COMPETENCY, CONSENT, AND ELECTROCONVULSIVE THERAPY: A MENTALLY ILL PRISONER'S RIGHT TO REFUSE INVASIVE MEDICAL TREATMENT IN OREGON'S CRIMINAL JUSTICE SYSTEM

by
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Psychiatrists in Oregon are overriding competent refusals of electroconvulsive therapy (ECT) by mentally ill prisoners and patients in state facilities. The United States Supreme Court has found that both prisoners and pretrial detainees have a significant liberty interest in being free from unwanted antipsychotic medication. A similar right to refuse ECT exists under the Due Process clause of the Fourteenth Amendment. Due process requires an adjudication of incompetence before treatment is forced. In addition, courts should make a substituted judgment for the prisoner or patient as to whether ECT is the appropriate medical treatment.

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I. INTRODUCTION

> There had been times when I'd wandered around in a daze for as long as two weeks after a shock treatment, living in that foggy, jumbled blur which is a whole lot like the ragged edge of sleep, that gray zone between light and dark, or between sleeping and waking or living and dying, where you know you're not unconscious any more but don't know yet what day it is or who you are or what's the use of coming back at all—for two weeks.[1]

> The doctor pressed a button on the small box she had been adjusting and the convulsion began. The woman went rigid and then began to convulse rhythmically. Her face became a ghastly blue as her convulsing muscles prevented her from breathing. It seemed like a long time before she started to breathe again, but it was probably only a few seconds. She made grunting and snorting sounds, as saliva, mixed with a little blood, frothed at the corners of her mouth. Once it was clear that she would continue to breathe, perhaps thirty seconds to a minute after the shock had been given, the doctor went to the next patient.[2]

In 2002, Neil Norton was found guilty but for insanity in a Washington County arson case.[3] He was transferred to the forensics ward of Oregon State Hospital and assigned to psychiatrist Dr. Charles Faulk. At the time of his commitment to the hospital, Mr. Norton's mental illness was well controlled with the use of two medications.[4] Dr. Faulk, labeling Mr. Norton a "pill-seeker," took him off both medications soon after his arrival. Mr. Norton's mental condition deteriorated rapidly over the next few months, but his cries for reinstating the medications went unanswered. By January 2003, Mr. Norton had lost almost 40 pounds, was hallucinating, and tended to be unresponsive. Dr. Faulk finally intervened at this point, but instead of putting Mr. Norton back on the medications that had been so successful before, he treated him with

[1] KEN KESEY, ONE FLEW OVER THE CUCKOO'S NEST 249 (40th Anniversary ed., Viking Penguin, 2002) (1962).

[2] LEE COLEMAN, THE REIGN OF ERROR: PSYCHIATRY, AUTHORITY AND LAW 116 (Beacon Press 1984), *available at* http://www.ect.org/resources/reign.html.

[3] Complaint at 3, Norton v. State, No. 04C-17107 (Or. Cir. Ct., July 27, 2004) (on file with Michelle R. Burrows, attorney for Neil Norton). Much of Neil Norton's story was provided by his attorney, Michelle R. Burrows.

[4] Psychology Admission Note, May 9, 2002, Frank L. Seibel, PsyD (on file with Michelle R. Burrows) ("Upon admission Mr. Norton was fully oriented and exhibited normal mood and affect. He is cooperative and friendly and participates appropriately in treatment . . . . He reports no present depression, suicidal ideation, or psychotic symptoms . . . . Mr. Norton reports Celexa has greatly assisted his depression and thus should be maintained on this medication.").

six rounds of electroconvulsive therapy (ECT).[5] Mr. Norton did not give his informed consent to the ECT. Dr. Faulk noted in his chart that he did not believe that the patient was capable of consenting to the treatment. Strangely enough, this same patient had been able to provide consent for an HIV test the day before.[6]

Dr. Faulk was the primary psychiatrist providing ECT at Oregon State Hospital at the time of Mr. Norton's commitment,[7] despite the fact that Oregon law appears to prohibit the use of ECT in both hospitals and non-hospital facilities. The statutory provision governing the custody and care of the mentally ill in Oregon states that "[a]ll methods of treatment, including the prescription and administration of drugs, shall be the sole responsibility of the treating physician. However, the person *shall not be subject to electroshock therapy* or unduly hazardous treatment and shall receive usual and customary treatment in accordance with medical standards in the community."[8]

When construing a statute, the court must first look at the plain meaning of the words used.[9] The words used in ORS § 426.072(2)(c) are clear on the face of the statute. The word "shall" should remove any discretion from the state and prohibit the use of ECT on patients committed to its care. While no Oregon court has ruled on the legality of using ECT, the Oregon Court of Appeals commented on this provision of the statute when another mentally ill patient appealed his right to a trial visit. The court stated: "[ORS 426.072] also prohibits certain types of treatment while the patient is in its custody."[10] The only type of treatment mentioned specifically in the statute is ECT, so the court seems to confirm that the use of ECT on custodial patients is prohibited by Oregon law.

Notwithstanding this language, Oregon State Hospital and other Oregon institutions currently use ECT as a treatment option on involuntarily committed patients.[11] The physicians in these facilities rely on another statutory provision,

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[5] *See, e.g.*, Michelle Roberts, *Reports Detail Psychiatrist's Mistreatment of Patient*, THE OREGONIAN, July 15, 2003, at A1.

[6] Oregon State Hospital, Informed Consent for Electrotherapy, Form #6 (on file with Michelle R. Burrows).

[7] Transcript of the Dep. of Charles Faulk, MD, June 24, 2004, at 30 (on file with Michelle R. Burrows) ("I'm the person that has utilized ECT at Oregon State Hospital the longest. . .Other physicians have attempted to begin treatment. . .[b]ut for one reason or another, decided not to proceed.").

[8] OR. REV. STAT. § 426.072(2)(c) (2003) (emphasis added).

[9] Portland Gen. Elec. Co. v. Bureau of Labor & Indus., 859 P.2d 1143 (Or. 1993).

[10] State v. Vonahlefeld, 914 P.2d 1104 (Or. App. 1996).

[11] "The use of ECT should be based on a thorough review of the severity of the patient's illness, medical indications and contraindications, and benefits and risks of all other treatments. Except for Primary use, ECT should be considered when alternative pharmacological and/or psychotherapeutic treatments have been given an adequate trial without good response. When a patient is suffering from therapy resistant psychotic or depressive illness, factors such as severity of illness, natural course, and risk of other treatments need to be taken into account." OREGON STATE HOSPITAL, MEDICAL DEPARTMENT MANUAL, sec. 5 policy no: 5.005, http://www.dhs.state.or.us/mentalhealth/osh/medman.htm #ECT (last visited Sept. 12, 2005).

and the Oregon Administrative Rules, which allow a doctor to force ECT on a committed patient "for good cause."[12] What would happen if mentally ill prisoners and patients went to court over the use of forced ECT? Apparent facial inconsistencies in the Oregon statutes make it uncertain whether courts would ban ECT from state institutions. If Oregon courts decide that ECT is not per se prohibited, attorneys for these individuals will have to fall back on traditional principles of due process and informed consent to protect a patient's right to refuse ECT.

Oregon, by administrative rule, provides for an independent medical review before any unconsented ECT is administered to a patient at Oregon State Hospital.[13] But Oregon has not provided for a judicial determination of incompetence, or even a court order, for the forced treatment. This allows the state to override a competent committed or incarcerated adult's decision regarding his own medical care without having to meet any evidentiary burden of proof. While treatment decisions are medical in nature, the right of a mentally ill prisoner or patient to refuse treatment should be adjudicated before that right is lost to the state.

This Comment will look at the history, science, and myths of ECT, as well as the medical standards of the psychiatric community. It will examine U.S. Supreme Court decisions regarding the appropriateness of forced antipsychotic medication on both prisoners and pretrial detainees. The Comment will further explore the doctrine of informed consent for both medical and psychiatric decision making within and without Oregon prisons and hospitals, and its intersection with competency issues for both pretrial detainees and prisoners. After exploring the current state of Oregon law, the Comment concludes with recommendations to ensure that the rights of mentally ill prisoners and patients to refuse unwanted invasive medical treatments such as ECT are adequately protected at all stages of their criminal proceedings.

II. ELECTROCONVULSIVE THERAPY (ECT)

When electroconvulsive therapy is mentioned in conversation it invokes strong reactions from scientists and laypeople alike. A swirl of controversy has always surrounded the use of shock treatment. ECT has undergone many changes since its creation in the early 1930s in Europe. But despite scientific innovations and legislative actions, Oregon and many other states are not sufficiently protecting the mentally ill population's constitutional right to refuse such an invasive and controversial treatment.

When a patient is deemed incompetent to give informed consent to ECT, Oregon requires a second opinion before treatment is forced.[14] Under the rule, if the patient's treating physician determines him to be incompetent to give consent, and the treatment is the most medically appropriate, "the

[12] *See* OR. REV. STAT. § 426.385(3) (2003); OR. ADMIN. R. 309-114-0020(1)(a)–(d) (2004).

[13] OR. ADMIN. R. 309-114-0020(2)(a).

[14] *Id.*

superintendent or chief medical officer of a state institution for the mentally ill shall obtain consultation and approval from an independent examining physician."[15] This safety net was instituted as part of a consent decree in a class action in Marion County in 1987, which challenged forced antipsychotic medication and ECT at Oregon State Hospital.[16]

A. History and Science

The first "shock treatments" were developed in 1933 by Manfred Sakel.[17] Using insulin to treat schizophrenia, clinicians noticed that patients exhibited signs of shock while being treated.[18] This breakthrough eventually led to seizure therapy, and subsequently clinicians began using electricity to induce these seizures in their patients.[19] ECT quickly grew in popularity. The United States military used ECT during World War II, and by the 1950s it "had become one of the standard treatments for hospital depression, accepted as a matter of course in U.S. and European psychiatry."[20] Following its rise in popularity, ECT seemed to almost vanish from the psychiatric forefront for approximately two decades amid an onslaught of public opposition to the procedure.[21] In contrast to the benefits espoused by western psychiatrists, ECT has also developed a reputation as a form of torture. Various reports detail electroshock being used to torment prisoners in Brazil, El Salvador, Morocco, and in South Africa under the apartheid regime.[22]

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[15] *Id*.

[16] Wilson v. Dravis, No. 02-1506-HU, 2004 U.S. Dist. LEXIS 19958 at *19 (D. Or. Sept. 23, 2004), *adopted*, No. 02-1506-HU, 2004 U.S. Dist. LEXIS 22668 (D. Or., Nov. 2, 2004) (discussing Burke v. Weissert, Civil No. 138674 and stating that as long as the hospitals and doctors were following the Oregon Administrative Rules, the patient's rights had not been injured).

[17] COLEMAN, *supra* note 2, at 116.

[18] MAX FINK, ELECTROSHOCK: RESTORING THE MIND xi (Oxford University Press, 1999) (signs of shock noted were "pallor, sweating, low blood pressure, rapid breathing, rapid pulse rate, and lowered levels of consciousness").

[19] *Id*.

[20] Edward Shorter, *The History of ECT: Unsolved Mysteries*, PSYCHIATRIC TIMES, Feb. 2004, *available at* http://www.psychiatrictimes.com/p040293.html.

[21] *Id*. "Then a wave of attacks began between the mid-1970s and mid 1980s on the procedure, resulting in a 1974 law against ECT in California." *Id*. "After its heyday in the 1940s and 1950s as a means of intimidating and controlling 'patients' in state mental hospitals, electroshock lost favor, partly due to the advent of neuroleptic drugs, partly because of the exposure of the horror of it all, as in the popular movie, 'One Flew Over The Cuckoo's Nest'." JOHN BREEDING, THE NECESSITY OF MADNESS (Chipmunka 2003), *available at* http://www.wildestcolts.com/mentalhealth/shock.html (last visited Sept. 12, 2005).

[22] CITIZENS COMMISSION ON HUMAN RIGHTS, *Psychiatry Destroys Minds: Electroshock Pain and Fraud in the Name of Therapy*, *available at* http://www.cchr.org/doctors/ect/eng/page20.htm.

The National Institutes of Health (NIH) developed a consensus statement on the recommended application of modern ECT,[23] but unless the reader is adequately versed in medical jargon and scientific terminology, the language is almost impossible to discern. To get a simpler picture of what happens during a course of ECT, I looked to a sample consent form printed by the American Psychiatric Association. The form reflects the kind of information the patient receives when deciding whether to consent to the treatment. The form states in relevant part:

> [t]he electrical current produces a seizure in the brain. The amount of electricity used to produce the seizure will be adjusted to my individual needs, based on the judgment of the ECT physician. The medication used to relax my muscles will greatly soften the contractions in my body that would ordinarily accompany the seizure. I will be given oxygen to breathe. The seizure will last for approximately 1 minute. During the procedure, my heart, blood pressure, and brain waves will be monitored. Within a few minutes, the anesthetic medication will wear off and I will awaken. I will then be observed until it is time to leave the ECT area.[24]

Reading the consent form gives the patient the impression that what he will encounter during his treatment is harmless. What it fails to emphasize, according to many opponents of ECT, are the true long-term cognitive effects of the procedure.[25] Buried on page three of the five-page "Informed Consent for Electrotherapy" form given to patients at Oregon State Hospital is some startling language about the side effects of the procedure: "I understand that memory loss is a common side effect of ECT. The memory loss with ECT has a characteristic pattern, including problems remembering past events and new information . . . . I may be left with permanent gaps in memory."[26] Patients who

[23] "Typically, ECT is administered as follows: the treatment is given in the early morning after an 8- to 12-hour period of fasting. Atropine or another anticholinergic agent is given prior to the treatment. An intravenous line is placed in a peripheral vein, and access to this vein is maintained until the patient is fully recovered. The anesthetic methohexital is given first, followed by succinylcholine for muscle relaxation. . . . Stimulus electrodes are placed either bifrontotemporally (bilateral) or with one electrode placed frontotemporally and the second electrode placed on the ipsilateral side (unilateral). . . . Seizure threshold varies greatly among patients and may be difficult to determine; nevertheless the lowest amount of electrical energy to induce an adequate seizure should be used. Seizure monitoring is necessary and may be accomplished by an EEG or by the 'cuff' technique." Electroconvulsive Therapy, NIH Consensus Statement Online 5(11):1−23 (Jun. 10−12, 1985), *available at* http://consensus.nih.gov/cons/051/051_statement.htm.

[24] AM. PSYCHIATRIC ASS'N, THE PRACTICE OF ELECTROCONVULSIVE THERAPY: RECOMMENDATIONS FOR TREATMENT, TRAINING, AND PRIVILEGING 320 (2d. ed. 2001).

[25] "In California in 1990, out of 656 complications reported as being the result of ECT, 82 percent included memory loss. . .The percentage of patients complaining of memory loss from ECT in California has increased dramatically: in 1991, it jumped to 96.2 percent, then 99.6 percent in 1993 and finally, 99.7 percent in 1994." CITIZENS COMMISSION ON HUMAN RIGHTS, *supra* note 22, *available at* http://www.cchr.org/doctors/ect/eng/page26.htm (citing statistics provided by the California Department of Health).

[26] Oregon State Hospital, Informed Consent for Electrotherapy, Form #6 (on file with Michelle R. Burrows).

are consenting to ECT are consenting to, among other side effects, the very real possibility of permanent memory loss.

B. Medical Standards of the Community

Like all medical treatments in informed consent controversies, the operative language in determining if the treatment was appropriate and if the risks were adequately conveyed is based in large part on the medical standards of the community. Despite its continued use in mental hospitals and other clinical settings, large disagreement exists in the psychiatric community as to when or whether ECT is appropriate as a treatment option.[27] Even among scientific proponents of ECT, there is no true consensus on whether ECT should be used as a first-line treatment against depression and other mental illnesses or whether it should only be sought when all other treatments have failed.[28]

The American Psychiatric Association Task Force recommends that medical providers not reserve ECT for use as a "last resort."[29] Oregon State Hospital policy, for example, provides for primary use of ECT when there is a "[n]eed for rapid, definitive response, such as lack of food/fluid intake [or] high suicide risk[.]"[30] On the other hand, many agencies and providers feel that ECT should never be the primary treatment. The National Mental Health Association recommends that "ECT be presented as an alternative with extreme caution, only after all other treatment approaches, such as medication and psychotherapy, have either failed or have been seriously and thoroughly

[27] "[T]here is continuing controversy concerning the mental disorders for which ECT is indicated, its efficacy in their treatment, the optimal methods of administration, possible complications, and the extent of its usage in various settings. These issues have contributed to concerns about the potential for misuse and abuse of ECT and to desires to ensure patient's [sic] rights." Electroconvulsive Therapy, NIH Consensus Statement Online, *supra* note 23. *See also* Shorter, *supra* note 20 (referring to the "ongoing reluctance" of the psychiatric profession to use or endorse ECT).

[28] AM. PSYCHIATRIC ASS'N, THE PRACTICE OF ELECTROCONVULSIVE THERAPY: RECOMMENDATIONS FOR TREATMENT, TRAINING, AND PRIVILEGING 5 (2d. ed. 2001). The Colorado statute governing the use of ECT requires the physician to inform the patient that there is a "difference of opinion within the medical profession" on its efficacy and use. COLO. REV. STAT § 13-20-401(4)(g) (2004).

[29] *Id. See also* Electroconvulsive Therapy, NIH Consensus Statement Online, *supra* note 23 ("In certain circumstances of acute risk to life or of medial status incompatible with the use of other effective treatments, ECT may be the first treatment.").

[30] OREGON STATE HOSPITAL, MEDICAL DEPTARTMENT MANUAL, sec. 5 policy no. 5.005; *see also* deposition of Charles Faulk, MD, June 24, 2004, at 28.

evaluated and rejected."[31] True opponents of the procedure liken it to torture and call for a complete ban of ECT.[32]

ECT is not the only psychiatric treatment surrounded by controversy. Psychosurgery is analogous to ECT in its inconsistent acceptance as an appropriate treatment. Commonly referred to in the past as lobotomy, psychosurgery is the surgical removal or destruction of part of the brain tissue with the intent to modify the patient's behavior.[33] Lobotomies had the effect of rendering a violent patient calm, but the side effects were extreme in many cases.[34] As a result, psychosurgery is altogether banned in Oregon.[35]

The opinions among the scientific community on the appropriateness of ECT are extremely varied. An internet search of ECT turns up a myriad of proponents and opponents to the procedure. It is difficult to see any consistent medical standard upon which to base a treatment decision. Unfortunately, for the patient who wishes to refuse ECT while in state custody, the legal standard is not much clearer.

III. DUE PROCESS LIBERTY INTEREST IN FREEDOM FROM UNWANTED MEDICATION

Courts and lawmakers have infrequently addressed the rights of mentally ill prisoners to refuse forced ECT. The use of forced antipsychotic medication, on the other hand, has been litigated often in both state and federal courts in recent years.[36] While forced ECT has not been at issue in recent litigation, the opinions are instructive as to how the courts might rule.

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[31] Nat'l Mental Health Ass'n, NMHA Position Statement – Electroconvulsive Therapy (2000), http://www.nmha.org/position/ps31.cfm. *See also* FINK, *supra* note 17, at 2−3 ("ECT is advisable when other treatments for a mental condition have failed, when normal life is severely compromised, and when medications elicit unpleasant or dangerous symptoms and their continued use is no longer feasible.").

[32] *See, e.g.*, CITIZENS COMMISSION ON HUMAN RIGHTS, *supra* note 22, *available at* http://www.cchr.org/doctors/ect/eng/page20.htm.

[33] BRUCE J. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT 103 (American Psychological Association 1997).

[34] *Id*. at 105.

> [Psychosurgery] also resulted in intellectual deterioration and personality changes, including apathetic, irresponsible, and asocial behavior, as well as a general blunting of emotional responsiveness and impairment of judgment, initiative, and creativity. Moreover, a variety of additional side effects, including irritability, epileptic seizures, disturbance of sleep or appetite, thirst, and sexuality and other manifestations of neurological trauma were not uncommon.

Id.

[35] OR. REV. STAT. § 426.385(3) (2003).

[36] If a patient or prisoner gives informed consent to medication, it is considered voluntary rather than forced. Brandy M. Rapp, *Casenote:* Sell v. United States*: Involuntary Administration of Antipsychotic Medication to Criminal Defendants*, 38 U. RICH. L. REV. 1047, 1049 (2004).

A. Prisoner's Right to Refuse

The U.S. Supreme Court has held in three cases that both mentally ill prisoners and pretrial detainees have a significant liberty interest in refusing the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment.[37] The right is not unqualified, however. In *Washington v. Harper*, the Court held that a competent, mentally ill prisoner's right to refuse medication could be overridden by the state if the inmate is dangerous to himself or others and if the treatment is in his best medical interest.[38] The Supreme Court reasoned that the rule comported with due process because the prisoner would be free from either unnecessary or arbitrary treatment.[39] An unsuccessful argument was made in *Harper* that the inmate must be found incompetent to have his right to refuse medication taken away, and even then, a substituted judgment must be made and medication forced only if it was determined that was what the inmate would want. The Court did not agree and rationalized that the inmate's right to refuse must be defined in the context of the prison environment.[40] Prisoners' constitutional rights may be limited if the regulation or activity has a reasonable relationship to legitimate penological interests.[41] A legitimate interest in remaining free from unwanted medication, therefore, may be overcome by a rational and legitimate state interest like prison safety.

B. Pre-Trial Detainee's Right to Refuse

The right to refuse unwanted medication applies equally to pretrial detainees. The Supreme Court explained its reasoning and used the *Harper* decision as a basis for reversing a state murder conviction in *Riggins v. Nevada*.[42] The defendant in *Riggins* had been forced to take antipsychotic medication and argued that because of the effect of the drugs, he was denied a full and fair trial.[43] The Court reasoned that if the Fourteenth Amendment protects prisoners even in the unique prison context, pretrial detainees have at least the same degree of protection.[44] The Court again expressed the importance of the constitutional right at issue. Because the Nevada courts did not "acknowledge the defendant's liberty interest in freedom from unwanted antipsychotic drugs" and failed to support their decision to force medication

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[37] Washington v. Harper, 494 U.S. 210 (1990); Riggins v. Nevada, 504 U.S. 127 (1992); Sell v. United States, 539 U.S. 166 (2003).

[38] *Harper*, 494 U.S. at 227.

[39] *Id*. at 222–23.

[40] *Id*. at 227.

[41] Turner v. Safley, 482 U.S. 78, 89 (1987) (allowing some deference to prison officials to deal with issues of prison security without being subjected to strict scrutiny for every decision made).

[42] *Riggins*, 504 U.S. at 129.

[43] *Id*. at 131.

[44] *Id*. at 135.

over the competent defendant's objections, the Court reversed the murder conviction.[45]

In 2004, the Supreme Court extended the *Harper* grounds for forced administration of antipsychotic drugs. In *Sell v. United States*, the court held that even if forced medication cannot be justified under the *Harper* analysis, a competent, mentally ill defendant can be forced to take antipsychotic drugs solely for trial competency purposes under certain limited conditions.[46] To permit this involuntary medication for trial competence, the court must find: (1) that important governmental interests are at stake; (2) that involuntary medication will significantly further those governmental interests; (3) that medication is necessary to further those interests; and (4) that involuntary medication is medically appropriate.[47] The Court stressed that this is a narrow holding which should force the lower courts to ask difficult medical and legal questions before allowing medication to be forced on a pretrial detainee.[48]

The court is right to demonstrate caution in allowing forced antipsychotic medication solely for the purpose of making a defendant competent to stand trial. Federal courts have consistently recognized two considerations when discussing why forced medication is such a serious invasion of liberty. Antipsychotic medication "tinkers with the mental processes," changing the patient's personality and interfering with his self-autonomy.[49] While it is apparent that the state is looking to alter some behaviors by forcing medication, it is inappropriate and contradictory to allow a defendant who is competent to refuse medication, but not competent to stand trial, to be forcibly changed, affecting his memory and cognition, solely to render him competent to stand trial—thereby overriding his competent decision to refuse treatment—when he is not a danger to himself or others.

Antipsychotic medication has known serious side effects, and those dangers are another concern for the Court.[50] Mild side effects range from drowsiness and dry mouth to muscle spasms, tremors, and blurred vision.[51] Some blood disorders result often enough to warrant increased monitoring of

[45] *Id*. at 137.

[46] 539 U.S. 166, 179 (2003).

[47] *Id*. at 180−81.

[48] "This standard will permit involuntary administration of drugs solely for trial competency purposes in *certain* instances. But *those instances may be rare*." *Id*. at 180 (emphasis added).

[49] United States v. Williams, 356 F.3d 1045, 1054 (9th Cir. 2004) (citing Mackey v. Procunier, 477 F.2d 877, 878 (9th Cir. 1973)); s*ee also* Washington v. Harper, 494 U.S. 210, 229 (1990) ("The purpose of the drugs is to alter the chemical balance in a patient's brain, leading to changes, intended to be beneficial, in his or her cognitive processes.").

[50] *Id*. ("While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects.").

[51] MELISSA K. SPEARING, NAT'L INST. OF MENTAL HEALTH, SCHIZOPHRENIA 18 (2004), *available at* http://www.nimh.nih.gov/publicat/schizoph.cfm; *see also* NATIONAL INSTITUTE OF MENTAL HEALTH [NIMH], MEDICATIONS 6 (4th ed. 2002), *available at* http://www.nimh.nih.gov/publicat/medicate.cfm#ptdep5.

patients taking certain antipsychotics.[52] One of the most unpleasant side effects is tardive dyskinesia (TD), a condition that causes involuntary muscle movements.[53] Despite these side effects, antipsychotic drugs are well-received by the medical community and are deemed appropriate in the treatment of mental disorders.[54] Any issues that potentially raise alarm for forced antipsychotic medication should be considered relevant when talking about forced ECT, since ECT also has serious side effects but lacks the same universal acceptance as antipsychotics.

In light of the *Harper* and *Riggins* decisions, some jurisdictions have changed their approach to forced medication. Arizona, for example, revised its rule of criminal procedure in 1997 to require a court determination before a pretrial detainee could be forced to take medication against his will.[55] In deciding that a doctor had acted in good faith when following a court order to force medication upon the detainee, the Ninth Circuit strongly demonstrated its stance on the importance of procedural safeguards: "The change [in Arizona Rules of Criminal Procedure] also lessens the precedential significance of this opinion, which, nonetheless, may be of use *in any jurisdiction not as enlightened* as post-1996 Arizona."[56] The choice of the word "enlightened" signals a change in attitudes about forced medication; it is an evolution of sorts, and indicates that future decisions allowing forced mediation with inadequate procedural protections could likely suffer the same fate.

C. Forced Medication as a Condition of Supervised Release

In 2004, the Ninth Circuit Court of Appeals used the *Harper*, *Riggins*, and *Sell* analyses as a basis for vacating a condition of supervised release that included forced antipsychotic medication.[57] It was concerned that the district

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[52] SPEARING, NAT'L INST. OF MENTAL HEALTH, *supra* note 51 at 14. "A condition called agranulocytosis (loss of the white blood cells that fight infection) – requires that patients be monitored with blood tests every one or two weeks" (referring to a side effect of clozapine). *Id.*

[53] NIMH, *supra* note 51 at 8. "[TD] is characterized by repetitive, involuntary, purposeless movements. Features of the disorder may include grimacing, tongue protrusion, lip smacking, puckering and pursing, and rapid eye blinking. Rapid movements of the arms, legs, and trunk may also occur." National Institute of Neurological Disorders and Stroke, [NINDS] Tardive Dyskinesia Information Page, http://www.ninds.nih.gov/disorders/tardive /tardive.htm.

[54] Riggins v. Nevada, 504 U.S. 127, 141 (1992) ("[Antipsychotic medications are considered] an effective treatment for psychotic thought disorders. . . . For many patients, no effective alternative exists for treatment of their illnesses.").

[55] Kulas v. Valdez, 159 F.3d 453, 456 (9th Cir. 1998). "In the context of both *Harper* and *Riggins* such an invasion of the human person can only be justified by a determination by a neutral factfinder that the antipsychotic drugs are medically appropriate and that the circumstances justify their application." *Id*.

[56] *Id.* (emphasis added).

[57] United States v. Williams, 356 F.3d 1045, 1055 (9th Cir. 2004) (holding an order requiring Williams to take antipsychotic medication against his will was an "unusually serious infringement of liberty that calls for more thorough consideration and justification than the conditions of supervised release this court has previously approved").

court had allowed a deprivation of fundamental rights without a medically-informed record. The Ninth Circuit held that "before a mandatory medication condition can be imposed at sentencing, the district court must make on-the-record, medically-grounded findings that court-ordered medication is necessary . . . . Also, the court must make an explicit finding on the record that the condition 'involves no greater deprivation of liberty than is reasonably necessary.'"[58] This holding demonstrates the Ninth Circuit's continued sensitivity to the invasiveness of forced treatments and the constitutional rights of mentally ill individuals, regardless of their placement in the criminal justice system.

Looking at the cases as a whole, a constitutional right to refuse antipsychotic medication exists at all stages of a criminal proceeding, but it is not an absolute right. A pretrial detainee can have his right to refuse medication overcome by important government interest in bringing him to trial under the narrow *Sell* test. A mentally ill prisoner can have his right overridden if he is dangerous and if medication is in his best medical interest under the *Harper* analysis. And a competent decision to refuse treatment as a condition of supervised release can be overcome if it poses no greater deprivation of liberty than necessary and if the court makes a finding of medical appropriateness. At all three stages, forced medication must exist within a framework of adequate procedural protections. The constitutional right to refuse medication is clearly considered significant.[59] This leaves the question of whether the same right to refuse treatment exists for an invasive procedure such as ECT and whether the same standards apply to pretrial detainees and post-adjudication confinees.

IV. JUDICIAL AND STATUTORY APPROACHES TO ECT

Despite the controversy surrounding ECT, case law is sparse and state legislatures infrequently draft specific ECT laws. When legislatures specifically address ECT, the approaches vary, but all states recognize a right to refuse treatment and a need for informed consent from the patient. What the state must do to override that refusal is where the differences appear. The states that have addressed the issue—either through the legislatures or the courts—offer greater protections for the mentally ill than the current Oregon scheme.

A. Judicial Decisions on ECT

While Oregon courts have yet to address the legality of ECT or its appropriateness as a treatment option on non-consenting patients, a few jurisdictions have been confronted with the issue head-on. In Kentucky, for example, the Court of Appeals held that absent an imminent emergency or a judicial declaration of incompetence, "a patient who has been involuntarily committed to a mental hospital for treatment cannot be compelled to undergo electroshock therapy against his will simply because it is considered to be in

[58] *Id*. at 1057.

[59] Washington v. Harper, 494 U.S. 210, 221 (1990)

the best interest of the patient."[60] The *Gundy* court reasoned it is generally accepted that the Due Process Clause of the Fourteenth Amendment protects a person from forcible "serious and potentially harmful medical treatment."[61]

The appellate court in Illinois more recently ruled on a similar ECT case.[62] In *In re A.M.P.,* the court considered whether a grant for a petition to authorize the use of ECT on a minor child was proper. The child's parents had requested the authorization after she had not responded to other forms of therapy. The court affirmed the order because the trial court had used the proper procedure in determining the child's rights.[63] Most notably, the court drew a parallel between minor children and wards of the state and held that "[i]n either situation, a hearing should be held to establish whether the patient is competent to exercise common law, statutory, or constitutional rights to refuse treatment. If not, *the trial court must determine* whether ECT is in the best interests of the patient, while ensuring . . . due process concerns . . . are met."[64]

Other courts addressing the issue of forced ECT have held that a hearing is required as part of due process,[65] that the petitioner must prove the necessity of ECT by clear and convincing evidence,[66] and that the court must set forth specific findings as to the patient's views on ECT.[67] Though the case law on forced ECT is sparse, the courts that have addressed the issue provide a framework for future decisions in other jurisdictions. Due process cannot exist when the state forces a competent mentally ill person to undergo ECT against his or her will. Due process can exist when there is an adjudication of incompetence or a substituted judgment test by a court of law. Procedure, in all of these opinions, is the key to protecting constitutional rights.

B. State Statutes

While the Oregon courts have yet to reach the issue, ECT appears in several state statutes enacted in different sessions. The legislature has declared its view on the rights of people committed to the care of the Department of Human Services:

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[60] Gundy v. Pauley, 619 S.W.2d 730, 731 (Ky. Ct. App. 1981) (reversing circuit court's order to force mentally ill patient to submit to ECT).

[61] *Id. See also* Rogers v. Okin, 634 F.2d 650 (1st Cir. 1980).

[62] *In re* A.M.P., 708 N.E.2d 1235, 1240 (Ill. App. Ct. 1999) (affirming trial court's order to authorize ECT for minor child at parent's request).

[63] *Id*. at 1241.

[64] *Id*. at 1240 (emphasis added).

[65] *In re* Conservatorship of Foster, 547 N.W.2d 81, 84 (Minn. 1996). "[ECT]. . .[is] sufficiently invasive so as to require a hearing before [it] can be administered in the absence of the consent of the party to whom the treatment is to be administered or the consent of the party's guardian." *Id*.

[66] *See, e.g.*, In re the Estate of Austwick, 659 N.E. 2d 779, 783 (Ill. App. Ct. 1995); McCarthy v. Schuoler, 723 P.2d 1103, 1110 (Wash. 1986).

[67] *McCarthy*, 723 P.2d at 1108. "The court should consider previous and current statements of the patient, religious and moral values of the patient regarding medical treatment and electroconvulsive therapy, and views of individuals that might influence the patient's decision." *Id*.

> Mentally ill persons committed . . . shall have the right to be free from potentially unusual or hazardous treatment procedures, *including convulsive therapy*, unless they have given their express and informed consent or authorized treatment . . . . This right may be denied . . . for good cause . . . but only after consultation with and approval of an independent examining physician.[68]

The Oregon Administrative Rules define good cause, and allow a "significant procedure" to be administered without the patient's informed consent if certain conditions exist: the patient is deemed unable to consent or refuse treatment, the procedure will "likely restore" mental or physical health, it is the most appropriate treatment "and *all other less intrusive procedures have been considered*," and there has been a good faith effort to get the patient's informed consent by explaining the procedure more than once.[69] ECT receives special treatment in the Oregon Revised Statutes where it is distinguished several times from other types of care.[70] The legislature regards ECT differently than other treatment procedures, as it is singled out as the example of procedures that are either potentially unusual or hazardous.

Section 426.072(2)(c) of the Oregon Revised Statutes appears to prohibit the use of ECT in the custodial setting.[71] The Oregon Court of Appeals has only commented on this section once, but its interpretation is clear. The court noted that the statute barred certain types of treatment on wards of the state.[72] ECT is the only type of treatment listed in the statute, so the court appears to read the statute as prohibiting the use of ECT on patients in the state's custody.

There are obvious inconsistencies in the Oregon statutes which leave the question whether ECT is permitted at all. One provision seems to establish that ECT is prohibited from use on wards of the state,[73] while others allow "convulsive therapy" if first reviewed by another physician.[74] Section 426.385 goes on to clearly prohibit psychosurgery.[75] Did the legislature intend to prohibit ECT altogether, or did it intend only to prohibit psychosurgery while attempting to put more safeguards on the use of ECT?

Legislative history does not shed much light on the subject, but the history of the laws themselves, as well as the changes in the informed consent law, indicate the legislature might not have considered how the statutes worked

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[68] OR. REV. STAT. § 426.385(3) (2003) (emphasis added).

[69] OR. ADMIN. R. 309-114-0020(1)(a)−(d) (2004) (emphasis added).

[70] OR. REV. STAT. § 426.072(2)(c) (2003) (stating mentally ill persons placed in the custody of hospital or nonhospital facilities shall not be subject to electroshock therapy or unduly hazardous treatment); *see also* OR. REV. STAT. § 426.237(3)(d)(A) (2003) (using the same language when discussing rights of mentally ill persons during the period of prehearing detentions).

[71] § 426.072(2)(c).

[72] State v. Vonahlefeld, 914 P.2d 1104, 1105 n.3 (Or. App. 1996).

[73] § 426.072(2)(c).

[74] § 426.385(3).

[75] *Id*. Psychosurgery is defined by OR. REV. STAT. § 677.190 (22)(b) as "any operation designed to produce an irreversible lesion or destroy brain tissue for the primary purpose of altering the thoughts, emotions or behavior of a human being."

together to create the inconsistency. Section 426.385 (allowing the psychiatrist to override the patient's decision for good cause) was initially enacted in 1967 and contained no provision on informed consent and ECT.[76] The law was amended in 1973 and included "electroshock and lobotomy" as examples of procedures that were considered unduly hazardous.[77] In 1981, the legislature further amended the law removing lobotomies from unduly hazardous procedures and banning them altogether, but leaving ECT intact.[78] No substantive changes have been made to that subsection since.

The legislature enacted section 426.072—custody and care of mentally ill patients—with the language preventing patients from being subjected to "electroconvulsive therapy or unduly hazardous treatment"[79] in 1987, six years after the change in the informed consent provision. Taken by itself, this section is clear; the legislature used the words "shall not be subject to electroconvulsive therapy."[80] Every first year law student learns quickly that the word "shall" in a rule does not mean "may"; it means there is no discretion.[81]

Taken in conjunction with section 426.385(3), we are left to wonder what the legislature intended. As the preference is for reading seemingly inconsistent provisions as to give effect to both,[82] a court could construe these provisions to mean that ECT can be forced under the conditions provided for, not that ECT is banned from Oregon institutions as psychosurgery was. But another way of interpreting the inconsistent statutes exists. The time sequence, from 1967 to 1987, shows a clear legislative trend *away* from ECT. The addition of section 426.072 could likely have added ECT to the banned procedure list which previously only included psychosurgery, at least for involuntarily confined individuals.

One step in clearing up the inconsistencies is for lawmakers to decide whether ECT is more closely analogous to the less controversial antipsychotic medication, or the banned procedure of psychosurgery. From a historical perspective, ECT seems much more like psychosurgery; both procedures share a litany of horror stories about abuse, side effects, and inhumane practices. Both procedures seem, to the layman, to be extremely invasive, and the forced treatment of either ECT or psychosurgery seems to violate a commonsense notion of fair and appropriate medical treatment. But ECT will not likely be banned from psychiatric institutions as psychosurgery was in some states. If anything, ECT is enjoying a resurgence in popularity in institutions, and will probably be characterized more closely to antipsychotic medications by the legislature.

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[76] ch. 460, § 4 (1967).

[77] ch. 838, § 28 (1973).

[78] ch. 372, § 3 (1981).

[79] § 426.072(2)(c).

[80] *Id.*

[81] *See also* BLACK'S LAW DICTIONARY 1407 (8th ed. 1999) (defining shall as meaning "Has a duty to; more broadly, is required to").

[82] OR. REV. STAT. § 174.010 (2003).

Some states have gone much farther than Oregon to protect the rights of the mentally ill by enacting legislation that provides for a judicial determination of incompetence before ECT may be forced. Texas law, for example, prohibits unconsented ECT from being forced on an involuntary patient "who has not been adjudicated by an appropriate court of law as incompetent to manage the patient's personal affairs."[83] California affords special protection to prisoners when the prisoner is unable to give informed consent by requiring the prison officials to "secure an order from the superior court to authorize the administration of the therapy. . . ."[84] Several other state legislatures have taken similar approaches in placing more stringent requirements and safeguards before a mentally ill person's right to refuse treatment is taken away.[85] These statutes, along with recent judicial opinions requiring a court's involvement, indicate sensitivity to the demands of due process and the respect of a competent refusal of treatment.

These states should inspire advocates to effect change in Oregon law. Oregon lawmakers can look to Texas or Washington for effective and constitutional models to confront and resolve the facial inconsistencies in the Oregon code. Changes in judicial approaches and state law may be signaling a slow trend toward greater protections of the mentally ill who are unable to give informed consent to highly invasive procedures such as ECT. With the Supreme Court's recognition of a significant liberty interest in remaining free from unwanted antipsychotic medication, courts should recognize a similar interest in being free from forced ECT.

V. A CONSTITUTIONAL RIGHT TO REFUSE ECT EXISTS

For purposes of analyzing due process, antipsychotic medication is analogous to ECT. It follows that if there is a significant liberty interest in remaining free from unconsented antipsychotic medication, there is at least as strong an interest (if not stronger) in remaining free from unconsented ECT. But ECT is not analogous to antipsychotic medication for all purposes. The Supreme Court held in *Harper* that a state policy does not have to include a judicial determination of incompetence or a substituted judgment test in order to protect the prisoner's substantive due process right to refuse unwanted antipsychotic medication, as long as the inmate is dangerous and the treatment is in his best medical interests.[86] But the states *should* require those very safeguards when choosing to force ECT on a mentally ill prisoner under the

[83] TEX. HEALTH & SAFETY CODE ANN. § 578.002(b)(2) (Vernon 2003).

[84] CAL. PENAL CODE § 2670.5(2) (West 2005).

[85] *See e.g.*, WASH. REV. CODE ANN. § 71.05.370(7)(a) (West 2004) ("The administration of [ECT] shall not be ordered unless the petitioning party proves by clear, cogent, and convincing evidence that there exists a compelling state interest that justifies overriding the patient's lack of consent . . . , that the proposed treatment is necessary and effective, and that medically acceptable alternative forms of treatment are not available, have not been successful, or are not likely to be effective."); *see also* MASS. GEN. LAWS ANN. Ch. 123 § 8B(d) (West 2005).

[86] *Harper*, 494 U.S. at 227.

Harper analysis because ECT is a highly controversial and invasive procedure with serious, long-term side effects.

A. ECT Under the Harper *Analysis: Substantive Due Process*

When determining if a patient's substantive due process right to be free from unconsented medical treatment has been violated, the court must balance the patient's individual liberties against the interest of the state in protecting the patient and those around him.[87] The first circumstance necessary to force ECT on a mentally ill prisoner under the *Harper* analysis is the inmate's dangerousness. The NIH recommends that ECT only be used to treat certain types of psychiatric disorders.[88] The decision to use ECT to treat the patient should be made after "a thorough review of severity of the patient's illness, medical indications and contraindications, and nonresponsiveness to other treatments."[89] In addition to the review of the patient's medical history, the treating physician must obtain the patient's informed consent and may also need to slowly remove the patient from his current medications.[90] All of these things, coupled with the need to obtain an independent doctor's approval, necessarily take time. No legal or medical justification for rapidly treating a prisoner with ECT exists; the state would have time, at a minimum, to get a court order to force treatment.

Oregon law requires the physician to attempt in "good-faith" to obtain the patient's informed consent on at least two separate occasions.[91] Under the current scheme, if the competent but "dangerous" patient refuses treatment, and the physician can satisfy the second prong of best medical interest discussed *infra*, the physician could force ECT without any judicial determination of incompetence. But ECT is more invasive than antipsychotic medication in many situations and should have a higher standard of review before a competent decision to refuse treatment is overridden. Under the *Harper* analysis, it would be appropriate to force this prisoner to take antipsychotic medication, however, while performing the necessary steps to get approval for ECT under a dangerousness test. If ECT is truly in the patient's best medical interest, the state will have little trouble in convincing a court of its necessity.

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[87] Jurasek v. Utah State Hosp., 158 F.3d 506, 510 (10th Cir. 1998) (citing *Harper* at 221−22).

[88] Electroconvulsive Therapy. NIH Consensus Statement Online 5(1): 1−23(Jun. 10−12, 1985), *available at* http://consensus.nih.gov/cors/051/051_statement.htm ("The consideration of ECT is most appropriate in those conditions for which efficacy has been established: Delusional and severe endogenous depressions, acute mania, and certain schizophrenic syndromes. ECT should rarely be considered for other psychiatric conditions.").

[89] *Id*.

[90] *Id*.

[91] OR. ADMIN. R. 309-114-0020(1)(d) (2004). "A 'conscientious effort' means a good faith attempt to obtain informed consent by attempting to explain the procedure more than one time and at different times . . . ."

The second circumstance necessary to force ECT on a mentally ill prisoner would be the finding that ECT was in the inmate's best medical interest. Under Oregon law, this determination is made by the inmate's physician with approval by an independent doctor.[92] Continuing this practice without judicial involvement poses serious substantive due process problems. First, it is problematic because there is no real consensus on whether ECT is appropriate. If the medical standards of the community are so varied, a best interest evaluation could be arbitrary and a presentation of the rationale for the treatment should be made to the court. While it might be argued that a judge is no better situated to resolve such a controversial and complex medical issue, a decision to force ECT should not be based on the particular whims of the attending physician, but should instead have an element of true neutral review. ECT should be proven to be the appropriate treatment in each case where its use is sought.

Secondly, ECT is rarely (if ever) going to be the least invasive medical treatment. The possibility of long-term side effects alone should subject ECT to a level of judicial scrutiny. In addition to the known effects on memory, a study published in 2003 shows that patients who are subjected to maintenance ECT treatment appear to suffer from other long-term cognitive dysfunction.[93] Thirdly, if ECT is inappropriately given, [94] but the psychiatrist has followed the procedures already in place, the patient has no remedy under Oregon's administrative rules because the doctors are protected by qualified immunity.[95] Finally, ECT should never be resorted to as an emergency treatment. If confronted with a violent emergency situation or a high risk of suicide, the patient could be sedated and/or restrained while a court order is obtained. While these are not perfect remedies, they avoid the kind of long-term behavior modification that would come from an emergency administration of ECT.

B. ECT Under the Harper *Analysis: Procedural Due Process*

Because there is an unquestionable liberty right in remaining free from unwanted medication, a state must provide basic safeguards to protect that

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[92] OR. ADMIN. R. 309-114-0020(2)(a) (2004).

[93] Nick Lamb, "*Cognitive impairment" after ECT treatment for Depression* (Feb. 19, 2003) http://www.ect.org/effects/2-18-2003_cognitivemaint.html (showing the maintenance ECT group scored lower on encoding new information and had lower frontal function test scores).

[94] While the statute obviously does not authorize inappropriate treatment, this author is of the opinion that a lack of procedural safeguards invites abuse. Neil Norton's case is just one example. Reports of abuse in the form of overprescribing ECT, treatment decisions based on economic factors, lack of information on side effects, inadequate training, and experimental techniques have all been noted. WINICK, *supra* note 33, at 93−94.

[95] Wilson v. Dravis, No. 02-1506-HU, 2004 U.S. Dist. LEXIS 19958, at *19 (D. Or. Sept. 23, 2004). ("An officer who acts in reliance on a duly enacted statute or ordinance is ordinarily entitled to qualified immunity.") (citations omitted) (holding that psychiatrist who administered involuntary antipsychotic medication pursuant to OR. ADMIN. R 309-114-0020(2)(a) could reasonably have relied on those procedures to believe that his conduct was not violating plaintiff's rights).

interest.[96] In *Harper*, the Supreme Court held that Washington's non-judicial policies for forced medication complied with procedural due process guarantees.[97] The Washington Department of Corrections had a four-part procedure to be followed before forcing medication: (1) the psychiatrist must determine the inmate is mentally ill and dangerous; (2) the refusing inmate may have a hearing in which a panel will determine if medication may be appropriately forced against the inmate's will; (3) the inmate retains procedural rights at all stages of the proceedings including notice of when the meeting will be held, the right to be unmedicated during the hearing, the right to present evidence and witnesses, a right to appeal the decision, and a judicial review in state court; and (4) if involuntary medication is approved there must be a periodic review of its appropriateness.[98] Because of the extensive safeguards in the Washington policy, the Court held it to be constitutional. Washington amended its mental illness statute in 1989 to require higher standards of proof and a court's involvement in the decision to override a refusal of treatment. The statute allows medication without a court order if the person poses an imminent threat of harm, there is no medically acceptable alternative, and the treating physician determines that it is a medical emergency.[99] Even in those extreme circumstances, the government must petition the court and there must be a hearing within two days of the forced treatment.[100] Interestingly, ECT is not included in the language that allows the emergency treatment, even though it appears throughout the statutory provision governing the limits of unconsented treatment. The change in the Washington statute shows that the legislature recognized a need for greater protections against forced ECT.

Oregon's policies fall short of the protections found in *Harper* and under the Washington statutory scheme: Oregon law simply does not protect the procedural due process rights of mentally ill prisoners. While *Harper* holds that a non-adjudicatory procedure can be sufficient to protect a prisoner's right to refuse forced treatment of antipsychotic medications, it is not enough to protect a prisoner's right to refuse ECT. First and foremost, ECT is again more invasive, more controversial, and can have more serious side effects than medication. The *Harper* decision can be said to apply to medication and procedures that are less invasive than medication, but the holding cannot be applied to *more* invasive procedures like ECT.

Oregon's policies fail to pass constitutional muster under the *Harper* test for several other reasons as well. The *Harper* Court made it clear that a judicial approval of forced medication was not necessary because Washington provided fair procedural mechanisms to protect the strong liberty interest in remaining

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[96] Mathews v. Eldridge, 424 U.S. 319, 332 (1976) ("Procedural due process imposes constraints on governmental decisions which deprive individuals of 'liberty' or 'property' interests within the meaning of the Due Process Clause of the Fifth or Fourteenth Amendment.").

[97] Washington v. Harper, 494 U.S. 210, 228 (1990).

[98] *Id*. at 215.

[99] WASH. REV. CODE ANN. § 71.05.370(7)(f)(i)−(iii) (West 2004).

[100] § 71.05.370(f).

free from unwanted treatment.[101] One of the most persuasive points to the Court was the independence of the members of the committee who would make the decision on forced treatment; not one of the three members on the board could be involved in the patient's psychiatric care. [102] This comports with the sense that due process requires a neutral fact-finder. Oregon does not provide such a neutral fact-finder in the decision making process; the treating physician determines herself that ECT is necessary and only one outside physician must sign off on the request. The outside physician approves of the requested procedure in 95% of the cases studied.[103] The independent physician is likely nothing more than a rubber stamp on the treating physician's request.

Justice Stevens's dissent in *Harper* mentions a concern that the policy in the state of Washington allowed inmates to be treated without determining whether the treatment is medically appropriate.[104] The majority refutes the argument, reasoning that the treating physician must make a determination of medical appropriateness prior to prescribing the medications.[105] But Justice Stevens's argument has a merit that is overlooked by the Court. The Court does say that medication cannot be forced for any reason other than treatment, but it then immediately discusses prison safety and "legitimate penological interests."[106] While the interest in keeping prisons safe for both staff and inmates is valid, it arguably gives the state an opportunity to make medication decisions based on something other than medical treatment. The state's strong and legitimate interest in prison safety could potentially and wrongfully overcome an inmate's choice in treatment options, decimating the prisoner's constitutionally protected liberty interest.

Under the *Harper* analysis, a court would likely uphold forced, involuntary ECT if both substantive and procedural due process safeguards were met. Oregon currently does not provide adequate due process safeguards for its mentally ill prisoners or involuntarily committed patients. Instead, competent decisions to refuse treatment are overridden by less than the minimally required constitutional safeguards. Competency to make medical decisions should remain the presumption until the state shows, by clear and convincing evidence, that the patient or prisoner is incompetent to refuse treatment. Civil commitment, for example, requires the clear and convincing evidence standard because "[it] constitutes a significant deprivation of liberty that requires due process protection."[107] The standard of proof placed on individual rights is a reflection of the value society places on that liberty.[108]

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[101] *Harper*, 494 U.S. at 231.

[102] "None of the hearing committee members may be involved in the inmate's current treatment or diagnosis." *Id*. at 233.

[103] *Id*. at 234. ("[I]ndependent examining physician used in Oregon psychiatric hospital concurred in decision to involuntarily medicate patients in 95% of cases.").

[104] *Id*. at 243.

[105] *Id*. at 221.

[106] *Id*. at 223.

[107] Addington v. Texas, 441 U.S. 418, 425 (1979).

[108] *Id.*

Society should be willing to protect the liberty interest in refusing unwanted ECT by requiring this same standard of proof.

VI. COMPETENCY

When a mentally ill prisoner has been deemed incompetent to give informed consent to medical procedures, there is no question that the state has the good cause required to treat the patient involuntarily under appropriate circumstances.[109] But many of the state's prisoners and involuntarily committed patients are not incompetent to make informed medical decisions. It is generally accepted that neither detention nor incarceration automatically removes an individual's ability to consent to or refuse medical treatment.[110] In Oregon, mentally ill prisoners transferred to a state institution "shall be entitled to the same legal rights as any other persons admitted" to these institutions.[111] This means that in a state hospital, prisoners and involuntarily committed patients should be accorded the same rights to consent to, or refuse, medication or other medical services. Patients who have been committed to the state's care for mental illness reasons have the same civil rights as people that are not committed, until they are adjudicated incompetent and have yet to return to competency.[112] Both civilly committed patients and mentally ill prisoners have a fundamental constitutional right to refuse ECT, absent a judicial determination that they are incompetent to make their own medical decisions.

A. Informed Consent Requires a Judicial Determination of Incompetence

The right of a competent adult to determine what is done with his body, including the right to consent to or refuse medical treatment, is constitutionally protected.[113] The common law doctrine of informed consent as it relates to medical treatment has been codified in Oregon. Physicians must explain three things to their patients in order to ensure that the patient is giving full and

[109] *See, e.g.*, OR. ADMIN. R. 309-114-0020(1)(a) (2004).

[110] FAY A. ROZOVSKY, CONSENT TO TREATMENT: A PRACTICAL GUIDE § 6.3 (3d ed. 2003); *see also* John Parry, *Summary, Analysis, and Commentary*, 9 MENTAL AND PHYSICAL DISABILITY LAW REPORTER 162 (1985) ("[I]n general, modern legal theory presumes that every person, mentally disabled or not, is capable of functioning normally in exercising any right or privilege unless facts can be marshalled to demonstrate that specific incapacities exist. The law generally endorses the view that, until a person has been adjudicated incompetent or a legitimate emergency exists and can be demonstrated after the fact, the principle of self-determination will win out over the best interests of the individual as reflected by community or medical standards").

[111] OR. REV. STAT. § 179.485 (2003).

[112] OR. REV. STAT. § 426.385 (2003).

[113] Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990) (reiterating that a competent person has a protected liberty interest in refusing unwanted medical treatment). *See also* Vitek v. Jones, 445 U.S. 480, 494 (1980).

informed consent for a procedure.[114] Implicit in the statute is a requirement that the physician take into account the patient's capabilities of understanding the information given so that the patient can make a rational treatment decision.[115] If the patient can show that he would not have consented to the treatment had he been given the required information, the patient has a cause of action against the physician.[116]

The issue of competency must naturally intersect with medical decision-making. Competency arises at several different stages with several different outcomes in the criminal justice system. In Oregon, a defendant is considered incompetent for trial purposes if he is not able to understand the nature of the proceedings against him, or to assist and cooperate with his counsel, or to participate in his defense.[117] This includes the ability to decide whether to plead an insanity defense.[118]

Insanity and mental illness, however, are two separate and distinct findings.[119] Oregon defines insanity for the purposes of criminal conviction as lacking "substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of law."[120] To be adjudicated mentally ill for civil commitment purposes, on the other hand, the state must show by clear and convincing evidence that the person is (1) dangerous to himself or others and (2) unable to provide for his basic personal needs.[121] This is true even if the individual is criminally incarcerated at the time of the hearing.[122] But does incarceration because of insanity or commitment because of mental illness automatically mean the person is incompetent?

The answer is no. In Oregon, patients committed because of mental illness have not lost their civil rights unless there has been a separate adjudication of incompetency.[123] This is also illustrated by a presumption of competency in the

[114] OR. REV. STAT. § 677.097(1)(a–c) (2003). The three necessary elements are (a) the procedure or treatment to be undertaken; (b) the availability of alternative procedures or methods of treatment; and (c) the risks to the procedure or treatment.

[115] Macy v. Blatchford, 8 P.3d 204, 210 (Or. 2000) (holding that the physician cannot be said to have explained anything to the patient if that patient is incapable of understanding the information being given).

[116] Mandell v. Maurer, 946 P.2d 706, 708 (Or. App. 1997) (holding it is a subjective test for causation, not whether an objective reasonable person would have consented to the treatment).

[117] OR. REV. STAT. § 161.360(2)(a–c) (2003).

[118] State v. Peterson, 689 P.2d 985, 991 (Or. App. 1984) (holding that the court does not have to decide if the defendant voluntarily and intelligently made the choice to plead non-responsibility due to mental disease if the defendant has already been deemed competent to stand trial).

[119] State v. Weller, 591 P.2d 732, 734 (Or. 1979) (describing that insanity is a legal, not medical, conclusion and holding that a condition of mental illness does not automatically remove defendant's criminal liability).

[120] OR. REV. STAT. § 161.295(1) (2003).

[121] OR. REV. STAT. § 426.005(1)(d) (2003).

[122] State v. Jensen (*In re* Jensen), 917 P.2d 541, 543 (Or. App. 1996).

[123] *See* OR. REV. STAT. § 426.385 (2003).

making of mental health decisions[124] and the ability to convey property and enter into contracts.[125] Oregon recognizes the need for informed consent in treatment decisions for its mentally ill prisoners and patients: "Unless adjudicated legally incapacitated for all purposes or for the specific purpose of making treatment decisions, a patient or resident shall be *presumed competent* to consent to, or refuse, withhold, or withdraw consent to significant procedures."[126]

A finding of guilty except for insanity alone is not enough to warrant hospitalization; the court must make a further determination that the defendant presents a substantial danger either to himself or others.[127] Without a finding of dangerousness, the court may order the defendant's release.[128] A determination of dangerousness coupled with the inability to conform one's behavior to the law are not enough to determine that the patient is incompetent to consent to or refuse medical treatment while hospitalized. The state consistently respects the autonomy of mentally ill prisoners and involuntarily committed patients to continue to make medical decisions.

Even where there has been a judicial determination of incompetence, some courts are more protective of the personal integrity of the patient because of the intrusive nature of organic therapies like ECT.[129] Oregon's informed consent laws lead to the conclusion that a substituted judgment should be made. The causation issue in an informed consent case is a subjective one. It asks "whether a physician's failure to warn of the risks of treatment 'causes' a plaintiff's injuries or damages depends on whether the plaintiff would have consented to the treatment had he or she been informed of all the material risks and alternatives."[130] The only way for a court to determine whether an incapacitated patient would have consented is to use its substituted judgment. The substituted judgment test serves to protect the patient's best medical interest and reduce the risk of error. Much of psychiatric diagnosis is a subjective determination based on medical impressions.[131] Just as a court would inquire into an unconscious patient's feelings about life support or feeding

[124] OR. REV. STAT. § 127.736 (2003) (declaration of mental health contains the following language: "[Treatment decision] instructions. . .will be followed only if a court or two physicians believe that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.").

[125] § 426.385(n); *see also* First Christian Church in Salem v. McReynolds, 241 P.2d 135, 138 (Or. 1952) ("[I]t may be stated that as a general rule, all proceedings testing the competency of a person, or involving the competency of an individual to perform a certain act, as to execute a valid conveyance of property or a contract, start with the presumption of competency, and that this presumption may be relied upon until the contrary is shown.").

[126] OR. ADMIN. R. 309-114-0010(2)(a) (2004) (emphasis added).

[127] State v. LeHuquet, 636 P.2d 467, 468 (Or. App. 1981).

[128] WAYNE T. WESTLING, OREGON CRIMINAL PRACTICE § 54.05 (Michie 1996).

[129] *See In re* Boyd, 403 A.2d 744 (D.C. 1979) (requiring the State to use a substituted judgment test and ask what choice the patient would make if he was competent to do so).

[130] Mandell v. Maurer, 946 P.2d 706, 708 (Or. App. 1997) (citing Arena v. Gingrich, 748 P.2d 547 (Or. 1988)).

[131] Addington v. Texas, 441 U.S. 418 (1979).

tubes, a court should inquire as to how the prisoner or committed patient would feel about ECT. This approach inserts an objective component that would aid in the determination of the patient's best medical interests.

Since the patient or prisoner is presumed competent until found incompetent, two events should occur before the state overrides the refusal of ECT treatment. The state should show by clear and convincing evidence that the patient is incompetent to make decisions regarding his medical care. The court should then make a substituted judgment for the patient by attempting to determine what the patient would choose if he were competent. The necessity of proving the patient's incompetency by clear and convincing evidence protects the patient's common law, statutory, and constitutional rights. We require this heightened standard before the state commits a person to a mental hospital because it is deemed a serious deprivation of liberty. When the state intends to further deprive a patient of his substantial right to refuse medical treatment, a lower standard should not be acceptable. Once the state has met its burden, the court could consider evidence of the patient's wishes balanced against the needs of the state, and then make a substituted judgment for the patient. This two prong approach provides the necessary due process protection by involving a neutral third party in the decision making process.

B. ECT for Trial Competency Under the Sell *Analysis*

The Supreme Court's decision in *Sell* allowing forced involuntary antipsychotic medication solely to render the defendant competent to stand trial has potentially raised many concerns for the rights of mentally ill pretrial detainees to refuse invasive treatments like ECT. Once a detainee is forced to take antipsychotic medication or ECT to render him competent to stand trial, and he is subsequently deemed competent to stand trial because of the forced treatment, has he also therefore returned to a state of competency to give informed consent? How can we deem him competent to assist in his own defense, but incompetent to make intimate medical decisions?

Substituting ECT into the *Sell* analysis leads to the conclusion that forcing ECT solely for trial competency purposes would not pass constitutional muster for many of the same reasons that it does not work on the *Harper* grounds. Under the *Sell* test, the court would have to find that (1) important government interests are at stake; (2) ECT would significantly further those interests; (3) ECT is necessary to further those interests; and (4) ECT is medically appropriate.[132] The first element of important governmental interest is not a hurdle for the state. Oregon has a strong and valid interest in bringing accused criminals to trial, especially for violent crimes. Under the second and third elements, the state would have to show not only that ECT would significantly further those interests, but that ECT was necessary to do so. The difficulty with this argument is apparent and troubling. At what point does the detainee's right to refuse kick in? The state would have to determine that the defendant was incompetent to stand trial, and then force treatment with the result that he

[132] Sell v. United States, 539 U.S. 166, 180-181 (2003).

would then be competent to stand trial. Once deemed competent to stand trial, is he then competent to give informed consent and refuse further treatment? Once prosecuted, is he at that point competent to refuse further treatment? If he is found incompetent to give informed consent, how can he be competent to stand trial? The legal and ethical issues lead to a circular nightmare of determining the patient's status to fit the convenience of the state, instead of focusing the inquiry where it should be: whether the treatment is medically appropriate within the constitutionally protected interest of this individual.

ECT fails to meet *Sell*'s last requirement of medical appropriateness for the same reasons that it fails the *Harper* test. The U.S. Supreme Court held that the state can override the detainee's constitutionally protected liberty interest and force medication if the treatment "is substantially unlikely to have side effects that may undermine the fairness of the trial."[133] In addition, the Court emphasized a previous holding and stated that forced medication can only be appropriate "by establishing that [the state] could not obtain an adjudication of [the defendant's] guilt or innocence . . . by using less intrusive means."[134] While forced antipsychotic medication may occasionally meet the strict requirements set forth in *Sell*, ECT does not fit in the analysis: ECT is not consistently held to be medically appropriate, ECT is unlikely to be the least intrusive method of treatment in a given situation, and ECT is very likely to have side effects that affect the right of the defendant to participate fairly in his defense. A detainee's ability to recall and communicate his version of the events he is being tried for can be an integral part of his defense. But ECT is known to affect both memory and cognition, which could lead to an impaired recollection of the truth. If the defendant suffers from ECT-induced gaps in his memory, he cannot possibly participate fairly in his own defense.

The Court recognized the difficulties that would be presented by allowing forced medication for trial competency when it could not be justified under the *Harper* grounds: "At the least, they will facilitate direct medical and legal focus upon such questions as: Why is it medically appropriate forcibly to administer antipsychotic drugs to an individual who (1) is *not* dangerous *and* (2) *is* competent to make up his own mind about treatment?"[135] This sends a strong signal to the courts below and gives some insight on how Oregon could be handling forced treatment issues. These are complicated constitutional questions that require the involvement of the courts, rather than a cursory approval by two physicians.

C. A Better Approach for Oregon

If there has been no previous determination of incompetence by the courts, the state should be required to justify forced treatment of its mentally ill prisoners and pretrial detainees to the satisfaction of a court. The court would then have three options: (1) it could declare the individual incompetent to make

[133] *Sell*, 539 U.S. at 179.
[134] *Id*.
[135] *Id*. at 183 (emphasis in original).

medical decisions and thereby allow the state to follow its procedures of treatment when informed consent is not possible; (2) it could declare the individual incompetent and make a substituted judgment as to what treatment the patient would likely want or what is in his best medical interests; or (3) it could declare the patient competent but issue a court order requiring treatment based on the patient's best medical interests balanced against the state's needs. In all three situations, the state would have to present its evidence to a neutral judge as to why it feels the patient is not competent to give informed consent and why ECT is in the patient's best medical interests. The same standard of proof by clear and convincing evidence used in civil commitment procedures should be used to prove that the prisoner or detainee is not competent to give informed consent to the procedure, and to assure that due process concerns are being met. In the case of a pretrial detainee, the court would have to look at the state's interest in bringing him to trial. When talking about a mentally ill prisoner, it would need to balance his liberty interest against any legitimate penological interests at stake.

Any of the three approaches provides better due process protection than the current Oregon scheme and would comport with the idea that, under Oregon law, patients and prisoners are presumed competent to make medical decisions until they are shown to be incompetent. In Neil Norton's case, the treating physician determined he was incompetent to give informed consent to ECT and got another physician to sign off on the request three days later based on one interview with the patient. This is a subjective determination made by one physician who wants to give the patient ECT and approved by another. With such a serious invasive treatment like ECT, the state should be required to meet the burden of proof and actually show incompetency before being allowed to deprive the patient of his right to refuse. Without better substantive and procedural due process protections, the forced treatment of ECT on Oregon prisoners is unconstitutional.[136]

VII. CONCLUSION

Facial inconsistencies in the Oregon code demand attention. Contradictory provisions must be resolved so that patients and prisoners have a clear understanding of their rights to refuse treatment while they are wards of the state. As cases like Neil Norton's come before the Oregon courts, decisions will have to be made on the appropriateness of forcing ECT within institutions and

[136] In addition to the informed consent and competency arguments, other potential constitutional arguments exist that are beyond the scope of this Comment. The first avenue would be freedom of religion. If a defendant or prisoner objected to ECT on a legitimate exercise of his religious freedom, the state could not constitutionally force him to participate in the treatment unless his refusal was harmful to society. The second potential argument is that ECT impairs the right to freedom of speech. An argument could be made that a procedure that impairs cognition, memory, focus, and personality also impairs that person's right to speak freely. Arguments are also available under the Eighth Amendment's prohibition against cruel and unusual punishment and the Equal Protection clause of the Fourteenth Amendment.

state hospitals. Attorneys for the state will have to justify why a patient, competent to assist in his own defense and competent to give informed consent to other medical procedures, could be forced to undergo ECT.

Neither the medical community nor the courts are in agreement as to the appropriateness of ECT in the criminal justice system. Because of the presumption of competency, the highly invasive nature of the procedure, the due process right to remain free from bodily intrusion, the dangers and long-term effects of the treatment, and the variance of opinions on the topic, ECT should be more rigorously examined before it is forced on a mentally ill patient or prisoner. The changes in some state laws and the few judicial opinions on forced ECT signal a slow trend toward increasing the protection of the right to refuse treatment.

It seems unlikely that the courts could find any justification for using ECT as a forced treatment on a defendant for trial competency purposes. With the known effects that ECT has on memory and cognition, ECT would almost certainly adversely affect the ability of the defendant to participate fairly in his own trial. If ECT is not going to be banned completely, further safeguards must be put into place. A judicial determination of incompetence to give informed consent is a necessary step missing from Oregon's policies around ECT. In addition, even with an adjudication of incompetence, a substituted judgment standard should be explored in order to give the most protection to the state's mentally ill population. The benefit of a rapid response may not outweigh the memory loss for every patient. Neither of these safeguards would burden the state unnecessarily, and they would assure Oregon's spot as a state which values and protects the constitutional rights of its citizens.