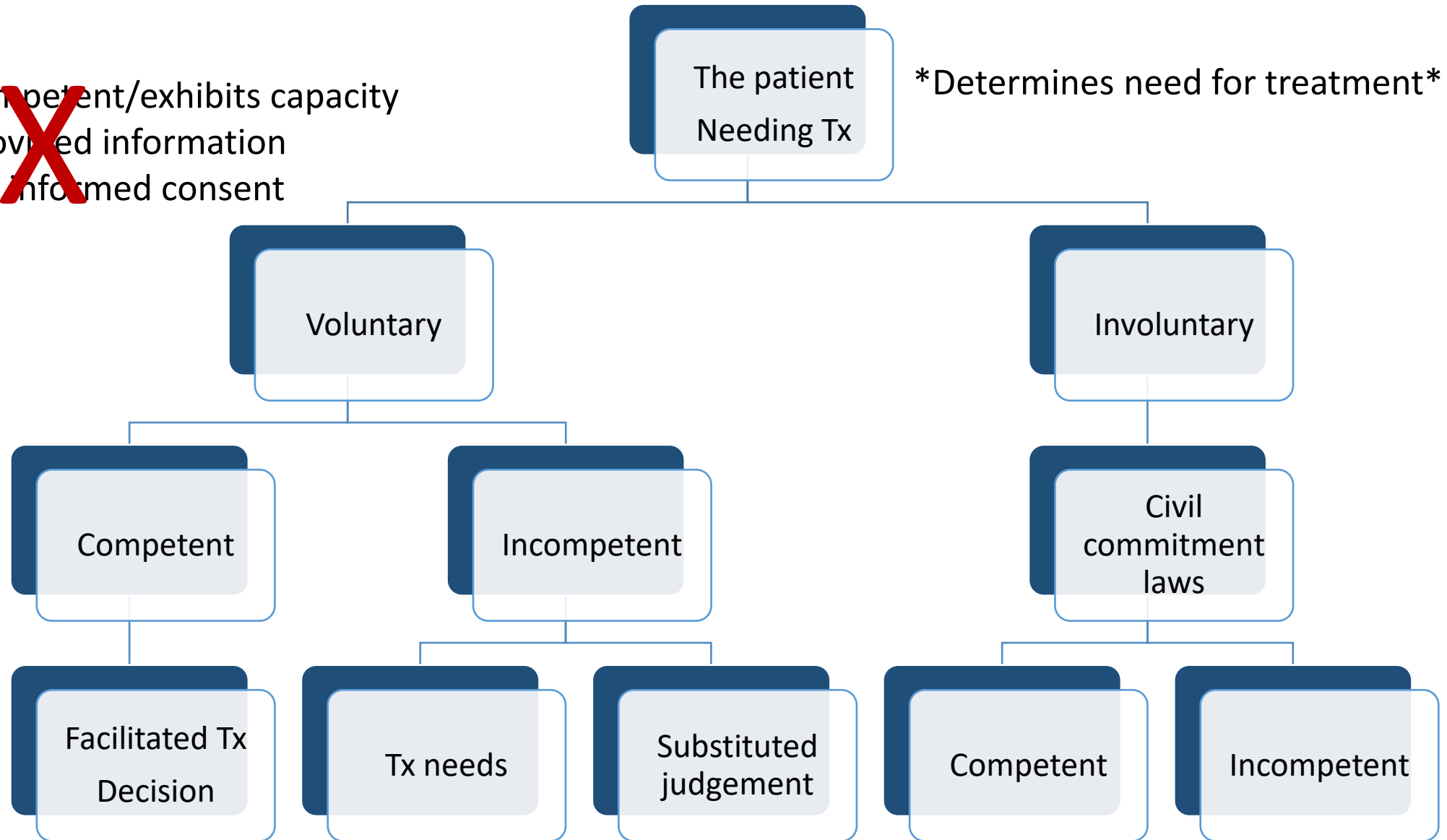
Patient signs
consent form

- Knowingly and well informed

CAPACITY TO MAKE MEDICAL DECISIONS

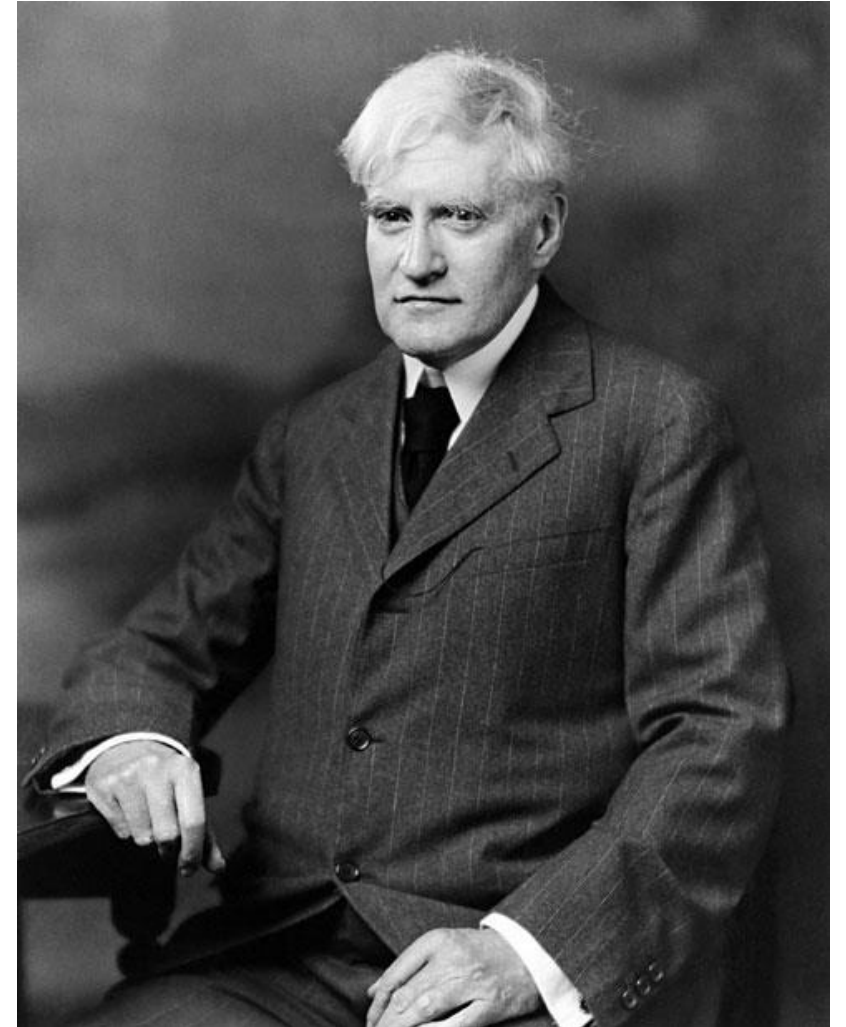
- ***Ability to expresses a choice***
- ***Shows understanding of the relevant information***
 - Risks and benefits
 - Alternatives to treatment
- ***Shows understanding of the situation/insight***
- ***Displays coherent thought process***
 - Ability to rationally manipulate relevant information

- Pt is ~~competent~~/exhibits capacity
- Pt is ~~provided~~ information
- Pt gives ~~informed~~ consent



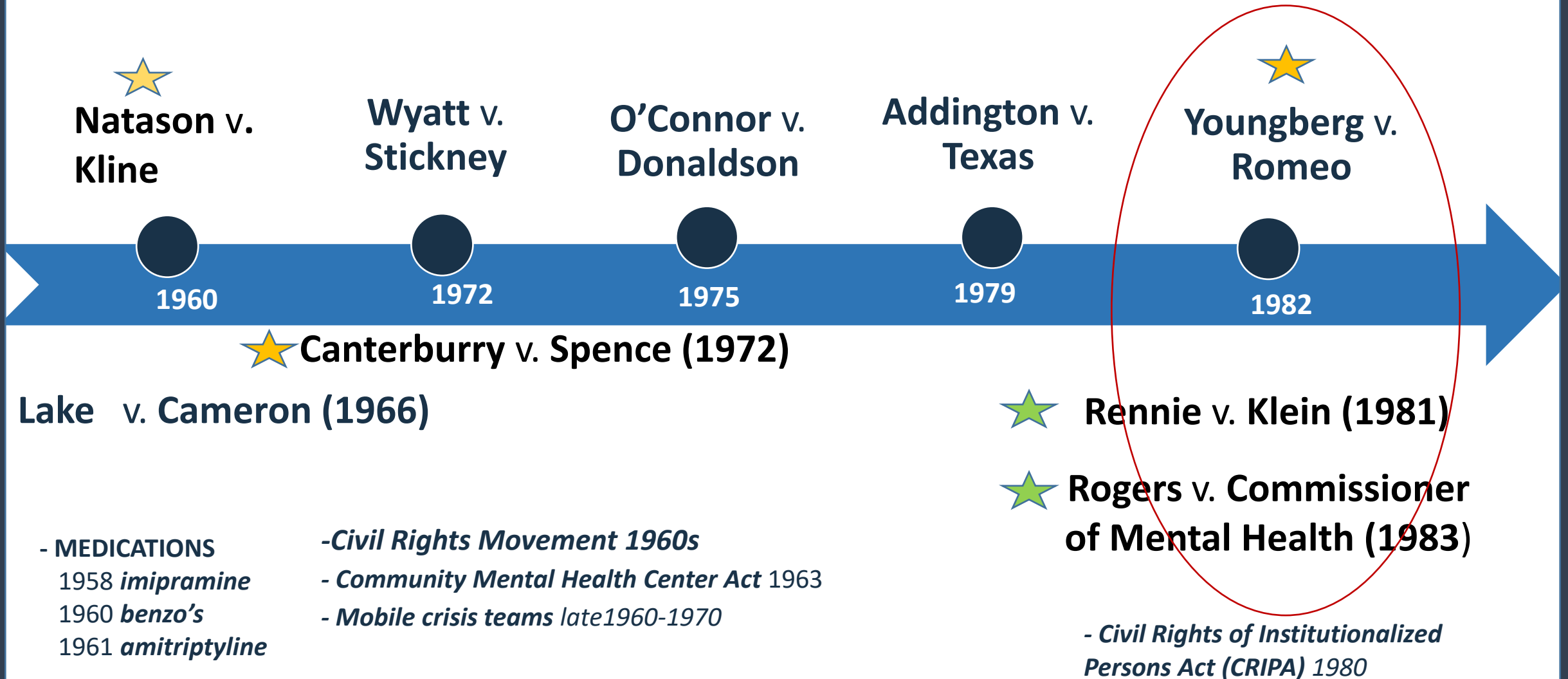
*Schloendorff v. The Society of
New York Hospital (1914)*

*“Every human being of
adult years and sound
mind has a right to
determine what shall be
done with his own body”*



Justice Cardozo

The Landmark cases timeline



Natson v. Kline

1960

FACTS: Irma Natason sustained burns from breast cancer radiation therapy and filed a malpractice suit against the radiologist.

COURT: Recommended the amount of disclosure sufficient for a physician to obtain informed consent

PARTIES:

- **Irma Natason** (patient)
- **Dr. Kline** (Radiologist)

IMPACT:

REASONABLE PRACTITIONER

HOLDING: “Full disclosure is too broad. The physician’s duty is to disclosure what a reasonable practitioner would disclose under similar circumstances.”

Lake v. Cameron

1966

FACTS: Catherine Lake was at St. Elizabeth's Hosp. for many years, despite not showing any evidence of dangerousness. She wanted to be released.

COURT: All patients who are not dangerous should not be confined if a less restrictive alternative is available.

PARTIES:

- **Catherine Lake** (patient)
- **Dale Cameron** (Hospital Superintendent)

IMPACT:

LEAST RESTRICTIVE OPTION

HOLDING: "Deprivations of liberty solely because of dangers to the ill person themselves should not go beyond what is necessary for their protection."

Canterbury v. Spence

1972

FACTS: Jerry Canterbury had spinal surgery and later became paraplegic. File suite for negligence alleging that he was not informed of the 1% risk of paralysis.

COURT: Based on medical training, the physician can sense what an average, reasonable patient would want to know.

PARTIES:

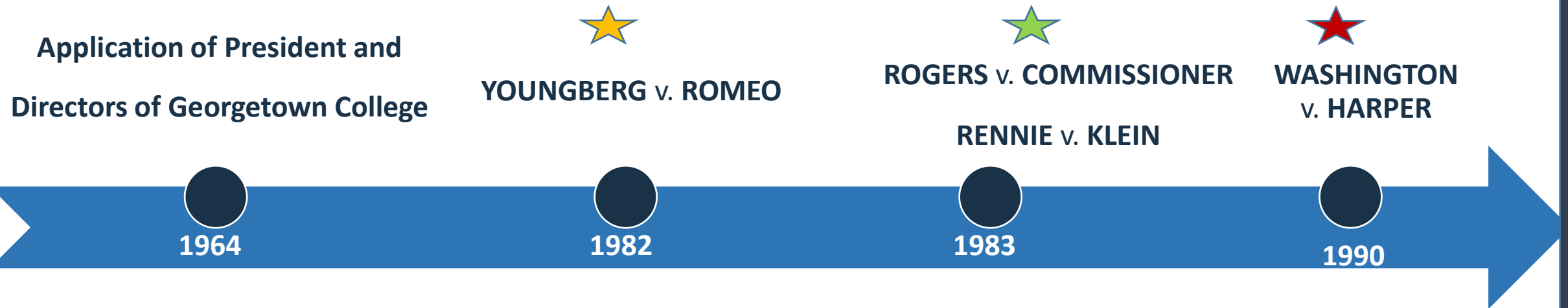
- **Jerry Canterbury** (patient)
- **Dr. Spence** (Neurosurgeon)

IMPACT:

REASONABLE PERSON

HOLDING: “The standard for disclosure is based on what a reasonable person would want to know.”

The Landmark cases timeline



Application of President and Directors of Georgetown College 1964

FACTS: Washington D.C. Mrs. Jones and her husband refused blood transfusion on the basis of religion. Death was imminent. Hospital Lawyer applied to District Court

COURT: Legal controversy to be decided; patient was unable to decide ; there was “responsibility to pt’s 7mo old child”

PARTIES:

- **Jessie Jones (25yp Jehovah’s witness)**
- **Georgetown Hospital staff**

IMPACT:

treatment refusal rights

HOLDING: Judge Wright ordered the transfusion be given (after visiting the Hosp).

DISSENT: Case was appealed in the US Supreme Court but certiori was denied.

Youngberg v. Romeo (1982)

FACTS: Nicholas Romeo was a 33yo wit IDD and a history of violence. He suffered injuries in multiple occasions during the 3 years he was civilly committed to a psych hospital.

COURT: Patients have a right to safe conditions, freedom from bodily restraint, and minimally adequate skills development to reduce the need for restraint.

PARTIES:

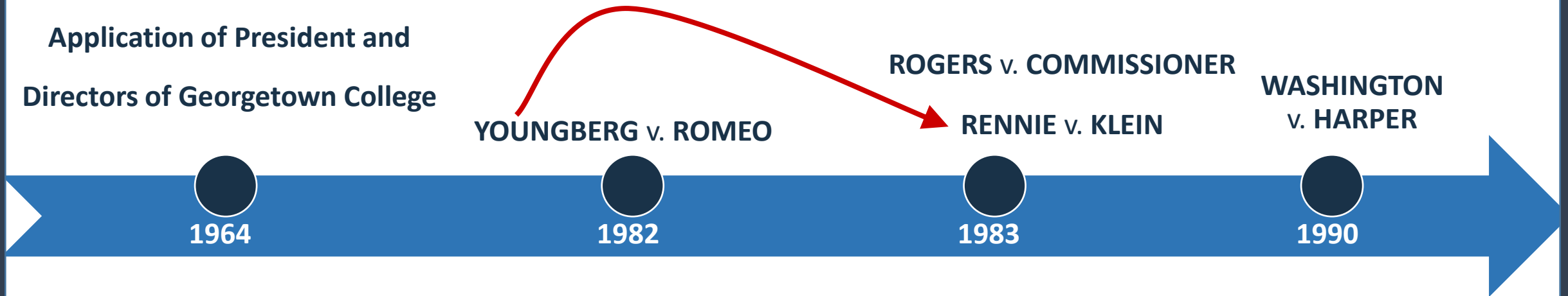
- **Nicholas Romeo** (patient)
- **Mr. Youngberg** (hosp Superintendent)

IMPACT:

14th amendment applied to bodily restraint

HOLDING: The 14th amendment right to liberty includes freedom from bodily restraints in hospitalized patients. In case of legitimate need for restraint, must not deviate from standard of care.

The **Landmark cases** timeline



ROGERS v. COMMISSIONER 1983

FACTS: Boston, MA. 7 plaintiffs.
Boston State Hospital. Filed a
class action lawsuit.

COURT: Initially Federal District
Court; then US Court of Appeals
(1st circuit) finally U.S. Supreme
court

PARTIES:

- Rubi Rogers and others (7 plaintiffs)
- Commissioner of the Department of MH and others

IMPACT:

RIGHTS-DRIVEN MODEL

HOLDING: Committed patient is competent until found incompetent. Judge decides. Substituted judgement (pt's previously expressed preference; religious convictions; impact on family from pt's viewpoint; probable side effects; prognosis with treatment; prognosis w/o tx.

Rennie v. Klein 1983

FACTS: New Jersey. Rennie was a patient at Ancora State Hosp. Initiated lawsuit during 12th hospitalization.

COURT: "professional judgement should consider if patient will suffer harmful SE. Difference with 3rd circuit was adding "least intrusive means test".

PARTIES:

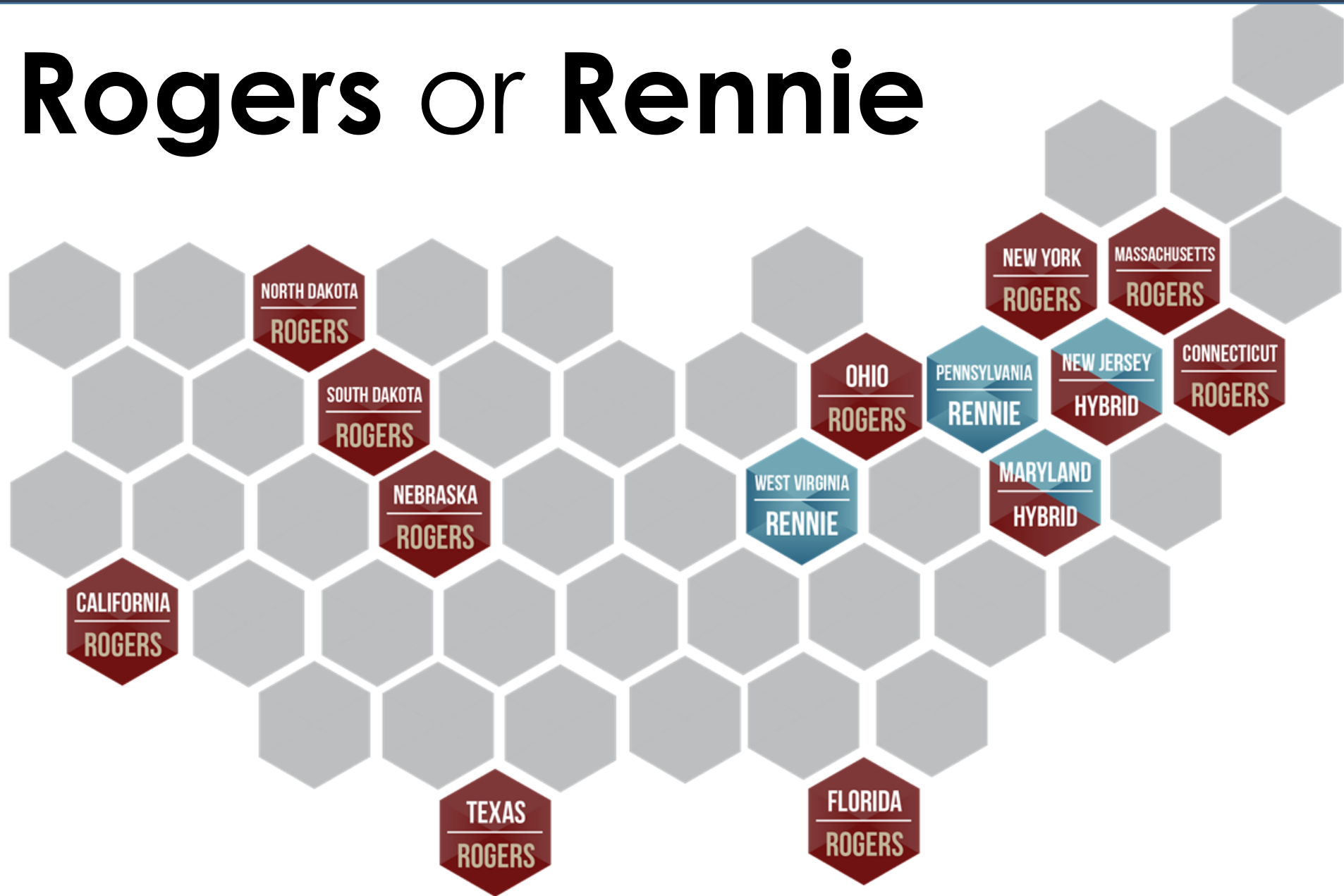
- **John Rennie** (involuntary patient)
- **Klein** (Hospital)

IMPACT:

TREATMENT-DRIVEN MODEL

HOLDING: Supreme Court, antipsychotics may be given to invol patients "whenever in the exercise of prof judgment such action is deemed necessary to prevent patient from endangering himself or others. Right to refuse is not absolute. Judge Brotman.

Rogers or Rennie



POSITIVES and NEGATIVE ASPECTS

RIGHTS DRIVEN (ROGERS)



1. Emphasizes patient's autonomy
2. Empowers patients

.....



1. Added cost to obtain a hearing
2. Treatment delay and milieu disruption
3. More seclusion and restraint

TREATMENT DRIVEN (RENNIE)

1. More rapid treatment
2. Seclusions are shorter
3. Shorter hospital stay

.....

1. Reduction of the incentive to negotiate
2. Patient may feel diminished by clinician dominated process

Patient Self-Determination Act (PSDA)

Passed Congress in 1990 and was effective in 1991.

The PSDA simply requires that most health care institutions (but not individual doctors) do the following:

1. Give, at the time of admission a written summary of:
 - Health care decision-making rights
 - The facility's policies with respect to recognizing advance directives.
2. Ask if the patient has an advance directive, and document it in the medical record.
3. Educate their staff and community about advance directives.
4. Never discriminate against patients based on whether or not they have an advance directive.

NCCHC STANDARDS

EMERGENCY

P-I-02 ESSENTIAL:

Health services staff follow policies developed for the emergency use of forced psychotropic medications as governed by laws applicable to the jurisdiction.

APPLICATION:

1. Create policies
2. Train staff
3. Ensure good documentation
4. Ensure follow-up visit after medication application

NON-EMERGENCY

NCCHC:

“For guidance in forcing psychotropic medication on a more frequent basis or as part of an ongoing treatment plan, staff are referred to case law.



TEXAS LAW

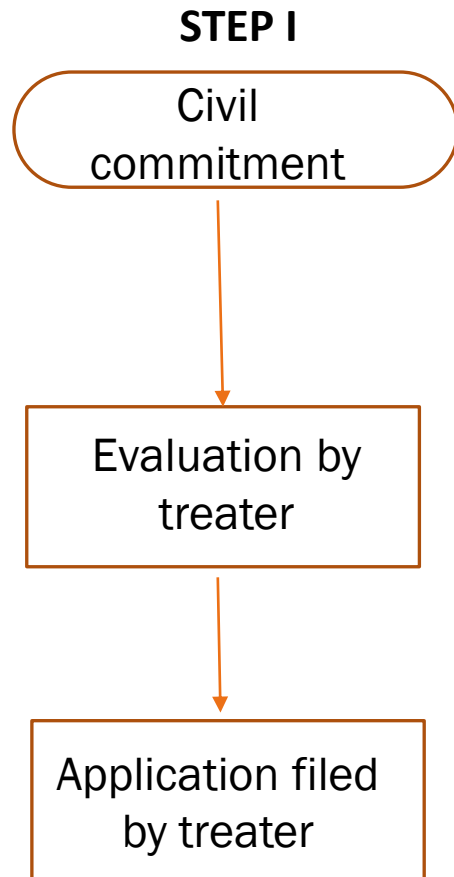
- Mental health patients have the right to refuse medications
- Medications cannot be used as punishment
- Medications cannot be used for the convenience of staff
- Authorization to administer medications to be requested by the physician who is treating the patient

TEXAS LAW

1. Physician believes that the patient lacks the capacity to make a decision regarding the administration of medication.
2. Physician determines that the medication is the proper course of treatment for the patient.
3. Patient is under an order for inpatient mental health services
4. Patient verbally or by other indication, refuses to take the medication voluntarily.

**These conditions also apply to patients in correctional settings.*

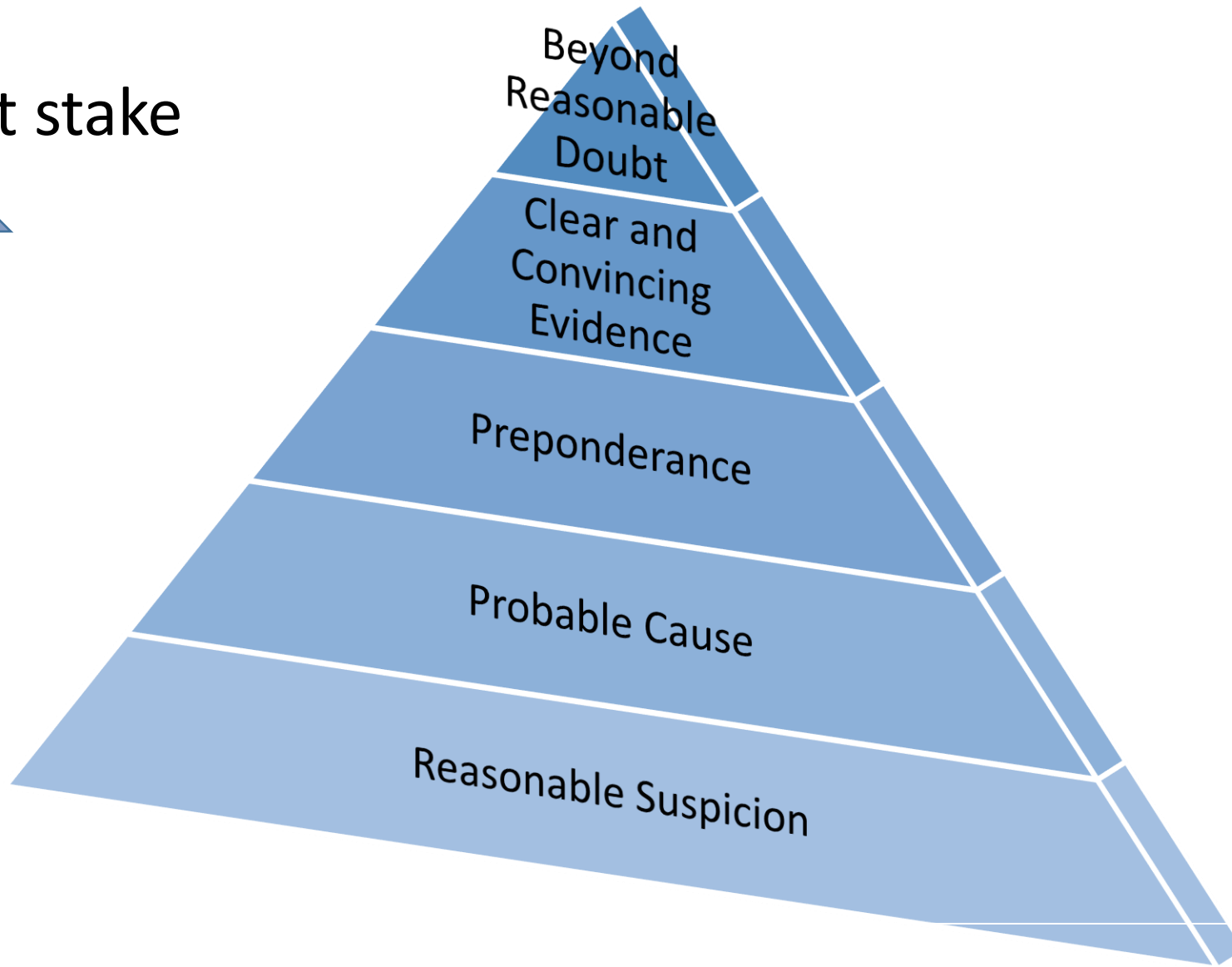
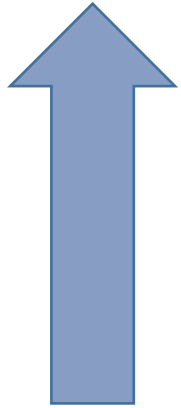
Filing process: **Community Hospital**



- STEP II**
- Patient gets safeguards
- Informed about intent to give meds against their will
 - Assigned lawyer to advocate for their interest
 - Informed of upcoming hearing

- STEP III**
- MD goes to court for testimony
- Assigned lawyer representing the state and the treater
 - Sworn and deposed
 - Cross examined
- Judge reveals decision

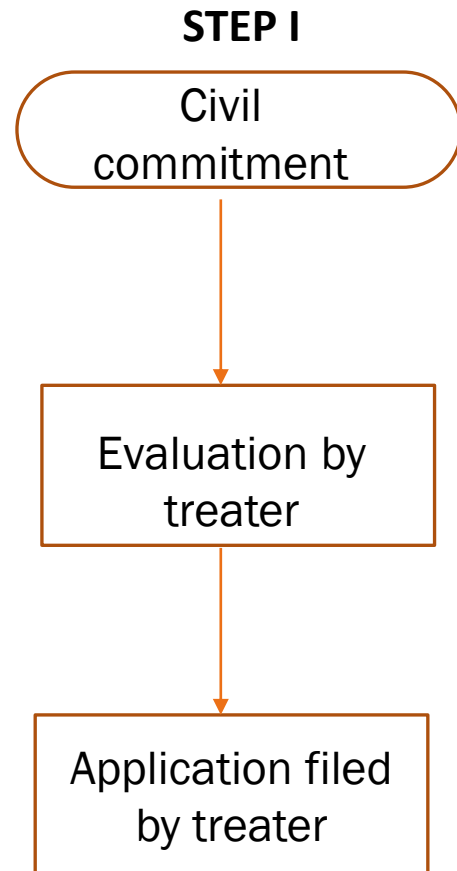
More is at stake



Filing process: **Corrections**

- A. Emergency forced psychotropic medications
- B. Non-emergency forced psychotropic medications

Filing process: **JAIL**



STEP II

Patient gets safeguards

- Informed about intent to give meds against their will
- Assigned lawyer to advocate for their interest
- Informed of upcoming hearing

STEP III

MD goes to court for testimony

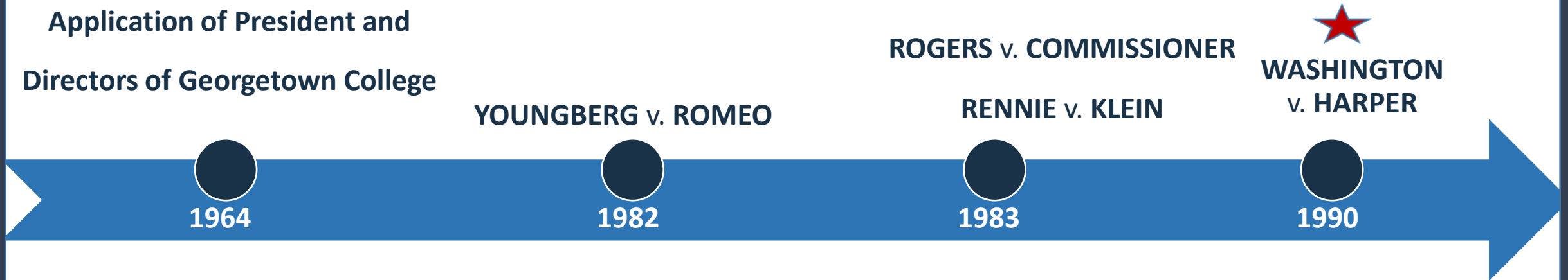
- Assigned lawyer representing the state and the treater
- Sworn and deposed
- Cross examined

Judge reveals decision

Filing process: **PRISON**

THE HARPER PANEL

The **Landmark cases** timeline:



Washington v. Harper

1990

FACTS: Walter Harper, was incarcerated in the Washington State Penal System. He was suffering from a severe mental illness (SMI) and had refused medications.

COURT: There is a legitimate state interest in combating danger posed by a violent mentally ill inmate.

PARTIES:

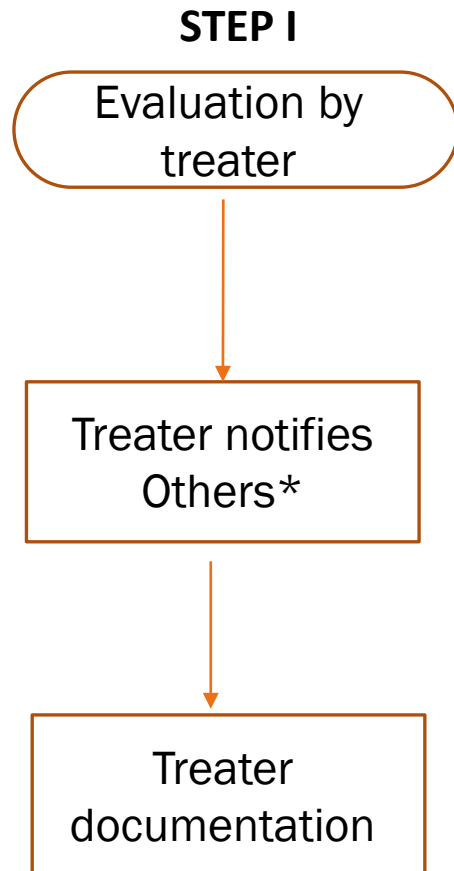
- **Walter Harper** (patient)
- **Washington State Penal System**

IMPACT:

invol. medication due process standard for prisons

HOLDING: “Liberty interest are better served by allowing the decision to medicate to be made by medical professionals.”

Filing process: **PRISON**



STEP II

Patient gets safeguards

- Informed about intent to give meds against their will
- Assigned an advocate for their interest
- Informed of upcoming administrative procedure

STEP III

Treater and others meet with patient

- Pt informed of reason for the procedure, roles of individuals, and pt's rights
- Non-treater questioning

Non-treater reveals decision

Filing process:

COMPETENCY RESTORATION

FOUR ELEMENTS ARE MET:

1. An important government interest is at stake
2. The medication is both substantially likely to render the individual competent and that the side effects will not interfere with this goal
3. Less intrusive treatment options are unlikely to produce similar results or that less intrusive options are not available.
4. The medication or medications are medically appropriate

This procedure will require the involvement of the probate court.



Review of Various Compelled Psychotropic Medication Interventions

- Short acting: Haloperidol, Fluphenazine, Olanzapine, Ziprasidone
- Long acting: Haloperidol, Fluphenazine, Olanzapine, Aripiprazole
- Argument for/against various agents
- High potency vs. atypical agents
- Do you need to do a test dose?
- What if patient is antipsychotic naïve?
- What if patient has an “allergy” to Medication X, Y, or Z?
- Do you use concomitant Benadryl and Cogentin as a prophylaxis against EPS?
- Other clinical pearls/strategies

Other Clinical Pearls

- Should family/guardians be contacted/notified/are they good sources of past history and other clinical information?
- How frequently should nursing re-assess?
- What should they be looking for?
- How to monitor ADL's?
- How to monitor fluid intake
- Detection and management of EPS?
- Acute dystonic reactions?
- What are emergency issues that warrant medical intervention/off-site/emergency transfer?

Other Important Points

- Always use highest standard of patient care
- Remember emergency situations do not require a court petition in the community, jail, nor Prison
- Forbidden use of antipsychotic to limit the mobility of a patient
- Review risks/benefits and alternatives
- Review the role of staff
- Make efforts to act in favor/advocate for the most therapeutic intervention

Other Important Points

- Explore patient's concerns
- Ensure it is not a religion-based refusal
- Check for patient's allergies
- Understand hx of response to prior medications
- Understand hx of side effects to prior medications
- Review risks/benefits and alternatives of proposed medication
- Look for comorbid conditions
- Look for medication interactions
- Monitor, monitor, monitor the patient status post intervention (nursing and mental health)





**QUESTIONS
&
COMMENTS
WELCOMED**



RESOURCES

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