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Civil Commitment and the Right to Refuse Treatment: Resolving Disputes from a Due Process Perspective

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Civil Commitment and the Right to Refuse Treatment: Resolving Disputes from a Due Process Perspective

I. INTRODUCTION	413
II. CIVIL COMMITMENT AND PROCEDURAL DUE PROCESS	415
III. IMPROVING THE CIVIL COMMITMENT PROCESS	422
IV. THE RIGHT TO REFUSE TREATMENT	424
V. ADVERSARIAL PROCEDURES TO PROTECT THE RIGHT TO REFUSE TREATMENT	438
VI. CONCLUSION	442

I. INTRODUCTION

The next time you attend a small gathering of about ten or twelve people, look around the room carefully. If the group is statistically average, one of the people there has been, is, or will be mentally ill and a patient in a mental hospital, perhaps involuntarily committed.¹ Moreover, many of that person's friends and associates may never know that he or she has suffered and recovered from this disability. Ten percent of all Americans have a personal brush with mental disturbance so serious as to require hospitalization. Far greater numbers endure lesser degrees of mental illness.² To these, and to all thinking citizens, the procedures for admission to hospitals for the mentally ill and the treatment within those hospitals present immediate and pressing problems.

When an individual who is mentally ill³ engages in potentially dangerous behavior,⁴ he or she may be taken involuntarily to an emergency

1. See M. Gregg Bloche & Francine Cournos, *Mental Health Policy for the 1990s: Tinkering in the Interstices*, 15 J. HEALTH POL. POL'Y & L. 387, 388-91 (1990) (citing statistics). The number of individuals who experience a mental disorder necessitating hospitalization represents less than one-half of the estimated total of the 52 million Americans—more than one in four—who suffer from any type of mental disorder during a year. See Darrel A. Regier et al., *The de Facto U.S. Mental and Addictive Disorders Service System*, 50 ARCHIVES GEN. PSYCHIATRY 85, 88 (1993). In addition, the number of individuals hospitalized falls far short of the actual need, since only 14.7% of the population ever receives some kind of treatment. *Id.* at 89-90, 92.

2. Bloche & Cournos, *supra* note 1, at 388; Regier, *supra* note 1, at 88.

3. For example, Florida law defines mental illness as an "impairment of the emotional processes, of the ability to exercise conscious control of one's actions, or of the ability to perceive reality or to understand, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology." FLA. STAT. § 394.455(3) (1995). See generally BARBARA A. WEINER & ROBERT M. WETTSTEIN, *LEGAL ISSUES IN MENTAL HEALTH CARE* 65-76 (1993) (defining legal standards for mental illness in each state); John Parry, *Survey of Standards for Extended Involuntary Commitment*, 18 MENTAL & PHYSICAL DISABILITY L. REP. 329 (1994).

4. See, e.g., FLA. STAT. § 394.463(1)(b)(2) ("a substantial likelihood that . . . he will cause

room by a police officer.⁵ Upon arrival, a psychiatrist may sign an order authorizing hospitalization for a time set by law.⁶ If hospital staff members subsequently determine that the individual requires longer term hospitalization, they will petition a court for a civil commitment order.⁷ After commitment, if the individual refuses to take prescribed medication, the hospital staff may seek an order through an administrative or judicial process to permit forced medication.⁸

Within the mental health system, a wide range of circumstances occur that could cause disputes to develop. Most disputes that arise, however, involve involuntary civil commitment or medication refusal.⁹ In these and other situations, the mechanisms for resolving disputes generally encompass a mixture of clinical and judicial decisionmaking, even though the law has not shown a preference for one model over another.¹⁰ In part, this reflects the inconsistency in court decisions concerning individuals with mental disabilities. The United States Supreme Court, for instance, has characterized involuntary civil commitment both as a

serious bodily harm to himself or others . . ."). See generally WALTER E. BARTON & GAIL M. BARTON, *ETHICS AND LAW IN MENTAL HEALTH ADMINISTRATION* 177-203 (1984) (discussing criteria and procedures for admission in several states); WEINER & WETTSTEIN, *supra* note 3, at 53-59.

5. See, e.g., FLA. STAT. § 394.463(2)(a)(2) ("A law enforcement officer shall take a person who appears to meet the criteria for involuntary examination into custody . . . for examination.").

6. See, e.g., *id.* § 394.463(2)(c) (72 hours).

7. See, e.g., *id.* § 394.463(2)(d)(4) ("A petition for involuntary placement shall be executed . . . when treatment is deemed necessary. . .").

8. See, e.g., *id.* § 394.459(3)(a) ("If any patient refuses to consent to treatment . . . the administrator shall immediately petition the court for a hearing . . ."); see also *Dautremont v. Broadlawns Hosp.*, 827 F.2d 291, 298 (8th Cir. 1987) (hospitalized civil patients may be involuntarily treated with psychotropic drugs against their will); *State ex rel. Jones v. Gerhardstein*, 416 N.W.2d 883, 889 (Wis. 1987) ("the state and county concede that psychotropic drugs are involuntarily given to all types of patients"); *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1351 n.151 (1974) [hereinafter *Civil Commitment*] ("Most civil commitment statutes . . . either do not discuss a patient's right to refuse unwanted treatments, or allow for the overruling of a competent patient's treatment decision for all but the most intrusive types of treatment." (citations omitted)).

9. See, e.g., Grant H. Morris, *Judging Judgment: Assessing the Competence of Mental Patients to Refuse Treatment*, 32 SAN DIEGO L. REV. 343, 343-64 & nn.79-82 (1995) (explaining disputes over mental patients' right to refuse treatment); *id.* at 408-22 (analyzing data from right to refuse cases). See generally Michael L. Perlin, *Pretexts and Mental Disability Law: The Case of Competency*, 47 U. MIAMI L. REV. 625 (1993) (discussing conflicts within the mental health system, especially those involving involuntary civil commitment).

10. See Catherine E. Blackburn, *The "Therapeutic Orgy" and the "Right to Rot" Collide: The Right to Refuse Antipsychotic Drugs Under State Law*, 27 HOUS. L. REV. 447, 476-79 & n.101, 493 & n.147 (1990) (citing statutes and comparing the 14 states using a clinical decisionmaker model with the 18 states using a judicial decisionmaker model); Julie M. Zito et al., *Toward a Therapeutic Jurisprudence Analysis of Medication Refusal in the Court Review Model*, 11 BEHAV. SCI. & L. 151, 151-53 (1993).

“ ‘massive curtailment of liberty,’ ”¹¹ and, in some cases, as based on a medical decision best left to the judgment of doctors.¹² Similarly, New York’s highest court found administrative decisionmaking in cases of medication refusal unconstitutional under state law,¹³ three years after a federal court found the same process constitutional under federal law.¹⁴

This Comment considers the procedures for resolving disputes in the contexts of involuntary civil commitment and medication refusal. Specifically, it addresses whether current methods for resolving admissions and treatment disputes meet the procedural due process requirements of the Fifth and Fourteenth Amendments; and whether those procedures adequately protect individuals in the mental health system. Part II surveys the civil commitment process with a discussion of the present state of the law. This discussion focuses on existing procedural due process protections for those individuals with mental disabilities. Part III offers some suggestions to improve commitment procedures within the guidelines established by the Supreme Court to protect an individual’s due process rights. Part IV analyzes the right to refuse treatment in the mental health system, particularly the right to refuse medication. Part V then argues that formal adversarial procedures offer the best due process protection for an individual’s right to refuse treatment.

II. CIVIL COMMITMENT AND PROCEDURAL DUE PROCESS

Due process may be defined roughly as using the legal system to protect a person’s rights.¹⁵ In construing an individual’s rights under the Due Process Clause,¹⁶ the Supreme Court has said that procedural due process is a flexible concept.¹⁷ In the context of administrative or judicial action that threatens a protected interest, the Court has concluded that due process demands “an opportunity to be heard.”¹⁸ Although the

11. *Vitek v. Jones*, 445 U.S. 480, 491 (1980) (quoting *Humphrey v. Cady*, 405 U.S. 504, 509 (1972)); *Addington v. Texas*, 441 U.S. 418, 425 (1979).

12. *E.g.*, *Youngberg v. Romeo*, 457 U.S. 307, 322-23 (1982); *Parham v. J.R.*, 442 U.S. 584, 607 (1979).

13. *Rivers v. Katz*, 495 N.E.2d 337, 344 (N.Y. 1986).

14. *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983).

15. More formally stated, due process of law is “[a] course of legal proceedings according to those rules and principles which have been established in our systems of jurisprudence for the enforcement and protection of private rights.” *BLACK’S LAW DICTIONARY* 500 (6th ed. 1990).

16. “No State shall . . . deprive any person of life, liberty, or property, without due process of law.” U.S. CONST. amend. XIV, § 1. The Fifth Amendment imposes a parallel requirement on the federal government. U.S. CONST. amend. V.

17. *Morrissey v. Brewer*, 408 U.S. 471, 481 (1972).

18. *Londoner v. Denver*, 210 U.S. 373, 385 (1908). Justice Frankfurter has also observed:

No better instrument has been devised for arriving at truth than to give a person in jeopardy of serious loss notice of the case against him and opportunity to meet it.

Court has not yet settled many issues concerning the number of procedural safeguards which the state must accord a person whom it seeks to commit involuntary, the Court has held that due process requires fair procedures to guard against erroneous deprivations of liberty.¹⁹ Specifically, the state must use fair procedures to determine that an individual is dangerous to himself or others due to a mental problem.²⁰ In addition, the Court has ruled that the state must grant equivalent procedural safeguards to individuals whom it seeks to commit in civil proceedings and who have been found mentally incompetent in connection with criminal trials.²¹

Nor has a better way been found for generating the feeling, so important to popular government, that justice has been done.

Joint Anti-Fascist Refugee Comm. v. McGrath, 341 U.S. 123, 171-72 (1951) (Frankfurter, J., concurring). See generally Henry J. Friendly, "Some Kind of Hearing", 123 U. PA. L. REV. 1267 (1975).

19. See, e.g., Greenholtz v. Nebraska Penal Inmates, 442 U.S. 1, 13 (1979) ("the quantum and quality of the process due in a particular situation depends upon the need to serve the purpose of minimizing the risk of error").

20. See O'Connor v. Donaldson, 422 U.S. 563, 572-76 (1975). Although circumstances may occur that would justify the government detaining a person at a mental health care facility for a short time prior to a hearing, due process normally requires that an adult receive notice and a hearing prior to being involuntarily committed to a state mental health facility. See Zinermon v. Burch, 494 U.S. 113, 138-39 (1990).

In *Zinermon*, the individual signed forms requesting voluntary admission and never received any type of hearing concerning whether he should have been committed to the facility. *Id.* at 118-20. In his subsequent suit against the government, he alleged that the hospital employees knew, or should have known, that he was mentally ill and incapable of giving consent to a voluntary admission, and that he would not have met the statutory conditions for involuntary placement. *Id.* at 121. Further, the hospital employees did not follow statutory procedures for short-term emergency admissions. *Id.* at 133-34. The *Zinermon* Court held only that the individual's complaint was sufficient to establish a due process violation if he could prove his allegations at trial. *Id.* at 139. The Supreme Court did not examine the state's procedures for short-term emergency admissions or explain the circumstances under which an adult could be detained at a mental health care facility prior to a hearing. See generally Bruce J. Winick, *Competency to Consent to Voluntary Hospitalization: A Therapeutic Jurisprudence Analysis of Zinermon v. Burch*, 14 INT'L J.L. & PSYCHIATRY 169, 177-82 (1991) (discussing the implications of the *Zinermon* decision).

21. *McNeil v. Director, Patuxent Inst.*, 407 U.S. 245, 249-50 (1972); *Jackson v. Indiana*, 406 U.S. 715, 738 (1972). The Court began eliminating the differences between civil commitment and civil trial procedures in cases such as *In re Gault*, 387 U.S. 1 (1967) (holding that notice, counsel, confrontation rights, and the right to remain silent be provided children alleged to be delinquent) and *In re Winship*, 397 U.S. 358 (1970) (holding that the reasonable doubt standard of proof must be applied in juvenile proceedings). In both cases, the Court declared that the potential for deprivation of liberty was a more important factor than the status of the defendant in determining appropriate procedures. A number of federal courts subsequently applied these principles to the mental health context. E.g., *Heryford v. Parker*, 396 F.2d 393 (10th Cir. 1968). In *Heryford*, the Tenth Circuit Court of Appeals wrote:

It matters not whether the proceedings be labeled "civil" or "criminal" or whether the subject matter be mental instability or juvenile delinquency. It is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feeble-

Similarly, in *Lessard v. Schmidt*,²² a landmark case declaring Wisconsin's civil commitment statutes unconstitutional, the district court found that "the interests in avoiding civil commitment are at least as high as those of persons accused of criminal offenses."²³ The court thus called for the same due process safeguards against unjustified deprivations of liberty that are accorded those accused of crime.²⁴ These safeguards included timely notice of "charges" justifying detention; adversary counsel; impermissibility of "hearsay evidence"; the privilege against self-incrimination; and a standard of proof beyond a reasonable doubt.²⁵ The court also defined dangerousness very narrowly: "[T]he state must bear the burden of proving that there is an extreme likelihood that if the person is not confined he will do immediate harm to himself or others."²⁶ In *Addington v. Texas*,²⁷ however, the Supreme Court rejected the *Lessard* standard of proof and held that the state must produce "clear and convincing" evidence that a person is mentally ill and dangerous before he or she may be involuntarily committed to a mental hospital.²⁸

The *Lessard* decision prompted state legislatures to change their commitment statutes to ensure that their laws provided mental patients with the new court-defined constitutional rights.²⁹ In particular, many

mindful or mental incompetent—which commands observance of the constitutional safeguards of due process.

Id. at 396.

22. 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded on procedural grounds*, 414 U.S. 473 (1974).

23. *Id.* at 1090; *see also* *Bell v. Wayne County Gen. Hosp.*, 384 F. Supp. 1085, 1092 (E.D. Mich. 1974) (echoing the *Lessard* court's analogy of commitment to conviction); *Dixon v. Attorney Gen.*, 325 F. Supp. 966, 972 (M.D. Pa. 1971) (same).

24. *Lessard*, 349 F. Supp. at 1090.

25. *Id.* at 1090-1103.

26. *Id.* at 1093.

27. 441 U.S. 418 (1979).

28. *Id.* at 431-33; *see also In re Irwin*, 529 N.W.2d 366, 374 (Minn. Ct. App. 1995) (citing statutory requirement of clear and convincing evidence); *cf. Heller v. Doe*, 113 S. Ct. 2637, 2644 (1993) (upholding Kentucky's higher burden of proof standard for commitment of the mentally ill than for the mentally retarded). A defendant acquitted of a criminal charge on the basis of an insanity defense, however, may be committed to a psychiatric facility on that basis, even though the defense was established by a "preponderance of the evidence," rather than by "clear and convincing" evidence. *Jones v. United States*, 463 U.S. 354, 366-68 (1983).

29. Reed Groethe, Comment, *Overt Dangerous Behavior as a Constitutional Requirement for Involuntary Civil Commitment of the Mentally Ill*, 44 U. CHI. L. REV. 562, 562-63, 565 (1977); John Q. La Fond, *An Examination of the Purposes of Involuntary Civil Commitment*, 30 BUFF. L. REV. 499, 499-500 (1981); Michael J. Leiber, *Interactions Between Civil Commitment and Protective Placement: An Empirical Assessment*, 15 INT'L J.L. & PSYCHIATRY 265, 265 (1992).

Despite the statutory protections for commitment, research has found that procedures for involuntary commitment tend to be perfunctory and a legal charade, which merely "rubber stamp" psychiatric recommendations. *See, e.g., Fred Cohen, The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEX. L. REV. 424, 448-50 (1966); Virginia A. Hiday,

states changed their involuntary commitment laws to require a finding of mental illness and dangerousness to self or to others as the only grounds for commitment.³⁰ A number of states, either by statute or by court decision, required the government to present evidence of recent overt acts demonstrating that the individual was dangerous.³¹ Most jurisdic-

Reformed Commitment Procedures: An Empirical Study in the Courtroom, 11 LAW & SOC'Y REV. 651, 655 (1977); Saleem A. Shah, *Some Interactions of Law and Mental Health in the Handling of Social Deviance*, 23 CATH. U. L. REV. 674, 714 (1974). Studies have illustrated the extremely brief nature of hearings, with little or no factual evidence presented on which to make a determination of mental illness or dangerousness. See Cohen, *supra*, at 430; Virginia A. Hiday, *Court Decisions in Civil Commitment*, 4 INT'L J.L. & PSYCHIATRY 159, 159 (1981). Although studies have found courts rejecting their judicial role and deferring to psychiatry, a study in one state suggests that the courts may be moving toward acting more independently in the commitment decision. Hiday, *Court Decisions in Civil Commitment*, *supra*, at 166-67; see also Morris, *supra* note 9, at 431 (describing data on the author's experience as a hearing officer in competency cases and concluding that hearings were not perfunctory). An independent system, as proposed in the next section, would continue to foster independence and conceivably eliminate the perfunctory nature of hearings. See discussion *infra* section III.

30. See WEINER & WETTSTEIN, *supra* note 3, at 49-52; La Fond, *supra* note 29, at 501; Leiber, *supra* note 29, at 265; John Parry, *Involuntary Civil Commitment in the 90s: A Constitutional Perspective*, 18 MENTAL & PHYSICAL DISABILITY L. REP. 320, 322-23 (1994). Compare *Rodriguez v. City of New York*, 861 F. Supp. 1173, 1183 (S.D.N.Y. 1994) (holding that statutory requirement of "conduct demonstrating that a person is dangerous to herself . . . incorporates wide range of behavior") and *In re Guardianship of Hedin*, 528 N.W.2d 567, 572 (Iowa 1995) (finding that "involuntary commitment is limited to [those] who are a danger to themselves or the community" and thus "[t]reatment alone is no justification for confinement") with James C. Beck & John W. Parry, *Incompetence, Treatment Refusal, and Hospitalization*, 20 BULL. AM. ACAD. PSYCHIATRY & L. 261, 262 (1992) (proposing a narrowing of commitment statutes based only on the need for treatment).

Some states have included harm to "property" as a commitment criterion. See, e.g., *Suzuki v. Yuen*, 617 F.2d 173 (9th Cir. 1980). In *Suzuki*, the Ninth Circuit Court of Appeals found such a provision in Hawaii's statute unconstitutionally broad:

We need not decide whether a state may ever commit one who is dangerous to property. This statute would allow commitment for danger to any property regardless of value or significance. . . . Under the current Hawaii definition of "danger to property," a person could be committed if he threatened to shoot a trespassing dog. The state's interest in protecting animals must be outweighed by the individual's interest in personal liberty.

Id. at 176.

31. See Groethe, *supra* note 29, at 576-79; La Fond, *supra* note 29, at 502. Some have argued, however, that the restriction of civil commitment to those who are overtly dangerous leaves too many severely ill individuals suffering silently without care. See Paul Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 494, 499-500 (1976); Darold A. Treffert, "Dying With Their Rights On", 130 AM. J. PSYCHIATRY 1041, 1041 (1973). Anecdotal accounts of patients who have "died with their rights on" are easily countered by other stories of patients who, under looser commitment criteria, have been needlessly confined for decades. See Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54, 67-79 (1982). To resolve these conflicts, researchers should conduct studies to compare the effects of the need for treatment with dangerousness-based commitment systems. Only then would we know whether a system inclined to favor involuntary treatment is likely to create a greater amount of needless suffering than one that errs in favor of liberty. See generally Mary L. Durham & John Q. La Fond, *A Search for the Missing Premise of Involuntary Therapeutic Commitment: Effective Treatment of the Mentally*

tions today also abide by the holding in *Wyatt v. Stickney*,³² that “[n]o person shall be deemed incompetent to manage his affairs, to contract, to hold professional or occupational or vehicle operator’s licenses, to marry and obtain a divorce, to register and vote, or to make a will *solely* by reason of his admission or commitment to the hospital.”³³

Despite the diversity of procedural protections among the states, the Supreme Court has largely avoided direct rulings on procedural aspects of civil commitment. In *Parham v. J.R.*,³⁴ however, the Court addressed the procedural mechanisms necessary to protect a minor’s liberty interests upon a parental or guardian request for commitment.³⁵ Applying the balancing formula announced three years earlier in *Mathews v. Eldridge*,³⁶ the *Parham* Court authorized the use of minimal, informal procedures as sufficient under the Due Process Clause. In refusing to find that children were entitled to the full panoply of due process protections that now characterize adult commitment, the Court held that an independent medical evaluation of the child’s need for hospitalization by a staff physician of the admitting hospital would be sufficient:

Due process has never been thought to require that the neutral and detached trier of fact be law trained or a judicial or administrative officer. Surely, this is the case as to medical decisions, for “neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments.” Thus, a staff physician will suffice, so long as he or she is free to evaluate independently the child’s mental and emotional condition and need for

Ill., 40 RUTGERS L. REV. 303, 325-30, 343-57, 360-61 (1988) (discussing the need for empirical studies to examine the efficacy of mental health treatment; highlighting the benefits and limits of drug therapy; noting the harmful effects of involuntary commitment; and concluding that further research is needed in a variety of contexts within the mental health system to develop sound public policy).

32. 344 F. Supp. 373 (M.D. Ala. 1972), *aff’d sub nom.* *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

33. *Id.* at 379; see also Barbara A. Weiner, *Rights of Institutionalized Persons*, in *THE MENTALLY DISABLED AND THE LAW* 251, 252, 258-59 (Samuel J. Brakel et al. eds., 3d ed. 1985) (noting that most states today follow *Wyatt*).

34. 442 U.S. 584 (1979).

35. Although the Court strongly suggested that the constitution requires, at some later point in time, procedures to determine whether continuing confinement is justified, it failed to address the issue directly. See *Parham*, 442 U.S. at 617.

36. 424 U.S. 319 (1976). In *Mathews*, the Court enunciated the following considerations which must be balanced in determining the procedures due in a particular situation:

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government’s interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

Id. at 335.

treatment.³⁷

Two aspects of the *Parham* approach to minimal due process safeguards have significance for adult commitment procedures.³⁸ First, the Court sanctioned the use of an expert decisionmaker in place of a judicial or administrative hearing official. Second, the Court indicated that an adjudicative-type adversary hearing is not the only form of decision-making encompassed within the concept of due process.

The Supreme Court has not ruled, however, that due process requires the use of a decisionmaker in the mental health context who has no connection with the relevant institution or state bureaucracy.³⁹ This procedural protection would not be necessary if the "due process hearing" is simply the initial examination by the staff psychiatrist. Only certain circumstances would demand independence from the institution.⁴⁰ For example, a hospital and its employees might have an interest in whether to administer medication, since that decision could affect safety and working conditions within a particular institution.⁴¹ To ensure neutrality, due process requires that the individual making the decision have no substantial involvement in arriving at the original decision to commit.⁴² Once an individual has rendered a decision to commit another, it is doubtful that he or she could fairly be entrusted with further decision-making responsibility, even if different procedures would develop more and, hopefully, better information. Most people cannot truly keep an open mind about a specific question upon which they have previously announced a position because they become "psychologically wedded" to

37. *Parham*, 442 U.S. at 607 (citations omitted).

38. *See id.* at 627-28 (Brennan, J., joined by Marshall, J. and Stevens, J., concurring in part and dissenting in part) (arguing that procedures equal to those provided adults should be required before commitment to mental institutions).

39. *See Vitek v. Jones*, 445 U.S. 480, 494-95 (1980) (holding that due process requires procedural safeguards which include an adversarial hearing before an independent institutional decisionmaker); *see also Wolff v. McDonnell*, 418 U.S. 539, 570-71 (1974); *Goldberg v. Kelly*, 397 U.S. 254, 264, 267-68 (1970).

40. *See, e.g., Goss v. Lopez*, 419 U.S. 565, 583-84 (1975) (due process requires, at a minimum, "give-and-take" between students and disciplinarians, notice to students of the grounds for suspension, and an opportunity for students to explain their actions); *see also In re Detention of R.R.*, 895 P.2d 1, 4-5 (Wash. Ct. App. 1995) (finding that although individuals must make commitment decisions "in a neutral and detached atmosphere," the burden of demonstrating a conflict of interest rests with the person asserting the conflict).

41. *See Robert Plotkin, Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 Nw. U. L. REV. 461, 478 (1978).

42. *See In re R.M.*, 889 P.2d 1201, 1204 (Mont. 1995) (finding violation of due process and civil commitment statute where the same person who filed the commitment petition also conducted the patient's examination); *see also Goldberg v. Kelly*, 397 U.S. 254, 271 (1970); *cf. Morrissey v. Brewer*, 408 U.S. 471, 485 (1972) ("In our view, due process requires that after the arrest, the determination that reasonable ground exists for revocation of parole should be made by someone not directly involved in the case.").

their initial position.⁴³

A final due process concern, distinct from the approach of *Parham* and its requirement that a decisionmaker remain neutral, involves providing individuals in the mental health system with procedures they will perceive as fair.⁴⁴ The Supreme Court addressed this concern in another context, holding in *Goldberg v. Kelly*,⁴⁵ that due process entitles welfare recipients to a hearing before the government may terminate their welfare benefits.⁴⁶ Although primarily concerned with issues of accuracy, the Court also recognized that termination without a hearing could be psychologically harmful, potentially damaging feelings of security, dignity, and self-worth.⁴⁷

Similarly, the doctrine of therapeutic jurisprudence⁴⁸ accords with the *Goldberg* Court's determination that people likely will perceive hearings that lack due process characteristics as unfair.⁴⁹ That unfairness, in turn, may have negative implications for the ensuing therapeutic

43. See *Withrow v. Larkin*, 421 U.S. 35, 57 (1975) (failing to find in this case "that the adjudicators would be so psychologically wedded to their complaints that they would consciously or unconsciously avoid the appearance of having erred or changed position," yet leaving open the possibility for such a finding in other circumstances).

44. For example, having the opportunity to participate fully in the resolution of conflict has a notable influence on perceived fairness. See *Marshall v. Jerrico, Inc.*, 446 U.S. 238, 242 (1980) (one of the "central concerns of procedural due process" is "the promotion of participation and dialogue by affected individuals in the decision making process"); *Codd v. Velger*, 429 U.S. 624, 636 (1977) (Stevens, J., dissenting); *Goldberg v. Kelly*, 397 U.S. 254, 264-65 (1970); JERRY L. MASHAW, *DUE PROCESS IN THE ADMINISTRATIVE STATE* 177-80 (1985) (discussing "the claim that the dignity and self-respect of the individual can be protected only through processes of government in which there is meaningful participation by affected interests"); Jerry L. Mashaw, *The Supreme Court's Due Process Calculus for Administrative Adjudication in Mathews v. Eldridge: Three Factors in Search of a Theory of Value*, 44 U. CHI. L. REV. 28, 50 (1976) ("[A] lack of personal participation causes alienation and a loss of that dignity and self-respect that society properly deems independently valuable."). See generally John J. Ensminger & Thomas D. Liguori, *The Therapeutic Significance of the Civil Commitment Hearing: An Unexplored Potential*, 6 J. PSYCHIATRY & L. 5 (1978); Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433 (1992).

45. 397 U.S. 254 (1970).

46. *Id.* at 264.

47. *Id.* at 264-66. See *infra* notes 181-189 and accompanying text.

48. The originators of therapeutic jurisprudence define it as "the study of the role of the law as a therapeutic agent." DAVID B. WEXLER & BRUCE J. WINICK, *ESSAYS IN THERAPEUTIC JURISPRUDENCE* 8 (1991); see Christopher Slobgin, *Therapeutic Jurisprudence: Five Dimensions to Ponder*, 1 PSYCHOL. PUB. POL'Y L. 193, 196 (1995) (describing therapeutic jurisprudence as "the use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects").

49. See WEXLER & WINICK, *supra* note 48, at 75-76, 79; David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research*, 45 U. MIAMI L. REV. 979, 985 (1991); see also Bruce J. Winick, *Harnessing the Power of the Bet: Wagering with the Government as a Mechanism for Social and Individual Change*, 45 U. MIAMI L. REV. 737, 766-67 (1991). See generally David B. Wexler, *Therapeutic Jurisprudence and Changing Conceptions of Legal Scholarship*, 11 BEHAV. SCI. & L. 17 (1993).

process. The next section, therefore, offers some ideas to improve existing procedures that would provide more meaningful opportunities for people to participate, to be treated with dignity and respect, and to receive the full panoply of due process protections.

III. IMPROVING THE CIVIL COMMITMENT PROCESS

The Supreme Court has indicated that compliance with due process neither requires the decisionmaker to be a judge nor the venue of the hearing to be a court.⁵⁰ Accordingly, an independent commitment system could be implemented that would assume all the responsibilities now assigned to the mental health and justice systems. Implementation of this new system may provide improved due process protections, offer greater therapeutic benefits, and ameliorate problems within the civil commitment process, such as the continued neutrality of a decisionmaker.

Under an independent system, clinicians would make initial evaluations and emergency commitment decisions. To perform this role, clinicians would undergo extensive training.⁵¹ Although these clinicians would not provide treatment, they would reevaluate patients after a decision had been made to file for long-term commitment. Clinicians would also furnish the relevant testimony at commitment hearings.

Hearing officers (perhaps judges, perhaps not) who have also received specialized training in the clinical and legal aspects of mental disorders would conduct hearings. Hearings would be conducted in a manner that fully considers individual views, that treats everyone with dignity and respect, and that fosters trust in authority and in the process.⁵² Specialists in mental health advocacy (probably, but not necessarily attorneys) would provide representation for both sides. One advocate would represent the petitioner, another the respondent. The advocates might periodically alternate the sides they represented to gain greater experience in and understanding of all aspects of the hearing process. Appeal from the hearing officer's decision would be available. The system, however, would operate on the assumption that appeals would rarely be pursued. Courts would place a heavy burden on appellants to demonstrate the inaccuracy of the hearing officer's

50. See *Washington v. Harper*, 494 U.S. 210 (1990); *Vitek v. Jones*, 445 U.S. 480 (1980); *Parham v. J.R.*, 442 U.S. 584 (1979).

51. Training would also include instruction in the laws, regulations, and policies of the civil commitment process. See, e.g., Parry, *supra* note 30, at 327.

52. See generally Pamela Casey et al., *Toward an Agenda for Reform of Justice and Mental Health Systems Interactions*, 16 *LAW & HUM. BEHAV.* 107, 117-21 (1992) (recommending a system that improves patients' perceptions and ensures dignity and respect).

determination.⁵³

In an effort to improve the civil commitment process, one state has already established an independent screening agency with the authority to review clinicians' recommendations for commitment, even in emergencies.⁵⁴ Some states have established administrative boards that sit for the sole purpose of making commitment decisions.⁵⁵ Other states use specialized hearing officers to adjudicate certain aspects of the commitment process.⁵⁶ Several jurisdictions have agencies that specialize in the representation of respondents at commitment hearings.⁵⁷ In addition, many state facilities rely on a small number of clinicians who evaluate all patients for whom commitment is proposed and offer testimony at the commitment hearings.⁵⁸

To complement this independent system, mediation would also be available.⁵⁹ Clinicians or hearing officers could recommend mediation to resolve difficult problems in a manner that is empowering to individuals in the mental health system. Any decision arrived at through mediation would seem more likely to be acceptable to the patient than one imposed coercively by an administrative body.⁶⁰

Mediation is one of the alternative dispute resolution mechanisms that has emerged in recent years in response to growing dissatisfaction with traditional judicial models of resolving disputes.⁶¹ A mediator facilitates negotiation and sometimes permits the parties to reach a negotiated settlement to their dispute when the parties themselves are unable to do so. Mediation has received extensive use in the resolution of fam-

53. Other systems with characteristics similar to those described herein include the Social Security Administration in its evaluation and adjudication of disability claims, *see, e.g.*, 20 C.F.R. § 404.915-916 (1995); boards of registration which undertake professional discipline, *e.g.*, FLA. STAT. § 458.307 (1995) (Board of Medicine); parole boards, *e.g.*, FLA. STAT. § 947.002 (1995); worker's compensation agencies, *e.g.*, FLA. STAT. § 440.015 (1995); and the Department of Veterans' Affairs disability determination apparatus, *see, e.g.*, 38 C.F.R. § 1.770-.775 (1995).

54. N.J. REV. STAT. §§ 30:4-27.2 to .5 (1995).

55. *E.g.*, NEB. REV. STAT. § 83-1035 (1994).

56. *E.g.*, California, CAL. WELF. & INST. CODE § 5256.1 (Deering 1995); Pennsylvania, 50 PA. CONS. STAT. § 7303 (1995).

57. *E.g.*, LA. REV. STAT. ANN. § 28:64 (West 1995); OHIO REV. CODE ANN. § 5123.60 (Anderson 1994).

58. *See, e.g.*, Bruce J. Winick, *Restructuring Competency to Stand Trial*, 32 UCLA L. REV. 921, 930-32 (1985) (discussing differences between inpatient and outpatient evaluation procedures for allegedly incompetent criminal defendants in state facilities).

59. *See generally* Joel Haycock et al., *Mediating the Gap: Thinking About Alternatives to the Current Practice of Civil Commitment*, 20 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 265, 279-89 (1994) (discussing the use of mediation in civil commitment).

60. For example, one study determined that patients' perceptions of fair procedures seemed to be an important determinant of perceived coercion. Jack Susman, *Resolving Hospital Conflicts: A Study on Therapeutic Jurisprudence*, 22 J. PSYCHIATRY & L. 107, 113-14 (1994); *see also* Dean G. Pruitt et al., *Long-term Success in Mediation*, 17 LAW & HUM. BEHAV. 313, 315 (1993).

61. *See* Pruitt et al., *supra* note 60, at 314.

ily, matrimonial, labor and commercial disputes,⁶² and this technique may hold much promise in the context of disputes arising within the mental health system. Furthermore, participation in the mediation process may foster independence and increase self-esteem in ways that will improve patient competency and community-living skills.⁶³

At present, the mental health system does not frequently use mediation to resolve disputes, perhaps because of the assumption that an individual diagnosed with a serious mental illness lacks the capacity to engage in a mediation process.⁶⁴ Empirical findings, however, do not support this belief.⁶⁵ For example, many persons diagnosed with a psychotic disorder are in a psychotic condition only episodically.⁶⁶ Moreover, former patients frequently assert that even when holding psychotic beliefs, they can often discuss and negotiate about aspects of their lives that are unrelated to such psychotic beliefs.⁶⁷ If a substantial percentage of mental health service recipients do have the capacity to engage in a negotiated decisionmaking process, mediation might provide a counterpart to the proposed independent system. In the alternative, it could be a viable option to use within the current system.

IV. THE RIGHT TO REFUSE TREATMENT⁶⁸

Even after legal confinement, an individual retains a constitutionally protected right to remain free from unwarranted government intrusions upon his or her person.⁶⁹ Courts have cast this right in various

62. *Id.*; see also Janet B. Abisch, *Medicational Lawyering in the Civil Commitment Context: A Therapeutic Jurisprudence Solution to the Counsel Role Dilemma*, 1 PSYCHOL. PUB. POL. & L. 120, 133-34 (1995).

63. Abisch, *supra* note 62, at 134; Haycock et al., *supra* note 59, at 282-83.

64. *But see* Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 LAW & HUM. BEHAV. 149, 173 (1995) (finding most hospitalized mental patients perform within an adequate range of treatment decisionmaking capacity).

65. *Id.*; Karen McKinnon et al., *Rivers in Practice: Clinicians' Assessments of Patients' Decision-Making Capacity*, 40 HOSP. & COMMUNITY PSYCHIATRY 1159, 1159-60 (1989).

66. *See generally* Bruce J. Winick, *The Side Effects of Incompetency Labeling and the Implications for Mental Health Law*, 1 PSYCHOL. PUB. POL'Y & L. 6, 30-33 (1995).

67. *See* Grisso & Appelbaum, *supra* note 64, at 168 (reporting that only 5% of respondents were unable to express a choice among treatment options).

68. *See generally* WEINER & WETTSTEIN, *supra* note 3, at 121-24 (summarizing significant right to refuse cases); Barbara A. Weiner, *Treatment Rights, in THE MENTALLY DISABLED AND THE LAW*, *supra* note 33, at 357-67 (providing table of states' restrictions on treatment).

69. *Youngberg v. Romeo*, 457 U.S. 307, 315-16 (1982); *Vitek v. Jones*, 445 U.S. 480, 491-94 (1980). In the context of the right to remain free from the administration of psychotropic medication, some courts have held that individuals have at least a qualified right to refuse treatment. *See, e.g.*, *Bee v. Greaves*, 744 F.2d 1387, 1392-93 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214 (1985); *Johnson v. Silvers*, 742 F.2d 823, 825 (4th Cir. 1984); *State ex rel. Jones v. Gerhardstein*, 416 N.W.2d 883, 891-92 (Wis. 1987); *People v. Medina*, 705 P.2d 961, 967-70

terms, often depending on the type of proposed governmental action, including a liberty interest in bodily integrity,⁷⁰ freedom from restraint,⁷¹ personal security,⁷² or as an aspect of the right to privacy.⁷³ The state, however, may exercise its power to subject a patient to treatment without his or her consent. The state's interests are divided into two categories—its *parens patriae* authority and its police power—which must be balanced against the individual's liberty interest before the state may forcibly administer medication.⁷⁴

The state's authority to act as *parens patriae* enables it to care for those persons unable to care for themselves.⁷⁵ For example, the Supreme Court employed the doctrine of *parens patriae* in an attempt to justify compulsory education in the case of *Wisconsin v. Yoder*.⁷⁶ Courts historically have applied the doctrine to the involuntary commitment of those unable to survive in the community.⁷⁷ Under the police power, the state has authority to protect the community,⁷⁸ and to commit dangerous, mentally ill people.⁷⁹ The distinction between the two interests is useful. The factors that are relevant to the assessment of state activity to provide care for the helpless differ from those that compel the state to protect the community from danger.⁸⁰

The *parens patriae* interest grew out of English common law pre-

(Colo. 1985); *Clites v. State*, 322 N.W.2d 917, 922 (Iowa Ct. App. 1982); *In re Boyd*, 403 A.2d 744, 748 (D.C. 1979).

70. *Schmerber v. California*, 384 U.S. 757, 772 (1966).

71. See *Youngberg*, 457 U.S. at 316; *Greenholtz v. Nebraska Penal Inmates*, 442 U.S. 1, 18 (1979) (Powell, J., concurring in part and dissenting in part).

72. See *Youngberg*, 457 U.S. at 315-16; *Hutto v. Finney*, 437 U.S. 678, 683 (1978).

73. *Winston v. Lee*, 470 U.S. 753, 759 (1985); *Schmerber*, 384 U.S. at 769-70.

74. Jessica Litman, Note, *A Common Law Remedy for Forcible Medication of the Institutionalized Mentally Ill*, 82 COLUM. L. REV. 1720, 1738 (1982).

75. E.g., *Rogers v. Okin*, 634 F.2d 650, 656-58 (1st Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. 291 (1982); *Winters v. Miller*, 446 F.2d 65, 70-71 (2d Cir. 1971), *cert. denied*, 404 U.S. 985 (1971); *Rogers v. Commissioner of Dep't of Mental Health*, 458 N.E.2d 308, 322 (Mass. 1983); *Rivers v. Katz*, 495 N.E.2d 337, 343 (N.Y. 1986).

76. 406 U.S. 205, 229-31 (1972). In *Yoder*, the respondents were Amish parents who objected to Wisconsin's compulsory school-attendance law because their children's attendance at a private or public school would be contrary to the Amish way of life. The state's interest in universal education is not totally free from a balancing process when it impinges upon other fundamental rights such as the Free Exercise Clause and the parents' interest in the religious upbringing of their children. The state's *parens patriae* power could not be sustained. *Id.*

77. See *Civil Commitment*, *supra* note 8, at 1207-22; see also *O'Connor v. Donaldson*, 422 U.S. 563, 583 (1975) (Burger, C.J., concurring).

78. *Addington v. Texas*, 441 U.S. 418 (1979). In *Addington*, appellant was committed to various institutions and later arrested on a misdemeanor charge of assault by threat. "[T]he state . . . has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill." *Id.* at 426; see also *Davis v. Hubbard*, 506 F. Supp. 915, 934-35 (N.D. Ohio 1980).

79. Litman, *supra* note 74, at 1738-39.

80. *Id.*; see, e.g., *Addington*, 441 U.S. at 426 (discussing the dichotomy of state interests).

rogatives of the monarch who had the power to act as "the general guardian of all infants, idiots, and lunatics."⁸¹ Although the basic function of the doctrine has been accepted in the United States, the Supreme Court has enlarged its scope beyond the original common law purpose.⁸² Society also has placed involuntary commitment of individuals under the guise of the *parens patriae* authority.⁸³ Although limited to some extent,⁸⁴ the doctrine of *parens patriae* empowers a state to administer treatment to a patient without obtaining consent,⁸⁵ and thus conflicts with the patient's liberty interest to refuse such treatment.

A state's police power to protect its citizens from harm also has been used to justify forcible administration of antipsychotic drugs to mentally ill patients.⁸⁶ The police power also extends to situations within a mental institution to ensure the safety of staff and other patients.⁸⁷ For example, in *Rogers v. Okin*⁸⁸ the district court held that a hospital could forcibly medicate in an emergency situation "in which a

81. *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 257 (1972) (quoting 3 WILLIAM BLACKSTONE, COMMENTARIES *47).

82. The enlargement of the purpose of *parens patriae* may have first begun in *Louisiana v. Texas*, 176 U.S. 1, 19 (1900). Louisiana, acting in its *parens patriae* capacity, sought injunctive relief against Texas officials who were prohibiting Louisiana merchants from distributing their goods in Texas under the guise of a quarantine statute designed to combat yellow fever. *Id.* at 8.

83. See, e.g., *O'Connor v. Donaldson*, 422 U.S. 563, 581-83 (1975) (confinement of a non-dangerous patient who is not receiving treatment is unconstitutional exercise of state's *parens patriae* authority).

84. The government may legitimately invoke its *parens patriae* power only in the case of individuals who, because of age or physical or mental disability, are incapable of determining their own best interests. E.g., *Bee v. Greaves*, 744 F.2d 1387, 1395 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214 (1985); *Rogers v. Okin*, 634 F.2d 650, 656-58 (1st Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. 291 (1982); *In re C.E.*, 641 N.E.2d 345, 353 (Ill. 1994); *Rivers v. Katz*, 495 N.E.2d 337, 343 (N.Y. 1986). Courts have recognized this limitation on the *parens patriae* power in the right to refuse treatment context, holding that assertions of this governmental purpose as a justification for forced medication must be restricted to patients determined to be incompetent to participate in treatment decisionmaking. E.g., *Rennie v. Klein*, 653 F.2d 836, 846 & n.12 (3d Cir. 1981) (en banc), *vacated and remanded*, 458 U.S. 1119 (1982); *Rogers*, 634 F.2d at 657; *In re C.E.*, 641 N.E.2d at 353; *Rivers*, 495 N.E.2d at 343.

85. *Winters v. Miller*, 446 F.2d 65, 71 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971); *Rogers v. Commissioner of Dep't of Mental Health*, 458 N.E.2d 308, 322 (Mass. 1983); *In re K.K.B.*, 609 P.2d, 747, 750 (Okla. 1980).

86. See, e.g., *Dautremont v. Broadlawns Hosp.*, 827 F.2d 291, 298 (8th Cir. 1987); *Rennie*, 653 F.2d at 838; *Rivers*, 495 N.E.2d at 343; *Rogers*, 458 N.E.2d at 310.

87. E.g., *State ex rel. Jones v. Gerhardstein*, 416 N.W.2d 883, 886, 894-95 (Wis. 1987) (holding that involuntarily committed individuals who have not been adjudicated incompetent have a right to refuse antipsychotic drugs, unless such drugs are required to prevent serious physical harm to the patient or others). Other courts have also recognized the state's police power interest in protecting hospital staff and other patients from violence to be sufficiently compelling to justify forced medication, at least in cases of emergency admission. E.g., *Project Release v. Prevost*, 551 F. Supp. 1298, 1309 (E.D.N.Y. 1982), *aff'd*, 722 F.2d 960 (2d Cir. 1983); *Rogers* at 321-22; *Rivers* at 343.

88. 478 F. Supp. 1342 (D. Mass. 1979).

failure to do so would result in a substantial likelihood of physical harm to that patient, other patients, or to staff members of the institution."⁸⁹ On appeal, the First Circuit Court of Appeals upheld the state's police power in administering antipsychotic medication, holding that it outweighed the patient's liberty interest in refusing medication.⁹⁰

The First Circuit, however, criticized the lower court's opinion in *Rogers* as a "simplistic unitary standard for police power emergency drug administration."⁹¹ The court favored, instead, a balancing approach overseen by qualified state physicians who would use informal procedures for making treatment decisions.⁹² As a result, forcible medication would take place only when the need to prevent violence outweighed the possibility of harm to the medicated patient, and the "reasonable alternatives to the administration of antipsychotics [are] ruled out."⁹³

One of the first cases to address the issue of a patient's right to refuse psychotropic medication in nonemergency situations was *Rennie v. Klein*.⁹⁴ In *Rennie*, the court examined New Jersey's administrative regulations governing medication refusals by hospitalized patients. Procedurally, the regulations provided for a three-step, in-house review of treatment refusals. First, the attending physician must disclose treatment information to the patient. If the patient then continues to refuse, the treatment team meets (with the patient present if his or her condition permits). If the treatment team does not resolve the issue, the facility's medical director must personally examine the patient and review the patient's records. The assistance of an independent psychiatrist is optional. Finally, the medical director has the authority to authorize forced medication.⁹⁵

Pointing to evidence that institutional pressures compromised the in-house review process, the *Rennie* court stated that the procedures did "not constitute the independent determination required by the due process clause."⁹⁶ The court required the implementation of a number of procedural safeguards, including an informal adversarial hearing before

89. *Id.* at 1365.

90. *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291 (1982).

91. *Id.* at 656.

92. *Id.* at 657.

93. *Id.* at 656.

94. 476 F. Supp. 1294 (D.N.J. 1979), *stay denied in part, granted in part*, 481 F. Supp. 552 (D.N.J. 1979), *modified and remanded*, 653 F.2d 836 (3d Cir. 1981) (en banc), *vacated and remanded*, 458 U.S. 1119 (1982).

95. *Id.* at 1303.

96. *Id.* at 1310.

an independent psychiatrist.⁹⁷ On appeal, however, the Third Circuit modified and remanded the district court's decision, finding that the New Jersey administrative regulations satisfied both substantive and procedural due process requirements.⁹⁸ The Third Circuit was satisfied that the "state's procedures, if carefully followed, pose only a minor risk of erroneous deprivation" and that "this risk will not be significantly reduced by superimposing the district court's own requirements on those already required by the state."⁹⁹ Central to the Third Circuit's reasoning was its characterization of the decisions necessary in a forced medication determination as "medical" in nature.¹⁰⁰ Accordingly, the court believed that the adversary hearing envisioned by the district court was "ill-suited" to these types of decisions.¹⁰¹

The Third Circuit supported its reasoning by quoting from the Supreme Court's decision in *Parham*, stating that "'due process is not violated by use of informal, traditional medical investigative techniques'" when dealing with essentially medical determinations.¹⁰² The court further relied on *Parham* in stating that adversary proceedings are "more likely to be counterproductive, adding to the tensions that may have contributed to the patient's initial commitment to the institution."¹⁰³ The court rejected the need for an independent review and asserted that the district court's procedures would impose "substantial additional financial burdens on the state and even greater expenditures of staff time at the hospitals."¹⁰⁴

Both the *Rennie* and *Rogers* decisions demonstrate judicial acceptance of flexible and informal administrative models for making treatment decisions. This acceptance continues under the influence of the Supreme Court's mandate in *Youngberg v. Romeo*.¹⁰⁵ The Court empha-

97. *Id.* at 1312. The court also required the use of patient consent forms and the establishment of a system of patient advocates. *Id.* at 1311.

98. *Rennie v. Klein*, 653 F.2d 836, 851 (3d Cir. 1981), *vacated and remanded*, 458 U.S. 1119 (1982).

99. *Id.* at 850.

100. *Id.*

101. *Id.*

102. *Id.* (quoting *Parham v. J.R.*, 442 U.S. 584, 608 (1979)).

103. *Id.* at 851 (citing *Parham*, 442 U.S. at 610).

104. *Id.*

105. 457 U.S. 307 (1982). In *Youngberg*, the Court held that patients committed to a state mental institution possess a liberty interest protected by the due process clause in safe conditions of confinement, freedom from bodily restraints, and minimally adequate training to insure these protected rights. *Id.* at 324. The Court said that these liberty rights were not absolute, but were subject to operational necessities of the institution. *Id.* at 319-20. In so holding, the Court focused upon "the proper standard for determining whether a State adequately has protected the rights of the involuntarily committed," concluding that courts are only required to make certain that professional judgment was exercised. *Id.* at 321. The *Youngberg* Court, however, "did not deal with decisions to administer or withhold medical treatment." *Cruzan v. Director, Mo. Dep't*

sized in *Youngberg* that "courts must show deference to the judgment exercised by a qualified professional. . . . Moreover, there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making [treatment] decisions."¹⁰⁶

The Supreme Court's decision in *Washington v. Harper*¹⁰⁷ further illustrates the influence of the *Youngberg* approach. In *Harper*, the Court stated that a convicted prisoner's "interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment"¹⁰⁸ is "adequately protected, and perhaps better served, by allowing the decision to medicate to be made

of Health, 497 U.S. 261, 280 (1990). Thus, the question remains unresolved as to whether a patient can refuse treatment prescribed under the professional judgment standard.

For a critique of the *Youngberg* decision and the professional judgment standard, especially in treatment refusal cases where the individual asserts a negative right against invasive state action, see Susan Stefan, *Leaving Civil Rights to the "Experts": From Deference to Abdication Under the Professional Judgment Standard*, 102 YALE L.J. 639 (1992).

106. 457 U.S. at 322-23. Shortly thereafter, the Court vacated and remanded *Rennie* for deliberation in light of *Youngberg*. *Rennie v. Klein*, 458 U.S. 1119 (1982), *vacating and remanding* 653 F.2d 836 (3d Cir. 1981) (en banc). On remand, the Third Circuit applied *Youngberg* and affirmed its previous judgment, modifying its earlier reliance on a "least intrusive means" analysis. *Rennie v. Klein*, 720 F.2d 266, 268 (3d Cir. 1983) (en banc). The court held "that antipsychotic drugs may be constitutionally administered to an involuntarily committed mentally ill patient whenever, in the exercise of professional judgment, such an action is deemed necessary to prevent the patient from endangering himself or others." *Id.* at 269.

107. 494 U.S. 210 (1990).

108. *Id.* at 221-22. Previously, the Court had held that the transfer of a prisoner to a mental hospital for treatment in a mandatory behavior modification program implicated one of the historic liberty interests protected by the Due Process Clause: "[T]he 'right to be free from, and to obtain judicial relief for, unjustified intrusions on personal security.'" *Vitek v. Jones*, 445 U.S. 480, 492 (quoting *Ingraham v. Wright*, 430 U.S. 651, 673 (1977)); see *Parham v. J.R.*, 442 U.S. 584, 600 (1979); *Humphrey v. Cady*, 405 U.S. 504, 509 (1972); see also *Zinermon v. Burch*, 494 U.S. 113, 131 (1990) (noting that an individual has a "substantial liberty interest in avoiding confinement in a mental hospital").

Numerous federal and state courts had also applied this liberty interest in freedom from unjustified governmental intrusions to involuntary treatment with antipsychotic drugs. See, e.g., *United States v. Watson*, 893 F.2d 970, 979 (8th Cir.), *reh'g granted in part, vacated in part sub nom.* *United States v. Holmes*, 900 F.2d 1322 (8th Cir.), *cert. denied sub nom.* *Watson v. United States*, 497 U.S. 1006 (1990) (intrusion on personal security represented by the "potential of psychotropic drugs for altering a patient's mental processes and the risk of severe side effects" gives rise to a constitutionally protected liberty interest); *accord Johnson v. Silvers*, 742 F.2d 823, 825 (4th Cir. 1984); *Rogers v. Okin*, 634 F.2d 650, 653 (1st Cir. 1980), *vacated sub nom.* *Mills v. Rogers*, 457 U.S. 291 (1982). Some courts have found a constitutional liberty interest implicated by compulsory treatment with antipsychotic drugs because such treatment invades bodily integrity and personal dignity. *United States v. Leatherman*, 580 F. Supp. 977, 979 (D.D.C. 1983), *appeal dismissed*, 729 F.2d 863 (D.C. Cir. 1984); *Davis v. Hubbard*, 506 F. Supp. 915, 929-31 (1980); *Riese v. St. Mary's Hosp. & Medical Ctr.*, 271 Cal. Rptr. 199, 206-08 (Ct. App. 1987); *Rogers v. Commissioner of Dep't of Mental Health*, 458 N.E.2d 308, 314 (Mass. 1983). Other courts have found forced drugging is analogous to the intrusion presented by physical restraints and therefore it gives rise to a constitutionally protected liberty interest. *United States v. Charters*, 863 F.2d 302, 305 (4th Cir. 1988); *Dautremont v. Broadlawns Hosp.*, 827 F.2d 291, 300 (8th Cir. 1987); *R.A.J. v. Miller*, 590 F. Supp. 1319, 1321 (N.D. Tex. 1984); *Project Release v. Prevost*, 551 F.

by medical professionals rather than a judge."¹⁰⁹ The Court maintained that "the fallibility of medical and psychiatric diagnosis [cannot] always be avoided by shifting the decision from a trained specialist . . . to an untrained judge . . . after a judicial-type hearing. Even after a hearing, the nonspecialist decisionmaker must make a medical-psychiatric decision."¹¹⁰ The Court also voiced a concern that "requiring judicial hearings will divert scarce prison resources, both money and the staff's time, from the care and treatment of mentally ill inmates."¹¹¹

Finding "no indication that any institutional biases affected or altered the decision to medicate respondent against his will," the majority was satisfied that existing procedures assured the "independence of the decisionmaker."¹¹² Further, the Court endorsed an internal review system, justifying its approval by citing studies which indicated that even outside decisionmakers most often concur with the treating physician's recommendation to medicate involuntarily.¹¹³ Finally, the Court reasoned that because medical personnel are conducting the review, the rules of evidence and a standard of proof are neither helpful nor required.¹¹⁴

Two years later, in *Riggins v. Nevada*,¹¹⁵ the Court again addressed the rights of prisoners, this time in the context of the forced medication with antipsychotic drugs of a criminal defendant during his trial. *Riggins* held that the state violated the defendant's due process rights when it forced him to stand trial while on a heavy dose of Mellaril, an antipsychotic drug that had negatively affected his demeanor and probably also his ability to participate in the proceedings.¹¹⁶ The Court's holding was narrow, turning on the absence of sufficient findings by the trial court to justify continuing medication over the defendant's objection.¹¹⁷ The Court's opinion contained important dicta, however, suggesting the

Supp. 1298, 1309 (E.D.N.Y. 1982), *aff'd*, 722 F.2d 960 (2d Cir. 1983); *Large v. Superior Court*, 714 P.2d 399, 406 (Ariz. 1986) (en banc).

109. *Harper*, 494 U.S. at 231.

110. *Id.* at 232 (quoting *Parham v. J.R.*, 442 U.S. at 609 (citation omitted)).

111. *Id.*

112. *Id.* at 233. Prior to administering drugs involuntarily to any inmate, prison procedures required that the inmate receive notice and a hearing before a tribunal of medical professionals and prison authorities, at which time the inmate could challenge the decision to give him the drug treatment. *Id.* at 215-16. The Court found that this informal hearing procedure complied with the requirements of the Due Process Clause. *Id.* at 225; *see also* *Walton v. Norris*, 59 F.3d 67, 68-69 (8th Cir. 1995) (upholding procedures similar to those discussed in *Harper*). The Supreme Court has not clarified whether such procedures would be sufficient outside the prison context.

113. 494 U.S. at 234 n.13.

114. *Id.* at 235.

115. 504 U.S. 127 (1992).

116. *Id.* at 137-38.

117. *Id.* at 138.

standards to be applied in future cases raising the right to refuse treatment issue in the criminal trial context.

Reiterating that antipsychotic medication intrudes on a significant liberty interest,¹¹⁸ the Court in *Riggins* restated the *Harper* standard as requiring that the state show both an "overriding justification" for such treatment and "a determination of medical appropriateness" for the individual.¹¹⁹ The Court identified two potential justifications for forced administration of antipsychotic medication in the criminal trial or pre-trial context, but found that the record in the case failed to support the presence of either. First, the Court noted that the state "certainly" would have satisfied due process "if the prosecution had demonstrated and the District Court had found" that involuntary medication was "medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins' own safety or the safety of others."¹²⁰ Second, the Court noted that the state "might" have been able to justify "medically appropriate" involuntary medication "by establishing that it could not obtain an adjudication of [his criminal charges] by using less intrusive means."¹²¹

Both the *Harper* and *Riggins* opinions are noteworthy. Specifically, the *Harper* Court expressly recognized that the right to refuse medical treatment is a constitutionally protected interest.¹²² However, in

118. *Id.* at 133-34.

119. *Id.* at 135.

120. *Id.*

121. *Id.* Recently, in *State v. Garcia*, 658 A.2d 947, 962 (Conn. 1995), the Supreme Court of Connecticut pondered the meaning of the United States Supreme Court's use of the word "might" in *Riggins*. In particular, the court was unclear as to whether "the state can justify involuntary treatment to restore a defendant to competency for the sole purpose of bringing him to trial, or whether . . . such treatment is justified . . . only if certain conditions are met." *Id.* The court concluded that "the state's interest in bringing the defendant to trial can constitute an overriding justification for the involuntary medication of the defendant under certain circumstances." *Id.* The decision also specified standards for a court to consider before a judge can order medication over a defendant's objection. *Id.* at 966. Connecticut thus joins approximately six other states that have developed criteria for involuntary medication of criminal defendants. See *Slants & Trends*, 13 MENTAL HEALTH L. REP. 41, 41 (1995).

122. *Washington v. Harper*, 494 U.S. 210, 221-22 (1990); see also *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 278 (1990) ("a competent person has a constitutionally protected interest in refusing unwanted medical treatment"); *In re C.E.*, 641 N.E.2d 345, 351 (Ill. 1994).

In a 1982 case involving the right of hospital patients to refuse psychotropic drugs, the Court avoided the opportunity to address the constitutional issues. *Mills v. Rogers*, 457 U.S. 291 (1982). The Supreme Court vacated the decision of the court of appeals, which had recognized a federal constitutional right to refuse medication. *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980). The Court remanded the case to the lower court to consider whether an intervening decision of the Supreme Judicial Court of Massachusetts, *In re Guardianship of Roe*, 421 N.E.2d 40 (Mass. 1981), which had recognized a right to refuse grounded in state law, rendered unnecessary the resolution of the federal constitutional question. *Mills*, 457 U.S. at 306. The Supreme Judicial Court of Massachusetts subsequently reiterated a right to refuse antipsychotic drugs in *Rogers v. Commissioner of Dep't of Mental Health*, 458 N.E.2d 308, 310 (Mass. 1983). The court of

Harper and later in *Riggins*, the Court only addressed the rights of convicted prisoners, failing to indicate whether those rights apply to involuntarily confined civil patients.¹²³ Moreover, the Court's decisions failed to discuss adequately the nature of the liberty interest it found to be invaded by involuntary antipsychotic medication. Most significantly, although recognizing that involuntary antipsychotic medication invades a "substantial liberty interest," the *Riggins* Court failed to clarify whether that interest will be deemed "fundamental," and therefore deserving of traditional strict judicial scrutiny, rather than the more deferential standard applied in *Harper*. The Court's decisions thus leave the constitutional issues raised by involuntary mental health treatment substantially unresolved and provide little guidance concerning how the asserted right to refuse treatment would be dealt with outside the prison.

On the other hand, in a line of cases dating back to the mid-1960's, the Supreme Court has repeatedly distinguished between the substantive and procedural rights of individuals imprisoned through the criminal justice system and those involuntarily hospitalized through the civil system.¹²⁴ This criminal-civil distinction suggests that the restrictions on a convicted prisoner's right to refuse antipsychotic drugs are not automatically applicable to civil patients. As the Court emphasized, "[t]here are few cases in which the State's interest in combating the danger posed by a person to both himself and others is greater than in a prison environment, which, 'by definition,' is made up of persons with 'a demonstrated

appeals thereafter approved the state procedures adopted in that case, finding them to "equal or exceed the rights provided in the federal Constitution." *Rogers v. Okin*, 738 F.2d 1, 9 (1st Cir. 1984).

123. *Harper*, for instance, applied the deferential approach for scrutinizing constitutional claims that the Court customarily uses in the prison context. *Harper*, 494 U.S. at 224 (applying a standard of "reasonableness"). *Harper* seems to reflect the approach of an increasingly conservative Supreme Court, disinclined to intrude into state processes and especially deferential to institutional administrators. See, e.g., *Thornburgh v. Abbott*, 490 U.S. 401 (1989) (prisons); *Turner v. Safley*, 482 U.S. 78 (1987) (prisons); *Regents of the Univ. of Mich. v. Ewing*, 474 U.S. 214 (1985) (state medical school's academic decisions); *Youngberg v. Romeo*, 457 U.S. 307 (1982) (mental retardation facilities); *Parham v. J.R.*, 442 U.S. 584 (1979) (mental hospitals); *Ingraham v. Wright*, 430 U.S. 651 (1977) (schools). Whether recent appointments to the Court will have an impact on these trends remains to be seen.

124. *Jones v. United States*, 463 U.S. 354, 366-68 (1983) (insanity defense acquittee may be committed to a psychiatric facility, even though the defense was established by a "preponderance of the evidence," rather than by "clear and convincing" evidence); *Vitek v. Jones*, 445 U.S. 480, 487-88 (1980) (prisoner subjected to transfer to mental hospital entitled to same procedural safeguards as in civil commitment); *Addington v. Texas*, 441 U.S. 418, 432 (1979) ("reasonable-doubt standard is inappropriate in civil commitment proceedings"); *Baxstrom v. Herold*, 383 U.S. 107, 111-12 (1966) ("no conceivable basis for distinguishing the commitment of a person [in jail] from all other civil commitments"). See generally John Parry, *The Supreme Court Fashions New Boundaries for Involuntary Care and Treatment*, 14 MENTAL & PHYSICAL DISABILITY L. REP. 198 (1990).

proclivity for antisocial criminal, and often violent, conduct.'"¹²⁵ The Court, in *Harper*, suggested that "under other circumstances [the state] would have been required to satisfy a more rigorous standard of review."¹²⁶

Contrary to the Court's decisions in *Harper* and *Riggins*, the interest of the mentally ill civil patient is at least as great, if not greater, than a convicted prisoner's interest. Indeed, the Supreme Court recognized that "[p]ersons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish."¹²⁷ As one federal circuit court of appeals also noted, in rejecting the state's contention that involuntary commitment takes away all aspects of a patient's constitutional liberty, "the patient's liberty is diminished [by commitment] only to the extent necessary to allow for confinement by the state so as to prevent him from being a danger to himself or to others."¹²⁸

More important, the determination made at an involuntary treatment hearing may put the civil patient's life or liberty at serious risk. This is analogous to the reasoning used by the Supreme Court in *Ake v. Oklahoma*.¹²⁹ In *Ake*, the Court reasoned that a mentally ill criminal defendant's interest in having "a competent psychiatrist who will conduct an appropriate examination and assist in evaluation, preparation, and presentation of the defense"¹³⁰ was uniquely compelling because the outcome of the judicial proceeding may put the defendant's life or liberty at risk.¹³¹ Furthermore, the Court found that the state's financial

125. *Harper*, 494 U.S. at 225.

126. *Id.* at 223. *But see* Bruce J. Winick, *Psychotropic Medication in the Criminal Trial Process: The Constitutional and Therapeutic Implications of Riggins v. Nevada*, 10 N.Y.L. SCH. J. HUM. RTS. 637, 702 (1993) (arguing that, based on *Riggins*, the Court will construe the right to refuse treatment outside the prison context more broadly than *Harper*).

127. *Youngberg v. Romeo*, 457 U.S. 307, 321-22 (1982); *see also* *Clark v. Donahue*, 885 F. Supp. 1164, 1166 (S.D. Ind. 1995) (entitling involuntarily committed patients to more protected conditions of confinement than convicted criminals).

128. *Rennie v. Klein*, 653 F.2d 838, 843 (3d Cir. 1981) (en banc), *vacated and remanded on other grounds*, 458 U.S. 1119 (1982).

129. 470 U.S. 68 (1985). In *Ake*, the Court considered "whether, and under what conditions, the participation of a psychiatrist is important enough to preparation of a defense to require the State to provide an indigent [criminal] defendant with access to competent psychiatric assistance in preparing a defense." *Id.* at 77. It expressed a particular concern with "the accuracy of a criminal proceeding that places an individual's life or liberty at risk." *Id.* at 78. This concern, the Court explained, weighed heavily in the analysis. *Id.* The Court recognized the significant role that a psychiatrist plays in creating and presenting a defense, as well as the many ways a psychiatrist can assist the defendant and his attorney. *Id.* at 79-82. Moreover, the Court trivialized the state's fiscal concern in requiring this procedural safeguard. *Id.* at 78.

130. *Id.* at 83.

131. *Id.* at 78.

burden in providing a psychiatrist was minimal, as compared to the significant personal interest at stake in a criminal proceeding.¹³² This reasoning is equally compelling with regard to the personal interest at stake in an involuntary treatment proceeding.

The due process protection extended to a criminal defendant or a convicted prisoner whose mental capacity is in issue should be extended to a civilly committed mental patient in danger of being medicated forcibly because the patient's mental capacity is also in issue. The judicial proceedings afforded to both the criminal and the civil patient are quite similar and, therefore, a hearing to determine mental capacity or treatment decisions should be labeled quasi-criminal in nature.¹³³ Due process concerns in both proceedings are virtually the same, and in some ways, much more troublesome for the involuntary mental patient. Similarly, both the patient and the criminal defendant are in danger of losing liberties.¹³⁴ Beyond this loss of physical liberty, however, the civil patient who is medicated forcibly is in danger of suffering irreversible harm caused by the side effects of the unwanted treatment.¹³⁵

A state could argue, however, under the professional judgment standard, displayed in *Youngberg*, *Parham*, and *Harper*, that by holding medical decisions "presumptively valid"¹³⁶ the institutions will be spared the long, arduous, and costly process of judicial hearings. However, speedy adjudication should not be the only goal when making

132. *Id.* at 78-79.

133. For example, the Supreme Court has held a probable cause hearing to be required in the criminal context. *Gerstein v. Pugh*, 420 U.S. 103, 124-25 (1975). Such a right should also apply in the civil commitment system.

134. See *Addington v. Texas*, 441 U.S. 418, 425 (1979) ("civil commitment for any purpose constitutes a significant deprivation of liberty").

135. The Supreme Court acknowledged in *Mills v. Rogers*, 457 U.S. 291 (1982) that certain drugs are "mind altering." Their effectiveness resides in their capacity to achieve such effects." *Id.* at 293 n.1. *Accord* *Riggins v. Nevada*, 504 U.S. 127, 134-35 (1992); *Washington v. Harper*, 494 U.S. 210, 230 (1990); *United States v. Charters*, 829 F.2d 479, 483 n.2 (4th Cir. 1987); *In re C.E.*, 641 N.E.2d 345, 352 (Ill. 1994). See *Rennie v. Klein*, 720 F.2d 266, 276 (3d Cir. 1983) (en banc) (Weis, J., concurring) ("Unlike the temporary and predictable effects of bodily restraints, the permanent side effects of antipsychotic drugs induce conditions that cannot be corrected simply by cessation of the regimen. The permanency of these effects is analogous to that resulting from such radical surgical procedures as a pre-frontal lobotomy."); *In re Guardianship of Roe*, 421 N.E.2d 40, 53 (Mass. 1981) ("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."); see also Thomas G. Gutheil & Paul S. Appelbaum, "Mind Control," "Synthetic Sanity," "Artificial Competence," and *Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 HOFSTRA L. REV. 77, 107-09 (1983); Elyn R. Saks, *Competency to Refuse Psychotropic Medication: Three Alternative to the Law's Cognitive Standard*, 47 U. MIAMI L. REV. 689, 730 (1993).

136. See *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982).

treatment decisions.¹³⁷ Rather, adequate protection of the valid liberty interest in being free from unnecessary antipsychotic medication should be given equal consideration. Forcibly medicating a patient, absent review of that decision, violates the patient's procedural due process rights.¹³⁸ Consequently, a counseled judicial hearing should be held to consider the questions of dangerousness and competence to make medication decisions.¹³⁹ In all cases, the law would follow its long-standing tradition of the presumption of competence to make medical decisions¹⁴⁰ and the more recent approach of not equating civil commitment with incompetency.¹⁴¹ Indeed, an individual may be mentally ill, even psychotic, and yet be capable of decisionmaking in a variety of areas, including evaluating the advantages and disadvantages of particular treatments.¹⁴² To rebut this presumption, the burden of proof would rest

137. Furthermore, in *United States v. Charters*, 829 F.2d 479 (4th Cir. 1987), the court notes that despite those who would argue that "judicial approval of forcible medication imposes a needless and unwieldy obstacle to proper and prompt treatment," *id.* at 498-99, such approval will not "slow the decisional process" since "the court can approve a reasonable treatment plan effective over a period of time and periodically review[]" it. *Id.* at 499 n.28. In short, judicial scrutiny of the right to refuse treatment "does not place a significant burden on institutional resources." *Id.*

138. Moreover, no evidence exists to establish that coerced medication of a patient is effective. *Durham & La Fond*, *supra* note 31, at 351-56, 367-68.

139. The Supreme Court has said indigent criminal defendants, *see Argersinger v. Hamlin*, 407 U.S. 25 (1972), and juveniles alleged to be delinquent, *see In re Gault*, 387 U.S. 1 (1967), have a right to appointed counsel. Since civil commitment can also lead to a deprivation of liberty, civilly committed patients should have a similar right to counsel.

140. *Schloendorff v. Society of N.Y. Hosps.*, 105 N.E. 92, 129 (N.Y. 1914) (According to Judge Cardozo, "[e]very human being of adult years and sound mind has the right to determine what shall be done with his own body."); *see also Lotman v. Security Mut. Life Ins. Co.*, 478 F.2d 868, 873 (3d Cir. 1973); *Winters v. Miller*, 446 F.2d 65, 68 (2d Cir. 1971), *cert. denied*, 404 U.S. 985 (1971); *Rogers v. Okin*, 478 F. Supp. 1342, 1361, 1363-64 (D. Mass. 1979), *aff'd in part, vacated and remanded*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291 (1982); *Child v. Wainwright*, 148 So. 2d 526, 527 (Fla. 1963); *Grannum v. Berard*, 422 P.2d 812, 814 (Wash. 1967); *see also Morris*, *supra* note 9, at 347; Barry D. Rosenfeld & Eric N. Turkheimer, *Modeling Psychiatric Patients' Treatment Decision Making*, 19 LAW & HUM. BEHAV. 389, 402 (1995). Even if such patients do not possess sufficient competence, allowing them as great a degree of choice as circumstances permit may be therapeutically beneficial. *Morris*, *supra* note 9, at 434.

141. *E.g., Winters*, 446 F.2d at 68 (finding a patient mentally ill does not create a presumption that he is incompetent to make decisions); *Rogers*, 478 F. Supp. at 1361 ("[A]lthough committed, a mental patient is nonetheless presumed competent to manage his affairs, dispose of property, carry on a licensed profession, and even to vote."). Virtually all states now provide by statute that civil commitment alone does not justify the conclusion that a patient may be deprived of civil rights or is incompetent to exercise them. *See Blackburn*, *supra* note 9, at 471-72 nn.87-88 (listing statutes).

142. *See, e.g., Grisso & Appelbaum*, *supra* note 64, at 173 (finding most patients in an empirical study who were hospitalized for schizophrenia and major depression able to engage in treatment decisionmaking within an acceptable range of competence); *McKinnon et al.*, *supra* note 65, at 1159 ("Clinical evidence suggests that despite alterations in thinking and mood,

with those seeking to medicate forcibly.¹⁴³

Since antipsychotic drugs carry potentially dangerous side effects, every decision to administer these drugs also needs review by a physician outside the mental health facility. This should be the case despite the argument that even an independent psychiatrist is likely to share the approach, perspective, and biases of the treating doctor.¹⁴⁴ Anything less than a review of this nature compromises the incompetent patient's due process interests by presuming that antipsychotic drugs best treat the illness.

Equally important, *Rivers v. Katz*¹⁴⁵ distinctly established that a patient has a liberty interest in deciding whether to be medicated.¹⁴⁶ In *Rivers*, the New York Court of Appeals relied on state constitutional and common law in holding that the administrative review procedures previously affirmed by the Second Circuit in *Project Release v. Prevost*¹⁴⁷ did not adequately protect the privacy interests of committed mental patients.¹⁴⁸ The court mandated a finding of incompetency before medicating a patient for treatment purposes against his or her will. " 'Otherwise, the very justification for the state's purported exercise of its *parens patriae* power—its citizen's inability to care for himself . . . would be missing.' " ¹⁴⁹

Granted, even when the constitution is relied on to support a patient's refusal of antipsychotic drugs, there is no guarantee that the refusal will be upheld. Constitutional rights are not absolute; they must be balanced against the government's legitimate reasons for infringement.¹⁵⁰ Generally, the more important the constitutionally protected interest, the stronger the government's justification must be to override the interest.¹⁵¹ At a minimum, a governmental infringement of a pro-

psychiatric patients are not automatically less capable than others of making health care decisions.").

143. See, e.g., *Rogers v. Commissioner of Dep't of Mental Health*, 458 N.E.2d 308, 314-15 (Mass. 1983).

144. See *Washington v. Harper*, 494 U.S. 210, 234 n.13 (1990); Alexander D. Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 179, 199 (1980); Morris, *supra* note 9, at 431-32.

145. 494 N.E.2d 337 (N.Y. 1986).

146. *Id.* at 341-42. The Supreme Court also has held that an individual has a constitutionally protected interest in refusing treatment. See, e.g., *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 278 (1990); *Washington v. Harper*, 494 U.S. 210, 221-22 (1990).

147. 722 F.2d 960 (2d Cir. 1983).

148. 494 N.E.2d at 341-44.

149. *Id.* at 343 (quoting *Rogers v. Okin*, 634 F.2d 650, 657 (1st Cir. 1980)).

150. *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982); *Mills v. Rogers*, 457 U.S. 291, 299 (1982).

151. *Price v. Sheppard*, 239 N.W.2d 905, 910 (Minn. 1976). In addition, the Supreme Court has found the right to freedom of choice in certain matters affecting a person's life to be of "fundamental" value. See *Roe v. Wade*, 410 U.S. 113, 152-54 (1973). The freedom to make

tected liberty interest must be "reasonably related to legitimate government objectives."¹⁵² However, as the intrusiveness of the government's action rises, the sufficiency of its justification must also increase.¹⁵³ A compelling governmental interest and a showing that no less intrusive means are available to achieve the objective must support highly intrusive conduct.¹⁵⁴ Thus, even when the government's interest in restricting a constitutionally protected right is sufficiently important, the least restrictive alternative doctrine imposes an additional burden.

The essence of this doctrine is that the government may not pursue its ends, however compelling, by means which unnecessarily encroach upon fundamental rights. The classic exposition of the doctrine came in *Shelton v. Tucker*,¹⁵⁵ in which the United States Supreme Court stated:

[E]ven though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose.¹⁵⁶

The least restrictive alternative principle is an analytical guideline for determining whether the government has exercised prudence in selecting the means to accomplish an otherwise legitimate end. The first case in the mental health area to apply the least restrictive alternative doctrine was *Lake v. Cameron*.¹⁵⁷ In that case, Chief Judge Bazelon questioned the necessity of the "complete deprivation of liberty" attendant to the continued institutionalization of a non-dangerous elderly woman.¹⁵⁸ Based on a District of Columbia commitment statute, the court held that the government has an affirmative duty to explore all treatment alternatives so that "deprivations of liberty . . . [do] not go beyond what is necessary for [the patient's] protection."¹⁵⁹ Thereafter,

fundamental decisions has been characterized as " 'implicit in the concept of ordered liberty' " or " 'deeply rooted in this Nation's history and tradition.' " *Bowers v. Hardwick*, 478 U.S. 186, 191-92 (1986) (citations omitted). Furthermore, the positive benefits of freedom of choice are well documented. See Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1705, 1755-68 (1992) (summarizing psychology of choice literature).

152. *Youngberg*, 457 U.S. at 320; see also *Bell v. Wolfish*, 441 U.S. 520, 539 (1979).

153. See Winick, *supra* note 19, at 400.

154. See *Winston v. Lee*, 470 U.S. 753, 766 (1985); *Schmerber v. California*, 384 U.S. 757, 768-70 (1966).

155. 364 U.S. 479 (1960). In *Shelton*, the Court addressed a challenge to a state statute that required school teachers to reveal all their organizational associations for the past five years.

156. *Id.* at 488 (footnote omitted).

157. 364 F.2d 657 (D.C. Cir. 1966) (en banc) (5-4 decision).

158. *Id.* at 660-61.

159. *Id.* at 659-60.

courts began applying the doctrine to commitment decisions,¹⁶⁰ conditions of confinement,¹⁶¹ and treatment decisions within institutions.¹⁶²

In sum, only sufficiently important governmental objectives may outweigh a patient's protected interests in refusing antipsychotic medication. However, the patient's rights are meaningless without accompanying procedural mechanisms to establish the validity of an asserted governmental objective. The Due Process Clause requires that procedural safeguards be employed when balancing a constitutionally protected right against a competing governmental interest. Even if not expressly protected by the Constitution, state law can also create liberty interests which are entitled to the minimum procedural protections mandated by the Due Process Clause.¹⁶³ Therefore, when state constitutional, statutory, or common law confers a right to refuse treatment, Fourteenth Amendment procedural protections must be observed.¹⁶⁴

V. ADVERSARIAL PROCEDURES TO PROTECT THE RIGHT TO REFUSE TREATMENT

Despite *Parham's* suggestion that the "supposed protections of an adversary proceeding . . . may well be more illusory than real,"¹⁶⁵ the courts should be the final decisionmaker when an involuntarily hospitalized patient refuses medication.¹⁶⁶ Although the Supreme Court has endorsed expert decisionmakers and minimal, informal procedures,

160. *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975).

161. *Halderman v. Pennhurst State Sch. & Hosp.*, 612 F.2d 84, 113 (3d Cir. 1979), *stay granted in part*, 448 U.S. 905 (1980), *rev'd*, 451 U.S. 1 (1981); *Dixon v. Weinberger*, 405 F. Supp. 974, 979 (D.D.C. 1975).

162. *Gary W. v. Louisiana*, 437 F. Supp. 1209, 1219-20, 1228-31 (E.D. La. 1976); *Davis v. Watkins*, 384 F. Supp. 1196, 1203 (N.D. Ohio 1974).

163. *Mills v. Rogers*, 457 U.S. 291, 300 (1982); *Vitek v. Jones*, 445 U.S. 480, 488 (1980).

164. *See Project Release v. Prevost*, 722 F.2d 960, 979 (2d Cir. 1983). Under certain circumstances, the state may also confer procedural protections of liberty interests that extend beyond those minimally required by the Federal Constitution. *Mills*, 457 U.S. at 300; *see, e.g., Jarvis v. Levine*, 418 N.W.2d 139, 148-50 (Minn. 1988) (holding that the state constitution guarantees a right to privacy even during civil commitment and requires judicial review before a patient may be medicated involuntarily); *Rivers v. Katz*, 495 N.E.2d 337, 344 (N.Y. 1986) (finding that neither mental disability nor hospitalization will justify overriding an individual's fundamental right to refuse treatment under the due process clause of the state constitution).

165. *Parham v. J.R.*, 442 U.S. 584, 609 (1979).

166. Through the years commentators have questioned the court's role in making treatment decisions. *See David L. Bazelon, Implementing the Right to Treatment*, 36 U. CHI. L. REV. 742, 742-43 (1969); *Brooks, supra* note 144, at 201-13; *Plotkin, supra* note 41, at 462-63; *Civil Commitment, supra* note 8, at 1333-36. Judge David Bazelon seems to have responded best to this criticism:

Very few judges are psychiatrists. But equally few are economists, aeronautical engineers, atomic scientists, or marine biologists. For some reason, however, many people seem to accept judicial scrutiny of, say, the effect of a proposed dam on fish life, while they reject similar scrutiny of the effect of

judges should remain in a role that assures that "there has been a full exploration of all relevant facts, opposing views and possible alternatives, [and] whether the results of the exploration relate rationally to the ultimate decision."¹⁶⁷ Through the adversary process, courts are assisted by attorneys representing each side in sorting motivational nuances, and operating within the context of conflicting facts, opinions, interests, and professional principles.¹⁶⁸

Merely because a medical expert may decide some issues in a case "does not justify dispensing with due process requirements. It is precisely '[t]he subtleties and nuances of psychiatric diagnoses' that justify the requirement of adversary hearings."¹⁶⁹ Courts should determine whether the given level of medical certainty—whatever that level may be—warrants infringement of a patient's constitutional rights. That determination should no more be left to medical discretion than the determination of probable cause under the Fourth Amendment is left to police discretion.

Furthermore, if a court is unable to make an informed decision on conflicting medical evidence after thorough evaluation, the Supreme Court has suggested that such uncertainty dictates against allowing the medical intervention. For example, in *Winston v. Lee*,¹⁷⁰ the Court denied the government's request to perform minor surgery on a suspect to recover a bullet for evidentiary purposes. After addressing the fundamental interests involved, the Court pointed to the dispute between medical experts on the degree of risk presented by the surgery and held that this "very uncertainty militates against finding the operation to be 'reasonable.'"¹⁷¹

Indeed, the reliance by the Supreme Court on expert decisionmakers using informal procedural mechanisms does not comport with its long-standing disparagement of the judgment of psychiatrists

psychiatric treatment on human lives. . . . [I]t can hardly be that we are more concerned for the salmon than the schizophrenic.

Bazelon, *supra*, at 743. Despite the controversy, courts providing only limited due process protection for the right to refuse treatment represent the minority view, at least among state courts. See generally Michael L. Perlin, *Decoding Right to Refuse Treatment Law*, 16 INT'L J.L. & PSYCHIATRY 151 (1993) (reviewing the trend toward a liberal interpretation of procedural due process protections on behalf of patients in state court proceedings).

167. David L. Bazelon, *Institutional, Deinstitutionalization and the Adversary Process*, 75 COLUM. L. REV. 897, 910 (1975).

168. See Winsor C. Schmidt & Randy Otto, *A Legal and Behavioral Science Analysis of Statutory Guidelines for Children's Mental Health and Substance Abuse Service: The Florida Case*, 16 J. PSYCHIATRY & L. 9, 49-50 (1988).

169. *Vitek v. Jones*, 445 U.S. 480, 495 (1980) (quoting *Addington v. Texas*, 441 U.S. 418, 430 (1979)).

170. 470 U.S. 753 (1985).

171. *Id.* at 766.

and psychologists and its concern about their ability to make reliable and valid decisions. As Chief Justice Burger noted in his concurring opinion in *O'Connor v. Donaldson*,¹⁷² "[t]here can be little responsible debate regarding the 'uncertainty of diagnosis in this field and the tentativeness of professional judgment.'" ¹⁷³ The majority, as well, acknowledged the "uncertainties of psychiatric diagnosis and therapy, and [that] the reported cases are replete with evidence of the divergence of medical opinion in this vexing area."¹⁷⁴ The Court in *Parham* similarly described medical and psychiatric diagnosis as fallible¹⁷⁵ and based on impressions drawn from subjective analysis.¹⁷⁶ This criticism continues unabated into the present decade.¹⁷⁷ In addition, studies have documented a high degree of inaccuracy in the clinical judgments of mental health professionals.¹⁷⁸

The Supreme Court's developing preference for informal administrative determinations and the very truncated scope of judicial review in this area also conflicts with the burgeoning research on procedural justice.¹⁷⁹ The consequences in the face of this research are that erroneous

172. 422 U.S. 563 (1975).

173. *Id.* at 584 (Burger, C.J., concurring) (quoting *Greenwood v. United States*, 350 U.S. 360, 375 (1956)).

174. *Id.* at 579.

175. *Parham v. J.R.*, 442 U.S. 584, 609 (1979). "Even under the best of circumstances psychiatric diagnosis and therapy decisions are fraught with uncertainties." *Id.* at 628 (Brennan, J., concurring in part and dissenting in part).

176. *Addington v. Texas*, 441 U.S. 418, 430 (1979).

177. *See, e.g., Foucha v. Louisiana*, 504 U.S. 71, 76 n.3 (1992) (acknowledging probable validity to view that "psychiatry is not an exact science and psychiatrists widely disagree on what constitutes a mental illness"); *id.* at 109 (Thomas, J., dissenting) ("it is unwise . . . to suggest that a determination that a person has 'regained sanity' is precise. 'Psychiatry is not . . . an exact science. . . .'" (quoting *Ake v. Oklahoma*, 470 U.S. 68, 81 (1985))); *Riggins v. Nevada*, 504 U.S. 127, 141 (1992) (Kennedy, J., concurring) (doubtful that experts can establish "baseline of normality" for any particular defendant); *Washington v. Harper*, 494 U.S. 210, 231 (1990) (noting the difficulty in assessing mental patients' intentions); *Schall v. Martin*, 467 U.S. 253, 293-94 (1984) (Marshall, J., dissenting) (evidence "overwhelming" in support of conclusion that available diagnostic tools cannot reliably predict whether minors will act violently); Edmund V. Ludwig, *The Mentally Ill Homeless: Evolving Involuntary Commitment Issues*, 36 VILL. L. REV. 1085, 1100 (1991) ("A number of Supreme Court Justices . . . have written on the incertitude of mental health clinician testimony.").

178. Hal R. Arkes, *Principles in Judgment/Decision Making Research Pertinent to Legal Proceedings*, 7 BEHAV. SCI. & L. 429 (1989); Steve Fuller, *Playing Without a Full Deck: Scientific Realism and the Cognitive Limits of Legal Theory*, 97 YALE L.J. 549 (1988); *see Barefoot v. Estelle*, 463 U.S. 880, 920-22 (1983) (Blackmun, J., dissenting) (noting that professional predictions of violence are more likely to be wrong than correct); *see also* Joseph J. Cocozza & Henry J. Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence*, 29 RUTGERS L. REV. 1084, 1094-1101 (1976); John Monahan & David B. Wexler, *A Definite Maybe: Proof and Probability in Civil Commitment*, 2 LAW & HUM. BEHAV. 37, 40-41 (1978).

179. *See, e.g.,* MICHAEL D. BAYLES, *PROCEDURAL JUSTICE: ALLOCATING TO INDIVIDUALS* (1990); E. ALLAN LIND & TOM R. TYLER, *THE SOCIAL PSYCHOLOGY OF PROCEDURAL JUSTICE*

decisions will go largely unchecked. Mentally disabled persons, left with perceptions of unfairness, will become more resistant to the treatment they are compelled to endure.¹⁸⁰

Procedural justice investigates various methods of dispute resolution, focusing primarily on the fairness of the decisionmaking process as perceived by the participants.¹⁸¹ The results of research on the perceived fairness between adversarial and inquisitorial procedures have been remarkably consistent.¹⁸² First, subjects express a clear preference for adversarial procedures over inquisitorial ones.¹⁸³ Second, subjective judgments of fairness strongly influence this preference; the adversarial process is perceived as more fair than the inquisitorial process.¹⁸⁴ Perceptions of fairness are related to the degree of control that disputants have over the dispute resolution process.¹⁸⁵

One of the consistent findings in the procedural justice literature is that the sense of fairness that arises out of genuinely adversarial proceedings evokes greater satisfaction with the outcome and more acceptance of the verdict, even by the losing party.¹⁸⁶ The failure to provide an adversarial forum, then, is likely to reduce compliance with the decision, thereby producing increased temporal, financial, and administrative burdens on the institutions and professionals who participate in proceedings perceived as unfair, biased, and unjust. Thus, a mental health system that prefers informal procedures and nonlegal decisionmakers to govern the right to refuse treatment may be antitherapeutic and detrimental to the population of mentally disabled persons.¹⁸⁷

(1988); Stephen LaTour, *Determinants of Participant and Observer Satisfaction with Adversary and Inquisitorial Modes of Adjudication*, 36 J. PERSONALITY & SOC. PSYCHOL. 1531 (1978); E. Allan Lind et al., *Voice, Control, and Procedural Justice: Instrumental and Noninstrumental Concerns in Fairness Judgments*, 59 J. PERSONALITY & SOC. PSYCHOL. 952 (1990); Norman G. Poythress, *Procedural Preferences, Perceptions of Fairness, and Compliance with Outcomes*, 18 LAW & HUM. BEHAV. 361 (1994); John Thibaut et al., *Procedural Justice as Fairness*, 26 STAN. L. REV. 1271 (1974).

180. See Paul S. Appelbaum & Thomas G. Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 AM. J. PSYCHIATRY 340, 341 (1980); Winick, *supra* note 20, at 192-99; Bruce J. Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection*, 28 HOUS. L. REV. 15, 46-53 (1991).

181. See LIND & TYLER, *supra* note 179, at 26-30 (discussing studies that show connections between perceived fairness and procedural rules).

182. Blair H. Sheppard, *Justice is No Simple Matter: Case for Elaborating Our Model of Procedural Fairness*, 49 J. PERSONALITY & SOC. PSYCHOL. 953, 956 (1985).

183. See LIND & TYLER, *supra* note 179, at 32-33; LaTour, *supra* note 179, at 1531-33.

184. See LIND & TYLER, *supra* note 179, at 28-29.

185. *Id.* at 34-35; Poythress, *supra* note 179, at 361-62.

186. LIND & TYLER, *supra* note 179, at 11; Susman, *supra* note 60, at 121.

187. The Supreme Court has impliedly acknowledged the therapeutic value of fair procedures in holding that parolees have a right to a probable cause hearing before their paroles may be revoked. *Morrissey v. Brewer*, 408 U.S. 471, 484 (1972); see also *Goldberg v. Kelly*, 397 U.S. 254, 264-65 (1970) (recognizing that a hearing furthered the government interest in reinforcing

Conversely, one study found that formal hearings permitted patients to better understand both their doctor's professional opinions, and reasons for requiring medication.¹⁸⁸ This shows hearings may have substantial therapeutic benefit to the patient; the ability to present an opinion to a physician on a relatively equal basis could help to improve self-esteem. If viewed as a forum for arbitrating a dispute in good faith, hearings also could strengthen the doctor and patient therapeutic alliance, which is crucial for proper treatment.¹⁸⁹ In this fashion, we might view judicial hearings as the only way to allow open exchanges between doctors and patients in settings that are inherently coercive.

VI. CONCLUSION

It is likely that few mental patients have read the Bill of Rights. The immediate problems they are unable to bear may seem remote from the Due Process Clause. Yet, the whole problem of admission of the mentally ill to hospitals is tied to the question of depriving citizens of their personal liberty.

At first glance, it may seem that a proposal for an independent commitment system that relies on non-adversarial procedures cannot be reconciled with an adversarial system necessary to protect the right of patients to refuse treatment. Perhaps it could also be argued that a disjunction between procedures for commitment and procedures for treatment may leave a group of committed patients who cannot be treated and for whom the psychiatric hospital becomes literally a place of detention. On the other hand, the present system is already a thinly disguised form of preventive detention that fails to enhance therapeutic values.

"the Nation's basic commitment . . . to foster the dignity and well-being of all persons within its borders"). Developing legal and psychological literature further examines how the legal system may act more therapeutically. See, e.g., Wexler & Winick, *supra* note 49, at 985 ("Although Chief Justice Warren Burger [in *Parham*] defended his judgment based on concerns that a hearing would burden the family relationship and be detrimental to the therapeutic goals of hospitalization, others have questioned these assumptions and suggested that there is a therapeutic value in holding formal commitment hearings."); see also WEXLER & WINICK, *supra* note 48, at 75-79. See generally DAVID B. WEXLER, THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT (1990).

188. Francine Cournois et al., *A Comparison of Clinical and Judicial Procedures for Reviewing Requests for Involuntary Medication in New York*, 39 HOSP. & COMMUNITY PSYCHIATRY 851, 855 (1988).

189. See, e.g., Paul S. Appelbaum & Stephen K. Hoge, *The Right to Refuse Treatment: What the Research Reveals*, 4 BEHAV. SCI. & L. 279, 291 (1986); Bruce J. Winick, *The Right to Refuse Mental Health Treatment: A Therapeutic Jurisprudence Analysis*, 17 INT'L J.L. & PSYCHIATRY 99, 112 (1994). Even outside the context of a hearing, the American Psychiatric Association has acknowledged that psychiatrists should "maximize the patient's participation in the treatment decisionmaking process; and, if the patient registers objections, to try to understand the basis for these objections . . ." Morris, *supra* note 9, at 434 (quoting AMERICAN PSYCHIATRIC ASS'N, RIGHT TO REFUSE MEDICATION RESOURCE DOCUMENT 3 (1989)).

The primary purpose of civil commitment is not to punish for past acts, but to control future ones. The impetus for a civil commitment system does not stem from retributive or deterrence concerns, but rather is based on a perceived need for incapacitation or treatment, or both. When individuals must be sent to mental hospitals against their will, they should not have to undergo an adversarial procedure where they are likely to be treated like criminals and be tried and convicted of being sick. Moreover, procedures in the admissions process are only stepping-stones to treatment. These procedures do not need to be under judicial control. An independent system, with both psychiatrists and hearing officers specially trained in civil commitment, would refine due process and enhance therapeutic values. As a result, treatment would be more effective, which would reduce the chances for involuntary intervention and lead to earlier release.

At the same time, all individuals hospitalized involuntarily are entitled to watchful protection of their rights, protection that arguably only the courts can provide.¹⁹⁰ Indeed, involuntarily hospitalized individuals are citizens first and mental patients second. For all its faults, the courtroom is still the most objective and fair forum for resolving disputes. The courts represent one branch of government whose mission is not to follow the whims of the majority. By design, men and women who remain relatively insulated from minor fluctuations in public opinion steer the courts. Therefore, the courts are uniquely capable and thus responsible for the protection of those whom the larger society may choose to ignore. Those concerned with civil commitment and involuntarily confined patients' legal rights will demand procedures that minimize the possibility of infringement of those rights, since it is the business of law to protect patients' constitutional rights.

DOUGLAS S. STRANSKY

190. *Contra* Samuel J. Brakel & John M. Davis, *Taking Harms Seriously: Involuntary Mental Patients and the Right to Refuse Treatment*, 25 *IND. L. REV.* 429, 433-34 & n.14 (1991) (noting that medical professionals rather than judges should make treatment refusal decisions). However, even Brakel and Davis concede that constitutional grounds may rebut this contention. *Id.* at 434.