No. 30725 - State of West Virginia ex rel. Jesse H. Riley v. Edward Rudloff, Administrator of the Eastern Regional Jail; Darrell V. McGraw, Jr., Attorney General of the State of West Virginia; and Jerome Lovrien, Commissioner, West Virginia Department of Health and Human Resources, Bureau for Behavioral Health and Health Facilities

FILED
January 6, 2003
RORY L. PERRY II, CLERK
SUPREME COURT OF APPEALS
OF WEST VIRGINIA

RELEASED
January 8, 2003
RORY L. PERRY II, CLERK
SUPREME COURT OF APPEALS
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Starcher, Justice, concurring:

I concur with the majority opinion authored by Chief Justice Davis and I appreciate its thorough and sound reasoning. Obviously, pre-trial detainees cannot be singled out and denied basic medical attention to treat their illnesses.

I write separately to call attention to an important decision of Wisconsin's highest court, *In re the Commitment of Dennis H.*, 255 Wis.2d 359, 647 N.W.2d 851 (2002), in which case the court's opinion discusses issues and principles that are significantly related to the "mental hygiene" issues in the instant case, and that should inform our future jurisprudence in this area.

Specifically, *Dennis H.* contains an up-to-date discussion of a number of constitutional issues that are often involved in considering statutes that govern when the state takes action to assure treatment for people who have severe mental illnesses, as applied to Wisconsin's statutory "fifth standard" for state action, which applies when a person's

> . . . mental illness renders them incapable of making informed medication decisions and makes it substantially probable that, without treatment, disability or deterioration will result, bringing on a loss of ability to provide self-care or control thoughts or

> actions. It allows the state to intervene with care and treatment before the deterioration reaches an acute stage, thereby preventing the otherwise substantially probable and harmful loss of ability to function independently or loss of cognitive or volitional control. There is a rational basis for distinguishing between a mentally ill person who retains the capacity to make an informed decision about medication or treatment and one who lacks such capacity. The latter is helpless, by virtue of an inability to choose medication or treatment, to avoid the harm associated with the deteriorating condition.

255 Wis. at ___, 647 N.W.2d at 861-862.

The *Dennis H.* opinion states:

> "The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable to care for themselves." *Addington v. Texas*, 441 U.S. 418, 426 (1979). The state also has "authority under its police power to protect the community" from any dangerous mentally ill persons. *Heller*, 509 U.S. at 332, 113 S.Ct. 2637 (citing *Addington*, 441 U.S. at 426, 99 S.Ct. 1804). The state's legitimate interest ceases to exist, however, if those sought to be confined "are not mentally ill or if they do not pose *some* danger to themselves or others." *Addington*, 441 U.S. at 426, 99 S.Ct. 1804 (emphasis added).
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> "[E]ven if there is no foreseeable risk of self-injury or suicide, a person is literally 'dangerous to himself' if for physical *or other reasons* he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends." *O'Connor v. Donaldson*, 422 U.S. 563, 574, n.9, 95 S.Ct. 2486, 45 L.Ed.2d 396 (1975) (emphasis added). Substantive due process has not been held to require proof of imminent physical dangerousness to self or others as a necessary prerequisite to involuntary commitment.
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> It is well-established that the state "cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." *Id.* at 576, 95 S.Ct. 2486; *see also Foucha v. Louisiana*, 504 U.S. 71, 78,

112 S.Ct. 1280, 118 L.Ed.2d 437 (1992) (involuntary mental health commitment is improper absent a determination of current mental illness and dangerousness). This does not mean, however, that substantive due process requires the state to restrict the scope of its mental health commitment statutes to only those individuals who are imminently physically dangerous. There is no "single definition that must be used as the mental condition sufficient for involuntary mental commitments." *Post*, 197 Wis. 2d at 304, 541 N.W.2d 115. In this complicated and difficult area, the Supreme Court "has wisely left the job of creating statutory definitions to the legislators who draft state laws." *Id.*

The fifth standard permits commitment only when a mentally ill person needs care or treatment to prevent deterioration but is unable to make an informed choice to accept it. This must be "demonstrated by both the individual's treatment history" and by the person's "recent acts or omissions." Wis. Stat. § 51.20(1)(a)2.e. It must also be substantially probable that if left untreated, the person "will suffer severe mental, emotional or physical harm" resulting in the loss of the "ability to function independently in the community" or in the loss of "cognitive or volitional control." Id. Only then may the individual be found "dangerous" under the fifth standard.

The fifth standard thus fits easily within the *O'Connor* formulation: even absent a requirement of obvious physical harm such as self-injury or suicide, a person may still be "dangerous to himself" if "he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends." *O'Connor*, 422 U.S. at 574, n.9, 95 S.Ct. 2486.

Moreover, by requiring dangerousness to be evidenced by a person's treatment history along with his or her recent acts or omissions, the fifth standard focuses on those who have been in treatment before and yet remain at risk of severe harm, *i.e.*, those who are chronically mentally ill and drop out of therapy or discontinue medication, giving rise to a substantial probability of a deterioration in condition to the point of inability to function independently or control thoughts or actions. *See* Darold A. Treffert, *The MacArthur Coercion Studies: A Wisconsin Perspective*, 82 Marq. L. Rev. 759, 780 (1999). The statute

> represents the fruition of the efforts of the Wisconsin State Medical Society and the Alliance for the Mentally Ill, professional organizations which recognized a need for a law that could be applied to those victims of mental illness who fell through the cracks under the old statutory scheme. *See id.*
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> By permitting intervention before a mentally ill person's condition becomes critical, the legislature has enabled the mental health treatment community to break the cycle associated with incapacity to choose medication or treatment, restore the person to a relatively even keel, prevent serious and potentially catastrophic harm, and ultimately reduce the amount of time spent in an institutional setting. This type of "prophylactic intervention" does not violate substantive due process.

255 Wis.2d 359, ___, 647 N.W.2d 851, 863-864 (paragraph numbers omitted).

Consistent with the approach approved by the Wisconsin court, our Legislature in 2001 modified the language of our mental hygiene statute to specifically authorize hospitalization and treatment under our mental hygiene system if a person's mental illness has resulted in conditions such that *serious physical or mental debilitation will ensue "unless adequate treatment is afforded."* *W.Va. Code*, 27-1-12 [2001] (emphasis added).

Science's understanding of the physical and biological aspects of brain disorders is growing by leaps and bounds. Our law must keep pace, and assure that the stigma attached to "mental" illness, that has hampered equal treatment in the past, is erased.[1] West Virginia's explicit adoption of a "need-for-treatment"-based standard, like the standard

[1]The "physical" versus "mental" illness distinction has become so blurred as to be almost useless. But due to the survival of this often stigmatizing distinction, a patient's inability to "consent to treatment" because they are demented from a high fever from influenza would not ordinarily be seen as legally impeding a doctor from administering therapeutic medicine – as it often would in the case of dementia caused by acute schizophrenia.

discussed in the *Dennis H.* opinion, is particularly important and timely in light of the current medical consensus that injuries to brain function from severe, untreated episodes of acute mental illness are long-lasting and may be permanent. No one should have to suffer permanent brain injury because of archaic distinctions between mental and physical illnesses.

Roughly two out of every one hundred persons will suffer from one of the two most serious brain disorders, bipolar disorder or schizophrenia, during their lifetime; in most cases, the illness is chronic. Thanks to medications and other treatments that have been introduced in the past fifty years (and even better ones are in the works), the large majority of people with these illnesses can manage the symptoms of these illnesses sufficiently to live safely and productively outside of hospital or other institutional settings.

However, it is a fact in every society that substantial number of persons who have been diagnosed as having these serious brain disorders – and this includes thousands of West Virginians – have difficulty sustaining compliance with prescribed treatment and medication regimes. *See generally, "I'm Not Sick – I Don't Need Help: Helping the Seriously Mentally Ill Accept Treatment -- a Practical Guide for Families and Therapists,"* Xavier F. Amador and Anna-Lica Johanson, Vida Press (2000).[2]

The reasons for a person's "non-compliance" with prescribed treatment and medication are usually overlapping and multifaceted. Many people – certainly not just people

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[2]Support for the general factual statements about mental illness and treatment in this separate opinion can be found in this book, and in almost any recent book on the subject. Further citations for such factual statements will be omitted, as they are included in this discussion to make general points and not to resolve particular issues in the instant case.

who have brain disorders – do not take prescribed medications or otherwise fully comply with their doctor's treatment recommendations. Medications and treatments may have undesirable side effects, and/or may be costly or unavailable. A person who is feeling okay while taking medication may be tempted to stop, in hopes that severe symptoms will not recur. Medical and social support that can help people comply with prescribed treatment regimes is often woefully lacking.

Additionally, experts estimate that many people who suffer from serious brain disorders – some say up to 50% – have, *as a neurologically-based component of their illness*, a lack of insight into the very fact they have an illness. (Clinically, this lack of insight is called "anosognosia.")

Obviously, if not appreciating that one has an illness is part of one's clinical symptomatic picture, sustained medication and treatment compliance can be difficult, especially if the patient's family or other social support system is not strong – a condition that describes far too many people. And of course, if an individual with a mental illness starts moving into significant delusion or psychosis, they are further deprived of their reasoning ability.[3]

Therefore, although there are treatments and medications that in most cases

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[3]Of course, medication noncompliance is not the only reason for severe psychiatric episodes that lead to mental hygiene proceedings. Situations, factors, and conditions like substance abuse, addiction, family violence, and dual diagnoses can create grounds for the dangerousness to self or others (active or passive) and need for treatment that are the legal foundation for the mental hygiene process.

could prevent the need for many hospitalizations, once a person's illness has been correctly diagnosed and treatment prescribed, in fact "revolving-door," recurring/repeat hospitalizations of persons with serious, chronic mental illnesses – for short-term treatment, to treat and alleviate acute symptoms like psychosis – are a fact of life in every industrialized nation. And in West Virginia, it is ordinarily in our mental hygiene system in which these recurring, short-term hospitalizations are authorized.

It is important to realize that for a number of seriously ill patients who may in fact be *willing* to accept hospitalization for treatment, the "involuntary hospitalization" process that is the core of the mental hygiene system is nevertheless utilized – precisely because our state psychiatric hospital system is so overstressed that they cannot accept a voluntary admission patient. And many people, deplorably, have no health insurance that would allow them to enter a private hospital.

Where there are comprehensive, community-based, assertive treatment programs, no doubt many hospitalizations for acute episodes of mental illness could be avoided. But such programs are costly and regrettably not to be found everywhere. And importantly, a lack of community services is *in no way* a reason or excuse for denying to ill people who are in crisis the treatment that they need – in hospitals, if that is the treatment that is available.

In West Virginia, I believe that our doctors, psychologists, social workers, law enforcement, courts, hospitals, and judiciary are trying to do the best they can, using the mental hygiene system, to get treatment to people who need it in a constitutional and therapeutic way.

To reiterate: as a society, we should ideally minimize the need for mental hygiene proceedings to get effective treatment for people with mental illnesses. But when we use these procedures – because they are what we have – they must be as fair and humane as possible – and available to all. The Court's opinion in the instant case takes this approach, holding that the status of being a pre-trial detainee does not deny to a person the same right to treatment that others have; and it reaches that result by applying clear principles of law.

Accordingly, I concur.