PAI Protection & Advocacy Inc.

SACRAMENTO LEGAL OFFICE
100 Howe Avenue, Suite 235N
Sacramento, CA 95825
Tel: (916) 488-9950
TTY: (800) 719-5798
Toll Free: (800)776-5746
Fax: (916) 488-9960

Advancing the rights of Californians with disabilities
www.pai-ca.org

May 21, 2007

Stephen Mayberg, Director MD
Cynthia Radavsky, Deputy Director, Long Term Care Services
Department of Mental Health
1600 9th St., Room 151
Sacramento, CA 95814

Re: Request for Policy Change re Involuntary Medication of Individuals committed under NGI

Dear Dr. Mayberg and Ms. Radavsky:

We are writing on behalf of Mr. Xx Xxxxxxxxxxx, a patient confined at Napa State Hospital under a NGI commitment. It has come to our attention that the staff of Napa State Hospital is involuntarily medicating patients who are confined under Not Guilty By Reason of Insanity (NGI) commitments in non-emergency situations and without judicial authorization. Specifically, we understand that between December 2006 and early January 2007, Mr. Xxxxx was involuntarily medicated with Thorazine, and that Mr. Xxxxx was, until recently, medicated with an amount of Seroquel he believed caused him to be overmedicated and too drowsy to attend daily morning groups. Both medications have interfered with his ability to fully participate in his daily treatment program at NSH.

We understand from the response to our Public Records Act request of March 23, 2007 that DMH has no written policy regarding the involuntary medication of NGI patients. We are asking that you enact a policy that provides NGI patients with the same rights against the involuntary administration of medication that you accord persons committed under the Sexually Violent Predator and Mentally Disordered Offender statutes.

As discussed more fully in the attached analysis, both the California and United States Constitutions limit the government's authority to forcibly medicate institutionalized persons. The only institutionalized persons not presently protected by statute or specific binding precedent are NGIs such as Mr. Xxxxx. Apparently DMH has determined that it may deny NGI patients the rights it accords other patients under the authority of *In re Locks*, 79 Cal.App.4th 890 (2000). But even if *Locks* was correctly decided, and our supreme court's harsh criticism of its reasoning suggests that it was not, the *Qawi* and *Calhoun* decisions have effectively abrogated its holding, because the Equal Protection clause of the federal Constitution does not allow the state to withhold from NGI patients the protections against involuntary medication that it accords all other institutionalized persons.

It is our desire to work with the Department toward the development of a special order that provides NGI committees with the same protections against involuntary medications afforded other state hospital residents and thus avoid the time and expense of litigation. To further this goal we have 1) attached a draft special order which we believe meets the requirements discussed in *Harper*, *Qawi*, and *Calhoun* and 2) would like to meet with you to discuss the draft order and its implementation.

Please let me know no later than Friday, June 1, 2007 if the Department is interested in meeting with us. You can contact me at xxxxxxxxxxxxxxxxxxx. You can also reach me via e-mail at xxxxxxxxxxxxxxxxx. Thank you for your time and attention to this matter.

Sincerely yours,

Sean Rashkis
Staff Attorney

Michael Risher
Staff Attorney
American Civil Liberties Union Foundation of Northern California

Enclosures: Legal Analysis
Proposed Special Order-NGI Involuntary Medication Procedure

Cc: Xxxxxxxxxx
Norm Black, Chief Counsel, Department of Mental Health

I. ANALYSIS

Both the California and United States constitutions limit the government's authority to forcibly medicate institutionalized persons. *Washington v. Harper*, 494 U.S. 210, 221-22 (1990); *In re Qawi*, 32 Cal.4th 1, 14 (2002); *Hydrick v. Hunter*, 466 F.3d 676, 696-97 (9th Cir. 2006) (SVPs). Specifically, the state may not medicate an institutionalized person (absent an emergency) without first showing that the treatment is medically appropriate and that the person is either incompetent to make medical decisions or poses a threat to his own or somebody else's safety. *Harper*, 494 U.S. at 227; *Qawi* , 32 Cal.4th at 15-16. This showing must be made to a neutral decision maker and the patient be given "notice, the right to be present at an adversary hearing, and the right to present and cross-examine witnesses." *Harper*, 494 U.S. at 233-35; *Doby v. Hickerson*, 120 F.3d 111, 113 (8th Cir. 1997). This hearing must occur before the start of long-term medication. *Jurasek v. Utah State Hosp.*, 158 F.3d 506, 513 (10th Cir. 1998) ("Hospital must afford him procedural due process *before* administering such treatment.") (emphasis added); *Davis v. Hubbard*, 506 F.Supp. 915, 938-39 (N.D. Ohio 1980); *see generally Zinermon v. Burch*, 494 U.S. 113, 127-28 (1990).

The California legislature has imposed detailed procedures to enforce these constitutional protections. These procedural protections mean that essentially all persons under the state's control have the right to refuse non-emergency medication without a judicial finding that the medication is necessary because the person poses a threat to safety, either their own or somebody else's. To date, the following persons are explicitly entitled to these protections by statute:

- Dangerous or Gravely Disabled Persons hospitalized under the LPS Act. *See Qawi*, 32 Cal.4th at 20-21
- Prison inmates, including inmates housed in state hospitals. Penal Code § 2600
- Mentally Disordered Offenders. P.C. § 2972(g); *see Qawi*, 32 Cal.4th at 9-10
- Persons incompetent to stand trial. P.C. § 1370; *see People v. O'Dell*, 126 Cal.App.4th 562

In addition, the California court of appeal recently extended these same protections to Sexually Violent Predators, on the grounds that equal protection prohibits the state from denying the same protections to one class of

institutionalized persons it grants to these others. *See In re Calhoun*, 121 Cal.App.4th 1315 (2004).

Thus the only institutionalized persons not presently protected by statute or specific binding precedent are NGIs such as Mr. Xxxx. And the state hospital has apparently determined that it may deny NGI patients the rights it accords other patients under the authority of *In re Locks*, 79 Cal.App.4th 890 (2000). But even if *Locks* was correctly decided – and our supreme court's harsh criticism of its reasoning suggests that it was not – the *Qawi* and *Calhoun* decisions have effectively abrogated its holding, because the Equal Protection clause of the federal Constitution does not allow the state to withhold from NGI patients the protections against involuntary medication that it accords all other institutionalized persons.

A. In re Qawi Effectively Overruled In re Locks

As our supreme court made clear in *Qawi*, "[t]he reasoning in Locks is flawed." 32 Cal.4th at 27. First, the *Locks* court completely failed to discuss or even identify the constitutional issues involved in the case. *Id*. Its most glaring omission is a complete failure even to mention – much less analyze -- *Harper* or the requirements of due process. In fact, it appears that the case did nothing more than try to apply P.C. § 2600 and the incorporated *Keyhea* injunction to NGI patients.[1] It is therefore likely that *Locks* never stood for anything other than the narrow proposition that § 2600 and the *Keyhea* injunction do not apply to NGI patients. *See People v. Barker*, 34 Cal.4th 345, 354 (2004) ("a decision does not stand for a proposition not considered by the court"). In any event, an analysis of what *Locks* did and did not decide is unnecessary, because the opinion is so clearly inconsistent with the supreme court's later opinion in *Qawi* that it has effectively been overruled. *See Kinoshita v. Horio*, 186 Cal.App.3d 959, 966 (1987).

As an initial matter, *Qawi* makes clear what Locks only partially conceded: a person who has been found not guilty by reason of insanity is not therefore incompetent to refuse medication.[2] 32 Cal.4th at 17-18, 24, 26. Thus, the Department may not rely on any presumption of incompetence to forcibly medicate an NGI patient.

---

[1] And it failed at even this limited goal. *Qawi*, 32 Cal.4th at 27.

[2] In fact, a person committed after a finding of NGI has necessarily been found competent to stand trial. *See* P.C. §§ 1367-1370; *People v. Hale*, 44 Cal.3d 531 (1988).

Qawi also makes it clear that a release or recommitment hearing cannot substitute for an involuntary-medication hearing, because the questions and standards at the two hearing are not the same.[3] *See Qawi*, 32 Cal.4th at 24-25, 27. Specifically, *Qawi* held that the finding that a person is an MDO does not itself authorize forcible medication because it does not require that the government show "recent dangerousness as evidence by tangible acts or threats of violence," as is required to medicate LPS patients. *Id*. at 24, 25. Similarly, NGI release hearings do not require any evidence of a recent act showing dangerousness. *People v. Hubbart*, 88 Cal.App.4th 1202, 1220-21 (2001). Moreover, unlike at an MDO commitment hearing, the government need not prove anything at all in an NGI release proceeding, because the patient bears the burden of proof; in contrast, in involuntary medication hearings, the government must shoulder the burden. Compare P.C. § 1026.2(k) *with Qawi*, 32 Cal.4th at 22 (government's burden of clear and convincing evidence) *with Jurasek v. Utah State Hosp.*, 158 F.3d 506, 513 (10th Cir. 1998) ("Once a patient objects to the forcible administration of antipsychotic medication, the state bears the burden of establishing the continued need and medical appropriateness of the treatment."). Thus, the theory espoused in *Locks* that a hearing under § 1026.2 is an adequate substitute for a medication hearing cannot be reconciled with *Qawi* and is no longer good law.[4]

Finally, *Qawi* rejected the idea that a patient "loses the right to refuse medication because he or she has been determined to be dangerous at some point in the past." *Id*. at 25.[5] This directly conflicts with *Locks's* approval of indefinite forced medication of patients simply because they had been adjudicated NGI. *See* 79 Cal.App.4th at 897.

Thus, to the extent *Locks* held that NGI patients do not have a due process right to a *Harper* hearing before they are forcibly medicated, *Qawi* has overruled this holding. The Department therefore cannot rely upon Locks to justify forcibly medicating NGI patients without a prior hearing. *See Kinoshita v. Horio*, 186 Cal.App.3d 959, 966 (1987). Instead, *Harper* and *Qawi* require that provide NGI patients the constitutional protections discussed above.

---

[4] In addition, a hearing under 1226 or 1026.2 will never address the question of whether a patient presents a danger to himself or others *within* the therapeutic environment of the state hospital, as opposed to in the public after release. *See United States v. Weston*, 206 F.3d 9, 13 (D.C. Cir. 2000) and on appeal after remand, 255 F.3d 873, 878-79 (D.C. Cir. 2001). Nor will it address the necessary question of whether medication is medically appropriate. *See Qawi*, 32 Cal.4th at 16.

[5] Although this and the preceding portion of *Qawi* deal with statutory rights, federal due process also requires that the government bear the burden of proving dangerousness with recent evidence. *See Jurasek*, 158 F.3d at 512, 513.

B. Equal Protection Mandates that the State Hospital Accord NGI Patients the Same Procedural Rights Against Involuntary Medication it Accords SVP and MDO Patients

Even if *Locks's* holding had survived *Qawi*, the recent case of *In re Calhoun* makes it clear that NGI patients have an Equal Protection right to the same protections against involuntary medication that MDO and SVP patents have. Because the *Locks* court never considered this issue, its holding is irrelevant to this question. *Barker*, 34 Cal.4th at 354.

The Equal Protection clauses of the state and federal constitutions require government policies that affect fundamental interests to treat similarly situated persons alike. *In re Moye*, 22 Cal.3d 465-66 (1978); *Calhoun*, 121 Cal.App.4th at 1353. Government policies or practices that fail to do this are presumptively unconstitutional and are valid only if necessary to further a compelling state interest. *Moye*, 22 Cal.3d at 466; *see Calhoun*, 121 Cal.App.4th at 1353.

As noted above, the involuntary medication of institutionalized persons affects a fundamental interest. *Harper*, 494 U.S. at 221-22; *Qawi*, 32 Cal.4th at 14. The government may therefore not deny certain classes of such persons the same procedural protections against medication that it provides to other committed persons without showing a compelling need to do so. *Calhoun*, 121 Cal.App.4th at 1353.

There is no compelling reason to draw distinctions in this regard between NGIs, SVPs and MDOs, because there is simply no relevant difference between the classes of patient that could support this disparate treatment. To the contrary, the similarities are overwhelming:

- Every person committed under each of these statutes is mentally ill and has committed a predicate criminal act. *See* P.C. §§ 25, 1026 (NGI); W&I § 6600(a)(1) (SVP); P.C. §§2962(b), 2962(d)(1) (MDO).

- Every person committed under these statutes is institutionalized for treatment and for the protection of the public.

- Finally, each is entitled to release when he ceases to pose a danger to the public. W&I 6605, 6608 (SVP); P.C. 2970 (MDO); P.C. 1025.2.

Because of these similarities, the courts have long held that persons in these various classes are all similarly situated for equal protection purposes. For example, our supreme court has held that NGIs and MDSOs (the predecessors to today's SVPs[6]) are similarly situated for equal protection purposes: "by reason of their commission of a prior criminal act and the finding of a mental disorder justifying the initial commitment, persons committed as MDSOs are 'similarly situated' with NGIs." *Moye* at 466. The court of appeals has applied *Moye* to hold that NGI committees facing recommitment under P.C. 1026.5 are similarly situated to SVPs, and that NGIs were therefore entitled to the same procedural protections as are SVPs. *People v. Superior Court (Blakely)*, 60 Cal.App.4th 202, 217 (1997). And, most relevant to this matter, the court in *Calhoun* held that MDOs and SVPs are similarly situated for the purposes of their rights to avoid involuntary medication. *See* 121 Cal.App.4th at 1351-52. The court thus held that even though the legislature had intentionally withheld from SVPs the protections against involuntary medication it had provide to MDOs and LPS patients, equal protection would not tolerate this distinction, because the government could not "demonstrate a compelling state interest that justifies the distinction between MDO's and SVP's concerning the right to refuse antipsychotic medication." *Calhoun*,121 Cal.App.4th at 1353-54.

NGI patients are therefore entitled to the same procedural protections against involuntary medication as are SVPs and MDOs. As the above cases demonstrate, all of these criminally insane patients are similarly situated. And there is simply no rational reason – much less a compelling reason – to provide NGI patients with fewer rights than are accorded these other patients.[7] Therefore, equal protection requires that the Department provide NGI patients with the same procedural rights relating to involuntary medications that it provides to MDO and SVP patients.

---

[6] There is no relevant distinction between an MDSO and an SVP for these purposes: "An SVP is similarly situated to an MDSO committed for treatment under former section 6316." *Calhoun*, 121 Cal.App.4th at 1341.

[7] If anything, NGI patients – who may have committed less serious crimes than the others and who have not specifically been found to present a danger to the public – are entitled to more, not fewer, protections: SVPs and MDOs have all committed a violent or sex-related felony, whereas NGIs may have committed a property crime or even a misdemeanor. And SVPs and MDOs may only be committed after a court has found beyond a reasonable doubt that they have committed a predicate crime and that they presently poses a danger to the public; NGIs are committed because legally insane when he committed their crime and continues to need evaluation, with no explicit finding of present or future dangerousness. *See* P.C. § 25.