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NO. 96-CA-0796-MR

PETER BARD — APPELLANT

v.

APPEAL FROM JEFFERSON CIRCUIT COURT
HONORABLE WILLIAM S. COOPER, SPECIAL JUDGE
ACTION NO. 93-CR-2373

COMMONWEALTH OF KENTUCKY — APPELLEE

OPINION
AFFIRMING

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BEFORE: ABRAMSON, DYCHE, and SCHRODER, Judges.

ABRAMSON, JUDGE: Peter Bard, a patient committed to Central State Hospital, appeals from a March 8, 1996, Judgment of Jefferson Circuit Court authorizing his doctor to medicate him forcibly and to implement a treatment plan for schizophrenia. Bard maintains that circuit court does not have jurisdiction to entertain his doctor's petition seeking such authority. He also complains that the trial court's failure to provide him with a guardian for the hearing on this matter and its premature authorization of one of the requested medications violated statutory provisions governing non-consensual medical treatment.

Believing that the circuit court acted within its jurisdiction and that it did not misconstrue applicable law, we affirm.

In October 1993, the Jefferson County Grand Jury indicted Bard for murder. A special judge was appointed to hear the matter, and in September 1995, the judge determined, pursuant to KRS 504.110(2), that Bard, who suffers from schizophrenia, was incompetent to stand trial, was unlikely to attain competency in the foreseeable future, and was in need of hospitalization at a psychiatric facility. Accordingly, the trial court ordered that the indictment against Bard be dismissed without prejudice and that Bard be committed to Central State Hospital, where he was admitted in October 1995. In January 1996 Bard's treating psychiatrist petitioned circuit court for authority to administer to Bard, forcibly if necessary, anti-psychotic medications--Risperidone and/or Haldol--and other treatments intended to ensure the safety and enhance the effectiveness of those medicines.[1] On March 1, 1996, the trial court convened a hearing on this petition. The petitioner, Walter Butler, M. D., the director of Central State Hospital's Grauman Unit, testified that Bard suffers from acute and probably chronic schizophrenia, and that he had refused to take the anti-psychotic medicine

[1]The judgment authorizes the administration of as much as 10 mg per day orally of Risperidone, as much as 40 mg per day orally or intra-muscularly of Haloperidol, and as much as 450 mg per month intra-muscularly of Haloperidol Decanoate. The latter two medicines are commonly referred to as Haldol. The judgment also authorizes the administration of Cogentin and Artane, medicines designed to lessen the side effects of the anti-psychotic drugs, and authorizes routine physical exams, including x-rays, to facilitate monitoring the drugs' effects.

offered to him. Dr. Butler further testified that Bard was persistently delusional, that owing to the paranoid, grandiose, and violent nature of his delusions he posed a significant threat to himself and others, and that, although his behavior had thus far been stable in the highly structured hospital environment, he was not apt to experience genuine relief from his symptoms or to become capable of living with less supervision except through the type of drug therapy recommended. Two other doctors testified. They corroborated Dr. Butler's assessment of Bard and endorsed his treatment recommendation.

Bard challenged both the propriety of the proposed treatment and the ostensible justification for its being imposed. He elicited testimony from the doctors concerning the risk of damaging side effects posed by Risperidone and Haldol and the limited effectiveness of those drugs. The doctors acknowledged both imperfections: there are significant side effects associated with these and other anti-psychotic drugs, and the drugs have provided better results for some patients than for others. Nevertheless, on the basis of published studies and their own observations, the doctors insisted that the potential and likely benefits to Bard more than justified the risks involved.

Bard also challenged the asserted justification for imposing this treatment involuntarily. He argued that his behavior at the hospital provided no ground for finding that he was a menace to anyone, and that the real albeit unstated reason for the state's desire to medicate him was to render him

competent for trial, a reason, he asserted, not sufficiently compelling to override his fundamental right to be free from unwanted therapy. The trial court, however, relied on the doctors' opinions that, left untreated, Bard's delusions (centering on global war, bloodshed, and death) created an unacceptable risk that he would eventually behave violently, particularly if he were removed from the Grauman Unit's regulated environment.

Finally, Bard objected to the proceedings on the grounds summarized above. Those grounds provide the basis for his appeal. He asserts that pursuant to KRS 202A.196(3), district rather than circuit court has exclusive jurisdiction over forcible medication petitions such as Dr. Butler's. He claims that KRS 503.110(4) mandates the appointment of a guardian in this situation and prohibits treatment absent the guardian's consent. He also claims that, because his doctors never specifically offered him Haldol, he never specifically refused that medication and thus the court's order authorizing Haldol injections was premature, in violation of KRS 202A.196(2). We review the trial court's interpretation of these statutes de novo. Commonwealth v. Collins, Ky., 821 S.W.2d 488 (1991).

As Bard acknowledges, the jurisdictional issue has previously been addressed. In Tolley v. Commonwealth, Ky., 892 S.W.2d 580 (1995), our Supreme Court considered a virtually identical scenario in which the circuit court, pursuant to KRS 504.110, determined that a felony defendant was incompetent for trial, then subsequently ordered that he be committed to Central

State Hospital and involuntarily treated with anti-psychotic medicines. In upholding the circuit court's authority to make the latter determinations, the Supreme Court distinguished commitment and medication proceedings that arise in the context of a felony indictment from such proceedings arising in a purely civil context. Jurisdiction in the former instance is in circuit court pursuant to KRS 23A.010, KRS 24A.110, and KRS 504.110 (or KRS 504.030).[2]

Contrary to Bard's interpretation, we do not believe that circuit court jurisdiction is overridden by KRS Chapters

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[2]KRS 23A.010 and KRS 24A.110 give circuit court jurisdiction over felonies. KRS 504.110 addresses the "[a]lternative handling of defendant depending on whether he is competent or incompetent to stand trial:"

> (1) If the court finds the defendant incompetent to stand trial but there is a substantial probability he will attain competency in the foreseeable future, it shall commit the defendant to a treatment facility or a forensic psychiatric facility and order him to submit to treatment for sixty (60) days or until the psychologist or psychiatrist treating him finds him competent, whichever occurs first, except that if the defendant is charged with a felony, he shall be committed to a forensic psychiatric facility unless the secretary of the Cabinet for Human Resources or the secretary's designee determines that the defendant shall be treated in another Cabinet for Human Resources facility. Within ten (10) days of that time, the court shall hold another hearing to determine whether or not the defendant is competent to stand trial.
>
> (2) If the court finds the defendant incompetent to stand trial but there is not substantial probability he will attain competency in the foreseeable future, it shall conduct an involuntary hospitalization proceeding under KRS Chapter 202A or 202B.
>
> (3) If the court finds the defendant competent to stand trial, the court shall continue the proceedings against the defendant.

202A and 202B, which address matters related to civil involuntary hospitalizations, nor do we believe that KRS 504.110(2) incorporates those chapters' provisions for district court jurisdiction. See, e.g., KRS 202A.014; KRS 202A.196(3).[3] Those provisions are addressed to the purely civil proceedings initiated in district court. Rather, KRS 504.110(2) directs the circuit court to incorporate Chapter 202A's substantive standards and procedural safeguards,[4] and thus by implication, as well as for the sake of efficiency and consistency, it contemplates that

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[3] KRS 202A.014. Jurisdiction.

> All proceedings for the involuntary hospitalization of mentally ill persons shall be initiated in the District Court of the county where the person to be hospitalized resides or in which he may be at the time of the filing of a petition.

KRS 202A.196. Hospital review committee; treatment plan.

> (3) If the patient still refuses to participate in any or all aspects of his individual treatment plan, the hospital may petition the district court for a de novo determination of the appropriateness of the proposed treatment. Within seven (7) days, the court shall conduct a hearing, consistent with the patient's rights to due process of law, and shall utilize the following factors in reaching its determination:
> (a) Whether the treatment is necessary to protect the patient or others from harm;
> (b) Whether the patient is incapable of giving informed consent to the proposed treatment;
> (c) Whether any less restrictive alternative treatment exists; and
> (d) Whether the proposed treatment carries any risk of permanent side effects.

[4] But see Turner v. Commonwealth, Ky., 860 S.W.2d 772 (1993) (finding the standard of proof in civil proceedings under KRS Chapter 202A inapplicable to competency and involuntary medication decisions under KRS 504.060).

the circuit court will retain jurisdiction over commitment and treatment matters which arise in the context of a felony prosecution. Cf. KRS 202A.201 (creating administrative jurisdiction over commitment and treatment proceedings involving inmates); see Tolley, supra; Schuttenmeyer v. Commonwealth, Ky. App., 793 S.W.2d 124 (1990) (same); and see Turner v. Commonwealth, Ky., 860 S.W.2d 772 (1993) (further distinguishing civil proceedings from those arising within a criminal action). For these reasons, we reject Bard's contention that circuit court lacked jurisdiction to order him to participate in his prescribed treatment plan. We also reject his assertion that this result so misconstrues the statutes involved as to be unconstitutional.

We are similarly unpersuaded by Bard's claim that the trial court erred in failing to appoint a guardian for him. He relies on KRS 503.110(4), a part of the chapter concerned with principles justifying the use of force. KRS 503.110(4) provides as follows:

> (4) The use of physical force by a defendant upon another person is justifiable when the defendant is a doctor or other therapist or a person assisting him at his direction, and:
> (a) The force is used for the purpose of administering a recognized form of treatment which the defendant believes to be adapted to promoting the physical or mental health of the patient; and
> (b) The treatment is administered with the consent of the patient or, if the patient is a minor or a mentally disabled person, with the consent of the parent, guardian, or other person legally competent to consent in his behalf, or the treatment is administered in an emergency when the defendant believes that no one competent to consent can be consulted and that a reasonable person, wishing to safeguard the welfare of the

patient, would consent.

As Bard correctly asserts, this statute derives from the general rule that an individual may not be subjected to medical treatment against his or her will. There are exceptions to this rule, however. KRS 503.110(4) itself provides for surrogate consent in the cases of minors and incompetents and further provides for non-consensual treatment in emergencies. We agree with the trial court that KRS 202A.196 (via KRS 504.110 in this instance) creates an additional exception to the general rule. That statute provides for non-consensual treatment upon a finding by a proper court that the proposed treatment is medically appropriate and is necessary to protect the patient or others from harm. See note 3, supra; see also Riggins v. Nevada, 504 U.S. ___, 112 S. Ct. 1810, 118 L. Ed. 2d 479 (1992) (holding that federal due process requires a finding that the proposed treatment is medically appropriate and that it serves a state interest important enough to override the patient's interest in avoiding unwanted treatments); and cf. Turner v. Commonwealth, supra, (upholding, pursuant to KRS 504.110(1), non-consensual treatment with anti-psychotic drugs as a means of rendering the patient competent to stand trial). Because KRS 202A.196 provides for treatment against the patient's will and without his consent, the surrogate consent of a guardian is likewise not required. This is not to say that the trial court may not, upon a proper motion, appoint a guardian for an incompetent patient facing a forced medication petition; such an appointment may well provide a valuable safeguard in certain cases. KRS 503.110(4), however,

did not require the trial court to appoint, sua sponte, a guardian for Bard.

Finally, relying on KRS 202A.196(2)[5] Bard contends that he cannot be said to have refused Haldol because his doctors never specifically offered it to him, always offering Risperidone instead. Thus, he claims, one of the necessary conditions for a forced treatment order was not established, and the trial court's order is invalid, at least to the extent it authorizes Haldol. We disagree.

Dr. Butler testified that he favored giving Risperidone, a relatively new anti-psychotic medication, because of clinical evidence that it causes fewer side effects than Haldol, one of the standard treatments. Unlike Haldol, however, Risperidone is not available in an injectable form and so may be administered only with the patient's cooperation. On numerous occasions, he said, he and other staff persons had urged Bard to take Risperidone, but Bard had steadfastly refused, making clear his unwillingness to be treated with that or any other anti-psychotic medication. The doctor's petition requested that Bard be ordered to take Risperidone, but also requested that, should

[5]That statute provides as follows:

> Upon the refusal of an involuntary patient to participate in any or all aspects of his treatment plan, the review committee shall examine the appropriateness of the patient's individual treatment plan. Within three (3) days of the refusal, the review committee shall meet with the patient and his counsel or other representative to discuss its recommendations. (emphasis added).

Bard refuse, the doctor be authorized to administer Haldol forcibly. The trial court approved these requests.

Even if we agreed with Bard that KRS 202A.196(2) required a patient's specific rejection of each aspect of a treatment plan before that aspect could be included in an involuntary treatment order, we would agree with the trial court that Dr. Butler's testimony adequately established Bard's rejection of all anti-psychotic medicines, including Haldol. We believe, moreover, that the statute requires no such showing. Rather, upon a showing that the patient refuses to cooperate with any significant aspect of a treatment plan, KRS 202A.196 authorizes the court to order compliance with the plan as a whole--provided that the plan meets the other statutory criteria of appropriateness and the proposed treatment is necessary to further a sufficiently important state interest, issues Bard has not raised in this appeal.

Here, Bard admittedly refused Risperidone and thereby rejected what his doctors regarded as the crucial aspect of his proposed treatment: anti-psychotic medication. The trial court did not err, therefore, by authorizing a treatment plan which would ensure that medication, either Risperidone or Haldol, could be administered.

For these reasons, we affirm the March 8, 1996, Judgment of Jefferson Circuit Court.

SCHRODER, JUDGE, CONCURS.

DYCHE, JUDGE, DISSENTING. I must respectfully dissent from the majority opinion. The Jefferson Circuit Court was

without subject matter jurisdiction over this proceeding. The General Assembly has placed exclusive jurisdiction over such actions in the district courts of this Commonwealth.

I find no "administrative inconvenience" to the courts or the parties. It would be a simple matter for the circuit court to remand an action such as this to the district court for purposes of a KRS 202A hearing, once the circuit court has found the defendant incompetent to stand trial. A similar procedure is currently used when a grand jury indicts a defendant on a misdemeanor charge not coupled with a felony.

I would vacate the order of the Jefferson Circuit Court, and remand this action to the Jefferson District Court for further proceedings pursuant to KRS 202A.

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