

Comments

An Involuntary Mental Patient's Right to Refuse Treatment with Antipsychotic Drugs: A Reassessment

State and federal courts generally agree that a competent,¹ involuntary mental patient² possesses the right to partake in his own treatment decisions. In the late 1970s, however, rights of incompetent,³ involuntary mental patients in the area of treatment with psychotropic—particularly antipsychotic—medication began to rise to levels comparable to those of competent patients. Lawsuits brought on behalf of mental patients, along with increased public awareness of the poor conditions of many mental hospitals, forced several state and federal courts to recognize an incompetent, involuntary mental patient's right to refuse treatment with antipsychotics.⁴ Both competent and incompetent involuntary mental patients now possess extensive rights in the management of their treatment.

The history of the recognition of the patient's right to refuse, however, is characterized by inconsistency. Several federal courts which first considered the issue of the right to refuse treatment with antipsychotics recognized a constitutional right to refuse under the fourteenth amendment's due process clause.⁵ The Supreme Court, however, later limited the effect of those earlier decisions in its remand of *Rennie v. Klein*⁶ and in its decision in *Mills v. Rogers*.⁷

1. "Competence," as used in this Article, is defined as having the mental capacity to make one's own medical treatment decisions, notwithstanding civil commitment based on general incompetence. See, e.g., *Rogers v. Okin*, 634 F.2d 650, 657 (1st Cir. 1980) ("whether the patient has the capacity to make a reasoned decision with respect to [the] proposed treatment . . .") (footnote omitted), quoted in *Rivers v. Katz*, 67 N.Y.2d 485, 498, 495 N.E.2d 337, 343, 504 N.Y.S.2d 74, 81 (1986).

2. An "involuntary mental patient" is a person who is civilly committed in a state mental institution against his will.

3. As opposed to "competence," "incompetence" is not possessing the mental capacity to make one's own medical treatment decisions. See generally Roth, Meisel & Lidz, *Test of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279 (1977).

The thesis of this Comment assumes that the competency determination of the patient has been made and that the patient already has been deemed incompetent.

4. See generally DuBose, *Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patient Justify Involuntary Treatment?*, 60 MINN. L. REV. 449 (1976); Gelman, *Mental Hospital Drugs, Professionalism, and the Constitution*, 72 GEO. L.J. 1725 (1984); Rhoden, *The Right to Refuse Psychotropic Drugs*, 15 HARV. C. R. C. L. REV. 363 (1980); Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219 (1985); Note, *The Right to Refuse Antipsychotic Drug Treatment: Substantive Rights and Procedural Guidelines in Massachusetts*, 7 W. NEW ENG. L. REV. 125 (1984); Note, *A Common Law Remedy for the Forcible Medication of the Institutionalized Mentally Ill*, 82 COLUM. L. REV. 1720 (1982).

5. See *Davis v. Hubbard*, 506 F. Supp. 915 (N.D. Ohio 1980); *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291 (1982); *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978) (class certified; preliminary injunction granted), *modified*, 653 F.2d 836 (3d Cir. 1981) (en banc), *vacated*, 458 U.S. 1119 (1982).

6. 458 U.S. 1119 (1982).

7. 457 U.S. 291 (1982).

In *Rennie*, the Third Circuit Court of Appeals recognized that an involuntary mental patient's right to refuse treatment with antipsychotic medication is a protected liberty interest under the fourteenth amendment.⁸ In addition, the court of appeals devised a rather elaborate due process mechanism to protect that right.⁹ On appeal, the Supreme Court vacated the Third Circuit's decision in *Rennie*,¹⁰ remanding it for decision in light of *Youngberg v. Romeo*,¹¹ a 1982 Supreme Court decision. In *Romeo*, the Court considered "for the first time the substantive [due process] rights of involuntarily committed mentally retarded persons."¹² *Romeo*, a "profoundly retarded" man with the mental capacity of an eighteen-month old child, had been committed to a Pennsylvania state mental institution at the behest of his mother.¹³ After *Romeo's* commitment, his mother became concerned about injuries he had suffered in the institution. She filed a section 1983 action as his "next friend" claiming that officials of the institution had violated his constitutional rights by failing to take appropriate measures to protect him against injuries.¹⁴ That suit presented the Court with the question of whether *Romeo* had "substantive rights under the due process clause of the fourteenth amendment to (i) safe conditions of confinement; (ii) freedom from bodily restraints; and (iii) training or 'habilitation.'"¹⁵ The Court held that the Constitution required only the exercise of professional judgment by a member of the professional staff in the deprivation of the patient's rights.¹⁶ Decisions made by professionals were therefore to be deemed "presumptively valid."¹⁷ Only where the decision was "such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment" could liability be imposed.¹⁸ The Court justified its holding by saying:

Such a presumption is necessary to enable institutions of this type—often, unfortunately, overcrowded and understaffed—to continue to function. A single professional may have to make decisions with respect to a number of residents with widely varying needs and problems in the course of a normal day. The administrators, and particularly professional personnel should not be required to make each decision in the shadow of an action for damages.¹⁹

Therefore, on remand, the Third Circuit in *Rennie* was to analyze the patient's right in light of "presumptively valid" treatment decisions under the *Romeo* standard.

The Court in *Mills v. Rogers* held that an involuntary mental patient only possesses a qualified fourteenth amendment right to refuse treatment with

8. *Rennie v. Klein*, 653 F.2d 836, 843 (3d Cir. 1981).

9. *Id.* at 848-54.

10. *Rennie v. Klein*, 458 U.S. 1119 (1982) *vacating* 653 F.2d 836 (3d Cir. 1981).

11. 457 U.S. 307 (1982).

12. *Id.* at 314.

13. *Id.* at 309-10.

14. *Id.*

15. *Id.* at 309.

16. *Id.* at 323.

17. *Id.*

18. *Id.*

19. *Id.* at 324-25.

antipsychotics.²⁰ Nevertheless, the Court in *Mills* did acknowledge that states are free to provide more protection under their own constitutional or statutory due process provisions.²¹ Therefore, though it is a bit uncertain, it seems from the Supreme Court's dispositions of *Youngberg*, *Rennie*, and *Mills*, that the federal courts will recognize an involuntary patient's constitutional right to refuse treatment, yet will limit the due process protection to shield that right.

Many states, as a result, have responded with vigor to the involuntary patient's situation and have provided extensive due process protection for the involuntary patient.²² Thus, a dichotomy has arisen—in the right-to-refuse area—between *Romeo's* call for increased judicial deference to professional decisions on the one hand, and the expansive protection states have provided to involuntary patients on the other.

This Comment will address this dichotomy and propose a more limited right of an involuntary mental patient to refuse treatment with antipsychotic drugs along with a different state due process procedure which provides state protection of that right. This Comment initially discusses the historical background of the states' recognition of the right and addresses the nature of antipsychotic medication. It then analyzes and criticizes the judicial analyses of the facts surrounding the right to refuse treatment cases and calls for a much more qualified right to refuse treatment. This Comment also analyzes the procedural mechanisms courts have established to protect the patient's right. Finally, it also sets forth alternative factors for courts and legislatures to consider in establishing due process protection for the patient's right to refuse treatment in light of Part II's proposal for a more qualified right.

I. BACKGROUND

A. *The Incompetent, Involuntary Patient's Right to Refuse Treatment with Antipsychotic Medication*

The state courts' analyses recognizing the right to refuse treatment are similar. Since state judicial decisions finding this right have relied heavily on pre-*Mills* federal decisions,²³ as well as state precedent, in reaching their conclusions, both state and pre-*Mills* federal decisions must be studied in order to fully comprehend the rationale state courts have used in recognizing the incompetent, involuntary patient's right to refuse treatment. The analysis courts have used can be broken down into three primary elements. The first element focuses on the nature of antipsychotic medication. The courts which have recognized a right to refuse treatment with antipsychotic drugs have viewed these drugs with great suspicion.²⁴ In general, they have focused

20. 457 U.S. 291, 299 (1982).

21. *Id.* at 300.

22. *See, e.g.*, *Goedecke v. State*, 198 Colo. 407, 603 P.2d 123 (1979); *In re Roe*, III, 383 Mass. 415, 421 N.E.2d 40 (1981); *Rivers v. Katz*, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986); *State ex. rel. Hawks v. Lazaro*, 157 W.Va. 417, 202 S.E.2d 109 (1974).

23. *See supra* note 5.

24. *See infra* text accompanying notes 62–80.

on the drugs' deleterious short-term and long-term side effects without carefully considering their positive, therapeutic effects.²⁵

The constitutional application of the various state due process provisions to the nature of antipsychotic drugs comprises the second element. These various due process provisions protect the patient's liberty interest in freedom from government interference with one's mental processes and with one's body.²⁶ The courts recognizing this right have held that since antipsychotic medication is inherently detrimental to the patient, so long as the patient is competent to make his own treatment decisions, the patient's decision to refuse treatment with the medication is part of the patient's protected liberty interest under both state and federal due process clauses.²⁷ Thus, the first element's factual determination regarding the nature of the medication is "bound-up" with the second element's constitutional application. By opining that the drugs' deleterious effects outweigh their positive effects on the patient, it was relatively simple for the courts recognizing a right to refuse treatment to conclude that these deleterious effects pose a threat to mental patient's liberty interest. From this recognition that the drugs present a real danger to the patient, the courts have made two conclusions. First, the courts have reasoned that some sort of process is due in order to determine whether the patient is competent to make his own treatment decision.²⁸ Second, if the patient is deemed incompetent, due process is required to determine whether the treatment proposed is "least restrictive" in terms of the drugs' negative effect(s) on the patient and the availability of any alternatives to the use of antipsychotic treatment.²⁹

The third and final element of the right to refuse analysis is the state's interest in treating the patient. The courts, in general, have held that the right to refuse treatment is qualified by several legitimate state interests which may override the patients' protected liberty interest. First, if the patient presents a danger to himself or to others, the state may use its police power to forcibly medicate the patient.³⁰ Second, if the patient does not possess the competence necessary to make his own treatment decisions, the state may use its *parens patriae* power to forcibly medicate the patient.³¹ The treatment the state proposes, however, must be the "least restrictive"—that is, the deleterious side effects of the drugs administered to the patient must be no more

25. *Id.*

26. See generally *Mills v. Rogers*, 457 U.S. 291, 299 (1982); *Rennie v. Klein*, 653 F.2d 836, 844-46 (3d Cir. 1981); *Davis v. Hubbard*, 506 F. Supp. 915, 929-36 (N.D. Ohio 1980); *In re Roe*, III, 383 Mass. 415, 433 n.9, 421 N.E. 41, 51 n.9 (1981); *Rivers v. Katz*, 67 N.Y.2d 485, 495 N.E.2d 337, 341, 504 N.Y.S.2d 74, 78 (1986); *In re K.K.B.*, 609 P.2d 747, 749 (Okla. 1980).

27. See *Rennie v. Klein*, 653 F.2d 836, 843-44 (3d Cir. 1981); *Rogers v. Okin*, 634 F.2d 650, 656, 659-60 (1st Cir. 1980).

28. *Rennie v. Klein*, 653 F.2d 836, 848-52 (3d Cir. 1981); *Rogers v. Okin*, 634 F.2d 650, 659-60 (1st Cir. 1980).

29. See *Rennie v. Klein*, 653 F.2d 836, 845 (3d Cir. 1981); *Rogers v. Okin*, 634 F.2d 650, 654-55 (1st Cir. 1980); *In re Roe*, III, 383 Mass. 415, 434-43, 421 N.E.2d 41, 52-56 (1981); see also *Davis v. Hubbard*, 506 F. Supp. 915, 934-35 (N.D. Ohio 1980).

30. See *Rennie v. Klein*, 653 F.2d 836, 845 (3d Cir. 1981); *Davis v. Hubbard*, 506 F. Supp. 915, 935 (N.D. Ohio 1980); *Rivers v. Katz*, 67 N.Y.2d 485, 498, 495 N.E.2d 337, 344, 504 N.Y.S.2d 74, 81 (1986).

31. *Parens patriae* refers traditionally to the role of the state as sovereign and guardian of persons under legal disability. See generally *West Virginia v. Chas Pfizer & Co.*, 440 F.2d 1079, 1089 (2d Cir. 1971).

severe than necessary in order to effectively treat the patient.³² Therefore, the courts must determine whether the patient is competent to make his decision and, if not, whether the treatment plan proposed is indeed "least restrictive."

B. The Nature of Antipsychotic Medication

1. In General

Antipsychotics are psychotropic drugs used, in general, to treat schizophrenic and other psychotic disorders.³³ They are widely accepted in present psychiatric practice as the treatment of choice for schizophrenia.³⁴ Because the controversy in the right to refuse treatment cases has centered primarily around the forcible use of antipsychotics, their effects and side effects have received the greatest attention.

Psychotic patients with schizophrenic symptoms such as loose association,³⁵ autism,³⁶ hallucinations,³⁷ delusions,³⁸ and paranoid ideation³⁹ normally are treated antipsychotics. The prescribed antipsychotic is designed to alleviate the severity of these symptoms, as well as restore the patient's cognitive faculties.⁴⁰ Though the drugs are not a "cure" for schizophrenia or other psychotic disorders, many psychiatrists maintain that such alleviation is a necessary component of successful treatment.⁴¹

The initial effect of the drugs is sedative.⁴² According to several medical authorities, this sedative effect must be distinguished from the drugs' antipsychotic effect, which may take several weeks to fully develop.⁴³ The positive antipsychotic effects are varied. In schizophrenic patients, various studies demonstrate that

32. See *Rennie v. Klein*, 653 F.2d 836, 844-46 (3d Cir. 1981); *Davis v. Hubbard*, 506 F. Supp. 915, 935 (N.D. Ohio 1980).

33. See generally A. CANCRO, *SCHIZOPHRENIA: CLINICAL ASPECTS AND BIOLOGICAL BASES OF PSYCHIATRIC DISORDERS* (1977).

34. *Rone v. Frieman*, 473 F. Supp. 92, 108 (N.D. Ohio 1979).

35. In psychiatry, "loose association" is a disorder in thinking in which associations of ideas become so shortened, fragmented, and disturbed as to lack logical relationship. *DORLAND'S ILLUSTRATED MEDICAL DICTIONARY* 130 (26th ed. 1985).

36. "Autism" is defined as the condition of being dominated by subjective, self-centered trends of thought or behavior. *Id.* at 140.

37. "Hallucinations" are a sense perception without a source in the external world; a perception of an external stimulus object in the absence of such an object. *Id.* at 578.

38. "Delusions" are a false personal belief based on incorrect inferences about external reality and firmly maintained in spite of incontrovertible and obvious proof or evidence to the contrary. *Id.* at 355.

39. "Paranoia" is a chronic, slowly progressive mental disorder characterized by the development of ambitions or suspicions into systematized delusions of persecution and grandeur which are built up in a logical form. *Id.* at 966.

40. See, e.g., THE NATIONAL INSTITUTE OF MENTAL HEALTH PSYCHOPHARMACOLOGY SERVICE CENTER COLLABORATIVE STUDY GROUP, *Phenothiazine Treatment in Acute Schizophrenia: Effectiveness*, 10 *ARCHIVES GEN. PSYCHIATRY* 246 (1964); Goldberg, Klerman, & Cole, *Changes in Schizophrenic Psychopathology and Ward Behaviour as a Function of Phenothiazine Treatment*, 111 *BRIT. J. PSYCHIATRY* 120 (1965).

41. See generally D. KLEIN, R. GILLETMAN, F. QUITKIN & A. RIFKIN, *DIAGNOSIS AND DRUG TREATMENT OF PSYCHIATRIC DISORDERS: ADULTS AND CHILDREN* 88-144 (2d ed. 1980); Gutheil & Appelbaum, "Mind Control," "Synthetic Sanity," "Artificial Competence," and *Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 *HOFSTRA L. REV.* 77, 100-01 (1983).

42. Byck, *Drugs and the Treatment of Psychiatric Disorders*, in *THE PHARMACOLOGICAL BASIS OF THERAPEUTICS* 158 (L. Goodman & A. Gilman eds. 1975).

43. *Id.*; Frazier & Winokur, *Therapeutic and Pharmacological Aspects of Psychotropic Drugs*, in *BIOLOGICAL BASES OF PSYCHIATRIC DISORDERS* 151, 156 (A. Frazier & A. Winokur eds. 1977); Fink & Abrams, *Selective Drug Therapies in Clinical Psychiatry: Neuroleptic, Anxiolytic, and Antimanic Agents*, in *TREATING MENTAL ILLNESS* 287, 306 (A. Freedman & H. Kaplan eds. 1972).

antipsychotics: (1) reduce mental confusion and improve speech order;⁴⁴ (2) reduce conceptual disorganization;⁴⁵ (3) reduce errors on the digit symbol subtest of the Wechsler Adult Intelligence Scale;⁴⁶ (4) reduce delays of information processing;⁴⁷ and (5) reduce overinclusive thinking.⁴⁸ In addition, at least one study has determined that when treatment is successful, discontinuation of the medication will often lead to a relapse of the illness.⁴⁹

Many of the judicial opinions recognizing a right to refuse have emphasized the deleterious side effects of antipsychotics.⁵⁰ It is clear from the medical literature that such side effects do occur. With regard to short-term side effects, judicial emphasis has been on the most extreme side effects, a class of motor impairments including dystonias,⁵¹ dyskinesias,⁵² and akathisia.⁵³ Though these effects can be quite severe, they can all be alleviated through either a reduction in the dose of medication or through the administration of "anti-parkinsonian" medication, a drug which counteracts the effects of the antipsychotics on the motor system without interfering with the beneficial effects on cognition.⁵⁴

One of the long-term side effects courts often referred to in the right-to-refuse cases is tardive dyskinesia.⁵⁵ The symptoms of tardive dyskinesia include involuntary movements of the muscles of the face, arm, and leg.⁵⁶ However, tardive dyskinesias usually appears only after prolonged use.⁵⁷ Although the incidence of tardive dyskinesias is unclear, it has been estimated that ten to forty percent of patients receiving long-term treatment may be affected.⁵⁸ Most courts which have recognized an involuntary patient's right to refuse treatment, however, have overlooked the fact that the symptoms of tardive dyskinesias are usually mild, not necessarily progressive, and very often disappear if the administration of the antipsychotic is halted.⁵⁹ Thus, though antipsychotics do possess the potential for causing adverse short and

44. Porteus, *Specific Behavior Changes Following Chlorpromazine*, 21 J. CONSULTING PSYCHOLOGY 257, 260 (1957).

45. Abrams, *Chlorpromazine in Treatment of Chronic Schizophrenia*, 19 DISEASES NERVOUS SYSTEM 20, 27-28 (1958). See also Clark, Ray & Ragland, *Chlorpromazine in Chronic Schizophrenic Women: Rate of Onset and Rate of Dissipation of Drug Effects*, 25 PSYCHOSOMATIC MED. 212 (1963).

46. The Wechsler Adult Intelligence Scale is a successor to the Weschler-Bellevue Intelligence Scale (WBIS). The WBIS is an early version of the standard IQ test that compares subjects' responses on a large number of questions to standardized norms. The test has a number of subsections that measure both verbal and performance skills. Gutheil & Appelbaum, *supra* note 41, at 104.

47. Baff & Saccuzzo, *Effect of Antipsychotic Medication on Speed of Information Processing in Schizophrenic Patients*, 139 AM. J. PSYCHIATRY 1127 (1982).

48. Phillipson, Baker & Williams, *Changes in "Overinclusive" Thinking of Schizophrenic Patients is Related to Plasma Phenothiazine Concentration*, 24 ADVANCES IN BIOCHEMICAL PSYCHOPHARMACOLOGY 591 (1980).

49. Davis, *Overview: Maintenance Therapy in Psychiatry I.: Schizophrenia*, 132 AM. J. PSYCHIATRY 1237 (1975).

50. See *infra* text accompanying notes 58-77.

51. The label "dystonia" describes acute and often painful spasms of muscle groups in the neck, back, face, eyes, or elsewhere in the body. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 415 (26th ed. 1985).

52. "Dyskinesias" is a condition of involuntary, repetitive motor movements, such as flicking the tongue in and out of the mouth or complex movements of the fingers. *Id.* at 412.

53. "Akathisia" is an emotional state characterized by a subjective need or desire to move. *Id.* at 42.

54. See Gutheil & Appelbaum, *supra* note 41, at 108.

55. See, e.g., Davis, v. Hubbard, 506 F. Supp. 915, 928-29 (N.D. Ohio 1980); Rivers v. Katz, 67 N.Y.2d 485, 490 n.1, 495 N.E.2d 337, 339 n.1, 504 N.Y.S.2d 74, 76 n.1 (1986).

56. AMERICAN PSYCHIATRIC ASSOCIATION, TASK FORCE REPORT NO. 18: TARDIVE DYSKINESIA 57 (1979).

57. *Id.*

58. *Id.* at 44.

59. *Id.* at 24-28.

long-term side effects, these side effects can be avoided, reduced, or even eliminated through careful medical monitoring and remedial action.⁶⁰

2. Judicial Perceptions of Antipsychotic Drugs—The First Element

The first element of the right-to-refuse analysis concerns judicial perceptions of antipsychotics. In general, the courts which have recognized a right to refuse have viewed these drugs with a great deal of suspicion. Though there are a large number of medical studies which have found treatment with antipsychotic drugs positive and that any negative side effects can be effectively mitigated,⁶¹ the courts have focused primarily on the deleterious short and long-term side effects of the medication without carefully considering these positive aspects and mitigating devices. A clash has therefore surfaced between various psychiatric perceptions and the majority of judicial perceptions of antipsychotics.

The state opinions which have recognized a right to refuse treatment have been fairly consistent in scrutinizing the therapeutic benefits of antipsychotic medication.⁶² Each of the following opinions either ignores or belittles the powerful medical literature available concerning the positive effects antipsychotics may have on the patient. The opinions also ignore the fact that any deleterious side effects which may arise through treatment with the drug can be adequately mitigated by the treating physician. Instead, as in the federal opinions, the courts unfairly characterize antipsychotics in conclusory and pejorative terms which minimize the positive attributes of antipsychotic medication.

For example, in *Goedecke v. State*⁶³ the Colorado Supreme Court found that a civilly committed inpatient possessed the right to refuse treatment with the antipsychotic drug prolixin.⁶⁴ The court focused on prolixin's negative side effects and determined that the physicians had chosen to use prolixin in treatment in order to "alter [the patient's] psychotic thought patterns."⁶⁵ The court also emphasized prolixin's "behavior-modifying capacity," and detailed its negative side effects.⁶⁶

60. See Gutheil & Appelbaum, *supra* note 41 at 109.

61. The studies emphasizing the therapeutic benefits of antipsychotics are too numerous to list in one footnote. For articles listing many of these studies, see generally Appelbaum & Gutheil, *The Boston State Hospital Case: "Involuntary Mind Control," the Constitution and the "Right to Rot"* 137 AM. J. PSYCHIATRY 720 (1980); Appelbaum & Gutheil, *"Rotting With Their Rights On": Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients*, BULL. AM. ACAD. PSYCHIATRY & LAW 306 (1979); Gutheil, *Restraint vs. Treatment: Seclusion as Discussed in the Boston State Hospital Case*, 137 AM. J. PSYCHIATRY 718 (1980). There are, however, many articles listing studies with opposing views. These studies have caught the courts' attention much more frequently than the former studies. For articles listing such studies, see generally Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U.L. REV. 461 (1977); Rhoden, *The Right to Refuse Psychotropic Drugs*, 15 HARV. C.R.-C.L. L. REV. 363 (1980); Note, *The Right to Refuse Antipsychotic Drug Treatment: Substantive Rights and Procedural Guidelines in Massachusetts*, 7 W. NEW ENG. L. REV. 125 (1984); Note, *A Common Law Remedy for the Forcible Medication of the Institutionalized Mentally Ill*, 82 COLUM. L. REV. 1720 (1982). At the very least, this argument concerning the benefits of antipsychotics suggests that courts should analyze the effects of antipsychotics more closely, for the area is not as clear as the courts' opinions suggest.

62. *Rogers v. Okin*, 478 F. Supp. 1342, 1360 (D. Mass. 1979).

63. 198 Colo. 407, 603 P.2d 123 (1979).

64. *Id.* at 411, 603 P.2d at 125.

65. *Id.* at 409-10, 603 P.2d at 124.

66. *Id.*

Another example is *In re K.K.B.*,⁶⁷ where the Oklahoma Supreme Court, in finding a right to refuse, characterized the antipsychotic medication in derogatory language similar to that of the other opinions which had recognized the right.⁶⁸ The court concerned itself almost exclusively with the drug's deleterious side effects and de-emphasized any therapeutic benefits. Indeed, the court generalized that the medication was marginally beneficial in treating a schizophrenic patient: "[T]he precise nature of the benefits of these drugs is as yet uncertain and the dangers the drugs seek to avoid are usually not great."⁶⁹

The Massachusetts Supreme Judicial Court's opinion in *In re Roe, III*⁷⁰ utilizes the same approach. In *Roe*, the Massachusetts court characterized the drugs in the following negative fashion:

A single injection of Haldol . . . can be effective for ten to fourteen days. The drugs are powerful enough to immobilize mind and body. Because of both the profound effect that these drugs have on the thought processes of an individual and the well-established likelihood of severe and irreversible adverse side effects . . . we treat these drugs in the same manner we would treat psychosurgery or electroconvulsive therapy . . . While the actual physical invasion involved in the administration of these drugs amounts to no more than an injection, the impact of the chemicals upon the brain is sufficient to undermine the foundations of personality.⁷¹

In addition, the court unfairly emphasized the "extreme" nature of antipsychotic treatment and stated that "among the most important reasons for their continued use is to control behavior."⁷² This simply is not true as the previous discussion of antipsychotics indicates.⁷³

Finally, the New York Court of Appeals' decision in *Rivers v. Katz*⁷⁴ held that treatment with antipsychotic drugs is presumptively harmful and discounted the beneficial impact the drugs may have on the patient:

Antipsychotic drugs, also known as "major tranquilizers" and "neuroleptics," are psychotropic drugs widely used in the treatment of mental illness, especially schizophrenia. Although they do not cure psychotic illness, their medical usefulness stems from their ability to influence thought patterns so as to eliminate psychotic symptoms . . . Numerous side effects are associated with their usage . . . The most potentially devastating side effect is tardive dyskinesia, an irreversible neurological disorder characterized by involuntary, rhythmic and grotesque movements of the face, mouth, tongue, jaw and extremities. Although this condition is fairly widespread, it is impossible to predict who will be a victim . . .⁷⁵

These various state opinions indicate a strong judicial prejudice against antipsychotics in right-to-refuse cases. This prejudice, in turn, forces the courts

67. 609 P.2d 747 (Okla. 1980).

68. *Id.* at 748 n.3.

69. *Id.* at 748.

70. 383 Mass. 415, 421 N.E.2d 40 (1981).

71. *Id.* at 436-37, 421 N.E.2d at 52-53.

72. *Id.* at 437, 421 N.E.2d at 53.

73. See *supra* text accompanying notes 33-60.

74. 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986).

75. *Id.* at 490 n.1, 495 N.E.2d at 339 n.1, 504 N.Y.S.2d at 76 n.1.

addressing the issue to recognize a broad right to refuse. However, as will be shown, if the courts perceive antipsychotics more realistically, a more limited right for the patient should result.

II. A CRITIQUE OF THE COURTS' PERCEPTION OF ANTIPSYCHOTICS UNDER THE FIRST ELEMENT

A constitutional right to refuse treatment with antipsychotics, as earlier stated, is based on the patient's liberty interest.⁷⁶ In order for the patient's interest to be asserted there must be a sufficient threat to that interest. In determining whether such a threat is present, two factors are relevant. First, the patient is confined to a mental institution against his will in order to be treated. This is a facet of the right-to-refuse cases which nearly every court has either overlooked or simply glossed over.⁷⁷ Therefore, there is a compelling state interest in treating the patient in order that he may one day return to society as a "normal" citizen. In addition, the patient *must* be treated or else he is being unconstitutionally confined. For example, in Ohio, it is statutorily required that the patient either be treated or released.⁷⁸ Other states have similar statutory provisions.⁷⁹ If the state has confined the patient and if the state must treat the patient, then it logically follows that a presumption is created in favor of the state in treating the patient, so long as the patient is incompetent to make his own treatment decisions.⁸⁰ If the patient is competent, however, then the state cannot forcibly medicate the patient absent other compelling state interests.⁸¹ This presumption in favor of treatment does not end the analysis in determining whether a threat to the patient's liberty interest is present because the mere state of confinement does not mean a state can arbitrarily infringe upon the patient's constitutional rights.

Second, antipsychotics do not pose a substantial threat to the patient's liberty interest if mitigating factors are present.⁸² Antipsychotics do cause negative side effects.⁸³ But they also cause positive effects.⁸⁴ Yet the courts have felt comfortable in discarding these positive effects and finding the negative effects more compelling.

76. See *supra* text accompanying notes 30-60.

77. This does not mean it has been completely ignored. See *supra* text accompanying notes 27-30.

78. OHIO REV. CODE ANN. § 5122.27 (Anderson 1981). Cf. *Rone v. Frieman*, 473 F. Supp. 92 (N.D. Ohio 1979), where the court held that where a patient is confined he must be treated by the state with the "means least burdensome to the patient."

79. See, e.g., ARIZ. REV. STAT. ANN. § 36-540 (1986); CAL. WELF. & INST. CODE § 5008(n) (West 1984); IOWA CODE ANN. § 229.1 (West 1985); N.Y. MENTAL HYG. LAW § 31.31 (McKinney 1978); S. C. CODE ANN. § 44-17-580 (Law. Co-op. 1985).

80. See *supra* text accompanying notes 26-28. See also *State v. Carter*, 64 N.J. 382, 394, 316 A.2d 449, 456 (1974) (treatment is "inherent in the rationale [for commitment]").

81. See *supra* text accompanying notes 27-30. See also *Price v. Sheppard*, 307 Minn. 250, 258-59, 239 N.W.2d 905, 911 (1976):

The question in the case before us is whether the state, consistent with [plaintiff's] right of privacy, can assume the decision of whether [plaintiff], an involuntarily committed mental patient, will undergo psychiatric treatment. We observe that the more fundamental decision, whether he was to undergo hospitalization, was assumed by the state at the commitment proceeding, the validity of which is not contested. . . . If th[e] interest of the state is sufficiently important to deprive an individual of his physical liberty, it would seem to follow that it would be sufficiently important for the state to assume the treatment decision. We hold that it is.

82. See *supra* text accompanying notes 50-60.

83. See *supra* text accompanying notes 50-57.

84. See *supra* text accompanying notes 42-49.

Such loaded terms as "involuntary mind control" are used casually, familiarly, and uncritically, and are therefore wrong. These characterizations are simply not in conformity with a great deal of medical analysis.⁸⁵ As a consequence, these implicit pejorative connotations downplay the essentially therapeutic, normative, and restorative effects of properly prescribed antipsychotic medication. These positive effects act as a counter to the intrusion on the patient's liberty interest. Moreover, the courts' negative connotations also ignore the mitigating devices of proper medical supervision and remedial action. In addition, the courts' language does not reveal the fact that psychiatrists do not administer antipsychotics in an attempt to "control" minds, but rather to restore minds to the patient's control.⁸⁶ Interestingly, these decisions ignore the decisions in criminal cases concerning the effect of antipsychotic drugs. These latter cases present quite a different view of antipsychotics. In the following cases, a mentally ill defendant has been treated with antipsychotic medication to enable him both to properly assist his attorney and to understand the proceedings against him.⁸⁷ Often these defendants allege insanity as a defense and argue, therefore, that they are entitled to present their true demeanor and mental disposition before the jury and have a right to be tried in an unmedicated state.⁸⁸

In *State v. Jojola*,⁸⁹ the Court of Appeals of New Mexico refused to recognize a fifth amendment-based right of a criminal defendant to stand trial in an unmedicated state. In so holding, the court characterized the therapeutic effects of antipsychotic medication as follows:

There is no evidence that [the drug] affected defendant's thought processes or the content of defendant's thoughts; the affirmative evidence is that [the drug] allows the cognitive part of the brain to come back into play. The expert witness declined to call [the drug] a mind altering drug. Rather, [the drug] allows the mind to operate as it might were there not some organic or other type of illness affecting the mind.⁹⁰

In *State v. Hayes*,⁹¹ the New Hampshire Supreme Court refused to find that the defendant had an absolute fifth amendment right to refuse to stand trial because he had been treated with antipsychotic drugs. In so holding, the court found that antipsychotics possess substantial normalizing tendencies which aid in restoring the patient's competency:

In the case before us there is no evidence that the drugs administered to the defendant affected the process or content of his thoughts. To the contrary, all the evidence indicates that the drugs used here allow the cognitive part of the defendant's brain, which has been altered by the mental disease, to come back into play. All the expert evidence supports the conclusion that the medication has a beneficial effect on the defendant's ability to function

85. See *supra* text accompanying notes 33-60.

86. See generally Gutheil, *Restraint vs. Treatment: Seclusion as Discussed in the Boston State Hospital Case*, 137 AM. J. PSYCHIATRY 718 (1980).

87. See *infra* text accompanying notes 88-94.

88. *Id.*

89. 89 N.M. 489, 553 P.2d 1296 (Ct. App. 1976).

90. *Id.* at 492, 553 P.2d at 1299.

91. 118 N.H. 458, 389 A.2d 1379 (1978).

and that without the medication he is incompetent to stand trial. There is no evidence that the defendant's competence to stand trial can be maintained by less intrusive techniques.⁹²

In *State v. Law*,⁹³ the South Carolina Supreme Court reached a similar conclusion to the fifth amendment issue presented in both *Jojoba* and *Hayes*. In analyzing the effects of the drugs, the court likewise noticed: "The consensus of the medical testimony at both the competency hearing and trial indicated that the psychotropic medications had positive effects, reversing the active state and allowing [the appellant] to function in a more rational manner."⁹⁴

It is conceivable that the difference in the rights comprising the underlying subject matter before the civil and criminal courts, one under due process and the other under the fifth amendment, may have led the courts to perceive the effects of antipsychotics differently. In civil cases, courts are usually concerned about possible ill effects of forced treatment on hospitalized psychiatric patients. In contrast, in criminal cases, courts are generally suspicious of defendants attempting to overturn convictions on the basis of competency caused by the medication at the time of trial. Yet, these divergent views on the same medications cannot be justified merely by saying different constitutional rights are at issue. Either the effects of these medications extend beyond the mere alleviation of psychotic symptoms or they do not. Either the drugs adversely affect the patient's mentation or they do not. At the very least, courts should begin their legal analysis, whether it be in a civil or criminal action, on the basis of a common set of factual presumptions concerning antipsychotic medication. Any other result simply serves to bring inconsistency and confusion when administration of antipsychotics are at issue.

One possible solution to remedy the problems that have been raised may be to eliminate the patient's right to refuse treatment with antipsychotics. Elimination of the right to refuse, however, is unacceptable for three reasons. First, the patient possesses a right to partake in the treatment process. This is a fundamental concept and cannot be altered. Second, the right to refuse is thoroughly ingrained in many jurisdictions. Elimination of the right to refuse would result in inconsistency in judicial decisions as well as legislative policy decisions. Third, elimination of the right to refuse is unnecessary. The issues raised in this Comment can be adequately addressed while preserving the patient's right to refuse treatment.

A preferred solution would therefore involve qualifying the existing right to refuse. As mentioned earlier, antipsychotics do indeed present real dangers to the patient in the form of deleterious side effects.⁹⁵ The courts have been correct in recognizing that these dangers exist. But the courts have been overly suspicious of the drugs and have not carefully assessed their therapeutic benefits and the potential mitigating devices to eliminate the negative side effects. Furthermore, the courts have been inconsistent, as demonstrated in the contrast with criminal suits, in character-

92. *Id.* at 461, 389 A.2d at 1381.

93. 270 S.C. 664, 244 S.E.2d 302 (1978).

94. *Id.* at 671, 244 S.E.2d at 306.

95. See *supra* text accompanying notes 47-57.

izing the drugs. A more qualified right would add consistency with the facts as they exist without eliminating the protection of the patient's liberty interest.

III. DUE PROCESS—THE SECOND AND THIRD ELEMENTS

A. *The Proposed Standards and Their Inadequacies*

The judicial recognition of an expansive right to refuse treatment for involuntary patients has not only presented factual and evidentiary problems to the courts, but due process problems as well. For example, Massachusetts currently employs the following judicially created due process framework for protecting the involuntary patient's right to refuse treatment.⁹⁶ The determination of a patient's competency is to be held before the courts.⁹⁷ In general, a person, whether committed or not, is presumed to be competent unless shown by the evidence not to be competent.⁹⁸ If the patient is deemed incompetent, then it is up to the court to appoint a guardian and to make a "substituted-judgment decision"—that is, it is up to the guardian to make treatment decisions for the patient.⁹⁹ In making the substituted judgment decision, the court must take into account the following factors: (1) the patient's express preferences regarding treatment;¹⁰⁰ (2) the strength of the patient's convictions to the extent they contribute to the refusal of treatment;¹⁰¹ (3) the impact of the decision on the patient's family;¹⁰² (4) the probability of adverse side effects;¹⁰³ (5) the prognosis with treatment;¹⁰⁴ and, (6) the prognosis without treatment.¹⁰⁵ If the judge decides to order treatment, she must then authorize a detailed treatment program which governs which drugs are to be used and when they are to be administered.¹⁰⁶ The guardian would monitor the treatment program.¹⁰⁷

The Massachusetts procedural mechanism poses a number of problems. First, it places too much confidence in the court to make complex treatment decisions. A court is simply not trained in prescribing treatment programs and should not attempt to do so.¹⁰⁸ Second, this procedure adds various costs onto the mental health system. For example, an elaborate due process mechanism may delay effective treatment of the patient. If in fact antipsychotic treatment is a necessary component of that treatment, the various due process steps and hurdles will only serve to postpone the patient's recovery. This delay ultimately hurts the patient and hampers the exigencies

96. *In re Roe*, III, 383 Mass. 415, 421 N.E.2d 40 (1981).

97. *Id.* at 435, 421 N.E.2d at 52.

98. *Id.* at 441, 421 N.E.2d at 55.

99. *Id.* at 442, 421 N.E.2d at 56.

100. *Id.* at 444, 421 N.E.2d at 57.

101. *Id.*

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

106. *Id.* at 448, 421 N.E.2d at 59.

107. *Id.* at 443, 421 N.E.2d at 56.

108. See generally Guthel, *supra* note 87. The Third Circuit recognized this limitation in *Rennie v. Klein*, 653 F.2d 836 (3d Cir. 1981), inferring that it is better to have "mental health professionals rather than judges who have doffed their black robes and donned white coats" make these decisions. *Id.* at 851.

of effective medical treatment. In addition, this added delay and resulting litigation will most certainly raise the price of mental health treatment. Adversarial proceedings will require expert testimony by psychiatrists, psychologists, and other hospital staff members. Such expenditures of staff time is a cost to the mental institution which a state cannot ignore. One may argue in response that these costs are *de minimis*. But such an argument ignores the fact that since 1981 state mental health systems have faced severe cutbacks and financial constraints.¹⁰⁹ State mental institutions are currently operating on a severely limited budget with finite resources available for the care of the mentally ill. As the Third Circuit in *Rennie v. Klein* recognized: "Diversion of these funds to finance nonessential administrative procedures, however beneficial and desirable, will not provide help for the patient's most critical needs."¹¹⁰

Another example of the type of due process mechanism that results from the recognition of an expansive right to refuse treatment is found in the New York Court of Appeals' decision in *Rivers v. Katz*.¹¹¹ In *Rivers*, the court concluded that since New York's statutory administrative review procedures did not adequately protect the patient's due process rights, the patient had a right to a judicial hearing to determine his competency.¹¹² The state would bear the burden by clear and convincing evidence that the patient is incompetent to make his own treatment decisions.¹¹³ If the state could not meet its burden, the administration of the antipsychotic would be proscribed.¹¹⁴ If the patient was found to be incompetent, then the state has to prove to the court by clear and convincing evidence that the treatment is "narrowly tailored to give substantive effect to the patient's liberty interest."¹¹⁵

The New York due process mechanism is flawed, like the Massachusetts plan, by its inability to recognize any judicial deference to legitimate treatment decisions. By placing the burden of proof on the state to prove incompetency by clear and convincing evidence, the New York Court of Appeals' due process mechanism will most likely chill the entire treatment process. For example, suppose a patient asserts

109. In 1980, the federal government gave \$293 million to the states expressly for the delivery and financing of mental health care. THE BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 1982, at 239-40. In 1981, the amount was \$342 million. THE BUDGET OF THE UNITED STATES GOVERNMENT, 1982 APPENDIX at I-K25.

The Reagan Administration, however, changed the method of distribution and the amount of these funds. Under the 1983 budget, the federal government would instead distribute to the states "Block grants," lump-sum payments consolidating four different areas of federal appropriations which were earlier treated individually by the executive branch. The four areas "Block grants" cover are: (1) services for women, infants, and children; (2) health prevention and services; (3) primary care; and, (4) alcohol, drug abuse, and mental health. The Administration tentatively appropriated \$433 million of the \$1.9 billion total proposed towards alcohol, drug abuse, and mental health—\$192 million less than the amount given in 1980 for alcohol, drug abuse, and mental health. THE BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 1983, at 5-134-135. The \$1.9 billion appropriated for the "Block grants," however, turned out to be merely a proposal; only \$1.2 billion was actually distributed in 1983. THE BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 1985, at 5-130. Thus, the amount given to the states for mental health services was probably much less. The Administration's proposal for 1988 remains at \$1.2 billion. THE BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 1988, at 5-110.

110. *Rennie v. Klein*, 653 F.2d 836, 851 (3d Cir. 1981).

111. 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986).

112. *Id.* at 497-98, 495 N.E.2d at 344, 504 N.Y.S.2d at 81.

113. *Id.*

114. *Id.*

115. *Id.*

his right to refuse. The state has two options in responding. First, it could respond with vigor and the hospital, consistent with its position as a "caring institution," could gather evidence and expend a great deal of its resources in defeating the patient's assertion. The state, however, will probably not choose this option because of the inherent costs involved in litigating the patient's right. Therefore, New York's proposal, by putting the burden of proof upon the state, forces New York's mental institutions to initiate the due process mechanism and, consequently, initiate the spending of its limited resources. This is clearly not within the institution's best interests. This leads to the second and more probable option. The state could simply refuse to litigate the patient's assertion because the costs to the entire institution outweigh the benefits to the patient in defeating his right-to-refuse assertion. The hospital would therefore have no other choice than concede to the patient's demand. Thus, those patients who are incompetent could make such demands and would never be properly treated. As a consequence, the New York plan will most likely chill the entire treatment process. The New York Court of Appeals' skepticism simply does not serve the state's nor the patient's legitimate interests in mental health treatment.

B. Alternative Factors in Devising Due Process Protection

Though some type of due process protection is needed to preserve an involuntary patient's right to refuse, the proposals set forth to date do not, in general, provide adequate, efficient, or realistic due process safeguards. Inherent in all of the procedural proposals is the misconception that treatment with antipsychotics is presumptively sinister and protection from these "mind controllers" is necessitated.¹¹⁶ The proposals refuse to defer to psychiatric decisions and instead insist on a high level of judicial scrutiny over these professional decisions.¹¹⁷ Furthermore, each of these devices add additional costs onto under-budgeted health care systems. If a more qualified right to refuse is instead adopted, the due process protection mechanisms will in turn become more limited. This Part will set forth alternative factors for states to consider in crafting due process protection for a more limited right to refuse.

First, the nature of the treatment with antipsychotics must be more realistically appraised. The state must determine whether the mitigating factors of medical supervision and remedial action are present and to what extent. Such a determination will reduce legitimate concerns for the potential deleterious side effects of antipsychotics. The state must determine the duration of the treatment with antipsychotics for, as discussed earlier, tardive dyskinesia arises most frequently when antipsychotics are used for a long period of time. Finally, the availability of alternatives to antipsychotics must also be considered. By using another medication other than antipsychotics to treat the patient, the entire right-to-refuse problem could be reduced if not eliminated.

116. *See supra* text accompanying notes 61-93.

117. *Id.*

Second, the burdens of proof ought to be reversed. The courts recognizing a right to refuse have found that due process mandates that there must be an initial determination of the patient's competency. If the patient is competent to make his own treatment decisions, he then presumptively has the right to refuse medication he does not wish to take. This notion is dictated by the law of battery and by the principle of autonomy which underlies the physician-patient relationship.¹¹⁸ If the patient is deemed incompetent, then the courts have found that due process requires the treatment prescribed to be "least restrictive." The state would bear the burden of proof in each of these determinations (competency and the nature of the treatment).¹¹⁹ But, if the courts recognize a more qualified right to refuse treatment with antipsychotics, with an acknowledgment that antipsychotics do not pose as great a threat to the patient as earlier believed, then coupled with that recognition would be a due process mechanism which is less comprehensive. Consistent with a less comprehensive due process procedure would then be a reallocation of burdens, for if the danger is not that great, then the patient ought to bear the burden of proof if the right to refuse is asserted.¹²⁰ In addition, this allocation is more consistent with the fact that since the patient is involuntarily committed, there exists a presumption in favor of treatment on the part of the state.¹²¹ Moreover, this allocation will tend to limit "frivolous" right-to-refuse claims and enable the mental health institution, and indeed the system generally, to operate more efficiently.¹²²

Third, the state must consider the limitations of the judiciary in making medical treatment and diagnosis decisions. Such decisions require attention to intricate details and cannot be broadly discarded with a constitutional brush. The Supreme Court's words in *Youngberg v. Romeo*¹²³ should not be ignored for there is a great deal of practical wisdom in holding medical decisions "presumptively valid."¹²⁴ There are limits to the reach of judicial reasoning and complex medical diagnosis decisions are, arguably, one of those limits.¹²⁵ The issues courts and psychiatrists face are very different and personal liberty interests should not be sacrificed for more deference to medical decisions. But at least courts and state legislatures should be aware of those limits and incorporate them into their respective analyses of the right-to-refuse problem. Such an awareness makes for better reasoning.

118. See generally B. FURROW, S. JOHNSON, T. JOST, & R. SCHWARTZ, *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 853-906 (1987) (discussing the "right to die" of incompetent patients). See also *infra* note 120.

119. See *supra* text accompanying notes 96-115.

120. Possible alternatives for the patient would be to sue the state for battery if in fact the determination of incompetency turns out to be erroneous or the treatment prescribed is not "least restrictive." See W. KEETON, D. DOBBS, R. KEETON & D. OWEN, *PROSSER & KEETON ON TORTS* § 9 (1984).

121. See *supra* text accompanying note 80.

122. For example, suppose the patient is incompetent and is in need of antipsychotic treatment, yet asserts his right to refuse treatment. The resulting due process procedure will most likely be long, arduous, and costly. If the process determines that the patient is competent and needs treatment, then the process was a waste. If instead the burden were on the patient, this would most likely deter him from asserting such a claim and would cut down on the number of right-to-refuse treatment assertions. In turn, this would result in quicker adjudications.

123. 457 U.S. 307 (1982).

124. *Id.* at 323.

125. See *supra* note 108. Cf. *Jarvis v. Levine*, 403 N.W.2d 298 (Minn. App. 1987) (the "professional judgment" standard of *Youngberg v. Romeo* is all that is necessary for due process requirements to be met).

Fourth, the patient's interest in successful long-range treatment must be considered. Courts and legislatures must be aware of the inherent stress-creating atmosphere of adversarial proceedings.¹²⁶ These proceedings are therefore more likely to be counterproductive to treatment, adding to the tensions that may have contributed to the patient's initial commitment to the institution.¹²⁷ The state therefore must consider this factor if it wishes to facilitate successful long-range treatment of its mentally ill.

Fifth, and finally, states must consider the fiscal constraints mental institutions now face. When the right-to-refuse cases first arose, in the late 1970s, mental institutions were still relatively well-funded. But the 1980s have seen a severe cutback in federal funding of state mental health systems.¹²⁸ Expansive protection for patients against reasonable professional treatment decisions adds costs onto these systems which they simply cannot afford. A more qualified right to refuse can reduce some of these costs while not sacrificing the patient's protected liberty interest.

IV. CONCLUSION

The involuntary patient's right to refuse treatment with antipsychotic drugs has presented various legal, factual, and policy problems to the states. Antipsychotics simply do not pose as great of a danger to the patient as the courts have presented. The dangers that do exist can be mitigated through various medical procedures. Moreover, recognition of a more qualified right to refuse, as proposed, does not eliminate the patient's right, but simply curtails it. The patient still possesses a protected liberty interest, but the protection provided is more limited. A qualified right to refuse treatment would be more consistent with the facts as they exist, adequately promote the state's interest in treating its involuntarily committed mentally ill, and better serve the mental health system's interest on the whole, for needed funds would not be diverted. In conclusion, a more qualified right to refuse would not substantially hurt the involuntary patient and would substantially benefit the state, its mental institutions, and, ultimately, the patient himself.

James A. King

126. See *Rennie v. Klein*, 653 F.2d 836, 851 (3d Cir. 1981).

127. *Id.*

128. See *supra* note 109.