Journal of Criminal Law and Criminology

Volume 81
Issue 4 *Winter*

Article 10

Winter 1991

Fourteenth Amendment--The Right to Refuse Antipsychotic Drugs Masked by Prison Bars

Patricia E. Sindel

0091-4169/91/8104-952
THE JOURNAL OF CRIMINAL LAW & CRIMINOLOGY
Vol. 81, No. 4
Printed in U.S.A.

FOURTEENTH AMENDMENT—THE RIGHT TO REFUSE ANTIPSYCHOTIC DRUGS MASKED BY PRISON BARS

Washington v. Harper, 110 S. Ct. 1028 (1990)

I. INTRODUCTION

In *Washington v. Harper*,[1] the United States Supreme Court reversed a Washington State Supreme Court decision[2] that required a judicial hearing before a prison inmate could be given antipsychotic drugs against his will.[3] The *Harper* Court determined that while a prison inmate retained a liberty interest in avoiding forced administration of antipsychotic drugs,[4] such treatment also served legitimate state interests. The Court further determined that the Washington State regulation governing involuntary treatment was related reasonably to the penological concerns asserted,[5] and provided adequate procedural protections under the due process clause of the fourteenth amendment.[6]

Confinement does not obliterate all constitutional rights; therefore, the finding that a prison inmate retains a liberty interest in avoiding antipsychotic drug treatment is consistent with past judicial policy. This Note argues that defining the liberty interest as "significant" rather than "fundamental" influenced the Court's ultimate decision in this case. The right to decide whether or not to take medication that chemically alters the mind and has potentially serious side effects is a fundamental liberty interest.

No liberty interest, though, is absolute; thus, in certain circumstances, a state's interests may outweigh an individual's liberty interest. This Note concludes that if the state's security and administrative concerns were inseverable from the state's obligation to provide medical treatment to a prison inmate, then the Washington regulation was related reasonably to legitimate penological con-

1 110 S. Ct. 1028 (1990).
2 Harper v. State, 110 Wash. 2d 873, 759 P.2d 358 (1988).
3 *Harper*, 110 S. Ct. at 1044.
4 *Id.* at 1036.
5 *Id.* at 1039.
6 *Id.* at 1044.

cerns. Had the *Harper* Court viewed each asserted state interest separately, however, its conclusions arguably would have been different. First, viewed in isolation, neither asserted interest would have been legitimate; and second, the regulation would not have been reasonably related to either interest. This Note thus concludes that had the Court defined the interest as fundamental rather than significant, it readily could have concluded that the regulation was an exaggerated response to penological concerns.

Washington's challenged regulation called for a hearing committee to review a doctor's prescription of drug treatment when the inmate refused such treatment. This Note concludes that, although a judicial hearing may not cure the problem of bias among the hearing committee members because of deference given to professional judgment, it at least affords the individual more protection for his fundamental right than a potentially biased hearing committee would.

Finally, this Note argues that in the appropriate circumstances, requiring formal commitment proceedings, with their attendant procedural safeguards, would better protect the inmate's interests.

II. BACKGROUND

A. THE FACTS[7]

Walter Harper was sentenced to the Washington State Penitentiary in Walla Walla for robbery.[8] From 1976 to 1980, the state housed him in the mental health unit there.[9] During that time, he voluntarily underwent antipsychotic drug therapy.[10] The state paroled Harper in 1980, contingent upon participation in psychiatric treatment.[11] The state revoked his parole after he assaulted two

[7] The facts are undisputed. Harper v. State, 110 Wash. 2d 873, 874, 759 P.2d 358, 360 (1988). For a full recording of the facts, see Petition for Writ of Certiorari to the Supreme Court of the State of Washington, Appendix B, Findings of Facts and Conclusions of Law, Washington v. Harper, 110 S. Ct. 1028 (1990) (No. 88-599) [hereinafter Findings of Facts].

[8] *Harper*, 110 Wash. 2d at 874, 759 P.2d at 360.

[9] *Harper*, 110 S. Ct. at 1032. Harper did not plead insanity as a defense. Findings of Facts, *supra* note 7, at B-4.

[10] *Harper*, 110 S. Ct. at 1032. Harper received a variety of antipsychotic drugs, including Trialafon, Haldol, Prolixin, Taractan, Loxitane, Mellaril, and Navane. Antipsychotic drugs, sometimes called "neuroleptics" or "psychotropic drugs," are medications often used for mental disorders such as schizophrenia. These medications affect the chemical balance in the brain and are administered to assist the patient in organizing his or her thoughts and in regaining a rational state of mind. These drugs have potential serious side effects. *Id.* For a discussion of the benefits versus the risks of antipsychotic drug treatment, see *infra* notes 100-117 and accompanying text.

[11] *Harper*, 110 S. Ct. at 1032.

nurses at Saint Cabrini Hospital in Seattle.[12] Upon return to prison, Harper went to the Special Offenders Center (SOC)[13] at Monroe in January, 1982.[14] Until November 1982, Harper voluntarily submitted to treatment including administration of antipsychotic drugs.[15] Upon his refusal to continue the drugs, Dr. Petrich, his attending physician, recommended that the medication be continued against Harper's will.[16]

Dr. Petrich presented his recommendation to a hearing committee, which authorized the administration of the drugs.[17] Harper appealed the decision to the Monroe Reformatory Superintendent, who upheld the decision.[18] For approximately one year, Harper continued to be medicated involuntarily.[19] In November, 1983, the state transferred Harper to the Washington State Reformatory, where he did not take any medication.[20] His condition deteriorated; one month later, the state transferred him back to the SOC. After another hearing, the involuntary drug treatment was reinstated.[21] The SOC medicated Harper until June 1986, when the state transferred him to the Washington State Penitentiary.[22]

Special Offenders Center Policy 600.30 provided the procedures for medicating Harper against his will.[23] The Findings of

---

12 *Id.* at 1033.

13 The SOC is a 144-bed correctional institution administered by Washington State's Department of Corrections. The state established the SOC to provide diagnosis and treatment of convicted felons having serious behavioral or mental disorders. The SOC's purpose is to help inmates attain a level of functioning so that they can be transferred to another correctional facility where they can serve the rest of their sentence. *Id.*

14 *Id.*

15 *Id.*

16 *Id.*

17 *Id.* at 1034.

18 *Id.*

19 *Id.*

20 *Id.*

21 *Id.*

22 *Id.* The state returned Harper to the SOC in April, 1987. In accordance with SOC Policy 600.30, Harper was medicaed involuntarily from September 1987 until May 1988, when the Washington Supreme Court rendered its opinion. *Id.* at 1035 n.6.

23 An earlier Supreme Court decision influenced the formulation of SOC Policy 600.30. Vitek v. Jones, 445 U.S. 480 (1980). In *Vitek*, the Court found that Nebraska infringed the liberty interests of a prison inmate when the inmate was transferred involuntarily from the state prison to a state mental hospital for treatment of a mental disease. *Id.* at 487-94. The Court found that the transfer to a mental hospital was stigmatic, involved exposure to behavior modification techniques, and was a major change in the conditions of confinement. *Id.* at 492. The Court enunciated clear standards for determining if the transfer should occur. Such transfers must be accompanied by adequate notice, opportunity for hearing before an independent decision-maker, a written statement by the fact-finder of the evidence relied on and the reasons for the decision, and provision by the state of a licensed attorney or lay advisor. *Id.* at 494-95.

Facts describe these procedures:

> a. [A] prisoner may be involuntarily medicated only where he suffers from a mental disorder and as a result of which is either gravely disabled or presents a likelihood of serious harm to himself or others . . . .[24]
>
> b. Medications must be ordered by, or in emergencies, approved by a psychiatrist. Where the patient/prisoner refuses medication, a special hearing committee is convened, consisting of a psychiatrist, psychologist, and the Associate Superintendent of SOC. None of the committee members may be currently involved in treatment or diagnosis of the patient . . . .
>
> c. The prisoner has certain procedural rights prior to the hearing, including i. twenty-four hours notice, during which time he may not be medicated; ii. notice of the tentative diagnosis, factual basis for the diagnosis, and the basis on which medical treatment is necessary.
>
> d. At the hearing the prisoner has the right to be present and present evidence; the institution is required to present its evidence; the inmate may present his own witnesses and cross examine the staff witnesses. The prisoner is also entitled to a lay advisor who has an understanding of the psychiatric issues in the case.
>
> e. [T]he prisoner has the right to appeal to the SOC Superintendent.
>
> f. After the initial hearing, involuntary medication can continue only with periodic reviews.[25]

The Court further explained that when Harper was initially

Justice White delivered the opinion for the Court, except on the issue of provision of a licensed attorney. Justice Powell delivered the opinion on this issue, concluding that a prison inmate is not constitutionally entitled to such counsel in a hearing for transfer to a mental hospital. *Id.* at 497-500.

[24] "Mental disorder" means "any organic, mental or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions." WASH. REV. CODE § 71.05.020(2) (Supp. 1990).

"Gravely disabled" means

> a condition in which a person, as a result of a mental disorder: (a) [i]s in danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety, or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety.

Id. § 71.05.020(1).

"Likelihood of serious harm" means

> either (a) [a] substantial risk that physical harm will be inflicted by an individual upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on one's self, (b) a substantial risk that physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm, or (c) a substantial risk that physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others.

Id. § 71.05.020(3).

[25] Findings of Fact, *supra* note 7, at B-3-4.

medicated the policy required the hearing committee to review its decision to medicate after seven days. If reapproved, medication could continue for fourteen days. At the end of the two week period, the policy required the treating psychiatrist to review the case and submit a report to the Department of Corrections Medical Director in Olympia for review. These fourteen day reviews continued as long as the patient was involuntarily medicated. The state amended SOC Policy 600.30 to allow a fourteen day initial treatment rather than a seven day period. If treatment continued for one hundred and eighty days, the state required the SOC to conduct a new hearing to consider the need for further treatment.[26] Finally, an inmate may obtain judicial review of the hearing committee's decision through either a personal restraint petition or a petition for an extraordinary writ.[27]

Harper did not dispute that the state followed the SOC procedures.[28] Nevertheless, in February, 1985, he filed suit in state court under 42 U.S.C. section 1983, claiming that the policy's failure to provide a judicial hearing before the involuntary administration of antipsychotic drugs violated the due process, equal protection, and free speech clauses of both the United States and Washington State Constitutions, as well as Washington tort law.[29]

B. THE TRIAL COURT DECISION

In March, 1987, the trial court dismissed the complaint with prejudice.[30] The court concluded the following: first, Harper did have a liberty interest protected by the due process clause in not being given antipsychotic medications; second, the decisions made by the Special Hearing Committee were in accordance with SOC Policy 600.30; and third, the SOC policy is consistent with the due process requirements of the Constitution.[31]

C. WASHINGTON SUPREME COURT OPINION

In a direct appeal, the Washington State Supreme Court, sitting *en banc*, reversed. Justice Brachtenbach authored the unanimous de-

---

[26] *Id.*

[27] *Harper*, 110 S. Ct. at 1034.

[28] Harper v. State, 110 Wash. 2d 873, 876, 759 P.2d 358, 361 (1988).

[29] Joint Appendix to Petition for Writ of Certiorari at 7, Washington v. Harper, 110 S. Ct. 1028 (1990) (No. 88-599). The Washington Supreme Court based its decision on due process grounds. The petition for certiorari only raised due process concerns; thus, the Court ignored equal protection and free speech claims and confined its analysis to due process issues. 110 S. Ct. at 1035 n.5.

[30] *Harper*, 110 S. Ct. at 1034.

[31] Findings of Facts, *supra* note 7, at B-8-9.

cision, holding that a prisoner is entitled to a judicial hearing before antipsychotic drugs can be administered against his will.[32]

Justice Brachtenbach agreed with the trial court that Harper had a protected liberty interest in refusing antipsychotic drug treatment, but concluded that this interest required the highest level of protection.[33] The court had previously ruled that refusal of electroconvulsive therapy (ECT) was a fundamental liberty interest requiring a high level of protection.[34] The court found administering antipsychotic drugs, given their serious side-effects, no less intrusive than ECT.[35]

Justice Brachtenbach did not agree, however, that the procedures of the SOC Policy 600.30 adequately protected this fundamental liberty interest. The court distinguished *Vitek v. Jones*,[36] which "concerned . . . the 'stigmatizing consequences' of a transfer to a mental health hospital for involuntary psychiatric treatment consisting of a behavior modification program."[37] Because the involuntary ingestion of antipsychotic drugs raised the prospect of serious, potentially permanent side-effects, the court determined Harper's liberty interest required greater protection than that in *Vitek*.[38]

The court held that involuntary antipsychotic drug treatment could be ordered by a court if, in a judicial hearing, the State "proves (1) a compelling state interest to administer antipsychotic drugs, and (2) the administration of the drugs is both necessary and effective for furthering that interest."[39] The court remanded the case to the lower court to make specific findings with regard to the state's interest in the treatment, the necessity and effectiveness of the treatment, and the desires of the patient.[40]

---

32 Harper v. State, 110 Wash. 2d at 881, 759 P.2d at 363.

33 *Id.* at 876, 759 P.2d at 361-62.

34 *In re* Schuoler, 106 Wash. 2d. 500, 723 P.2d 1103 (1986).

35 *Harper*, 110 Wash. 2d at 878, 759 P.2d at 362.

36 445 U.S. 480 (1980).

37 *Harper*, 110 Wash. 2d at 880, 759 P.2d at 363 (citing Vitek v. Jones, 445 U.S. 480, 494 (1980)).

38 *Id.*

39 *Id.* at 883, 759 P.2d at 364. The court refused to apply a reasonable relation analysis to the medication policy as urged by the state, finding that the uniquely intrusive nature of antipsychotic drug treatment was distinguishable from the first amendment interests involved in the cases cited by the state, Turner v. Safley, 482 U.S. 78 (1987) and O'Lone v. Estate of Shabazz, 482 U.S. 342 (1987). *Harper*, 110 Wash. 2d at 883, 759 P.2d at 364 n.9.

40 *Id.* at 884, 759 P.2d at 365. The lower court could also enter a substitute judgment on behalf of the prisoner in accordance with *Schuoler*. *Id.* (citing *In re* Schuoler, 106 Wash. 2d 500, 723 P.2d 1103 (1986)).

III. Opinions of the Supreme Court

The Supreme Court granted certiorari to decide whether a judicial hearing was required before a state could treat a mentally ill prisoner with antipsychotic drugs against his will. Resolution of the issue required a discussion of the protections afforded a prisoner under the due process clause of the fourteenth amendment.[41]

Justice Kennedy wrote the opinion for the Court; he was joined by Chief Justice Rehnquist and Justices White, Blackmun, O'Connor, and Scalia. The Court first addressed Harper's contention that the case was moot because the state had ceased administering antipsychotic drugs to him against his will.[42] The Court unanimously decided that the case was ripe for adjudication.[43] Beyond the mootness issue, Justice Stevens wrote a dissenting opinion, in which Justices Brennan and Marshall joined.

A. THE MAJORITY OPINION

The Court first determined that Harper did have a liberty interest in "avoiding the unwanted administration of antipsychotic drugs."[44] The Court reasoned that SOC Policy 600.30 allowed Harper to have an expectation that the drugs would not be arbitrarily administered.[45] According to Justice Kennedy, the due process clause of the fourteenth amendment confirmed that expectation.[46] The inmate's right to refuse medication, however, is limited by the fact of his or her confinement.[47] Justice Kennedy explained that the limitation comes from considering the inmate's medical interests, given the legitimate needs of the institution.[48] The Court concluded that Harper retained a liberty interest in refusing the drugs, but that interest was not greater than that set forth in the state-created policy.[49]

The Court applied the standard of review for prison regulations

41 Washington v. Harper, 110 S. Ct. 1028, 1032 (1990).

42 *Id.* at 1035.

43 *Id.* At the time of the decision, no evidence demonstrated that Harper had recovered from his mental illness. He was still serving his sentence. He previously had been transferred back to the SOC. As the Court pointed out, in April, 1987, two years after he filed his claim, the state transferred Harper back to the Center and involuntarily medicated him pursuant to Policy 600.30 from September 1987 to May 1988. The SOC suspended medication only because of the Washington Supreme Court's decision. The possibility existed that Harper would be medicated again, against his will. *Id.*

44 *Id.* at 1036.

45 *Id.*

46 *Id.* at 1037.

47 *Id.*

48 *Id.*

49 *Id.* at 1040.

enunciated in *Turner v. Safley*[50] and *O'Lone v. Estate of Shabazz*.[51] This standard states that a prison regulation that is claimed to infringe on an inmate's constitutional rights is valid if it is "reasonably related to legitimate penological interests."[52] Applying the three relevant factors taken from *Turner* to determine the reasonable relation to the challenged prison regulation, the Court concluded that SOC Policy 600.30 comported with constitutional requirements.[53] The government interests asserted to justify the regulation included the obligations to provide medical treatment and to insure the safety of the prison population, including staff and administrative personnel.[54] According to the Court, there could be no doubt that these were legitimate objectives.[55] Treating mentally ill inmates who posed a danger to themselves and/or others was a "rational means" of furthering the state's legitimate objectives.[56] The Court found no apparent alternatives to satisfying the state's interests.[57]

Turning to the procedural protections necessary to protect Harper's liberty interest in refusing the drug treatment, the Court held that SOC Policy 600.30 comported with procedural due process demands.[58]

Taking into consideration the inmate's private interests, the government's interests, and the value of the procedural requirements, the Court first tackled the primary issue of whether or not a judicial hearing was required.[59] Recognizing that the due process clause never has required that the trier of fact be trained legally,[60]

---

50 482 U.S. 78 (1987) (prison regulation concerning marriage held constitutionally invalid and another concerning inmate correspondence held constitutionally valid).

51 482 U.S. 342 (1987) (prison regulation concerning participation in religious service held constitutionally valid).

52 *Turner*, 482 U.S. at 89.

53 *Harper*, 110 S. Ct. at 1038. The three relevant factors are as follows: (1) " 'a "valid, rational connection" between the prison regulation and legitimate governmental interest put forward to justify it,' " *id.* (quoting *Turner*, 482 U.S. at 89); (2) the impact that accommodating the individual's constitutional right will have on the prison population and the allocation of resources, *id.* (citing *Turner*, 482 U.S. at 90); and (3) the absence of ready alternatives without having to shoot down all conceivable possibilities, *id.* (citing *Turner*, 482 U.S. at 90-91). *Id.*

54 *Id.* at 1037, 1039.

55 *Id.* at 1038.

56 *Id.* at 1039.

57 *Id.* The Court rejected Harper's proffered alternative, that as a precondition to antipsychotic drug treatment, the State must find him incompetent and then obtain court approval of the treatment using a "substituted judgment" standard. The Court also found physical restraints or seclusion unsatisfactory.

58 *Id.* at 1040.

59 *Id.*

60 *Id.* at 1042 (citing Parham v. J.R., 442 U.S. 584, 607 (1979)). In *Parham*, a severely retarded man was found to have constitutional rights to safe conditions and freedom

the Court concluded that medical personnel were better equipped to assess the necessity of medication, especially for the mentally ill.[61] The Court reasoned that the prisoner's interests were protected, because the medical personnel must have determined the following: first, the inmate suffered from a mental disorder; and second, as a result of that disorder, he was dangerous to himself or others.[62] Because the decision was mainly a medical one, the Court held that a state may conclude that a judicial hearing would not be effective.[63]

The Court further determined that SOC Policy 600.30 provided adequate procedural safeguards for the protection of the inmates interests.[64] Policy 600.30, without evidence to the contrary, provided for notice, the right of the prisoner to be present at the hearing, and the right to present and cross-examine witnesses.[65] The Court also was satisfied that the involvement of an independent lay advisor who understood the psychiatric issues would also provide sufficient protection.[66]

The Court, in conclusion, found that the challenged regulation met the demands of the due process clause, because

> [i]t is an accommodation between an inmate's liberty interests in avoiding the forced administration of antipsychotic drugs and the state's interests in providing appropriate medical treatment to reduce the danger that an inmate suffering from a serious mental disorder represents to himself or others.[67]

B. JUSTICE STEVENS' DISSENTING OPINION

Justice Stevens took issue with both the majority's definition of the liberty interest and what procedures were necessary to protect that liberty interest.

According to Justice Stevens, Harper's right to refuse anti-

---

from bodily restraint; whether his rights had been adequately protected was a decision left to professionals and considered presumptively valid.

61 *Id.* at 1042-43. In addition to *Parham*, the Court relied on Youngberg v. Romeo, 457 U.S. 307 (1982), to substantiate this conclusion. In *Romeo*, the Court held that children had a constitutional right to be free from confinement; therefore, in a parent's commitment application for the child, great deference was given to the professional in determining the child's medical needs. *Id.*

62 *Harper*, 110 S. Ct. at 1042-43.

63 *Id.*

64 *Id.* at 1043.

65 *Id.* at 1044. The Court also saw no reason why the rules of evidence should be followed when medical personnel make the decision. *Id.*

66 *Id.*

67 *Id.*

psychotic drugs was fundamental.[68] The interest had two essential dimensions. The physical dimension stemmed from the desire to avoid the highly intrusive invasion of the drugs into the body, which could cause serious, potentially permanent, side effects. The intellectual dimension stemmed from our nation's most basic value, the right to be free in thoughts, emotions, sensations, and beliefs.[69] Justice Stevens equated forced drugging with altering the will and the mind of the individual.[70] In defining the liberty interest, Justice Stevens, unlike Justice Kennedy, greatly emphasized Harper's adamant refusal of the drug treatment and the side effects he already was experiencing.[71]

Justice Stevens agreed that a state interest[72] might be advanced to justify the deprivation of this liberty interest.[73] The majority said that providing the drugs in the medical interests of the inmate was a legitimate state interest. According to the dissent, however, the SOC policy failed on the majority's terms, because it did not require a finding that the drugs would benefit the inmate's medical condition.[74] The only justifications Justice Stevens found for the forced administration of the drugs were institutional and administrative concerns, especially prison security.[75]

Although the state certainly had a legitimate interest in prison security, according to Justice Stevens, the Court misapplied the standard of review announced in *Turner*.[76] The dissent contended that the SOC policy was not related reasonably to the interest in security and management. Rather it was an exaggerated response to a legitimate purpose.[77]

---

68 *Id.* at 1047 (Stevens, J., dissenting).

69 *Id.* at 1045 (Stevens, J., dissenting).

70 *Id.* (Stevens, J., dissenting).

71 *Id.* at 1046 nn. 5 & 8 (Stevens, J., dissenting).

72 The three possible state interests that could have been asserted included: (1) drug treatment as punishment for the crime he committed; (2) as a "cure" for his mental illness; or (3) as a mechanism to maintain order in the prison. According to the dissent, the Court recognized Harper's liberty interest only as against the first. *Id.* at 1047 (Stevens, J., dissenting).

73 *Id.* (Stevens, J., dissenting).

74 *Id.* at 1049 (Stevens, J., dissenting).

75 *Id.* at 1051 (Stevens, J., dissenting).

76 *Id.* at 1049 (Stevens, J., dissenting).

77 *Id.* at 1050 (Stevens, J., dissenting). The dissent illustrated this by reference to another SOC policy for involuntary medication in emergency situations when the inmate poses a serious harm to himself and others. The policy is to medicate involuntarily the individual. According to Justice Stevens, the state makes no distinction between the emergency and non-emergency situations; thus, addressing security risks by forced use of antipsychotic drugs in a non-emergency situation was an "exaggerated response" to that concern. *Id.* (Stevens, J., dissenting).

Justice Stevens' main objection to Justice Kennedy's analysis was its failure to consider separately the asserted justifications for forced medication—the inmate's medical interests and the security concerns.[78] According to Justice Stevens, the majority opinion resulted in a "muddled rationale" combining state and individual medical interests which, in the end, only protected institutional concerns at the expense of the inmate's "substantive" liberty interest.[79]

In the dissent's eyes, the Court fared no better in considering what procedures were necessary to protect the liberty interest.[80] Justice Stevens objected that the members of the hearing committee were not disinterested parties for several reasons.[81] First, the panel members had to review the work of treating physicians—their colleagues—and, on subsequent occasions, those very panel members' work might be before another hearing committee. Such a system forced colleagues to sit in judgment of one another.[82] Second, the policy only proscribed the attending physician from participating in the *initial* seven day medication approval.[83] Third, the composition of the committee ensured that its decisions were biased toward institutional concerns.[84] Finally, all the other procedural "safeguards" seemed to be geared toward institutional concerns.[85] In sum, the dissent objected to the institutional concerns that plagued the decision to administer antipsychotic drugs, with seemingly little regard for the inmate's medical interest, thus depriving an inmate of a fundamental liberty interest.

IV. Analysis and Discussion

A. The Substantive Issue

The Supreme Court recognized that the question of whether a prisoner is entitled to a judicial hearing before antipsychotic drugs

78 *Id.* at 1051 (Stevens, J., dissenting).

79 *Id.* (Stevens, J., dissenting).

80 *Id.* at 1052 (Stevens, J., dissenting).

81 *Id.* (Stevens, J., dissenting).

82 *Id.* (Stevens, J., dissenting).

83 *Id.* at 1053 (Stevens, J., dissenting) (emphasis added). In fact, Dr. Petrich, Harper's attending physician, participated in the committee that approved long-term medication after the initial seven day period. *Id.* (Stevens, J., dissenting).

84 *Id.* (Stevens, J., dissenting). Only one member of the three person committee is trained and licensed to prescribe antipsychotic drugs, and one member has no medical expertise at all. In addition, appeals are made to the SOC superintendent. *Id.* at 1053-54 (Stevens, J., dissenting).

85 *Id.* at 1055 (Stevens, J., dissenting). The committee need not consider less intrusive measures or the severity of the medication being prescribed. The hearing is only for the seven day initial period and the inmate has no opportunity to object to the decision to medicate on a long-term basis. *Id.* at 1054-55 (Stevens, J., dissenting).

can be administered against his or her will had substantive as well as procedural aspects.

A substantive due process issue first involves defining the constitutionally protected interest and then deciding under what circumstances the state's interest might outweigh it.[86] In *Harper*, the issue specifically was "what factual circumstances must exist before the state may administer antipsychotic drugs to the prisoner against his will?"[87]

1. The Individual's Liberty Interest

Defining the liberty interest is crucial to the ultimate decisions of when the constitutionally protected interest may be overridden and what procedures will safeguard the liberty interest. The Court was unanimous in deciding that Harper had a liberty interest in avoiding the unwanted administration of antipsychotic drugs. The members of the Court could not agree on whether or not the interest was a fundamental one. The Court, though, lacked an objective method for determining what constitutes a liberty interest.

> 'While this Court has not attempted to define with exactness the liberty . . . guaranteed [by the fourteenth amendment] the term has received much consideration and some of the included things have been definitely stated. Without doubt, it denotes not merely freedom from bodily restraint but also the right of the individual to contract, to engage in any of the common occupations of life, to acquire useful knowledge, to marry, establish a home and bring up children, to worship God according to the dictates of his own conscience, and generally to enjoy those privileges long recognized . . . as essential to the orderly pursuit of happiness by free men.' . . . In a Constitution for a free people, there can be no doubt that the meaning of 'liberty' must be broad indeed.[88]

The definition of liberty interests apparently is left to the discretion of the Court. The majority in *Harper* defined the liberty interest at issue as significant, but recognized that the right was no greater than that defined by the state.[89] However, the dissent defined it as a "fundamental liberty interest deserving the highest order of protection."[90] Without an objective means for deciding between these two definitions, neither approach can be wrong.

---

86 Mills v. Rogers, 457 U.S. 291, 299 (1982).

87 *Harper*, 110 S. Ct. at 1036.

88 Board of Regents v. Roth, 408 U.S. 564, 572 (1972) (quoting Meyer v. Nebraska, 262 U.S. 390, 399 (1923)).

89 *Harper*, 110 S. Ct. at 1037.

90 *Id.* at 1047 (Stevens, J., dissenting).

Given the importance of the individual's decision about medical care, though, the latter definition makes more sense.

The Washington legislature created a liberty interest to which Harper was entitled; namely, the reasonable expectation that unwanted antipsychotic drugs would not be administered indiscriminately. Even though the state liberty interest may not exist under the federal constitution, the Supreme Court nonetheless recognizes state created liberty interests and requires procedural protections for said interests.[91]

In *Harper*, the state created liberty interest also existed under the due process clause.[92] If a state policy creates a liberty interest but provides less protection than the federal constitution would provide, then the policy will be declared unconstitutional. Thus, how the Court defines the liberty interest protected by the constitution is crucial. Harper's constitutional right to refuse drugs required greater protection than Policy 600.30 afforded, because it was a fundamental liberty interest requiring the highest order of protection, and prison bars did not affect the fundamental nature of the interest.

It is well established that, although deprived of freedom, a prisoner retains his or her constitutional rights,[93] including the right to due process of law.[94] However, the majority could not find that Harper retained a fundamental liberty interest, because it did not isolate the liberty interest from the needs of the institution.[95] Justice Kennedy failed to support why a prisoner's right under the due process clause "must be defined in the context of the inmate's confinement."[96] On the other hand, the dissent argued that the majority ignored the "physical" and "intellectual" dimensions of the liberty interest, because it not only failed to consider the serious and potentially permanent injury, even early death the drugs can cause, but it also overrode "a competent person's choice to reject a specific form of medical treatment."[97]

---

91 *See* Hewitt v. Helms, 459 U.S. 460 (1983).

92 Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2851 (1990) (competent individual has a constitutionally protected liberty interest in refusing unwanted medical treatment).

93 *See, e.g.*, O'Lone v. Estate of Shabazz, 482 U.S. 342, 348 (1987); Turner v. Safley, 482 U.S. 78, 84 (1987); Bell v. Wolfish, 441 U.S. 520, 545 (1979); Pell v. Procunier, 417 U.S. 817, 822 (1974); Procunier v. Martinez, 416 U.S. 396, 412 (1974).

94 Wolff v. McDonnell, 418 U.S. 539 (1974).

95 Washington v. Harper, 110 S. Ct. 1028, 1037 (1990).

96 *Id.*

97 *Id.* at 1045 (Stevens, J., dissenting). A competent person is entitled to reject medical treatment. Cruzan v. Director, Missouri Dep't of Health, 110 U.S. 2841, 2851 (1990); United States v. Stanley, 483 U.S. 669, 710 (1987); Mills v. Rogers, 457 U.S. 291,

Conflicting assessments of the scientific data concerning the risks and benefits of antipsychotic drug treatment influenced Justice Kennedy's and Justice Stevens' definitions of the liberty interest, and therefore, how each ultimately decided the issue. Prescribing antipsychotic drugs to an inmate against his will presented a novel issue for the Court, but weighing the risks and benefits of antipsychotic drugs did not.[98] The courts' assessments of risks and benefits have not been consistent.[99] This comes as no surprise considering the disagreement among medical experts. The American Psychiatric Association (APCA) and the American Psychological Association (APLA) filed amicus curiae briefs in *Washington v. Harper*, the former on behalf of the State of Washington, and the

294 n.4 (1982); Doe v. Bolton, 410 U.S. 179, 213 (1973). The notion that mind altering is a deprivation of liberty, in the most literal and fundamental sense, is derived from the right to be let alone set out in Olmstead v. United States. 277 U.S. 438, 478 (1928). If Harper was not a prison inmate, no doubt can exist that he would have a right to refuse the administration of any medication, including antipsychotic medication. Overcoming such a right would require a compelling state interest.

98 *See, e.g.*, United States v. Charters, 863 F.2d 302 (4th Cir. 1988), *cert. denied*, 110 S. Ct. 1317 (1990). In *Charters*, the federal government had committed a prison inmate involuntarily to a psychiatric hospital. The trial court declared the inmate was incompetent to stand trial because of the danger he posed to himself and others. Without accepting a particular assessment of drug treatment, the Fourth Circuit held that the inmate did retain a liberty interest, but the decision to medicate against the patient's will was at base a medical one and did not require judicial approval. *See also* Bee v. Greaves, 744 F.2d 1387 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214 (1985). A pretrial detainee, while in jail, challenged the forcible administration of antipsychotic drugs. The plaintiff had been found competent to stand trial. The court recognized that the pretrial detainee retains a liberty interest in refusing unwanted drugs. Because of the potentially serious side-effects, the Tenth Circuit held that the state's security interest could only overcome the inmate's interest if less restrictive alternatives were considered. It further held that extended medication may represent an exaggerated response to the legitimate state purpose of security. *See also* Rennie v. Klein, 653 F.2d 836 (3d Cir. 1981), *vacated and remanded*, 458 U.S. 1119 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983). In *Klein*, the Third Circuit concluded that mentally ill patients committed involuntarily to state institutions retain a constitutional right to refuse antipsychotic drugs. Only after the patient is found to endanger himself or others can professionals make the decision to involuntarily medicate. The decision is presumed valid unless it is shown to be a substantial departure from accepted professional judgment. Finally, see Mills v. Rogers, 457 U.S. 291 (1982), *overruled on other grounds*, Pennhurst State School & Hospital v. Halderman, 465 U.S. 89 (1984), *on remand*, 738 F.2d 1 (1st Cir. 1984). This complex litigation concerned the rights of involuntarily committed mentally ill patients. In *Rogers*, the First Circuit avoided the constitutional question, vacated the lower court's decision, and remanded the case for a determination of the rights and duties of the parties entirely under state law. *See also infra* notes 136 and 163 for discussion of *Rogers*.

99 *Cf.* Goedecke v. State, 198 Colo. 407, 603 P.2d 123 (1979) (en banc) (court concentrated on the negative side effects in a right to refuse case); State v. Hayes, 118 N.H. 458, 389 A.2d 1379 (1978); State v. Jojola, 89 N.M. 489, 553 P.2d 1296 (Ct. App. 1976); State v. Law, 270 S.C. 664, 244 S.E.2d 302 (1978) (courts recognized competency restoring qualities of antipsychotic drugs when criminal defendants were to appear in court).

latter on behalf of Harper. The diametrically opposed views of these two associations illustrate the depth of professional disagreement.

It is undisputed that antipsychotic drugs are important to the treatment of mental disorders.[100] It is also undisputed that antipsychotic drug treatment can result in potentially serious and, in some cases, permanent side-effects.[101] The dispute arises in weighing the benefits and risks.[102] Without commenting on the relative success of drug treatment or the relative gravity of side-effects, the following attempts to sketch the two sides of the issue.

Antipsychotic drugs have been used widely to treat psychoses, particularly schizophrenia.[103] The chemical effect is to clear hallucinations and delusions produced by the psychoses. This, in turn, provides stability, facilitates therapy, and reduces hospitalization.[104] Some experts have gone as far as to suggest that the drugs "reinforce the most important aspects of mental functioning" and have a normalizing effect.[105] However, it is also undisputed that serious side effects exist.

The side-effects of antipsychotic drugs include dystonia, a severe involuntary spasm of the upper throat, tongue or eyes; akathe-

100 Buried in the APLA's severe criticism of antipsychotic drugs is a concession that "[t]he use of [antipsychotic] drugs may be appropriate to treat schizophrenia, paranoia, childhood psychosis, and certain neuropsychiatric disorders such as Tourette syndrome and Huntington's chorea." It further recognized that "[f]or some patients, these drugs may be helpful—even essential—in restoring mental function." Brief of the American Psychological Association as Amicus Curiae in Support of Respondent at 10, 15, Washington v. Harper, 110 S. Ct. 1028 (1990) (No. 88-599) [hereinafter APLA Brief].

101 The APCA's glowing review of antipsychotic drug treatment readily admits "psychotropic medication may cause unwanted side effects" and does not wish to "diminish the gravity of [particular] uncomfortable and potentially serious side effect[s] of antipsychotic medication." Brief of the American Psychiatric Association and the Washington State Psychiatric Association as Amici Curiae in Support of Petitioner at 14, 16, Washington v. Harper, 110 S. Ct. 1028 (1990) (No. 88-599) [hereinafter APCA Brief].

102 Accounting for the biases of the two professional associations is beyond the scope of this article. However, it is not unreasonable to assume a certain inclination on the part of psychiatrists to view mental disorders as organic, thereby favoring the use of drugs, and for psychologists to concentrate on the social and mental aspects of the disease, thereby disdaining the use of drugs in favor of an alternative method of treatment. This debate is not likely to be settled in the near future.

103 APCA Brief, *supra* note 101, at 11 (citing Kane, *Treatment of Schizophrenia*, 13 SCHIZOPHRENIA BULL. 133 (1987).

104 *Id.* at 12 (citing Appelbaum & Gutheil, *Rotting with Their Rights On*, 7 BULL. AM. ACAD. PSYCHIATRY & L. 306, 308 (1979); Spohn, *Phenothiazine Effects on Psychological and Psychophysiological Dysfunction in Chronic Schizophrenics*, 34 ARCHIVES GEN. PSYCHIATRY 633 (1977)).

105 Gutheil & Appelbaum, *"Mind Control," "Synthetic Sanity," "Artificial Competence," and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 HOFSTRA L. REV. 77, 119 (1983).

sia, the inability to remain still, restlessness and agitation; and pseudo-Parkinsonism manifested by a mask-like face, drooling, muscle rigidity, stiffness, tremors and a shuffling gait. Nausea, skin rashes, dry mouth, congestion, diminished energy, suppression of personality, vomiting, diarrhea, blurred vision, nocturnal confusion, tremors and spasms have also been attributed to the use of antipsychotic drugs.[106] Liver damage, changes in heart rate (including cardiac arrest), convulsions, neuroleptic malignant syndrome (which often leads to death),[107] and tardive dyskinesia are considered the most severe side effects.[108]

Harper was first diagnosed as suffering from manic-depressive disorder; subsequently, he was thought to have schizo-affective disorder. The diagnosis at the time of the trial was schizophrenia.[109] He received voluntarily and involuntarily Trialafon, Haldol, Prolixin, Taractan, Loxitane, Mellaril, and Navane.[110] As a result, Harper exhibited symptoms of acute dystonic reaction and akathesia.[111] He did not exhibit symptoms of tardive dyskinesia.[112]

The state and its amici argued that Harper's drug treatment was positive and rehabilitating. Harper, because of his mental illness, had a tendency toward assaultive behavior which was reduced with drug treatment.[113] Recall that Harper was unmedicated when he was paroled. The state revoked his parole after he assaulted two nurses.[114] In contrast, Harper and his amici argued that his chance of suffering from tardive dyskinesia was greater than one in four, given the length of time he had been taking these drugs.[115] The APLA charged that the APCA relied on reports rendered obsolete

---

106 APLA Brief at 6-9, *supra* note 100, and accompanying footnotes.

107 *See* Brief for the New Jersey Department of the Public Advocate as Amicus Curiae in Support of Respondent, Washington v. Harper, 110 S. Ct. 1028 (1990) (No. 88-599).

108 APLA Brief, *supra* note 100, at 7-8 (citing PHYSICIAN'S DESK REFERENCE (43d ed. 1989)). Most of the controversy centers on the severity of tardive dyskinesia, the likelihood of its manifestation, its permanence, and treatment for it.

> Tardive dyskinesia is characterized by bizarre, uncontrollable movements of the face (lip smacking, chewing, protruding tongue, grimacing) and similar rhythmic, involuntary movements of the trunk, arms and legs. At times it occurs in a mild form, but its more serious form can include severe physical and other effects [including severe respiratory complications, persistent vomiting; psychological disturbances such as anxiety, guilt, depression and even suicide].

Id.

109 Findings of Facts, *supra* note 7, at B-5.

110 *Id.* at B-7.

111 *Id.* at B-8.

112 *Id.*

113 APCA Brief, *supra* note 101, at 5.

114 Findings of Facts, *supra* note 7, at B-4.

115 Brief of Respondent at 18, Washington v. Harper, 110 S. Ct. 1028 (1990) (No. 88-599).

by more recent research that indicated the following: (1) the prevalency of tardive dyskinesia had increased; (2) it was impossible to predict which patients would develop the disorder; (3) the chances of development increased the longer the patient stayed on the medication; (4) and the disorder was reversible in only one-third of the patients that suffered from it.[116] The APLA also charged that there was a high rate of misdiagnosis of the disorder, mistaking symptoms to be caused by the mental disorder itself, and that antipsychotic drugs were being administered indiscriminately.[117]

Harper demonstrates that the conflicting body of information can lead to different definitions of the liberty interest. Dwelling on the curative effects of the drugs, Justice Kennedy focused on how the drugs benefitted Harper. It was unnecessary for Justice Kennedy, therefore, to separate the needs of the prison from Harper's interest; they were one and the same. Defining the interest as "significant" was plausible. On the other hand, by considering why Harper refused the drugs, Justice Stevens separated Harper's interest from the concerns of the prison. The serious physical and mental intrusion of these drugs strongly supported Justice Stevens' conviction that the interest was fundamental, and prison bars should not alter that fact.

Defining the interest, though, is just one step in the court's judgment. A prison regulation that conflicts with a liberty interest will be subjected to the same test,[118] regardless of whether the interest is defined as "fundamental," "substantial," or "significant."

2. *Competing State Interests*

The Court was not willing to find that Harper had an absolute liberty interest in refusing antipsychotic drugs.[119] Thus, regardless of whether or not Harper's interest was fundamental, the Court had to consider the competing state interest. Even the dissent recognized that "[t]he State clearly has a legitimate interest in prison security and administrative convenience that encompasses responding to potential risks to persons and property."[120] The Court must balance the individual's interest against the state's interest.

---

116 APLA Brief, *supra* note 100, at 8.

117 *Id.* at 9-14.

118 Turner v. Safley, 482 U.S. 78, 89 (1987).

119 The fourteenth amendment states that no person shall be deprived of life, liberty or property without due process of law. U.S. CONST. amend. XIV, § 1. While debate over the meaning of these words has raged for over one hundred years, we would be hard pressed to think of any interest, including a life interest, that is absolute.

120 Harper v. Washington, 110 S. Ct. 1028, 1049 (1990) (Stevens, J., dissenting).

Protection of inmates' rights is a relatively new phenomenon.[121] Movement away from the "hands-off"[122] doctrine was inspired by the courts' recognition of criminal defendants' constitutional rights prior to conviction.[123] Once courts recognized criminal defendants' rights, it seemed inconsistent not to recognize the rights of those convicted and incarcerated. The expansion of 42 U.S.C. section 1983 claims to prison inmates provided the inmates with the means to force the courts to address their rights.[124]

Protection of prisoners' rights, though, largely is inconsistent with the long-standing policy of deference to administrative officials (police and prison authorities). The Supreme Court thus only considered the prisoner's rights within the context of his or her confinement.[125] The extent to which officials would be given deference, though, remained unclear.

Clarification came in *Turner v. Safley*,[126] where the Court enunci-

---

121 Historically, courts have neither been anxious to hear prisoners' complaints nor to interfere with the administration of prisons. Note, *The New Standard of Review of Prisoners' Rights: A "Turner" for the Worse?*, 33 VILL. L. REV. 393, 399 (1988) (citing Berger, *Withdrawal of Rights and Due Deference: The New Hands-Off Policy in Correctional Litigation*, 47 UMKC L. REV. 1, 2-5 (1978) and Robbins, *The Cry of Wolfish in the Federal Courts: The Future of Federal Judicial Intervention in Prison Administration*, 71 J. CRIM. L. & CRIMINOLOGY 211, 212-13 (1980)).

122 The "hands-off" doctrine refers to the judicial refusal of jurisdiction for prisoners' claims. Courts have relied on three primary rationales to support their position of nonintervention: 1) the possibility that intervention would violate the separation of powers doctrine; 2) lack of judicial expertise regarding penology; and 3) the fear that intervention by the courts would subvert prison discipline. Goldfarb & Singer, *Redressing Prisoners' Grievances*, 39 GEO. WASH. L. REV. 175, 181 (1970) [hereinafter Goldfarb].

123 *See, e.g.*, Miranda v. Arizona, 384 U.S. 436 (1966) (Miranda warnings required before one is questioned by a law enforcement official); Escobedo v. Illinois, 378 U.S. 478 (1964) (evidence elicited when no warning of right to remain silent and suspect denied counsel is inadmissible against defendant at trial); Mapp v. Ohio, 367 U.S. 643 (1961) (evidence illegally obtained by state officers is not admissible in a state trial); Dowd v. United States *ex rel.* Cook, 340 U.S. 206 (1951) (habeas corpus proceeding appropriate).

See also Goldfarb, *supra* note 122 at 183-85; *see generally* Note, *Constitutional Rights of Prisoners: The Developing Law*, 110 U. PA. L. REV. 985 (1962).

124 Cooper v. Pate, 378 U.S. 546 (1964).

125 Jones v. North Carolina Prisoners' Union, 433 U.S. 119, 129 (1977) ("In seeking a 'mutual accommodation between the institutional needs and objectives [of prisons] and the provisions of the Constitution that are of general application,'. . . this Court has repeatedly recognized the need for major restrictions on a prisoner's rights.") (quoting Wolff v. McDonnell, 418 U.S. 539, 556 (1974)); Procunier v. Martinez, 416 U.S. 396, 404-07 (1974) (addressing need to formulate a standard of review that responds both to "the traditional policy of judicial restraint regarding prisoner complaints and the need to protect constitutional rights"); Pell v. Procunier, 417 U.S. 817, 822 (1974) ("[A] prison inmate retains those First Amendment rights that are not inconsistent with his status as a prisoner or with the legitimate penological objectives of the corrections system.").

126 482 U.S. 78 (1987).

ated the standard of review for prison regulations. Specifically, a prison regulation that burdens constitutional rights is valid if it is related reasonably to legitimate penological objectives,[127] but invalid if it represents an exaggerated response to those concerns.[128] The *Turner* Court delineated several factors relevant to making this determination: (1) there "must be a 'valid, rational connection' between the prison regulation and the legitimate governmental interest put forward to justify it;" (2) "whether there are alternative means of exercising the right that remain open to inmates;" (3) consideration of "the impact accommodation of the asserted constitutional right will have on guards and other inmates, and on the allocation of prison resources generally;" and (4) the absence of ready alternatives.[129]

Recognizing that SOC Policy 600.30 impinged upon a liberty interest, the *Harper* Court considered whether or not the regulation was related reasonably to legitimate penological concerns. The Court identified the legitimate state interests as "combating the danger posed by a person to both himself and others . . . in a prison environment" and the state's "obligation to provide prisoners with medical treatment consistent not only with their own medical interest, but also with the needs of the institution."[130] Justice Kennedy concluded that the policy was a "rational means of furthering the State's legitimate objectives."[131] The Court, further, found no apparent alternatives.[132]

Justice Stevens' objected to the majority's conclusions. He wrote:

> The flaw in Washington's Policy 600.30—and the basic error in the Court's opinion today—is the failure to divorce from each other the two justifications for forced medication and to consider the extent to which the Policy is reasonably related to either interest. The State, and arguably the Court, allows the SOC to blend the state interests in responding to emergencies and in convenient prison administration with the individual's interest in receiving beneficial medical treatment.[133]

---

127 *Id.* at 89.

128 *Id.* at 87.

129 *Id.* at 89-90. The *Turner* Court validated a prison regulation prohibiting correspondence between inmates and invalidated a regulation that prohibited inmates from marrying absent the showing to the superintendent of a compelling reason.

130 Washington v. Harper, 110 S. Ct. 1028, 1038-39 (1990).

131 *Id.* at 1039.

132 *Id.* The Court would not accept the requirement of first finding the inmate incompetent. "[Such] a rule takes no account of the legitimate governmental interest in treating him where medically appropriate for the purpose of reducing the danger he poses." *Id.*

133 *Id.* at 1051 (Stevens, J., dissenting).

Separating the interests may not have been as easy as Justice Stevens assumed. Justice Kennedy stated, "Where an inmate's mental disability is the root cause of the threat he poses to the inmate population, the state's interest in decreasing the danger to others necessarily encompasses an interest in providing him with medical treatment for his illness."[134] Justice Kennedy's justification for why he collapsed the two state interests into one another is not satisfying, however, because it emphasizes the problem that Stevens suggested. SOC Policy 600.30 did not explicitly require a determination that forced medication would be in the inmate's medical interest.[135] The only evidence that the Policy called for a medical determination was that the individual had to be suffering from a mental disorder—a medical decision in itself.

The question of whether a medical decision was being made is more complicated than either Justice suggested. Ostensibly, the medical determination of mental illness was made prior to the state's decision to medicate involuntarily (*i.e.*, the state transferred Harper to the SOC because he suffered from a mental disorder). Harper was at the SOC to be rehabilitated to the point when he could be returned to the regular correctional facility to serve the rest of his sentence. The decision to use drugs may be a medical one,[136] but the state made this decision primarily to serve an institutional concern and not necessarily because it was the treatment of preference for curing Harper's medical illness. This subtle distinction is extremely important in determining if the Court properly applied the standard of review for prison regulations. If the "legitimate" interest in providing medical treatment is nonexistent,

---

134 *Id.* at 1039.

135 *Id.* at 1048-49. (Stevens, J., dissenting). Policy 600.30 requires: "In order for involuntary medication to be approved, it must be demonstrated that the inmate suffers from a mental disorder and as result of that disorder constitutes a likelihood of serious harm to himself or others and/or is gravely disabled." The dissent refused to accept that a medical determination was implicit in the policy, for the drug could not be administered unless the state found that the inmate suffered from a mental illness. *Id.*

136 In Mills v. Rogers, 457 U.S. 291 (1982), the Court intimated that a decision to administer forcibly drugs when the patient poses a threat to himself or others may be a medical one given that, under the Constitution a doctor may make this decision in the case of involuntarily committed mentally ill patients. *Id.* at 303-04. This suggestion resulted from reliance on Youngberg v. Romeo, 457 U.S. 307, 322-23 (1982), which was decided in the same term. The Supreme Court later remanded the same issue involving the forcible medication of involuntarily committed mentally ill patients, stating that the issue be decided in light of *Youngberg*. *See* Rennie v. Klein, 720 F.2d 266 (3d Cir. 1983) (*en banc*) (on remand from Rennie v. Klein, 458 U.S. 1119 (1982)). The Third Circuit held that the decision to medicate only after the patient is found to endanger himself or others is a medical one and does not violate due process.

then the Court was unjustified in conflating the two asserted state interests into one another.

Regardless of whether a legitimate state interest in providing medical treatment existed, had the Court separated the analysis of the two distinct state interests, as it did in *Turner*,[137] the regulation would have been invalid.[138] The drugs administered to Harper have been shown to alleviate many of the symptoms that manifest themselves as dangerous activity and have undisputed therapeutic benefits, but it was obvious that Harper did not think the drug treatment was in his best interest.[139] At least one court has suggested that the prison's obligation to provide medication when the inmate refuses is not a legitimate state interest:[140]

> True, the jail is under a constitutional duty to treat the medical needs of pretrial detainees . . . and such treatment includes mental as well as physical disorders . . . . The premise underlying this duty is that the state may not deliberately fail to provide necessary medical treatment *when it is desired by the detainee*. Medical treatment is designed to ensure that the conditions of pretrial detention do not amount to the imposition of punishment. . . . This constitutional requirement cannot be turned on its head to mean that if a competent individual chooses not to undertake the risks or pains of a potentially dangerous treatment, the jail may force him to accept it. Absent legitimate government objectives . . . we believe that involuntary medication may itself amount to unconstitutional punishment.[141]

The entire *Harper* Court found that security concerns for the inmates, others and property, constituted legitimate state interests. If drug treatment decreases the danger that the inmate poses, as a matter of judgment, one could draw the conclusion that forced drug treatment is related rationally to the desired goal of security. As a

---

137 Turner v. Safley, 482 U.S. 78, 94-99 (1987).

138 Justice Stevens found, when applying the *Turner* test to the state's security interest, that the policy failed as an "overexaggerated response." *Harper*, 110 S. Ct. at 1050 (Stevens, J., dissenting). The basis for this conclusion was that another SOC Policy permitting involuntary medication on an emergency basis was triggered by an imminent danger of injury. In contrast, Policy 600.30 was triggered by illness-induced injury or property damage, evidenced by past behavior, and allowed for prolonged periods of medication. Involuntary medication, then, was the response to two distinct penological concerns, according to Justice Stevens. Justice Stevens failed to explain why responding to both concerns by medicating involuntarily was so outlandish, especially considering that a hearing was involved in the case of prolonged medication and probably not in the case of an emergency. To buttress the conclusion that Policy 600.30 failed the *Turner* test, Justice Stevens pointed to ready alternatives. *Id.* at 1051 (Stevens, J., dissenting). He suggested segregation, standard disciplinary sanctions, and treatment with other drugs, such as tranquilizers. *Id.* (Stevens, J., dissenting).

139 *Id.* 1046 & n.4 (Stevens, J., dissenting).

140 Bee v. Greaves, 744 F.2d 1387 (10th Cir. 1984).

141 *Id.* at 1395 (citations omitted) (emphasis in the original).

matter of judgment, though, given the intrusive nature of the drugs, forced treatment should be viewed as an exaggerated response. Justice Stevens' argument that involuntary drug treatment responds to more than one penological concern is not novel.[142]

Justice Stevens likely is objecting to the *Turner* test itself, which he originally rejected in his *Turner* dissent.[143] In *Turner*, he joined the Court's opinion regarding invalidation of the prison's marriage regulation, which was viewed as an exaggerated response to institutional concerns.[144] Justice Stevens seemed anxious in *Harper* to use the "exaggerated response" rationale to validate the reasonable relation test as a means of protecting the individual's interests. Whether we separate the state's interests or not, one can argue that the regulation could be seen as an exaggerated response to the state's legitimate institutional concerns.

Whether or not the Justices viewed the regulation as an exaggerated response reflects their definitions of the liberty interest. The dissent's charge that the majority failed to put each interest separately through the reasonable relation test may be correct, but the Court ultimately would have upheld the regulation as valid. The *Turner* Court invalidated the marriage regulation after it determined that the right to marry was no less fundamental[145] for the prison inmate than it was for the civilian.[146] The majority in *Harper* would not recognize the inmate's right to refuse antipsychotic drugs as fundamental, but rather insisted on considering the liberty interest

---

142 *See id.* at 1395-96. "Absent an emergency . . . we do not believe forcible medication with antipsychotic drugs is 'reasonably related' to the concededly legitimate goals of jail safety and security."

143 *Turner*, 482 U.S. 78, 100-16 (1987) (Stevens, J., dissenting).

> But if the standard can be satisfied by nothing more than a '*logical* connection' between the regulation and any legitimate penological concern perceived by a cautious warden [majority opinion at 94 (emphasis in the original)], it is virtually meaningless. Application of the standard would seem to permit disregard for inmates' constitutional rights whenever the imagination of the warden produces a plausible security concern and a deferential trial court is able to discern a logical connection between that concern and the challenged regulation.

Id. at 100-01.

144 The Court first suggested the notion of an exaggerated response in Pell v. Procunier, stating that prohibition of face-to-face media interviews was not an exaggerated response to security consideration. 417 U.S. 817, 827 (1974). The *Turner* Court adopted this notion as a means to invalidate the marriage regulation in question. The state asserted two particular objectives to justify the regulation, a security interest and a rehabilitative interest. The Court held that the regulation was an exaggerated response to security concerns, because it failed to meet the relevant factors outlined. *Turner*, 482 U.S. at 97-99.

145 The decision to marry is a fundamental right. Zablocki v. Redhail, 434 U.S. 374 (1976); Loving v. Virginia, 388 U.S. 1 (1967).

146 *Turner*, 482 U.S. at 96.

only within the context of the inmate's confinement. The *Turner* Court also looked at the right to marry in the context of confinement, but was unwilling to allow confinement to alter the fundamental nature of the liberty interest.[147] Therefore, Justice Kennedy's suggestion that confinement necessarily alters the nature of the liberty interest[148] was unfounded. It appears that the Court's definition of the liberty interest influenced the standard of review analysis.

What is even more significant is that in applying the reasonable relation test, the Court did not consider the individual's interest, except in terms of what "costs" the state would suffer in allowing the individual to exercise the right. The reasonable relation test is not a balancing test.

It is arguable that the regulation could have failed the reasonable relation test, because ready alternatives to drug treatment satisfying each separate interest existed. With regard to the security interest, there are obvious alternatives for dealing with an inmate's danger to himself and others that are used all the time by prisons. In fact, Justice Stevens suggested several of these alternatives in his dissent—restraints, confinement, and other drugs such as tranquilizers. The state and its amici argued, however, that these were not viable alternatives.[149] Under *Turner*, the state needs only to show that the ready alternatives do not "fully accommodat[e] the prisoner's rights at *de minimis* cost to valid penological interests."[150] This also is not a least restrictive means test; the state need not present all alternatives and reject each one. Justice Kennedy concluded that the state satisfied this burden.

With regard to the medical interests of the inmate, the record indicated that Harper's antipsychotic drug treatment was of mixed therapeutic value and was used almost principally to deal with potential violent behavior. The question of whether there existed other means to treat Harper's mental illness thus remained open. Given, however, that the Court could not separate medical from institutional concerns, involuntary antipsychotic drug treatment, according to the Court, was the only method for achieving both ends.[151]

---

147 "These incidents of marriage, like the religious and personal aspects of the marriage commitment, are unaffected by the fact of confinement or the pursuit of legitimate corrections goals." *Id.* at 95.

148 Washington v. Harper, 110 S. Ct. 1028, 1037 (1990).

149 *Id.* at 1039 & n.10.

150 *Turner*, 482 U.S. at 91.

151 Justice Kennedy's inability to separate the state's interest in providing medical care to the inmate from the state's interest in institutional concerns may be more significant than Justice Stevens at first realized. In a case before the Court this term, the State

B. THE PROCEDURAL QUESTION

Once it is determined that there is a protected constitutional right that may be overridden by the state's interest under certain circumstances, courts face the final frontier of a due process question—what procedural protections are necessary to safeguard against arbitrary or erroneous decisions to medicate against an inmate's will. The SOC Policy provided for a hearing before a three-person fact-finding panel. The Washington State Supreme Court held that this was insufficient to protect the inmate's fundamental liberty interest and that a full judicial hearing was required. Justice Stevens, in his dissent, agreed; Justice Kennedy, writing for the Court, however, found the policy's procedural protections satisfactory.[152]

Justice Kennedy commented that the major point of disagreement between the opinions was whether a judicial decision-maker was required. A comparison of his opinion with that of Justice Stevens' indicates that the Justices largely disagreed over whether the hearing fact-finders were impartial.[153]

The SOC Policy required that the hearing committee be com-

---

of Louisiana sought to give forcibly to a prisoner on death row antipsychotic drugs solely in an attempt to make him mentally competent to be executed. (It is cruel and unusual punishment to execute insane prisoners. Ford v. Wainright, 477 U.S. 399 (1986).) The trial court ordered the medication. The Supreme Court granted certiorari after it decided *Harper*. Perry v. Louisiana, 110 S. Ct. 1317 (1990). The Court heard oral arguments on October 2, 1990. Louisiana v. Perry, 59 U.S.L.W. 3021 (U.S. Oct. 23, 1990) (No. 89-5120). The Court then vacated the trial court's decision and remanded the case "for further consideration in light of *Washington v. Harper*." 59 U.S.L.W. 4007 (U.S. Nov. 13, 1990) (No. 89-5120).

152 For the past fifteen years, the question of what process is due has been guided by the factors set out in Mathews v. Eldridge:

> the specific dictates of due process generally require consideration of three distinct factors: 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.

424 U.S. 319, 335 (1976).

While commentators have criticized these factors, *see, e.g.*, J. MASHAW, DUE PROCESS IN THE ADMINISTRATIVE STATE (1985); Mashaw, *The Supreme Court's Due Process Calculus for Administrative Adjudication in Mathews v. Eldridge: Three Factors in Search of Value*, 44 U. CHI. L. REV. 28 (1976), both the majority and dissent seem satisfied with their application.

153 *Harper*, 110 S. Ct. at 1052 n.20 (Stevens, J., dissenting). Justice Stevens would have upheld the Washington Supreme Court's decision to require a judicial hearing, but suggested that "a review procedure administered by impartial, nonjudicial professionals might avoid the constitutional deficiency in Policy 600.30." *Id.* at 1055 (Stevens, J., dissenting). The requirement of an impartial decision-maker was not contested and was required under *Vitek*. *See* Vitek v. Jones, 445 U.S. 480, 495 (1980).

posed of a psychiatrist, psychologist, and the Center's Associate Superintendent. Furthermore, none of the committee members could be involved in the inmate's treatment or diagnosis at the time of the hearing.[154] The decision was subject to the Superintendent's review, and the inmate was entitled to judicial review.[155] Justice Kennedy stated, "In the absence of record evidence to the contrary, we are not willing to presume that members of the staff lack the necessary independence to provide an inmate with a full and fair hearing in accordance with the policy."[156]

Justice Stevens argued, however, that the decision-makers had "two disqualifying conflicts of interest."[157] First, colleagues of the treating physician comprised the panel and therefore reviewed each others' decisions.[158] Second, the panel members, as Center staff members, were concerned not only with the inmate's medical interests but also with controlling the inmate.[159] In particular, Justice Stevens questioned whether the panel members were qualified to make medical decisions,[160] if, in fact, that is what they were doing.[161] Justice Stevens concluded that a judicial hearing was the only viable alternative capable of ensuring an impartial decision.[162]

There is support for each of the Justices' points of view. Some states, such as Massachusetts, require a judicial model for determining if a patient can be medicated against his will.[163] Justice Kennedy

---

154 This only applied to the initial seven day period and not to the decisions to extend the period of medication. In fact, Dr. Petrich, Harper's attending physician, served on the committee approving long-term medication. *Harper*, 110 S. Ct. at 1053 & n.23 (Stevens, J., dissenting).

155 Judicial review was only available in the form of a personal restraint petition or a petition for an extraordinary writ. *Id.* at 1034.

156 *Id.* at 1043.

157 *Id.* at 1052 (Stevens, J., dissenting).

158 *Id.* (Stevens, J., dissenting).

159 *Id.* at 1053 (Stevens, J., dissenting).

160 *Id.* (Stevens, J., dissenting). Two of the committee members were not licensed to prescribe medication, and one of those had no medical expertise.

161 There is a suggestion in the record that the medication prescribed to sedate Harper was used prophylactically and may have exacerbated his psychosis. *Id.* at 1054, 1050 n.16, & 1051 n.17. (Stevens, J., dissenting).

162 *Id.* at 1055 (Stevens, J., dissenting). Justice Kennedy cited Parham v. J.R., 442 U.S. 584, 607 (1977) for the contention that the due process clause has never been thought to require a judicial hearing. *Harper*, 110 S. Ct. at 1042. Justice Stevens did not indicate that judicial hearings are required, but they would be the best means for achieving impartial decision making. *Id.* at 1055 (Stevens, J., dissenting).

163 *See* Rogers v. Commissioner of Dep't of Mental Health, 390 Mass. 489, 458 N.E.2d 645 (1983). In *Rogers*, the Massachusetts Supreme Judicial Court held that involuntarily committed mental patients may refuse antipsychotic drug treatment. This right of refusal existed until a judge declared the patient incompetent, at which point the judge must substitute his or her judgment for that of the patient. The Third Circuit rejected this two-tiered judicial approach in Rennie v. Klein, 720 F.2d 286 (3d Cir. 1983), and the

referred to literature which indicated that outside decision-makers, including judges, concur with the treating physician's decision.[164] Justice Stevens' claims may be valid, but if there is any validity to the assertion that outside decision-makers tend to rubber stamp the treating physician's recommendation, then there can be little support for the dissent's conclusion, especially if it results in financial and expedience costs. If Harper had a fundamental right to refuse antipsychotic drugs and the state had a legitimate interest in medicating him, then protecting Harper's right would have required independent, unbiased decision-makers, which he may not have, in fact, had. While a court may give great deference to a medical professional's recommendation, it also would give the individual whose right is jeopardized the right to counsel, the protection of the rules of evidence, and the appellate process—in other words, more opportunity to protect his or her fundamental liberty interest.

C. THE COMPETENCY FACTOR

In a very short, but pithy concurrence Justice Blackmun wrote,

> [m]uch of the difficulty will be lessened if, in any appropriate case, the mentally ill patient is formally committed. This on occasion may seem to be a bother or a nuisance, but it is a move that would be protective for all concerned, the inmate, the institution, its staff, the physician, and the State itself.[165]

Harper did not plead insanity as a defense. The state neither judged him incompetent to stand trial nor formally committed him to a mental hospital.[166] Harper suffered from a mental illness,[167] and the state transferred him to the SOC for treatment[168] so that he could be returned to a regular correctional institution to serve the remainder of his sentence.[169] While at the SOC he initially submitted to antipsychotic drug treatment.[170] He subsequently refused the

---

Supreme Court suggested that the Massachusetts scheme exceeds the protections required by the due process clause. *See* Mills v. Rogers, 457 U.S. 291 (1982).

164 *See Harper*, 110 S. Ct. at 1043 n.13 (citing Appelbaum, *The Right to Refuse Treatment with Antipsychotic Medications: Retrospect and Prospect*, 145 AM. J. PSYCHIATRY 413, 417-18 (1988); Bloom, Faulkner, Holm, & Rawlinson, *An Empirical View of Patients Exercising Their Right to Refuse Treatment*, 7 INT'L J. L. & PSYCHIATRY 315, 325 (1984); Hickman, Resnick, & Olson, *Right to Refuse Psychotropic Medication: An Interdisciplinary Proposal*, 6 MENTAL DISABILITY L. REP. 122, 130 (1982)).

165 *Harper*, 110 S. Ct. at 1044-45 (Blackmun, J., concurring).

166 *Id.* at 1032.

167 *Id.* at 1033.

168 *Id.*

169 *Id.*

170 *Id.*

treatment.[171]

As competent civilians, we have the right to accept or refuse medication.[172] In certain instances, due to mental illness, individuals are considered either as a danger to themselves or others, or as unable to decide what is in their best interests. In those instances, the state will seek to have the person committed. Because the state exerts control over the individual, attendant procedural safeguards are required.[173] The basic liberty interest of freedom from restraint is being denied. The state has taken responsibility for the individual at that point. It decides what is in the best interests of the individual through its *parens patriae* authority,[174] for incompetency does not obliterate an individual's liberty interest.[175] The exercise of *parens patriae* authority to force psychiatric treatment is premised on the need to help individuals who are incapable of making their own treatment decisions.[176]

Although the Court has declined the opportunity to decide whether or not an involuntarily committed mental patient is entitled to a judicial hearing before being forcibly medicated with antipsychotic drugs, the Court did suggest that it was not required under the due process clause.[177] The rationale for the Court's suggestion is conceivably that the state, through judicial procedures, has determined that the individual is incapable of deciding what is in his or her best interests. This includes the inability to determine what medical treatment would be best.

---

171 *Id.*

172 An individual's decision to accept or forego medical treatment is not wholly a medical decision, but is directed by one's personal values. This idea forms the foundation of informed consent.

> The very foundation of the doctrine of [informed consent] is every man's right to forego treatment or even cure if it entails what *for him* are intolerable consequences or risks, however warped or perverted his sense of values may be in the eyes of the medical profession, or even of the community, so long as any distortion falls short of what the law regards as incompetency. Individual freedom here is guaranteed only if people are given the right to make choices which would generally be regarded as foolish.

Davis v. Hubbard, 506 F. Supp. 915, 931-32 (N.D. Ohio 1988) (quoting 2 F. HARPER & F. JAMES, JR., THE LAW OF TORTS 61 (1968 Supp.)) (emphasis in treatise). *See also* Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2041, 2046-47 (1990).

173 Addington v. Texas, 441 U.S. 418, 426-27 (1979). Clear and convincing evidence for incompetency is required in involuntary commitment hearings, because the interest of the individual far outweighs that of a state, which has no legitimate interest in confining individuals who are not mentally ill and do not pose a danger to themselves or others.

174 *Parens patriae*, literally "parent of the country," refers to the state's role as guardian of a person with legal disability.

175 *Cruzan*, 110 S. Ct. at 2852.

176 *Addington*, 444 U.S. at 426.

177 Mills v. Rogers, 457 U.S. 291, 304 (1982).

When there are no formal commitment procedures, the prisoner faced with forcible drug treatment has not been afforded a judicial determination that he or she is considered incapable of making such a determination.

The State of Washington has provided that involuntarily committed mental patients may refuse antipsychotic drug treatment. Involuntary treatment may only be administered by court order, except in the case of an emergency.[178] Washington thus recognizes that an involuntarily committed individual, who receives the full panoply of procedural safeguards in commitment proceedings,[179] has a fundamental liberty interest in refusing antipsychotic drugs. By virtue of the fact that Walter Harper is behind bars, however, he does not.

V. CONCLUSION

Justice Kennedy's legal analysis of a prison inmate's right to refuse antipsychotic medication was sound. Definition of a liberty interest is a judgment left to the discretion of the Court and defining the interest within the context of the inmate's confinement was not contrary to precedent. In addition the state has a legitimate interest in institutional concerns which entails providing medical treatment; drug treatment is related reasonably to this legitimate state interest. Ready and efficient alternatives are not available. While professionals outside the prison facility would be more likely to be unbiased decision-makers, this alternative would be costly. As determined by the *Harper* Court, Washington State's SOC Policy 600.30 does provide procedural safeguards in accordance with the due process requirements.

Given the highly intrusive nature of antipsychotic drugs, Justice Stevens' conclusion that refusal of antipsychotic drug treatment is a fundamental liberty interest is more convincing. Given the law regarding prison regulations, the only means of invalidating the challenged policy was to conclude that no actual medical determination was required and that the regulation was an exaggerated response to security concerns. That the state could overcome an individual's right to refuse or accept medication without the highest level of protection seems aberrational in light of the common law tradition of informed consent. A judicial determination that the individual is incapable of determining for himself or herself what is or is not in his or her best medical interests should be afforded any person, crimi-

178 WASH. REV. CODE § 71.05.370 (Supp. 1990).
179 *Id.* § 71.05.150.

nal or not, before forced medication is administered. Where possible, formal commitment proceedings for mentally ill inmates should be conducted.

PATRICIA E. SINDEL