

# ABOVE THE LAW

## Psychiatric Diagnosis, Detention, and Forced Treatment: Summary of One Patient's Involuntary Involvement with the Texas Public Mental Health System

By  
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### Introduction

There is one class of people in the United States right now who are routinely denied their constitutional rights by popular demand – those who have been accused of having a mental illness. How acceptable would the American public find it if any state made a law stating that all persons considered to be at high risk of committing a future illegal act be “protected” from potential future law-breaking by restriction of their liberty and freedom? Such a law could conceivably be supported by statistical data on crime and race, socio-economic status, family make-up, academic achievement, developmental history, etc. Deafening public outcry against any attempt to pass such a law would be expected in this country.

Yet, legislation to exempt people who have been accused by psychiatrists of mental illness from the protection of the constitution -- couched as it often is in terms of necessary and humane “protection” and “help” for those who are considered (by the psychiatrists) to be incapable of helping themselves -- is almost always passed when it is introduced in state legislatures. Few voters and legislators recognize that a legally established violation of the constitution for any one group sets a precedent for similar violations for any other group.

As the late Supreme Court Justice Louis Dembitz Brandeis said, “Experience teaches us to be most on our guard to protect liberty when the government's purpose is beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding.”

It was precisely to prevent abuses of individual civil rights, based on potential popular bias, or prejudice, or fear, or government convenience, that this country's founders added Amendments IV and V to the United States Constitution. These amendments guarantee that the government may not intrude in a person's private life by searching or taking his/her body or possessions without sworn and affirmed probable cause, or by depriving him/her of life, liberty, or property without due process of law.

Amendment XIV Section 1 was added in 1868 to insure that state governments did not make laws that deprived not only citizens of those states, but any persons residing in those states, of their civil liberties. This amendment states that no state shall “deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.”

The fact is, though, that a person forced to submit to involuntary psychiatric treatment is likely to have committed no crime and to have been adjudicated into psychiatric treatment based solely on one or two psychiatrists' predictions of his/her future behavior. Texas has stringent laws concerning the involuntary hospitalization of persons accused of mental illness. These laws include a standard of “clear and convincing evidence” which is explicitly defined. That these laws are ignored by psychiatric practitioners and by the courts should be evident in the case summary that follows.

It seems that psychiatrists, using perfectly legitimate psychiatric language, can easily convince judges that all persons who don't agree with their diagnoses (whether justified or not), and who don't voluntarily do what the psychiatrists recommend, are lacking in “insight and judgment.” In English a lack of insight and judgment suggests that a person has no comprehension or understanding of reality, and that that person is, therefore, highly likely to behave in foolish and potentially dangerous ways.

In psychiatric language, lack of insight and judgment simply means that a person doesn't believe (s)he has the mental illness a psychiatrist says (s)he has and does not obey the psychiatrist. Unfortunately, judges and juries speak English, but they rely on psychiatrists to inform them about a person's capacities to function independently and to make informed decisions about treatment.

In states such as Texas, where the law does not explicitly deny constitutional protection of liberty and freedom to individuals accused of mental illness, judges routinely rely on testimony by psychiatrists to inform them about a person's competency to make independent decisions about what happens to his/her own body and mind, and to predict whether or not a person is likely to be a future danger to him/herself or others. This medical, expert testimony is presumed to be based on objectively obtained evidence, leading to scientifically supported conclusions, which are accepted in courts of law as factual data.

### **Purpose**

The purpose of the following individual case summary is to illustrate by example some of the subjective methods and assumptions used by psychiatrists to make and support diagnoses, predict future behavior, determine treatment, and prepare court testimony.

This is an inside look at what happened to one patient in a well respected public acute-care psychiatric hospital in Texas. The simple assertion that psychiatric evidence is not objectively obtained, conclusions are not scientifically supported, and court testimony is not factual, is clearly supported by this case summary. It is highly likely that what happened to this person is typical in the public mental health system in any state in this country.

### **Background**

The information in this summary is taken from the patient's and her husband's reports, two sets of court papers served on the patient by the court, and more than 100 pages of hand-written, signed, and dated notes and reports from the acute-care psychiatric hospital where the patient was confined twice, for a total of 34 days.

The patient was diagnosed as "bipolar, manic, with psychotic features" when she was 50 years old. She had no prior psychiatric history. Her husband, not a mental health professional, made the diagnosis and gave it to hospital staff at an emergency psychiatric facility. The diagnosis was accepted without question by all mental health professionals the patient encountered during the six weeks she was involuntarily involved with the public mental health system.

Prior to the patient's involuntary hospitalization, she had experienced twelve days of persistent phone harassment (10-30 'breathing' messages left on her answering machine daily) and internet hacking and attempted computer hijacking through backdoor trojans (denial of service attacks and uploading of personal files while she was working on the Internet).

Eight days before her husband was able to have her involuntarily committed, their 16-year-old daughter had suffered a concussion and the patient had stayed up all night to monitor her condition. The combination of the stress of being a target of harassment, worrying about her daughter, and having her sleep cycle interrupted, caused her to be unable to sleep for days, even though she had tried, and had begged her family to leave her alone to let her sleep.

She had been acting oddly for about five days, during which time all these things had been occurring, and her family, having familiarity with only one "mental illness" -- bipolar disorder -- decided that that was what was wrong with her. The night before her husband was successful in having her committed, he and a family friend told her that the FBI wanted her to be interviewed by a psychiatrist so she could

testify against cyber-criminals. She, being easily influenced due to lack of sleep, believed them. She didn't meet criteria for involuntary hospitalization that night, since no one was able to say she was dangerous.

On the way home from the psychiatric center that night, she asked her husband to be quiet and let her sleep or to stop the car and let her out to call a cab. He refused to do either. She was in the back seat and opened the car door in an effort to get him to stop the car or to stop yelling at her. When he didn't stop the car, she gave up and closed the door. This was to constitute her "suicide attempt." A "homicide threat" against her husband consisted of her having said, after they returned home, "If have to stay in this house and listen to you for one more minute, I'll probably feel like I want to kill you!" After she said this, she immediately left the house and spent the night with a friend. With "evidence" of her dangerousness and his own diagnosis, her husband was able to have her committed.

### **Crisis Care**

At the emergency psychiatric facility, all information about the patient's condition other than hospital staff's observations of "disorganized behavior and agitation," was obtained from the patient's husband. A psychiatrist, who never had a face-to-face interview with the patient, immediately had her injected with what her husband was told was a combination of an antipsychotic and an antianxiety drug.

The psychiatrist wrote on the certificate of medical examination that the treatment she gave and authorized was "evaluation, observation, and medication." She also wrote that she had determined that emergency detention was the least restrictive means by which the patient could be restrained from doing serious harm to herself or others because "Patient with poor insight and judgment."

The patient was kept drugged to unconsciousness throughout her two-day stay in the emergency facility, and was transported to an acute-care public psychiatric hospital while she was apparently semi-conscious, since the hospital record shows that she was interviewed by and responded to a psychiatrist upon her arrival. She has no memory of this interview.

### **Acute-Care Hospital Evaluation and Treatment – First Admission**

Hospital staff's daily charting -- hand-written, dated, and signed notes and reports -- reveals that, throughout the patient's first detention in this facility, she never showed evidence of dangerousness. Lack of suicidal or homicidal ideation is specifically noted twice daily by the nursing staff on every day of the patient's hospitalization.

Staff did not note a single incident of disruptive or disorganized behavior during the patient's thirteen days of hospitalization. In addition, staff specifically noted the lack of such behavior in nine chart entries. Nurses noted that she presented "no management problem," had "no outbursts in behavior," and was "quiet."

There are no physiological tests for mental illness. The only standard for diagnosis in psychiatry at the time of the patient's hospitalization was the DSM IV (The Diagnostic Statistical Manual of Mental Disorders, Volume Four). The DSM was developed to "provide operational definitions of all the various categories of mental disorders." Volume Four, was issued in 1994 and describes each disorder in terms of checklists of symptoms. A disorder is defined as "a cluster of symptoms and objective findings that, grouped together, are related to an identifiable or diagnosable condition."

The patient did not meet the DSM IV criteria for a diagnosis of “Bipolar Disorder, Manic, with Psychotic Features” based on the following data from staff notes:

- Criterion A for a DSM diagnosis requires: “A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).” Hospital staff noted that the patient exhibited “irritable mood” fourteen times. They supported their observations of this symptom with statements such as these: “Patient angry; feels she’s not a danger to herself and others,” and “difficult to engage,” and “[Patient] wants a ‘medical review;’ asks ‘why can’t I read DSM IV?’”

Criterion A was met for “irritable mood,” if, and only if, the following assumptions are accepted:

- It is irrelevant that the patient’s mood and/or affect were charted by nurses as appropriate or euthymic (calm) eighteen times in thirteen days -- more often than any single disturbance in mood was noted.
  - It is agreed that what the patient was responding to -- confinement, coercion to take psychoactive medication, refusal of hospital staff to believe what she said to them, and refusal of hospital staff to justify their diagnosis and treatment plans with objective evidence -- can be considered minimal stimuli or irritants;
  - It is agreed that demonstrating by statements and facial expressions the emotions of hostility or anger, and refusing to talk to people responsible for the stimuli, can be considered excessive reactions;
  - It is irrelevant that the symptom of “blunted affect” -- a significant reduction in the intensity of emotional expression -- was also noted fourteen times by hospital staff -- the same number of times irritable mood was noted;
  - It is irrelevant that the symptom of “labile affect” -- an affect type that indicates abnormal sudden rapid shifts in affect -- was observed by the same nurses to have co-occurred with “blunted affect,” its opposite, each of the nine times they noted it.
- None of the B criteria for a DSM diagnosis of “Bipolar Disorder, Manic” were met. Four of the seven symptoms discussed below must have “persisted and have been present to a significant degree” to justify a DSM diagnosis of mania.
    - The only evidence given by hospital staff to support the patient’s symptom of “grandiosity” was: “Says she has 4 jobs, Masters Degree in psychology;” “Per patient she is a psychology teacher w/ many students;” and “Says she’s a psychotherapist.” The patient actually did have four (part-time) jobs, does have a master’s degree in psychology, has taught large college classes, and had worked as a psychotherapist.
    - Except for three nights when her sleep was interrupted by severe back spasms (documented in the chart), the patient slept an average of 6.7 hours per night.
    - The patient’s speech was observed and charted by nurses as “normal in rate and volume” twice daily in their Nursing Flow Sheet / Progress Notes. They never noted observing pressured speech. In four nursing notes, nurses noted their intention to “encourage verbalization” as a treatment intervention.
    - There is nothing in the medical record to support the symptoms of flight of ideas or racing thoughts.
    - There is nothing in the medical record that indicates that the patient was persistently distractible.

- Twice daily nurses noted that the patient's psychomotor activity was "appropriate." There is no evidence in the medical record to support the symptom of an increase in goal-directed activity or of psychomotor agitation.
- There are no indications in the hospital record that the patient indulged in, or wished to indulge in, pleasurable activities with a high potential for painful consequences.

The patient's most frequently noted symptom was a lack of insight and judgment -- noted 38 times. Hospital staff consistently based the presence of this symptom on the patient's refusal to believe that the behaviors she exhibited met the DSM criteria for a diagnosis of Bipolar Disorder, and on her refusal to follow the psychiatrists' recommended treatment for that disorder. In fact, according to hospital staff's charting, the patient was correct in her assessment of her own behavior: it did not meet the DSM criteria for a diagnosis of that disorder, and, therefore, the recommended medications were inappropriate.

Evidence of the patient's psychotic symptoms is based entirely on the staff's certainty that the patient was deluded in her belief that she had attained an education and had an occupational history that the staff was not accustomed to seeing in their facility, and that she had been the target of telephone and computer harassment. These are beliefs that would in no way cause the patient to be dangerous to herself or others, or limit her ability to take care of her basic needs, even if they were not true.

In a "Master Treatment Plan for Mania," the attending psychiatrist set the following criteria for the patient's discharge:

- Compliance with medication
- Speech at normal volume and tone
- Diminished or cessation of grandiose thoughts expressed
- No attempt to harm self during hospital stay

To meet the criteria, the patient had to be "stable for 48-72 hours."

On the first day of the patient's stay, six psychoactive medications were ordered for her – a mood stabilizer, two antianxiety drugs, an antidepressant, an antipsychotic, and an anticholinergic. The mood stabilizer, one of the antianxiety drugs, and the antidepressant were to be taken daily, with the others to be administered as needed. On the patient's second day in the hospital, the attending psychiatrist discontinued the daily antianxiety drug and ordered a daily antipsychotic. The patient refused to take any of these drugs throughout this first detention in the hospital.

Treatment interventions were focused on staff's attempts to gain the patient's compliance with medications and her acceptance of the diagnosis she was given. The interventions were unsuccessful.

### **Court Procedures and Decisions – Probable Cause and Furlough**

Five days after the patient was taken into emergency custody and drugged to unconsciousness and three days after she was transported to the acute-care public psychiatric hospital, a "Probable Cause Hearing for Immediate Restraint" was held. The state based its case for restraint on the medical examination report of the psychiatrist who had written it with no face-to-face contact with the patient, and on the patient's husband's written affidavit requesting mental health service. Neither the doctor nor the patient's husband attended this hearing.

When the patient's court-appointed attorney attempted to present the patient's account of her alleged suicide attempt and homicide threat, and her description of the events that preceded her hospitalization, the presiding judge held a private conversation with her office on a cell phone. The patient was ordered into protected custody at this hearing. She received no paperwork from the court

regarding this order. She was returned to the hospital's locked psychiatric unit to await a hearing for court-ordered mental health service, to be held in nine days.

**Texas Health and Safety Code Sec.574.025(f)**, on Probable Cause Hearings, states: "The state may prove its case on the physician's certificate of medical examination filed in support of the initial motion." This state law appears to be unconstitutional under Amendment XIV of the US Constitution.

In the U.S. Supreme Court case **Mathews v. Eldridge, 424 U.S. 319, 343 -45 (1976)**, the court found written presentations of evidence to be insufficient in meeting the requirements of the due process clause of the fifth and fourteenth amendments, for a decision regarding termination of social security disability benefits. Mr. Justice Powell delivered the opinion of the Court:

"Written submissions do not afford the flexibility of oral presentations; they do not permit the recipient to mold his argument to the issues the decision maker appears to regard as important. Particularly where credibility and veracity are at issue, ... written submissions are a wholly unsatisfactory basis for decision."

And in the U.S. Supreme Court case **Joint Anti-Fascist Comm. v. McGrath, 341 U.S. 123, 168 (1951) (Frankfurter, J., concurring)**, Mr. Justice Burton, speaking for the court, stated that:

"The right to be heard before being condemned to suffer grievous loss of any kind, even though it may not involve the stigma and hardships of a criminal conviction, is a principle basic to our society."

Certainly the potential loss of liberty for a period of up to 30 days (allowed under **Texas Health and Safety Code Sec.574.005(c)**), in the absence of any allegations of illegal behavior, and the stigma of psychiatric diagnosis and commitment, constitute "grievous loss," and therefore entitle the defendant to due process protection under the law. Also, in this case, "credibility and veracity" are at issue. Therefore, written submissions in probable cause hearings for psychiatric commitments should also be seen as wholly unsatisfactory bases for decision.

The patient was initially kept in the acute care hospital for thirteen days, while hospital staff waited for a court order to have her forcibly medicated. On the day she was scheduled to have a hearing, approximately one hour after the time the hearing was scheduled to begin, the court served notice to her of a hearing on a "Petition for an Order to Administer Psychoactive Medication," that was to have begun an hour before the notice was served.

One of the court papers was a copy of the "Petition for an Order to Administer Psychoactive Medication," dated nine days before. The petition had been signed and dated by the attending psychiatrist, who had had it notarized on the same day. This document stated that the patient was already subject to an order for court-ordered mental health services effective on a date that would not occur until nine days after the petition was signed, dated and notarized.

On the afternoon of the day she was scheduled to have a hearing, the court had her court-appointed attorney orally inform her that she had been given a "furlough," and that she was required to visit the office of a psychiatrist the court had chosen, and then to return for a hearing for court-ordered mental health services and a hearing on a petition for an order to administer psychoactive medication seven days later.

Furloughs from psychiatric hospitals are treatment decisions which are made by hospital treatment teams in the transition phase of patient treatment planning. Use of the word "furlough" is being phased out in the Texas mental health system, to be replaced by the phrase "trial placement." (Texas Administrative Code, Title 25, Part 1, Chapter 402).

**Texas Health and Safety Code Sec.574.082(a)**, regarding furloughs, discharges, and terminations of court-ordered mental health services, states: “The facility administrator may permit a patient admitted to the facility under an order for temporary or extended inpatient mental health services to leave the facility under a pass or furlough.” This patient was not under an order for temporary or extended inpatient mental health services, she was under an order of protective custody. The court furloughed the patient from the hospital; the hospital did not.

The court does not have the power to make specific treatment decisions, such as the granting of furloughs. In fact, in granting this furlough, the court appeared to have contradicted its earlier determination that the patient was so dangerous and incompetent that it was necessary to keep her locked up in order to protect others and herself.

### **Acute-Care Hospital Discharge and Return**

When the attending psychiatrist was informed of the court's decision to furlough the patient, she immediately discharged the patient from the hospital and signed a discharge summary stating that, at discharge, the patient demonstrated “an adequate sleep pattern and appetite, improved thought processing, less irritability, no threatening behaviors, no psychosis, and no suicidal or homicidal ideation.” A hospital form informing the court of the patient's discharge – “Request to Dismiss Order of Protective Custody,” Form # [Hospital's Initials]-80317(Rev. 04/02) -- should have been submitted to the court by the attending psychiatrist as soon as she decided to discharge the patient. When the patient left the hospital, she was given a “Social Service Aftercare Form” identifying the type of discharge as “Dismissal of Commitment [by] M.D.”

Believing that she had been released from commitment, the former patient felt no obligation to visit a psychiatrist she hadn't chosen or to appear for a hearing she had not been served notice for. The court apparently didn't agree, and eleven days later the former patient was picked up by constables and returned to the hospital. Although she was never given any paperwork from the court, on the hospital's “Interdisciplinary Patient Assessment” form, the “Informant” name is “Courts – Furlough Return.”

**Texas Health and Safety Code Sec.574.083(a)** states: “The facility administrator of a facility to which a patient was admitted for court-ordered inpatient health care services may authorize a peace officer of the municipality or county in which the facility is located to take an absent patient into custody, detain the patient, and return the patient to the facility by issuing a certificate as prescribed by Subsection (c) to a law enforcement agency of the municipality or county.”

**Texas Health and Safety Code Sec.574.083(c)** states: “The certificate or affidavit filed under Subsection (a) must set out facts establishing that the patient is receiving court-ordered inpatient mental health services at the facility and show that the facility administrator reasonably believes that:

- (1) the patient is absent without authority from the facility;
- (2) the patient has violated the conditions of a pass or furlough; or
- (3) the patient's condition has deteriorated to the extent that the patient's continued absence from the facility under a pass or furlough is inappropriate.”

The hospital did not authorize the patient's return to the facility; the courts did. The patient had never been court-ordered to receive mental health services. The patient was not absent without authority from the facility – she had been discharged from the hospital, and was no longer a patient there. No allegations were ever made that the former patient had experienced any deterioration in mental functioning during the eleven days that followed her discharge.

**Texas Health and Safety Code Sec.574.084(a)** states: “A furlough may be revoked only after an administrative hearing held in accordance with department rules. The hearing must be held within 72 hours after the patient is returned to the facility.”

The patient was never served court papers about the furlough or the revocation of the furlough, nor was she given a hearing within 72 hours. She was taken to the hospital, where she was readmitted as a former patient.

### **Acute-Care Hospital Evaluation and Treatment – Second Admission**

Upon her second admission, in an initial psychiatric examination, the resident psychiatrist described the patient as “well presented, calm and cooperative, good rapport.” Her speech was noted as being “spontaneous, coherent, relevant, normal tone, rate, and volume.” The resident found “no formal thought disorder, no loosening of association, no flight of ideas, no circumstantiality.” She stated that the patient had “no delusions, no grandiose ideas/delusions. No ideas of hopelessness/worthlessness/guilt. No suicidal ideations; no homicidal ideations. Optimistic.” The patient’s mood was described as “euthymic [calm]. [The patient] perceived [her own] mood as ‘angry but controlled, not depressed.’” The doctor also reported that the patient’s “judgment seem[ed] good. Insight [appeared] level.” She estimated the patient’s intelligence to be “average to above average.”

Although the attending psychiatrist signed the resident psychiatrist’s initial psychiatric examination and made no amendments, he chose to keep the patient detained. He interviewed her for approximately fifteen minutes the next day, found evidence of “under wraps” affect and “underlying irritability/demandingness,” determined that she was “working on containing emotions,” and ascertained that she “appear[ed] to have poor insight and low judgment, [speech was] not quite pressured, but thoughts seem accelerated.” He also decided to continue to confine the patient based on his perception that “old records strongly support a psychotic, manic state.”

In a “Master Treatment Plan for Mania with Psychosis,” the attending psychiatrist set the following criteria for the patient’s discharge:

- Compliant with medication
- States name, dosage, reason, time of medication
- Compliant with diagnostic testing – lab
- Euthymic mood
- States 4 symptoms of illness
- Self-reports diminished or cessation of paranoid delusional thoughts
- Sleeps 6 hours daily
- Decreased psychomotor agitation
- Attends to adult daily living skills
- Is referred for aftercare treatment upon discharge
- Family conflict is mediated/reduced
- Identifies 4 relapse prevention techniques

To meet the criteria, the patient had to be “stable for 48 hours.”

None of the twelve criteria for discharge required that the patient show evidence that she did not pose a danger to herself or others. None of the criteria required that the patient demonstrate an ability to provide for her basic needs, including food, clothing, health, or safety.

Only four of the twelve criteria for discharge related to the cessation of symptoms of Bipolar Disorder, Manic, with Psychotic Features. Of the remaining eight criteria, six required that the patient demonstrate agreement with the psychiatrist’s diagnosis and obedience to his orders. The remaining

two criteria required that the patient's personal grooming and her relationship with her family meet with hospital staff's approval, before she would be discharged.

Again, six psychoactive medications were ordered for the patient, with three of them – a mood stabilizer, an antidepressant, and an antipsychotic – to be administered daily. Again the patient refused to take the medications.

As in the first hospitalization, treatment interventions were focused on staff's attempts to gain the patient's compliance with medications and her acceptance of the diagnosis she was given.

### **Court Procedures and Decisions – Court-Ordered Mental Health Treatment and Forced Administration of Psychoactive Medication**

On the first day of this second involuntary hospitalization, the patient was orally informed by her court-appointed attorney that hearings for court-ordered mental health services and forced medication would be held at 8:30 a.m. three days later. The patient was not served any paperwork by the court. Late in the afternoon, on the day she was told that she was scheduled to have a hearing, her court-appointed attorney orally informed her that the hearings had been rescheduled, due to the illness of the judge, and would take place in three days. This would constitute the second continuance of the Hearing on a Petition for an Order to Administer Psychoactive Medication. The patient was not consulted about either continuance.

**Texas Health and Safety Code Sec.574.104(e)**, regarding date requirements for Petition for an Order to Administer Psychoactive Medication hearings, states: "Subject to the requirement in Subsection (d) that the hearing shall be held not later than 30 days after the filing of the application, the court may grant one continuance on a party's motion and for good cause shown. The court may grant more than one continuance only with the agreement of the parties." (Emphasis added)

The hearings for court-ordered mental health services and forced medication took place 31 days after the patient was first taken into emergency custody. Clear and convincing psychiatric evidence that she was mentally ill, dangerous to herself and others, incompetent to care for herself, and unable to make a rational and informed decision as to whether or not to submit to treatment, came from the medical examination report by the psychiatrist at the emergency facility, who had never had face-to-face contact with the patient, and who had written the report 31 days before the hearing took place.

Clear and convincing psychiatric evidence that the patient was in need of forced psychoactive medication came from a "Petition for an Order to Administer Psychoactive Medication," written by the attending psychiatrist who had discharged the patient seventeen days earlier, documenting that, at the time of discharge, the patient demonstrated "an adequate sleep pattern and appetite, improved thought processing, less irritability, no threatening behaviors, no psychosis, and no suicidal or homicidal ideation."

This petition had been signed, dated, and notarized twenty-one days prior to this hearing. The petition stated that the patient was subject to an order for court-ordered mental health services, effective on a date that had occurred seventeen days before the hearing for mental health services actually took place and which was not going to occur until nine days after the date the petition had been signed, dated, and notarized.

The diagnosis on the petition was "Bipolar Disorder – Mixed." The doctor had documented that the patient was incapable of making decisions about medication because she was "illogical, grandiose, paranoid, and delusional." The patient's necessary medications were listed as: "antidepressants, antipsychotics, anxiolytics/sedatives/hypnotics, and mood stabilizers" for a "fair" prognosis. Her prognosis without these drugs was predicted to be "further decompensation." The doctor indicated that

she had considered no alternative to psychoactive medication because the patient “needs psychoactive medication.”

A second opinion regarding the patient’s need for court-ordered mental health services and forced psychoactive medication was provided by a court-appointed psychiatrist who had spoken with the patient for about 20 minutes, and who accepted the patient’s husband’s diagnosis. This expert witness told the court that anyone with a bipolar disorder was potentially dangerous unless they were hospitalized and medicated, and that she would refuse to treat a private patient with bipolar disorder if that person would not go into the hospital to be stabilized on medication.

She also testified that it wasn’t unusual for a person over the age of fifty to have a first episode of bipolar disorder, since the onset of bipolar disorder was equally likely to occur at any time in the lifespan. Finally, she told the court that the patient could not make decisions about her own medical treatment because people with unmedicated Bipolar Disorder lack insight and don’t know they are sick, and they are, therefore, highly likely to engage in very risky behavior.

At the conclusion of this hearing, the judge said he would make a decision by the next day. The patient never received any oral notification or documentation from the court about the decisions made at this hearing. The state’s attorney privately informed the patient’s husband after the hearing that, if his wife refused medications, she would be injected with something that would make her so uncomfortable she would soon agree to take oral medication.

**Texas Health and Safety Code Sec.574.105**, concerning the rights of a patient for whom an application for an order to authorize the administration of a psychoactive medication is filed, states that: “the patient is entitled to oral notification, at the conclusion of the hearing, of the court’s determinations of the patient’s capacity and best interests.” (Emphasis added)

Eight days after this second hospitalization began and two days after the hearing took place, the patient was orally informed by hospital staff that she had been court-ordered to receive mental health services and to submit to forced medication. The written order was delivered by the court to hospital staff and not to the patient. She was kept for an additional 13 days, and forcibly injected with Prolixin, an antipsychotic, until she suffered an acute dystonic reaction. The experience of this painful and frightening side-effect convinced her to orally ingest the drugs the doctor wanted her to take.

On the patient’s last day of confinement, the attending and resident psychiatrist signed a discharge summary stating that, at discharge: “The patient was compliant with treatment and tolerated medications. Mood was euthymic with no agitation, suicidal or homicidal ideations. No overt psychosis or bizarre behaviors. The patient was not demonstrating dangerousness to self or others.”

With the exception of the psychiatrists’ report of the patient’s compliance with treatment, the summary documented that, after 34 days of confinement and 13 days of forced medication, the patient’s condition at discharge was identical to the condition the resident psychiatrist had found her to be in on the first day of this second involuntary hospital admission. It was also identical to the condition that the previous attending and resident psychiatrists had found her to be in when they had discharged her from her first hospitalization 31 days earlier. The patient was finally released with her husband’s diagnosis still on the records and a referral to the county MHMR facility, so she could continue to receive medication for her chronic mental illness.

### **Post-Commitment**

The day before the patient was released, her husband, in opposition to his wife’s wishes, put their elder daughter on a plane to Florida. The patient’s daughter, her husband, and her sister had all agreed that living with a mother with Bipolar Disorder would be too stressful for the teenager.

The former patient had three jobs that were to have begun during the time she was hospitalized – a college teaching position, a consulting position for a museum, and employment as an on-line scorer of standardized essay tests. During her confinement, the patient's husband had informed her two local employers that his wife was in the hospital being involuntarily treated for mania.

The former patient also lost her volunteer position in her church. The church board of directors voted unanimously to relieve her of her position as an elected church officer. No board members felt it necessary to even talk to her about that decision before it was made. The former patient had been elected vice president of the board of directors of the church, and had been an active, effective, and respected volunteer there for over 13 years.

The patient was able to engage a private psychiatrist after she was released from involuntary hospitalization, and that psychiatrist helped her to carefully withdraw from the psychoactive medication she was court-ordered to ingest while she was hospitalized. (Sudden withdrawal from many psychoactive medications can cause severe physical and behavioral symptoms.) The psychiatrist also gave the patient a less stigmatizing diagnosis -- "Psychotic Disorder, NOS." The private psychiatrist expressed a reluctance to diagnose the patient at all, since she found no evidence of a mental disorder at the time she saw the patient, and since the patient was not using insurance. She made the diagnosis at the patient's request.

Throughout both hospitalizations, hospital staff continually referred to the patient's statements about computer intrusion as evidence of delusional psychosis. Several months after the patient was released from involuntary hospitalization, she was able to verify the computer intrusion using System Mechanic, AdAware, and SpyBot software, even though her husband had manually removed an unknown number of malware files and folders prior to and during his wife's six-week-long involuntary involvement with the public mental health system.

The former patient attempted to engage a private attorney to address the personal injuries, medical malpractice, judicial malfeasance, and civil rights violations she had experienced. None of the attorneys she contacted were interested in taking her case. She spoke with a legal assistant at the office of her local American Civil Liberties Union (ACLU) representative, and gave the assistant a packet of documents. The ACLU lawyer never contacted the former patient and never returned her phone calls and emails.

One attorney, who advertises throughout the state of Texas that his practice deals exclusively with cases involving psychiatric and psychological malpractice, informed the former patient that his firm only took cases for families of patients who were wrongfully released from psychiatric treatment, and who then attempted or committed suicide. In other words, the attorney himself believes, and expects judges and juries to believe, that psychiatrists are capable of predicting a person's future behavior, and that they are responsible for controlling it. Faced with even the remote possibility of a wrongful death lawsuit, a moderately honorable psychiatrist might be tempted to deny civil rights to the labeled, whose unsound judgment is already presumed, rather than to risk his/her own professional and financial future.

The former patient is about to embark on a new career. The first thing she encountered when she began to fill in the paperwork for the required training for this federally supported program was this question on the application: "Have you ever been under the treatment of a physician for an emotional problem or nervous disorder? Explain." She was able to convince the program director that the question was in violation of the Code of Federal Regulations; Title 34; Chapter I; Section 104.42: "Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving Federal Financial Assistance -- Post-secondary Education -- Admissions and Recruitment." The director removed the question from the application, and the former patient was accepted into the program. The patient believes that she will continue to be asked to answer similar questions for the rest of her life.

## **Conclusions**

In a country that is a “country of laws, and not of men” (John Adams), giving power to any select group, which allows that group to control others without regard to the law, is very dangerous for all citizens. If psychiatrists are permitted to continue to hold such powers over the lives of law-abiding citizens, any person, corporation, or government entity could conceivably convince any psychiatrist that any individual they find to be annoying, eccentric, troublesome, or inconvenient is mentally disturbed, and have that person indefinitely incarcerated and medicated, even if there are no allegations that the person has done anything illegal.

The former patient recognizes that she was fortunate to have encountered the public mental health system only once in 50 years, and that she is fortunate that she had the opportunity to have experienced a half a century to develop and learn to trust her competence and personal integrity prior to having to go through what she calls “the worst six weeks” of her life. She knows that many others are not so fortunate.

With the advent of the president’s “New Freedom Initiative,” children as young as three years old may have to endure the type of “evaluation” and “treatment” that the former patient endured in middle age. The effects of labeling and medicating young children before they have completed their physical, cognitive, and emotional development are unknown. It is, however, highly unlikely to be advantageous for them.

The former patient is willing to sign a release for her medical records for anyone who believes (s)he can use them to help prevent what happened to her from happening to anyone else. You may contact her by emailing this writer at [BilloWrightz@aol.com](mailto:BilloWrightz@aol.com).

As Frederick Douglass said in 1857, “Power concedes nothing without a demand. It never did and it never will. Find out just what any people will quietly submit to and you have found out the exact measure of injustice and wrong which will be imposed upon them, and these will continue till they are resisted. ... The limits of tyrants are prescribed by the endurance of those whom they oppress.”