

The Right to "Just Say No": A History and Analysis of the Right to Refuse Antipsychotic Drugs

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The Right to "Just Say No": A History and Analysis of the Right to Refuse Antipsychotic Drugs

Dennis E. Cichon*

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I. INTRODUCTION

Autonomous decisionmaking in matters affecting the body and mind is one of the most valued liberties in a civilized society.¹ This liberty encompasses the right to self-determination in medical matters as evidenced by the protection long accorded this entitlement under the common law.² This legal right to choose whether to submit to proposed medical treatment has, at times, been a source of controversy between the medical and legal professions. The physician, socialized in the values of health and care, may deem a particular treatment medically appropriate and necessary. The patient may, nonetheless, assert his legal right to refuse the intervention after weighing its benefits and risks in light

1. See Immanuel Kant, *Fundamental Principles of the Metaphysics of Morals*, in *Problems of Moral Philosophy* 2336 (Paul W. Taylor ed., 2d ed. 1972); Charles Fried, *An Autonomy of Values: Problems of Personal and Social Choice* 34-39, 138 (1970).

2. The tort of battery includes medical procedures performed on patients without their consent. See generally 1 Fowler V. Harper & Fleming James, Jr., *The Law of Torts* §§ 3.1-3.3, at 211-20 (1956).

of personal values, preferences, and fears. Even if the patient's decision appears unwise, foolish, or life-threatening, the law requires that it be respected if competently made.³

Perhaps at no time is this medical/legal debate more pronounced than when institutionalized mentally disabled individuals refuse prescribed psychiatric treatment. The therapy which has generated the most controversy is the administration of antipsychotic drugs.⁴ This treatment has proven successful in controlling the symptoms of psychoses. By reducing the duration and severity of psychotic episodes, antipsychotic medication has allowed many patients, who otherwise would have faced long periods of hospitalization, to lead productive lives in the community.⁵ Since their introduction in the early 1950s, antipsychotic drugs have become the most common mode of treatment for the institutionalized mentally ill.⁶ The conflict surrounding their use derives from the fact that each antipsychotic drug is capable of producing a wide variety of serious side effects, some of which are permanently debilitating and even fatal.⁷

Following the initial observations of the drugs' efficacy, institutional psychiatrists eschewed the potential for hazardous side effects.⁸ While the prevalence of side effects began to rise, instances of abuse in the prescribing of these drugs also began to surface. The over-crowded and under-staffed conditions at most public institutions invited use of the drugs for purposes other than treatment, including restraint, punishment, and convenience.⁹ Not surprisingly, patients began to refuse this medication and sought to give force to their objections through the legal system.

3. See *infra* notes 193-194 and accompanying text.

4. For commentary exemplifying the heated and emotional character of this controversy, see Paul S. Appelbaum & Thomas G. Gutheil, *The Boston State Hospital Case: "Involuntary Mind Control," the Constitution, and the "Right to Rot,"* 137 Am. J. Psychiatry 720 (1980); Thomas G. Gutheil, *In Search of True Freedom: Drug Refusal, Involuntary Medication, and "Rotting with Your Rights On,"* 137 Am. J. Psychiatry 327 (1980); Robert Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment,* 72 Nw. U. L. Rev. 461 (1977); Stephen Rachlin, *One Right Too Many,* 3 Bull. Am. Acad. Psychiatry & L. 99 (1975); Harvey Schwed, *Social Policy and the Rights of the Mentally Ill: Time for Re-examination,* 5 J. Health Pol., Pol'y & L. 193 (1980).

5. 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, 100 (1983).

6. Barry R. Furrow, *Public Psychiatry and the Right to Refuse Treatment: Toward an Effective Damage Remedy,* 19 Harv. C.R.-C.L. L. Rev. 21, 24 (1984); see *infra* note 171 and accompanying text.

7. See *infra* notes 70-167 and accompanying text.

8. See *infra* notes 168-180 and accompanying text.

9. See *infra* notes 181-189 and accompanying text.

Traditionally, courts viewed the custody, care, and treatment of involuntarily committed mental patients to be within the complete discretion of institutional authorities.¹⁰ The 1960s and 1970s, however, witnessed a breakdown of this legal immunity as advocates for the mentally disabled attacked virtually every component of state mental health systems. Litigated issues included the criteria for involuntary commitment, patient rights, institutional conditions, the interplay between the criminal process and the civil mental health systems, and the adequacy of treatment.¹¹

In many instances, lawyers and mental health professionals formed alliances to promote legislative and judicial reform of antiquated procedures, practices, and facilities. This interprofessional relationship began to crumble in *Rennie v. Klein*,¹² when the New Jersey federal district court announced that involuntarily committed mental patients have a legal right to refuse antipsychotic drugs. A year later the Massachusetts federal district court issued a similar holding in *Rogers v. Okin*.¹³ These two cases prompted further refusal litigation in both federal and state courts.¹⁴

The growing recognition of the right to refuse posed a fundamental challenge to a well established and widely used treatment and to deeply ingrained notions of institutional professional discretion. Psychiatrists vehemently opposed this emerging legal concept, maintaining that it directly contradicts their professional duty to treat the institutionalized mentally ill.¹⁵ The right to refuse antipsychotic drugs soon became the most controversial and divisive issue between the medical and legal professions.

Most courts which have addressed the issue have recognized a right to refuse medication although they have differed on the right's legal

10. See generally Jessica Litman, Note, *A Common Law Remedy for Forcible Medication of the Institutionalized Mentally Ill*, 82 Colum. L. Rev. 1720 (1982).

11. See generally Note, *Developments in the Law, Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190 (1974).

12. The district court issued two opinions in *Rennie*. The first opinion was based on a motion for a preliminary injunction filed on behalf of John Rennie. 462 F. Supp. 1131 (D.N.J. 1978). The second opinion was generated by a class action filed on behalf of patients of five New Jersey state mental hospitals based on John Rennie's amended complaint. 476 F. Supp. 1294 (D.N.J. 1979), *aff'd in part, modified in part, and remanded*, 653 F.2d 836 (3d Cir. 1981) (en banc), *vacated and remanded*, 458 U.S. 1119, 102 S. Ct. 3506 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983).

13. 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part, rev'd in part, vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. 291, 102 S. Ct. 2442 (1982).

14. See, e.g., *infra* notes 289, 295 and accompanying text.

15. For a listing of psychiatric literature on the topic, see Alexander D. Brooks, *The Right to Refuse Antipsychotic Medications: Law and Policy*, 39 Rutgers L. Rev. 339, 340 n.2 (1987).

source. Some courts have drawn upon federal constitutional provisions, while others have relied on state constitutional, statutory, or common law.¹⁶ The courts have also disagreed over which governmental interests are sufficient to override a patient's refusal.¹⁷ Additionally, the procedural safeguards employed, which ultimately shape, define, and protect the substantive right, have varied dramatically. Some courts have adopted a due process procedural model, requiring judicial intervention before a patient's refusal can be overridden in non-emergency situations.¹⁸ Other courts have deferred to professional decisionmaking by authorizing in-house or independent medical review systems.¹⁹ A third approach demonstrates an unqualified deference to institutional decisionmaking by allowing forced medication upon the decision of a treating physician exercising professional judgment.²⁰

After more than a decade of litigation, the United States Supreme Court finally addressed the refusal issue in *Washington v. Harper*.²¹ In *Harper*, the Court recognized that a mentally ill convicted prisoner retains a liberty interest in refusing antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment.²² However, the Court drastically limited the scope of this right as well as the procedural protections which must accompany it in the prison setting.

While *Harper* firmly establishes that the right to refuse antipsychotic drugs is a constitutionally protected liberty interest, the decision raises many questions. The Court did not address whether other constitutional protections, such as those afforded by the First Amendment, may also encompass the right to refuse.²³ Also, the Court's extensive limitations on the scope of this right result from a rationale developed in a recent line of prison cases. Whether this reasoning is transferable to the civil institutional setting is an unanswered but critical issue. And perhaps the most important question raised and left unanswered by *Harper* is whether

16. See *infra* notes 197-309 and accompanying text.

17. See *infra* notes 339-401 and accompanying text.

18. See *infra* notes 598-626 and accompanying text.

19. See *infra* notes 533-556 and accompanying text.

20. See *infra* notes 557-597 and accompanying text.

21. 494 U.S. 210, 110 S. Ct. 1028 (1990). The Court avoided the issue on two previous occasions. See *Rennie v. Klein*, 458 U.S. 1119, 102 S. Ct. 3506 (1982); *Mills v. Rogers*, 457 U.S. 291, 102 S. Ct. 2442 (1982).

22. *Harper*, 494 U.S. at 221-22, 1102 S. Ct. at 1036.

23. *Id.* at 258 n.32, 110 S. Ct. at 1050 n.32 (Stevens, J., dissenting). Generally, the more important a constitutionally protected right is, the stronger the government's reason must be for infringement. Thus, whether an individual's right to refuse is outweighed by countervailing governmental interests may very well depend on the constitutional source upon which the right is based. See *infra* note 311 and accompanying text. This analysis no longer applies in the prison environment. See *infra* notes 816-818 and accompanying text.

the minimal procedural safeguards upheld by the Court would satisfy due process requirements outside the prison context.

The professional discord surrounding the right to refuse antipsychotic drugs reflects the inherent tension between the law's respect for the values of self-determination and bodily integrity and the medical profession's concern for the treatment and care of the mentally ill. Another relevant consideration is the government's interest in orderly management and security in public institutional settings. Within a very brief time, we have experienced the recognition of a right to refuse, and have witnessed periods of expansion and retraction of the right. This tumultuous evolution represents the legal system's desperate search for the proper balance between respect for individuality and concern for protection.

This article traces the disordered development of the right to refuse antipsychotic drugs and attempts to analyze the complex legal, medical, and ethical issues involved. The article begins by describing the dual nature of the medication in providing therapeutic benefits while posing a substantial risk of hazardous side effects. After depicting the circumstances which led to the initial "right to refuse" litigation, the article analyzes the various legal grounds on which courts have based the right to refuse.

Even when based on a constitutional source, the right to refuse is not absolute. The right must be balanced against the government's reasons for infringement.²⁴ The article examines this balancing process by taking into account the private interests at stake, the level of intrusiveness presented by antipsychotic drugs, and the government's objectives behind forced treatment.

The two governmental interests which courts have recognized as being sufficient, under appropriate circumstances, to justify forced medication are next addressed. First, the government's police power interest in preventing a mentally ill individual from harming himself or others is explained. While some courts authorize forced drugging based on a mere prediction of future violent behavior, other courts limit this police power authority to emergency situations. Second, the government's *parens patriae* interest in caring for those individuals who are unable to care for themselves is examined. The article explains that a traditional precondition to forced treatment based on the *parens patriae* authority is a finding that the patient is incompetent to make his own treatment decisions. The article examines the concept of competency and describes recent medical research which documents that many drug refusals by mentally ill individuals are the product of rational and considered decisions. An emergency exception to the competency limitation on the

24. See *infra* note 310 and accompanying text.

parens patriae authority is also discussed. In addition, the article addresses whether the least restrictive alternative doctrine is applicable as another restriction on the government's ability to compel treatment under either the police power or the *parens patriae* authority.

Next, the issue of procedural due process is addressed. The article describes the three models of procedural review referred to above and the court opinions which adopt them.²⁵ A detailed analysis of the appropriateness of these review systems is undertaken. This inquiry is guided by the considerations announced by the Supreme Court for determining the procedures due in a particular situation,²⁶ and the most recent medical research and empirical data on the benefits and drawbacks of procedural due process for medication refusals are investigated.

Finally, the article analyzes the substantive and procedural components of the Supreme Court's decision in *Harper*. Although this decision is limited to a convicted prisoner's right to refuse antipsychotic drugs, its interpretation could impact thousands of mentally ill and retarded individuals confined in civil institutions. In addition, as one commentator noted, the ramifications of *Harper* could extend to "even larger numbers of individuals residing in the community who are released from civil hospitals, diverted from the criminal justice system, or paroled from prison, on the basis that they accept treatment as a condition of their release."²⁷ The article, therefore, concludes by examining the potential effects of the *Harper* decision on the right of an individual to refuse antipsychotic drugs outside the prison environment. This examination includes an analysis of the Supreme Court's recent opinion in *Riggins v. Nevada*²⁸ in which the Court addressed the right of a pretrial detainee to refuse the administration of antipsychotic drugs.

II. THE NATURE OF ANTIPSYCHOTIC DRUGS

Antipsychotic drugs were introduced into the United States in 1954 and released for marketing the following year.²⁹ These medications, also

25. See *supra* text accompanying notes 18-20.

26. See *Mathews v. Eldridge*, 424 U.S. 319, 96 S. Ct. 893 (1976).

27. Bruce J. Winick, *The Right to Refuse Mental Health Treatment: A First Amendment Perspective*, 44 U. Miami L. Rev. 1, 5 (1989).

28. 112 S. Ct. 1810 (1992).

29. Chlorpromazine, a phenothiazine derivative and one of the most widely used antipsychotic drugs, was synthesized and developed in the early 1950s by French researchers. It was initially used as part of a "cocktail" developed as a new anesthesia. The drug was found to alter patients' mental awareness and sedate them without inducing unconsciousness. Patients receiving chlorpromazine appeared quiet and unconcerned about their external environment. Because of these findings, the drug was tested for the treatment of schizophrenia in 1952 and found to ameliorate psychotic episodes. Robert Julien, *A Primer of Drug Action* 149-50 (5th ed. 1988); Leo E. Hollister, *Clinical Use of Psycho-*

referred to as neuroleptics or major tranquilizers, are only one category of psychoactive or psychotropic drugs. Other classes of these mood and behavior altering drugs include the sedative-hypnotic compounds such as barbiturates and antianxiety agents, antidepressants and convulsants, narcotic analgesics, and the psychedelics and hallucinogens.³⁰

Each class of psychoactive drugs serves a different function, and no class is effective in treating all mental disorders.³¹ In addition, each class poses distinct toxic effects.³² This article focuses on antipsychotic drugs because of their widespread use and the conflict generated between the rationale for their administration and the justifications for refusal.

therapeutic Drugs 3-5 (1977). The development of psychotherapeutic drugs is marked by the fact that most were designed for other uses, with their psychiatric benefits being discovered rather fortuitously. *Id.* at 5.

30. Julien, *supra* note 29, at 37. Neuroleptic is defined as "denoting a neuropharmacologic agent that has antipsychotic action affecting principally psychomotor activity." Lawrence D. Gaughan & Lewis H. LaRue, *The Right of a Mental Patient to Refuse Antipsychotic Drugs in an Institution*, 4 L. & Psychol. Rev. 43, 46 (1978) (quoting Dorland's Illustrated Medical Dictionary 1041 (25th ed. 1974)). The drugs' principal effect is on muscular action resulting from the mental processes. *Id.* See generally Hollister, *supra* note 29, at 7 (explaining the inappropriateness of such nomenclatures and suggesting new labels based on the actual clinical uses of the drugs); Peter R. Breggin, *Psychiatric Drugs: Hazards to the Brain* 82-85 (1983) (noting that the label "major tranquilizer" is misleading in that antipsychotic drugs do not tranquilize but instead, commonly produce uncomfortable, suppressing effects).

31. Breggin, *supra* note 30, at 146. There still exists no satisfactory definition outlining the boundaries of the concept "mental illness" or "mental disorder." See Robert L. Sadoff, *Basic Facts About Mental Illness*, in *Legal Rights of Mentally Disabled Persons* 163 (1979); American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* xxii (3d ed. Rev. 1987) [hereinafter "DSM III-R"]. Mental disorders include anxiety, a term usually referring to a state of tension or uneasiness which is not traceable to any specific source; neurosis, an emotional disorder usually accompanied by anxiety which interferes with a person's ability to cope with life; mania, the uncontrollable, excited phase of a manic-depressive illness; depression, characterized by pessimism and hopelessness which can result in impairment of function and often occurs cyclically with mania; and psychosis, a rather generic label which refers to major mental disorders characterized by an inability to recognize reality and often accompanied by delusions, hallucinations, and illusions. Julien, *supra* note 29, at 146-47. There are two major categories of psychoses: (1) those resulting from organic brain disorders such as injury to the brain or brain disease, and (2) those not attributable to physical or organic conditions. The latter category is composed of three groups: the schizophrenias, characterized by disorders of thought; the major affective disorders, characterized by disturbances of mood; and the paranoid states, characterized by delusions. See generally DSM III-R, at 97-203; Robert Julien, *A Primer of Drug Action* 122 (2d ed. 1978).

Anxiety and neurosis are commonly treated with the sedative-hypnotic compounds. These drugs are not useful in the treatment of psychoses and manic-depressive illness, as they can induce depression or deep sleep in patients afflicted with these conditions. The antidepressants are likewise of little benefit to psychotic patients but are useful in treating some forms of depression. Julien, *supra* note 29, at 148.

32. Julien, *supra* note 29, at 31.

The largest class of antipsychotic drugs and the most commonly prescribed are the phenothiazines. One of the first derivatives of the phenothiazines was chlorpromazine, often known by its trade name Thorazine. Most other antipsychotic drugs are derivatives of the phenothiazine class of compounds.³³ Trade names of other antipsychotic drugs include Trilafon (brand of perphenazine), Stelazine (brand of trifluoroperazine), Prolixin (brand of fluphenazine), Navane (brand of thiothixene) and Haldol (brand of Haloperidol).³⁴ The various types of antipsychotic drugs share similar clinical properties although their toxicities may differ.³⁵

There appears to be no widely accepted theory on the biochemical manner in which antipsychotic drugs work.³⁶ Although they differ in chemical structure, the pharmacological action of each drug appears similar.³⁷ Because these drugs are most effective in controlling the symptoms of schizophrenia and the major affective disorders, many pharmacologists believe these psychoses have a chemical origin. It is hypothesized that psychotic episodes are caused by either a chemical over-sensitivity or imbalance in the part of the brain that regulates emotion and motivation. This condition causes undirected, overly-stimulated neural activity resulting in schizophrenic symptomology. Since this theory views the source of schizophrenia as chemically based, antipsychotic drugs are considered the preferred treatment for alleviating its symptoms.³⁸ Not all pharmacologists accept this theory. Alternative

33. *Id.* at 155. More than 20 derivatives of phenothiazine are available for use. Julien, *supra* note 31, at 127.

34. Breggin, *supra* note 30, at 8-10; *see generally* Hollister, *supra* note 29, at 14-20 (presenting a detailed explanation of the chemical and pharmacological differences between the various antipsychotic drugs).

35. Breggin, *supra* note 30, at 8-10. For a study which compares the differences in the onset of relief between different antipsychotic drugs, *see* F. S. Abuzzahab & R. L. Zimmerman, *Psychopharmacological Correlates of Post-Psychotic Depression: A Double Blind Investigation of Haloperidol v. Thiothixene in Outpatient Schizophrenia*, 43 *J. Clinical Psychiatry* 105 (1982).

36. Singh & Smith, *Kinetics and Dynamics of Response to Haloperidol in Acute Schizophrenia: A Longitudinal Study of the Therapeutic Process*, 14 *Comparative Psychiatry* 363 (1979); Gaughan & LaRue, *supra* note 30, at 47.

37. Hollister, *supra* note 29, at 22.

38. Stephen Beyer, Comment, *Medicine and Madness: The Forcible Administration of Psychotropic Drugs*, 1980 *Wis. L. Rev.* 497, 498. This view has been labeled the dopamine theory of schizophrenia. It is hypothesized that a psychotic episode is accompanied by an increased level of dopamine, a biogenic amine, in the limbic system. An alternative hypothesis is that it is not an increased level of dopamine which causes schizophrenic symptoms but instead, an increased sensitivity of the dopamine receptors. In either case, the effects of dopamine are apparently blunted by antipsychotic medication which, in turn, reduces psychotic symptoms. *Id.* at 498 and n.6. The dopamine theory is supported by the fact that drugs which stimulate dopamine receptors induce schizophrenic-like symptoms. Julien, *supra* note 29, at 153.

theories are that schizophrenia is an inherited disease or is caused by environmental factors.³⁹ The list of theories is growing and a consensus does not appear imminent.⁴⁰ It is estimated that up to one percent of the general population suffers from schizophrenia. This condition is responsible for approximately two-thirds of mental hospital admissions and over one-quarter of all hospital admissions.⁴¹

The term schizophrenia means "splitting of the mind" and consists of an apparently related collection of mental syndromes involving an imbalance between emotional reactions and the thought content associated with the emotions.⁴² Schizophrenia may develop quickly, in which case it is referred to as "acute." Chronic schizophrenia, on the other hand, develops slowly over a longer period of time.⁴³ Diagnostic symptoms include unrealistic thinking, severe anxiety, suspiciousness, confusion, withdrawal, auditory and other hallucinations, delusions, blunted affect, over-activity, apprehension of impending doom, and generalized motor inhibition.⁴⁴ Antipsychotic drugs were found to ameliorate many of these symptoms, and their effectiveness established drug therapy as the primary treatment for schizophrenia.⁴⁵

A. *The Benefits of Antipsychotic Drugs*

Before the introduction of antipsychotic drugs, there was no broadly applicable effective treatment for psychotic patients. Patients suffering from severe psychoses were usually hospitalized on a long-term or per-

39. See Hollister, *supra* note 29, at 13; Julien, *supra* note 29, at 152. The inheritance theory, although not verified, is supported by studies which indicate that although the incidence of schizophrenia in the general population is approximately 1%, among children with one parent suffering from the condition, the incidence increases to 7%-16%. Where both parents suffer from schizophrenia, the rate among children increases to 40%-68%. *Id.* at 152.

40. Walter A. Brown & Lawrence R. Herz, *Response to Neuroleptic Drugs as a Device for Classifying Schizophrenia*, 15 *Schizophrenia Bull.* 123, 126 (1989) (admitting the psychiatric profession's "complete ignorance" about schizophrenia's pathophysiology); Breggin, *supra* note 30, at 66.

41. Julien, *supra* note 29, at 147. During any one year, 500,000 to one million individuals will require treatment for schizophrenia. Harold I. Kaplan & Benjamin J. Sadock, *Modern Synopsis of Comprehensive Textbook of Psychiatry III* 301 (3d ed. 1980).

42. Gaughan & LaRue, *supra* note 30, at 48; Julien, *supra* note 29, at 146.

43. Nancy K. Rhoden, *The Right to Refuse Psychotropic Drugs*, 15 *Harv. C.R.-C.L. L. Rev.* 363, 377 (1980).

44. National Inst. of Mental Health—Psychopharmacology Service Center Collaborative Study Group, *Phenothiazine Treatment in Acute Schizophrenia*, 10 *Archives Gen. Psychiatry* 246, 249 (1964).

45. See *infra* note 171 and accompanying text.

manent basis.⁴⁶ In 1955, the year antipsychotic drugs were released for marketing in the United States, there were over 558,000 patients in state mental hospitals. By 1970, however, this number had dropped to less than 340,000 despite a dramatic increase in admissions. By 1980, the number of patients in state mental hospitals had dropped to just over 137,000.⁴⁷ This decrease in the average length of hospitalization has been attributed to the effectiveness of antipsychotic drugs in reducing the severity and duration of psychotic episodes and lengthening the interval between relapses.⁴⁸

The above figures demonstrate that antipsychotic drugs have revolutionized the treatment of psychoses. They were found to reduce hallucinations, delusions, agitation, disorganized mentation, and other psychotic symptoms.⁴⁹ Not only has this reduction in psychotic symptoms enabled many patients to leave the hospital for productive lives in the community, it is claimed that it also has reduced incidents of violence and disruption among those who remain in the hospital. This, in turn, has resulted in more humane treatment by hospital staff who now need to depend less on physical restraint and seclusion.⁵⁰

46. Julien, *supra* note 29, at 149; Gutheil & Appelbaum, *supra* note 5, at 100. For an explanation of other treatment modalities for the mentally ill, see Plotkin, *supra* note 4, at 461. Psychotherapy is one such treatment. Psychotherapy is grounded upon the doctor-patient alliance in which emotional and mental problems are dealt with through a conversational process over a long period of time. *Id.* at 481 n.130. Because schizophrenia is believed by many to be related, in part, to environmental factors, it is generally held that its most effective treatment is drug therapy combined with a psychotherapeutic program. Kaplan & Sadock, *supra* note 41, at 334; James C. Beck et al., *An Empirical Investigation of Psychotherapy with Schizophrenic Patients*, 7 *Schizophrenic Bull.* 241 (1981); Hollister, *supra* note 29, at 55. However, some studies indicate that psychotherapy provides little value in the treatment of schizophrenia and its effects provide no greater results than drug therapy alone. Donald R. Gorham & Alex D. Pokorny, *Effects of a Phenothiazine and/or Group Psychotherapy with Schizophrenics*, 25 *Diseases of the Nervous System* 77 (1964); Lester Grinspoon et al., *Long-term Treatment of Chronic Schizophrenia*, 4 *Int'l J. Psychiatry* 116 (1967). In addition, the value of psychotherapy as a viable treatment modality is limited in state hospitals due to a shortage of psychiatric staff. Plotkin, *supra* note 4, at 481 n.130; Eugene Z. DuBose, Jr., *Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patient Justify Involuntary Treatment?*, 60 *Minn. L. Rev.* 1149, 1167-68 (1976).

47. Gutheil & Appelbaum, *supra* note 5, at 100; Julien, *supra* note 29, at 149. Between 1955 and 1965, the annual admission rate to state psychiatric hospitals nearly doubled. *Id.* at 149-50.

48. Gutheil & Appelbaum, *supra* note 5, at 100. The typical hospital stay was reduced from 44 days in 1971 to 26 days by 1975 and is now even shorter. Alexander D. Brooks, *Law and Antipsychotic Medications*, 4 *Behavioral Sciences & L.* 247, 248-49 (1986).

49. Gutheil & Appelbaum, *supra* note 5, at 100.

50. Alexander D. Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 *Bull. Am. Acad. Psychiatry & L.* 179, 182-83 (1981). However, it is also maintained that the use of physical restraints in state hospitals has declined due to the

It is indisputable that antipsychotic drugs provide great benefit to many psychotic patients. However, claims of their overall effectiveness are not without controversy. The drugs do not cure psychoses, they merely suppress some of the symptoms while often leaving others untouched.⁵¹ These medications are only effective while in the patient's bloodstream and relapse frequently occurs once treatment is terminated.⁵² The drugs seem to be more effective in treating the symptoms of acute schizophrenia rather than the long-term chronic cases.⁵³ Studies indicating the apparent benefits of antipsychotic medications are now being questioned on an increasing basis.⁵⁴ Empirical studies claiming that drug therapy is responsible for reducing the average length of hospital stays have been disputed by studies suggesting that other factors, such as legal reforms and the policy of deinstitutionalization, are responsible for this decrease.⁵⁵ Furthermore, the studies attributing decreased hospital stays to drug treatment rarely measure the scope of improved ability to cope

inappropriate use of drugs as a means of control and restraint. Sheldon Gelman, *Mental Hospital Drugs, Professionalism, and the Constitution*, 72 Geo. L.J. 1725, 1750-51 (1984). See also *Davis v. Hubbard*, 506 F. Supp. 915, 926 and n.7 (N.D. Ohio 1980) (finding the prevalent use of psychotropic drugs for staff convenience and the punishment of patients).

51. Gutheil & Appelbaum, *supra* note 5, at 101; Gelman, *supra* note 50, at 1749; Hollister, *supra* note 29, at 13-14. See also John M. Davis & Jonathan O. Cole, *Anti-psychotic Drugs*, in 5 Am. Handbook of Psychiatry 441, 445 (Daniel X. Freedman & Jarl E. Dyrud eds., 2d ed. 1975) (noting that there are a substantial number of cases in which the drugs fail to provide any symptomatic control).

52. Gutheil & Appelbaum, *supra* note 5, at 100; Gaughan & LaRue, *supra* note 30, at 48.

53. Brooks, *supra* note 50, at 183; Litman, *supra* note 10, at 1725.

54. Many of the studies which indicate that antipsychotic drugs are effective in controlling psychotic symptoms have been criticized on the basis of their methodology. The studies are intended to be double-blind, that is, neither the patients nor the investigators know whether a drug or a placebo is administered. However, due to the neurotoxic effects of these drugs, it is likely that both the investigator and patient are aware when a drug is administered. Furthermore, the studies have been criticized on the grounds of bias in choosing which symptoms are analyzed and which are ignored and in the selection of study participants. Gaughan & LaRue, *supra* note 30, at 55; Breggin, *supra* note 30, at 59-60. See also Beyer, *supra* note 38, at 539 and n.184 (noting criticisms of the interpretations of even reliable statistical data); Mary C. Durham & John Q. La Fond, *A Search for the Missing Premise of Involuntary Therapeutic Commitment: Effective Treatment of the Mentally Ill*, 40 Rutgers L. Rev. 303, 346-47 (1988) (pointing out that because medication studies are usually performed in controlled environments with carefully designed procedures, it is unlikely that they replicate the actual practices in public psychiatric hospitals).

55. See Brooks, *supra* note 50, at 182 n.15 (citing commentary indicating that deinstitutionalization is more the product of policy, not pharmacology); Breggin, *supra* note 30, at 61-65 (referring to studies documenting the role of factors other than drugs in reducing the length of hospital stays).

with life outside the mental institution.⁵⁶ While some studies show that re-hospitalization rates for medicated patients are less than for non-medicated patients, there are other studies which indicate that medicated patients function no better than non-medicated patients in the community.⁵⁷ In fact, there is scientific evidence that drug therapy fosters hospital dependency and thus serves to increase the likelihood of re-hospitalization.⁵⁸

A substantial number of patients receive no benefit from antipsychotic medication and some actually deteriorate while being administered the drugs.⁵⁹ These results are true even for acute schizophrenics despite the claimed efficacy of the drugs in these cases.⁶⁰ Relapse while on medication is not uncommon.⁶¹ A number of studies indicate that many schizophrenics actually improve after medication is terminated.⁶² One

56. Gelman, *supra* note 50, at 1741-42; Dubose, *supra* note 46, at 1191-92.

57. See DuBose, *supra* note 46, at 1196-97; Beyer, *supra* note 38, at 541-42.

58. DuBose, *supra* note 46, at 1196-97; Beyer, *supra* note 38, at 541-42 and n.194. See also J. Sanbourne Bockoven & Harry C. Solomon, *Comparison of Two Five-Year Follow-up Studies: 1947 to 1952 and 1967 to 1972*, 132 Am. J. Psychiatry 796 (1975) (suggesting that drugs may prolong the social dependencies of some discharged patients); Breggin, *supra* note 30, at 58-59. Other studies have indicated that drug therapy has no effect on post-hospitalization functioning in the community. See Brooks, *supra* note 50, at 183.

59. Ross J. Baldessarini & Frances R. Frankenburg, *Clozapine: A Novel Antipsychotic Agent*, 324 New Eng. J. Med. 746, 746 (1991) (twenty percent of schizophrenic patients receive no benefit from antipsychotic drugs); Brown & Herz, *supra* note 40, at 123 (approximately twenty percent of schizophrenic patients are clearly resistant to even high doses of antipsychotic drugs); T. Kolakowska et al., *Schizophrenia with Good and Poor Outcome*, 146 British J. Psychiatry 229 (1985) (nearly forty-one percent of schizophrenic patients studied received no benefit from drug treatment); Robert Prien et al., *High Dose Trifluoperazine Therapy in Chronic Schizophrenia*, 126 Am. J. Psychiatry 305 (1969) (approximately ten percent of chronic schizophrenic inpatients deteriorate on medication).

60. Beyer, *supra* note 38, at 540 and n.191.

61. Jeffrey A. Lieberman et al., *Replying to Letter "Ethics of Drug Discontinuation Studies in Schizophrenia,"* 46 Archives Gen. Psychiatry 387 (1989) (approximately thirty percent relapse rate despite continued drug compliance); Tobias & MacDonald, *Withdrawal of Maintenance Drugs with Long-Term Hospitalized Mental Patients: A Critical Review*, 81 Psychology Rev. 107 (1974) (approximately forty percent of schizophrenic inpatients relapse within two years of discharge despite continued medication).

62. Janos Karucz & John Fallon, *Dose Reduction and Discontinuation of Antipsychotic Medication*, 31 Hosp. & Community Psychiatry 117, 118-19 (1980) (authors estimate that if the results of medication termination on one hospital ward could be matched hospital-wide, approximately twenty percent of medicated patients could improve enough to leave the hospital if drug therapy is discontinued); Prien et al., *supra* note 59, at 305 (fourteen percent of patients studied improved after their medication was replaced by placebo); Stephen R. Marder et al., *Predicting Drug Free Improvement in Schizophrenic Psychosis*, 36 Archives Gen. Psychiatry 1080, 1080 (1979) (eight of twenty-two schizophrenic patients studied showed substantial improvement during drug-free period); D. Shumway et al., "80 Percent Neuroleptic Reduction in Chronic Psychotics," presented at the 140th

study indicated that fifty percent of chronic schizophrenic outpatients receive no benefit from continued drug therapy.⁶³ Researchers studying chronic schizophrenic inpatients concluded that withdrawal of low-dosage maintenance drugs fail to have deleterious effects when replaced with positive social-environmental programs.⁶⁴ And for those patients who do improve on medication, the scope of improvement is subject to controversy.⁶⁵

Complicating the matter is the fact that the diagnosis of schizophrenia is an imprecise science. It has been estimated that misdiagnosis of schizophrenia may be as high as forty percent. This statistic suggests that antipsychotic drugs are inappropriately prescribed in a number of cases.⁶⁶ In fact, the drugs themselves may mask psychotic symptoms which in turn interferes with continuing diagnosis.⁶⁷ Even when there is an accurate diagnosis, there is not yet a scientifically sound method to determine the most appropriate antipsychotic drug to prescribe.⁶⁸ Once a drug is selected, its proper dosage can only be determined on a trial and error basis. As one group of researchers stated, "Drugs are chosen by custom and rumored repute, and dosage is commonly adjusted upward until the patient either responds or develops toxic symptoms."⁶⁹

Meeting of the American Psychiatric Association, Chicago, Illinois, May 1987, cited in Brown & Herz, *supra* note 40, at 127-28 (study showing that nearly fifty percent of patients either improve or remain unchanged after antipsychotic drugs are withdrawn or dosage is reduced); John M. Davis, *Antipsychotic Drugs*, in *Comprehensive Textbook of Psychiatry* IV 1481, 1487 (Harold I. Kaplan & Benjamin J. Sadock eds., 1985) (study showing that twenty-five percent of psychotic patients improve significantly without medication).

63. George Gardos & Jonathan Cole, *Maintenance Antipsychotic Therapy: Is the Cure Worse Than the Disease?*, 133 *Am. J. Psychiatry* 32, 34 (1976).

64. Gordon L. Paul et al., *Maintenance Psychotropic Drugs in the Presence of Active Treatment Programs*, 27 *Archives Gen. Psychiatry* 106, 113 (1972). See also Phillip R.A. May et al., *Predicting Outcome of Antipsychotic Drug Treatment From Early Response*, 137 *Am. J. Psychiatry* 1088, 1088 (1980) (substantial number of schizophrenic patients do not deteriorate after discontinuation of drug treatment); Wayne S. Fenton & Thomas H. McGlashan, *Sustained Remission in Drug Free Patients*, 144 *Am. J. Psychiatry* 1306, 1308-09 (1987) (finding a sustained good outcome over a prolonged postdischarge period for a definite proportion of schizophrenic patients after drug withdrawal).

65. See Paul et al., *supra* note 64, at 106; Breggin, *supra* note 30, at 56-59. For a detailed critique of the methodology and results of various psychiatric studies concerning the effects of antipsychotic drugs, see DuBose, *supra* note 46.

66. Donald J. Kemna, *Current Status of Institutionalized Mental Health Patients' Right to Refuse Psychotropic Drugs*, 6 *J. Legal Medicine* 107, 115 (1985); Litman, *supra* note 10, at 1724.

67. Gaughan & LaRue, *supra* note 30, at 55.

68. Louis S. Goodman & Alfred Gilman, *The Pharmacological Basis of Therapeutics* 172-74 (5th ed. 1975); Hollister, *supra* note 29, at 30-32; Theodore Van Putten & Phillip R.A. May, *Subjective Response as a Predictor of Outcome in Pharmacotherapy: The Consumer Has a Point*, 35 *Archives Gen. Psychiatry* 477 (1978).

69. Plotkin, *supra* note 4, at 475 quoting Phillip R.A. May et al., *Predicting Individual*

From this brief discussion, it should be clear that although antipsychotic drugs benefit many patients, there is a good deal of controversy concerning the presence of benefit in a substantial number of cases and the extent of benefit in others. Psychopharmacology is still in an early stage of development and the accompanying uncertainties must be a factor in weighing the benefits of its use against the potential costs to the patient.

B. *The Cost Side of the Equation: Side Effects of Antipsychotic Drugs*

The benefits that result from use of antipsychotic drugs must be balanced against their temporary and permanent side effects. Although the toxicity of each medication may differ, all antipsychotic drugs are capable of producing a wide variety of side effects.⁷⁰ Adverse patient reactions to the drugs were noticed shortly after their introduction into this country. However, in the general euphoria caused by their observed benefits, the side effects were downplayed and often ignored.⁷¹ It is only now that the drugs' serious side effects are receiving widespread recognition.

Side effects are prevalent even when the drugs are responsibly and carefully administered.⁷² A complete listing of side effects is beyond the scope of this article, but the most common fall into the following general categories:

1. *Non-neurological Side Effects*

At the onset of drug therapy, patients often experience drowsiness and fatigue. The extent and duration of this sedation vary according to the physiology of the patient, ranging from merely bothersome to severely limiting. These effects generally dissipate as the patient becomes more accustomed to the drug.⁷³

Various anticholinergic disturbances of the autonomic nervous system may occur. Patients often experience dry mouth and throat, stuffy nose, urinary retention, constipation and in rare cases, a type of paralysis of

Responses to Drug Treatment in Schizophrenia: A Test Dose Model, 162 J. Nervous & Mental Disease 177, 178 (1976).

70. Timothy Howell & Ronald J. Diamond, *The Use of Psychotropic Drugs in Elderly Patients with Chronic Mental Illness*, 29 *New Directions for Mental Health Services* 47, 51 (1986); Hollister, *supra* note 29, at 46-47; Breggin, *supra* note 30, at 70; Beyer, *supra* note 38, at 512-13.

71. Brooks, *supra* note 50, at 183; Breggin, *supra* note 30, at 49; *see infra* notes 168-180 and accompanying text.

72. Brooks, *supra* note 50, at 183.

73. Kemna, *supra* note 66, at 111; Gaughan & LaRue, *supra* note 30, at 51.

the intestine (paralytic ileus).⁷⁴ Patients may also suffer orthostatic or postural hypotension, a faintness or dizziness upon standing up due to a decrease in blood pressure.⁷⁵ Blurred vision often results from the drugs' effects on the nervous system.⁷⁶ More seriously, eyesight can be impaired by opaque deposits on the lens and cornea of the eye (oculocutaneous pigmentation) or an accumulation of pigment on the retina of the eye (retinitis pigmentosa).⁷⁷ In rare cases, high doses of thioridazine may cause blindness.⁷⁸

Antipsychotic medication may cause sexual dysfunctions including reduced libido and impotence.⁷⁹ Males may suffer an inability to ejaculate or, more painful, a reversal of ejaculation into the bladder.⁸⁰ The drugs may also induce priapism, a sustained and painful erection occurring without sexual stimulation. The erection does not subside after orgasm and often requires emergency surgery.⁸¹ Various endocrine and hormonal disorders are not uncommon. Patients often have an increased appetite resulting in substantial weight gain.⁸² Females may experience spontaneous lactation and irregularities in the menstrual cycle. In some cases, menstruation may be completely blocked resulting in infertility. Breast enlargement in males may occur.⁸³ Skin disorders have also been reported, ranging from hypersensitivity and rashes to an often irreversible discoloration of pigmentation.⁸⁴ The drugs may also interfere with body temperature regulation.⁸⁵

Antipsychotic drugs may cause a variety of blood disorders called dyscrasias. Dyscrasias result from allergic or toxic effects of antipsychotic drugs on the hematologic system. The most serious blood dyscrasia induced by the drugs is agranulocytosis, a decrease in certain white blood cells which destroy bacteria. This condition renders the patient

74. Gaughan & LaRue, *supra* note 30, at 51-52; Breggin, *supra* note 30, at 71.

75. Gaughan & LaRue, *supra* note 30, at 51-52; Julien, *supra* note 29, at 157; Kemna, *supra* note 66, at 111-12.

76. Julien, *supra* note 29, at 157; Kemna, *supra* note 66, at 111.

77. Kemna, *supra* note 66, at 111; DuBose, *supra* note 46, at 1204.

78. Julien, *supra* note 29, at 159-60; Beyer, *supra* note 38, at 535-36 n.177; Breggin, *supra* note 30, at 71; Hollister, *supra* note 29, at 53.

79. Hollister, *supra* note 29, at 52; Beyer, *supra* note 38, at 535.

80. Julien, *supra* note 29, at 158; Breggin, *supra* note 30, at 71.

81. Donald G. Gold, Jr. & Joseph D. Justino, "Bicycle Kickstand" Phenomenon: Prolonged Erections Associated with Antipsychotic Agents, 81 S. Med. J. 792, 793 (1988).

82. Hollister, *supra* note 29, at 52. In some cases, phenothiazines may suppress the appetite resulting in weight loss. Julien, *supra* note 29, at 158.

83. Julien, *supra* note 29, at 158; Beyer, *supra* note 38, at 535.

84. Julien, *supra* note 29, at 159-60; Hollister, *supra* note 29, at 51; DuBose, *supra* note 46, at 1204.

85. Julien, *supra* note 29, at 158; Beyer, *supra* note 38, at 535.

highly susceptible to life-threatening infections.⁸⁶ This potentially fatal disorder may be reversible if detected within one or two weeks of its onset.⁸⁷ Agranulocytosis is of special concern in the use of clozapine, an antipsychotic drug recently approved by the Federal Drug Administration for distribution in the United States. It is estimated that up to two percent of patients receiving clozapine will be afflicted with agranulocytosis.⁸⁸ Other serious physiological side effects of antipsychotic drugs include cholestatic jaundice, liver dysfunction, and cardiovascular irregularities.⁸⁹

86. DuBose, *supra* note 46, at 1205-06; Beyer, *supra* note 38, at 537-38 and n.180; Hollister, *supra* note 29, at 50-51.

87. Rathe, *Two Drugs Offer Great Hope for Refractory Patients*, *Psychiatric Times*, July 1989, at 1, col. 3.

88. *Id.* A weekly blood monitoring system has been developed for patients receiving clozapine in order to facilitate the early detections of agranulocytosis. Other common side effects of the drug include sedation and fatigue (thirty-nine percent prevalence rate), hypersalivation (thirty-one percent prevalence rate), tachycardia (twenty-five percent prevalence rate), hypotension (eleven percent prevalence rate), weight gain (thirty-four percent prevalence rate), fever (five percent prevalence rate), and electrocardiographic changes (two percent prevalence rate). In addition, clozapine poses a substantial risk of grand mal seizure (one percent-two percent prevalence rate at doses below 300 mg./day; three percent-four percent prevalence rate at doses below 600 mg./day; five percent-ten percent prevalence rate at doses of 600-900 mg./day). *Id.*; Promotional Literature, distributed by Sandoz Pharmaceuticals Corp. (Nov. 1989); Baldessarini & Frankenburg, *supra* note 59, at 751. A recent report stated that "[o]ther less frequent or less serious side effects include dry mouth, tremor, stiffness, mild akathisia, headache, confusion, sweating, urinary or sexual dysfunction, constipation, cataplexy, hypertension, low temperature, altered liver chemistry, eosinophilia, leukocytosis, and thrombocytopenia." *Id.* Recent reports also associate clozapine with the potentially fatal neuroleptic malignant syndrome. Del P. Miller et al., *A Case of Clozapine-Induced Neuroleptic Malignant Syndrome*, 52 *J. Clinical Psychiatry* 99 (1991); Eve S. Anderson & Pauline S. Powers, *Neuroleptic Malignant Syndrome Associated with Clozapine Use*, 52 *J. Clinical Psychiatry* 102 (1991); Krishna DasGupta & Asja Young, *Clozapine-Induced Neuroleptic Malignant Syndrome*, 52 *J. Clinical Psychiatry* 105 (1991). Unlike other antipsychotic drugs, however, the risk of severe extrapyramidal side effects associated with clozapine appears low at this early point in time. The drug is being recommended for patients who have failed to respond to trials of at least three other antipsychotic drugs or those individuals suffering severe extrapyramidal symptoms which preclude the use of other antipsychotic agents. Rathe, *supra* note 87, at 1, col. 3.

89. Liver damage has been linked to treatment with the phenothiazines. The frequency of liver damage has been reduced to the extent that it has all but disappeared. Hollister, *supra* note 29, at 50; Breggin, *supra* note 30, at 71. More common is the onset of jaundice, probably due to hypersensitivity or an allergic reaction to the drugs. Termination of drug therapy will alleviate this condition. *Id.* at 71; Julien, *supra* note 29, at 159-60.

There is evidence which links antipsychotic drugs to various cardiovascular complications including re-polarization changes, conduction abnormalities, and various arrhythmias. Claire M. Lathers & Leslie J. Lipka, *Cardiac Arrhythmia, Sudden Death, and Psychoactive Agents*, 27 *J. Clinical Psychopharmacology* 1 (1987); Breggin, *supra* note 30, at 71; Ernesto B. Baello, Jr. & David J. Skorton, *Effects of Psychotropic Drugs on the Cardiovascular System*, 73 *J. Iowa Med. Soc'y* 370, 372 (1983). Evidence also exists

2. Neurological Side Effects

a. Extrapyramidal Side Effects

All antipsychotic medications are neurotoxic and capable of producing a wide variety of neurologic disorders.⁹⁰ Most of these disorders involve abnormal body motions caused by the drugs' effect on the extrapyramidal system of the brain. The extrapyramidal system is a nonvoluntary nervous system which controls the coordination of muscular movements.⁹¹

One category of extrapyramidal side effects is parkinsonism. As its name implies, this impairment mimics the more serious Parkinson's disease.⁹² Its symptoms include a mask-like face, tremors of the limbs, muscle rigidity, spasms, drooling, a stooped and shuffling gait, and a general slowing of motor responses.⁹³ The prevalence of parkinsonism is disputed with estimates of the rate of infliction ranging anywhere from five percent to ninety percent of all patients treated with antipsychotic drugs.⁹⁴ At least one psychiatrist believes that upon close observation, subtle parkinsonism can be detected in virtually all patients treated with effective doses of the drugs.⁹⁵ This impairment is usually controllable by a reduction in drug dosage or through the use of anti-parkinsonian or anticholinergic medication.⁹⁶ Parkinsonism eventually

that antipsychotic drugs may have the potential to induce fatal cardiac tachyarrhythmias. Lathers & Lipka, *supra*, at 1; Beyer, *supra* note 38, at 536-37 and n.179; Hollister, *supra* note 29, at 52-53. In addition, there is some evidence, although inconclusive, which associates the effects of antipsychotic drugs to a number of other sudden patient deaths. Breggin, *supra* note 30, at 71-73; Beyer, *supra* note 38, at 538-39 and nn.181-83.

90. Breggin, *supra* note 30, at 73-74.

91. DuBose, *supra* note 46, at 1203 and n.147; Kemna, *supra* note 66, at 112. The risk of extrapyramidal side effects associated with the use of clozapine appears low in comparison to other antipsychotic drugs. *See supra* note 88.

92. Gutheil & Appelbaum, *supra* note 5, at 107; Gelman, *supra* note 50, at 1745.

93. Kemna, *supra* note 66, at 112; Beyer, *supra* note 38, at 530-31.

94. *See studies cited in* Breggin, *supra* note 30, at 87-88. One recent study indicated a forty-two percent nonrecognition rate of parkinsonism by clinical psychiatrists. Peter J. Weiden et al., *Clinical Nonrecognition of Neuroleptic-Induced Movement Disorders: A Cautionary Study*, 144 *Am. J. Psychiatry* 1148, 1150 (1987).

95. Breggin, *supra* note 30, at 87-88.

96. Kemna, *supra* note 66, at 112; Gutheil & Appelbaum, *supra* note 5, at 108. However, a study of parkinsonism in children and adolescents found that the symptoms of the disorder remained constant despite the use of anti-parkinsonian agents and worsened upon the lowering of antipsychotic drug dosage. Mary A. Richardson et al., *Neuroleptic Use, Parkinsonian Symptoms, Tardive Dyskinesia, and Associated Factors in Child and Adolescent Psychiatric Patients*, 148 *Am. J. Psychiatry* 1322, 1326 (1991). The study also revealed that the symptoms of parkinsonism often go unrecognized by staff clinicians although the children "were well aware of these symptoms in themselves and their peers, describing them as 'zombie-like' and implicating them as a reason for outpatient treatment noncompliance." *Id.*

disappears upon termination of drug therapy, although symptoms may linger for months.⁹⁷

A subcategory of parkinsonism is akinesia, characterized by a decrease in spontaneous mobility and speech along with a general feeling of listlessness and apathy.⁹⁸ Even mild akinesia is socially debilitating. This impairment is especially distressful for patients with any intellectual interests, as reading and talking become virtually impossible.⁹⁹ Akinesia is difficult to diagnose and is often mistaken for depression or the negative effects of psychosis. The burden of detection is on the physician as the patient "often denies any difficulty and is seemingly locked in a peaceful, apathetic remoteness."¹⁰⁰ The emotional apathy induced by akinesia often leads to a feeling of emptiness and depression.¹⁰¹ Studies suggest that approximately thirty to thirty-five percent of individuals on maintenance medication develop akinesia.¹⁰² Anti-parkinsonian drugs assist in controlling akinesia but cannot be relied upon to completely alleviate the impairment.¹⁰³

A particularly agonizing drug induced extrapyramidal side effect is akathisia. This impairment is characterized by a painful irritability and a persistent desire to move.¹⁰⁴ Symptoms can include a constant tapping of feet, alteration of posture and shifting of legs, fidgeting, pacing, and an inability to feel comfortable in any position. In a severe case, the patient reaches a point of extreme agitation and panic, being unable to remain motionless for more than a few minutes.¹⁰⁵ This severe anxiety is sometimes mistaken for the patient's original psychiatric disorder and,

97. See Breggin, *supra* note 30, at 88-89 (citing studies which indicate that remnants of parkinsonism symptomology may linger for months and even years after cessation of drug therapy); Richardson et al., *supra* note 96, at 1326 (citing studies which reveal that symptoms of parkinsonism may persist up to eighteen months after discontinuation of drug therapy).

98. Gelman, *supra* note 50, at 1744; Gutheil & Appelbaum, *supra* note 5, at 107.

99. Brooks, *supra* note 50, at 184; Theodore Van Putten & Stephen R. Marder, *Behavioral Toxicity of Antipsychotic Drugs*, 48 *J. Clinical Psychiatry* 13, 15-16 (1987).

100. Van Putten & Marder, *supra* note 99, at 16. One patient described the effects of akinesia as follows: "I ceased to have any moods. I ceased to care about anything. Nothing moved me—not even the death of my parents. I forgot what it felt like to be happy or unhappy. Was it good or bad? It was neither. It was nothing." *Id.* at 15. One recent study indicated a forty percent nonrecognition or misdiagnosis rate by clinical psychiatrists. Weiden et al., *supra* note 94, at 1150.

101. Van Putten & Marder, *supra* note 99, at 16-17; Brooks, *supra* note 50, at 184.

102. Van Putten & Marder, *supra* note 99, at 16.

103. *Id.*

104. Theodore Van Putten, *Why Do Schizophrenic Patients Refuse to Take Their Drugs?*, 31 *Archives Gen. Psychiatry* 67, 68-69 (1974); Breggin, *supra* note 30, at 75.

105. Van Putten, *supra* note 104, at 68-69. Gelman, *supra* note 50, at 1743-44.

on occasion, may actually exacerbate the underlying psychosis.¹⁰⁶ Patients often find akathisia intolerable, being more difficult to endure than the symptoms of the underlying psychosis.¹⁰⁷ As one patient stated:

[The akathisia] is like an inner shakiness . . . an inner agitation. It makes me feel more vulnerable. It's like an unprotected feeling. The inner antsiness reaches a point where it's like I'm standing raw in front of the world like a little child . . . like I'm standing naked in front of everybody.¹⁰⁸

An increasing body of recent medical research has connected severe akathisia to both suicidal and homicidal behavior.¹⁰⁹

As with any of the extrapyramidal side effects, the methods for detecting akathisia are in a primitive state.¹¹⁰ There have been few systematic attempts to measure the prevalence of akathisia. One early study found that forty-five percent of the patients observed experienced akathisia at one time or another.¹¹¹ A more recent study, however, indicates a much higher prevalence rate. After only one five milligram dose of haloperidol, sixty-four percent of the test group experienced akathisia, with twenty-two percent suffering a severe case. At the end of one week of treatment with a daily ten milligram dose, seventy-six percent of the patients experienced the impairment. Sixty-three percent of another test group experienced akathisia after four weeks of treatment with a fixed dose of thiothixene.¹¹²

Some researchers believe that this syndrome can be improved by treatment with anti-parkinsonian medications.¹¹³ However, these addi-

106. Van Putten & Marder, *supra* note 99, at 14; Gutheil & Appelbaum, *supra* note 5, at 108. A mistaken diagnosis of akathisia may result in a higher dosage of antipsychotic medication (the causative agent) administered to the patient. Theodore Van Putten, *The Many Faces of Akathisia*, 16 *Comprehensive Psychiatry* 43, 43 (1975). This result is disturbing in light of a recent study indicating a thirty-five percent clinical misdiagnosis rate. In addition, the study revealed a sixty-five percent nonrecognition rate by clinical psychiatrists. It was found that patients with unrecognized akathisia received higher doses of antipsychotic drugs than those patients with diagnosed akathisia. Weiden et al., *supra* note 94, at 1150-51.

107. Van Putten & Marder, *supra* note 99, at 14.

108. Quoted in Theodore Van Putten et al., *Subjective Response to Antipsychotic Drugs*, 38 *Archives Gen. Psychiatry* 187, 189-90 (1981).

109. John N. Herrera et al., *High Potency Neuroleptics and Violence in Schizophrenics*, 176 *J. Nervous & Mental Disease* 558 (1988); Van Putten & Marder, *supra* note 99, at 14 (stating that cited case literature "reads convincingly: it is reasonable to conclude that akathisia, in the extreme case, can drive people to suicide or to homicide."); Gelman, *supra* note 50, at 1744-45 and n.97; Beyer, *supra* note 38, at 538-39 and nn.181-83.

110. Van Putten & Marder, *supra* note 99, at 13.

111. Van Putten, *supra* note 104, at 45.

112. Van Putten & Marder, *supra* note 99, at 14-15.

113. Gutheil & Appelbaum, *supra* note 5, at 108.

tional drugs tend to increase the anticholinergic side effects of antipsychotic medications.¹¹⁴ Other psychiatrists believe that anti-parkinsonian agents are not effective in alleviating akathisia and that dosage reduction or complete withdrawal of antipsychotic medication is the only effective measure.¹¹⁵

The dystonias are another type of extrapyramidal impairment. Dystonic reactions often involve acute and very painful spasms of muscle groups including those in the neck, face, eyes, pelvis, trunk, and the extremities. These debilitating and grotesque spasms frequently affect young patients and are extremely frightening.¹¹⁶ Dystonias can generally be alleviated by continuous treatment with anti-parkinsonian medications.¹¹⁷

A somewhat similar impairment, only recently associated with antipsychotic drugs, is Meige's Syndrome. This disorder involves involuntary movements of the face, neck, and jaws with other muscles being affected in rare cases. A typical feature of this disorder is uncontrollable spasms of the eyelids which result in obstruction of vision.¹¹⁸ Unlike the dystonias, Meige's Syndrome does not respond to anti-parkinsonian medication. Complete withdrawal of antipsychotic drugs may lead to recovery if the disorder is diagnosed in its early stage.¹¹⁹

The final category of extrapyramidal side effects involve the dyskinesias, characterized by chronic, repetitive, involuntary movements and tremors.¹²⁰ These bizarre movements are not usually painful but are

114. Gaughan & LaRue, *supra* note 30, at 52.

115. Dilip V. Jeste & Richard J. Wyatt, Understanding and Treating Tardive Dyskinesia 43 (1982). See also Herrera et al., *supra* note 109, at 560 (stating that "it has been well-observed clinically that akathisia often appears despite prophylactic anti-parkinsonian medication and is often resistant to such treatment"); Van Putten & Marder, *supra* note 99, at 17 (finding that even with an anti-parkinson drug, a persisting akathisia is not uncommon).

116. Gutheil & Appelbaum, *supra* note 5, at 108; Beyer, *supra* note 38, at 531-32.

117. Gutheil & Appelbaum, *supra* note 5, at 108. However, a recent study revealed a sixty-seven percent misdiagnosis rate with dystonic reactions often being attributed to psychopathology. Weiden et al., *supra* note 94, at 1151-52. One type of dystonic disorder, tardive dystonia, appears to be immune from treatment with anticholinergic agents in most victims. This impairment can appear within three months of drug treatment and may continue indefinitely in some patients even after drug therapy is terminated. Joanne D. Wojcik et al., *A Review of 32 Cases of Tardive Dystonia*, 148 Am. J. Psychiatry 1055 (1991).

118. Jambur Ananth et al., *Meige's Syndrome Associated with Neuroleptic Treatment*, 145 Am. J. Psychiatry 513, 513 (1988).

119. *Id.* at 515.

120. Jeste & Wyatt, *supra* note 115, at 4. A tremor is "a regular rhythmic movement of a part of the body, resulting from alternate contractions of agonist and antagonist muscles The usual frequency is 3 to 12 per second, although occasionally it may be as high as 20 per second. The body parts most commonly affected by tremors include fingers, toes, head, and tongue." *Id.* at 39-41.

often extremely distressing and disruptive to a patient.¹²¹ Acute dyskinesias are usually responsive to anti-parkinsonian drugs.¹²² However, there is one type of dyskinesia which is so prevalent and dangerous that it deserves its own separate classification.

b. Tardive Dyskinesia

Tardive dyskinesia (TD) is a syndrome associated with the chronic administration of antipsychotic drugs.¹²³ TD is manifested by uncontrollable repetitive movements principally affecting the face, tongue, mouth, trunk (including respiratory muscles), upper and lower extremities, neck, shoulders, and pelvis. In the more pronounced cases, patients may have difficulty in swallowing (resulting in weight loss), talking, and breathing (with potentially fatal results).¹²⁴ This impairment not only presents serious physical complications, but even slight cases can be socially disabling and embarrassing.¹²⁵ One group of medical researchers described TD as follows:

Typically, TD begins insidiously and is initially detectable only as worm-like contractions of the tongue when the patient is asked to open his mouth but not protrude the tongue. In other patients, tic-like movements of the lips, face or frequent blinking are early harbingers of TD. Later manifestations include obvious protruding, curling and twisting tongue movements; pouting, sucking, smacking and puckering lip movements; retraction of mouth corners (bridling); bulging of the cheeks; chewing and lateral jaw movements. Finally, arms, legs, and digits can display rhythmical movements, while involuntary swaying to and fro trunk movements as well as abnormal postures, expiratory grunts and noises on respiration may occur.¹²⁶

As its name suggests, the symptoms of TD usually do not appear until later in the drug treatment program.¹²⁷ In some cases, however,

121. Breggin, *supra* note 30, at 74.

122. Gutheil & Appelbaum, *supra* note 5, at 108.

123. Gideon Salzberger, *Tardive Dyskinesia: A Risk in Long-Term Neuroleptic Therapy*, 31 *Med. Trial Tech. Q.* 203, 203 (1984).

124. Jeste & Wyatt, *supra* note 115, at 44-54 (setting forth a detailed explanation of tardive dyskinesia and including a vivid series of photographs showing the debilitating effects of the disorder); Daniel E. Casey & Peter Rabins, *Tardive Dyskinesia as a Life-Threatening Illness*, 135 *Am. J. Psychiatry* 486 (1978); DuBose, *supra* note 46, at 1204.

125. In one case, an institutionalized patient was unable to wear her dentures because of involuntary mouth movements. As a result, she was put on a diet of ground food and became the object of disparaging and humiliating staff treatment. See Brooks, *supra* note 50, at 185.

126. Joseph T. Smith & Robert I. Simon, *Tardive Dyskinesia Revisited*, 31 *Med. Trial Tech. Q.* 342, 343 (1985).

127. *Id.* at 342-43.

the impairment has developed within weeks of the initiation of drug therapy.¹²⁸ Although initial symptoms of the affliction are often reversible by drug withdrawal, early detection of the syndrome is extremely difficult. Usually, by the time the impairment is diagnosed, it has been present for months or years and has already become disabling.¹²⁹ To make matters worse, symptoms of TD are often unmasked only by withdrawal of medication for two to four weeks. And yet, ironically, drug withdrawal may only aggravate the condition. In other cases, symptoms will appear after lowering the dosage of medication.¹³⁰

The most frightening aspect of TD is that, if not detected in its early stages, it is usually irreversible.¹³¹ There is no effective cure or treatment for TD.¹³² Use of anti-parkinsonian drugs is ineffective. In fact, these agents can trigger or exacerbate the condition. The most effective means of managing the symptoms of TD is to increase the dosage of the antipsychotic drug.¹³³ However, treatment with the causative agent is unacceptable as structural brain damage may result.¹³⁴ In fact, studies have associated TD with brain cell degeneration.¹³⁵

The traditional psychiatric perception was that the risk of TD was slight and well worth taking given the benefits of antipsychotic drugs.¹³⁶ Although this attitude is still prevalent among institutional clinicians,¹³⁷ recent studies have led several noted psychiatrists to label TD as a major

128. George Gardos & Jonathan O. Cole, *Overview: Public Health Issues in Tardive Dyskinesia*, 137 *Am. J. Psychiatry* 776, 777 (1980); C. Thomas Gualtieri et al., *Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic Treatment*, 14 *J. Psychiatry & L.* 187, 201, 204 (1987); Beyer, *supra* note 38, at 532; Breggin, *supra* note 30, at 92-93.

129. Salzberger, *supra* note 123, at 204; Jeste & Wyatt, *supra* note 115, at 57; Brooks, *supra* note 50, at 185.

130. Smith & Simon, *supra* note 126, at 343; Hollister, *supra* note 29, at 49; Gualtieri et al., *supra* note 128, at 199-200.

131. Salzberger, *supra* note 123, at 204; Breggin, *supra* note 30, at 90.

132. Ronald S. Lipman, *Overview of Research in Psychopharmacological Treatment of the Mentally Ill/Mentally Retarded*, 22 *Psychopharmacology Bull.* 1046, 1052 (1986); Gelman, *supra* note 50, at 1743; Beyer, *supra* note 38, at 533 and n.165.

133. Salzberger, *supra* note 123, at 203; Jeste & Wyatt, *supra* note 115, at 56.

134. Hollister, *supra* note 29, at 50; Breggin, *supra* note 30, at 99-103; Gualtieri et al., *supra* note 128, at 203.

135. Hollister, *supra* note 29, at 49; *see generally* Breggin, *supra* note 30, at 103-06 (citing studies which link neurologic syndromes induced by antipsychotic drugs with brain pathology).

136. Brooks, *supra* note 50, at 185.

137. *Id.* at 185-86; Mark J. Mills, *The Rights of Involuntary Patients to Refuse Pharmacotherapy: What is Reasonable?*, 8 *Bull. Am. Acad. Psychiatry & L.* 313, 320-21 (1980); M. Jerome Fialkov & Steven Hasley, *Psychotropic Drug Effects Contributing to Psychiatric Hospitalization of Children: A Preliminary Study*, 5 *J. Developmental & Behavioral Pediatrics* 325, 325 (1984); Breggin, *supra* note 30, at 106-07.

public health concern.¹³⁸ Due in part to the difficulty in diagnosing TD, estimated prevalence rates vary considerably. Based on data gathered before 1980, the American Psychiatric Association (APA) estimated an affliction rate of ten to twenty percent for patients exposed to anti-psychotics for more than a year.¹³⁹ Prevalence rates have been rising steadily since the APA released its initial report.¹⁴⁰ Recent studies indicate much higher prevalence rates ranging up to in excess of fifty-five percent for patients exposed to antipsychotic drugs over a prolonged period.¹⁴¹ Susceptibility to TD is even higher among children and the elderly.¹⁴² The affliction rate may be as high as sixty percent for individuals between the ages of fifty and seventy, and seventy-five percent for patients over seventy.¹⁴³

With increasing study devoted to the diagnosis of TD, prevalence rates are growing annually.¹⁴⁴ And yet, this serious disorder continues to be underdiagnosed at an extremely high rate in clinical settings. In

138. Gardos & Cole, *supra* note 128, at 778; Smith & Simon, *supra* note 126, at 342; Lipman, *supra* note 132, at 1052.

139. American Psychiatric Association Task Force Report 18, Tardive Dyskinesia (1980), summarized in *Tardive Dyskinesia: Summary of a Task Force Report of the American Psychiatric Association*, 137 Am. J. Psychiatry 1163, 1165 (1980). The report questioned other existing studies which indicated much higher affliction rates by stating that "[a]t present, it is impossible to say whether patients showing slight hyperactivity of the tongue and slight choreic movements of the finger have tardive dyskinesia." *Id.* Recent studies indicate that the higher rates were, indeed, a more accurate estimation of the prevalence of tardive dyskinesia.

140. The American Psychiatric Association released an updated report on tardive dyskinesia in 1992. This report summarizes several prevalence and incidence rate studies. *Tardive Dyskinesia: A Task Force Report of the American Psychiatric Association 61-91* (1992).

141. See, e.g., Alan F. Schatzberg & Jonathan O. Cole, *Manual of Clinical Psychopharmacology* 99 (1986) (fifty percent-sixty percent prevalence rate); T. R. E. Barnes et al., *Tardive Dyskinesia: A 3-Year Follow-up Study*, 13 Psychol. Med. 71, 80 (1983) (forty-seven percent prevalence rate); Breggin, *supra* note 30, at 91-99 (citing numerous affliction rate studies); Leo E. Hollister, *Antipsychotic and Antimanic Drugs (Lithium)*, in *Review of General Psychiatry* 590, 596 (Goldman ed., 1984) (twenty percent-forty percent prevalence rate); Robert Sovner et al., *Tardive Dyskinesia and Informed Consent*, 19 Psychosomatics 172, 173 (1978) (indicating a fifty-six percent prevalence rate among chronically hospitalized schizophrenic patients).

142. Howell & Diamond, *supra* note 70, at 52; Jeste & Wyatt, *supra* note 115, at 38; Gualtieri et al., *supra* note 128, at 201.

An issue which has been largely ignored is the effects of antipsychotic and other psychotropic medications on children. Fialkov & Hasley, *supra* note 137, at 329; Richardson et al., *supra* note 96, at 1322; Breggin, *supra* note 30, at 93. However, recent studies indicate that susceptibility to many side effects is higher among children than adults. *Id.* at 98-99. And yet, the use of drugs on children is widespread. See *infra* note 170 and accompanying text.

143. Breggin, *supra* note 30, at 92.

144. Gualtieri et al., *supra* note 128, at 206.

a recent study performed at an inpatient psychiatric facility, only one of ten patients suffering from TD was accurately diagnosed by the clinicians.¹⁴⁵ This ninety percent non-recognition rate by clinical psychiatrists is corroborated by another study performed at a Veterans Administration teaching hospital. The results of this study demonstrated a seventy-five percent clinical non-recognition rate of TD.¹⁴⁶

Considering the widespread use of antipsychotic drugs in institutions for both the mentally ill and developmentally disabled, nursing homes, facilities for children, and the community, the above cited prevalence rates translate into an alarming number of individuals afflicted with TD. One physician recently stated that among the mentally retarded population alone, there are hundreds of thousands of individuals suffering from the syndrome.¹⁴⁷ If all individuals who receive prolonged treatment with antipsychotic drugs are considered and a conservative prevalence rate of twenty percent is used, one to two million persons suffer from TD in any given year.¹⁴⁸ And as of yet, there is no available method of predicting who will be afflicted by TD and no effective way to prevent its occurrence nor to manage its symptoms once they are displayed.¹⁴⁹ Unfortunately, despite the growing medical concern with the problem, a solution is not in sight.¹⁵⁰

c. Neuroleptic Malignant Syndrome

Neuroleptic malignant syndrome (NMS) is one of the most devastating side effects of antipsychotic medication. Although documented as early as 1958, this disorder is only now beginning to receive attention by academic psychiatrists in this country.¹⁵¹ The cardinal features of

145. Weiden et al., *supra* note 94, at 1151. The researchers concluded that "[w]ithout significant remediation of errors in diagnostic methods and training insufficiencies, it is likely that extrapyramidal side effects will continue to be underdiagnosed at an alarmingly high rate." *Id.* at 1153.

146. *Id.* at n.12, citing T. E. Hansen et al., TD Prevalence: Research and Clinical Differences, in New Research Abstracts, 139th Annual Meeting of the American Psychiatric Association (1986).

147. Lipman, *supra* note 132, at 1052.

148. Breggin, *supra* note 30, at 108.

149. Jeste & Wyatt, *supra* note 115, at 289-90; Smith & Simon, *supra* note 126, at 348.

150. Jeste & Wyatt, *supra* note 115, at 8.

151. Harrison G. Pope et al., *Frequency and Presentation of Neuroleptic Malignant Syndrome in a Large Psychiatric Hospital*, 143 *Am. J. Psychiatry* 1227 (1986). It is not yet known whether neuroleptic malignant syndrome ("NMS") represents a severe distribution of severe extrapyramidal effects or is a distinct impairment. *Id.* at 1231.

NMS are hyperthermia (fever), severe skeletal rigidity, elevated blood pressure, tachycardia, and alterations in consciousness including delirium, mutism, stupor, and coma.¹⁵² This syndrome typically develops swiftly, often over a twenty-four to seventy-two hour period.¹⁵³ As one medical commentary reported, "[i]n some cases, a patient takes only a few hours to go from symptoms without serious illness to an inability to swallow, coma, kidney failure or brain damage."¹⁵⁴

NMS can last from several days to several weeks, even after antipsychotic medication is discontinued.¹⁵⁵ This disorder is fatal in twenty to thirty percent of the cases with the risk of death being even higher when depot (sustained action intermuscular) forms of antipsychotics are used. Death usually occurs within three to thirty days after the onset of symptoms and is frequently caused by respiratory failure, cardiovascular collapse and acute kidney failure.¹⁵⁶ NMS can also cause permanent neurological damage, indicated by dementia and signs of parkinsonism.¹⁵⁷

152. *Id.* at 1227; B. Bower, *When Antipsychotic Drugs Can Be Lethal*, 130 *Sci. News* 260, 260 (1986).

153. Barry H. Guze & Lewis R. Baxter, *Neuroleptic Malignant Syndrome*, 313 *New Eng. J. Med.* 163 (1985). Some cases develop more insidiously. Gerard Addonizio et al., *Symptoms of Neuroleptic Malignant Syndrome in 82 Consecutive Inpatients*, 143 *Am. J. Psychiatry* 1587, 1588 (1986).

154. Bower, *supra* note 152, at 260.

155. When oral antipsychotic medication is used, the symptoms usually last from five to ten days. However, when depot antipsychotics are used, the symptoms usually last from thirteen to thirty days. David E. Sternberg, *Neuroleptic Malignant Syndrome: The Pendulum Swings*, 143 *Am. J. Psychiatry* 1273, 1273 (1986); Guze & Baxter, *supra* note 153, at 163.

156. Guze & Baxter, *supra* note 153, at 164; Sternberg, *supra* note 155, at 1273. For a vivid description of five reported deaths associated with NMS, see *Amicus Brief for the National Association of Protection and Advocacy Systems* at 14, *Washington v. Harper*, 494 U.S. 210, 110 S. Ct. 1028 (1990) (No. 88-599). A typical account is as follows:

A second man, 20 years old, was allowed to refuse drugs until he broke one of the ward rules. He was then forcibly injected. One day later, he was found lying on his back with his tongue protruding outward, his head contorted in a grotesque position, unable to speak. When these reactions subsided, his dosage was increased and physical reactions to the drugs continued. His mother and uncle found him stiff as a board when they visited him during the last days of his life. The day before he died, he was drooling, shuffling around the ward with his arms out stiffly from his side, needing assistance getting in and out of the shower and in dressing. The next morning, he was found dead in his bed, face down in his pillow. The county medical examiner determined that the severe muscle stiffness resulting from Neuroleptic Malignant Syndrome had prevented him from turning over, thus resulting in death by suffocation.

Id.

157. Pope et al., *supra* note 151, at 1227.

All antipsychotic drugs are capable of inducing NMS, and all patients exposed to these agents are at risk.¹⁵⁸ The onset of this disorder does not appear to be related to either dosage level or the duration of exposure to antipsychotic agents.¹⁵⁹ A recent study in a large psychiatric hospital revealed an annual frequency rate of 1.4 percent.¹⁶⁰ However, the researchers believe that they may have underestimated the frequency of NMS. Due to the retrospective nature of their study, it is likely that some cases occurring during the one-year period either went unrecognized or were forgotten by hospital staff members by the time they were interviewed. In addition, this one-year study did not take into account patients who had previously developed NMS or who are destined to develop it at some point in the future. The researchers concluded that "[i]n short, the probability that a patient will develop neuroleptic malignant syndrome at some point during his or her lifetime exposure to neuroleptics might exceed our estimate."¹⁶¹ Another recent study, which did not take into account milder variants of NMS, revealed a prevalence rate of 2.4 percent.¹⁶² When one considers that up to three million people are exposed to antipsychotic drugs each year, these affliction rates are alarming.¹⁶³ As one group of investigators stated, "even a conservative estimate would place the annual prevalence of neuroleptic malignant syndrome in the United States in the thousands of cases, a significant number of which may have fatal consequences."¹⁶⁴

Despite the seriousness and prevalence of NMS, most authoritative texts fail to even mention the syndrome.¹⁶⁵ This disorder continues to be underdiagnosed by clinicians, even in sophisticated academic hospital settings.¹⁶⁶ Due to the explosive course of this condition, lack of early recognition can prove fatal. And even when recognized, treatment remains problematic. Other than the obvious measure of immediate dis-

158. Guze & Baxter, *supra* note 153, at 163. The syndrome appears to be more common in young men.

159. *Id.*; Sternberg, *supra* note 155, at 1274.

160. Pope et al., *supra* note 151, at 1231.

161. *Id.* The authors also noted that the hospital in which their study was performed administered lower doses of drugs than do many other hospitals. Thus, if NMS is eventually associated with the level of dosage, it is even more likely that the affliction rate is higher than estimated.

162. Addonizio et al., *supra* note 153, at 1588.

163. Bower, *supra* note 152, at 260. In 1983, six types of antipsychotic drugs qualified as being among the 200 most prescribed medications in the United States. Guze & Baxter, *supra* note 153, at 163.

164. Pope et al., *supra* note 151, at 1232.

165. Sternberg, *supra* note 155, at 1273; Pope et al., *supra* note 151, at 1232.

166. Pope et al., *supra* note 151, at 1231-32; Addonizio et al., *supra* note 153, at 1587; Sternberg, *supra* note 155, at 1274.

continuation of antipsychotic agents, specific treatment recommendations have been impeded by a lack of controlled studies.¹⁶⁷

III. THE PSYCHIATRIC PROFESSION'S INITIAL RESPONSE

The discovery of antipsychotic drugs was followed by a period of unguarded optimism among psychiatric professionals. Psychotic patients who were formerly unamenable to treatment were being restored to a greater degree of normalcy, and many were able to reenter the community. Patients on institutional rolls became less agitated and functioned more rationally, thereby reducing problems for under-staffed and overburdened hospital personnel.

Unfortunately, because of the remarkable efficacy of the medications in managing the symptoms of psychoses, their limitations and dangers went unheeded for many years. Indeed, the few psychiatrists who made the initial effort to study and publicize the potential dangers of the drugs were admonished and derided.¹⁶⁸ Until the early 1970s, academic psychiatrists even ignored one of the most symptomatic and serious of the drugs' side effects—tardive dyskinesia.¹⁶⁹ Despite the growing recognition of the drugs' dangers and limitations by academic psychiatrists in the early 1970s, the next decade was marked by a general pattern of unawareness and apathy on the part of state institutional clinicians. Psychopharmacology continued to increase to the point of becoming routine therapy in public mental hospitals.¹⁷⁰ The use of antipsychotic

167. Addonizio et al., *supra* note 153, at 1589; Sternberg, *supra* note 155, at 1274.

168. See generally Gelman, *supra* note 50, at 1752-54 and nn.136-41 (describing the adverse reaction to the efforts of Dr. George Crane in studying and publicizing the prevalence of tardive dyskinesia and other side effects).

169. *Id.* at 1754.

170. Furrow, *supra* note 6, at 24. Antipsychotic drugs began and continue to be used for treatment of impairments other than schizophrenia and the affective disorders. The drugs have been used to treat chronic organic brain syndrome, serious anxiety and depression, manic-depressive disease, and neurotic conditions. Gualtieri et al., *supra* note 128, at 204; Gaughan & LaRue, *supra* note 30, at 49. As one commentary noted, antipsychotic drugs are sometimes used for any mental disorder which presents serious symptoms. *Id.*

Antipsychotic and other psychotropic drugs are also widely used for treating behavior and adjustment problems in juveniles. A study at one psychiatric hospital revealed that fifty-nine percent of child and adolescent residents were being administered antipsychotic medication. Only twenty-eight percent of these juveniles had a diagnosis of psychosis or major affective disorder; the others were being treated for various conduct, adjustment, developmental, and personality disorders. Richardson et al., *supra* note 96, at 1324, 1326.

Studies reveal that approximately two percent of school children receive psychotropic drugs for hyperactivity and 2.3% of elementary school children in special education classes are administered these medications. Fialkov & Hasley, *supra* note 137, at 325. Indeed, one study found that a substantial number of first admissions of children for psychiatric

drugs became and continues to be the predominant form of treatment

hospitalization are apparently due to the side effects of previously administered antipsychotic or other psychotropic medications. *Id.* at 326, 328. See also Maureen Keiffer, Comment, *Establishing Standards for Treating Children in Mental Institutions With Psychotropic Drugs*, 5 Pub. L. Forum 215, 217-18 (1986) (estimating that 500,000 to 600,000 school age children are currently receiving antipsychotic or other types of psychotropic medications). In addition, fifty-one percent of institutionalized mentally retarded children receive psychotropic drugs, with antipsychotics as the most commonly prescribed. Twenty percent of these children have been on medication for four years or more. Fialkov & Hasley, *supra* note 137, at 325. Another study found that over one-third of autistic children have been treated with antipsychotic drugs. See Gualtieri et al., *supra* note 128, at 204. As one group of medical researchers concluded:

Despite the paucity of knowledge and the complexity of the interactions between host and pharmacological agent, many practitioners appear to maintain a "laissez-faire" attitude regarding the use of psychotropic agents in children. These drugs are often assumed to be comparatively safe and relatively free of undesirable effects. Consequently, these drugs may be administered to a pediatric population on a "trial and error" basis, without due consideration of the significant risk to the child.

Fialkov & Hasley, *supra* note 137, at 325.

Furthermore, antipsychotic drugs are administered to a substantial number of mentally retarded adults. Studies indicate that up to sixty-four percent of institutionalized mentally retarded adults receive antipsychotic medications. Many of these individuals are administered the drugs on a long-term basis ranging from four years to an indefinite period. These studies have also revealed that the universally condemned practice of polypharmacology and over-prescription are not uncommon. See Gordon T. Heistad et al., *Long-term Usefulness of Thioridazine for Institutionalized Mentally Retarded Patients*, 87 Am. J. Mental Deficiency 243 (1982). Antipsychotic drugs are also used for the treatment of borderline personality disorders. Gutheil & Appelbaum, *supra* note 5, at 102 n.150. The extensive use of antipsychotic drugs for impairments other than schizophrenia and affective disorders remains prevalent despite serious controversy over the drugs' effectiveness and safety in such cases. See, e.g., Breuning et al., *Effects of Thioridazine on the Intellectual Performance of Mentally Retarded Drug Responders and Nonresponders*, 40 Archives Gen. Psychiatry 309 (1983); Paul et al., *supra* note 64, at 107; Gaughan & LaRue, *supra* note 30, at 49.

The use of these drugs is also prevalent in nursing homes despite the elderly's increased susceptibility to side effects. A recent Massachusetts study found that approximately two-thirds of nursing home residents are prescribed psychoactive drugs with the practice of polypharmacology being common. Mark Beers et al., *Psychoactive Medication Use in Intermediate-Care Facility Residents*, 260 J. Am. Med. Ass'n 3016, 3016, 3018 (1988). Studies indicate that twenty-one percent-forty-four percent of nursing home residents receive antipsychotic medication. See Judith Garrard et al., *Evaluation of Neuroleptic Drug Use by Nursing Home Elderly Under Proposed Medicare and Medicaid Regulations*, 265 J. Am. Med. Ass'n 463, 466 (1991). Most disturbing is the finding that approximately fifty percent of the prescriptions for antipsychotic drugs are ineligible under the Health Care Financing Administration Guidelines due to inadequate documentation of a diagnosis supporting the drugs' use or the inappropriate clinical use of the drugs. *Id.* at 466-67. Antipsychotic agents are widely used for conditions other than psychosis despite a failure to show specific therapeutic benefits. Beers et al., *supra*, at 3017. Given the above evidence, "[t]here is good reason to fear, therefore, that psychoactive drugs in general, and neu-

in state mental health facilities.¹⁷¹ And yet, as recently as 1978 when thousands of patients were suffering from tardive dyskinesia,¹⁷² an American Psychiatric Association Task Force Report stated that the condition was rare.¹⁷³ Many clinical psychiatrists overlooked symptoms of drug side effects and when they did take notice, simply viewed them as a sign of drug effectiveness or merely as a drug-induced behavioral disorder.¹⁷⁴ The prevailing view was that side effects, when acknowledged, were a necessary and inconsequential cost of drug therapy.¹⁷⁵

The inexcusable denial of one of the drugs' most serious side effects, tardive dyskinesia, was evidenced in 1974. Two New Jersey social workers issued a press release revealing the prevalence of the impairment in the Ancora State Psychiatric Hospital. The Department of Mental Health commissioned a study of the charges by faculty members of the New

roleptics in particular, may be used to sedate and incapacitate patients rather than as appropriate therapy for diagnosed mental disorders." Stephen F. Jencks & Steven B. Clauser, *Managing Behavior Problems in Nursing Homes*, 265 J. Am. Med. Ass'n 502, 502 (1991).

171. Aaron S. Mason et al., *Patterns of Antipsychotic Drug Use in Four Southeastern State Hospitals*, 38 *Diseases of the Nervous System* 541 (1977) (indicating that more than ninety-three percent of patients in four state hospitals studied were receiving antipsychotic medications); Breggin, *supra* note 30, at 10-12 (citing studies indicating that from eighty-five percent to one hundred percent of state mental hospital patients are administered antipsychotic drugs); Lipman, *supra* note 132, at 1046-48. As one pair of commentators stated:

There appears to be a general presumption that every patient should be placed on some sort of medication, including an antipsychotic drug. These presumptions are probably not part of any institutional policy, but rather non-normative principles determining a widespread course of institutional professional practice. Rarely is an institutionalized patient encountered who has never been on medication. Even taking into account controlled studies which are favorable to antipsychotic medication, the evidence suggests that these drugs are overprescribed in mental institutions.

Gaughan & LaRue, *supra* note 30, at 53-54.

172. One cannot help but assume that tardive dyskinesia was at least as prevalent then as it is today. See *supra* notes 136-144 and accompanying text.

173. Am. Psychiatric Ass'n Task Force, *Professional Liability Insurance and Psychiatric Malpractice II* (1978) cited in Brooks, *supra* note 15, at 349-50 n.31.

174. Van Putten & May, *supra* note 68, at 478. These researchers maintain that drug-induced discomfort or depression is generally overlooked in at least forty percent of the cases. They note that physicians rarely inquire into how the drugs make their patients feel. *Id.* at 480; Gelman, *supra* note 50, at 1757-60 and n.175 (citing blatant examples of state psychiatrists ignoring obvious and painful side effects in their patients).

175. Brooks, *supra* note 50, at 187. For a description of one advocate's personal experience in confronting this attitude and its effects on patients, see Gelman, *supra* note 50, at 1758 n.175. See also *Rennie v. Klein*, 476 F. Supp. 1294, 1302-03 (D.N.J. 1979) (court noting that the failure to acknowledge patients' side effects "appears to be a result of institutional self-interest. A diagnosis of possibly irreversible side effects would impugn the wisdom of previous use of psychotropics and would necessitate less reliance on drugs in treating the patient in the future.").

Jersey College of Medicine and Dentistry. The investigation consisted merely of sending questionnaires to hospital doctors and reviewing patient charts supplied by the hospitals. Not surprisingly, the investigators reported that they could find no evidence of tardive dyskinesia, an incredible conclusion given the actual prevalence of the impairment.¹⁷⁶ This refusal by state psychiatrists and mental health bureaucrats to acknowledge existing cases of tardive dyskinesia was repeated in 1978. After the filing of *Rennie v. Klein*,¹⁷⁷ a suit challenging drug practices at Ancora, a second study was commissioned. This investigation, performed by state department of mental health officials, consisted only of a survey of patient charts. Predictably, the results once again indicated no cases of tardive dyskinesia and, in addition, indicated that the prevalence of other drug-induced side effects was minimal. At about the same time, Ancora hospital officials reported to the Joint Commission on Accreditation of Hospitals that tardive dyskinesia was nonexistent.¹⁷⁸

The truth behind the New Jersey investigations and reports was revealed in testimony during the *Rennie* litigation. An independent expert, Dr. George Crane, personally examined a sampling of one hundred patients at Ancora. Dr. Crane found that twenty percent of these patients suffered from obvious symptoms of tardive dyskinesia and in nearly all the cases, the symptomology was not charted. Dr. Crane also reported that another fifteen percent of the patients studied suffered from drug-induced parkinsonism.¹⁷⁹ Under legal pressure, Ancora's medical director finally admitted that approximately twenty-five to forty percent of the hospital's patients were probably suffering from tardive dyskinesia.¹⁸⁰

The *Rennie* litigation not only revealed existing cases of drug-induced side effects, but also widespread abuse, incompetence, and callousness in the administration of medications.¹⁸¹ Inappropriate and unnecessary drugs which actually harmed patients were regularly prescribed. Polypharmacology, the universally condemned practice of administering a variety of antipsychotic drugs at the same time, was a common practice. Medical charts and records containing critical information were often

176. Sheldon Gelman, *Mental Hospital Drugging—Atomistic and Structural Remedies*, 32 Clev. St. L. Rev. 221, 231-32 (1983-84); Brooks, *supra* note 50, at 187.

177. 462 F. Supp. 1131 (D.N.J. 1978).

178. Gelman, *supra* note 176, at 232-33; Brooks, *supra* note 50, at 187.

179. Gelman, *supra* note 176, at 233; Brooks, *supra* note 50, at 187. Other administrative investigations during this period also ignored the existence of tardive dyskinesia. A 1975 survey of drug practices and side effects in Veterans Administration Hospitals by the General Accounting Office made no mention of tardive dyskinesia. Gelman, *supra* note 50, at 1755 and n.152. In 1979, a similar study of New York mental hospitals likewise ignored the existence of tardive dyskinesia. *Id.* at 1755 and n.153.

180. Brooks, *supra* note 50, at 187.

181. *Rennie*, 462 F. Supp. 1131.

misplaced and lost.¹⁸² Patients who resisted medication were subjected to retaliation by doctors and staff. In one case, a patient who complained of the distressing effects of Prolixin had his dosage doubled. In another case, when a patient complained of a side effect, his physician withdrew a medication intended to alleviate that side effect.¹⁸³ Patients were accused of "faking" side effects although testimony revealed that these accusations were absurd. Staff who called attention to side effects were criticized and intimidated by their supervisors.¹⁸⁴ The court described doctors as "blatantly ignoring" side effects and prescribing drugs in a "grossly irresponsible" manner.¹⁸⁵

Such practices were not limited to New Jersey state hospitals. A federal court in Ohio found widespread use of antipsychotic drugs in a counter-therapeutic manner, being prescribed merely for the convenience of staff and for punitive purposes.¹⁸⁶ The court found that "[p]sychotropic drugs are . . . freely prescribed . . . by both licensed and unlicensed physicians [who] . . . regularly prescribe drugs for any patient without regard to whether he is personally assigned to the patient or whether he has even seen the patient."¹⁸⁷ The court further noted that physicians often accepted recommendations by attendants for increased dosages without having examined the patient.¹⁸⁸ Investigations of hospitals in other states during the late 1970s revealed similar practices.¹⁸⁹ It is not surprising then that institutionalized mental patients turned to the courts for legal enforcement of a right to refuse the unwanted administration of drugs.

IV. LEGAL BASES FOR THE RIGHT TO REFUSE

The values of bodily integrity and self-determination are deeply imbedded in the philosophy of Western Civilization.¹⁹⁰ Common law protection of these values is displayed, in part, through the torts of assault, battery, and infliction of emotional distress.¹⁹¹ The Supreme

182. *Rennie v. Klein*, 476 F. Supp. 1294, 1299-1301 (D.N.J. 1978).

183. Brooks, *supra* note 15, at 351 (describing the *Rennie* litigation). For detailed and vivid accounts of such individual case histories, see Gelman, *supra* note 176, at 254-59.

184. *Rennie*, 476 F. Supp. at 1301-02.

185. *Id.*

186. *Davis v. Hubbard*, 506 F. Supp. 915, 926 (N.D. Ohio 1980).

187. *Id.* at 926.

188. *Id.* at 926-27.

189. See generally Brooks, *supra* note 50, at 189 and nn.50-51 (describing the discovery of such practices in both California and New York state mental hospitals); *Davis*, 506 F. Supp. at 926 n.7 (noting that misuse of drugs is common in large institutions for the mentally ill).

190. See *supra* note 1 and accompanying text.

191. Fredrick W. Maitland, *The Forms of Action of Common Law* 40, 43, 53 (1985); W. Page Keeton et al., *Prosser & Keeton on the Law of Torts* § 9, at 39 (5th ed. 1984).

Court has recognized the importance of these values, stating: "No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."¹⁹²

The tort of battery has long included medical procedures performed on patients without their consent.¹⁹³ The judiciary has expanded this protection through the development of the informed consent doctrine. This doctrine requires that a patient's consent be made in a competent, knowledgeable and voluntary manner in order to be legally valid.¹⁹⁴

Traditionally, the institutionalized mentally ill were not protected by the informed consent doctrine. Courts were not only reluctant to subject institutional staffs to liability in damages,¹⁹⁵ but there was a widespread assumption that institutionalized patients, due to their mental impairments, were *per se* incompetent to make rational treatment decisions.¹⁹⁶ As a result of this perceived inapplicability of tort law protection, lawyers representing patients in the initial drug refusal cases turned to the United States Constitution and state constitutions for a remedy.

A. Constitutional Sources for the Right to Refuse

A number of constitutional provisions have been relied on as sources for the right to refuse potentially hazardous psychiatric treatments. Some courts have relied on the Eighth Amendment's prohibition of cruel and unusual punishment. Other courts have turned to the First Amendment's guarantees of free exercise of religion and freedom of thought and expression as a basis for the right to refuse. Most frequently, courts have relied upon the protections offered by the Due Process clauses of the Fifth and Fourteenth Amendments.

192. *Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250, 251, 11 S. Ct. 1000, 1001 (1890).

193. *Cobbs v. Grant*, 502 P.2d 1, 7 (Cal. 1972) (en banc); *In re Quackenbush*, 383 A.2d 785, 789 (Morris County Ct. 1978); *Schloendorf v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. App. 1914). See generally *Harper & James*, *supra* note 2, at 211-20.

194. See *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170, 181 (Cal. App. 1st Dist. 1957); *Natanson v. Kline*, 350 P.2d 1093, 1106 (Kan. 1960). See generally *Jay Katz, Informed Consent—A Fairy Tale? Law's Vision*, 39 U. Pitt. L. Rev. 137 (1977); *Plotkin*, *supra* note 4, at 486.

195. *Rogers v. Okin*, 478 F. Supp. 1342, 1383 (D. Mass. 1979), *aff'd in part, rev'd in part, vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. 291, 102 S. Ct. 2442 (1982).

196. See *Price v. Sheppard*, 239 N.W.2d 905, 911 (Minn. 1976) (relying on "the need for the state to assume the decision-making role regarding the psychiatric treatment for one who, presumptively, based on the fact of commitment on the grounds of mental illness, is unable to *rationaly* do so for himself"). See also *Denny v. Tyler*, 85 Mass. (3 Allen) 225, 227 (1861); *In re Oakes*, 8 L. Rep. 122, 125 (Mass. 1845). See generally *Litman*, *supra* note 10, at 1722-23.

1. *The Eighth Amendment*

The Eighth Amendment's prohibition of cruel and unusual punishment has, in some limited situations, provided a valid basis for the challenge of psychiatric interventions.¹⁹⁷ Although the state has a legitimate interest in treating committed mental patients, it does not have such an interest in punishing them because of their illness.¹⁹⁸ The key issue then becomes, what constitutes punishment as opposed to treatment?

Merely characterizing an act as "treatment" does not automatically insulate it from Eighth Amendment scrutiny.¹⁹⁹ In *Mackey v. Procunier*,²⁰⁰ for example, a state prisoner was forcibly administered the drug succinylcholine which induced sensations of paralysis and inability to breathe, resulting in extreme fright. The state claimed the drug was administered as part of an aversive conditioning behavior treatment program.²⁰¹ The Ninth Circuit, nonetheless, applied the Eighth Amendment in reversing the lower court's dismissal of the complaint and emphasized that experimental use of the drug on fully conscious prisoners was inappropriate.²⁰²

In *Knecht v. Gillman*,²⁰³ inmates of a forensic mental institution were forcibly injected with the drug apomorphine for minor breaches of the behavior protocol. After injection, the inmates were exercised which induced vomiting for up to an hour. The state labeled this procedure aversive therapy and presented evidence of its long-term benefits.²⁰⁴ The Eighth Circuit, however, rejected the state's "treatment" contention and applied the cruel and unusual punishment clause while noting the unproven nature of the drug and its painful and debilitating effects.²⁰⁵ In *Nelson v. Heyne*,²⁰⁶ the Seventh Circuit relied on the Eighth

197. The Eighth Amendment provides that "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." U.S. Const. amend. VIII. The Supreme Court held this amendment applicable to the states in 1947. *Louisiana ex rel. Francis v. Resweber*, 329 U.S. 459, 67 S. Ct. 374 (1947).

198. *Jackson v. Indiana*, 406 U.S. 715, 92 S. Ct. 1845 (1972); *Robinson v. California*, 370 U.S. 660, 82 S. Ct. 1417 (1962).

199. See *Trop v. Dulles*, 356 U.S. 86, 95, 78 S. Ct. 590, 595 (1958) (stating that the legislative classification of a statute is not conclusive in determining an Eighth Amendment violation. The substance of the statute must be examined as "even a clear legislative classification of a statute as 'nonpenal' would not alter the fundamental nature of a plainly penal statute"); *Knecht v. Gillman*, 488 F.2d 1136, 1139 (8th Cir. 1973).

200. 477 F.2d 877 (9th Cir. 1973).

201. *Id.* at 878.

202. *Id.* The drug was "recommended as an adjunct to electric-shock therapy and as a relaxant in conjunction with administration of anesthesia." *Id.*

203. 488 F.2d 1136 (8th Cir. 1973).

204. *Id.* at 1138.

205. *Id.* at 1140.

206. 491 F.2d 352 (7th Cir. 1974), *cert. denied*, 417 U.S. 976, 94 S. Ct. 3183 (1974).

Amendment in enjoining the use of antipsychotic drugs in a juvenile correctional facility. The court emphasized the lack of monitoring by medical personnel and the fact that the drugs were administered "not as part of an ongoing psychotherapeutic program, but for the purpose of controlling excited behavior."²⁰⁷

These cases indicate that courts will look through the label of "treatment" and apply the Eighth Amendment when psychiatric intervention is experimental or of unproven therapeutic benefit, is excessive or improper, causes unnecessarily harsh adverse consequences, or is used merely for punishment and control.²⁰⁸ However, when the intervention is part of a bona fide treatment program, the Eighth Amendment will generally be inapplicable.²⁰⁹ Thus, because the administration of antipsychotic drugs in conjunction with a treatment plan is widely accepted as legitimate therapy, the Eighth Amendment will be of little use to patients wanting to refuse such therapy absent exceptional circumstances.²¹⁰

207. *Id.* at 356-57. See also *Vann v. Scott*, 467 F.2d 1235, 1240 (7th Cir. 1972) (stating that "neither the label which a state places on its own conduct, nor even the legitimacy of its motivation, can avoid the applicability of the Federal Constitution. We have no doubt that well intentioned attempts to rehabilitate a child could, in extreme circumstances constitute cruel and unusual punishment proscribed by the Eighth Amendment").

208. In *Rennie v. Klein*, 426 F. Supp. 1131, 1143 (D.N.J. 1978), the district court found the Eighth Amendment applicable to psychiatric treatment in mental institutions, but only when it was "found to have no proven therapeutic value and its use was not recognized as acceptable medical practice" or "the adverse effects seemed unnecessarily harsh" or it was "used improperly and for punishment rather than as part of an ongoing psychotherapeutic program").

209. *Id.*; *Peek v. Ciccone*, 288 F. Supp. 329, 337 (W.D. Mo. 1968).

210. David Zlotnick, *First Do No Harm: Least Restrictive Alternative Analysis and the Right of Mental Patients to Refuse Treatment*, 83 W. Va. L. Rev. 375, 417 (1981); Bruce J. Winick, *The Right to Refuse Psychotropic Medication: Current State of the Law and Beyond*, in *The Right to Refuse Antipsychotic Medication* 7, 15 (David Rapoport and John Parry eds., 1986). As Professor Winick points out, in a case scrutinizing conditions of confinement for pretrial detainees under the Fifth Amendment's Due Process Clause, the Supreme Court emphasized the importance of "intent" behind state action over the "affect" of the action in defining the term punishment. As the Court stated:

Absent a showing of an express intent to punish on the part of detention facility officials, that determination generally will turn on "[w]hether an alternative purpose to which [the restriction] may rationally be connected is assignable for it and whether it appears excessive in relation to the alternative purpose assigned [to it]" Thus, if a particular condition or restriction . . . is reasonably related to a legitimate governmental objective, it does not, without more, amount to "punishment." Conversely, if a restriction or condition is not reasonably related to a legitimate goal—if it is arbitrary or purposeless—a court permissibly may infer that the purpose of the governmental action is punishment.

Bell v. Wolfish, 441 U.S. 520, 538-39, 99 S. Ct. 1861, 1873-74 (1979), cited in *Winick*, *supra* n.210, at 15.

There is also a question as to whether the Eighth Amendment is even applicable outside the criminal context. In refusing to apply the cruel and unusual punishment proscription to disciplinary corporal punishment in public schools, the Supreme Court stated that the Eighth Amendment "was designed to protect those convicted of crimes."²¹¹ In explaining its holding, however, the Court emphasized the safeguards already available to public schoolchildren. The Court noted that public schools, unlike prisons, are open institutions subject to community supervision and common law constraints; thus, there is little need for the protection afforded by the Eighth Amendment.²¹² One can certainly make a convincing argument that mental institutions lack similar safeguards and are more analogous to the prison setting.²¹³ In fact, the Court expressly withheld judgment on whether the Eighth Amendment could be applied to involuntarily committed patients in mental institutions.²¹⁴ Courts remain split on this issue.²¹⁵

211. *Ingraham v. Wright*, 430 U.S. 651, 664, 97 S. Ct. 1401, 1409 (1977).

212. *Id.* at 670, 975 S. Ct. at 1416. The Court also pointed out that children in school are generally not physically restrained from leaving during school hours and are free to return home after the school day; they have the support of family and friends; and witnesses are available to report any mistreatment. *Id.* The situation of an involuntarily committed mental patient is much different. A state mental institution is a culture within itself, closed-off from the general community. Many committed mental patients lack the support of interested and caring family members and friends. In addition, the number of witnesses willing to report instances of abuse is reduced in institutions because many staff members tend to be protective of each other and because patients may be hesitant to report abuse for fear of staff retaliation. *See generally* Erving Goffman, *Asylums* (1961).

213. *See supra* note 212.

214. The Court stated:

Some punishments, though not labeled "criminal" by the State, may be sufficiently analogous to criminal punishments in the circumstances in which they are administered to justify application of the Eighth Amendment. . . . We have no occasion in this case, for example, to consider whether or under what circumstances persons involuntarily confined in mental or juvenile institutions can claim the protection of the Eighth Amendment.

Ingraham, 430 U.S. at 669 n.37, 97 S. Ct. at 1411 n.37.

215. For example, the United States Court of Appeals for the Third Circuit in *Rennie v. Klein*, 653 F.2d 836, 844 (3d Cir. 1981), disagreed with the district court's opinion that the Eighth Amendment's protection extends beyond the criminal context to committed mental patients. *See supra* note 208. The Third Circuit held that the Eighth Amendment provided inadequate minimal protection for mental patients, stating:

It is a throwback to a more callous attitude of the past to equate the mentally ill or retarded person's constitutional right of personal integrity to that of criminals. We reject the eighth amendment, therefore, as the proper minimal standard for the treatment of the plaintiff classes. They are entitled to more humane consideration.

Rennie, 653 F.2d at 844.

The court relied on *Bell v. Wolfish*, 441 U.S. 520, 99 S. Ct. 1861 (1979), in resolving

2. *The First Amendment*

The First Amendment's guarantee of freedom of speech has provided another basis for the right of an institutionalized individual to refuse certain types of psychiatric treatment.²¹⁶ Although the amendment refers to "freedom of speech," that clause has been interpreted by the Supreme Court to include other rights deemed essential to free speech.²¹⁷ The "freedom to think" or "freedom of the mind" has been held as one such prerequisite to free speech.²¹⁸ In holding that the First Amendment prohibits the criminalization of the private possession of obscenity, the Supreme Court stated that "[o]ur whole constitutional heritage rebels at the thought of giving government the power to control men's minds."²¹⁹ Psychiatric interventions which affect a patient's thought processes, emotions, attitudes, and concentration would certainly seem to implicate First Amendment values.²²⁰

One of the initial cases applying the First Amendment to psychiatric treatment was *Kaimowitz v. Michigan Department of Mental Health*.²²¹ A detainee under a sexual psychopath law was selected for experimental psychosurgery to control his aggression. The surgery was enjoined, in part, on First Amendment grounds.²²² The court noted that the First Amendment "protects the generation and free flow of ideas from un-

any doubt left by *Ingraham* on whether the Eighth Amendment is available only to those convicted of crimes. *Rennie*, 653 F.2d at 844 n.10. However, the Supreme Court did not necessarily go that far in *Bell*. The Court merely held that the Due Process Clause, not the Eighth Amendment, was the appropriate vehicle for analyzing the claims regarding conditions and restrictions brought by pretrial detainees. *Bell*, 441 U.S. at 535, 99 S. Ct. at 1872. The Court did not hold that the Eighth Amendment protects only those convicted of crimes. Compare with *In re K.K.B.*, 609 P.2d 747, 751 (Okla. 1980) ("[T]he use of drugs [on an involuntarily committed mental patient] for control or punishment, rather than as part of an on-going psychotherapeutic program designed to aid the patient, violates the eighth amendment respecting cruel and unusual punishment").

216. The First Amendment provides in part: "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech. . . ." U.S. Const. amend. I. The Supreme Court held this amendment applicable to the states in 1925. *Gitlow v. New York*, 268 U.S. 652, 45 S. Ct. 625 (1925).

217. See Winick, *supra* note 27, at 13-14.

218. *Stanley v. Georgia*, 394 U.S. 557, 89 S. Ct. 1243 (1969); *Aboud v. Detroit Bd. of Educ.*, 431 U.S. 209, 97 S. Ct. 1782 (1977); *Wallace v. Jaffree*, 472 U.S. 38, 105 S. Ct. 2479 (1985) (plurality opinion). See generally Winick, *supra* note 27, at 17-19.

219. *Stanley*, 394 U.S. at 565, 89 S. Ct. at 1248.

220. Winick, *supra* note 210, at 9. For a comprehensive overview concluding that the First Amendment is implicated by intrusive forms of psychiatric treatment, see Winick, *supra* note 27.

221. Civ. No. 73-19434-AW (Wayne County [Mich.] Cir. Ct., July 10, 1973) reprinted in *The Legal Rights of Handicapped Persons* 808 (Robert Burgdorf ed., 1980).

222. *Id.* at 820-22.

warranted interference with one's mental processes."²²³ In examining the side-effects of psychosurgery, the court stated:

Experimental psychosurgery . . . often leads to the blunting of emotions, the deadening of memory, the reduction of affect, and limits the ability to generate new ideas. Its potential for injury to the creativity of the individual is great, and can impinge upon the right of the individual to be free from interference with his mental processes.²²⁴

Other intrusive forms of psychiatric treatment have also been held to implicate First Amendment values. After noting several adverse effects on a patient's intellect, memory, and personality, the Seventh Circuit held that electroconvulsive therapy may invade First Amendment interests.²²⁵ The Ninth Circuit held that the forced administration of the drug succinylcholine which caused the patient in *Mackey* to have frightening nightmares raised serious constitutional questions respecting "impermissible tinkering with the mental processes."²²⁶

Whether the effects of antipsychotic drugs rise to a First Amendment level of interference with a patient's mental processes has been the subject of controversy. Psychiatrists have criticized judicial characterization of antipsychotic drugs as "mind altering" and "thought controlling."²²⁷ They emphasize the primary effects of the medications in reducing psychotic symptoms such as hallucinations, agitation, delusions, and disordered thinking. And although the drugs are admittedly "mind altering," psychiatrists argue that courts often fail to recognize that this alteration in mental functioning is in the direction of normality;²²⁸ that although the drugs may modify behavior, the behavior which is modified is derived from the mental illness itself.²²⁹ Accordingly, it is argued that a decision not to medicate can, in fact, result in more restrictions on freedom of thought than would occur with forced administration of the drugs. As one psychiatrist forcefully stated after noting "the failure of the legal mind to grasp clinical realities":²³⁰

[A] psychosis is *itself* involuntary mind control of the most extensive kind and itself represents the most severe "intrusion on the integrity of a human being." The physician seeks to

223. *Id.* at 822.

224. *Id.*

225. *Lojuk v. Quandt*, 706 F.2d 1456, 1465 (7th Cir. 1983).

226. *Mackey v. Procunier*, 477 F.2d 877, 878 (9th Cir. 1973).

227. *Appelbaum & Gutheil*, *supra* note 4; *Gutheil*, *supra* note 4; *Schwed*, *supra* note 4; *Gutheil & Appelbaum*, *supra* note 5.

228. *Gutheil & Appelbaum*, *supra* note 5, at 100, 118.

229. *Id.* at 80.

230. *Gutheil*, *supra* note 4, at 327.

liberate the patient from the chains of illness: the judge, from the chains of treatment. The way is paved for patients to "rot with their rights on."²³¹

The beneficial primary effects of antipsychotic drugs on psychotic symptomatology are widely recognized.²³² The argument has been made that even these ameliorative and normalizing effects implicate First Amendment values. The basis of this argument is that the First Amendment protects the mental process from government intrusion, even though that mental process is characterized by disordered thought.²³³

Professor Winick convincingly argues that involuntary government alteration of the mental process, even if in the direction of normalcy, should be subject to First Amendment scrutiny.²³⁴ He points out that there is no definitive method for "[d]istinguishing 'normal' from 'abnormal' mental states. . . ."²³⁵ Likewise, because of the vague criteria for defining a mental illness, "the distinction between sane and disordered thought is elusive."²³⁶ In addition, such criteria are value laden and inconsistently applied by clinicians.²³⁷ As a result of all this imprecision, the potential for abuse is high.²³⁸ Finally, as Professor Winick emphasizes, subjecting involuntary psychiatric treatment to First Amendment scrutiny does not necessarily mean that the patient will go untreated. "Rather, it erects a presumption against forced governmental intrusion into the mind, one that may be overcome only on a showing of compelling necessity, thus requiring careful scrutiny both of the ends sought by intrusive treatment and the means selected to accomplish those ends."²³⁹

Despite the above reasoning, courts have been hesitant to extend First Amendment protection to disordered thoughts.²⁴⁰ Therefore, legal advocates of a right to refuse antipsychotic medication generally base their First Amendment arguments on the secondary effects of the drugs

231. *Id.*

232. See Gutheil & Appelbaum, *supra* note 5, at 100 and nn.141-42.

233. Beyer, *supra* note 38, at 513. This assertion has been labeled the "unconditional" argument "because its force does not depend upon the existence of any actual impairment but rather upon the very goal of the treatment." *Id.* at 514.

234. Winick, *supra* note 27, at 41-60.

235. *Id.* at 58.

236. *Id.* at 46.

237. *Id.* at 46-52.

238. Professor Winick analogizes to psychiatric practice in the Soviet Union where political dissidents are labeled mentally ill, committed to hospitals, and subjected to intrusive treatment to alter their views. It is not incomprehensible that many Soviet psychiatrists view this practice as benevolent in nature. *Id.* at 52.

239. *Id.* at 60.

240. In *Rennie v. Klein*, 462 F. Supp. 1131, 1144 (P.N.J. 1978), the court made reference to the issue but found it unnecessary to address it.

on a patient's otherwise normal mental processes and communicative ability. As described earlier, antipsychotic drugs are capable of producing numerous adverse side effects. At the onset of medication, patients often experience drowsiness and fatigue to varying degrees. Although this sedation often decreases for many patients as they become accustomed to the drugs, for others it can severely limit the ability to think and function normally.²⁴¹

Thus, neurological side effects impair otherwise normal mental functioning and awareness and, even if they successfully treat the abnormality, they do not "liberate the patient from the chains of illness."²⁴² For example, akinesia, which is characterized by a decrease in spontaneous mobility and speech along with a general feeling of emotional apathy and indifference, impairs the ability to concentrate, read, and talk.²⁴³ Akathisia, an emotional state characterized by a painful irritability and constant desire to move, also adversely affects mentation.²⁴⁴ Dystonic reactions, often involving acute and very painful spasms of muscle groups in the neck, face, eyes, pelvis, and extremities, can seriously interfere with concentration and communication.²⁴⁵ In addition, the chronic, repetitive, involuntary movements and tremors induced by the dyskinesias are often extremely distressing and disruptive to patients.²⁴⁶ Although many of these side effects can be reduced or alleviated by anti-parkinsonian medications, only a discontinuation of antipsychotic therapy will eliminate others.²⁴⁷ Long-term use of antipsychotic drugs may permanently impair memory, learning, and reasoning ability.²⁴⁸

Most courts which have addressed the First Amendment issue in right to refuse cases have concluded that First Amendment protections can be infringed by drug side effects.²⁴⁹ The Third Circuit was the first court to recognize First Amendment guarantees as a basis for the right

241. See *supra* note 73 and accompanying text; Winick, *supra* note 27, at 70-71.

242. See *supra* note 231 and accompanying text.

243. See *supra* notes 98-101 and accompanying text.

244. See *supra* notes 104-109 and accompanying text; Gutheil & Appelbaum, *supra* note 5, at 109.

245. See *supra* notes 116-117 and accompanying text.

246. See *supra* notes 120-126 and accompanying text.

247. See *supra* notes 103, 115, and 133 and accompanying text; Gutheil & Appelbaum, *supra* note 5, at 109 n.190.

248. Winick, *supra* note 210, at 11.

249. *Id.* Another First Amendment argument in support of drug refusal arises from the amendment's protection of free exercise of religion. In *Winters v. Miller*, 446 F.2d 65, 67 (2d Cir.), cert. denied, 404 U.S. 985, 92 S. Ct. 450 (1971), the court held that the forced medication of an involuntary but competent mental patient over her religious objection stated a valid First Amendment claim. Thus, a competent mental patient who refuses antipsychotic medication on bona fide religious grounds may not be forcibly treated absent an emergency sufficient to override the constitutional interest. *Id.* at 69.

to refuse antipsychotic drugs in *Scott v. Plante*.²⁵⁰ After noting that the variety of drugs forcibly administered to Scott can produce "a dazed condition, engendering apathy and slowing the thought process,"²⁵¹ the court stated that "the involuntary administration of drugs which affect mental processes, if it occurred, could amount, under an appropriate set of facts, to an interference with Scott's rights under the first amendment."²⁵²

In *Rogers v. Okin*,²⁵³ the Massachusetts federal district court also referred to the First Amendment in finding a source for the right to refuse antipsychotic medication. The court labeled the drugs as mind-altering, but in the sense that they "reduce the level of psychotic thinking."²⁵⁴ However, the court then focused on the range of possible side effects which accompany drug therapy²⁵⁵ and noted that the communication of ideas "presupposes a capacity to produce ideas" which is protected by the First Amendment.²⁵⁶ The court further stated:

Whatever powers the Constitution has granted our government, involuntary mind control is not one of them, absent extraordinary circumstances. The fact that mind control takes place in a mental institution in the form of medically sound treatment of mental disease is not, itself, an extraordinary circumstance warranting an unsanctioned intrusion on the integrity of a human being.²⁵⁷

250. 532 F.2d 939 (3d Cir. 1976), *vacated and remanded*, 458 U.S. 1101, 102 S. Ct. 3474 (1982).

251. *Scott*, 532 F.2d at 945 n.8.

252. *Id.* at 946. *See also* Davis v. Hubbard, 506 F. Supp. 915, 929 (N.D. Ohio 1980) (favorably citing First Amendment cases in finding a constitutional right to refuse antipsychotic medication while basing its holding on the liberty guarantee of the Fourteenth Amendment).

253. *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part and rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom* Mills v. Rogers, 457 U.S. 291, 102 S. Ct. 2442 (1982).

254. *Id.* at 1360.

255. *Id.*

256. *Id.* at 1367.

257. *Id.* The court's opinion can possibly be interpreted as supporting the "unconditional" argument that First Amendment protections encompass the generation of even disordered thought. *See supra* note 233 and accompanying text. In finding First Amendment implications, the court made the broad statement that "psychotropic medication has the potential to affect and change a patient's mood, attitude and *capacity to think*." *Id.* at 1366 (emphasis added). The court also stated that "[t]he right to produce a thought . . . is a fundamental element of freedom." *Id.* at 1367. These statements, standing alone, could imply that any thought, even if psychotic, is entitled to First Amendment protection. However, the court noted that "[w]ithout the capacity to think, we merely exist, not function." *Id.* It is doubtful that the court intended psychotic thought to be included within the statement "capacity to think" which allows "functioning." *See* Beyer, *supra*

In *Bee v. Greaves*,²⁵⁸ the Tenth Circuit stated that the First Amendment protects both the capacity to produce and to communicate ideas.²⁵⁹ After noting the adverse side effects of antipsychotic medications,²⁶⁰ the court concluded that “[a]ntipsychotic drugs have the capacity to severely and even permanently affect an individual’s ability to think and communicate.”²⁶¹

In the 1987 panel decision of *United States v. Charters (Charters I)*,²⁶² the Fourth Circuit found that a pretrial detainee retained a constitutional right to refuse antipsychotic drugs based, in part, on the First Amendment.²⁶³ The court noted that even if a patient’s mental disorder renders him incapable of making treatment decisions, he may, nonetheless, remain capable of engaging in other activities protected by the First Amendment. Drug side effects may, however, diminish these otherwise unaffected capabilities.²⁶⁴ The court compared the potential effects of antipsychotic drugs on a patient’s freedom of thought with the effects of psychosurgery, stating, “There is, at least, no principled distinction between the chemical invasion of drug therapy and the mechanical invasion of surgery.”²⁶⁵ The court concluded that “[s]uch mind altering medication has the potential to allow the government to alter or control thinking and thereby to destroy the independence of thought and speech so crucial to a free society.”²⁶⁶ However, this decision was deprived of its precedential effect by an en banc review of the case.²⁶⁷ Although a constitutional right to refuse antipsychotic medication was affirmed, the

note 38, at 517. In addition, the court later concluded that “a competent patient has a fundamental right to decide to be left alone, absent an emergency situation.” *Rogers*, 478 F. Supp. at 1367. This statement indicates that even if the court intended to protect psychotic thinking, it was relying primarily on an individual’s right to privacy. *See id.* at 1366 & n.28. *See also* *Davis v. Hubbard*, 506 F. Supp. 915, 933 (N.D. Ohio 1980) (stating that “[i]t is enough to observe that ‘the power to control men’s minds’ is ‘wholly inconsistent’ not only with the ‘philosophy of the first amendment but with virtually any concept of liberty’”) (quoting *Stanley v. Georgia*, 394 U.S. 557, 565-66, 89 S. Ct. 1243, 1248 (1964)).

258. 744 F.2d 1387 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214, 105 S. Ct. 1187 (1985).

259. *Id.* at 1393-94.

260. *Id.* at 1390-91 & nn.3-4.

261. *Id.* at 1394.

262. 829 F.2d 479 (4th Cir. 1987), *rev’d and remanded*, 863 F.2d 302 (4th Cir. 1988) (en banc), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990).

263. *Id.* at 490.

264. *Id.* at 489. The court noted that “[t]he drugs may affect mood and emotion, dull the senses and make reading and concentration difficult.” *Id.*

265. *Id.* Numerous courts have likened the intrusiveness of treatment with antipsychotic medication to that of electroshock and psychosurgery. *See infra* note 326.

266. *Id.* at 492.

267. *United States v. Charters*, 863 F.2d 302 (4th Cir. 1988) (en banc), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990) (*Charters II*).

court based this holding on a due process liberty interest rather than on the First Amendment.²⁶⁸

It should be noted that there may be some limitations on First Amendment applicability to involuntary antipsychotic drug treatment. In *Rennie v. Klein*,²⁶⁹ the district court suggested that the First Amendment could be implicated by the forced administration of antipsychotic drugs, stating, "Any court must be deeply concerned with potential state control of individual thought and carefully scrutinize instances of forced psychiatric treatment."²⁷⁰ The court, however, relied on the constitutional right to privacy, rather than the First Amendment, as a basis for the right to refuse.²⁷¹ The court declined to apply the First Amendment for two reasons. First, because the plaintiff asserted in his action a desire and right to be treated and cured, he was deemed to have waived his First Amendment claim against the hospital's efforts to alter his thinking disorder.²⁷² The facts of this particular case were the basis for the court's second reason. It was noted that the plaintiff's ability to perform on intelligence tests was not impaired and that his side effects were only expected to last a short period.²⁷³ The court concluded that this "temporary dulling of the senses" did not rise to the level of a First Amendment violation.²⁷⁴

The assertion of a desire and right to be treated and cured would appear to be an inappropriate justification for holding that a waiver of First Amendment claims has taken place. The mere fact that a person asserts a desire to receive treatment does not mean that he is willing to submit to any type of treatment regardless of its risk/benefit ratio. If a proposed treatment has the primary or secondary effects of interfering with a person's otherwise functional mental or communicative processes, that person should retain his First Amendment protections from those undesired consequences regardless of any initial assertion of a right to treatment. The particular treatment, in that instance, should not be deemed appropriate or adequate to meet the patient's desires and asserted rights.²⁷⁵

268. *Id.* at 305-06.

269. 462 F. Supp. 1131 (D.N.J. 1978).

270. *Id.* at 1144.

271. *Id.*

272. *Id.*

273. *Id.*

274. *Id.*

275. See generally Shari L. Kahn, Comment, *The Right to Adequate Treatment Versus the Right to Refuse Antipsychotic Drug Treatment: A Solution to the Dilemma of the Involuntarily Committed Psychiatric Patient*, 33 Emory L.J. 441 (1984) (setting forth a philosophical explanation of why the emerging constitutional right to adequate treatment for involuntarily committed mental patients is consistent with a constitutional right to refuse particular psychiatric interventions).

The court's second reason for not applying the First Amendment—that the plaintiff's side effects in this particular case were not serious and were of short duration—indicates that there may be some minimum level of impairment which must be reached before courts will apply First Amendment scrutiny.²⁷⁶ Patients react differently to antipsychotic medications depending on their physiology, the type and number of drugs administered, the dosage and the duration of their use. *Rennie* suggests that First Amendment applicability will depend, in part, on the evidentiary showing of the drugs' potential side effects in any particular case.²⁷⁷

3. *Liberty and Self-Autonomy*

Even after legal confinement, an individual retains a constitutionally protected right to remain free from unwarranted government intrusions upon his person.²⁷⁸ This right has been cast in various terms, often depending on the type of proposed governmental action, including a liberty interest in bodily integrity,²⁷⁹ freedom from restraint,²⁸⁰ personal security,²⁸¹ or as an aspect of the right to privacy.²⁸²

Recently, in *Washington v. Harper*,²⁸³ the United States Supreme Court held that a convicted prisoner "possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment."²⁸⁴ 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: "[a] right to be free from, and to obtain judicial relief

276. This requirement arises from what has been termed the "conditional" analysis of First Amendment applicability. Unlike the "unconditional" argument, *see supra* note 233 and accompanying text, conditional application of the amendment's protections depends upon whether there is an impairment of the patient's normal mental processes by the treatment and how serious that impairment is. *See Beyer, supra* note 38, at 513.

277. *See Winick, supra* note 27, at 75 (asserting that the typical treatment program with antipsychotic drugs will exceed any *de minimis* level of intrusiveness required for First Amendment scrutiny).

278. *Youngberg v. Romeo*, 457 U.S. 307, 315-16, 102 S. Ct. 2452, 2458 (1982); *Vitek v. Jones*, 445 U.S. 480, 491-94, 100 S. Ct. 1254, 1263-64 (1980); *Hutto v. Finney*, 437 U.S. 678, 688, 98 S. Ct. 2565, 2572 (1978).

279. *Schmerber v. California*, 384 U.S. 757, 772, 86 S. Ct. 1826, 1836 (1966).

280. *See Youngberg*, 457 U.S. at 316, 102 S. Ct. at 2458; *Greenholtz v. Nebraska Penal Inmates*, 442 U.S. 1, 18, 99 S. Ct. 2100, 2109 (1979) (Powell, J., concurring in part and dissenting in part).

281. *See Youngberg*, 457 U.S. at 315-16, 102 S. Ct. at 2458; *Hutto*, 437 U.S. at 683, 98 S. Ct. at 2570.

282. *See Winston v. Lee*, 470 U.S. 753, 759, 105 S. Ct. 1611, 1616 (1985); *Schmerber*, 384 U.S. at 769-70, 86 S. Ct. at 1835.

283. 494 U.S. 210, 110 S. Ct. 1028 (1990).

284. *Id.* at 221-22, 110 S. Ct. at 1036.

for, unjustified intrusions on personal security.”²⁸⁵ In a case involving the commitment of juveniles into a state mental hospital, the Supreme Court stated that “[i]t is not disputed that a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment. . . .”²⁸⁶ And in *Youngberg v. Romeo*,²⁸⁷ the Court held that an involuntarily committed mentally retarded individual retains Fourteenth Amendment liberty interests in reasonably safe conditions of confinement, freedom from unreasonable bodily restraint, and such minimally adequate training as is reasonably necessary to assure those interests.²⁸⁸

Even before the Supreme Court’s decision in *Harper*, numerous federal and state courts applied this liberty or privacy interest in freedom from unjustified governmental intrusions to involuntary treatment with antipsychotic drugs.²⁸⁹ For example, in *Bee v. Greaves*²⁹⁰ the Tenth Circuit

285. *Vitek v. Jones*, 445 U.S. 480, 492, 100 S. Ct. 1254, 1263 (quoting *Ingraham v. Wright*, 430 U.S. 651, 673, 97 S. Ct. 1401, 1413 (1977)).

286. *Parham v. J.R.*, 442 U.S. 584, 600, 89 S. Ct. 2493, 2503 (1979). The Supreme Court has held that involuntary commitment to a mental institution constitutes a “massive curtailment of liberty.” *Humphrey v. Cady*, 405 U.S. 504, 509, 92 S. Ct. 1048, 1052 (1972). See also *Zinermon v. Burch*, 494 U.S. 113, 131, 110 S. Ct. 975, 986 (1990) (an individual has a “substantial liberty interest in avoiding confinement in a mental hospital”).

287. 457 U.S. 307, 102 S. Ct. 2452 (1982).

288. *Id.* at 316, 102 S. Ct. at 2458.

289. *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*, 110 S. Ct. 3243 (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); Opinion of the Justices, 465 A.2d 484, 489 (N.H. 1983); *State ex rel. Jones v. Gerhardstein*, 400 N.W.2d 1, 6 (Wis. App. 1986), *aff’d*, 416 N.W.2d 883 (1987); *Rogers v. Okin*, 634 F.2d 650, 653 (1st Cir. 1980). *Davis v. Hubbard*, 506 F. Supp. 915, 929-31 (N.D. Ohio 1980) (constitutional liberty interest implicated by compulsory treatment with antipsychotic drugs because such treatment invades bodily integrity and personal dignity). Accord *Riese v. St. Mary’s Hosp. & Medical Ctr.*, 243 Cal. Rptr. 241, 249-50 (Cal. App. 1st Dist. 1987), *opinion superceded*, 751 P.2d 893 (Cal. 1988), *dismissed*, 774 P.2d 698 (1989); *In re Mental Commitment of M.P.*, 510 N.E.2d 645, 646 (Ind. 1987); *United States v. Leatherman*, 580 F. Supp. 977, 979 (D.D.C. 1983), *appeal dismissed*, 729 F.2d 863 (D.C. Cir. 1984); *Williams v. Wilzack*, 573 A.2d 809, 820 (Md. 1990); *Rogers v. Commissioner of Dep’t of Mental Health*, 458 N.E.2d 308, 314 (Mass. 1983); *Savastano v. Saribeyoglu*, 480 N.Y.S.2d 977, 978 (S. Ct. 1984); *In re K.K.B.*, 609 P.2d 747, 749 (Okla. 1980); *Henderson v. Yocom*, No. 7948A, mem. op. at 9 (S.D. 1st Cir. 1987), *aff’d*, 438 N.W.2d 225 (S.D. 1989) (table opinion), *reported in* 11 *Mental & Physical Disability L. Rep.* 327 (1987); *State ex rel. Jones v. Gerhardstein*, 400 N.W.2d at 6; *Rogers v. Okin*, 634 F.2d at 653. *United States v. Charters*, 863 F.2d 302, 305 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990) (forced drugging is analogous to the intrusion presented by physical restraints and therefore gives rise to a constitutionally protected liberty interest). Accord *Dautremont v. Broadlawns Hosp.*, 827 F.2d 291, 300 (8th Cir. 1987); *R.A.J. v. Miller*, 590 F. Supp.

held that pretrial detainees retain a liberty interest in "freedom from physical and mental restraint of the kind potentially imposed by antipsychotic drugs."²⁹¹ The Third Circuit stated that the forced administration of antipsychotic drugs "implicates the 'right to be free from, and to obtain judicial relief for, unjustified intrusions on personal security'. . . . This intrusion rises to the level of a liberty interest warranting the protection of the due process clause of the fourteenth amendment."²⁹²

A second interest protected by the constitutional privacy doctrine is the right to make fundamental decisions in certain matters concerning one's person. This right of self-autonomy was first accorded constitutional recognition by the United States Supreme Court in 1965.²⁹³ Courts have reasoned that this right encompasses the same values protected by the common law doctrine of informed consent.²⁹⁴ Ironically, courts have

1319, 1321 (N.D. Tex. 1984); *Project Release v. Prevost*, 551 F. 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); *Anderson v. State*, 663 P.2d 570, 574 (Ariz. Ct. App. 1982). *Rennie v. Klein*, 462 F. Supp. 1131, 1144 (D.N.J. 1978) (forced medication implicates the constitutionally protected interest in privacy which encompasses the right to protect one's mental processes and bodily autonomy from government interference). *Accord* *Rogers v. Okin*, 634 F.2d at 653; *Scott v. Plante*, 532 F.2d 939, 946 n.9 (3d Cir. 1976); *Souder v. McGuire*, 432 F. Supp. 830, 832 (M.D. Pa. 1976); *Riese v. St. Mary's Hosp. & Medical Ctr.*, 243 Cal. Rptr. at 249-50; *Jarvis v. Levine*, 418 N.W.2d 139, 148-49 (Minn. 1988); *Henderson v. Yocom*, No. 7948A, mem. op. at 9.

290. 744 F.2d 1387 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214, 105 S. Ct. 1187 (1985).

291. *Id.* at 1393.

292. *Rennie v. Klein*, 653 F.2d 836, 844 (3d Cir. 1981), *vacated*, 458 U.S. 1119, 102 S. Ct. 3506 (1982) (citation omitted).

293. *Griswold v. Connecticut*, 381 U.S. 479, 85 S. Ct. 1678 (1965). The Constitution does not expressly mention the right to privacy and various constitutional provisions have been pointed to as its source. In *Griswold*, Justice Douglas' plurality opinion stated that "specific guarantees in the Bill of Rights have penumbras" which create "zones of privacy" applicable to the states through the Fourteenth Amendment. *Id.* at 484, 85 S. Ct. at 1681. In his concurring opinion, Justice Goldberg, joined by Chief Justice Warren and Justice Brennan, found the right to privacy emanating from the Ninth Amendment. *Id.* at 487, 85 S. Ct. at 1683 (Goldberg, J., concurring). Justice Harlan found that the privacy right is "implicit in the concept of ordered liberty" and thus encompassed by the Due Process Clause of the Fourteenth Amendment. *Id.* at 500, 85 S. Ct. at 1690 (Harlan, J., concurring). See generally Laurence H. Tribe, *American Constitutional Law* § 15-3 at 1308-12 (2d ed. 1988).

294. *Davis v. Hubbard*, 506 F. Supp. 915, 931-33 (N.D. Ohio 1980) (the constitutional right of privacy to refuse medication is based on the tort law concept of informed consent); *Rennie v. Klein*, 462 F. Supp. 1131, 1144 (D.N.J. 1978) (the constitutional privacy right to refuse medical treatment "accords with the usual common law rule against involuntary medical treatment") (citing *Winters v. Miller*, 446 F.2d 65, 68 (2d Cir.), *cert. denied*, 404 U.S. 985, 92 S. Ct. 450 (1971)); *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 424 (Mass. 1977) (the constitutional privacy right arises "from the same regard for human dignity and self-determination" as that encompassed by the informed consent doctrine).

not hesitated in utilizing this branch of the privacy doctrine as a source for the right to refuse psychiatric treatment despite the traditional notion that the mentally ill were incapable of providing informed consent.²⁹⁵

In *Davis v. Hubbard*,²⁹⁶ an Ohio federal district court stated that the forced administration of psychotropic drugs implicates the "principle that the constitution recognizes the individual's right to make intimate decisions which fundamentally affect the individual."²⁹⁷ The Tenth Circuit held that:

an individual has a constitutionally protected interest in making his own decision whether to accept or reject the administration of potentially dangerous drugs. . . . Thus, we agree . . . that the decision whether to accept treatment with antipsychotic drugs is of sufficient importance to fall within this category of privacy interests protected by the Constitution.²⁹⁸

Similarly, in *Rogers v. Okin*,²⁹⁹ the First Circuit stated:

We begin our analysis with what seems to us to be an intuitively obvious proposition: a person has a constitutionally protected interest in being left free by the state to decide for himself whether to submit to the serious and potentially harmful medical

295. *Rennie*, 462 F. Supp. at 1144-45 (constitutional right of privacy includes a patient's decision to accept or decline treatment with antipsychotic drugs); *Jarvis v. Levine*, 418 N.W.2d 139, 148 (Minn. 1988) (right to refuse treatment with neuroleptic drugs is encompassed within the state constitutional right to privacy as "the final decision to accept or reject a proposed medical procedure and its attendant risks is ultimately *not* a medical decision, but a personal choice"); *Price v. Sheppard*, 239 N.W.2d 905, 910 (Minn. 1976) (right to refuse electroshock is encompassed within the "concept of personal autonomy—the notion that the Constitution reserves to the individual, free of governmental intrusion, certain fundamental decisions about how he or she will conduct his or her life"); *Rivers v. Katz*, 495 N.E.2d 337, 341 (N.Y. 1986) (mentally ill patient has state constitutional liberty interest with respect to "decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires"); *In re K.K.B.*, 609 P.2d 747, 749-50 (Okla. 1980) (right to refuse based on constitutional right of privacy which recognizes that "liberty includes the freedom to decide about one's own health"); *In re Schuoler*, 723 P.2d 1103, 1108 (Wash. 1986) (even an incompetent mental patient retains the constitutionally protected privacy interest to choose "one type of medical treatment over another, or to refuse medical treatment altogether"); *Guardianship of Roe*, 421 N.E.2d 40, 51 n.9 (Mass. 1981) (recognizing a constitutionally protected interest in being left free to decide whether to submit to treatment with antipsychotic drugs).

296. 506 F. Supp. 915 (N.D. Ohio 1980).

297. *Id.* at 932-33.

298. *Bee v. Greaves*, 744 F.2d 1387, 1392-93 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214, 105 S. Ct. 1187 (1985).

299. *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291, 102 S. Ct. 2442 (1982).

treatment that is represented by the administration of antipsychotic drugs.³⁰⁰

However, in its recent opinion in *Cruzan v. Director, Missouri Department of Health*,³⁰¹ the Supreme Court appears to have limited the scope of the constitutional privacy doctrine by suggesting that it does not encompass the right to refuse medical treatment. In a footnote to the majority opinion drafted by Chief Justice Rehnquist, the Court stated that "[a]lthough many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional right of privacy, we have never so held. We believe this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest."³⁰² The Court then cited its decision in *Bowers v. Hardwick*³⁰³ in which it held that consensual homosexual sodomy is not a fundamental right of the type protected by the constitutional privacy doctrine.³⁰⁴

B. Common Law and Statutory Sources

As explained above, the institutionalized mentally ill were traditionally deprived of the protections afforded by the informed consent doctrine due to their perceived incompetency. Evidence brought forth in treatment refusal litigation and through medical research, however, has documented the fact that many mentally ill individuals are capable of making informed treatment decisions.³⁰⁵ As a result, judicial reluctance to apply the common law as a form of relief for the forced treatment of mentally ill patients is declining.³⁰⁶

300. *Id.* at 653.

301. 110 S. Ct. 2841 (1990).

302. *Id.* at 2851 n.7.

303. 478 U.S. 186, 106 S. Ct. 2841 (1986).

304. *Cruzan*, 110 S. Ct. at 2851 & n.7. For ramifications of the Court's preference in labeling the right to refuse treatment as a liberty interest rather than as a right protected by the privacy interest in personal decisionmaking, see *infra* notes 332-334 and accompanying text.

305. See, e.g., *Rennie v. Klein*, 653 F.2d 836, 846 & n.12 (3d Cir. 1981), *vacated*, 458 U.S. 1119, 102 S. Ct. 3506 (1982); *Rogers v. Okin*, 634 F.2d 650, 657-59 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291, 102 S. Ct. 2442 (1982); *Davis v. Hubbard*, 506 F. Supp. 915, 935-36 (N.D. Ohio 1980); *People v. Medina*, 705 P.2d 961, 973 (Colo. 1985) (en banc); *Rivers v. Katz*, 495 N.E.2d 337, 341-42 (N.Y. 1986); *In re K.K.B.*, 609 P.2d 747, 752 (Okla. 1980); *Mills*, *supra* note 137, at 321; Richard Jaffe, *Problems of Long-term Informed Consent*, 14 Bull. Am. Acad. Psychiatry & L. 163, 167 (1986); James C. Beck, *Right to Refuse Antipsychotic Medication: Psychiatric Assessment and Legal Decision-Making*, 11 Mental & Physical Disability L. Rep. 368, 369 (1987).

306. See, e.g., *Nolen v. Peterson*, 544 So. 2d 863, 867 (Ala. 1989); *Riese v. St. Mary's Hosp. & Medical Ctr.*, 243 Cal. Rptr. 241, 249 (Cal. App. 1st Dist. 1987), *opinion superseded*, 751 P.2d 893 (Cal. 1988), *dismissed*, 774 P.2d 698 (Cal. 1989); *Keyhea v.*

Virtually every state now has legislation which provides that mentally ill individuals are not deemed incompetent to exercise personal and civil rights solely by reason of commitment or mental health treatment.³⁰⁷ Some courts have relied on this type of legislation in finding a statutory right to refuse antipsychotic medication.³⁰⁸ In addition, since the initial drug refusal cases, a number of states have enacted legislation which specifically provides for at least a qualified right to refuse antipsychotic drugs and other intrusive forms of psychiatric treatment.³⁰⁹

V. BALANCING THE INDIVIDUAL AND GOVERNMENT INTERESTS

Even when a constitutional source 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 reasons for infringement.³¹⁰ Generally, the more important the constitutionally protected interest, the stronger the government's justification must be to override the interest.³¹¹ As explained earlier, an individual has a constitutionally protected liberty or privacy interest in being free from unwarranted governmental intrusions. Whether an intrusion is unwarranted depends upon its nature and the justification supporting it. At a minimum, a governmental infringement of this protected liberty or privacy interest must be "reasonably related to legitimate government objectives."³¹² However, as the intru-

Rushen, 223 Cal. Rptr. 746, 754 (Cal. App. 1st Dist. 1986); *People v. Medina*, 705 P.2d 961, 967 (Colo. 1985); *Goedecke v. State Dep't of Inst.*, 603 P.2d 123, 125 (Colo. 1979); *In re Orr*, 531 N.E.2d 64, 74 (Ill. App. 4th Dist. 1988); *Rogers v. Commissioner of Dep't of Mental Health*, 458 N.E.2d 308, 314 (Mass. 1983); *In re Guardianship of Roe*, 421 N.E.2d 40, 41, 51 n.9 (Mass. 1981); *In re Schuoler*, 723 P.2d 1103, 1107 (Wash. 1986).

307. 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, 471-72 nn.87-88 (1990) (listing state legislation providing that individuals committed to institutions do not forfeit civil rights and are not automatically presumed incompetent); Samuel V. Brakel et al., *The Mentally Disabled and the Law* 375 and Table 7.2 (1985) (survey of the relationship between involuntary institutionalization and legal competence in state legislation).

308. E.g., *Rennie*, 653 F.2d at 846 n.12; *Henderson v. Yocom*, No. 7948A, mem. op. at 8-9 (S.D. 1st Cir. 1987), *aff'd*, 438 N.W.2d 225 (S.D. 1989) (table opinion).

309. See Blackburn, *supra* note 307, at 466-72 (describing state legislation on the right to refuse psychiatric treatment).

310. *Youngberg v. Romeo*, 457 U.S. 307, 321, 102 S. Ct. 2452, 2461 (1982); *Mills v. Rogers*, 457 U.S. 291, 299, 102 S. Ct. 2442, 2448 (1982).

311. *Price v. Sheppard*, 239 N.W.2d 905, 910 (Minn. 1976). See generally Tribe, *supra* note 293, at § 15-9, 1329-37. The United States Supreme Court has carved an exception to this rule in a recently developed line of prison cases. See *infra* notes 814-818 and accompanying text.

312. *Youngberg*, 457 U.S. at 320, 102 S. Ct. at 2460. See also *Bell v. Wolfish*, 441 U.S. 520, 539, 99 S. Ct. 1861, 1874 (1979).

siveness of the government's action rises, the sufficiency of its justification must also increase. Highly intrusive conduct must be supported by a compelling governmental interest and a showing that there are no less intrusive means available to achieve the objective.³¹³

Thus, in *Schmerber v. California*,³¹⁴ the United States Supreme Court validated the slight intrusion into "human dignity and privacy" presented by a pin prick for a blood test based on the legitimate state interest in gathering evidence of a crime.³¹⁵ The Court qualified its holding by emphasizing a number of factors, including the necessity of the test, the fact that it was performed by a physician in a hospital environment, and the lack of potential adverse side effects.³¹⁶ However, in *Winston v. Lee*,³¹⁷ the Supreme Court held that the surgical removal of a bullet under general anesthesia for the same legitimate purpose of collecting evidence of a crime is impermissible when other evidence of the crime already exists.³¹⁸ And in *Rochin v. California*,³¹⁹ the Court invalidated the forced insertion of a stomach pump, even if it is the only available means of collecting criminal evidence, because the legitimate state interest did not justify the highly intrusive procedure.³²⁰ Various attempts have been made at defining criteria for measuring the intrusiveness of government action.³²¹ Professor Tribe believes that some of the crucial

313. *Winston v. Lee*, 470 U.S. 753, 766, 105 S. Ct. 1611, 1619-20 (1985); *Schmerber v. California*, 384 U.S. 757, 768-70, 86 S. Ct. 1826, 1834-35 (1966). See generally Tribe, *supra* note 293, at § 15-9, 1329-37.

314. 384 U.S. 757, 86 S. Ct. 1826 (1966).

315. *Id.* at 771, 86 S. Ct. at 1836.

316. *Id.* at 772, 86 S. Ct. at 1836. Other factors the Court referred to include the high effectiveness of the test in accomplishing its purpose; that such tests are commonplace; the blood extracted was minimal; that for most people, the test involves virtually no risk, trauma, or pain; and the petitioner did not protest on grounds of fear, concern for health, or religious reasons. *Id.* at 771, 86 S. Ct. at 1836. The Court emphatically limited its holding to the particular facts of the case and stated:

The integrity of an individual's person is a cherished value of our society. That we today hold that the Constitution does not forbid the State's minor intrusions into an individual's body under stringently limited conditions in no way indicates that it permits more substantial intrusions, or intrusions under other conditions.

Id.

317. 470 U.S. 753, 105 S. Ct. 1611 (1985).

318. *Id.* at 755-56, 105 S. Ct. at 1614. The Court noted that the surgery sought by the state was "an example of the 'more substantial intrusion' cautioned against in *Schmerber* . . ." *Id.* at 755, 105 S. Ct. at 1614. The Court further stated that "[a] compelled surgical intrusion into an individual's body for evidence . . . implicates expectations of privacy and security of such magnitude that the intrusion may be 'unreasonable' even if likely to produce evidence of a crime." *Id.* at 759, 105 S. Ct. at 1616.

319. 342 U.S. 165, 72 S. Ct. 205 (1952).

320. *Id.* at 172, 72 S. Ct. at 209-10.

321. See, e.g., *Price v. Sheppard*, 239 N.W.2d 905, 913 (Minn. 1976), where the court listed the following considerations in determining the intrusiveness of psychiatric treatment:

factors to consider are "the presence of physical pain, the creation of anxiety and apprehension of medical or other damage, the permanence of any disfigurement or any ensuing complication, the risk of irreversible injury to health, and the danger to life itself."³²² Professor Tribe maintains that it would be proper for courts to invalidate "an intrusion that fared ill along any of those dimensions."³²³ Additionally, he suggests

(1) the extent and duration of changes in behavior patterns and mental activity effected by the treatment, (2) the risks of adverse side effects, (3) the experimental nature of the treatment, (4) its acceptance by the medical community of this state, (5) the extent of intrusion into the patient's body and the pain connected with the treatment, and (6) the patient's ability to competently determine for himself whether the treatment is desirable.

Another proposed set of criteria for measuring the intrusiveness of government action on mental processes contains the following considerations:

(i) the extent to which the effects of the therapy upon mentation are reversible; (ii) the extent to which the resulting psychic state is "foreign," "abnormal" or "unnatural" for the person in question, rather than simply a restoration of his prior psychic state. . . .; (iii) the rapidity with which the effects occur; (iv) the scope of the change in the total "ecology" of the mind's functions; (v) the extent to which one can resist *acting* in ways impelled by the psychic effects of the therapy; and (vi) the duration of the change.

Michael H. Shapiro, *Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 S. Cal. L. Rev. 237, 262 (1974). For criticism of Shapiro's criteria in the context of First Amendment analysis, see Rhoden, *supra* note 43, at 390-96. For additional commentary on the intrusiveness of psychiatric treatment, see Bruce J. Winick, *Legal Limitations on Correctional Therapy and Research*, 65 Minn. L. Rev. 331 (1981); Alan A. Stone, *Mental Health and Law: A System in Transition* 103-05 (1976).

322. Tribe, *supra* note 293, at § 15-9, 1333.

323. *Id.* More generally, Tribe lists four separate tests, any of which would constitute an unauthorized intrusion on the body: "(1) that the imposition was deficient in procedural regularity, or (2) that it was needlessly severe, or (3) that it was too novel, or (4) that it was lacking in a fair measure of reciprocity." *Id.* at 1332. The criteria stated are those for determining whether the intrusion is needlessly severe.

In explaining the first test regarding procedural regularity, Tribe feels that because bodily invasions are not as easily remedied by damage awards as deprivations of property, "the state, absent a clear emergency, must *precede* any deliberate invasion by an adversary hearing, even if only an informal one." *Id.* Thus, absent an emergency, the forced administration of drugs which is not preceded by a prior adversarial hearing would arguably be excessively intrusive.

Whether the third test is met—that the treatment of mental illness with antipsychotic drugs, is, as of yet, too novel—is a debatable issue. Tribe's criteria for this test is frequency and regularity of use demonstrating wide acceptability. *Id.* at 1334. Antipsychotic drugs are regularly prescribed and are well-accepted by the psychiatric community as an effective treatment for psychoses. However, their efficacy is not without serious controversy. This form of treatment is relatively new, the drugs' physiological action remains undetermined, whether they will be effective or harmful for any particular patient is not known until after administration, and dosage is determined on a trial and error basis.

that any intrusion sufficiently minimal to pass the above test should, nonetheless, be invalidated if there are any less restrictive means available to effectively achieve the government's objective.³²⁴

The forced administration of antipsychotic drugs appears to meet several of Tribe's suggested criteria. It should also be emphasized that antipsychotic drugs act directly upon the chemical structure of the brain in a manner which is not yet understood and the effects of these drugs, both primary and secondary, cannot be resisted.³²⁵ While the appropriateness of these and other proposed criteria can be disputed, it appears that forced administration of antipsychotic drugs is a highly intrusive form of treatment. Therefore, a compelling government justification is needed to override the individual's protected interest in remaining free from unwarranted governmental intrusions of this nature.³²⁶

When the constitutional source of the right to refuse antipsychotic drugs is the privacy interest in personal decisionmaking, the government

See supra notes 36-69 and accompanying text.

The fourth test, that of reciprocity, is intended to "minimize the danger that a bodily invasion will be justified solely on the basis that the greater good of the society is served thereby," so that the person cannot be used "as means to the ends of others. . . ." Tribe, *supra* note 293, at 1334-35. When drug therapy is used as part of a bona fide treatment program rather than for patient control and convenience of staff, this standard would not appear to be violated.

324. *Id.* at 1333-34.

325. *See id.* at 1327 ("there is little doubt that constitutional objections to coercive therapy rise in direct proportion to the therapy's power to produce changes against the will of the person subjected to it, and to the irreversibility of any such results."); Winick, *supra* note 321, at 365-68.

326. *See United States v. Charters*, 829 F.2d 479, 489 (4th Cir. 1987), *modified*, 863 F.2d 302 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990) (likening the "chemical invasion of drug therapy" to the "mechanical invasion" of psychosurgery; *In re Guardianship of Roe*, 421 N.E.2d 40, 52-53 (Mass. 1981):

We can identify few legitimate medical procedures which are more intrusive than the forcible injection of antipsychotic medication 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 side effects . . . we treat these drugs in the same manner we would treat psychosurgery or electroconvulsive therapy.

Jarvis v. Levine, 418 N.W.2d 139, 146 (Minn. 1988) (explanation of why antipsychotic drugs are as intrusive as electroshock and psychosurgery); *In re K.K.B.*, 609 P.2d 747, 749, 51 (Okla. 1980) (a compelling state interest is needed to override a competent patient's refusal of antipsychotic drugs, the effects of which can be classified with those resulting from electroshock and psychosurgery); *Harper v. State*, 759 P.2d 358, 362-64 (Wash. 1988), *rev'd sub nom.* *Washington v. Harper*, 494 U.S. 210, 110 S. Ct. 1028 (1990) (requiring a compelling state interest to override a refusal because antipsychotic drugs are no less intrusive than electroshock).

For an analysis of various criteria proposed for measuring the concept of intrusiveness and how under any such criteria the forced administration of antipsychotic drugs should be deemed highly intrusive, hazardous, and uncertain, see Beyer, *supra* note 38, at 528-42.

must likewise justify its intrusion with a compelling objective. The right to freedom of choice in certain matters affecting a person's life has been found to be of "fundamental" value.³²⁷ The freedom to make such decisions has been characterized as "implicit in the concept of ordered liberty" or "deeply rooted in this Nation's history and tradition."³²⁸ And, as the Supreme Court has stated, "Where such 'fundamental rights' are involved . . . regulation limiting these rights may be justified only by a 'compelling state interest.'"³²⁹ In addition, "[L]egislative enactments must be narrowly drawn to express only the legitimate state interests at stake."³³⁰

As described earlier, however, the Supreme Court has recently indicated that the right to refuse medical treatment is more properly classified as a liberty interest rather than as an aspect of the right to privacy.³³¹ Such classification suggests that the Court is unwilling to grant "fundamental" status to the right to refuse treatment. This determination is surprising considering the common law's historical recognition of the value of self-determination in medical matters.³³² This decision, however, is in accord with the Court's earlier opinion in *Bowers* in which it suggested that the only fundamental decisionmaking rights encompassed by the privacy doctrine are those concerning family, marriage, or procreation, which have been previously recognized.³³³ The Court indicated its unwillingness to add to these established fundamental rights by stating that "[t]here should be . . . great resistance to expand the substantive reach of [the Due Process Clauses of the Fifth and Fourteenth Amendments] particularly if it requires redefining the category of rights deemed to be fundamental."³³⁴

The scope of the right to refuse treatment has been diminished by its characterization as a liberty interest. A fundamental right encompassed within the privacy doctrine can be overridden only by a compelling

327. *Roe v. Wade*, 410 U.S. 113, 152-54, 93 S. Ct. 705, 726-27 (1973). See generally John E. Nowak, Ronald D. Rotunda, and Jesse N. Young, *Constitutional Law* 371 (4th ed. 1991).

328. *Bowers v. Hardwick*, 478 U.S. 186, 191-92, 102 S. Ct. 2841, 2844 (1986) (citations omitted).

329. *Roe*, 410 U.S. at 155, 93 S. Ct. at 728. Accord *Shapiro v. Thompson*, 394 U.S. 618, 634, 89 S. Ct. 1322, 1338 (1969); *Kramer v. Union Free School Dist.*, 395 U.S. 621, 627, 89 S. Ct. 1886, 1889-90 (1969); *Rogers v. Okin*, 478 F. Supp. 1342, 1368 (D. Mass. 1979), *aff'd in part and rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291, 102 S. Ct. 2442 (1982); *Rennie v. Klein*, 462 F. Supp. 1131, 1144 (D.N.J. 1978); *In re K.K.B.*, 609 P.2d at 751.

330. *Roe*, 410 U.S. at 155, 93 S. Ct. at 728.

331. See *supra* notes 301-304 and accompanying text.

332. See *supra* notes 191-194 and accompanying text.

333. *Bowers*, 478 U.S. at 190-91, 106 S. Ct. at 2844.

334. *Id.* at 195, 106 S. Ct. at 2846.

governmental objective. However, when classified as a liberty interest, a refusal of treatment—at least when such treatment is deemed less than highly intrusive—may be outweighed by a mere rational or legitimate governmental interest.

When the First Amendment is utilized as the basis for the right to refuse, there is no question that the government's interest must be compelling. First Amendment protections have traditionally enjoyed a "preferred position" in the hierarchy of constitutional rights.³³⁵ Therefore, an encroachment on these protections "cannot be justified upon a mere showing of a legitimate state interest". . . . The interest advanced must be paramount, one of vital importance, and the burden is on the government to show the existence of such an interest."³³⁶ Furthermore, in achieving its interest, the government "must do so by narrowly drawn regulations designed to serve those interests without unnecessarily interfering with First Amendment freedoms. . . . It is not enough to show that the government's ends are compelling; the means must be carefully tailored to achieve those ends."³³⁷ Indeed, given the historical and deep-seated value attributed to First Amendment interests, "the first amendment claim should stand as the most significant barrier protecting involuntary mental patients against state imposition of mind-altering drugs."³³⁸

VI. THE GOVERNMENT INTERESTS

Courts have identified two governmental interests which, under appropriate circumstances, may justify the forced administration of anti-

335. *Murdock v. Pennsylvania*, 319 U.S. 105, 115, 63 S. Ct. 870, 876 (1943).

336. *Elrod v. Burns*, 427 U.S. 347, 362, 96 S. Ct. 2673, 2684 (1976). *Accord* *West Virginia State Bd. of Educ. v. Barnette*, 319 U.S. 624, 639, 63 S. Ct. 1178, 1186 (1943); *Sable Communications of Cal., Inc. v. FCC*, 492 U.S. 115, 126-27, 109 S. Ct. 2829, 2836 (1989). In limited situations addressing certain types of expression, such as commercial and sexually explicit speech, the Supreme Court has used a less exacting standard of review. *See, e.g., Posados de Puerto Rico Assoc. v. Tourism Co.*, 478 U.S. 328, 106 S. Ct. 2968 (1986); *City of Renton v. Playtime Theatres, Inc.*, 475 U.S. 41, 106 S. Ct. 925 (1986). However, as Professor Winick points out:

Unlike these activities . . . the mentation and expressive conduct of the mentally ill serve important values within the core of those traditionally protected by the first amendment. As a result, this lesser scrutiny applied in cases involving what some members of the court regard as "lower value" speech should be inapplicable in the context of forced treatment of the mentally ill. Because freedom of mental processes is a predicate for the exercise of all first amendment protection, including the "exacting scrutiny" typically applied in the first amendment context.

Winick, *supra* note 27, at 91-92.

337. *Sable Communications*, 492 U.S. at 126, 109 S. Ct. at 2836 (citations omitted). *Accord* *Shelton v. Tucker*, 364 U.S. 479, 488-89, 81 S. Ct. 247, 252-53 (1960); *Elrod*, 427 U.S. at 363, 96 S. Ct. at 2684-85.

338. Comment, *The Forcible Medication of Involuntarily Committed Mental Patients with Antipsychotic Drugs*—*Rogers v. Okin*, 15 Ga. L. Rev. 739, 760 (1981).

psychotic drugs. The first is the government's police power interest in preventing the mentally ill from harming themselves or others. The second is the government's *parens patriae* authority to care for those citizens who are unable to care for themselves.³³⁹ The situations in which these government objectives are deemed sufficient to outweigh an individual's interest in refusing treatment have not been uniformly defined and vary according to the particular jurisdiction.

A. The Police Power

While it is undisputed that the state has a legitimate interest in preventing the mentally ill from harming themselves or others,³⁴⁰ the issue is: under what circumstances does this interest become sufficient to override the patient's interest in refusing medication? Courts addressing this question have agreed that while the police power interest authorizes the state to commit a mentally ill individual to prevent physical harm to himself or others, the authority does not automatically extend to involuntary treatment of that person once confined.³⁴¹ Even when the initial commitment is based on emergency grounds, that finding alone does not indicate that the person will continue to present a threat to himself or others once hospitalized.³⁴² The state's police power to forcibly administer antipsychotic drugs must be justified within the institutional environment rather than the community setting.

The scope of the state's police power authority has been defined in terms of either an "emergency" or "dangerousness" standard or both. Courts have used these labels interchangeably, but there is a major difference in scope between the underlying standards. Although the literal definitions vary slightly, emergency authority is limited to situations where the threat of physical violence is current or imminent.³⁴³ In emer-

339. Note, *supra* note 11, at 1212, 1307-09.

340. *Addington v. Texas*, 441 U.S. 418, 426, 99 S. Ct. 1804, 1809 (1979); *Rogers v. Okin*, 634 F.2d 650, 654 (1st Cir. 1980).

341. *Winters v. Miller*, 446 F.2d 65, 70 (2d Cir.), *cert. denied*, 404 U.S. 985, 92 S. Ct. 450 (1971); *Rogers v. Okin*, 478 F. Supp. 1342, 1368-69 (D. Mass. 1979), *aff'd in part and rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291, 102 S. Ct. 2422 (1982); *Rennie v. Klein*, 462 F. Supp. 1131, 1145 (D.N.J. 1978); *Rivers v. Katz*, 495 N.E.2d 337, 343 (N.Y. 1986); *In re K.K.B.*, 609 P.2d 747, 751 (Okla. 1980). *But see Dautremont v. Broadlawns Hosp.*, 827 F.2d 291, 297-300 (8th Cir. 1987) (basing the police power authority to forcibly administer antipsychotic drugs on a hospitalized patient's previous activity within the community).

342. Opinion of the Justices, 465 A.2d 484, 489 (N.H. 1983); *State ex rel. Jones v. Gerhardtstein*, 416 N.W.2d 883, 894 (Wis. 1987).

343. See, e.g., *Rennie v. Klein*, 476 F. Supp. 1294, 1313 (D.N.J.), *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), *vacated*, 458 U.S. 1119, 102 S. Ct. 3506 (1981) (an emergency is a "sudden, significant change in the patient's condition which creates danger to the patient himself or to others in the hospital"); *Anderson v. State*, 663 P.2d 570, 573 (Ariz. Ct.

gency situations, courts agree that the state's police power is sufficient to justify forced administration of drugs for a limited time period, at least when no less intrusive measures are available.³⁴⁴ Some courts have expanded the scope of the police power authority by employing a "dangerousness" standard. Under this standard, forced medication is authorized on the prediction that a patient will present a future threat of violence if not on medication. Courts have differed on the criteria and procedures necessary to authorize forced treatment based on dangerousness.

In *Rennie v. Klein*,³⁴⁵ the district court upheld police power authority to administer antipsychotic medication on the basis of dangerousness. The standard the court employed required an informal adversarial proceeding presided over by an independent psychiatrist as decisionmaker.³⁴⁶ The court's standard broadly defined dangerousness as "the patient's physical threat to other patients and staff at the institution."³⁴⁷ However, the court held that a threshold finding of dangerousness is only one factor in the forced medication determination. The decisionmaker must then weigh the potential for permanent side effects from the proposed medication. Consideration must also be given to the availability of less restrictive treatments.³⁴⁸

On appeal, the Third Circuit affirmed the sufficiency of the police power authority to medicate forcibly based on a dangerousness standard.³⁴⁹ The circuit court, however, vacated the lower court's required

App. 1982) (an emergency situation is "an immediate threat of physical injury"); *Rivers*, 495 N.E.2d at 343 (an emergency means "imminent danger to a patient or others in the immediate vicinity"); *Rogers v. Commissioner of Dep't of Mental Health*, 458 N.E.2d 308, 321 n.25 (Mass. 1983) (an emergency calls for "immediate action").

344. See, e.g., *Bee v. Greaves*, 744 F.2d 1387, 1396-97 (10th Cir. 1984), cert. denied, 469 U.S. 1214, 105 S. Ct. 1187 (1985) (emergency treatment cannot be extended indefinitely); *Rennie*, 476 F. Supp. at 1313-14 (limiting emergency treatment to seventy-two hours); *People v. Medina*, 705 P.2d 961, 975 (Colo. 1985) (court approval for emergency treatment must be obtained as soon as practicable); *Rogers*, 458 N.E.2d at 322 (requiring judicial authorization for continued emergency treatment); *In re Guardianship of Roe*, 421 N.E.2d 40, 50 (Mass. 1981) (judicial review of emergency treatment must be obtained with reasonable diligence).

345. *Rennie v. Klein*, 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), vacated, 458 U.S. 1119, 102 S. Ct. 3506 (1982).

346. *Id.* at 1314. The court criticized the in-house review process established by a New Jersey regulation as being compromised by institutional pressures. *Id.* at 1310. For an explanation of the different procedural models adopted by courts for forced medication determinations, see *infra* notes 533-626 and accompanying text.

347. *Id.* at 1297.

348. *Id.*

349. *Rennie v. Klein*, 653 F.2d 836, 845-48 (3d Cir. 1981), vacated, 458 U.S. 1119, 102 S. Ct. 3506 (1982).

procedures and balancing considerations which the lower court held had to accompany the initial prediction of dangerousness before medication could be authorized. Instead, the Third Circuit found adequate the existing New Jersey regulatory procedures which left the dangerousness determination and the resulting decision to medicate within the judgment of hospital psychiatrists subject to supervisory review.³⁵⁰

In *Rogers v. Okin*,³⁵¹ the district court also justified forced administration of antipsychotic drugs based on the police power standard of dangerousness. The court rejected a "psychiatric" definition of dangerousness proffered by the state as being "too broad, subjective and unwieldy."³⁵² Instead, the court required a situation in which a failure to medicate would result in a "*substantial likelihood* of physical harm to that patient, other patients, or to staff members of the institution."³⁵³ Although this definition is more restrictive than the one adopted in *Rennie*, the court did not temper this initial predictive determination with any further balancing of other considerations.

On appeal, the First Circuit drastically broadened the district court's dangerousness standard for involuntary medication.³⁵⁴ The appellate court accepted the state's argument that a requirement of predicting a substantial likelihood of physical harm is "overly rigid and unworkable"³⁵⁵ and criticized the lower court's definition as a "simplistic unitary standard" forcing psychiatrists to make impossible predictions of violence that meet a "quantitative level of probability."³⁵⁶ Instead, the First Circuit instructed the district court to design procedures which would merely ensure that state psychiatrists exercise professional judgment in medication determinations based on police power grounds.³⁵⁷ The court noted that professional judgments should be based on such considerations

350. *Id.* at 851.

351. *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part and rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291, 102 S. Ct. 2442 (1982).

352. *Id.* at 1365. The state argued that forced medication would be justified in the following situations: (1) suicidal behavior, whether seriously meant or a gesture; (2) assaultiveness; (3) property destruction; (4) extreme anxiety and panic; (5) bizarre behavior; (6) acute or chronic emotional disturbance having the potential to seriously interfere with the patient's ability to function on a daily basis; (7) the necessity for immediate medical response in order to prevent or decrease the likelihood of further severe suffering or the rapid worsening of the patient's clinical state. *Id.* at 1364.

353. *Id.* at 1365 (emphasis added). Although the court labeled this situation an emergency, it is actually a dangerousness standard based on a prediction of violence if medication is not administered.

354. *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291, 102 S. Ct. 2442 (1982).

355. *Id.* at 654-55.

356. *Id.* at 656.

357. *Id.* at 656-57.

as "the possibility and type of violence, the likely effects of particular drugs on a particular individual, and an appraisal of alternative, less restrictive courses of action."³⁵⁸

In *Bee v. Greaves*,³⁵⁹ the Tenth Circuit addressed the state's police power authority to medicate jailed pre-trial detainees. The court indicated a concern over whether the concededly legitimate goals of jail safety and security were sufficiently compelling to justify the forced administration of antipsychotic drugs. The court concluded that "[a]bsent an emergency . . . we do not believe forcible medication with antipsychotic drugs is 'reasonably related' . . . to the concededly legitimate goals of jail safety and security."³⁶⁰ However, despite this concern and the use of the term "emergency," the court appeared to fashion a broad dangerousness standard similar to the one adopted by the First Circuit in *Rogers*. The court held that the determination of whether a situation exists sufficient to warrant involuntary treatment is within the discretion of state medical authorities.³⁶¹ The court left the balancing of the jail's safety concerns against the inmate's interest in refusal to the professional judgment of those state authorities.³⁶² However, the Tenth Circuit did require that the medical decisionmakers evaluate all "the relevant circumstances, including the nature and gravity of the safety threat, the characteristics of the individual involved, and the likely effects of particular drugs."³⁶³ The court also required consideration of available, less restrictive courses of action such as segregation or the use of tranquilizers or sedatives.³⁶⁴

Although the criteria and requirements vary, other courts have affirmed the use of the dangerousness standard in authorizing forced administration of antipsychotic drugs.³⁶⁵ The Colorado Supreme Court fashioned the most restrictive standard of dangerousness and required that the forced medication determination under this standard be made by a court of law.³⁶⁶ The court ruled that a threshold determination

358. *Id.* at 655-56.

359. 744 F.2d 1387 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214, 105 S. Ct. 1187 (1985).

360. *Id.* at 1395 (quoting *Bell v. Wolfish*, 441 U.S. 520, 539, 99 S. Ct. 1861, 1874 (1979)).

361. *Id.* at 1395-96.

362. *Id.*

363. *Id.* at 1396.

364. *Id.*

365. *E.g.*, *Rivers v. Katz*, 495 N.E.2d 337, 343 (N.Y. 1986) (broadly defining dangerousness as a determination that "the patient presents a danger to himself or other members of society or engages in dangerous or potentially destructive conduct within the institution"); *United States v. Watson*, 893 F.2d 970, 980 (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*, 110 S. Ct. 3243 (1990).

366. *People v. Medina*, 705 P.2d 961, 972-73 (Colo. 1985).

must be made that without medication, the patient will likely constitute a continuing and significant threat of serious harm to himself or others in the institution.³⁶⁷ The court emphasized that past occasions of violence or the mere risk of some possibility of future violence were not sufficient to meet its standard, as "[s]uch a method of institutional control would be irreconcilable with the personal dignity of the individual and would render the patient's interest in bodily integrity nothing more than an illusion."³⁶⁸ If it is established that the patient does present a "continuing and significant threat" of serious harm, the reviewing court must take additional steps before it can authorize forced medication. The court must next weigh the threat presented against the individual's reasons for objecting to treatment. In addition, the court must determine whether there are any less intrusive methods of alleviating the danger created by the patient's condition.³⁶⁹

Other courts have rejected a prediction of dangerousness as a sufficient justification for the involuntary administration of antipsychotic medication. These courts are concerned with the potential for abuse inherent in allowing forced medication determinations to be based on predictions of future violence. Litigation and investigations have revealed that forced medication based on predictions of danger is, at times, motivated by such reasons as management, control, punishment, and staff convenience.³⁷⁰ For example, in *Davis v. Hubbard*,³⁷¹ the court discovered that approximately seventy-three percent of the patients at an Ohio state hospital received psychotropic drugs with polypharmacology routinely practiced.³⁷² The court found that "the testimony at trial established that the prevalent use of psychotropic drugs is countertherapeutic and can be justified only for reasons other than treatment—namely, for the convenience of the staff and for punishment."³⁷³ The court noted that in this regard, the Ohio facility appeared to be "little different than any other large institution for the mentally ill."³⁷⁴ In addressing the state's police power authority to forcibly administer drugs, the court stated that danger must be "sufficiently grave and imminent" in order to overcome the patient's interest in refusal.³⁷⁵ The court held that:

367. *Id.* at 973-74.

368. *Id.* at 974.

369. *Id.*

370. See *supra* notes 181-189 and accompanying text.

371. 506 F. Supp. 915 (N.D. Ohio 1980).

372. *Id.* at 926.

373. *Id.*

374. *Id.* at 926 n.7.

375. *Id.* at 934.

[a]s a constitutional minimum, therefore, the State must have at least probable cause to believe that the patient is *presently* violent or self-destructive, and in such condition presents a present danger to himself, other patients or the institution's staff before it may disregard the patient's interests in refusing treatment.³⁷⁶

The court further suggested that even when danger is imminent, the forced medication determination should be made at an informal hearing by an independent decisionmaker.³⁷⁷

The concern that drugs were being used to keep prisoners at a mental health facility "docile and manageable regardless of potential serious physical and emotional consequences" led the Arizona Supreme Court to reject the dangerousness standard as a basis for forced medication.³⁷⁸ The court held that even if an inmate presented a legitimate security problem, less intrusive measures, such as incarceration or isolation, should be taken.³⁷⁹ The court stated that "[a]bsent a true emergency, we do not believe that forcible medication with dangerous psychotropic drugs 'is reasonably necessary for the security of the institution.'"³⁸⁰ The court held that "forcible medication with dangerous drugs should be limited to specific emergencies under procedural safeguards."³⁸¹

A number of other courts have likewise invalidated the use of a dangerousness standard as insufficient to justify forced administration of antipsychotic drugs.³⁸² An Illinois appellate court recently overturned

376. *Id.* at 935.

377. *Id.* at 938-39. However, the court stated that when the urgency of the situation does not permit time for these procedures, the state may act immediately, as long as notice and a hearing follow as soon as possible. *Id.* at 939.

378. *Large v. Superior Court*, 714 P.2d 399, 409 (Ariz. 1986).

379. *Id.* at 408. Evidence indicated that the petitioner was highly disruptive and assaultive and was placed on a drug program to prevent further dangerous behavior. *Id.* at 403.

380. *Id.* at 407-08 (citation omitted).

381. *Id.* at 408. The court emphasized the urgency required to constitute a true emergency by analogizing to situations where prison authorities would be justified in shooting the prisoner. *Id.* at 409.

382. For example, in *Anderson v. State*, 663 P.2d 570 (Ariz. Ct. App. 1982), the trial court permitted forced administration of antipsychotic drugs on the allegation by a state psychiatrist that a committed mental patient was a danger to both himself and others. Evidence indicated that the patient had a long history of antisocial behavior, presented a management problem even when on a maximum security ward, and lacked insight into the dangerousness of his acts. *Id.* at 571. After noting the potential side effects of antipsychotic drugs, the appellate court did not deem the situation urgent enough to warrant the forced treatment. The court held that drugs may be forcibly administered only when "the patient poses an immediate threat of physical injury to himself or others."

a lower court's decision allowing the forced medication of an institutionalized patient based on the treating physician's prediction of future violence.³⁸³ The court indicated concern that "the request for authority to force medications was made to enable behavioral control and the elimination of 'pestiness' and noncompliance with institutional rules."³⁸⁴ Forced medication on police power grounds was authorized only when "an emergency situation exists where the individual poses an *immediate* threat of physical harm to himself or others."³⁸⁵ The court also held that even in such emergency situations, "psychotropic medications may be forcibly administered as a last resort, only after alternative treatment plans have been considered."³⁸⁶

In *Rogers v. Commissioner of Department of Mental Health*,³⁸⁷ an opinion which contained numerous cites to commentary, litigation, and investigations revealing abuse of antipsychotic drugs for purposes of management and convenience, the Massachusetts Supreme Judicial Court held that "[n]o State interest justifies the use of antipsychotic drugs in a non-emergency situation without the patient's consent."³⁸⁸ The court stated that when antipsychotic drugs are used for public safety and security purposes, they function as chemical restraints. As such, under state law the drugs can only be used with written authority "in cases of emergency such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide."³⁸⁹ The court defined "emergency" as a situation that calls for immediate action³⁹⁰ and noted that "[p]redictable crises are not within the definition of emergency."³⁹¹ The court further held that even in an emergency situation, less intrusive alternatives to antipsychotic drugs must be used, if available.³⁹²

Id. at 573.

Likewise, the New Hampshire Supreme Court held that forced medical care on police power grounds is justified only in emergency situations where an immediate and urgent need for treatment is required. Opinion of the Justices, 465 A.2d 484, 489-90 (N.H. 1983). See also *In re Mental Commitment of M.P.*, 510 N.E.2d 645, 647 (Ind. 1987):

the fact there is a possibility the patient might harm himself or another person is not a sufficient justification for permitting forced medication with antipsychotic drugs. Given the significant risks inherent in the use of these drugs, the propensity for dangerousness is not sufficient to overcome the patient's liberty interest in being free from unreasonable intrusions into his body and mind.

383. *In re Orr*, 531 N.E.2d 64 (Ill. App. Ct. 1988).

384. *Id.* at 73.

385. *Id.*

386. *Id.*

387. 458 N.E.2d 308 (Mass. 1983).

388. *Id.* at 310.

389. *Id.* at 321.

390. *Id.* at 321-22 n.25.

391. *Id.* at 322 n.26.

392. *Id.* at 321-22.

The case law indicates a split of authority on what substantive police power interests are sufficient to override a patient's constitutionally protected interests in refusing treatment with antipsychotic drugs. Courts have held, however, that police power interests based on considerations other than the prevention of harm to the patient or others within the institution are not sufficient to override a patient's right to refuse. Therefore such concerns as administrative convenience,³⁹³ finances,³⁹⁴ patients' length of stay,³⁹⁵ staff turnover,³⁹⁶ and intrusion into the realm of medical decisionmaking and treatment authority³⁹⁷ are inadequate to outweigh patients' constitutionally protected interests.

B. *The Parens Patriae Power*

The government's *parens patriae* authority has also been deemed sufficient, under certain circumstances, to justify the forced treatment of mentally ill individuals. The benevolent intentions behind this power do not shield the exercise of it from the requirements of substantive due process.³⁹⁸ Even when the government's objective is compelling, if fundamental individual interests are implicated, its action must not merely be related to its objective, but must be *necessary* to achieve its goal.³⁹⁹ When invoked for the purpose of forced psychiatric treatment, the *parens patriae* power is based on the need to help citizens who, due to their mental disorder, are incapable of evaluating their need for psychiatric treatment.⁴⁰⁰ Without this finding of incompetence, the very justification for the government's exercise of its *parens patriae* power would be lacking. Accordingly, most courts have held that before forced treatment

393. *Rogers v. Okin*, 478 F. Supp. 1342, 1370 (D. Mass. 1979), *aff'd in part and rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291, 102 S. Ct. 2442 (1982); *Keyhea v. Rushen*, 223 Cal. Rptr. 746, 756 (Cal. Ct. App. 1st Dist. 1986); *Rogers*, 458 N.E.2d at 320; *Rivers v. Katz*, 495 N.E.2d 337, 343 n.6 (N.Y. 1986); *State ex rel. Jones v. Gerhardstein*, 416 N.W.2d 883, 895 (Wis. 1987).

394. *Davis v. Hubbard*, 506 F. Supp. 915, 937 (N.D. Ohio 1980); *Okin*, 478 F. Supp. at 1370; *Rivers*, 495 N.E.2d at 343 n.6; *Jones*, 416 N.W.2d at 895.

395. *Okin*, 478 F. Supp. at 1369-70; *Rogers*, 458 N.E.2d at 320.

396. *Rogers*, 458 N.E.2d at 320.

397. *Davis*, 506 F. Supp. at 937-38; *Okin*, 478 F. Supp. at 1370; *Rogers*, 458 N.E.2d at 320; *Jarvis v. Levine*, 418 N.W.2d 139, 149 (Minn. 1988); *Rivers*, 495 N.E.2d at 343 n.6; *Jones*, 416 N.W.2d at 895.

398. Note, *supra* note 11, at 1210. As Justice Brandeis remarked, "Experience should teach us to be most on guard to protect liberty when . . . purposes are beneficent The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding." *Olmstead v. United States*, 277 U.S. 438, 479, 48 S. Ct. 564, 572-73 (1928) (Brandeis, J., dissenting).

399. See *Roe v. Wade*, 410 U.S. 113, 155, 93 S. Ct. 705, 728 (1973).

400. *Addington v. Texas*, 441 U.S. 418, 426, 99 S. Ct. 1804, 1809 (1979). See generally Note, *supra* note 11, at 1207-09.

with antipsychotic drugs can be justified by the beneficent purpose underlying the government's *parens patriae* authority, a separate determination of incompetency to make treatment decisions is necessary.⁴⁰¹

1. *Mental Illness and Competence to Make Treatment Decisions*

Despite its importance in the treatment decisionmaking process, competence has proven to be an illusive and confusing concept. There is no universally accepted definition of competence, and the methods used to measure treatment decisionmaking capability are still rudimentary.⁴⁰² However, two principles have become widely accepted by both mental health professionals and the courts.

a. *Mental Illness is Selective*

The first principle legally and medically accepted is that mental illness is highly selective in nature, often affecting only limited areas of functioning while leaving other faculties intact. In most cases, even the most severely mentally ill retain a certain amount of reasoning power.⁴⁰³ Therefore, as one court stated, mental illness "is not the equivalent of

401. See *infra* note 435 and cases cited therein.

402. One commentator pointed out that a number of factors will affect a competency determination, including the following: (1) the specific types of decisions that are at issue; (2) the professional point of view used to analyze competency; (3) the particular jurisdiction in which the definition is determined; and (4) the vicissitudes and eccentricities of the individual being evaluated and those doing the evaluation. John Parry, *Psychiatric Care and the Law of Substitute Decision-making*, 11 *Mental & Physical Disability L. Rep.* 152, 153 (1987).

Doctors Appelbaum and Roth have noted that an evaluation of competency, regardless of the test used, may be affected by a number of clinical factors: "(1) psychodynamic elements of the patient's personality; (2) the accuracy of the historical information conveyed by the patient; (3) the accuracy and completeness of the information disclosed to the patient; (4) the stability of the patient's mental status over time; (5) the effect of the [evaluation] setting;" and (6) the nature of the person performing the evaluation. Paul S. Appelbaum & Loren H. Roth, *Clinical Issues in the Assessment of Competency*, 138 *Am. J. Psychiatry* 1462, 1462 (1981).

403. Brooks, *supra* note 50, at 191; Maurice D. Ford, *The Psychiatrist's Double Bind: The Right to Refuse Medication*, 137 *Am. J. Psychiatry* 332, 333 (1980); Benjamin Freedman, *Competence, Marginal and Otherwise*, 4 *Int'l J.L. & Psychiatry* 53, 54 (1981). One study indicated that the degree of psychopathology is a poor indicator of a patient's evaluative abilities, and the mentally ill appear to be as competent to make treatment decisions as their medical counterparts. Barbara Stanley et al., *Preliminary Findings on Psychiatric Patients as Research Participants: A Population at Risk?*, 138 *Am. J. Psychiatry* 669, 671 (1981).

incompetency, which renders one incapable of giving informed consent to medical treatment."⁴⁰⁴

Patients' subjective responses to antipsychotic drugs have, until recently, been given little credence and have received virtually no systematic inquiry.⁴⁰⁵ A growing body of evidence brought forth in drug refusal litigation and medical research, however, verifies that many drug refusals are the product of rational and considered decisions.⁴⁰⁶ Recent medical studies refute the traditional assumption held by the psychiatric community that drug reluctance is merely a form of symptomatic behavior. Although many drug refusals are delusionally based, significant correlations have been documented between many patients' refusals and the side effects they experience.

A study by Van Putten and colleagues revealed a strong association between an initial dysphoric response to medication and subsequent drug refusals.⁴⁰⁷ The researchers noted that the refusers found the extrapyramidal side effects (EPS) which they experienced intolerable—"an assault on their personality."⁴⁰⁸ Other studies have also found a strong corre-

404. *Rennie v. Klein*, 462 F. Supp. 1131, 1145 (D.N.J. 1978). See also Charles M. Culver et al., *ECT and Special Problems of Informed Consent*, 137 Am. J. Psychiatry 586 (1980) ("in the view of most psychiatrists serious mental illness does not usually render a patient incapable of making informed decisions about treatment"); Robert Weinstock et al., *Competence to Give Informed Consent for Medical Procedures*, 12 Bull. Am. Acad. Psychiatry & L. 117, 124 (1984) (study indicating that psychiatric patients who are incompetent for some purposes may nonetheless be competent to give informed consent). But see Schwed, *supra* note 4, at 195 (implying that individuals suffering from severe mental illness retain very little, if any, rational reasoning power to make treatment decisions).

405. Theodore Van Putten et al., *Response to Antipsychotic Medication: The Doctor's and the Consumer's View*, 141 Am. J. Psychiatry 16 (1984); Van Putten et al., *supra* note 108, at 189-90.

406. Many courts confronted with drug refusals have pointed to evidence indicating that the objections are associated with adverse side effects or a considered appraisal that the drugs are ineffective. *Bee v. Greaves*, 744 F.2d 1387, 1389-90 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214, 105 S. Ct. 1187 (1985); *Rennie v. Klein*, 476 F. Supp. 1294, 1305 (D.N.J.), *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), *vacated*, 458 U.S. 1119, 102 S. Ct. 3506 (1982); *Rennie v. Klein*, 462 F. Supp. 1131, 1140 (D.N.J. 1978); *Large v. Superior Court*, 714 P.2d 399, 404 (Ariz. 1987); *Riese v. St. Mary's Hosp. & Medical Ctr.*, 243 Cal. Rptr. 241, 244 (Cal. App. 1st Dist. 1987), *opinion superseded*, 751 P.2d 893 (Cal. 1988), *dismissed*, 774 P.2d 698 (Cal. 1989); *In re Mental Commitment of M.P.*, 510 N.E.2d 645, 647 (Ind. 1987); *Jarvis v. Levine*, 418 N.W.2d 139, 140-41 (Minn. 1988); *Henderson v. Yocom*, No. 7948A, mem. op. at 4 (S.D. 1st Cir. 1987), *aff'd*, 438 N.W.2d 225 (S.D. 1989) (table opinion).

407. Van Putten et al., *supra* note 108, at 188-89.

408. *Id.* at 189. The researchers also discovered that an early dysphoric response resulted in a poor prognosis for further drug treatment. *Id.* at 187.

lation between drug refusals and side effects.⁴⁰⁹ One study found that eighty-nine percent of the drug refusers experienced EPS, whereas only twenty percent of the compliers experienced these side effects.⁴¹⁰ The study indicated that drug reluctance is most notably associated with akathisia.⁴¹¹ Because the symptoms of akathisia are purely subjective, it is frequently misdiagnosed or unrecognized. This difficulty in diagnosis may account for the failure to lend credence to patients' drug refusals.⁴¹² Evidence that the patients studied were aware of the drug-induced side effects was emphasized by the fact that many insisted on increases of anti-parkinsonian agents and even privately stored these medications.⁴¹³ The author also noted that some of the patients who took less than the prescribed dosage functioned better on the lower dose, "thus supporting the possibility that the patient's view of optimal dosage is very much worth listening to."⁴¹⁴

A study by Marder and associates revealed that although some reasons for drug refusal are bizarre, others were associated with a history of severe side effects, suggesting that such refusals were rationally considered.⁴¹⁵ Hasenfeld and Grumet compared in-hospital and post-hospital outcomes of ten refusers and ten compliers.⁴¹⁶ They discovered that "[i]n general, the two groups were found to be remarkably similar in all important outcome measures."⁴¹⁷ When examining the patients who were later readmitted, however, it was found that refusers remained outside the hospital twice as long as compliers.⁴¹⁸ In addition, those who refused drugs initially and then later accepted, fared better post-hospital than did compliers. The authors speculated that perhaps these patients "retained a healthy skepticism about doctors, medicine, and psychiatry and some sense of themselves as not without power and control over their lives. These qualities may have helped the 'refusers' to better cope with life outside the hospital."⁴¹⁹ Another possible explanation was that the refusers were "healthier" than the compliers to begin with.⁴²⁰ The investigators concluded that perhaps "some patient refusal [sic] represent

409. See, e.g., Van Putten, *supra* note 104; Van Putten & May, *supra* note 68.

410. Van Putten, *supra* note 104, at 70.

411. *Id.* at 71.

412. *Id.* at 70-71.

413. *Id.* at 70.

414. *Id.*

415. Stephen R. Marder et al., *A Comparison of Patients Who Refuse and Consent to Neuroleptic Treatment*, 140 *Am. J. Psychiatry* 470, 472 (1983).

416. Irwin N. Hasenfeld & Barbara Grumet, *A Study of the Right to Refuse Treatment*, 12 *Bull. Am. Acad. Psychiatry & L.* 65, 68 (1984).

417. *Id.* at 72.

418. *Id.*

419. *Id.*

420. *Id.*

a relatively healthy expression of autonomous strivings, while others are driven to refuse by delusional necessity."⁴²¹

In recent research performed at a large New York state hospital, Zito and associates studied twenty instances of drug refusal.⁴²² The treating psychiatrist classified a refusal as meritorious or non-meritorious based on the reasons for objections. Four patient refusals were classified as meritorious. Non-meritorious refusals included seven patients who feared that the drugs were poisonous, five patients who denied their mental illness, and two patients who objected based on unconfirmed religious reasons.⁴²³

The researchers admit that this data is "biased by the interpretation of the treating psychiatrist."⁴²⁴ They found that the "meritoriousness" of refusal needs better definition due to the "difficulty of objective assessment of behavioral side effects which involve a subjective, internal state, such as akathisia and dysphoria and in the use of metaphorical language by patients."⁴²⁵ Thus, the patients who objected out of fear that the medications were poisonous may have been conveying legitimate concerns about side effects.⁴²⁶ Therefore, fifty-five percent of the refusals may have been rationally based. These and other studies refute the traditional assumption that mentally ill patients are necessarily unable to make rational treatment decisions.⁴²⁷

b. Involuntary Commitment Is Not Equivalent to a Finding of Incompetency

The second point of general consensus is that involuntary commitment into a mental hospital is not, as has been traditionally assumed,

421. *Id.* at 73.

422. Julie M. Zito et al., *One Year Under Rivers: Drug Refusal in a New York State Psychiatric Facility*, 12 Int'l J.L. & Psychiatry 295 (1990).

423. *Id.* at 299.

424. *Id.* at 304.

425. *Id.*

426. See Beck, *supra* note 305, at 370; Brooks, *supra* note 15, at 358.

427. See *supra* notes 403-404 and accompanying text. One recent study revealed that even children and adolescents refuse antipsychotic medication due to a recognition of side effects. In discussing the prevalence of parkinsonism among juveniles treated with antipsychotic drugs at one psychiatric center, the researchers found that "the patients were well aware of these [parkinsonism] symptoms in themselves and their peers, describing them as 'zombie-like' and implicating them as a reason for outpatient treatment non-compliance." Richardson et al., *supra* note 96, at 1326.

Another interesting study indicated that some patients make a considered refusal out of a preference for psychotic symptoms. Theodore Van Putten et al., *Drug Refusal in Schizophrenia and the Wish to Be Crazy*, 33 Archives Gen. Psychiatry 1443 (1976). The researchers compared a group of habitual refusers with a group of compliers and found

ipso facto evidence of a person's incompetence. As noted earlier, most states now have legislation which expressly provides that a patient is not deemed incompetent to exercise personal and civil rights solely by reason of commitment. Patients, therefore, generally retain the legal ability to contract, hold professional and vehicle licenses, marry, divorce, vote, make a will, and exercise other such rights.⁴²⁸ Nonetheless, some mental health professionals argue that a judicial decision to commit is, at least, an implicit finding that the person is incapable of making treatment decisions.⁴²⁹ This argument, however, ignores the fact that a decision to commit and a finding of incompetency are separate and distinct determinations resting upon different criteria.

A commitment decision is basically medical in nature. One common basis for commitment is a finding, based on medical evidence, that an individual is mentally ill and, due to that mental illness, poses a danger to himself or others in the community.⁴³⁰ But a finding of mental illness and dangerousness does not mean that the person is incapable of making treatment decisions. The other typical basis for commitment is a finding that a mentally ill person is incapable of caring for himself and is in need of treatment.⁴³¹ These essentially medical determinations, however, do not necessarily mean that once in the institution, the patient is incapable of making a rational decision regarding proposed treatments.⁴³² A commitment determination does not address the individual's capability

that while the refusers experienced grandiose delusions upon discontinuation of drugs, the compliers suffered from high levels of anxiety and depression. *Id.* at 1444. The researchers believe that some patients refuse out of a preference for a psychotic state over drug-induced, relative normality. *Id.* at 1443.

For a synopsis of various studies related to the causes and effects of drug refusal, see Phil Brown, *Psychiatric Treatment Refusal, Patient Competence, and Informed Consent*, 8 Int'l. J.L. & Psychiatry 83 (1986).

428. See *supra* note 307 and accompanying text.

429. E.g., Rachlin, *supra* note 4, at 100-01 (stating that "[t]he involuntarily hospitalized psychiatric patient has, as indicated by such status, a judgmental impairment. How, then, can we say that he is able to make an informed choice as to whether or not treatment is indicated?").

430. See Richard Van Duizend et al., *An Overview of State Involuntary Civil Commitment Statutes*, 8 Mental & Physical Disability L. Rep. 328 (1984) (summarizing and tabulating state commitment criteria); Brakel et al., *supra* note 307, at 114 Table 2.6 (survey of state criteria for involuntary commitment).

431. See *supra* note 430.

432. The fact that a person is committed for treatment or, once committed, asserts a right to treatment does not mean that the person has a correlative obligation to submit to any treatment which is proposed. For a discussion on how a right to treatment does not conflict with a right to refuse a particular treatment, see Kahn, *supra* note 275; Gaughan & LaRue, *supra* note 30, at 44-45; Brooks, *supra* note 50, at 195.

of contributing to treatment decisions.⁴³³ Thus, as one commentator stated, "the commitment order should have no effect whatsoever on the individual's liberty interest regarding treatment decisions. Neither the substantive norms nor the procedural regularity of a commitment hearing can support the legitimacy of a decision never reached in that context."⁴³⁴

The modern legislative and judicial trend is not only to distinguish the concept of competency to make treatment decisions from commitment, but to presume the competency of committed individuals until a separate determination holds otherwise.⁴³⁵ Likewise, recent psychiatric

433. It should be noted that a few states have enacted legislation requiring that a separate determination of competency to make treatment decisions be made at the initial commitment hearing once an individual is found to meet the commitment criteria. See *infra* note 691 and accompanying text.

434. Zlotnick, *supra* note 210, at 409. Zlotnick notes, separating the concepts of competency and commitment does not necessarily mean that the commitment order authorizes only mere custody of the individual. Although arguable, the commitment order may authorize minimally intrusive forms of treatment, such as group or milieu therapy, vocational rehabilitation, occupational therapy, and psychiatric consultation. *Id.* at 411. See also Winick, *supra* note 27, at 63-84 (providing a continuum of mental health treatments based on intrusiveness and determining those that implicate the First Amendment).

435. For a listing of state statutes which provide that committed individuals are presumed competent, see Blackburn, *supra* note 307, at 472 n.88. See also *Bee v. Greaves*, 744 F.2d 1387, 1395 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214, 105 S. Ct. 1187 (1985) (*parens patriae* authority does not authorize the forced treatment of a competent pretrial detainee); *Rennie v. Klein*, 653 F.2d 836, 846 & n.12 (3d Cir. 1981), *vacated*, 458 U.S. 1119, 102 S. Ct. 3506 (1982) ("[i]t is simply not true that all persons involuntarily committed are always incapable of making a rational decision on treatment"); *Scott v. Plante*, 532 F.2d 939, 946 (3d Cir. 1976) (even though an individual is properly committable, due process demands a separate judicial hearing to determine if he is incapable of giving informed consent to medical treatment); *Winters v. Miller*, 446 F.2d 65, 68, 71 (2d Cir. 1971), *cert. denied*, 404 U.S. 985, 92 S. Ct. 450 (1971) (because commitment does not raise even a presumption of incompetency under state law, a judicial determination of incompetency is required before treatment may be forcibly administered under the *parens patriae* power); *United States v. Waddell*, 687 F. Supp. 208, 209 (M.D.N.C. 1988) (a judicial finding of incompetence required before an inmate can be forcibly medicated); *United States v. Leatherman*, 580 F. Supp. 977, 979 (D.D.C. 1983), *appeal dismissed*, 729 F.2d 863 (D.C. Cir. 1984) (suggesting a mental patient must be determined incompetent before treatment can be forcibly administered on *parens patriae* grounds); *Davis v. Hubbard*, 506 F. Supp. 915, 935 (N.D. Ohio 1980) (no necessary relationship exists between mental illness and incompetency to provide informed consent to medical treatment); *Anderson v. State*, 663 P.2d 570, 573 n.1 (Ariz. Ct. App. 1982) ("[e]ven if the court finds that the patient is 'unwilling to accept or incapable of accepting treatment voluntarily,' such a finding is not the equivalent of a finding that the patient is incompetent to participate in treatment decisions, once a treatment program is started. We believe there is a significant difference between getting the patient into treatment in the first place and subsequently determining the course of that program"); *Riese v. St. Mary's Hosp. & Medical Ctr.*, 243 Cal. Rptr. 241, 248-49 (Cal. App. 1st Dist. 1987), *opinion superseded*, 751 P.2d 893 (Cal. 1988), *dismissed*, 774 P.2d 698 (Cal. 1989) (incompetency may not be presumed solely because of hospitalization, and state statutory and common law protect

literature indicates a growing professional consensus that there is no necessary relationship between commitment and the ability to make rational treatment decisions.⁴³⁶

Beyond the above two areas of concurrence, there is a wide disparity of professional opinion regarding treatment decisionmaking ability. Despite an increasing sophistication in the complex area of incompetency determinations, there are still no well-articulated standardized criteria for measuring a person's ability for rational decisionmaking. Various substantive standards for determining competency to consent to medical treatment have been proposed, but these tests vary widely.⁴³⁷ The less

the right of a patient not adjudicated incompetent to give or withhold consent to medical treatment); *People v. Medina*, 705 P.2d 961, 973 (Colo. 1985) (non-consensual drugging of mental patient for treatment purposes requires judicial determination of incompetence to participate in the treatment decision); *Goedecke v. State*, 603 P.2d 123, 125 (Colo. 1979) (a patient's common law right to decline medical treatment is not abrogated by commitment); *In re Orr*, 531 N.E.2d 64, 73 (Ill. App. 4th Dist. 1988) ("[a]n involuntarily committed person is not necessarily legally incompetent"); *Rogers v. Commissioner of Dep't of Mental Health*, 458 N.E.2d 308, 314 (Mass. 1983) (a committed mental patient "has the right to make treatment decisions and does not lose that right until the patient is adjudicated incompetent by a judge through incompetence proceedings"); *Jarvis v. Levine*, 418 N.W.2d 139, 148-49 & n.7 (Minn. 1988) (a separate finding of legal incompetency is a prerequisite to involuntarily medicating a committed patient); *Rivers v. Katz*, 495 N.E.2d 337, 342 (N.Y. 1986) ("there is no significant relationship between the need for hospitalization of mentally ill patients and their ability to make treatment decisions"); *In re Milton*, 505 N.E.2d 255, 257-58 (Ohio 1987), *cert. denied sub nom.* Ohio Dep't of Mental Health v. Milton, 484 U.S. 820, 108 S. Ct. 79 (1987) (a "person properly committed to a mental institution may be legally competent. . . . Thus, it is apparent that the state may not act in a *parens patriae* relationship to a mental hospital patient unless the patient has been adjudicated incompetent"); *In re K.K.B.*, 609 P.2d 747, 749 (Okla. 1980) ("competency is not a medical decision and should not merge with the commitment decision. . . . Commitment in an institution does not necessarily mean a person is incapable of appropriately deciding whether or not he prefers to be treated with psychotropic drugs"); *Henderson v. Yocom*, No. 7948A, mem. op. at 10-11 (S.D. 1st Cir. 1987), *aff'd*, 438 N.W.2d 225 (S.D. 1989) (table opinion) (the burden is on the state "to show a person involuntarily committed is not competent to make the decision to refuse antipsychotic drugs as part of its treatment plan"); *State ex rel. Jones v. Gerhardstein*, 416 N.W.2d 883, 896 (Wis. 1987) ("[a]n involuntary commitment is not equivalent to a finding of incompetency with respect to involuntary treatment decisions").

436. See, e.g., Alan A. Stone, *The Right to Refuse Treatment: Why Psychiatrists Should and Can Make It Work*, 38 Archives Gen. Psychiatry 358, 359 (1981); Beck, *supra* note 305, at 369; Henry C. Weinstein, *The Right to Refuse Treatment*, 5 Bull. Am. Acad. Psychiatry & L. 425, 427 (1977); Loren H. Roth et al., *Tests of Competency to Consent to Treatment*, 134 Am. J. Psychiatry 279, 279 (1977).

437. Various approaches for determining competency to make treatment decisions are categorized in Roth et al., *supra* note 436. These categories and variations thereof have been utilized or proposed by a number of commentators. See Elyn Saks, *Competency to Refuse Treatment*, 69 N.C. L. Rev. 945 (1991). Richard M. Ratzan, *Informed Consent from the Mentally Incompetent Elderly*, Postgraduate Med., Oct. 1986, at 81; Laurence Tancredi, *Competency for Informed Consent; Conceptual Limits of Empirical Data*, 5

stringent approaches are the most respectful of individual autonomy in the sense that most patients will have their decisions respected as competently made. The more difficult standards elevate an interest in health over autonomy. The basic problem is that competency is not merely a descriptive, evaluative, or empirical concept. Each proposed standard presupposes a moral theory and reflects different social values. Every competency proceeding reflects the tension between respect for self-determination and concern for protection and health. As one commentator notes, in the search for an appropriate standard:

We cannot know where to look unless we know what we are looking for. A theory of the values embedded in the ascription of competency, and of its significance, needs to be provided. Insofar as this theory will be one which is intended to guide conscientious action, it will be of necessity an ethical theory.⁴³⁸

An appropriate standard for determining competency is one which encompasses an acceptable balance between concern for providing needed medical care and preservation of individual autonomy.

2. *A Parens Patriae Emergency Exception?*

As explained above, a finding of incompetency is necessary before the government can forcibly administer antipsychotic drugs based on its *parens patriae* power. The great majority of courts faced with this issue have refused to recognize any exception to this limit on the government's *parens patriae* authority. A few courts, however, have fashioned a narrow "emergency" exception to this requirement.

In *Rogers v. Okin*,⁴³⁹ the state urged the court to recognize a "psychiatric emergency" which would allow forced medication without an initial incompetency determination. Situations which qualified as psychiatric emergencies included extreme anxiety and panic, bizarre behavior, emotional disturbances having the potential to interfere with daily functioning, the likelihood of further severe suffering, or the rapid worsening of the patient's clinical state.⁴⁴⁰ The district court rejected the proffered definition as "too broad, subjective and unwieldy," and limited any

Int'l J.L. & Psychiatry 51 (1982); Paul S. Appelbaum & Loren H. Roth, *Competency to Consent to Research*, 39 Archives Gen. Psychiatry 951 (1982); Freedman, *supra* note 403; Paul R. Friedman, *Legal Regulation of Applied Behavior Analysis in Mental Institutions and Prisons*, 17 Ariz. L. Rev. 39 (1975); James H. Hardisty, *Mental Illness: A Legal Fiction*, 48 Wash. L. Rev. 735 (1973).

438. Freedman, *supra* note 403, at 56.

439. *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part and rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291, 102 S. Ct. 2442 (1982).

440. *Id.* at 1364.

emergency exception to the context of the state's police power considerations.⁴⁴¹ On review, the First Circuit broadened the district court's definition of emergency to include the *parens patriae* interest in situations where any delay in medication could "result in significant deterioration of the patient's mental health" such as the slipping into "possibly chronic illness while awaiting an adjudication of incompetency."⁴⁴² Even in these situations, however, the First Circuit merely waived the necessity of a judicial appraisal of incompetency and remanded the case for consideration of alternative procedures for making an incompetency determination.⁴⁴³

Likewise, the Massachusetts Supreme Judicial Court has fashioned a limited *parens patriae* emergency exception by waiving the necessity of a judicial determination of incompetency where any delay would result in the "possibility of immediate, substantial, and irreversible deterioration of a serious mental illness."⁴⁴⁴ However, the court expressly noted that "[e]xpert testimony indicated that the prognosis for most individuals with untreated schizophrenia was 'gradual worsening,'"⁴⁴⁵ and that "the possibility that the ward's schizophrenia might deteriorate into a chronic, irreversible condition at an uncertain but relatively distant date does not satisfy our definition of emergency. . . ."⁴⁴⁶ The Massachusetts high court subsequently reaffirmed this *parens patriae* emergency exception in *Rogers v. Commissioner of Department of Mental Health*.⁴⁴⁷ However, the court made it clear that such emergencies merely obviated the need for a prior adjudication of incompetency. The court required that before medication could be forcibly administered, the doctors must make an incompetency determination based on their professional judgment with an expedited adjudication to follow.⁴⁴⁸ The Colorado Supreme Court also abrogated the need for a prior adjudication of incompetency when forced medication is necessary to prevent the "immediate and irreversible deterioration of the patient due to a psychotic episode."⁴⁴⁹ This court also required judicial authorization of the forced treatment as soon as practicable.⁴⁵⁰

441. *Id.* at 1365. The court stated that a "committed mental patient may be forcibly medicated in an emergency situation in which a 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." *Id.*

442. *Rogers v. Okin*, 634 F.2d 650, 660 (1st Cir. 1980), *vacated sub nom.* *Mills v. Rogers*, 457 U.S. 291, 102 S. Ct. 2442 (1982).

443. *Id.*

444. *In re Guardianship of Roe*, 421 N.E.2d 40, 55 (Mass. 1981).

445. *Id.* at 54.

446. *Id.* at 55.

447. 458 N.E.2d 308, 322 (Mass. 1983).

448. *Id.* at 322 & n.29.

449. *People v. Medina*, 705 P.2d 961, 974 (Colo. 1985).

450. *Id.* at 975.

It should be emphasized that, as the Massachusetts Supreme Judicial Court noted, immediate and substantial deterioration caused by a delay in treatment with antipsychotic drugs is extremely rare.⁴⁵¹ Furthermore, studies indicate that patients who are medicated after a delay respond just as well as patients medicated immediately.⁴⁵² Perhaps this is the reason that most courts do not recognize an emergency exception to the incompetency determination required before medication is forcibly administered. A broader definition of emergency—such as the potential for any deterioration in the patient's mental condition—would seem inappropriate and vulnerable to abuse given the values protected by the doctrine of informed consent.⁴⁵³ As one commentator stated, "If . . . the consequence of withholding treatment is merely that the patient may suffer pain but not permanent physical detriment, to permit the physician to treat without first obtaining informed consent seriously undermines individualism without any substantial countervailing gain in promoting the societal interest in health."⁴⁵⁴

VII. THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE

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 the 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*,⁴⁵⁵ 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

451. See *In re Guardianship of Roe*, 421 N.E.2d 40, 54-55 (Mass. 1981). The authors of one study claim that the additional delay created by the requirement of a court hearing caused some patients to decompensate and necessitated the use of emergency medication, seclusion, or restraint. J. Richard Ciccone et al., *Right to Refuse Treatment: Impact of Rivers v. Katz*, 18 Bull. Am. Acad. Psychiatry & L. 203, 213 (1990). However, neither the number of patients nor the type or severity of decompensation was addressed.

452. Appelbaum & Gutheil, *Drug Refusal: A State of Psychiatric Inpatients*, 137 Am. J. Psychiatry 340, 345 (1980); Hassenfeld & Grumet, *supra* note 416, at 72; Joseph D. Bloom et al., *The Influence of the Right to Refuse Treatment on Precommitment Patients*, 16 Bull. Am. Acad. Psychiatry & L. 5, 7 (1988).

453. See Brooks, *supra* note 15, at 357; Vicki Anderson, Note, *Right to Refuse Antipsychotic Medication: A Proposal for Legislative Consideration*, 17 Ind. L. Rev. 1035, 1056 (1984).

454. Alan Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 Wis. L. Rev. 413, 436.

455. 364 U.S. 479, 81 S. Ct. 247 (1960).

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.⁴⁵⁶

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.

Over the past three decades, the Supreme Court has invoked the doctrine in a number of contexts where government action has unnecessarily restricted fundamental personal liberties. Fundamental liberties which have received the doctrine's protection include the right to association, expression, privacy, vote, marry, travel, and freedom from bodily restraint.⁴⁵⁷

The least restrictive alternative doctrine was first applied in the mental health area in *Lake v. Cameron*.⁴⁵⁸ 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.⁴⁵⁹ The court, based on a District of Columbia commitment statute, held that the government must demonstrate that no less restrictive placement alternatives are available prior to involuntary institutionalization.⁴⁶⁰ Only three years later, the same court expanded the application of the doctrine in *Covington v. Harris*.⁴⁶¹ The court indicated that the least restrictive alternative principle had a constitutional basis as applied to commitment decisions and ward assignments within the institution.⁴⁶²

456. *Id.* at 488, 81 S. Ct. at 252 (footnote omitted).

457. *N.A.A.C.P. v. Button*, 371 U.S. 415, 433-36, 83 S. Ct. 328, 338-40 (1963) (association); *Shelton*, 364 U.S. at 488, 81 S. Ct. at 252 (association); *Butler v. Michigan*, 352 U.S. 380, 383, 77 S. Ct. 524, 525-26 (1957) (expression); *Cleveland Bd. of Educ. v. LaFleur*, 414 U.S. 632, 644-46, 94 S. Ct. 791, 198-99 (1974) (privacy); *Griswold v. Connecticut*, 381 U.S. 479, 485, 85 S. Ct. 1678, 1682 (1965) (privacy); *O'Connor v. Donaldson*, 422 U.S. 563, 580, 95 S. Ct. 2486, 2496 (1975) (freedom from restraint); *McNeil v. Director, Patuxent Inst.*, 407 U.S. 245, 248-50, 92 S. Ct. 2083, 2086-87 (1972) (freedom from restraint); *Dunn v. Blumstein*, 405 U.S. 330, 342-43, 92 S. Ct. 995, 1003 (1972) (vote); *Zablocki v. Redhail*, 434 U.S. 374, 388, 98 S. Ct. 673, 682 (1978) (marriage); *Memorial Hosp. v. Maricopa County*, 415 U.S. 250, 268-69, 94 S. Ct. 1076, 1087-88 (1974) (travel); *Vlandis v. Kline*, 412 U.S. 441, 451, 93 S. Ct. 2230, 2236 (1973) (travel); *Shapiro v. Thompson*, 394 U.S. 618, 634-37, 89 S. Ct. 1322, 1331-33 (1969) (travel).

458. 364 F.2d 657 (D.C.C. 1966).

459. *Id.* at 660-61.

460. *Id.* at 659-60.

461. 419 F.2d 617 (D.C.C. 1969).

462. *Id.* at 623-24. The court stated:

The principle of the least restrictive alternative consistent with the legitimate purposes of a commitment inheres in the very nature of civil commitment, which entails an extraordinary deprivation of liberty. . . . A statute sanctioning such

Thereafter, courts began applying the doctrine to commitment decisions,⁴⁶³ conditions of confinement,⁴⁶⁴ and treatment decisions within the institution.⁴⁶⁵ Additionally, the doctrine has been urged in support of a right to adequate treatment.⁴⁶⁶

In the context of the right to refuse psychiatric treatment, the issue is whether the least restrictive alternative doctrine requires that, when a patient objects to a particular treatment, the state must attempt, or at least consider, less intrusive interventions before administering the proposed treatment.⁴⁶⁷ The doctrine was applied in a number of early right to refuse cases. In 1976, the Minnesota Supreme Court, in *Price v. Sheppard*,⁴⁶⁸ ruled that before psychiatrists could perform intrusive forms of therapy, such as electroshock or psychosurgery, on a committed patient, the authorizing court must examine whether the intrusive procedures are necessary and reasonable in light of less intrusive treatments.⁴⁶⁹ Two years later, the district court in *Rennie v. Klein*⁴⁷⁰ extended

a drastic curtailment of the rights of citizens must be narrowly, even grudgingly construed in order to avoid deprivations of liberty without due process of law.

Id. at 623. The court went on to hold:

The principle of the least restrictive alternative is equally applicable to alternate dispositions *within* a mental hospital. It makes little sense to guard zealously against the possibility of unwarranted deprivations prior to hospitalization, only to abandon the watch once the patient disappears behind hospital doors. The range of possible dispositions of a mentally ill person within a hospital, from maximum security to outpatient status, is almost as wide as that of dispositions without. The commitment statute no more authorizes unnecessary restrictions within the former range than it does within the latter.

Id. at 623-24.

463. *O'Connor v. Donaldson*, 422 U.S. 563, 575, 95 S. Ct. 2486, 2493-94 (1975); *Halderman v. Pennhurst State School & Hosp.*, 612 F.2d 84, 103-08 (3d Cir. 1979), *stay granted in part*, 448 U.S. 905, 100 S. Ct. 3046 (1980), *rev'd*, 451 U.S. 1, 101 S. Ct. 1531 (1981); *Suzuki v. Quisenberry*, 411 F. Supp. 1113, 1132-33 (D. Haw. 1976), *modified sub nom. Suzuki v. Yuen*, 438 F. Supp. 1106 (D. Haw. 1977), *aff'd in part, rev'd in part*, 617 F.2d 173 (9th Cir. 1980); *Lynch v. Baxley*, 386 F. Supp. 378, 392 (M.D. Ala. 1974); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1995-96 (E.D. Wis. 1972), *vacated*, 414 U.S. 473, 94 S. Ct. 713 (1974).

464. *Halderman*, 612 F.2d at 113; *Dixon v. Weinberger*, 405 F. Supp. 974, 978-79 (D.D.C. 1975); *Welsch v. Likins*, 373 F. Supp. 487 (D. Minn. 1974), *opinion supplemented*, 68 F.R.D. 589 (D. Minn.), *aff'd*, 525 F.2d 987 (8th Cir. 1975).

465. *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); *Wyatt v. Stickney*, 344 F. Supp. 373, 379-81 (M.D. Ala. 1972), *aff'd in part, rev'd in part sub nom. Wyatt v. Anderholt*, 503 F.2d 1305 (5th Cir. 1974).

466. See Roy G. Spece, Jr., *Preserving the Right to Treatment: A Critical Assessment and Constructive Development of Constitutional Right to Treatment Theories*, 20 *Ariz. L. Rev.* 1, 33-46 (1978).

467. See generally Winick, *supra* note 210, at 18-21; Zlotnick, *supra* note 210, at 375.

468. 239 N.W.2d 905 (Minn. 1976), cited in Winick, *supra* note 27, at 18.

469. *Id.* at 912-13.

470. 462 F. Supp. 1131 (D.N.J. 1978). *Accord Davis v. Hubbard*, 506 F. Supp. 915,

the application of the principle to a case involving the refusal of treatment with antipsychotic drugs. Quoting Professor Winick, the court stated that under the least restrictive alternative doctrine, a patient "may challenge the forced administration of drugs on the basis that alternative treatment methods should be tried before a more intrusive technique like psychotropic medication is used."⁴⁷¹ Because evidence indicated that lithium plus an antidepressant would be a reasonable alternative to antipsychotics, the court ordered that the patient be given a fair trial on this less intrusive treatment program.⁴⁷²

On appeal, the Third Circuit affirmed the applicability of the least restrictive alternative doctrine but modified the district court's approach.⁴⁷³ Central to the appellate court's least restrictive analysis was a balancing of the costs and benefits to the patient presented by the proposed treatment. The court stated:

The least intrusive means standard does not prohibit all intrusions. It merely directs attention to and requires avoidance of those which are unnecessary or whose cost benefit ratios, weighed from the patient's standpoint, are unacceptable. There must be a balancing of the patient's interest with those to be furthered by administering the psychotropic drug.⁴⁷⁴

The Third Circuit qualified the district court's application of the doctrine in two ways. First, it did not require that less intrusive therapies necessarily be attempted before administration of the proposed treatment, but merely that they be consciously considered.⁴⁷⁵ Second, the appellate court construed the doctrine as applying to a "regimen or treatment

935 n.24 (N.D. Ohio 1980) (even in an emergency situation, the state has the obligation to provide the least restrictive treatment).

471. *Id.* at 1146, quoting Bruce J. Winick, *Psychotropic Medication and Competence to Stand Trial*, 1977 Am. Bar Found. Res. J. 769, 813. The court held that the availability of less restrictive treatments was one of four considerations in determining whether antipsychotic drugs could be forcibly administered in a non-emergency situation. The other relevant factors were the patient's physical threat to others within the institution, the patient's capacity to make treatment decisions, and the risk of permanent side effects from the proposed medication. *Id.* at 1148.

472. *Id.* at 1146.

473. *Rennie v. Klein*, 653 F.2d 836, 847 (3d Cir. 1981), *vacated*, 458 U.S. 1119, 102 S. Ct. 3506 (1982). Four of the nine judges sitting en banc felt that it was inappropriate to apply the least restrictive alternative principle to drug refusal cases, believing instead that reviewing courts should defer to the judgment of medical professionals. *See id.* at 854-55 (Seitz, C.J., concurring), 855, 861-63 (Garth, J., concurring).

474. *Id.* at 847. The court emphasized that "what is reviewable is whether the choice of a course of treatment strikes a proper balance between efficacy and intrusiveness." *Id.*

475. *Id.* at 847, 851. The court held the least restrictive alternative doctrine applicable even in emergencies but suggested that in such situations more discretion be granted to the attending physician. *Id.* at 847.

program" rather than discrete instances of medication, stating that such "hourly or daily judicial oversight" would be "unworkable."⁴⁷⁶ Such a standard, in the court's view, "merely serves to advise the psychiatric community that a conscious weighing of the constitutional liberty interest in any determination of proper treatment alternatives is necessary."⁴⁷⁷

In *Rogers v. Okin*,⁴⁷⁸ the district court went so far as to suggest that the least restrictive alternative doctrine would always preclude the forced administration of antipsychotic drugs in non-emergency situations. The court reasoned:

There are alternative methods of treating mental patients, though some may be slower and less effective than psychotropic medication. . . . Given the alternatives available in non-emergencies, subjecting a patient to the humiliation of being disrobed and then injected with drugs powerful enough to immobilize both body and mind is totally unreasonable by any standard.⁴⁷⁹

On review, the First Circuit upheld the use of the least restrictive alternative principle but rejected the district court's blanket preclusion of antipsychotic drugs.⁴⁸⁰ In addressing the police power authority to compel treatment with drugs, the court required that physicians balance the relevant patient and state interests. In so doing, "reasonable alternatives to the administration of antipsychotics must be ruled out. Otherwise, the administration of the drugs would not be necessary to accomplish the state's objective. Indeed, it may be possible that in most situations less restrictive means will be available."⁴⁸¹

476. *Id.* at 847-48.

477. *Id.* The Third Circuit's opinion left the standard of review unclear. At one point the court states that "what is reviewable is whether the choice of a course of treatment strikes a proper balance between efficacy and intrusiveness." *Id.* at 847. This statement suggests that the reviewing court determine whether the professional judgment strikes the proper balance. However, the court's statement that the doctrine merely serves to advise the physicians that a conscious weighing of interests is required, *id.*, and that "[t]o the extent that other possibilities are discussed and discarded, the process . . . provides a reasonable exploration of the least intrusive means," *id.* at 851, indicates that the court is limited to reviewing only whether such considerations took place and not the correctness of the conclusion.

478. *Rogers v. Okin*, 478 F. Supp. 1342, 1369 (D. Mass. 1979), *aff'd in part and rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291, 102 S. Ct. 2442 (1982).

479. *Id.*

480. *Rogers v. Okin*, 634 F.2d. 650, 656 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291, 102 S. Ct. 2442 (1982).

481. *Id.* at 655-56. The First Circuit in *Okin* was much clearer than the Third Circuit in defining the standard of review. In remanding the case, the First Circuit directed that when the police power is asserted, the district court "limit its own role to designing procedures for ensuring that the patients' interests in refusing antipsychotics are taken

While the *Rennie* appeal was pending, the Third Circuit issued its decision in *Romeo v. Youngberg*.⁴⁸² *Romeo* involved the claims of an institutionalized, mentally retarded individual to freedom from bodily restraint, safe conditions, and adequate treatment. The court held that restraints could only be used when necessary for protection or treatment and when it was demonstrated that restraints were the "least restrictive means of handling the resident—that other, less severe measures had been tried or considered and found unworkable."⁴⁸³ Regarding treatment programs, as in *Rennie*, the Third Circuit applied the least restrictive alternative approach focusing on risk-benefit ratios. The court noted that where the possibility of both improvement and serious side effects existed, treatment decisions should err on the side of patient safety.⁴⁸⁴

The Supreme Court subsequently vacated and remanded the Third Circuit's decision in *Romeo*.⁴⁸⁵ The Court held that an involuntarily committed, mentally retarded individual retains constitutionally protected liberty interests in reasonably safe conditions of confinement, freedom from unreasonable bodily restraint, and such minimally adequate treatment as reasonably may be required to assure those interests.⁴⁸⁶ However, the Court noted that these protected interests could, in appropriate circumstances, be overridden by legitimate state concerns.⁴⁸⁷ In weighing the competing interests, the Court held that a proper balance is struck when restrictions on these personal rights are the result of decisions made by appropriate institutional authorities exercising professional judgment.⁴⁸⁸ The Court further ruled that such decisions are entitled to a presumption of correctness and "liability may be imposed only when

into consideration and that antipsychotics are not forcibly administered absent a finding by a qualified physician that those interests are outweighed in a particular situation and less restrictive alternatives are unavailable." *Id.* at 657:

Shortly after the First Circuit's opinion in *Okin*, the Massachusetts Supreme Judicial Court applied the least restrictive alternative principle in a drug refusal case. *In re Guardianship of Roe*, 421 N.E.2d 40 (1981). The issue presented was whether a non-institutionalized mentally ill ward could be forcibly medicated with antipsychotics upon the consent of his guardian. The Massachusetts court held that authorization was necessary by a reviewing court exercising substituted judgment and taking into account the least restrictive alternative doctrine. *Id.* at 61.

482. 644 F.2d 147 (3d Cir. 1980) (en banc), *vacated and remanded*, 457 U.S. 307 (1982).

483. *Id.* at 172.

484. *Id.* at 166 and n.45.

485. *Youngberg v. Romeo*, 457 U.S. 307, 102 S. Ct. 2452 (1982).

486. *Id.* at 324, 102 S. Ct. at 2462. The Court expressly limited its standard for the amount of training constitutionally required to the facts of this particular case. The Court felt it unnecessary to go further as the respondent requested nothing more than that which the Court granted. *Id.* at 319 and n.25.

487. *Id.* at 319-21, 102 S. Ct. at 2460-61.

488. *Id.* at 321, 102 S. Ct. at 2461.

the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment."⁴⁸⁹ The Court, however, did not address the applicability of the least restrictive alternative principle, explicitly noting that the respondent did not feel it a necessary issue to the determination of the case.⁴⁹⁰

The Supreme Court subsequently vacated and remanded *Rennie* to the Third Circuit for reconsideration in light of the *Youngberg* decision.⁴⁹¹ The Third Circuit's en banc decision split three ways over the applicability of the least restrictive alternative doctrine to drug refusal cases.⁴⁹² Five judges determined that because the Supreme Court failed to apply a least restrictive analysis in *Youngberg*, it was inappropriate to employ the concept in *Rennie*.⁴⁹³ Four judges would have applied the doctrine, noting that the Supreme Court believed that the issue was irrelevant to the *Youngberg* fact situation which was distinguishable from drug refusal cases.⁴⁹⁴ One judge did not explicitly address the question.

Despite the majority's refusal to apply the least restrictive alternative doctrine in *Rennie*, several other courts have continued to apply the principle in drug refusal cases. In *Bee v. Greaves*,⁴⁹⁵ where the Tenth Circuit found that pretrial detainees have a constitutional right to refuse treatment with antipsychotic drugs,⁴⁹⁶ the court held that "less restrictive alternatives, such as segregation or the use of less controversial drugs like tranquilizers or sedatives, should be ruled out before resorting to antipsychotic drugs" in response to safety or security threats.⁴⁹⁷ The Tenth Circuit acknowledged that the Supreme Court declined to apply

489. *Id.* at 323, 102 S. Ct. at 2462.

490. *Id.* at 313 n.14, 102 S. Ct. at 2457 n.14. As evidenced by the following exchange during oral presentation before the Court, Mr. Tiryak, respondent's counsel, affirmatively argued that the Court need not address the least restrictive alternative issue:

Mr. Tiryak: We don't feel as though the least intrusive standard is a standard that is necessary to be used to decide this case. To the extent that the Court of Appeals has used that standard, we don't feel it's necessary. We accept the fact that—

Question: You don't think that's necessary.[sic]

Mr. Tiryak: Yes. It's unnecessary to decide the case, to get to those issues.

And we haven't urged them in our brief.

Transcript of oral argument, *Youngberg v. Romeo*, 55 (Anderson Reporting Co.).

491. *Rennie v. Klein*, 458 U.S. 1119, 102 S. Ct. 3506 (1982).

492. *Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983).

493. *Id.* at 269.

494. *Id.* at 275 (Weis, J., concurring).

495. 744 F.2d 1387 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214, 105 S. Ct. 1187 (1985).

496. *Id.* at 1394.

497. *Id.* at 1396.

the doctrine in *Youngberg*,⁴⁹⁸ but found that case distinguishable because it "involved temporary physical restraints rather than mental restraints with potentially long term effects."⁴⁹⁹ The court also noted that "Romeo had been certified as severely retarded and unable to care for himself" while the present case involved a pretrial detainee who "ha[d] not been declared mentally incompetent under appropriate state procedures."⁵⁰⁰

In the 1987 panel decision of *United States v. Charters* ("*Charters I*"),⁵⁰¹ the Fourth Circuit also held that pretrial detainees have a constitutionally protected interest in refusing treatment with antipsychotic medication⁵⁰² and followed the Tenth Circuit's lead in applying a least restrictive alternative analysis in discussing the government's authority to medicate forcibly to prevent violence.⁵⁰³ The Fourth Circuit elaborated on the rationale used by the Tenth Circuit in distinguishing *Youngberg* from cases involving forced drugging of a mentally ill individual. The potentially serious side effects presented by antipsychotic drugs were emphasized.⁵⁰⁴ The Fourth Circuit also distinguished *Youngberg* on the basis of competency. The court noted that Romeo had no ability to participate in treatment decisions due to the profundity of his retardation. However, because a mentally ill individual such as Charters can be competent to make decisions regarding medical care, "[t]he balance of individual and governmental interests is quite different."⁵⁰⁵ In addition, the court relied on the fact that "unlike the purely physical restraints considered in *Romeo*, antipsychotic medication has the potential to infringe upon an individual's freedom of thought."⁵⁰⁶

A South Dakota circuit court, while focusing on the potentially serious side effects of antipsychotic drugs, held that a least restrictive alternative analysis is constitutionally required when reviewing a forced medication determination made under either the state's police or *parens patriae* power.⁵⁰⁷ In addition, the Washington Supreme Court held that an authorizing court is constitutionally required to engage in a least restrictive alternative analysis when reviewing a patient's refusal of electroshock therapy.⁵⁰⁸

498. *Id.* at 1396 n.7.

499. *Id.*

500. *Id.* For an excellent discussion in support of the court's reasoning, see Winick, *supra* note 210, at 20-21.

501. 829 F.2d 479 (4th Cir. 1987), *modified*, 863 F.2d 302 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990).

502. *Id.* at 491-92.

503. *Id.* at 493.

504. *Id.* at 489.

505. *Id.* at 488.

506. *Id.* at 489.

507. *Henderson v. Yocom*, No. 7948A mem. op. at 4-5, 12 (S.D. 1st Cir. 1987), *aff'd*, 438 N.W.2d 225 (S.D. 1989) (table opinion).

508. *In re Schuoler*, 723 P.2d 1103, 1108 (Wash. 1986) (en banc).

On the other hand, several federal courts have failed to explicitly address the least restrictive alternative doctrine in drug refusal cases. Under the influence of *Youngberg*, these courts have simply held that constitutional requirements are satisfied if forced medication decisions are made in the exercise of professional judgment.⁵⁰⁹ For example, the Fourth Circuit, sitting en banc in *United States v. Charters* ("*Charters II*"),⁵¹⁰ relied on the professional judgment standard in reversing much of its decision in *Charters I*. In listing some of the factors which a professional should consider in making a forced medication decision, the court made no mention of less intrusive alternative treatments.⁵¹¹

The Eighth Circuit explicitly rejected the doctrine in addressing the government's police power authority to drug a prison inmate determined to be dangerous.⁵¹² Citing *Rennie*, the court stated:

If the government shows that it cannot control a mentally ill prisoner in the general prison population, due process does not require it to provide the least restrictive treatment modality. . . . Rather, we hold that psychotropic drugs may be constitutionally administered to a mentally ill federal prisoner whenever, in the exercise of professional judgment, such an action is deemed necessary to remove that prisoner from seclusion and to prevent the prisoner from endangering himself or others.⁵¹³

Unlike the Eighth Circuit, the Arizona Supreme Court, relying on the state constitution, required a least intrusive means analysis in reviewing the state's police power authority to drug prisoners.⁵¹⁴ In determining the state's authority to medicate incompetent mental patients on either police power or *parens patriae* grounds, the Colorado Supreme Court used both state statutory and common law to mandate application of the least restrictive alternative principle.⁵¹⁵ Several other courts have applied the doctrine in treatment refusal cases based on state constitutional, statutory, and common law.⁵¹⁶

509. *Dautremont v. Broadlawns Hosp.*, 827 F.2d 291, 300 (8th Cir. 1987); *Johnson v. Silvers*, 742 F.2d 823, 825 (4th Cir. 1984); *Project Release v. Prevost*, 722 F.2d 960, 980 (2d Cir. 1983); *R.A.J. v. Miller*, 590 F. Supp. 1319, 1322 (N.D. Tex. 1984).

510. 863 F.2d 302 (4th Cir. 1988) (en banc), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990).

511. *Id.* at 312.

512. *United States v. Watson*, 893 F.2d 970, 982 (8th Cir. 1990).

513. *Id.* (citation omitted).

514. *Large v. Superior Court*, 714 P.2d 399, 408 (Ariz. 1986) (en banc).

515. *People v. Medina*, 705 P.2d 961, 974 (Colo. 1985) (en banc).

516. *In re Orr*, 531 N.E.2d 64, 73 (Ill. App. 4th Dist. 1988); *In re Mental Commitment of M.P.*, 510 N.E.2d 645, 647 (Ind. 1987); *In re Foster*, 426 N.W.2d 374, 379-80 (Iowa 1988) (dictum); *Rogers v. Commissioner of Dep't of Mental Health*, 458 N.E.2d 308, 321-22 (Mass. 1983); *Jarvis v. Levine*, 418 N.W.2d 139, 147 (Minn. 1988); *Rivers v. Katz*, 495 N.E.2d 337, 344 (N.Y. 1986). As explained *infra*, in the recent case of *Riggins v.*

VIII. PROCEDURAL DUE PROCESS

A patient's protected interests in refusing antipsychotic medication may be outweighed only by sufficiently important governmental concerns. However, the patient's rights are rendered meaningless without accompanying procedural mechanisms to establish the validity of an asserted governmental objective in a given situation. The Due Process Clauses of the Fifth and Fourteenth Amendments require that procedural safeguards be employed when balancing a constitutionally protected right against a competing governmental interest.⁵¹⁷ In addition, even if not expressly protected by the Constitution, state law can create liberty interests which are entitled to the minimum procedural protections mandated by the Due Process Clause.⁵¹⁸ Therefore, when a right to refuse treatment is conferred by state constitutional, statutory, or common law, Fourteenth Amendment procedural protections must be observed.⁵¹⁹ A state may also confer procedural protections of liberty interests that extend beyond those minimally required by the Federal Constitution.⁵²⁰

Procedural due process is a flexible concept.⁵²¹ In *Mathews v. Eldridge*,⁵²² the United States Supreme 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.⁵²³

Prior to *Washington v. Harper*,⁵²⁴ the Supreme Court did not have frequent opportunity to review the sufficiency of procedural safeguards surrounding institutional decisionmaking in the mental health context. In the cases it had examined, the mandated procedural protections varied extensively according to the particular situation. For example, in *Parham*

Nevada, 112 S. Ct. 1810, 1815 (1992), the United States Supreme Court suggested the constitutional applicability of the least restrictive alternative doctrine to drug refusal cases. See *infra* notes 878-890 and accompanying text.

517. See generally Nowak et al., *supra* note 327, at 527.

518. *Mills v. Rogers*, 457 U.S. 291, 300, 102 S. Ct. 2442, 2449 (1982); *Vitek v. Jones*, 445 U.S. 480, 488, 100 S. Ct. 1254, 1261 (1980); *Wolff v. McDonnell*, 418 U.S. 539, 557, 94 S. Ct. 2963, 2975 (1974).

519. See *Project Release v. Prevost*, 722 F.2d 960, 979 (2d Cir. 1983); Opinion of the Justices, 465 A.2d 484, 489 (N.H. 1983).

520. *Mills*, 457 U.S. at 300, 102 S. Ct. at 2449.

521. *Morrissey v. Brewer*, 408 U.S. 471, 481, 92 S. Ct. 2593, 2600 (1972).

522. 424 U.S. 319, 86 S. Ct. 893 (1976).

523. *Id.* at 335, 86 S. Ct. at 903 (citation omitted).

524. 494 U.S. 210, 110 S. Ct. 1028 (1990).

v. *J.R.*,⁵²⁵ the Court addressed the procedural mechanisms necessary to protect a minor's liberty interests upon a parental or guardian request for commitment. In applying the balancing formula previously announced in *Mathews* to the facts of *Parham*, the Court authorized the use of minimal informal procedures as sufficient under the Due Process Clause. These procedures consisted merely of a properly filed application followed by staff examination, observation, and periodic review.⁵²⁶

In *Vitek v. Jones*,⁵²⁷ the Supreme Court held that a convicted prisoner retains a residuum of liberty which is implicated by transfer to a mental hospital for mandatory behavior modification treatment.⁵²⁸ The Court found that the stigma associated with being labeled mentally ill and the threat to personal security presented by the compelled treatment gave rise to this liberty interest.⁵²⁹ The Court held that the Due Process Clause requires procedural safeguards including an adversarial hearing before an independent institutional decisionmaker (as opposed to a judge).⁵³⁰

In 1982, the Supreme Court decided *Youngberg v. Romeo*⁵³¹ and addressed the rights of a profoundly retarded, institutionalized individual to freedom from bodily restraint, safe conditions, and minimal treatment. *Youngberg* was to have a substantial impact on subsequent drug refusal cases. As described earlier, the Court in *Youngberg* announced the professional judgment standard as striking the proper constitutional balance between the competing personal and state interests at issue in the case.⁵³² Under *Youngberg's* influence, a number of courts have applied the professional judgment standard, in varying degrees, to drug refusal cases. Several of these courts have authorized an in-house or independent professional review procedural system for treatment refusals. A few courts have gone further, displaying a virtually unqualified deference to professional decisionmaking. Other courts have rejected the applicability of *Youngberg's* professional judgment standard to drug refusal cases. These courts have adopted a more protective due process procedural model for reviewing a patient's refusal of antipsychotic drugs.

525. 442 U.S. 584, 99 S. Ct. 2493 (1979).

526. *Id.* at 614-17, 99 S. Ct. at 2510-11.

527. 445 U.S. 480, 100 S. Ct. 1254 (1980).

528. *Id.* at 493-94, 100 S. Ct. at 1263-64.

529. *Id.* at 492, 100 S. Ct. at 1263.

530. *Id.* at 494-95, 100 S. Ct. at 1264-65. The Court also required written notice; disclosure of the evidence on which the state is relying; the opportunity to be heard and present documentary evidence; the right to present witnesses and cross-examine except upon finding of good cause for not permitting such presentation and confrontation; a written opinion by the factfinder; availability of legal counsel, furnished by the state to indigent prisoners who are unable to understand or exercise their rights; and "effective and timely" notice of the foregoing rights. *Id.* at 494-97, 100 S. Ct. at 1264-66.

531. 457 U.S. 307, 102 S. Ct. 2452 (1982).

532. See *supra* notes 485-490 and accompanying text.

A. Professional Review Models

In *Rennie v. Klein*,⁵³³ the district court examined the New Jersey administrative regulations governing medication refusals by hospitalized patients. Procedurally, the regulations provided for a three-step, in-house review of treatment refusals. The attending physician must first disclose treatment information to the patient. If the patient continues to refuse, the treatment team meets (with the patient present if his condition permits). If the treatment team does not resolve the issue, the facility's medical director or his designee must personally examine the patient and review the patient's records. The assistance of an independent psychiatrist is optional. The medical director then has the authority to authorize forced medication.⁵³⁴

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."⁵³⁵ The court required the implementation of a number of procedural safeguards including an informal adversarial hearing before an independent psychiatrist appointed by the Commissioner of Mental Health.⁵³⁶ An authorization of forced medication was limited to sixty days.⁵³⁷

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.⁵³⁸ In applying the considerations announced in *Mathews*, 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."⁵³⁹ Central to the Third Circuit's reasoning was its characterization of the decisions necessary in a forced medication determination as "medical" in nature.⁵⁴⁰ Accordingly, the court believed that the adversary hearing envisioned by the district court was "ill-suited" to these types of decisions.⁵⁴¹

533. 476 F. Supp. 1294 (D.N.J.), *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), *vacated*, 458 U.S. 1119, 102 S. Ct. 3506 (1982).

534. *Id.* at 1303.

535. *Id.* at 1310.

536. *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.

537. *Id.* at 1315.

538. *Rennie v. Klein*, 653 F.2d 836, 851 (3d Cir. 1981), *vacated*, 458 U.S. 1119, 102 S. Ct. 3506 (1982).

539. *Id.* at 850.

540. *Id.*

541. *Id.*

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.⁵⁴² 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."⁵⁴³ 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."⁵⁴⁴

In *R.A.J. v. Miller*,⁵⁴⁵ a federal district court in Texas approved a two-tiered, in-house, non-adversarial review process for medication refusals in non-emergency situations. Although the procedures included an incompetency determination by the clinical director, patients found competent could, nonetheless, be forcibly medicated after a third-level review of the decision by an independent psychiatrist. The court indicated that involuntary commitment sufficiently extinguishes a competent patient's interest in refusing medication for treatment purposes.⁵⁴⁶

Relying on the Supreme Court decisions in both *Parham* and *Youngberg*, the Second Circuit has allowed ultimate authority to rest with state officials exercising professional judgment in deciding whether to forcibly medicate even competent patients on either *parens patriae* or police power grounds.⁵⁴⁷ The court, however, stated that "[w]hile we are aware that deference must be accorded medical judgment in such matters, . . . we are also mindful that '[t]he medical nature of the inquiry . . . does not justify dispensing with due process requirements.'" ⁵⁴⁸ The court held that "due process requires an opportunity for hearing and review of a decision to administer antipsychotic medication—but such a hearing need not be judicial in nature."⁵⁴⁹ The Second Circuit upheld a New York three-tiered administrative review procedure in which patients were permitted to be represented by legal counsel as sufficient under due process. However, this case was undercut

542. *Id.* (quoting *Parham v. J.R.*, 442 U.S. 584, 607, 97 S. Ct. 2493, 2507 (1979)).

543. *Id.* at 851 (citing *Parham*, 442 U.S. at 610, 99 S. Ct. at 2508).

544. *Id.*

545. 590 F. Supp. 1319 (N.D. Tex. 1984).

546. *Id.* at 1322-23.

547. *Project Release v. Prevost*, 722 F.2d 960, 971 (2d Cir. 1983).

548. *Id.* at 979 (citations omitted) (quoting *Vitek v. Jones*, 445 U.S. 480, 495-96, 100 S. Ct. 1254, 1265 (1980)).

549. *Id.* at 981.

by a subsequent state court decision which adopted an approach more protective of patient interests.⁵⁵⁰

The United States District Court for the District of Columbia applied a more limited version of the professional judgment standard to drug refusal cases. In *United States v. Leatherman*,⁵⁵¹ the court strongly implied that competent patients have an absolute right to refuse antipsychotic drugs proposed for treatment purposes.⁵⁵² The court, however, held that judicial determinations of incompetency are unnecessary because "[t]o require the courts to pass on such issues would embroil them in a never-ending controversy concerning medical judgments for which courts have neither the institutional resources nor the necessary expertise."⁵⁵³ Relying on *Youngberg*, the court affirmed the hospital's internal administrative review procedures for determining incompetency and the necessity of forced medication for those patients found incompetent—which included consideration of available alternative treatment options—as sufficient under due process requirements.⁵⁵⁴

Likewise, the New Hampshire Supreme Court found that although a finding of incompetency is necessary before the state may exercise its *parens patriae* authority to compel drug therapy, a judicial determination on this matter is not necessary to satisfy due process requirements.⁵⁵⁵ The court held that before medication could be forcibly administered on police power grounds, a true emergency must exist as determined by more than one physician.⁵⁵⁶

B. Unqualified Deference to Professional Judgment

Relying heavily on the Supreme Court decisions in *Parham* and *Youngberg*, a few courts have gone as far as abrogating a patient's right to even an in-house review of a nonconsensual medication decision if made with professional judgment. In *Dautremont v. Broadlawns Hospital*,⁵⁵⁷ the Eighth Circuit held that committed patients can be forcibly medicated on either police power or *parens patriae* grounds by treating physicians exercising professional judgment.⁵⁵⁸ The court made no dis-

550. *Rivers v. Katz*, 495 N.E.2d 337 (N.Y. 1986) (see *infra* notes 608-611 and accompanying text).

551. 580 F. Supp. 977 (D.D.C. 1983).

552. *Id.* at 979.

553. *Id.*

554. *Id.* at 980.

555. Opinion of the Justices, 465 A.2d 484, 490 (N.H. 1983). See also *In re Bryant*, No. 1428-85 (D.C. Super. Ct., Fam. Div., Oct. 13, 1986) (dicta indicating a preference for nonjudicial determinations of incompetency).

556. Opinion of the Justices, 465 A.2d at 489-90.

557. 827 F.2d 291 (8th Cir. 1987).

558. *Id.* at 300.

inction between competent and incompetent patients.⁵⁵⁹ Moreover, the Eighth Circuit required no procedures, in-house or otherwise, to assure the integrity of the medical decisionmaking process. In arriving at its conclusion, the court emphasized that according to *Youngberg*, freedom from bodily restraint (and therefore, arguably, mental restraint) is “protected by the Due Process Clause from *arbitrary governmental action*.”⁵⁶⁰ An evaluating court’s standard of review is merely to ensure that a treatment decision has not deviated from accepted professional standards to such an extent that it can only be described as arbitrarily made.⁵⁶¹ The Eighth Circuit stated that the decisions to forcibly medicate in this case were not arbitrary because they were “made by professionals exercising their professional judgment” in an attempt to meet “the government’s legitimate objective to return [the patient’s] behavior to that which is acceptable to society.”⁵⁶²

In 1984, the Fourth Circuit addressed the right of an involuntarily committed mental patient to refuse antipsychotic drugs. In *Johnson v. Silvers*,⁵⁶³ the Fourth Circuit focused on the liberty interest in freedom from physical restraint recognized by the Supreme Court in *Youngberg* and held that “the forcible administration of antipsychotic drugs presents a sufficiently analogous intrusion upon bodily security to give rise to such a protectable interest.”⁵⁶⁴ The court relied on *Youngberg*’s professional judgment standard in allowing treating physicians to retain discretion to medicate patients on an involuntary basis.⁵⁶⁵

However, only three years later the Fourth Circuit turned full circle in adopting a very protective due process procedural model for reviewing

559. The Eighth Circuit believed that the petitioner, Dautremont, was competent. Dautremont argued that certain of his claims were not barred by the statute of limitations due to Iowa’s tolling statute. That statute extends the limitation periods in favor of mentally ill individuals for one year after their disability terminates. The court held the tolling statute inapplicable, reasoning that although Dautremont was mentally ill he was nonetheless cognizant of his legal rights. *Id.* at 296. The court supported its holding by citing Iowa legislation, Iowa Code Ann. § 229.27 (West 1985), which explicitly stated that involuntary hospitalization is not to be equated with, nor does it raise a presumption of, incompetency for any purpose. *Id.*

560. *Id.* at 300 (court’s emphasis) (quoting *Youngberg v. Romeo*, 457 U.S. 307, 316, 102 S. Ct. 2452, 2458 (1982)).

561. See *Youngberg*, 457 U.S. at 323, 102 S. Ct. at 2462.

562. *Dautremont*, 827 F.2d at 300. See also *Stensvad v. Reivitz*, 601 F. Supp. 128, 130-31 (W.D. Wis. 1985), where the United States District Court for the Western District of Wisconsin took the unprecedented step of holding that involuntary commitment itself justifies nonconsensual treatment decisions if made with professional judgment. *Id.* at 130-31. This ruling, however, was stripped of precedential effect by a subsequent state court holding. See *infra* note 619 and accompanying text.

563. 742 F.2d 823 (4th Cir. 1984).

564. *Id.* at 825.

565. *Id.*

medication refusals. In the panel decision of *Charters I*,⁵⁶⁶ the Fourth Circuit shifted its focus from the interest in freedom from physical restraint to the interests in privacy and free expression as sources for a federal pretrial detainee's right to refuse antipsychotic drugs.⁵⁶⁷ The court authorized forced medication on police power grounds only in emergency situations where "it is determined that, without medication, a patient presents an immediate threat of violence that cannot be avoided through the use of less restrictive alternatives."⁵⁶⁸

The Fourth Circuit adopted the modern scientific view that competency is situation-specific and thereby refused to equate a finding of incompetency to stand trial with incapacity to make treatment decisions.⁵⁶⁹ The court held that absent a prior judicial determination of incompetency to make treatment decisions, an involuntarily confined individual retains an absolute right to refuse antipsychotic medication proposed for treatment purposes.⁵⁷⁰ The Fourth Circuit rejected the argument that the government's interest in ensuring that the defendant regains competency to stand trial is sufficient to justify forced drug therapy. The court stated that "[a]lthough we do not intend to downplay the importance of the government's obvious interest in resolving the guilt or innocence of a particular defendant, the interest does not permit such a draconian invasion of the individual's freedom and the risk of permanent physical injury."⁵⁷¹

The Fourth Circuit held that for patients who are adjudicated incompetent, the court is the appropriate body to determine the necessity of compelled medication.⁵⁷² The court expressly rejected the professional judgment standard and reasoned:

The decision here, whether to hazard the substantial risks of a course of antipsychotic medication, is an individual decision, not normally delegated to professionals. Furthermore, the use of antipsychotic medication may present a substantial conflict of interest for institutional professionals because, quite apart from its therapeutic benefits, the medication serves the institutional goals of maintaining control and ameliorating staffing costs.⁵⁷³

566. *United States v. Charters*, 829 F.2d 479 (4th Cir. 1987), *modified*, 863 F.2d 302 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990).

567. *Id.* at 491-92.

568. *Id.* at 493.

569. *Id.* at 495.

570. *Id.*

571. *Id.* at 494. The court also expressed concern that the side effects of antipsychotic drugs may mislead the jury concerning the defendant's mental state or may make the defendant apathetic and unable to assist his attorney in the defense. *Id.*

572. *Id.* at 498-99.

573. *Id.* at 497.

In making the medication determination, the authorizing court is to be guided by the substituted judgment standard, at least to the extent that it is "possible clearly to ascertain what a patient would have done if he were competent."⁵⁷⁴ This approach, reasoned the Fourth Circuit, avoids depriving "the incompetent patient of rights which are afforded competent patients, by ignoring their uniqueness and imposing upon them the views of a hypothetical majority or 'reasonable man.'"⁵⁷⁵ However, when clear evidence of intent is lacking, the court should decide on the basis of the patient's best interests.⁵⁷⁶

As described earlier, the Fourth Circuit distinguished *Youngberg* by noting that the Supreme Court did not address the interests of competent patients. In addition, the Court did not have occasion to consider the serious side effects posed by antipsychotic medication and the drugs' potential to infringe upon first amendment values.⁵⁷⁷ The Fourth Circuit also found the situation in *Youngberg* to be an emergency because the patient's history unmistakably indicated the need to take some action to prevent further physical injury to the patient and perhaps to others. Thus, as when the government exercises its police power authority in an emergency situation, deference to professional judgment was more appropriate, especially when the preventive measure employed posed no threat of permanent injury.⁵⁷⁸

Approximately fourteen months later, the Fourth Circuit once again reversed its position on the scope of a patient's right to refuse medication. In *Charters II*,⁵⁷⁹ the court (sitting en banc) essentially overruled its decision in *Charters I* and returned to an approach of unqualified deference to professional judgment. The Fourth Circuit began its opinion in *Charters II* by recognizing that legally confined individuals retain significant constitutionally protected interests.⁵⁸⁰ Citing its earlier decision in *Johnson v. Silvers*, the court again relied on the liberty interest in freedom from restraint as a source for the right to refuse and ignored the privacy and first amendment interests identified in *Charters I*.⁵⁸¹ In evaluating the sufficiency of countervailing governmental objectives, the court stated that the protected interests retained by legally confined individuals "must yield to the legitimate governmental interests that are incidental to the basis for legal institutionalization."⁵⁸² In determining

574. *Id.* at 498.

575. *Id.* at 497.

576. *Id.* at 498.

577. See *supra* notes 503-506 and accompanying text.

578. *Charters I*, 829 F.2d at 489.

579. *United States v. Charters*, 863 F.2d 302 (4th Cir. 1988) (en banc), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990).

580. *Id.* at 305.

581. *Id.* at 305-06.

582. *Id.* at 305.

which such governmental interests are legitimate, the court held that the protected rights retained by involuntarily confined individuals "are only afforded protection against arbitrary and capricious government action."⁵⁸³

The Fourth Circuit then shifted to a procedural due process analysis to determine the mechanisms necessary to protect the individual substantive interests from arbitrary and capricious government action. The court looked to the considerations enunciated by the Supreme Court in *Mathews* to determine the procedures due in this particular situation.⁵⁸⁴ Referring to the "mind-altering" quality of the proposed treatment" and "the risk of possibly drastic mental and physical side effects," the court considered the private interest at stake as "sensitive."⁵⁸⁵

The Fourth Circuit next inquired into whether the government's current process of placing responsibility for compelled medication decisions in the institution's medical personnel was sufficient protection against the risk of erroneous deprivation of the private interest. The court quoted from the Supreme Court's opinion in *Parham*, stating that "it has long been recognized that '[w]hat process is constitutionally due cannot be divorced from the nature of the ultimate decision that is being made.'"⁵⁸⁶ Like the Third Circuit in *Rennie*, the Fourth Circuit characterized the determinations necessary in a forced medication decision as "medical" in nature.⁵⁸⁷ For example, the court viewed the potential for side effects and the patient's capacity to make rational treatment decisions as mere factors "in the ultimate [best interests] medical decision to administer the medication involuntarily."⁵⁸⁸ Having characterized such determinations as "medical," the court relied on both *Parham* and *Youngberg* in holding that the committing of these decisions to the government's professionals, subject to judicial review for arbitrariness, satisfies due process requirements.⁵⁸⁹ The Fourth Circuit relied on *Parham* in reasoning that "while medical and psychiatric diagnosis obviously was fallible," because the questions involved are medical and psychiatric in nature, "there was no reason to suppose that it was more so than would be the comparable diagnosis of a judge or hearing officer."⁵⁹⁰ The role of the court, therefore, is merely to guarantee professional judgment was exercised in the base-line decisionmaking prior to deprivation.⁵⁹¹

583. *Id.*

584. *Id.* at 306-07.

585. *Id.* at 307.

586. *Id.* at 308 (quoting *Parham v. J.R.*, 442 U.S. 584, 608, 99 S. Ct. 2493, 2507 (1979)).

587. *Id.*

588. *Id.* at 311-12.

589. *Id.* at 307-08.

590. *Id.* at 308.

591. *Id.* at 309.

The court criticized the adjudicatory regime envisioned in *Charters I* as installing "the federal courts as the base-line providers of procedural due process, collapsing their normal review function into this threshold function."⁵⁹² Thus, "[d]istrict judges would thereby be cast in the role of making the primary decisions on purely medical and psychiatric questions, rather than reviewers of such decisions made by qualified professionals."⁵⁹³ The court also believed that the proposed adjudicative system would impose heavy burdens on the government in efforts to discharge its duties as a "benign custodian of one legally committed to it for medical care and treatment."⁵⁹⁴ The Fourth Circuit thus held that adequate due process protection is found, first, "in the general professional competence and integrity of the government's medical personnel, and second, in the availability of judicial review to guard against arbitrariness in making particular decisions."⁵⁹⁵

In addressing how the government's current regime should be properly administered, the Fourth Circuit again relied on *Parham* and stated: "Making an acceptable professional judgment of the sort here in issue does not require any internal adversarial hearing. The decision may be based upon accepted medical practices in diagnosis, treatment, and prognosis, with the aid of such technical tools and consultative techniques as are appropriate in the profession."⁵⁹⁶

In accentuating the limited scope of judicial review, the Fourth Circuit cited *Youngberg* and stated that only one question is relevant: "[W]as this decision reached by a process so completely out of professional bounds as to make it explicable only as an arbitrary, nonprofessional one?"⁵⁹⁷

592. *Id.*

593. *Id.*

594. *Id.* at 312.

595. *Id.* at 307-08.

596. *Id.* at 312 (citation omitted). Later, the court seemingly contradicted itself by stating that "under the approved regime such a decision is of a piece with other pre-deprivation governmental decisions such as those leading to job or social benefit terminations, prison transfers, disciplinary sanctions and the like." *Id.* at 314. However, many such determinations have been held to require procedural safeguards, often including an adversarial hearing before an impartial decisionmaker, which go far beyond those mandated by the Fourth Circuit's interpretation of the professional judgment standard. See, e.g., *Vitek v. Jones*, 445 U.S. 480, 100 S. Ct. 1254 (1980) (the determination to transfer a prisoner to a mental health facility requires an adversarial hearing before an impartial decisionmaker); *Morrissey v. Brewer*, 408 U.S. 471, 92 S. Ct. 2593 (1972) (requiring procedural safeguards, including an adversarial hearing before a neutral and detached hearing body, for parole revocation); *Goldberg v. Kelly*, 397 U.S. 254, 90 S. Ct. 1011 (1970) (a decision to terminate Aid to Families with Dependent Children benefits requires procedural safeguards, including an adversarial hearing before an impartial decisionmaker).

597. *Charters II*, 863 F.2d at 313.

C. Due Process Models

As illustrated by the above case law, the Supreme Court's deference to institutional professional decisionmaking displayed in such cases as *Parham* and *Youngberg* has persuaded several courts to apply the professional judgment standard to drug refusal cases. Other courts have rejected the professional judgment standard as insufficient under due process requirements. These courts have stressed the different interests and types of determinations that are involved when an individual refuses antipsychotic drugs.

In *Bee v. Greaves*,⁵⁹⁸ the Tenth Circuit rejected the professional judgment standard in holding that a non-dangerous detainee, who had not been determined incompetent to make treatment decisions by a court of law, retained the absolute right to refuse antipsychotic drugs.⁵⁹⁹ The Oklahoma Supreme Court reached a similar decision in a case involving an involuntarily hospitalized patient.⁶⁰⁰ The court stated that because "competency is not a medical decision," a separate judicial determination is necessary.⁶⁰¹ For those patients adjudicated incompetent, the court required an appointment of a guardian to make the treatment decision. It was suggested that the guardian be governed by the substituted judgment standard.⁶⁰²

598. 744 F.2d 1387 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214, 105 S. Ct. 1187 (1985). The court held that jailed pretrial detainees retain a constitutional right to refuse antipsychotic drugs. *Id.* at 1394. As described earlier, the Tenth Circuit distinguished *Youngberg* on the grounds that "it involved temporary physical restraints rather than mental restraints with potentially long term effects, and because [the patient] had been certified as severely retarded and unable to care for himself." *Id.* at 1396 n.7 (citations omitted). Rather than relying on the liberty interest in freedom from physical restraint, the court pointed to the privacy interest in making fundamental personal decisions, the liberty interest in personal security and the First Amendment interest in producing and communicating ideas. *Id.* at 1392-94.

599. *Id.* at 1395. The government's contention that it was entitled to forcibly medicate the appellant in order to maintain his competency for trial was rejected. The court pointed out that the detainee had not been found incompetent, and suggested that because of the potentially dangerous side effects of drugs, the governmental interest in bringing an accused to trial is not sufficiently compelling to outweigh the individual interest in refusing. *Id.* As described earlier, the Tenth Circuit left police power authority to medicate within the discretion of governmental authorities exercising professional judgment. *See supra* notes 359-364 and accompanying text.

600. *In re K.K.B.*, 609 P.2d 747 (Okla. 1980). The court equated antipsychotic drugs with such intrusive therapies as psychosurgery and electroshock and relied on the federal constitutional right to privacy as a source for the right to refuse. *Id.* at 749-50. Absent a police power emergency, it was held that competent patients have an absolute right to refuse medication. *Id.* at 750.

601. *Id.* at 749-50.

602. *Id.* at 751-52 & n.16.

In *Rogers v. Commissioner of Department of Mental Health*,⁶⁰³ the Massachusetts Supreme Judicial Court required a judicial determination of incompetency before the state could forcibly administer medication on *parens patriae* grounds. For patients adjudicated incompetent, the court, as opposed to state professionals, is to make the treatment decision based on a substituted judgment standard.⁶⁰⁴ Only when medication is necessary to prevent the "immediate, substantial, and irreversible deterioration of a serious mental illness" can it be forcibly administered for a limited time without a prior adjudication of incompetency.⁶⁰⁵

Relying on the federal and state constitutional interest in privacy, as well as state statutory law, a South Dakota court held that competent mental patients have an absolute right to refuse antipsychotic drugs in non-emergency situations.⁶⁰⁶ The court expressly rejected the professional judgment standard, stating that an adversarial judicial hearing "wherein 'professional judgment' testimony can be weighed with other testimony is a better method of determining both competency and necessity of use of antipsychotic drugs."⁶⁰⁷

In *Rivers v. Katz*,⁶⁰⁸ 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*⁶⁰⁹ were inadequate to protect the privacy interests of committed mental patients.⁶¹⁰ The court mandated a finding of incompetency before a patient could be medicated against his will for treatment purposes because "[o]therwise, 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."⁶¹¹ An adjudication of incompetency was required because "[s]uch a determination is uniquely a judicial, not a medical function."⁶¹² For patients adjudicated incompetent, the court is

603. 458 N.E.2d 308 (Mass. 1983). The court relied on state statutory and common law in defining the scope of a committed mental patient's right to refuse drugs. Absent a police power emergency requiring immediate intervention, a competent patient has the absolute right to refuse drug treatment. *Id.* at 321-22.

604. *Id.* at 314-15.

605. *Id.* at 322 (quoting *In re Guardianship of Roe*, 421 N.E.2d 40, 55 (Mass. 1981)).

606. *Henderson v. Yocom*, No. 7948A mem. op. at 8-11 (S.D. 1st Cir. 1987), *aff'd*, 438 N.W.2d 225 (S.D. 1989) (table opinion).

607. *Id.* at 12.

608. 495 N.E.2d 337 (N.Y. 1986).

609. 722 F.2d 960 (2d Cir. 1983).

610. *Id.* at 341.

611. *Id.* at 343 (quoting *Rogers v. Okin*, 634 F.2d 650, 657 (1st Cir. 1980)) (citation omitted). The court limited nonconsensual medication on police power grounds to emergency situations. *Id.*

612. *Id.* (citations omitted).

to make the forced medication determination by considering all relevant circumstances.⁶¹³

The Wisconsin Supreme Court avoided the *Youngberg* decision by relying on the federal and state constitutional guarantee of equal protection in holding that involuntarily committed individuals who have not been adjudicated incompetent have an absolute right to refuse unless antipsychotic drugs are required to prevent serious physical harm to the patient or others.⁶¹⁴ The court required an adversarial judicial hearing to determine incompetency "in order to avoid having individuals routinely declared incompetent for the sake of mere convenience, control, or expense."⁶¹⁵ If the individual is determined incompetent, court authorization is needed before medication can be forcibly administered.⁶¹⁶ While noting that the judgment of treating physicians is valuable in assisting in the incompetency determination, the court rejected the professional judgment standard.⁶¹⁷ The court reasoned that "[c]onstitutional guarantees may not be replaced by professional judgment, and their protection and enforcement cannot be considered to be judicial interference."⁶¹⁸ This ruling nullified a previous holding by a federal district court which had adopted an unqualified professional judgment approach.⁶¹⁹

The Minnesota Supreme Court distinguished *Youngberg* by noting that unlike many mentally ill individuals, the patient in that case was incompetent. The court stressed the intrusiveness of antipsychotic drugs⁶²⁰ and criticized the applicability of the professional judgment standard to drug refusal cases as being insufficient to protect the basic human right of privacy as recognized by the Minnesota Constitution.⁶²¹ Absent an emergency, the court required a judicial hearing on the issues of incompetency and the appropriateness of nonconsensual medication for patients adjudicated incompetent.⁶²²

Several other courts have issued similar opinions rejecting the professional judgment standard.⁶²³ The Colorado Supreme Court relied on

613. *Id.* at 344. The relevant circumstances include: the patient's best interests; the benefits to be gained from treatment; the adverse side effects associated with the treatment; and, any less intrusive alternative treatments.

614. *State ex rel. Jones v. Gerhardstein*, 416 N.W.2d 883, 894-95 (Wis. 1987).

615. *Id.* at 898.

616. *Id.*

617. *Id.* at 895-96.

618. *Id.* at 896.

619. *Stensvad v. Reivitz*, 601 F. Supp. 128 (W.D. Wis. 1985). *See supra* note 562.

620. *Jarvis v. Levine*, 418 N.W.2d 139, 147-48 (Minn. 1988).

621. *Id.*

622. *Id.* at 147-48 & n.7.

623. *See, e.g., In re Orr*, 531 N.E.2d 64, 73 (Ill. App. 4th Dist. 1988); *Goedecke v. State Dep't of Insts.*, 603 P.2d 123, 125 (Colo. 1979) (en banc).

state statutory and common law in requiring an adjudication of incompetency and court authorization before drugs can be forcibly administered for treatment purposes.⁶²⁴ A California appellate court also relied on state law in reaching a similar decision.⁶²⁵ For a patient adjudicated incompetent, medication may be authorized by the court for up to fourteen days. Thereafter, permission must be granted by an appointed surrogate exercising a substituted judgment.⁶²⁶

IX. THE MISAPPLICATION OF THE PROFESSIONAL JUDGMENT STANDARD TO DRUG REFUSAL CASES

As illustrated in the prior section, the Supreme Court's deference to institutional professional decisionmaking displayed in *Parham* and *Youngberg* has persuaded several courts to apply the professional judgment standard, in varying degrees, to drug refusal cases. Other courts have rejected the professional judgment standard as insufficient under procedural due process requirements. These courts have emphasized the different interests and types of determinations that are involved when an individual refuses antipsychotic drugs. In analyzing the application of the professional judgment standard under the procedural considerations announced by the Supreme Court in *Mathews*, the latter approach appears most persuasive.

A. *The Private Interests Affected by the Government Action*

In *Youngberg*, the Supreme Court began its analysis by recognizing that a profoundly retarded institutionalized patient retains liberty interests in safety and freedom from physical restraint protected by the Due Process Clause of the Fourteenth Amendment.⁶²⁷ Noting that constitutional rights are not absolute, the Court balanced the asserted liberty interests against the state's reasons for infringement.⁶²⁸ The Court noted that the private interests at stake were to some extent in conflict, as physical restraint was necessary to assure the respondent's safety.⁶²⁹ In addition, the type of restraint was mild, posing little threat of injury.

624. *People v. Medina*, 705 P.2d 961, 973 (Colo. 1985) (en banc).

625. *Riese v. St. Mary's Hosp. & Medical Ctr.*, 243 Cal. Rptr. 241 (Cal. App. 1st Dist. 1987), *opinion superseded*, 751 P.2d 893 (Cal. 1988), *dismissed*, 774 P.2d 698 (Cal. 1989). See also *Keyhea v. Rushen*, 223 Cal. Rptr. 747, 754-55 (Cal. App. 1st Dist. 1986).

626. *Riese*, 243 Cal. Rptr. at 254.

627. *Youngberg v. Romeo*, 457 U.S. 307, 315-16, 102 S. Ct. 2452, 2458 (1982).

628. *Id.* at 319-20, 102 S. Ct. at 2460. As explained earlier, a government encroachment on interests of this nature must, at a minimum, be reasonably related to legitimate government objectives. However, as the intrusiveness of the government action rises, the sufficiency of its justification must also increase.

629. *Id.* at 320, 102 S. Ct. at 2460.

In light of the nature of the individual interest at issue and the level of intrusiveness presented, the Court concluded that the restrictions should be upheld upon the minimal showing of a reasonable relation to legitimate objectives.⁶³⁰ The Court then provided guidance to reviewing courts by articulating the professional judgment standard as a method of determining whether the government's showing is sufficient.

Courts extending the professional judgment standard to drug refusal cases have analogized the bodily restraints at issue in *Youngberg* to the intrusion presented by the forced administration of antipsychotic drugs. However, as demonstrated by such courts as the Tenth Circuit in *Bee v. Greaves* and the Fourth Circuit panel in *Charters I*, the protected interests at stake in *Youngberg* are distinguishable.

Youngberg involved the use of soft arm restraints for short periods of time.⁶³¹ While these physical restraints are certainly a restriction on liberty, they arguably served only the respondent's best interest by protecting him from his own violence and that of other patients.⁶³² The effects of physical restraints are predictable and can be easily identified and monitored. Soft arm restraints pose little risk of injury, and the restriction on liberty ceases once they are removed. The intrusion presented by the forced administration of antipsychotic drugs is not comparable to temporary physical restraints. Physicians cannot predict the adverse effects drugs may have on a patient.⁶³³ Indeed, as described earlier, many side effects may remain undetected during drug treatment.⁶³⁴ Antipsychotic drugs also pose a threat of serious harm—harm which, as evidenced by tardive dyskinesia and neuroleptic malignant syndrome, may be irreversible and sometimes fatal. Other adverse effects, although reversible, may afflict the patient for months after termination of drug therapy. Thus, antipsychotic drugs are much more intrusive than temporary physical restraints, encroaching upon bodily integrity and personal security to a far greater degree.

In analogizing to the protected interests recognized in *Youngberg*, courts applying the professional judgment standard have ignored the possible First Amendment implications posed by the forced administration of antipsychotic drugs. As addressed earlier, unlike the temporary physical restraints at issue in *Youngberg*, drug side effects may adversely impact upon a patient's otherwise normal thought processes.⁶³⁵ As the Fourth Circuit panel in *Charters I* noted, even if a patient's mental

630. *Id.* at 320-22, 102 S. Ct. at 2460-62.

631. *Id.* at 310, 311 n.8, 102 S. Ct. at 2455, 2456 n.8.

632. *Id.* at 324, 102 S. Ct. at 2462.

633. Goodman & Gilman, *supra* note 68, at 172-74; Hollister, *supra* note 29, at 30-32; Plotkin, *supra* note 4, at 474-75.

634. See *supra* text accompanying notes 73-167.

635. See *supra* text accompanying notes 216-277.

disorder renders him incapable of making rational treatment decisions, he may, nonetheless, be capable of engaging in other activities protected by the First Amendment. These capabilities, however, may be drastically diminished by drug side effects.⁶³⁶ The Fourth Circuit concluded that "[i]n short, the decision in the present case may profoundly impact an interest at the core of liberty—the protection of the thought processes that define individuality—an interest which was not at issue in *Romeo*."⁶³⁷ Courts relying on the Supreme Court's reasoning in *Youngberg* have also failed to confront the possibility that forced medication will implicate the fundamental privacy interest in personal decisionmaking. Many mentally ill individuals retain the capacity to make rational treatment decisions. The respondent in *Youngberg*, however, was profoundly retarded and certified incapable of contributing to his own treatment decisions. Thus, the Supreme Court in *Youngberg* did not address the protected interest in treatment decisionmaking retained by competent individuals.⁶³⁸

The private interests affected by the forced administration of antipsychotic drugs are not analogous to the liberty interest in freedom from physical restraint which served as the basis for the Supreme Court's analysis in *Youngberg*. The Supreme Court's decision in *Parham v. J.R.* is distinguishable on the same grounds. The private interest affected in a commitment proceeding is the same interest at issue in *Youngberg*, freedom from unreasonable bodily restraint.⁶³⁹ A decision to commit, although a "massive curtailment of liberty,"⁶⁴⁰ does not implicate the same fundamental interests involved in a decision to compel treatment with medication posing potentially serious and harmful side effects.

In addition, as in *Youngberg*, the Supreme Court in *Parham* did not address the rights of a competent patient but rather the interests of a minor, one considered *de jure* incompetent. Moreover, the Court stressed that the minor's liberty interest is "inextricably linked with the parents' interest in and obligation for the welfare and health of the child, [thus] the private interest at stake is a combination of the child's

636. *United States v. Charters*, 829 F.2d 479, 489 (4th Cir. 1987), *modified*, 863 F.2d 302 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990).

637. *Id.* The court's cite is to *Youngberg v. Romeo*, 457 U.S. 307, 102 S. Ct. 2452 (1982).

638. As explained earlier, the Supreme Court appears to prefer characterizing a competent patient's right to refuse medical treatment as a liberty interest rather than as an aspect of the right to privacy. See *supra* notes 301-304, 331-334 and accompanying text. However, as the Supreme Court conceded, a state court may base the right to refuse on the privacy interest in personal decisionmaking found in the state constitution. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2851 (1990).

639. *Parham v. J.R.*, 442 U.S. 584, 601, 99 S. Ct. 2493, 2504 (1979).

640. *Humphrey v. Cady*, 405 U.S. 504, 509, 92 S. Ct. 1048, 1052 (1972).

and parents' concerns."⁶⁴¹ The Court held that the child's individual interest in remaining free from commitment is substantially diminished by the parents' interest in retaining authority to make decisions on what is in the child's best interest.⁶⁴² The Court also emphasized the "traditional presumption that the parents act in the best interests of their child" as offering additional protection for the child.⁶⁴³

Nonconsensual drug therapy poses not only a far greater infringement of constitutionally protected interests than does physical restraint, but the interests threatened are of a more varied and important nature. Therefore, the balancing of individual and governmental interests should be quite different. The rational basis standard applied in both *Youngberg* and *Parham*, with its resulting deference to professional decisionmaking, is a grossly inadequate standard for protecting the important interest retained by institutionalized mental patients in refusing antipsychotic drugs.

The grounds on which *Youngberg* and *Parham* have been distinguished would also appear to support the application of the higher standard of constitutional protection represented by the least restrictive alternative doctrine to drug refusal cases.⁶⁴⁴ At a minimum, it would seem that when an intrusive treatment is at issue, contemporary medical standards would require a weighing of the costs and benefits and consideration of less intrusive therapies in order that the ultimate judgment be professionally acceptable.⁶⁴⁵ A strict application of the least restrictive alternative doctrine would require that a reviewing court, after consideration of all the evidence, assure that the correct professional choice—striking the proper balance between efficacy and intrusiveness—is implemented.⁶⁴⁶ This may, however, constitute the type of judicial intervention which the Supreme Court criticized in *Youngberg* when it expressed

641. *Parham*, 442 U.S. at 600, 99 S. Ct. at 2503.

642. *Id.* at 604, 99 S. Ct. at 2505.

643. *Id.*, 99 S. Ct. at 2505.

644. See generally Winick, *supra* note 210, at 20-21. Professor Winick believes that the Supreme Court's decision in *Winston v. Lee*, 470 U.S. 753, 105 S. Ct. 1611 (1985), indicates that the least restrictive alternative doctrine has survived *Youngberg*, at least in cases involving intrusions more serious than the use of physical restraints. Winick, *supra* note 210, at 21. In *Winston*, the state sought compelled surgery to remove a bullet from a suspect's body for evidentiary purposes. The Court held that due to the highly intrusive nature of the procedure and its uncertain risks, the state interest was insufficient to override the respondent's privacy interests given the existence of additional evidence available to the state. *Winston*, 470 U.S. at 766, 105 S. Ct. at 1619-20. As explained *infra*, the Supreme Court has recently suggested the constitutional applicability of the least restrictive alternative doctrine to drug refusal cases. See *infra* note 889 and accompanying text.

645. See Winick, *supra* note 210, at 21; Zlotnick, *supra* note 210, at 430-31.

646. The district court in *Rennie* applied the least restrictive alternative principle in this manner. See *supra* notes 470-472 and accompanying text.

concern over placing "an undue burden on the administration of institutions . . . [which] also would restrict unnecessarily the exercise of professional judgment as to the needs of residents."⁶⁴⁷

Considering the significant difference in the degree of intrusiveness between antipsychotic medication and soft arm restraints, a higher level of judicial oversight may very well be warranted in drug refusal cases.⁶⁴⁸ However, even a less stringent utilization of the least restrictive alternative principle would offer invaluable protection to a patient's fundamental interests while not unduly hampering the exercise of professional care. Application of the doctrine in this sense would require that a reviewing court merely ensure that a cost-benefit analysis from the patient's perspective has taken place—that the proper considerations were taken into account through appropriate procedures. If the government could present sufficient evidence that the necessary concerns were conscientiously considered by the appropriate professionals, the court would not involve itself in a substantive determination of the correct choice.⁶⁴⁹ This relaxed standard of review would at least ensure that the professional judgment at issue was not unduly influenced by the severe administrative, staff, and economic pressures that are inherent in most public institutions—concerns which are "simply not significant enough to justify a patient's exposure to the serious risks accompanying use of [antipsychotic] drugs."⁶⁵⁰

B. The Risk of an Erroneous Deprivation by Deferring to Professional Judgment and the Value of Additional Procedural Safeguards

In *Parham*, the Supreme Court stated that "[w]hat process is constitutionally due cannot be divorced from the nature of the ultimate decision that is being made."⁶⁵¹ The Court went on to characterize the questions involved in a child's commitment determination as essentially medical in nature.⁶⁵² The Court concluded:

Although we acknowledge the fallibility of medical and psychiatric diagnosis, we do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision

647. *Youngberg v. Romeo*, 457 U.S. 307, 322, 102 S. Ct. 2452, 2461 (1982). See generally Winick, *supra* note 210, at 20-21.

648. Winick, *supra* note 210, at 20-21.

649. *Id.* Professor Winick suggests that an appropriate standard of review would be the substantial evidence test or the arbitrary and capricious abuse of discretion standard employed for review of administrative agency decisions. *Id.* at 21. See also Zlotnick, *supra* note 210, at 439.

650. *Rennie v. Klein*, 720 F.2d 266, 276 (3d Cir. 1983) (Weis, J., concurring).

651. *Parham v. J.R.*, 442 U.S. 584, 608, 99 S. Ct. 2493, 2507 (1979).

652. *Id.* at 609, 99 S. Ct. at 2507-08.

from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing. Even after a hearing, the non-specialist decisionmaker must make a medical-psychiatric decision.⁶⁵³

As illustrated most notably by the Third Circuit's opinion in *Rennie v. Klein* and the Fourth Circuit's decision in *Charters II*, courts have relied heavily on this reasoning in justifying the application of the professional judgment standard to drug refusal cases. By characterizing the questions involved in a forced medication determination as medical or psychiatric, deference to professional decisionmaking is thereby held appropriate, obviating the need for additional procedural safeguards. However, the basic premise underlying this reasoning is false. Unlike the questions involved in a child's commitment proceeding, the issues inherent in a forced medication determination are not solely medical in nature.

For example, the Fourth Circuit characterized the "special risk of drastic side-effects posed by the antipsychotic medication here in issue" as a purely medical issue.⁶⁵⁴ Admitting that it did not undertake an "exhaustive analysis of the scientific literature before us documenting these side-effects and their statistical probability," the court merely cited to scientific disagreement as to the severity, susceptibility to treatment, duration, and probability of various side effects and to the fact that neither party asserted that antipsychotic drugs should never be administered even with patient consent.⁶⁵⁵ Given these circumstances, the court relegated the issue to "an element of the ultimate 'best interests' medical decision" more capable of assessment and review by institutional professionals than by an adjudicative process.⁶⁵⁶ However, this risk of serious harm, which is not at issue in the commitment context, presents a high degree of intrusiveness into fundamental interests in privacy and personal security. This grave threat to important individual interests raises a considerably greater need for legal concern and evaluation. The fact that there is scientific disagreement over the degree (not the presence) of risk would appear to support the need for legal safeguards so that varying medical viewpoints can be adequately assessed.

A growing body of scholarly literature documents a court's ability to evaluate and weigh social science research.⁶⁵⁷ Indeed, a court has the

653. *Id.* (citations omitted).

654. *United States v. Charters*, 863 F.2d 302, 310 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990).

655. *Id.* at 310-11 & n.6.

656. *Id.* at 311.

657. *See, e.g.*, Laurens Walker & John Monahan, *Social Facts: Scientific Methodology*

duty to thoroughly examine such data, especially when an individual's fundamental rights are involved.⁶⁵⁸ The Fourth Circuit avoided this evaluative task by simply asserting an inability to reconcile or choose between the conflicting scientific assessments of the risk of side effects which were advanced in the case.⁶⁵⁹ By leaving this evaluative function to institutional personnel, the court abdicated a critical judicial responsibility necessary for the protection of patients' constitutional rights.⁶⁶⁰

Contrary to the inference made by the Supreme Court in the above quote from *Parham*, the judge's dispositional decision is not the product of his own diagnosis. While it is obvious that the judge is "untrained" to diagnose, such is not his function. Instead, the court's role is to assure 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."⁶⁶¹ Through

as *Legal Precedent*, 76 Calif. L. Rev. 877 (1988); Laurens Walker & John Monahan, *Social Frameworks: A New Use of Social Science in Law*, 73 Va. L. Rev. 559 (1987); John Monahan & Laurens Walker, *Social Authority: Obtaining, Evaluating and Establishing Social Science in Law*, 134 U. Pa. L. Rev. 477 (1986).

658. *Jarvis v. Levine*, 418 N.W.2d 139, 147-48 (Minn. 1988); *State ex rel. Jones v. Gerhardstein*, 416 N.W.2d 883, 896 (Wis. 1987).

659. *United States v. Charters*, 863 F.2d 302, 311 n.6 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990).

660. For a critical analysis of the Fourth Circuit's opinion in *Charters II*, including its reluctance to confront the social science and empirical questions involved, see Michael L. Perlin, *Are Courts Competent to Decide Competency Questions?: Stripping the Facade from United States v. Charters*, 38 Kan. L. Rev. 957 (1990). Professor Perlin quotes Judge Bazelon:

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

Id. at 960 (quoting David L. Bazelon, *Implementing the Right to Treatment*, 36 U. Chi. L. Rev. 742, 743 (1969)).

As Professor Perlin points out, the Fourth Circuit placed heavy reliance on a 1981 article by Baldessarini and Lipinski which stated that "the use of available antipsychotic agents continues to be the cornerstone of management for these serious and disabling mental illnesses." Ross J. Baldessarini & Joseph F. Lipinski, *Risks of Antipsychotic Drugs Overemphasized*, 305 N. Eng. J. Med. 588 (1981). However, a more thorough examination of scientific research would have revealed that Baldessarini had recently qualified the above statement by pointing out that the effectiveness of antipsychotic medication is questionable in many cases and that drug therapy is compromised by neurological side effects. Perlin, *supra*, at 991-92 (quoting Ross J. Baldessarini et al., *Significance of Neuroleptic Dose and Plasma Levels in the Pharmacological Treatment of Psychoses*, 45 Archives Gen. Psychiatry 79, 79 (1988)).

661. David L. Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process*, 75 Colum. L. Rev. 897, 910 (1975).

the adversary process, the court is assisted by attorneys representing each side who are trained in cross-examination, at sorting motivational nuances, and operating within the context of conflicting facts, opinions, interests, and professional principles.⁶⁶² The ultimate determination on whether antipsychotic drugs should be forcibly administered is not based on the judge's personal diagnosis, but rather on a thorough and objective evaluation of all the relevant facts, the often conflicting professional opinions, and the important medical and legal interests at stake. The fact that the questions may be partially or even entirely medical in nature "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."⁶⁶³ It is for the court to determine whether the given level of medical certainty about the need to administer the drugs—whatever that level may be—warrants infringement of the patient's constitutional rights. That determination is no more left to medical discretion than the determination of probable cause under the Fourth Amendment is left to police discretion.

The importance of the adversary process in this context is underscored by a new generation of research into the processes of professional decisionmaking. Recent studies by cognitive psychologists document a high degree of inaccuracy in the clinical judgments of mental health professionals.⁶⁶⁴ After a comprehensive review of this research, one psychologist concluded that "mental health professionals are no more accurate than lay decisionmakers and that both professionals and laypeople rely on the same judgment strategies and make the same errors."⁶⁶⁵ This commentator stated:

[I]t is not too polemical to conclude that professional judgment is, in fact, not much better than arbitrary judgment. . . . [P]rofessional judgment is simply judgment made by a professional, not a judgment that has any special aura of reliability or validity and is often no better than lay judgment. If, from the Supreme Court's perspective, the only questions are whether "professional judgment *in fact* was exercised," or whether the clinician "substantial[ly] depart[ed] from accepted professional judgment, practice, or standards," then mentally disabled per-

662. 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).

663. *Vitek v. Jones*, 445 U.S. 480, 495, 100 S. Ct. 1254, 1265 (1980) (citation omitted).

664. For a review of this research, see Donald N. Bersoff, *Judicial Deference to Nonlegal Decisionmakers: Imposing Simplistic Solutions on Problems of Cognitive Complexity in Mental Disability Law*, 46 SMU L. Rev. 329 (1992).

665. *Id.* at 360.

sons will be vulnerable to erroneous decisions and unlikely to prevail if they seek to challenge those decisions. . . . The preference for "informal, traditional medical investigative techniques" and reliance on an "administrative review using medical decisionmakers" will bar access to the adversary process, and hence bar the opportunity to challenge judgments of mental health professionals through competent cross-examination, the use of competing experts, and other devices that serve as correctives to often confident but mistaken judgments by psychiatrists and psychologists.⁶⁶⁶

It should also be noted that if, after thorough evaluation, a court is unable to make an informed decision on conflicting medical evidence, the Supreme Court has suggested that such uncertainty dictates against allowing the medical intervention. In *Winston v. Lee*,⁶⁶⁷ 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.'"⁶⁶⁸

Courts relying on *Youngberg* and *Parham* in extending the full measure of the professional judgment standard to drug refusal cases have ignored the traditional application of the informed consent doctrine. Instead, medical opinion, supported by the objective of restoring behavior "to that which is acceptable to society,"⁶⁶⁹ dictates the forced drugging of competent patients. Under this approach of unqualified deference to professional judgment, a patient's competence is, at best, relegated to "simply another factor in the ultimate medical decision to administer the medication involuntarily."⁶⁷⁰ Such a standard diminishes

666. *Id.* at 362 (citations omitted). The author went on to state, "When, as in *Parham*, the decisionmaker's judgment is subject to review only by a colleague and fellow employee or, as in *Harper*, where the judgment of the psychiatrist recommending compelled administration of medication is reviewed only by other nonlegal professionals, the context is provided for operation of all the biasing heuristics discussed herein." *Id.* at 362-63. It must be emphasized that an inappropriate decision made by a professional may be immune from challenge under the "substantial departure from accepted professional judgment" standard articulated by the Supreme Court. *Youngberg v. Romeo*, 457 U.S. 307, 323, 102 S. Ct. 2452, 2462 (1982). As Bersoff notes, "Proof of negligence, consonant with a malpractice standard, will not suffice. . . . [T]he *Youngberg* rule . . . requir[es] something akin to recklessness or fault, closer to deliberate indifference than simple negligence." Bersoff, *supra* note 664, at 333.

667. 470 U.S. 753, 105 S. Ct. 1611 (1985).

668. *Id.* at 766, 105 S. Ct. at 1619.

669. *Dautremont v. Broadlawns Hosp.*, 827 F.2d 291, 300 (8th Cir. 1987).

670. *United States v. Charters*, 863 F.2d 302, 311-12 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990).

the value our society has placed on bodily integrity and self-determination, interests long protected by the common law and encompassed within the Due Process Clauses of the Fifth and Fourteenth Amendments.⁶⁷¹ In addition, this standard reflects a failure to recognize that forcing treatment on a competent individual will reduce the therapeutic benefits and can cause substantial injury to self-esteem.⁶⁷² Neither *Youngberg* nor *Parham* suggested such an approach.

As in *Youngberg*, the Supreme Court in *Parham* did not address the rights of a competent patient but rather the interests of a legally incompetent minor. The commitment decision in *Parham* focused on whether the child suffered from a mental illness which precluded the receipt of care and treatment in the community.⁶⁷³ However, these essentially medical determinations do not necessarily mean that once committed, a mentally ill adult patient is incapable of making a rational decision regarding proposed treatments. Thus, unlike the situation in *Parham*, the threshold question in a forced treatment determination should be whether the patient is competent. And, as many noted psychiatrists readily admit, "[t]he concept of competency . . . is social and legal and not merely psychiatric or medical."⁶⁷⁴ One court has accepted the following explanation:

"Competence is not a clinical, medical, or psychiatric concept. It does not derive from our understanding of health, sickness, treatment, or persons as patients. Rather, it relates to the world of law, to society's interest in deciding whether an individual should have certain rights (and obligations) relating to person, property and relationships."⁶⁷⁵

A legal competency inquiry encompasses social and personal values which are not present in the clinical determination.⁶⁷⁶ Medical professionals are trained to act in the medical best interests of a patient as reflected by medical standards on which their professional judgments are based.⁶⁷⁷ This treatment bias was exemplified in the *Charters I*

671. See *supra* notes 293-304 and accompanying text.

672. *State ex rel. Jones v. Gerhardstein*, 416 N.W.2d 883, 890 (Wis. 1987); Appelbaum & Roth, *supra* note 402, at 1466.

673. *Parham v. J.R.*, 442 U.S. 584, 605, 99 S. Ct. 2493, 2505 (1979).

674. Roth et al., *supra* note 436, at 279.

675. *Riese v. St. Mary's Hosp. & Medical Ctr.*, 243 Cal. Rptr. 241, 253 (Cal. App. 1st Dist. 1987), *opinion superseded*, 751 P.2d 893 (Cal. 1988), *dismissed*, 774 P.2d 698 (Cal. 1989) (quoting Robert Michels, *Competence to Refuse Treatment, in Refusing Treatment in Mental Health Institutions—Values in Conflict* 115, 115 (A. Edward Doudera & Judith P. Swazey eds., 1982)).

676. Some psychiatrists continue to assert that medical professionals are better qualified to make competency judgments. See Schwed, *supra* note 4; Rachlin, *supra* note 4.

677. See Brooks, *supra* note 50, at 190-91; Meisel, *supra* note 454, at 451.

litigation where the attending psychiatrist "took the position that Charters' medical incompetence was evidenced by his refusal to accept anti-psychotic medication since refusing the medication was not, in [the psychiatrist's] view, the decision most beneficial to Charters."⁶⁷⁸

On the other hand, a legal competency evaluation is broader in focus, taking into account not only medical concerns, but the patient's personal interests in self-determination and bodily integrity. A treating physician is not adequately socialized in these legal values to effectively balance them with medical concerns. The same problem is inherent to an in-house or independent psychiatric review system. As one commentator noted, "[t]he independent [p]sychiatrist shares the socialization process, the values, the experience, and the professional outlook of the treating doctor."⁶⁷⁹ The independent psychiatrist also faces the pressure of the long-established tradition of "doctors deferring to other doctors"⁶⁸⁰ and the unpleasant prospect of overturning the treatment decisions of colleagues which may imply criticism of competence or performance.⁶⁸¹ An examination of the independent psychiatric hearing system decreed by the district court in *Rennie*,⁶⁸² before being overturned by the Third Circuit, supports these concerns. The study indicated that independent psychiatrists not only shared a bias towards treatment, but viewed their roles more as consultants to attending physicians than as objective hearing officers.⁶⁸³

Given the serious risks accompanying the forced administration of antipsychotic drugs, the constitutionally protected interests in self-autonomy and bodily integrity are implicated to a much greater degree than in a decision to commit. And "[w]hen medical judgments collide with a patient's fundamental rights . . . it is the courts, not the doctors, who possess the necessary expertise."⁶⁸⁴

678. *United States v. Charters*, 829 F.2d 479, 484 (4th Cir. 1987), *modified*, 863 F.2d 302 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990). *See generally* Meisel, *supra* note 454, at 451.

679. Brooks, *supra* note 50, at 199.

680. Gelman, *supra* note 176, at 251.

681. Brooks, *supra* note 50, at 199. In addition, well-trained psychiatrists are not likely to be attracted by the low state compensation budgeted for independent psychiatric reviewers. *Id.*

682. *Rennie v. Klein*, 476 F. Supp. 1294, 1312 (D.N.J.), *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), *vacated*, 458 U.S. 1119, 102 S. Ct. 3506 (1982).

683. *See* Gelman, *supra* note 176, at 252.

684. *Jarvis v. Levine*, 418 N.W.2d 139, 147-48 (Minn. 1988). Thus, unlike the reasoning employed by the Fourth Circuit in *Charters II*, committing base-line decisionmaking to medical professionals subject only to an after-the-fact judicial review for arbitrariness is inadequate protection for the constitutional interests at issue in a drug refusal case. As one commentator noted, "if the ultimate treatment decision is made by a physician, we can expect that it will favor health values and underemphasize or even ignore individualistic values." Meisel, *supra* note 454, at 478.

In *Charters II*, the Fourth Circuit feared that requiring adjudications of incompetency would "pose an unavoidable risk of completely anomalous, perhaps flatly inconsistent, determinations of mental competence by different judicial tribunals."⁶⁸⁵ However, there is not even a clinical consensus on the definition of incompetency, and the methods used to make these determinations are unrefined.⁶⁸⁶ As the noted psychiatrist Doctor Loren Roth stated, "[w]e don't know who is competent and who is not competent."⁶⁸⁷ The Fourth Circuit's concerns simply underscore the need for well-defined criteria which are specific enough to be interpreted by courts.⁶⁸⁸ Delegating the incompetency determination to medical professionals is not a resolution to such concerns. Although consistency may be gained, it will favor treatment concerns at the expense of individual values. As Dr. Roth candidly admitted, "[n]o matter what the law does, we'll always treat all the people we want. I hate to say that, but that's my experience. By hook or by crook, most of the patients will continue to be treated."⁶⁸⁹ The medical uncertainty and treatment bias illustrated by Dr. Roth's remarks demonstrate the need for adversarial competency hearings wherein a law-trained decisionmaker, guided by appropriate criteria, can exercise the experience and aptitude necessary to give due concern to legally protected values while objectively weighing both medical and other evidence.⁶⁹⁰

685. *United States v. Charters*, 863 F.2d 302, 310 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990).

686. *See supra* note 402 and accompanying text; Meisel, *supra* note 454, at 440-41; Parry, *supra* note 402, at 153; Roth et al., *supra* note 436, at 280-82.

687. Conference Report, *Refusing Treatment in Mental Health Institutions: Values in Conflict*, 32 *Hosp. & Community Psychiatry* 255, 257 (1981) [hereinafter Conference Report].

688. *See supra* notes 437-438 and accompanying text.

689. Conference Report, *supra* note 687, at 258.

690. The Fourth Circuit also relied on the fact that, although the appellee had not been determined incompetent to make treatment decisions, he had been adjudicated incompetent to stand trial. The court stated that "[w]hile in theory there may be a difference between the two mental states, it must certainly be one of such subtlety and complexity as to tax perception by the most skilled medical or psychiatric professionals." *United States v. Charters*, 863 F.2d 302, 310 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990). However, incompetency is no longer considered as global in nature. Mental illness may render an individual incompetent to make one type of decision while leaving reasoning ability in other areas intact. *See supra* note 403 and accompanying text. Incompetency is now viewed as situation-specific, with each type of decision-making situation being viewed individually and independently. Ruth Macklin, *Some Problems in Gaining Informed Consent from Psychiatric Patients*, 31 *Emory L.J.* 345, 360 (1982). To be deemed competent to stand trial, a defendant must be able to understand the nature of the charges against him and to participate in his defense. *Dusky v. United States*, 362 U.S. 402, 402, 80 S. Ct. 788, 788-89 (1960) (*per curiam*). This is wholly different than the capacity to make treatment decisions. Courts do not equate these two types of

To avoid a separate hearing on the competency of an involuntarily committed individual, it has been recommended that the determination be made during the initial commitment proceeding.⁶⁹¹ This proposal, however, presents a number of significant problems. If a patient is adjudicated both suitable for commitment and incompetent to make treatment decisions, an order allowing compelled medication would grant the institution free reign in forcing drugs with no independent mechanism for checking abuses which may arise. Moreover, because a mentally ill individual's capacity to make reasoned treatment decisions may fluctuate, the patient may regain competence during the period of commitment.⁶⁹² At that point, the patient may make a reasoned decision to forego further medication due to side effects or for other rational reasons. This decision could be ignored by institutional personnel who are operating under the continuing order authorizing forced drug treatment.

While the above problems could be addressed by limiting the duration of the forced medication order to a reasonable period, other inherent difficulties persist. As described earlier, a decision to commit and a determination of incapacity to make treatment decisions are separate

capabilities. See *Bee v. Greaves*, 744 F.2d 1387, 1395 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214, 105 S. Ct. 1187 (1985). See also *United States v. Charters*, 829 F.2d 479, 488 (4th Cir. 1987), *modified*, 863 F.2d 302 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990); *United States v. Waddell*, 687 F. Supp. 208, 209 (M.D.N.C. 1988). Indeed, competence to stand trial has even been distinguished from competence to waive counsel. See *Westbrook v. Arizona*, 384 U.S. 150, 150, 86 S. Ct. 1320, 1320 (1966). It should also be noted that determinations of both competence to stand trial and to waive counsel invoke the protection of a court and are not left to psychiatrists. See *Pate v. Robinson*, 383 U.S. 375, 385, 86 S. Ct. 836, 842 (1966); *Johnson v. Zerbst*, 304 U.S. 458, 465, 58 S. Ct. 1019, 1023 (1938).

691. See Loren H. Roth, *A Commitment Law for Patients, Doctors, and Lawyers*, 136 Am. J. Psychiatry 1121 (1979). In New Mexico, if the court finds that the criteria for involuntary commitment are met, it must then determine whether the person is capable of informed consent. N.M. Stat. Ann. § 43-1-11 (D) (1989). Wisconsin legislation allows a committing court to determine whether the individual is incompetent to refuse treatment and whether the treatment will be therapeutic and will not unreasonably impair the individual's ability to participate in subsequent legal proceedings. If the appropriate findings are made, the court may authorize nonconsensual treatment, but only for the period between the hearing to determine probable cause for commitment and the final commitment order. Wis. Stat. § 51.61(1)(g)(2) (West 1991). Further compelled treatment after a final commitment order must be authorized by an additional court hearing wherein the individual is found incompetent or the treatment is necessary to prevent serious physical harm. Wis. Stat. § 51.61(1)(g)(3) (West 1991).

The American Psychiatric Association's model civil commitment law requires a finding of incapacity to make an informed decision concerning treatment before an individual may be involuntarily committed. See Clifford D. Stromberg & Alan A. Stone, *A Model Statute on Civil Commitment of the Mentally Ill*, 20 Harv. J. on Legis. 275, 330-38 (1983). Utah's commitment law incorporates this criterion for involuntary civil commitment. Utah Code Ann. § 62A-12-234(1)(a) (Supp. 1992).

692. Appelbaum & Roth, *supra* note 402, at 1465; Rhoden, *supra* note 43, at 387.

and distinct, based on different criteria and affecting different individual interests.⁶⁹³ At the time of the initial commitment hearing, there is not enough information upon which to base either a finding that the individual is incapable of making an informed treatment decision or that antipsychotic medication is an appropriate treatment. Institutional physicians have not had sufficient opportunity to observe and evaluate the individual in order to formulate an accurate diagnosis. Little is known about the types and dosages of drugs which may be warranted or the individual's susceptibility to the various side effects posed by antipsychotic medication. Without adequate information to communicate, the person's ability to make an informed decision cannot be measured. Even if a finding of incompetency could be accurately made, the decisionmaker has inadequate information from which to determine the appropriateness of drug treatment.

Another danger is that, in all likelihood, a finding of incapacity will summarily follow a decision to commit. A hearing officer who commits a mentally ill individual as dangerous or unable to care for himself may be reluctant to make a finding which would allow the patient to refuse treatment which institutional authorities argue is necessary.⁶⁹⁴ A decision to commit will unduly influence the incompetency determination by blurring the distinction between the separate criteria on which each decision should be based. Thus, the risk of "rubber stamping" the patient incapable of making an informed decision is substantial.

To assure accuracy, the incompetency determination must be made at the time a person refuses a proposed medication. To avoid frequent hearings and yet provide the necessary safeguard of eventual review, an order authorizing the forced administration of antipsychotic drugs should be limited to a reasonable duration. Four to six weeks has been suggested as an adequate time period in which most patients will have recovered their competence while minimizing the risk of debilitating side effects. For those patients who have not sufficiently improved, the efficacy of drug therapy should be called into question.⁶⁹⁵

The above discussion has assumed that when an individual is adjudicated incompetent, it is most appropriate for the court to act as the proxy decisionmaker. Another alternative would be to commit decisional authority to a guardian. However, the guardianship system presents a number of deficiencies. The process is dependent upon an available supply of qualified substitute decisionmakers. Frequently, fam-

693. See *supra* notes 428-436 and accompanying text.

694. Brooks, *supra* note 50, at 196.

695. See Robert D. Miller, *Involuntary Civil Commitment of the Mentally Ill in the Post-Reform Era* 159 (1987).

ily members are used on the assumption that they are most familiar with the patient's values, preferences, and best interests.⁶⁹⁶ The institutionalized mentally ill, however, often lack close family ties.⁶⁹⁷ The objectivity of family members who are available may be compromised by prior conflicts with the patient as well as other psychological and economic factors.⁶⁹⁸ Public guardians are in short supply and lack familiarity with the patient. It has also been suggested that guardians are too easily influenced by treating professionals and have neither the time nor ability to examine the relevant concerns involved.⁶⁹⁹ In addition, a guardianship proceeding is a time-consuming process which may unduly delay appropriate treatment for an incompetent individual.⁷⁰⁰ Finally, once a guardian consents to medication, the system does not contain adequate review mechanisms for patients who may eventually regain their competency.⁷⁰¹

Likewise, it would seem inappropriate to delegate substitute decisionmaking authority to mental health professionals. Patients are not deprived of their constitutionally protected interests by reason of their incompetency. The decision to risk the hazards posed by drug therapy remains an individual decision, even though exercised by proxy.⁷⁰² As described above, mental health professionals, whether in-house or independent, are socialized in the values of treatment and protection, a bias which dictates against adequate consideration of other legally protected individual interests. In addition, because institutional professionals make the initial decision of whether to pursue an incompetency deter-

696. Rhoden, *supra* note 43, at 402.

697. Ford, *supra* note 403, at 336; Thomas G. Gutheil et al., *Legal Guardianship in Drug Refusal: An Illusory Solution*, 137 Am. J. Psychiatry 347, 350 (1980).

698. One commentator noted:

[E]ven if family members are available and willing, they may be disturbed themselves, may have a history of conflict with the patient or may have initiated the involuntary commitment proceedings against the patient. A guardian may fear that if he does not authorize the treatment hospital personnel desire, the patient will be released into the guardian's custody and once again become a family burden.

Rhoden, *supra* note 43, at 403 (citations omitted). See also Gelman, *supra* note 176, at 242 n.112 ("relatives who had once taken a neuroleptic were often sympathetic to a patient's drug refusal, while other relatives generally were not"); Gutheil et al., *supra* note 697, at 350; Karucz & Fallon, *supra* note 62, at 118 (noting that relatives often insist on continued drug therapy even when physicians recommend discontinuation).

699. Gelman, *supra* note 176, at 242; Gutheil et al., *supra* note 697, at 350; Mills, *supra* note 137, at 313, 326 n.23 (1980); Rhoden, *supra* note 43, at 404.

700. Ford, *supra* note 403, at 336; Gutheil et al., *supra* note 697, at 350; Rhoden, *supra* note 43, at 404.

701. Rhoden, *supra* note 43, at 404-05.

702. *Rogers v. Commissioner of Dep't of Mental Health*, 458 N.E.2d 308, 316 (Mass. 1983); *In re Guardianship of Ingram*, 689 P.2d 1363, 1368 (Wash. 1984) (en banc).

mination, placing ultimate decisionmaking authority in their hands may provide an undue incentive to pursue such means in order to treat a refusing patient.⁷⁰³ Institutional decisionmaking is also vulnerable to compromise by pressures to maintain patient control and to ease administrative and staff burdens through the use of medication.⁷⁰⁴

Another issue concerns the standard which guides the court in the proxy decisionmaking process. The traditional approach requires the decisionmaker to evaluate both medical and other evidence and reach an independent decision on what is in the "best interests" of the incompetent patient.⁷⁰⁵ The operative guideline is "what a reasonable person would do if competent."⁷⁰⁶ The more modern "substituted judgment" standard requires the proxy to inquire into the values and preferences of the patient and attempt to make a decision as the patient would, were he competent.⁷⁰⁷

The "best interests" approach has been criticized as depriving incompetent individuals of rights which are accorded others "by ignoring their uniqueness and imposing upon them the views of a hypothetical majority or 'reasonable man.'"⁷⁰⁸ Community consensus replaces what are otherwise uniquely personal decisions. One commentator has stated: "What this homogenized decisionmaking tool lacks is the individual's point of view as reflected in notions of advocacy, individualized treatment plans, personal autonomy and democracy. When used appropriately, best-interests reflects the values of the collective, not necessarily the values and preferences of the individual."⁷⁰⁹

The substituted judgment standard was developed in an attempt to afford respect to the personal values of the incompetent patient.⁷¹⁰ However, in the many cases where clear evidence is lacking on how the

703. Meisel, *supra* note 454, at 476. Professor Meisel states:

Since the power to invoke an exception [to the informed consent doctrine] is the power to alter the balance between individualism and health, it is preferable that the right to make the ultimate treatment decision ordinarily not be vested in the physician since to do so would be to further tip the balance away from that established by the doctrine of informed consent—a balance favoring individualism.

Id.

704. See *supra* notes 370-392 and accompanying text.

705. Rhoden, *supra* note 43, at 399.

706. Parry, *supra* note 402, at 154.

707. *Id.*

708. *United States v. Charters*, 829 F.2d 479, 497 (4th Cir. 1987), *modified*, 863 F.2d 302 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990).

709. John Parry, *A Unified Theory of Substitute Consent: Incompetent Patients' Right to Individualized Health Care Decision-making*, 11 *Mental & Physical Disability L. Rep.* 378, 381 (1987).

710. See John A. Robertson, *Organ Donations by Incompetents and the Substituted Judgment Doctrine*, 76 *Colum. L. Rev.* 48, 62-68 (1976).

incompetent patient would decide if competent, strict adherence to this doctrine converts it into a legal fiction. In these cases, the standard often camouflages the fact that the proxy is, in reality, making an independent decision for the incompetent individual.⁷¹¹

The hybrid approach employed in *Charters I* for guiding proxy decisionmaking appears to strike an appropriate balance between respect for an incompetent patient's individualism and concern for his health and protection. The court should look to the patient's previously expressed preferences, values, and beliefs in an effort to exercise a substituted judgment. However, if clear and convincing evidence⁷¹² on this matter is lacking, as it often is, the decision should be based on the patient's best interests.⁷¹³

The judicial intervention suggested above will promote consistency, fairness, and objectivity in both the incompetency determination and the resulting forced medication decision. A law-trained judge can evaluate submitted evidence in an unbiased manner, providing adequate concern for individualism as well as society's interest in protection and health. Due consideration to these interests will be further assured by the visibility of this decisionmaking process, visibility which is lacking when decisions are made behind institutional walls.

C. The Government's Interests, Including the Function Involved and the Administrative and Fiscal Burdens Imposed by Additional Procedures

As previously explained, courts have deemed the objectives underlying the government's police power and *parens patriae* authority as sufficiently compelling, under certain circumstances, to justify forced medication. Courts relying on the police power have agreed that an

711. As the court in *Charters I* noted, in such situations the incompetent patient is placed "at substantially greater risk of an incorrect decision than he would have been had the inquiry focused on his best interests." *Charters I*, 829 F.2d at 498. See also Robertson, *supra* note 710, at 63.

712. The higher "beyond a reasonable doubt" standard, usually reserved for criminal cases where the associated stigma is high and a person's liberty is often at stake, would appear inappropriate when the goal is to honor a patient's wishes. The lower "preponderance of the evidence" standard appears inadequate due to the important interest in protecting the patient's health. See *In re Storar*, 420 N.E.2d 64, 72 (N.Y. 1981).

713. *Charters I*, 829 F.2d at 498. See Parry, *supra* note 709, at 384-85. One commentator has stated:

[S]uch an attempt would continue to regard [the patient], even during his incapacity, as an individual with free choice and moral dignity, and not as someone whose preferences no longer mattered. Even if we were mistaken in ascertaining his preferences, the person [upon regaining competence] could still agree that he had been fairly treated

Robertson, *supra* note 710, at 63.

emergency situation, in which the patient presents an imminent or current threat of physical harm to self or others, justifies forced drugging for a limited period when no less restrictive alternatives are available. Courts, however, disagree on whether police power authority is sufficient when based on a dangerousness standard. Under this standard, as described earlier, forced medication is justified when based on predictions of future violence if the patient remains unmedicated.⁷¹⁴

As the Massachusetts Supreme Judicial Court succinctly stated, forced drugging based on a prediction of future violence amounts to nothing more than preventive chemical restraint.⁷¹⁵ The dangerousness standard allows long-term medication for security purposes even when drugs are not therapeutically beneficial.⁷¹⁶ Widespread abuse under such a standard has been well documented.⁷¹⁷ Because most public mental health facilities continue to be plagued by overcrowded and understaffed conditions, the inherent potential for the misuse of antipsychotic drugs for the purposes of convenience, management, and control remains high. Furthermore, even most psychiatrists agree that it is virtually impossible to accurately predict future violent behavior.⁷¹⁸ In addition, less intrusive measures such as temporary seclusion and other alternative treatments may effectively address the perceived risk of violence.⁷¹⁹ In light of the potential for abuse, the predictive uncertainty, and the availability of less restrictive measures to guard against future violence, it would appear that the dangerousness standard is insufficient to justify the extensive intrusion presented by antipsychotic drugs.

714. See *supra* notes 340-397 and accompanying text.

715. *Rogers v. Commissioner of Dep't of Mental Health*, 458 N.E.2d 308, 321 (Mass. 1983). See *supra* notes 387-392 and accompanying text.

716. *Washington v. Harper*, 494 U.S. 210, 244-45, 110 S. Ct. 1028, 1049 (1990) (Stevens, J., dissenting).

717. See *supra* notes 370-392 and accompanying text. One study found that even when the dangerousness standard is rejected but no provision is made for review of cases in which drugs are forcibly administered on emergency grounds, many refusing patients are inappropriately medicated under the emergency rubric. Lisa A. Callahan, *Changing Mental Health Law: Butting Heads With a Billygoat*, 4 Behavioral Sci. & L. 305, 313 (1986).

718. See Bersoff, *supra* note 664, at 355-57 (reviewing studies which document the futility in attempting to accurately predict future violent behavior); *Barefoot v. Estelle*, 463 U.S. 880, 920, 103 S. Ct. 3383, 3408 (1983) (Blackmun, J., dissenting) (quoting Brief for American Psychiatric Association as Amicus Curiae); Alan A. Stone, *Law, Psychiatry, and Morality* 139-40 (1984); Alan A. Stone, *Mental Health and Law: A System in Transition* 25-37 (1975); Bruce J. Ennis & Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 Calif. L. Rev. 693, 749 (1974).

719. See *supra* notes 495-508 and accompanying text. See also Julie M. Zito et al., *The Treatment Review Panel: A Solution to Treatment Refusal?*, 12 Bull. Am. Acad. Psychiatry & L. 349, 356-57 (1984) [hereinafter Review Panel] (suggesting temporary seclusion as an effective and therapeutic measure for controlling anxiety based assaultiveness and for coping and mastering impulses).

While the government has been allowed to forcibly administer antipsychotic medication for treatment purposes, most courts have required a finding of incompetency before this *parens patriae* authority may be invoked.⁷²⁰ As maintained above, an incompetency determination should be made by a judicial decisionmaker. Moreover, the court, as opposed to a guardian or mental health professionals, should act as the proxy decisionmaker for individuals who are adjudicated incompetent.

While courts adopting the professional judgment standard have criticized additional procedural safeguards as unduly interfering with the government's role as "benign custodian,"⁷²¹ their apprehensions appear unwarranted. In *Rennie v. Klein*, the Third Circuit cited the Supreme Court's concerns in *Parham* in stating that adversarial-type hearings "are more likely to be counterproductive, adding to the tensions that may have contributed to the patient's initial commitment," thereby interfering with successful long-term treatment.⁷²² In *Parham*, however, the Court was concerned that a hearing upon an initial parental request for commitment would pit the "parents and child as adversaries," thereby risking an exacerbation of "whatever tensions already exist between the child and parents."⁷²³ This concern does not exist regarding a hearing on whether a mentally ill adult should be forcibly drugged by institutional authorities following an involuntary commitment.

Furthermore, research has established that additional procedural protections have practical medical benefits. They encourage patient input which is beneficial because physicians must depend upon their patients for evidence of the subjective effects of medication.⁷²⁴ The prospect of facing formalized procedures causes physicians to consult and negotiate with their patients which, in turn, promotes a more thorough evaluation of the benefits and risks of medication and any available alternatives.

720. See *supra* notes 398-401 and accompanying text.

721. *United States v. Charters*, 863 F.2d 302, 312 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990). The dissent criticized this characterization of the government's role, stating:

The prospect that the views of a governmental medical officer may be inclined to coincide with those of the federal prosecutor on the desirability of the trial's proceeding and a resulting conviction leading to lengthy incarceration is not remote. They are, when all is said and done, fellow employees. Nor should we ignore the likelihood that Butner would rather be freed of the concerns such as diversion of experts it would rather detail to other tasks than the care of Charters. It may well be that something other than Charters' well-being drives the opining medical officials.

Id. at 315 (Murnaghan, J., dissenting) (footnote omitted).

722. *Rennie v. Klein*, 653 F.2d 836, 851 (3d Cir. 1981), *vacated*, 458 U.S. 1119, 102 S. Ct. 3506 (1982).

723. *Parham v. J.R.*, 442 U.S. 584, 610, 99 S. Ct. 2508 (1979).

724. See *Rennie v. Klein*, 462 F. Supp. 1131, 1145 (D.N.J. 1978).

Thus, the physicians will explore concerns that might otherwise go unnoticed.⁷²⁵

This negotiation may result in respect for a patient's refusal or mutually agreeable improvements to the treatment program.⁷²⁶ This open communication enhances the patient's adaptation to the doctor-patient relationship which increases cooperation, including compliance with the proposed treatment schedule. Moreover, valuing a patient's viewpoint enhances his self-esteem, and is thus therapeutic in itself.⁷²⁷

In addition, research indicates that the adversarial process itself may be therapeutic. A recent study performed at Manhattan Psychiatric Center, a New York public hospital, found that the judicial adversarial process allows patients "considerably greater representation and participation" than the previous administrative review system.⁷²⁸ The patients were offered "the opportunity to hear a detailed discussion of their physician's reasoning and to present their own views."⁷²⁹ The researchers concluded that "[s]ome patients may gain a better understanding of the need for treatment through a process that offers this degree of patient involvement."⁷³⁰ Moreover, a judicial hearing on the necessity of forced medication, even if decided in the affirmative, instills a sense of fairness

725. See Ciccone et al., *supra* note 451, at 213-14; Appelbaum & Gutheil, *supra* note 4, at 345; John G. Malcolm, *Treatment Choices and Informed Consent in Psychiatry: Implications of the Osheroff Case for the Profession*, 14 J. Psychiatry & L. 9, 39 (1987); Roger D. Miller et al., *The Impact of the Right to Refuse Treatment in a Forensic Patient Population: Six-Month Review*, 17 Bull. Am. Acad. Psychiatry & L. 107, 114, 118 (1989).

726. See *supra* note 725. Studies have not yet documented the number of patient refusals which are being respected due to the prospect of a judicial hearing. Based on conversations with patient advocates, attorneys, and treating psychiatrists, it appears to this commentator that the number is substantial. A New York study indicates that rather than incurring the time and expense of seeking judicial authorization for forced medication, "staff became understandably and predictably eager to find satisfactory mechanisms to respond to patients' refusal of medication." Ciccone et al., *supra* note 451, at 214.

727. See *supra* note 725. A Wisconsin study found that upon implementation of a judicial review system, much more staff time was spent discussing the risks and benefits of treatment with patients and soliciting cooperation. The researchers acknowledged the resulting clinical benefits including the fact that thirty-three percent of the refusers eventually consented to treatment. Miller et al., *supra* note 725, at 118. See also Nathan T. Sidley, *The Right of Involuntary Patients in Mental Institutions to Refuse Drug Treatment*, 12 J. Psychiatry & L. 231, 244 (1984); Franklin J. Hickman et al., *Right to Refuse Psychotropic Medication: An Interdisciplinary Proposal*, 6 Mental Disability L. Rep. 122, 130 (1982); Brooks, *supra* note 50, at 209-10.

728. Francine Cournos 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).

729. *Id.*

730. *Id.*

in the patient which often leads to greater cooperation in the treatment program.⁷³¹

A judicial adversarial process subjects the proposed treatment plan to a heightened degree of scrutiny. A study by the Massachusetts Department of Mental Health found that even when forced medication is ultimately authorized, judicial review often results in improved modifications of the proposed treatment regime.⁷³² Research indicates that even in-house or independent administrative review procedures often result in positive changes in the treating physician's proposed drug therapy program.⁷³³ Granting a right to refuse medication also increases patients' cooperation in other treatment programs.⁷³⁴

731. See Callahan, *supra* note 717, at 313 (informal hearing before medical director considered a "sham" by patients); Bersoff, *supra* note 664, at 367-68 ("The failure to provide an adversarial forum, then, is likely to reduce compliance with the decision, producing increased temporal, financial, and administrative burdens on the institutions and professionals who participate in proceedings perceived as unfair, biased, and unjust."). *Id.* at 63-64; see also *supra* note 727 and accompanying text.

732. Massachusetts Department of Mental Health, Report on the Department of Mental Health's Implementation of the Supreme Judicial Court's Decision in *Rogers v. Commissioner* 30 (1988) [hereinafter DMH Report]. A recent study in Minnesota also revealed court involvement in the modification of proposed treatment plans. The author, a prescribing psychiatrist at the state facility in which the study took place, did not view the court involvement favorably. Michael G. Farnsworth, *The Impact of Judicial Review of Patients' Refusal to Accept Antipsychotic Medication at the Minnesota Security Hospital*, 19 Bull. Am. Acad. Psychiatry & L. 33, 41 (1991). However, research indicates that New York courts, operating under the *Rivers* decision, tend to focus almost exclusively on the competency of the patient and do not generally make a detailed inquiry into the appropriateness of the requested medication. As a result, ninety-six percent of court orders approving forced medication contain no modifications to the state's requested treatment program. Julie M. Zito et al., *New York Under the Rivers Decision: An Epidemiologic Study of Drug Treatment Refusal*, 148 Am. J. Psychiatry 904, 906 (1991) [hereinafter Epidemiologic Study]; Zito et al., *supra* note 422, at 305. The researchers call into question the propriety of certain treatment programs requested by the state and approved by the court as submitted. The authors justifiably criticize the courts' limited inquiries as failing to "meet the *Rivers* standard of narrowly tailoring drug therapy to individual patients' clinical needs, with ongoing review of risks and benefits." Epidemiologic Study, *supra*, at 908. Upon a finding of patient incompetency, one must question whether, in New York, patients' attorneys go on to challenge the appropriateness of the state's proposed treatment programs.

733. William A. Hargreaves et al., *Effects of the Jamison-Farabee Consent Decree: Due Process Protection for Involuntary Psychiatric Patients Treated With Psychoactive Medication*, 144 Am. J. Psychiatry 188, 192 (1987); Julie M. Zito et al., *Drug Treatment Refusal, Diagnosis and Length of Hospitalization in Involuntary Psychiatric Patients*, 4 Behavioral Sciences & L. 327, 334-36 (1986) [hereinafter Treatment Refusal]; Julie M. Zito et al., *Clinical Characteristics of Hospitalized Psychotic Patients Who Refuse Antipsychotic Drug Therapy*, 142 Am. J. Psychiatry 822, 824 (1985) [hereinafter Clinical Characteristics].

734. Callahan, *supra* note 717, at 311.

In *Charters II*, the Fourth Circuit feared that if adjudications of incompetency were required, the resulting delays might cause patients to deteriorate to such an extent that treatment would no longer be efficacious.⁷³⁵ This danger, however, can be alleviated by authorizing an emergency exception as envisioned by the First Circuit in *Rogers*. If the patient needs medication immediately to prevent significant and irreversible deterioration in his condition, alternative procedures could be employed and, if determined incompetent, the patient could receive medication until an adjudication could be arranged.⁷³⁶ However, as noted earlier, such a situation is extremely rare. Most individuals with untreated schizophrenia gradually deteriorate and respond just as well whether medication is delayed or immediate.⁷³⁷

The initial recognition of a right to refuse medication generated dire predictions by psychiatrists that refusals would disrupt hospital wards, jeopardizing the safety of staff and patients and preventing adequate treatment.⁷³⁸ An early study by Gill performed at the Boston State Hospital during the initial phases of the *Rogers* litigation appeared to lend some credence to these fears. Gill reported that the use of seclusion increased from 244 instances during the year prior to the issuance of a temporary injunctive order granting a right to refuse to 392 cases during the second year after the court's decree.⁷³⁹ Subsequent studies, however, indicate that this increase may have been largely due to an overcautious and anxious reaction by institutional staff during an initial period of adjustment before formalized procedures were in place.⁷⁴⁰

In Minnesota, a study performed during the initial twenty-month implementation period of a multidisciplinary treatment review panel

735. *United States v. Charters*, 863 F.2d 302, 312 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990).

736. *See supra* notes 439-450 and accompanying text.

737. *See supra* notes 445-446 and accompanying text.

738. Some psychiatrists described the right to refuse antipsychotic drugs as the right to rot with your rights on. *See* Gutheil, *supra* note 4; Appelbaum & Gutheil, *supra* note 4.

739. Michael J. Gill, *Side Effects of a Right to Refuse Treatment Lawsuit: The Boston State Hospital Experience*, in *Refusing Treatment in Mental Health Institutions—Values in Conflict* 81, 85-86 (A. Edward Doudera & Judith P. Swazey eds. 1982).

740. As Professor Brooks noted, Doctor Gill, a named defendant in the *Rogers* litigation,

with admirable candor, indicates that overly zealous staff may have, on occasion, consciously or unconsciously, tolerated or even encouraged patient deterioration by withholding medications and by applying the court standards in a particularly conservative way in order to assist the defense during litigation by "proving" that permitting refusals results in disturbance and violence.

Brooks, *supra* note 50, at 205-06.

(TRP) revealed a substantial decline in referrals based on risk of physical harm.⁷⁴¹ The researchers stated that “[t]his trend suggests greater acclimation of treatment staff members to the TRP referral process and their acceptance of the non-emergency situation as a viable one for forced medication administration.”⁷⁴² In a subsequent study performed at the same facility, the investigators compared the negative behavioral indicators of a matched group of consenters and refusers.⁷⁴³ The researchers found that the “refusers did not display more threatening, assaultive, or destructive behavior, nor did they demonstrate greater noncompliance with other parts of the treatment program” despite the fact that most of them had been medication-free for over a month.⁷⁴⁴ The study discovered that seclusion, physical restraint, transfer to locked wards, and one-to-one supervision were not more frequently used with the refuser groups.⁷⁴⁵ A California study by Hargreaves and associates found that the right to refuse medication did not have any impact on “length of stay, use of seclusion and restraint, or the frequency of injury incidents.”⁷⁴⁶ As illustrated by the Fourth Circuit in *Charters II*, the alleged “cumbersomeness, expense and delay” incident to additional procedural safeguards have weighed heavily in the decision by some courts to leave forced medication determinations within the discretion of institutional professionals.⁷⁴⁷ However, the above data suggest that these concerns are exaggerated.

When all refusals are considered as a whole, approximately fourteen to fifty percent of patients refuse medication at some point during their institutionalization.⁷⁴⁸ Many of these refusals, however, do not persist long enough to require outside intervention, with a considerable number being withdrawn within twenty-four hours. Thus, studies of formalized refusal procedures or those requiring refusals to persist for at least twenty-four hours have found much lower rates.⁷⁴⁹ Psychiatrists now

741. Review Panel, *supra* note 719, at 352-54.

742. *Id.* at 354.

743. Clinical Characteristics, *supra* note 733.

744. *Id.* at 825-26.

745. *Id.* at 826.

746. Hargreaves et al., *supra* note 733.

747. *United States v. Charters*, 863 F.2d 302, 309 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990). The Fourth Circuit did not cite any authority supporting this allegation.

748. For a synopsis of many of these studies, see Paul S. Appelbaum & Steven K. Hoge, *The Right to Refuse Treatment: What the Research Reveals*, 4 Behavioral Sci. & L. 279, 280-81 (1987).

749. See *id.* at 281. For civil patients, these refusal rates range from less than one percent to seven percent, although one study at a state hospital in Minnesota revealed a fifteen percent refusal rate. Zito et al., *supra* note 422, at 298 (1.3% of involuntary patients or 0.6% of hospital population required court review of refusal); Epidemiologic

admit that "[t]he feared epidemics of clinically significant treatment refusal, therefore, have not materialized to date."⁷⁵⁰ The delay between a physician's request for override of a patient's refusal and the review of the refusal varies according to the number of refusing patients, the type of review process, and the efficiency in implementing that process.⁷⁵¹

Study, *supra* note 732, at 905-06 (petitions for refusal review filed for approximately 1% of all civil and forensic admissions; however, nearly one-third of these petitions were withdrawn before court review); Ciccone et al., *supra* note 451, at 208-11 (1.2% of private hospital admittees and 3% of public hospital admittees initiated a formal refusal. However, only one of the sixteen refusers at the private facility (.08% of admittees) and fourteen of the forty refusers at the public hospital (1% of admittees) required court review of the refusal); South Dakota Human Services Center, Annual Report, Fiscal Year 1990, twenty-two (2.7% of adult involuntary patients in state hospital required judicial review of refusal in 1990; 2.5% in 1989); Steven K. Hoge et al., *The Right to Refuse Treatment Under Rogers v. Commissioner: Preliminary Empirical Findings and Comparisons*, 15 Bull. Am. Acad. Psychiatry & L. 163, 168 (1987) (2% of state hospital patients in Massachusetts received court review of refusal); Hargreaves et al., *supra* note 733, at 190 (although approximately 50% of involuntary patients at California state hospitals objected to medication at some point during the first eight weeks of hospitalization, only 5% of those refusals persisted for at least twenty-four hours); Review Panel, *supra* note 719, at 355 (15% refusal rate among involuntary patients at a Minnesota public hospital); Joseph D. Bloom et al., *An Empirical View of Patients Exercising Their Right to Refuse Treatment*, 7 Int'l J.L. & Psychiatry 315, 320 (1984) (7% refusal rate for involuntary patients at Oregon state hospital); Hassenfeld & Grumet, *supra* note 416, at 68 (0.08% refusals by admittees of New York state hospital); Robert Keisling, *Characteristics and Outcome of Patients Who Refuse Medication*, 34 Hosp. & Community Psychiatry 847, 848 (1983) (2.4% refusal rate at Washington, D.C., public hospital); Henry C. Weinstein, *The Right to Refuse Treatment*, 5 Bull. Am. Acad. Psychiatry & L. 425, 435 (1977) (0.1% refusal review rate at New York public hospital).

Refusal rates for forensic patients average slightly higher, ranging from two to fourteen percent. Farnsworth, *supra* note 732, at 36 (37 of 255 admittees (14%) to high security state forensic facility referred for refusal review); Miller et al., *supra* note 725, at 110-11 (39 of 272 admittees (14%) to maximum security forensic facility required court review of refusal); Leta D. Smith, *Medication Refusal and the Rehospitalized Mentally Ill Inmate*, 40 Hosp. & Community Psychiatry 491, 495 (1989) (2.3% refusal rate in New York forensic facility); Jeffrey T. Young et al., *Treatment Refusal Among Forensic Inpatients*, 15 Bull. Am. Acad. Psychiatry & L. 5, 10 (1987) (13% refusal by admittees to Oregon forensic hospital); Callahan, *supra* note 717, at 308 (9.5% refusal rate at Ohio forensic facility); A. Heller, *Due Process as Ordered in Clinical Practice as Protection of Patient Right to Refuse*, unpublished manuscript, reported in Appelbaum & Hoge, *supra* note 748, at 281 (8% refusal rate among population of Ohio forensic facility).

750. Appelbaum & Hoge, *supra* note 748, at 281. See also Hargreaves et al., *supra* note 733, at 192.

751. Oregon's review system, involving an independent psychiatrist who interviews the refusing patient and makes a recommendation to the facility's superintendent for final decision, averages 12.5 days at one hospital. Bloom et al., *supra* note 452, at 7. However, studies of New York's prior system indicated a delay of 5.4 to in excess of 7 weeks. Cournos et al., *supra* note 728, at 853 (5.4 week delay); Hassenfeld & Grumet, *supra* note 416, at 70 (mean delay of 52.2 days). This process consisted of a paper review by the head of service and the hospital director before a final decision by an independent

There is no evidence that these delays result in any type of significant harm to the patient.⁷⁵² In fact, studies reveal that delays caused by procedural safeguards do not even result in longer hospital stays.⁷⁵³

psychiatrist acting under the auspices of the regional director within the state Office of Mental Health. Cournos et al., *supra* note 728, at 852.

New York's judicial review system after *Rivers v. Katz* continues to include a modified initial clinical review involving an interview by the treating physician and clinical director and averages only 5.8 weeks at one state hospital. *Id.* at 853. At least one public hospital utilizes an independent psychiatrist rather than the hospital's clinical director in the administrative review preceding the judicial hearing. Ciccone et al., *supra* note 451, at 205. Other studies of New York's procedural scheme reveal even shorter delays. A study by Ciccone and associates reveals delays ranging from three to seven weeks, depending on the court's schedule. Ciccone et al., *supra* note 451, at 210. Zito and colleagues discovered that the median time is only thirty-five days and note that the judicial procedure is more expedient than the previous administrative review system. Zito et al., *supra* note 422, at 303; *see also* Epidemiologic Study, *supra* note 732, at 906 (58% of cases resolved within thirty days of petition; 25% within thirty to sixty days; 10% within ninety days; and 6% within 91-547 days).

Minnesota's procedural scheme entails an evaluation of the patient's refusal by a multidisciplinary treatment review panel. If the panel recommends forced medication, the patient is entitled to a judicial review. In an emergency situation, drugs may be administered pending the completion of the process. Farnsworth, *supra* note 732, at 39-40. A study by Farnsworth at a state forensic facility revealed that in non-emergency situations, the average time between a petition for review and the court decision is approximately ten weeks. In emergency cases, however, the court decision is rendered about 6.5 weeks after the petition is filed. *Id.* at 37. A study by Miller and associates found a delay of only slightly more than thirty days during the initial six months of Wisconsin's judicial review system. Miller et al., *supra* note 725, at 111.

Data from Massachusetts during the first twelve months of the judicial review system decreed in *Rogers v. Commissioner* indicated an average delay of 4.5 months. Jorge Veliz & William S. James, *Medicine Court: Rogers in Practice*, 144 Am. J. Psychiatry 62, 63 (1987). A more recent report, however, reveals that when physicians deem the circumstances urgent, a court order can be obtained from within a few hours to fourteen days. DMH Report, *supra* note 732, at 31. However, when reviews are scheduled into the regular probate schedule, delay can range from two to four months. *Id.* All medication decisions in both mental health and mental retardation facilities are judicially reviewed, even for *consenting* patients. *See id.* at 29. The Massachusetts Supreme Judicial Court did not require that medication determinations be reviewed for consenting patients. However, it did suggest that "because incompetent persons cannot meaningfully consent to medical treatment, a substituted judgment by a judge should be undertaken for the incompetent patient even if the patient accepts the medical treatment." *Rogers v. Commissioner of Dep't of Mental Health*, 458 N.E.2d 308, 315 n.14 (Mass. 1983).

Similar delays were experienced in South Dakota during the initial phases of a judicial review process. Despite only ten referrals during an eight month period, judicial review through the regular circuit court schedule resulted in a 2.5 month average delay. Chief of Social Services, South Dakota Human Services Center Memorandum (Sept. 6, 1989). Fifteen override petitions were actually filed during this period, but five patients voluntarily withdrew their refusals. *Id.*

752. *See supra* notes 445-452 and accompanying text; Brooks, *supra* note 15, at 370.

753. In a recently published study of consenters and refusers in a New York hospital,

In one study which did indicate a longer hospitalization period for refusers, the increase was attributed to the delay between the time of refusal (rather than physician's request for override) and the ultimate decision on whether to treat.⁷⁵⁴ Nevertheless, refusers who accepted medication after a sometimes lengthy review process were better able to function postdischarge than compliers.⁷⁵⁵ The researchers concluded that "[t]he increased length of stay and the concomitant increase in hospital cost is probably a small price to pay for allowing these [refusing] patients to maintain some sense of autonomy, which is useful for coping with life outside of the hospital."⁷⁵⁶

Zito and associates found that refusers had shorter hospital stays to a degree approaching statistical significance. Zito et al., *supra* note 422, at 301. The authors cite anecdotal evidence that some refusers may be transferred or discharged "to rid the treatment program of troublemakers and uncooperative patients." *Id.* at 305.

Williams and colleagues compared hospitalized insanity acquittees who had refused drug treatment with non-refusing insanity acquittees in an Oregon forensic facility. The researchers "were unable to establish that the treatment refusal incident itself had an effect on the patient's length of stay in the hospital." Mary H. Williams et al., *Drug Treatment Refusal and Length of Hospitalization of Insanity Acquittes*, 16 Bull. Am. Acad. Psychiatry & L. 279, 283 (1988). In this study, treatment refusal was overridden in all cases and the review process was estimated to average approximately eleven days. *Id.*

In comparing refusers of antipsychotic drugs with a matched sample of consenters at a Minnesota state hospital, researchers found there was no significant difference between the two groups in the number of patients discharged. Moreover, discharged refusers had a shorter median length of stay than did the discharged consenters. Clinical Characteristics, *supra* note 733, at 824. The sample of refusers chosen were those who had been approved for non-emergency forced medication by the treatment review panel. *Id.* at 823.

754. Hassenfeld & Grumet, *supra* note 416, at 70. See also Bloom et al., *supra* note 749, at 327 (fourteen day increase in length of stay for refusers). Some physicians make the unwarranted assumption that a delay occasioned by a review process automatically results in a concomitant increase in the length of hospitalization. For example, Ciccone and colleagues studied the impact of the judicial review process implemented in New York pursuant to the *Rivers* decision. Ciccone et al., *supra* note 451. The study revealed an increase in the time between refusal and resolution. The authors went on to assume that each day of this increase translated into an additional day of hospitalization with its accompanying cost. *Id.* at 210. However, their study revealed no significant difference in the length of a refuser's hospitalization pre-*Rivers* and post-*Rivers*. *Id.* at 208. See also Farnsworth, *supra* note 732, at 40-41 (unsupported assumption that the delay occasioned by judicial review automatically translates into a concomitant increase in length of hospitalization).

755. Hassenfeld & Grumet, *supra* note 416, at 72-73.

756. *Id.* at 73. For other studies indicating that the treatment refusal incident does not harm the patient, see Sally L. Godard et al., *The Right to Refuse Treatment in Oregon: A Two-Year Statewide Experience*, 4 Behavioral Sci. & L. 293, 302-04 (1986); Bloom et al., *supra* note 452, at 7.

The upholding of a refusal does not necessarily result in harm to the patient. Data on the effects of long-term successful refusal is insufficient. A study of forty-four patients whose refusals were upheld on review at a state hospital in California revealed that

Despite the lack of resulting harm, procedural protections should not unduly delay necessary and appropriate treatment. Delays, however, are not a valid reason for diminishing the protections designed to assure that intrusive treatment is, in fact, necessary and appropriate. Some delay is inherent to the implementation of new procedural mechanisms and is eliminated by further refinements and adoption of standardized guidelines.⁷⁵⁷ In addition, measures are available to enhance the efficiency of judicial review systems. For example, in Massachusetts, a probate session is scheduled to be held on the grounds of some facilities each month.⁷⁵⁸ Another suggestion has been to implement "a system of 'on-call' probate judges."⁷⁵⁹ In 1990, the South Dakota Legislature eliminated long delays by enacting legislation requiring the court hearing to be held within thirty days from service of the petition for review.⁷⁶⁰ Only one year later, the legislature reduced this period to fifteen days and limited any extension to one seven-day continuance, to be restrictively granted only for good cause.⁷⁶¹

New procedures efficiently and timely implemented entail higher financial costs. A study of the independent psychiatric review system in California revealed that during its first year of implementation, each patient review cost approximately \$100. This figure accounted for the salaries of independent psychiatric reviewers, patient advocates, hospital and departmental support staff, and various non-personnel expenses.⁷⁶² The researchers estimated that it would cost approximately \$1-1.5 million

significant deterioration occurred in twenty-five patients, of whom twenty were medicated. No adverse effects were observed in eight patients. The effect of refusal was unclear in the remaining patients. Hargreaves et al., *supra* note 733, at 190. Thus, there was no observable harm to patients in 42% of the cases and presumably no long-term harm to the twenty patients later medicated. A six-month study in Wisconsin revealed that of nineteen patients whose refusals were respected, only one deteriorated to the point where an involuntary medication order was sought. Miller et al., *supra* note 725, at 111.

757. See DMH Report, *supra* note 732, at 16-17 and n.18.

758. *Id.* at 32.

759. Veliz & James, *supra* note 751, at 62.

760. S.D. Codified Laws § 27A-12-11.6 (Supp. 1990). Conversations with staff and patient advocates at the South Dakota Human Services Center revealed that the court system adequately adjusted to this legislative mandate.

761. S.D. Codified Laws § 27A-12-3.14 (1992). In 1992, the South Dakota Legislature enacted legislation introduced by the National Alliance for the Mentally Ill which allows forced medication pending the court review, if approved by a medical/administrative panel. S.D. Codified Laws § 27A-12-3.12 (1992). This provision thus allows nonconsensual treatment before the judicial determination on the patient's competency. A South Dakota circuit court recently issued a preliminary injunction barring implementation of this legislation. *Lindquist v. Thorpe*, No. 92-367 (S.D. 1st Cir. Oct. 29, 1992) (unpublished opinion). This case, however, was subsequently dismissed when the patient began to voluntarily accept the administration of antipsychotic drugs. Further litigation is expected.

762. Hargreaves et al., *supra* note 733, at 192. This figure did not include the hidden cost of clinician time expended on paperwork. *Id.*

annually for reviews at the five major state hospitals in California.⁷⁶³

Researchers in Minnesota estimated that the cost for each patient review under the former multidisciplinary treatment review panel system averaged approximately \$162.⁷⁶⁴ Farnsworth, in a study of the first year implementation of Minnesota's current judicial review process, estimates an annual cost of \$150,000 for the Minnesota Security Hospital, although he provides no basis for this figure.⁷⁶⁵

As Professor Brooks points out, accurate estimates of long-term financial outlays are difficult during the initial implementation of procedural mechanisms. Costs are likely to diminish as adjustments and refinements are made.⁷⁶⁶ Evidence also indicates that some of these expenses are offset by savings from decreased medication usage.⁷⁶⁷ In any event, given the important interests protected and the practical medical benefits arising from additional procedural safeguards, these expenses appear reasonable in the context of the total funding necessary to operate a state mental health system.⁷⁶⁸

It is also argued that additional procedural protections are a waste of administrative and financial resources. This argument is based on reports that most refusals are overridden regardless of the type of review

763. *Id.* But see Hickman et al., *supra* note 727, at 129-30 (after six months with a similar review system, the medical director of an Ohio state hospital reported a low rate of refusal resulting in no significant administrative burden); Kemna, *supra* note 66, at 119 ("The practical application of right to refuse due process procedures seems to undercut psychiatric objections related to excessive or undue cost."); Brooks, *supra* note 50, at 201 (citing a New Jersey mental health official who acknowledged that the cost of implementing the independent psychiatric review system ordered by the district court in *Rennie* was nominal).

764. This estimate included the cost of time spent by each of the five or more panelists and the reviewers involved in a two-step appeal process. Review Panel, *supra* note 719, at 355. The appeal process involved review of the panel's decision by the facility's medical director and a subsequent review by a hospital review board. *Id.* at 352. During the study period, the panel averaged 3.72 reviews per week. *Id.* at 355.

765. Farnsworth, *supra* note 732, at 41. Doctor Farnsworth adds an additional \$205,000 to this figure as representing the cost of total hospital days between patients' refusals and the ultimate dispositions. However, as noted earlier, this cost is based on the mistaken premise that delays occasioned by procedural safeguards automatically result in an increase in the length of hospitalization. See *supra* note 754. Ciccone and associates engage in the same unwarranted assumption. See *id.* The Massachusetts Legislature budgeted over \$800,000 in 1986 to cover the legal, clinical, and support staff costs incurred by the comprehensive judicial review system implemented after the *Rogers* decision, a system which requires review of both refusing and consenting patient decisions. DMH Report, *supra* note 732, at 20.

766. Brooks, *supra* note 50, at 202.

767. *Id.* (citing a report from one New Jersey hospital indicating a one year savings of \$100,000 because of decreased use of medication as a result of the *Rennie* decree).

768. See Brooks, *supra* note 15, at 373.

system.⁷⁶⁹ Unfortunately, studies rarely address the substantive criteria on which refusal overrides are based. As a result, few conclusions can be accurately drawn from the available data.⁷⁷⁰ Nonetheless, critics of

769. A study performed at the Lima State Hospital in Ohio revealed that the medical director, who presides over an adversarial-type hearing, overrides 75% of patient refusals. In no case was the medical director's decision overturned by the independent reviewing psychiatrist. Hickman et al., *supra* note 727, at 129-30. Other studies at the same facility found a 71% to 86% override rate by the medical director. Heller, *supra* note 749, reported in Appelbaum & Hoge, *supra* note 748, at 289 (71% override rate); Callahan, *supra* note 717, at 312 (86% override rate). A study performed at St. Elizabeth Hospital in Washington, D.C., found that all nine patient refusals reviewed by the medical director were overridden on grounds of patient incompetency. Keisling, *supra* note 749, at 847. Studies from Oregon, where the patient is not entitled to a hearing, indicate a 95% to 100% override rate by independent psychiatric reviewers. Bloom et al., *supra* note 749, at 315 (95% override rate); Young et al., *supra* note 749, at 7 (100% override rate). Under a similar system in California, a one-year study at Napa State Hospital reveals a 98.9% override rate by independent psychiatrists. Hargreaves et al., *supra* note 733, at 188. Likewise, a report on a comparable process previously implemented in New York revealed a 95% override rate by the reviewing independent psychiatrist. Cournos et al., *supra* note 728, at 853.

A 1982 study of the treatment review panel system previously in effect in Minnesota discovered the lowest reported rate of refusal overrides. The multidisciplinary panel at Anoka State Hospital overrode 67% of patient refusals. Review Panel, *supra* note 719, at 355. However, a subsequent study at the Minnesota Security Hospital revealed an 87% override rate by the panel. Farnsworth, *supra* note 732, at 40. This retrospective study also reported on Minnesota's current procedural system in which panel recommendations for forced treatment are referred for court review. It was found that under these circumstances, in which the review panel does not act as the ultimate decisionmaker, 95% of patient refusals are overridden and forwarded to the judiciary. *Id.* at 37.

Information from Massachusetts indicates that judges overturn patient refusals in 90% to 98.6% of reviews. Veliz & James, *supra* note 751, at 64 (90% override rate); Hoge et al., *supra* note 749, at 167 (96% override rate); DMH Report, *supra* note 732, at 26 (98.6% override rate). A Minnesota study found that judges override forensic patient refusals in 93% of the cases referred by the clinical review panel. Farnsworth, *supra* note 732, at 39. Studies from New York reveal that requests to forcibly medicate are approved by the judiciary in 85% to 91% of the cases. Ciccone et al., *supra* note 451, at 211 (85% authorization rate); Zito et al., *supra* note 422, at 300 (87% approval rate); Cournos et al., *supra* note 728, at 853 (89% authorization rate); Epidemiologic Study, *supra* note 732, at 906 (91% approval rate). In South Dakota, the judicial override rate was 85% in 1989 and 77% in 1990. South Dakota Human Services Center, Annual Report, Fiscal Year 1990 at 22.

770. Other variables which may affect the override rate are the reason for the patient's commitment and the quality of representation for the patient during the refusal review. A Wisconsin study revealed that during the first six months of judicial review, courts overrode 100% of the forensic cases presented. Miller et al., *supra* note 725, at 115. However, most of the refusers were committed as incompetent to stand trial. The authors speculated that "judges were unwilling to permit defendants who were incompetent to proceed to avoid trial by choosing to refuse treatment." *Id.* In addition, the authors noted that "few defense attorneys seriously challenged our recommendations for involuntary treatment." *Id.* Another factor contributing to the high judicial override rate was a lack of knowledge regarding appropriate criteria and procedures during this initial implementation period. *Id.* at 112, 115.

court involvement argue that the high judicial override rates indicate that the legal review process does little to protect patient rights.⁷⁷¹ Studies indicate, however, that only those patients deemed most in need of antipsychotic medication are referred for court review.⁷⁷² Indeed, in both New York and Minnesota, patient refusals are first subject to a clinical review process. Only those refusals which are overridden during this initial screening are referred for court review.⁷⁷³ Thus, high judicial override rates are not surprising. And yet the data indicates that override rates are generally higher when the decisionmaker is a physician rather than a judge.⁷⁷⁴

It can also be persuasively argued that high override rates do not justify revocation of procedural protections. Even a ninety percent override rate means that ten percent of the patients reviewed are protected from the inappropriate and unnecessary administration of an intrusive treatment. It should also be emphasized that the utility of the adversarial review process cannot be judged by the number of refusals which are upheld by the court. Instead, the advantages referred to earlier, including the fostering of consultation and negotiation with the patient, allowing the patient to participate in his own treatment plan, and taking such input seriously, are the true measures of the value of judicial involvement. As Professor Brooks stated, the legal system serves to remind "mental health professionals, particularly psychiatrists, what many of them had long ignored and should have known, that their patients have a moral as well as a legal right to participate in their own treatment programs and to express their reactions to medications."⁷⁷⁵

X. *WASHINGTON V. HARPER*: THE UNITED STATES SUPREME COURT ADDRESSES THE RIGHT TO REFUSE IN THE PRISON SETTING

A. *The Proceedings Below*

In *Harper v. State*,⁷⁷⁶ the Washington Supreme Court rejected the applicability of the professional judgment standard to drug refusal cases.⁷⁷⁷ *Harper* involved a convicted felon, Walter Harper, incarcerated in the Special Offenders Center (SOC). This correctional institution was es-

771. Veliz & James, *supra* note 751, at 66.

772. See *supra* notes 726-727; Veliz & James, *supra* note 751, at 63; Zito et al., *supra* note 422, at 302.

773. See *supra* note 751.

774. See *supra* note 769.

775. Brooks, *supra* note 15, at 374.

776. *Harper v. State*, 759 P.2d 358 (Wash. 1988), *rev'd sub nom.* *Washington v. Harper*, 494 U.S. 210, 110 S. Ct. 1028 (1990).

777. *Washington v. Harper*, 489 U.S. 1064, 109 S. Ct. 1337 (1989).

established to diagnose and treat prisoners suffering from "serious behavioral or mental disorders."⁷⁷⁸

After being diagnosed as mentally ill, Harper voluntarily submitted to treatment with antipsychotic medication. He was administered a wide variety of drugs, including Trialafon, Haldol, Prolixin, Taractan, Loxitane, Mellaril, and Navene.⁷⁷⁹ Harper began experiencing symptoms of dystonia and akathisia which led to his refusal of the medication after approximately ten months of treatment.⁷⁸⁰ Harper had a history of assaultive behavior which was attributed to his mental disorder. His treating physician believed that antipsychotic drugs reduced such conduct and sought authorization for involuntary medication.⁷⁸¹

The offenders center had a stated policy (Policy 600.30) which allowed forced treatment with antipsychotic drugs upon a finding that a prisoner suffers from a mental illness and, as a result, is gravely disabled or presents a likelihood of serious harm to himself, others, or their property.⁷⁸² Procedurally, the policy provided for an informal, in-house hearing before a committee consisting of a psychiatrist, a psychologist, and the associate superintendent of the center. At the time of the hearing, committee members could not be involved in the inmate's diagnosis or treatment, although such past involvement was not prohibited.⁷⁸³

The prisoner was entitled to at least twenty-four hours notice of the hearing and an explanation of why the drugs were being proposed. The inmate also had the right to attend the hearing, present evidence, and cross-examine staff witnesses.⁷⁸⁴ There was no right to legal counsel, although the assistance of a lay advisor was made available.⁷⁸⁵ Prior to an involuntary medication hearing, the committee met with institutional staff, *ex parte*, to determine whether the policy's requirements had been complied with. At this pre-hearing meeting, staff were allowed to explain their positions to committee members.⁷⁸⁶

778. *Harper*, 759 P.2d at 360.

779. *Washington v. Harper*, 494 U.S. 210, 214, 110 S. Ct. 1028, 1032 (1990).

780. Brief of Respondent at 20-21, *Harper*, 494 U.S. 210, 110 S. Ct. 1028; *Harper*, 759 P.2d at 360-61 & n.4.

781. Brief of Respondent at 2-3, *Harper*, 494 U.S. 210, 110 S. Ct. 1028.

782. *Harper*, 494 U.S. at 215, 110 S. Ct. at 1033.

783. *Id.*

784. *Id.* at 216, 110 S. Ct. at 1033. The rights to present testimony and cross-examine could be restricted "for reasons that 'include, but are not limited to such things as irrelevance, lack of necessity, redundancy, possible reprisals, or other reasons relating to institutional interests or security, order, and rehabilitation.'" *Id.* at 1055 (Stevens, J., dissenting) (quoting Record, Book 9, Policy 600.30, p.3).

785. *Id.* at 216, 110 S. Ct. at 1033-34.

786. *Harper v. State*, 759 P.2d 358, 362-63 (Wash. 1988), *rev'd*, 494 U.S. 210, 110 S. Ct. 1028 (1990).

The policy required approval by the psychiatrist and one other committee member to authorize non-emergency forced medication.⁷⁸⁷ The committee's order, effective for seven days, was appealable to the center's superintendent.⁷⁸⁸ After seven days, a similarly composed committee could authorize indefinite involuntary medication based on a paper review of the inmate's file and the minutes of the hearing.⁷⁸⁹ Members of the initial hearing committee and treating staff were permitted to serve on this long-term panel.⁷⁹⁰ Once indefinite drug treatment was authorized, the only safeguard was a bi-weekly review and report by the treating psychiatrist.⁷⁹¹

During his hearing, Harper was represented by a nurse practitioner from another institution.⁷⁹² The committee found Harper to be a danger to others as a result of a mental disorder and approved involuntary medication. The SOC superintendent upheld the committee's order on appeal.⁷⁹³ Harper was administered antipsychotic drugs on an involuntary basis until he was transferred to a state penitentiary nearly four years later.⁷⁹⁴ Prior to his transfer, Harper filed suit in state court charging that the forced medication violated his constitutional rights to equal protection, free expression, and due process.⁷⁹⁵ Although the trial court found that Harper retained a liberty interest in refusing antipsychotic drugs, it held that the mandates of Policy 600.30 satisfied due process requirements.⁷⁹⁶ Harper appealed directly to the Washington Supreme Court.⁷⁹⁷ The Washington Supreme Court had previously held in the case of *In re Schouler*⁷⁹⁸ that an involuntarily committed mental patient had a fundamental privacy interest in being free to decide whether to undergo electroshock therapy (ECT).⁷⁹⁹ In *Harper v. State*, the same court held that because "antipsychotic drug treatment is no less intrusive than ECT," prisoners retain a fundamental privacy interest, arising from the Due Process Clause of the Fourteenth Amendment, in refusing drug

787. *Washington v. Harper*, 494 U.S. 210, 215-16, 110 S. Ct. 1028, 1033 (1990).

788. *Id.* at 216, 110 S. Ct. at 1034.

789. *Id.* at 251, 110 S. Ct. at 1052.

790. *Id.* In this case, Harper's treating psychiatrist was not a member of this long-term committee. *Id.* at 216, 110 S. Ct. at 1034.

791. *Id.*, 110 S. Ct. at 1034.

792. *Id.* at 217, 110 S. Ct. at 1034.

793. *Id.*, 110 S. Ct. at 1034.

794. *Id.*, 110 S. Ct. at 1034.

795. *Id.*, 110 S. Ct. at 1034. Harper also brought tort claims under state law.

796. *Id.* at 217-18, 110 S. Ct. at 1034.

797. *Harper v. State*, 759 P.2d 358, 360 (Wash. 1986), *rev'd*, 494 U.S. 210, 110 S. Ct. 1028 (1990).

798. *In re Schouler*, 723 P.2d 1103 (Wash. 1986).

799. *Id.* at 1108.

therapy.⁸⁰⁰ The court based the right to refuse on due process grounds, and did not address Harper's equal protection and First Amendment claims.⁸⁰¹

The Washington Supreme Court upheld the trial court's determination that the policy satisfied due process. The state first pointed to the Supreme Court's decision in *Vitek v. Jones*⁸⁰² and argued that due process merely requires an independent institutional decisionmaker rather than a judge in a forced medication review.⁸⁰³ The state further relied on *Youngberg* in maintaining that a "professional decisionmaker" adequately protects the due process rights of mentally disabled persons.⁸⁰⁴

The Washington Supreme Court, however, distinguished both *Youngberg* and *Vitek*. The court noted that *Youngberg* did not involve the issues relevant to a forced medication determination.⁸⁰⁵ The court stated that "[h]ere, we are concerned with the administration of mind altering drugs that have adverse, potentially permanent, side effects. We believe that the highly intrusive nature of antipsychotic drug treatment warrants greater protections than those necessary to protect the interest at issue in *Vitek*."⁸⁰⁶ The court concluded that "a judicial hearing is required before the State may administer antipsychotic drugs to a prisoner against his will."⁸⁰⁷

The Washington Supreme Court relied on *Schuoler* in defining the criteria for judicial authorization of forced medication. The reviewing court must first determine whether the inmate's refusal is competently made. If not, the court would then make a substituted judgment for the individual.⁸⁰⁸ A competent refusal or one arising from the substituted judgment can only be overridden by a compelling state interest.⁸⁰⁹ If a compelling state objective is found, the court must then determine whether

800. *Harper*, 759 P.2d at 362. The court labeled this right to refuse antipsychotic drugs a "liberty" interest. In so doing, the court cited its previous decisions in *Schuoler* and *In re Guardianship of Ingram*, 689 P.2d 1363 (Wash. 1984). *Id.* at 361. These cases make it clear that the court was relying on the privacy interest in making fundamental personal decisions and remaining free from unwarranted government intrusions. See *Schuoler*, 723 P.2d at 1108; *In re Guardianship of Ingram*, 689 P.2d 1363, 1368 (Wash. 1984).

801. *Harper*, 759 P.2d at 361 n.2. The court did not address the state law tort claims. *Id.* at 361.

802. 445 U.S. 480, 100 S. Ct. 1254 (1980).

803. *Harper*, 759 P.2d at 363.

804. *Id.* (quoting *Youngberg v. Romeo*, 457 U.S. 307, 323, 102 S. Ct. 2452, 2462 (1982)).

805. *Id.*

806. *Id.*

807. *Id.* The court further supported its holding by noting that the Supreme Court in *Vitek* stated that "[i]t is precisely '[t]he subtleties and nuances of psychiatric diagnosis' that justify the requirement of adversary hearings." *Id.*

808. *Id.* at 365.

809. *Id.* at 364.

treatment with antipsychotic drugs is both necessary and effective, considering the prognosis with and without the drugs as well as other less intrusive measures.⁸¹⁰

B. *The Supreme Court's Review*

The United States Supreme Court granted certiorari in *Washington v. Harper*⁸¹¹ and agreed with the Washington high court in holding that a prisoner retains a constitutionally protected interest "in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment."⁸¹² A six to three majority, however, overruled *Harper* by finding that Policy 600.30 satisfied both substantive and procedural due process requirements.

1. *The Substantive Issue*

While conceding that a prisoner's interest in refusing medication is "significant,"⁸¹³ the Court stated that the "extent of a prisoner's right . . . to avoid the unwanted administration of antipsychotic drugs must be defined in the context of the inmate's confinement."⁸¹⁴ The majority then turned to a recently developed line of prison cases emphasizing the "[s]tate's interests in prison safety and security."⁸¹⁵ This jurisprudence, beginning with the Court's decision in *Turner v. Safley*,⁸¹⁶ has established that "the proper standard for determining the validity of a prison regulation claimed to infringe on an inmate's constitutional rights is to ask whether the regulation is 'reasonably related to legitimate penological interests.'"⁸¹⁷ The Court emphasized that "[t]his is true even when the constitutional right claimed to have been infringed is fundamental, and the State under other circumstances would have been required to satisfy a more rigorous standard of review."⁸¹⁸ The Court

810. *Id.* at 364-65.

811. *Washington v. Harper*, 494 U.S. 210, 110 S. Ct. 1028 (1990).

812. *Id.* at 221-22, 110 S. Ct. at 1036. The Court described this right as a liberty interest and cited both *Youngberg* and *Parham* for support. *Id.* at 222, 110 S. Ct. at 1036-37. In so doing, it appears the Court analogized to the liberty interest in freedom from bodily restraint rather than the privacy interest in personal decisionmaking and freedom from unwarranted government intrusions relied on by the Washington Supreme Court. However, in a subsequent case, Justice Rehnquist stated that the right to refuse medical treatment is more properly categorized as a liberty rather than a privacy interest. See *supra* notes 301-304, 331-334 and accompanying text.

813. *Id.*, 110 S. Ct. at 1036.

814. *Id.*, 110 S. Ct. at 1037.

815. *Id.* at 223, 110 S. Ct. at 1037.

816. *Turner v. Safley*, 482 U.S. 78, 107 S. Ct. 2254 (1987).

817. *Harper*, 494 U.S. at 223, 110 S. Ct. at 1037 (quoting *Turner*, 482 U.S. at 89).

818. *Id.*, 110 S. Ct. at 1037.

determined that the Washington Supreme Court erred in requiring a compelling rather than a rational state interest to override the respondent's right to refuse medication.⁸¹⁹

The Court stressed the legitimacy of the governmental interest, stating that "[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 proclivity for antisocial criminal, and often violent, conduct."⁸²⁰ Citing evidence indicating the effectiveness of antipsychotic drugs in "treating and controlling a mental illness likely to cause violent behavior," the Court found that Policy 600.30 is a "rational means of furthering the State's legitimate objectives."⁸²¹

The Court rejected Harper's contention that he must be found incompetent before the State may forcibly treat him with antipsychotic drugs. Focusing again on the "context of the inmate's confinement,"⁸²² the Court reasoned that the respondent's argument "takes no account of the legitimate governmental interest in treating him where medically appropriate for the purpose of reducing the danger he poses."⁸²³

The Supreme Court also rejected the applicability of the least restrictive alternative doctrine. Under *Turner's* "reasonableness" standard of review as applied in *Harper*, prison officials need not consider less intrusive means in controlling dangerousness, as long as the treatment method chosen is reasonable.⁸²⁴ Only if an "inmate claimant can point to an alternative that fully accommodates the prisoner's right at *de minimus* cost to valid penological interests" may the court "consider that as evidence that the [treatment] does not satisfy the reasonable relationship standard."⁸²⁵ The Court concluded its substantive analysis by stating:

We hold that, given the requirements of the prison environment, the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest.⁸²⁶

The Court's analysis of the substantive issue is confusing in a number of respects. Policy 600.30, which the Court purportedly upholds, falls

819. *Id.*, 110 S. Ct. at 1037.

820. *Id.* at 225, 110 S. Ct. at 1038 (quoting *Hudson v. Palmer*, 468 U.S. 517, 526, 104 S. Ct. 3194, 3200 (1984) (Stevens, J., dissenting)).

821. *Id.* at 226, 110 S. Ct. at 1039.

822. *Id.* at 222, 110 S. Ct. at 1037.

823. *Id.* at 226, 110 S. Ct. at 1039.

824. *Id.* at 225-26, 110 S. Ct. at 1038-39.

825. *Turner v. Safley*, 482 U.S. 78, 91, 110 S. Ct. 2254, 2262 (1987).

826. *Harper*, 494 U.S. at 227, 110 S. Ct. at 1039-40.

short of the standards articulated by the Court. While the policy authorizes forced drugging based on a risk of harm to property, the Court's holding is limited to danger to self or others. In addition, as Justice Stevens pointed out in dissent, Policy 600.30 does not require that antipsychotic drugs be medically appropriate for the inmate. On its face, the policy allows the forced drugging of a prisoner "based purely on the impact that his disorder has on the security of the prison environment."⁸²⁷ The majority merely assumed that an institutional psychiatrist would not prescribe drugs for reasons other than the inmate's medical needs.⁸²⁸ However, the Court then blends the prisoner's interest in medically appropriate treatment with institutional concerns by remarking that "the treatment in question will be ordered only if it is in the prisoner's medical interests, given the legitimate needs of his institutional confinement."⁸²⁹ This statement suggests a balancing by institutional professionals which may result in forced drugging, even when not medically appropriate, if institutional needs are deemed to outweigh an inmate's medical interests.⁸³⁰

Authorization of long-term drugging based on the policy's "likelihood of serious harm" standard flows directly from the majority's failure to adequately distinguish between a prisoner's medical needs and institutional concerns. As defined by the policy, this police power standard allows the forced administration of drugs based on mere speculation that an inmate poses a risk of future harm.⁸³¹ There is no requirement that the risk of harm be imminent. The abuse that such a "dangerousness" standard invites has been described earlier.⁸³² The Court allows antipsychotic drugs to be used as a form of chemical restraint in order to accommodate an ongoing penological interest in security and convenient management. As the dissent stated, "It is difficult to imagine what, if any, limits would restrain such a general concern of prison administrators who believe that prison environments are, 'by definition,' . . . made up of persons with 'a demonstrated proclivity for antisocial criminal, and often violent, conduct.'"⁸³³ The dissent concluded that "[t]he result is a muddled rationale that allows the 'exaggerated response'

827. *Id.* at 243, 110 S. Ct. at 1048 (Stevens, J., dissenting).

828. *Id.* at 222 n.8, 110 S. Ct. at 1037 n.8.

829. *Id.* at 222, 110 S. Ct. at 1037.

830. However, the Court later stated that the governmental interest was to treat Harper "where medically appropriate for the purpose of reducing the danger he poses." *Id.* at 226, 110 S. Ct. at 1039. This statement suggests that the medication must be determined medically appropriate before it can be administered to reduce danger.

831. *Id.* at 215 n.3, 110 S. Ct. at 1033 n.3.

832. See *supra* text accompanying notes 370-392.

833. *Id.* at 247, 110 S. Ct. at 1050 (quoting *Hudson v. Palmer*, 468 U.S. 517, 526, 104 S. Ct. 3194, 3200 (1984) (Stevens, J., dissenting)).

of forced psychotropic medication on the basis of purely institutional concerns. So serving institutional convenience eviscerates the inmate's substantive liberty interest in the integrity of his body and mind."⁸³⁴

The Court's refusal to require a finding of incompetence as a precondition to forced drugging is not surprising in the context of the state's police power authority. Several lower courts which have authorized forced medication on police power grounds have not deemed it necessary to address the patient's ability to make treatment decisions. Whether competent or not, if the individual presents a threat of violence reaching the requisite degree, forced treatment has been allowed.⁸³⁵

By upholding Policy 600.30, the Court purportedly affirms the regulation's "gravely disabled" standard for compelling drug treatment. This affirmance creates additional confusion when considered in the context of the Court's specific holding, which restricts forced medication to prisoners who are dangerous. As defined, the gravely disabled criterion includes an individual who "manifests severe deterioration in routine functioning . . . and is not receiving such care as is essential for his or her health or safety."⁸³⁶ The Court did not have occasion to thoroughly address this standard as the respondent did not fall within its parameters. Indeed, the Court justified its holding by referring to the drugs' efficiency in controlling violent conduct⁸³⁷ and pointing to the respondent's "long history of serious, assaultive behavior."⁸³⁸ In addition, the Court emphasized the state's police power interest in preventing violence in a setting populated by individuals with "a demonstrated proclivity for antisocial criminal, and often, violent conduct."⁸³⁹

The gravely disabled standard implicates the state's *parens patriae* rather than its police power authority to force treatment. However, the Court failed to distinguish between a gravely disabling condition and a condition presenting a "likelihood of serious harm." Instead, the majority appears to combine the two under the label of "dangerousness" and implements the same "reasonableness" standard of review for both. Perhaps the Court deemed an inmate experiencing deterioration in functioning as particularly vulnerable to abusive and violent behavior in a prison setting. However, labeling a mere deterioration in functioning as

834. *Id.* at 249-50, 110 S. Ct. at 1051 (Stevens, J., dissenting).

835. *See* *Bee v. Greaves*, 744 F.2d 1387, 1395-96 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214, 105 S. Ct. 1187 (1985); *Rogers v. Okin*, 634 F.2d 650, 655-56 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291, 102 S. Ct. 2442 (1982); *People v. Medina*, 705 P.2d 961, 974 (Colo. 1985); *Rivers v. Katz*, 495 N.E.2d 337, 343 (N.Y. 1986).

836. *Harper*, 494 U.S. at 215 n.3, 110 S. Ct. at 1033 n.3.

837. *Id.* at 226, 110 S. Ct. at 1039.

838. *Id.* at 227 n.11, 110 S. Ct. at 1040 n.11.

839. *Id.* at 228, 110 S. Ct. at 1038.

dangerousness, thereby invoking the police power standard of review, eviscerates the restrictions traditionally associated with the state's *parens patriae* authority to compel medical treatment.

As explained earlier, when invoked to justify the forced treatment of the mentally ill, the *parens patriae* power is based on the compelling need to help individuals who, because of their mental impairments, are incapable of evaluating their own need for psychiatric treatment. Thus, the Court's perfunctory rejection of the need for a finding of incompetence before medication can be forced is disturbing in light of the policy's gravely disabled standard. Whether the Court intended to deprive a competent prisoner of the right to decide whether to submit to intrusive treatment when no danger of violence is threatened is less than clear from its opinion. However, as explained below, in a subsequent clarification of *Harper*, the Court has indicated that the decision is limited to situations involving a threat of physical violence.⁸⁴⁰

The Court refused to consider the less intrusive measures proffered by the respondent as acceptable alternatives to forced drugging. The majority held that measures such as seclusion and physical restraints do not satisfy the *Turner* standard because they impose more than a *de minimus* cost on limited prison resources.⁸⁴¹ The Court also indicated concern that physical restraints leave "the staff at risk of injury while putting the restraints on or tending to the inmate who is in them."⁸⁴² However, as the dissent stated, "Harper's own record reveals that administrative segregation and standard disciplinary sanctions were frequently imposed on him over and above the forced medication and thus would add no new costs."⁸⁴³ In addition, applying physical restraints or administering less intrusive drugs such as sedatives pose no greater risk to staff than nonconsensual intramuscular injections of antipsychotics.⁸⁴⁴

2. The Procedural Issue

The Court in *Harper* began a procedural analysis of Policy 600.30 by repeating the guiding considerations previously enunciated in *Mathews*.⁸⁴⁵ In addressing the first factor, the private interest at stake, the Court described several side effects of antipsychotic drugs. The majority once again acknowledged that the "[r]espondent's interest in avoiding

840. See *infra* notes 914-916 and accompanying text. In *Harper*, the Court supported its holding on the incompetence issue by reasoning that the respondent's argument did not take account of the government's interest in "reducing the danger he poses." *Harper*, 494 U.S. at 226, 110 S. Ct. at 1039.

841. *Id.* at 226, 110 S. Ct. at 1039.

842. *Id.* at 227, 110 S. Ct. at 1039.

843. *Id.* at 248, 110 S. Ct. at 1051 (Stevens, J., dissenting).

844. See *id.*, 110 S. Ct. at 1051 (Stevens, J., dissenting).

845. *Id.* at 229, 110 S. Ct. at 1041.

the unwarranted administration of antipsychotic drugs is not insubstantial."⁸⁴⁶ Notwithstanding the described risks of the drugs, the Court, citing its previous decisions in *Parham* and *Youngberg*, upheld the policy's procedures as adequate under the Due Process Clause. The majority supported its holding by characterizing the necessary inquiries—whether the inmate suffers from a mental disorder and whether, as a result of that disorder, he is dangerous—as “medical” in nature.⁸⁴⁷ Like the Fourth Circuit in *Charters II*, the Supreme Court classified the risks associated with antipsychotic drugs as “for the most part medical ones.”⁸⁴⁸ So characterized, the Court concluded that “an inmate’s interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge.”⁸⁴⁹ Like the Fourth Circuit in *Charters II*, the Court quoted from *Parham* in maintaining 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.”⁸⁵⁰ 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.”⁸⁵¹

Finding that there was “no indication that any institutional biases affected or altered the decision to medicate respondent against his will,” the majority was satisfied that the policy’s procedures assured “independence of the decisionmaker.”⁸⁵² The Court further justified its approval of an internal review system by citing studies which indicate that even outside decisionmakers most often concur with the treating physician’s recommendation to medicate involuntarily.⁸⁵³ 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.⁸⁵⁴ The Court refused to mandate provision of legal counsel, stating that the “provision of an independent lay advisor who understands the psychiatric issues involved is sufficient protection.”⁸⁵⁵

The criticisms of additional procedural safeguards made by the Supreme Court in *Harper* are the same as those made by other courts

846. *Id.*, 110 S. Ct. at 1041.

847. *Id.* at 232, 110 S. Ct. at 1042.

848. *Id.* at 233, 110 S. Ct. at 1042.

849. *Id.* at 232, 110 S. Ct. at 1042.

850. *Id.*, 110 S. Ct. at 1042.

851. *Id.*, 110 S. Ct. at 1042.

852. *Id.* at 233, 110 S. Ct. at 1043.

853. *Id.* at 234 n.13, 110 S. Ct. at 1043 n.13.

854. *Id.* at 235, 110 S. Ct. at 1044.

855. *Id.*, 110 S. Ct. at 1044.

which have deferred to professional decisionmaking in drug refusal cases.⁸⁵⁶ The dissent accused the majority of according insufficient weight to the private interests at issue by downplaying the side effects of antipsychotic drugs. As the dissent noted, the Court relied on outdated data supplied by the American Psychiatric Association which indicated an unrealistically low prevalence rate of tardive dyskinesia.⁸⁵⁷

Following the Fourth Circuit's lead in *Charters II*, the Supreme Court classified the determinations necessary in a forced medication decision, including the potential for side effects, as medical in nature.⁸⁵⁸ Thus, the Court concluded that the determinations are best left to medical professionals rather than a judge.⁸⁵⁹ As explained earlier, however, the risk of serious harm associated with antipsychotic drugs and the scientific disagreement over the degree of that risk in any particular case requires judicial involvement so that varying medical opinions may be thoroughly and objectively assessed.⁸⁶⁰

The Court cited *Parham* in criticizing judicial hearings as diverting money and staff time from the care and treatment of mentally ill prisoners.⁸⁶¹ The majority, however, failed to consider the growing body of research, previously described, which documents the therapeutic benefits inuring to adult patients as a result of the judicial process.⁸⁶² Nor did the Court take into account the very low percentage of refusals which actually require a hearing.⁸⁶³ In addition, for the reasons set forth earlier, the high rate of refusal overrides to which the Court referred is not a benchmark of the value of an independent review process.⁸⁶⁴

The majority was satisfied with the independence of the decision-maker in spite of a record which indicated bias and conflicting interests inherent to the policy's procedural structure. The committee's pre-hearing meeting with institutional staff, held *ex parte*, is but one example of this bias. Objectivity was further compromised by the fact that panel members were under the pressure of reviewing the work of colleagues who, in turn, regularly evaluate panel members' decisions. As the dissent stated, "Such an in-house system pits the interest of an inmate who

856. See *supra* text accompanying notes 533-597.

857. *Id.* at 239 n.5, 110 S. Ct. at 1046 n.5 (Stevens, J., dissenting). See also *supra* notes 139-144 and accompanying text.

858. *Harper*, 494 U.S. at 231, 110 S. Ct. at 1039.

859. *Id.* However, as the dissent noted, "two of the committee members are not trained or licensed to prescribe psychotropic drugs, and one has no medical expertise at all." *Id.* at 254, 110 S. Ct. at 1053 (Stevens, J., dissenting).

860. See *supra* notes 654-666 and accompanying text.

861. *Harper*, 494 U.S. at 232, 110 S. Ct. at 1042.

862. See *supra* notes 724-734 and accompanying text.

863. See *supra* notes 749-750 and accompanying text.

864. See *supra* notes 771-775 and accompanying text.

objects to forced medication against the judgment not only of his doctor, but often his doctor's colleagues."⁸⁶⁵

In addition, committee members, as staff of the facility, were necessarily influenced by institutional concerns unrelated to the inmate's medical interest. The record revealed instances of abuse due to institutional pressures. For example, at one point a physician added an antipsychotic drug to Harper's treatment program merely to "sedate him at night" thereby relieving the evening staff of a supervisory burden.⁸⁶⁶ The prescribing physician later served on the committee which authorized long-term involuntary medication for Harper.⁸⁶⁷

The Court's denial of the right to counsel effectively limits a mentally ill prisoner's ability to present evidence and cross-examine witnesses on the complex issues involved in a forced medication decision.⁸⁶⁸ Furthermore, as the dissent noted, the loyalty of a state-employed lay advisor is problematic.⁸⁶⁹ The majority also failed to explain why a standard of proof is "neither required nor helpful when medical personnel are making the judgment" as opposed to when the decisionmaker is a judge or jury.⁸⁷⁰ The dissent termed the proceeding a "mock trial"⁸⁷¹ and concluded that "it is difficult to imagine how a committee convened under Policy 600.30 could conceivably discover, much less be persuaded to override, an erroneous or arbitrary decision to medicate or to maintain a specific dosage or type of drug."⁸⁷²

XI. BEYOND HARPER: EFFECTS ON THE RIGHT TO REFUSE OUTSIDE THE CRIMINAL CONTEXT

The *Harper* decision is noteworthy. For the first time, the Supreme Court expressly recognized that the right to refuse medical treatment is a constitutionally protected interest.⁸⁷³ The extensive qualifications placed

865. *Harper*, 494 U.S. at 251, 110 S. Ct. at 1052 (Stevens, J., dissenting).

866. *Id.* at 254, 110 S. Ct. at 1054 (Stevens, J., dissenting).

867. *Id.* at 254, 110 S. Ct. at 1053 (Stevens, J., dissenting).

868. This compromised right to present evidence and to cross-examine could be further restricted or denied based on "reasons relating to institutional interests of security, order, and rehabilitation." See *supra* note 781.

869. To make matters worse, the inmate was not introduced to the lay advisor until the commencement of the hearing. *Harper*, 494 U.S. at 256 n.30, 110 S. Ct. at 1055 n.30.

870. See *id.* at 235, 110 S. Ct. at 1044.

871. *Id.* at 237, 110 S. Ct. at 1045.

872. *Id.* at 257, 110 S. Ct. at 1055. The decision to administer long-term medication is not preceded by a hearing, but rather by a mere paper review. *Id.* at 251, 110 S. Ct. at 1052.

873. *Id.* at 221-22, 110 S. Ct. at 1036. See also *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2851 (1990) (citing *Harper* for the "principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment").

on this right in *Harper* are the result of a rationale developed by the Supreme Court in cases addressing the rights of convicted prisoners. The Court did not discuss whether some or all of these limitations apply to involuntarily confined civil patients. In a line of cases dating back to the mid-1960s, however, 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.⁸⁷⁴ 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.

The Court's reasoning in *Harper* revolved around three factors: 1) the respondent was convicted of criminal behavior; 2) because of a mental illness, he was deemed to present a danger of violent behavior to other inmates and staff; and 3) he was confined in a prison environment. The Court's "reasonableness" standard for reviewing state penological objectives was developed out of concern for preventing violence in the prison setting. The Court stated that the extent of a convicted prisoner's right to refuse "must be defined in the context of the inmate's confinement."⁸⁷⁵ As the Court emphasized, "There 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 proclivity for antisocial criminal, and often violent, conduct.'"⁸⁷⁶ The Court, in *Harper*, suggested that "under other circumstances [the State] would have been required to satisfy a more rigorous standard of review."⁸⁷⁷

Not long after the *Harper* decision, the Supreme Court had occasion to review slightly different circumstances. In the 1992 case of *Riggins v. Nevada*,⁸⁷⁸ the Court addressed the right of a pretrial detainee to refuse antipsychotic drugs deemed necessary by the State to insure trial competency. The petitioner Riggins, who was asserting an insanity defense, claimed that the forced administration of antipsychotic medication violated rights guaranteed by the Sixth and Fourteenth Amendments. Riggins argued that the drugs "denied him the ability to assist in his

874. *Baxtrom v Herold*, 383 U.S. 107, 86 S. Ct. 760 (1966); *Jackson v. Indiana*, 406 U.S. 715, 92 S. Ct. 1845 (1972); *Addington v. Texas*, 441 U.S. 418, 99 S. Ct. 1804 (1979); *Vitek v. Jones*, 445 U.S. 480, 100 S. Ct. 1254 (1980); *Jones v. United States*, 463 U.S. 354, 103 S. Ct. 3043 (1983). See generally John Parry, *The Supreme Court Fashions New Boundaries for Involuntary Care and Treatment*, 14 *Mental & Physical Disability L. Rep.* 198 (1990).

875. *Harper*, 494 U.S. at 222, 110 S. Ct. at 1037.

876. *Id.* at 225, 110 S. Ct. at 1038 (citation omitted).

877. *Id.* at 223, 110 S. Ct. at 1037.

878. 112 S. Ct. 1810 (1992).

own defense and prejudicially affected his attitude, appearance, and demeanor at trial."⁸⁷⁹

The majority referred to *Harper* in stating that a prison inmate has a Fourteenth Amendment liberty interest in avoiding the unwanted administration of antipsychotic drugs.⁸⁸⁰ However, "[t]aking account of the unique circumstances of penal confinement . . . due process allows a mentally ill inmate to be treated involuntarily with antipsychotic drugs where there is a determination that 'the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest.'"⁸⁸¹ Thus, the Court stated that "[u]nder *Harper*, forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of overriding justification and a determination of medical appropriateness."⁸⁸² The Court went on to hold that "[t]he Fourteenth Amendment affords at least as much protection to persons the State detains for trial."⁸⁸³

After acknowledging the lack of substantive standards for judging the forced administration of antipsychotic drugs in the trial or pretrial settings, the majority established parameters for such determinations.⁸⁸⁴ The State would have satisfied due process upon a finding that the "medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins' own safety or the safety of others."⁸⁸⁵ In addition, the State might have justified medically appropriate, forced medication by establishing that its fundamental interest in obtaining an adjudication of guilt or innocence could not be accomplished by any less intrusive means.⁸⁸⁶ The Court did not find it necessary to finally prescribe such substantive standards, as the lower court allowed the administration of antipsychotic drugs "without making *any* determination of the need for this course or *any* findings about reasonable alternatives Nor did the order indicate a finding that safety considerations or other compelling concerns outweighed Riggins' interest in freedom from unwanted antipsychotic drugs."⁸⁸⁷ The Court, therefore, reversed and remanded the case for further findings.

Although the majority refused to mandate substantive criteria in *Riggins*, it did suggest a more rigorous standard of review for the involuntary medication of pretrial detainees than that articulated in *Harper* for convicted inmates. Rather than deferring to a rational state

879. *Id.* at 1813.

880. *Id.* at 1814.

881. *Id.* at 1815.

882. *Id.*

883. *Id.*

884. *Id.*

885. *Id.*

886. *Id.*

887. *Id.* at 1815-16.

interest as in *Harper*, the Court indicated that "safety considerations or other compelling concerns" must be asserted in order to override a pretrial detainee's liberty interest in refusing antipsychotic drugs.⁸⁸⁸ The Court also suggested a less intrusive analysis of the type rejected in *Harper*.⁸⁸⁹ As Justice Thomas acknowledged in dissent, "[e]ither the Court is seeking to change the *Harper* standards or it is adopting different standards for detainees."⁸⁹⁰

The Supreme Court's opinions in *Harper* and *Riggins* establish an interesting categorization of drug refusal cases. At one end are cases involving individuals who have been determined by a court to have engaged in criminal behavior and are incarcerated in a prison environment. Under *Harper*, these inmates' refusals would be subject to a "reasonableness" standard of review. A showing that without medication the prisoner presents a risk of danger to himself or others due to a mental illness would justify medically appropriate, involuntary treatment. Less intrusive alternatives need not be considered as long as the proposed state action is reasonable.⁸⁹¹

A middle category of cases involve pretrial detainees, individuals held in a prison setting but not yet convicted. The Supreme Court's opinion in *Riggins* indicates that drug refusals by these individuals are subject to a much stricter standard of review. To override the refusal, the state must show that medically appropriate drugs are essential to prevent danger or to accomplish some other "compelling" objective. In addition, a finding that forced administration of antipsychotic drugs is the least intrusive measure to accomplish the state objective appears to be required.⁸⁹²

At the other end of the spectrum are cases involving individuals who have been involuntarily committed to civil psychiatric facilities. These individuals would appear to be entitled to the most exacting standard of review. The justifications for the "reasonableness" standard adopted in *Harper* are lacking in these cases. Persons committed through the civil process are not confined because they have been convicted of criminal behavior. Thus, these individuals should be entitled to at least as much protection as that accorded pretrial detainees. Moreover, involuntarily committed individuals are not confined in a prison environment. Security concerns in a public hospital, while important, cannot be equated with those present in a prison. The Supreme Court emphasized this point in *Jones v. United States*.⁸⁹³ In addressing the com-

888. *Id.* at 1816.

889. *Id.*

890. *Id.* at 1826 (Thomas, J., dissenting).

891. See *supra* notes 813-825 and accompanying text.

892. *Riggins*, 112 S. Ct. at 1815.

893. 463 U.S. 354, 103 S. Ct. 3043 (1983).

mitment of a defendant found not guilty by reason of insanity, the Court stated that "[t]he fact that a person has been found, beyond a reasonable doubt, to have committed a criminal act certainly indicates dangerousness."⁸⁹⁴ The Court suggested that this "concrete evidence" of criminal behavior is what sets such defendants apart as generally being more dangerous than individuals committed through the civil system.⁸⁹⁵ Both *Jones* and *Harper* indicate that the Supreme Court considers the prison environment especially vulnerable to security and management problems because its population has an established capacity for criminal behavior.

The refusal issue was presented to Maryland's highest court only three months after the *Harper* decision. In *Williams v. Wilzak*,⁸⁹⁶ a case decided before the Supreme Court's opinion in *Riggins*, the Maryland Court of Appeals was presented with a constitutional challenge to a statute which authorized a clinical review panel to override an institutionalized patient's objection to medication.⁸⁹⁷

The appellant, Williams, had been charged with attempted rape and battery. After being found competent to stand trial, Williams was adjudicated not criminally responsible for his criminal conduct due to a mental disorder.⁸⁹⁸ As a result of this verdict, Williams was committed to a state psychiatric institution until he was no longer deemed to present a danger to self, others, or property.⁸⁹⁹

While institutionalized, Williams refused antipsychotic medication based on his fear of side effects and the drugs' ability to disrupt his thought processes. Williams claimed that the medication would interfere with his ability to engage in Muslim religious prayer and to assist his attorney in subsequent release hearings.⁹⁰⁰ On two separate occasions,

894. *Id.* at 364, 103 S. Ct. at 3049.

895. *Id.* This holding cannot be interpreted to justify the forced medication of any mentally ill prisoner on the basis of dangerousness simply due to past criminal behavior in the community. As the *Harper* opinion makes clear, compelled drugging must be based on a showing that an inmate, as a result of mental illness, presents a danger to himself or others within the prison setting. *Washington v. Harper*, 494 U.S. 210, 227, 110 S. Ct. 1028, 1039 (1990).

896. 573 A.2d 809 (Md. 1990).

897. The statute allowed an institutionalized patient to refuse medication except in emergency situations where the patient presents a danger to himself or others or in non-emergency situations when the medication is approved by a clinical review panel. The panel is composed of the clinical director if a physician, or a non-treating physician designated by the director; a non-treating psychiatrist; and a non-physician mental health service provider. *Id.* at 810.

898. *Id.* at 810-11.

899. *Id.* at 811.

900. *Id.*

the clinical review panel authorized forced drugging based on a finding that without medication, Williams would become more hostile.⁹⁰¹

Williams filed suit and, on appeal to the Maryland high court, argued that a competent individual has a constitutional right to refuse drug treatment in non-emergency situations.⁹⁰² Williams further claimed that due process requires a court determination of incompetency before drugs can be forcibly administered.⁹⁰³

The Maryland court emphasized the civil-criminal distinction in examining the substantive component of the statute.⁹⁰⁴ While noting that the case did not involve a convicted felon confined in a penal institution as in *Harper*, the appellant's confinement "was mandated by law as a consequence of his having been found not criminally responsible for his criminal acts."⁹⁰⁵ Because Williams' confinement was a result of proven criminal behavior, the court applied *Harper* in upholding the substantive portion of the Maryland legislation.⁹⁰⁶ The court found that the statute appropriately "limits the authority of the panel to order that such drugs be involuntarily given to Williams for any purpose other than for his mental disorder and only to treat the illness which renders him a danger to himself or others."⁹⁰⁷

In examining the procedural component of the statute, however, the court found that it fell short of the procedures upheld in *Harper*. The court therefore held the statute invalid under procedural due process requirements.⁹⁰⁸ As a result, the case was governed by the common law of Maryland which, ironically, prohibits forcing medication on an adult who has not been adjudicated incompetent, absent an emergency.⁹⁰⁹

Williams indicates that the civil-criminal distinction may be less clear when individuals are committed to a civil psychiatric facility due to a risk of violent behavior. However, the Maryland court, by focusing solely on the appellant's proven criminal conduct, ignored the Supreme Court's directive in *Harper* that the extent of the right to refuse "must

901. *Id.* at 811-12. The panel described Williams as "moderately hostile and suspicious." The panel also found that Williams was unable to make a rational treatment decision despite expert testimony to the contrary.

902. Williams claimed that the state statute violated his "state and federal constitutional rights to privacy, due process, freedom of speech, thought, and religion." He later added an equal protection claim. *Id.* at 812.

903. *Id.* at 812-13. Williams pointed out that under Maryland law, commitment does not give rise to a presumption of incompetence.

904. *Id.* at 820.

905. *Id.*

906. *Id.*

907. *Id.*

908. *Id.* at 820-21.

909. *Id.* at 821.

be defined in the context of the inmate's confinement."⁹¹⁰ As explained above, the "reasonableness" standard of review applied in *Harper* was developed out of concern for security in the prison setting. Applying this minimal review to a case involving a civil inpatient setting removes the standard from its conceptual underpinnings. Unlike the situation in *Harper*, an individual committed into a non-forensic civil psychiatric facility is not placed into an environment which "'by definition' is made up of persons with 'a demonstrated proclivity for antisocial criminal, and often violent, conduct.'"⁹¹¹ Thus, although security and orderly management are important concerns in public hospitals, the level of such concerns cannot be equated to that present in penological settings. Therefore, when an intrusive treatment is proposed, the patient's medical interests should not, as was the case in *Harper*, be blended with institutional concerns in security and ease of management. At a minimum, a standard of review should distinguish between emergency and non-emergency situations which can be addressed by less intrusive measures. Further, the least restrictive alternative principle should apply where citizens have not been convicted of a crime and are placed in a therapeutic rather than a penal environment.⁹¹² Indeed, application of the principle appears required in light of the Supreme Court's opinion in *Riggins*. There, the Court indicated the necessity of a least intrusive analysis when reviewing the refusal of a pretrial detainee, even though confined in a prison setting.⁹¹³

The effects of the *Harper* decision on the scope of the state's *parens patriae* authority is less than clear given the Court's upholding of the prison policy at issue. As explained above, an unsettling possibility is that the Court's opinion may provide a basis for equating a hospitalized patient's deterioration in functioning with dangerousness. In such a case, the justification for imposing treatment would shift from the *parens patriae* rationale to the police power authority. Under this reasoning, a finding of incompetency—the traditional precondition to the exercise of the state's *parens patriae* authority—would no longer be necessary.⁹¹⁴ However, this concern has been diminished by Justice Kennedy, the drafter of the *Harper* decision. In his concurring opinion in *Riggins*,

910. *Washington v. Harper*, 494 U.S. 210, 244, 110 S. Ct. 1028, 1037 (1990).

911. *Id.* at 225, 110 S. Ct. at 1038. As the Supreme Court pointed out in *Jones*, there is no legally sufficient finding that an individual who is civilly committed has engaged in criminal behavior. See *supra* notes 893-895 and accompanying text. Furthermore, most states do not limit civil commitment to those who present a risk of violent conduct. Many mentally ill individuals are committed because of an inability to meet their basic needs in the community. See *supra* notes 430-431 and accompanying text.

912. See Parry, *supra* note 874, at 202.

913. See *supra* notes 885-887 and accompanying text.

914. See *supra* notes 398-401 and accompanying text.

Justice Kennedy clarified *Harper* by indicating that the decision was intended to address only situations in which a threat of physical violence is present.⁹¹⁵ Thus, a mere deterioration in functioning, in itself, would not qualify under the dangerousness standard articulated in *Harper*. This interpretation would appear appropriate. While the treatment of serious physical and mental disorders is a legitimate state objective as well as a duty in both the criminal and civil context, the Tenth Circuit has stated:

The premise underlying this duty is that the state may not deliberately fail to provide medical treatment *when it is desired by the detainee*. . . . This . . . 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 [state] may force him to accept it.⁹¹⁶

Ironically, the Supreme Court recently affirmed the applicability of the informed consent doctrine in the mental disability area. In a 1990 case, *Zinnermon v. Burch*,⁹¹⁷ the Court ruled that state officials can be held liable for damages under 42 U.S.C. § 1983 for failing to obtain the informed consent of a mentally ill individual before hospitalizing him on a voluntary basis.⁹¹⁸ The right to exercise informed consent to intrusive medical treatment, a right deeply imbedded in the common law and encompassed within the Due Process Clauses of the Fifth and Fourteenth Amendments, should not be taken from a nonviolent, competent individual, whether institutionalized in a penological or civil setting.⁹¹⁹

Procedurally, the Supreme Court in *Harper* upheld an informal in-house review of treatment refusals as satisfying due process requirements. Whether such procedures would be sufficient outside the prison context is unclear. The Court's inappropriate characterization of the necessary inquiries as "medical" in nature may indicate its willingness to defer to institutional decisionmaking.

915. *Riggins v. Nevada*, 112 S. Ct. 1810, 1818 (1992) (Kennedy, J., concurring). Justice Kennedy stated that *Harper* was a case "in which the purpose of the involuntary medication was to insure that the incarcerated person ceased to be a physical danger to himself or others." *Id.*

916. *Bee v. Greaves*, 744 F.2d 1387, 1395 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214, 105 S. Ct. 1187 (1985) (emphasis in original).

917. 494 U.S. 113, 110 S. Ct. 975 (1990).

918. *Id.* at 137, 110 S. Ct. at 990.

919. Although the Supreme Court in *Jones* stated that a finding of criminal conduct beyond a reasonable doubt indicates dangerousness, a more specific inquiry is necessary before the state may invoke its police power authority. It must also be determined that the inmate, due to a mental disorder, presents a risk of violence in the prison setting. See *supra* note 895 and accompanying text.

The Court, however, took into account only three inquiries: 1) whether the prisoner suffers from a mental disorder; 2) whether, as a result of that disorder, the inmate is dangerous; and 3) the risks associated with antipsychotic drugs.⁹²⁰ It must be emphasized that the Court did not address competency inquiries which are necessary when the state invokes its *parens patriae* authority to force treatment. Competency, as previously addressed, is a legal and not a medical concept. These determinations should continue to be made by a judicial decisionmaker. The *Harper* decision provides no basis to argue otherwise.

XII. CONCLUSION

In *Youngberg v. Romeo*, the Supreme Court did not intend to establish one standard of review to be applied in all cases involving the rights of institutionalized disabled individuals. The Court applied its traditional analytical framework for determining whether government action unconstitutionally infringes upon protected individual interests. The Court balanced the private interest at stake—defined as a liberty interest in freedom from physical restraints—against the state's reasons for infringement.⁹²¹ Considering the nature of the protected interest involved under the circumstances and the character of the state action, the Court concluded that the restrictions should be upheld upon the minimal showing of a reasonable relation to legitimate objectives.⁹²² The Court then fashioned the professional judgment standard as a method of determining whether the state's showing satisfies the "reasonableness" standard.

By automatically applying *Youngberg's* professional judgment standard to drug refusal cases, courts such as the Fourth Circuit in *Charters II* and the Eighth Circuit in *Dautremont* invert the traditional framework for constitutional analysis. These courts misuse a standard of review to define the constitutional interests at issue as opposed to assuring that such rights are appropriately implemented.⁹²³ Under the rubric of "professional judgment," the protected interests implicated by the forced

920. *Harper*, 494 U.S. at 232, 110 S. Ct. at 1042.

921. *Youngberg v. Romeo*, 457 U.S. 307, 319-20, 102 S. Ct. 2452, 2460 (1982).

922. *Id.* at 320-22, 102 S. Ct. at 2460-61.

923. See generally Parry, *supra* note 709, at 384. A standard of review simply "denotes the degree of deference that a reviewing court gives to the actions or decisions under review." Martha S. Davis, *A Basic Guide to Standards of Judicial Review*, 33 S.D. L. Rev. 469, 469 (1987-88). Justice Brennan stated: "A standard of review frames the terms in which justification may be offered, and thus delineates the boundaries within which argument may take place. The use of differing levels of scrutiny proclaims that on some occasions official power must justify itself in a way that otherwise it need not." *O'Lone v. Estate of Shabazz*, 482 U.S. 342, 356-58, 107 S. Ct. 2400, 2408-09 (1987) (Brennan, J., dissenting).

administration of potentially hazardous drugs are automatically equated to the interests at issue in *Youngberg*. As a result of this blind extension of *Youngberg*, any retained interests of an involuntarily institutionalized individual "must yield to the legitimate governmental interests that are incidental to the basis for legal institutionalization . . . and are only afforded protection against arbitrary and capricious government action."⁹²⁴ This appears to remain true regardless of the nature of the interests at stake and the extent of the intrusion presented.

Conspicuously absent from the Supreme Court's opinion in *Harper* is any mention of the professional judgment standard. Indeed, in its recent *Cruzan* decision, the Court expressly acknowledged that *Youngberg* "did not deal with decisions to administer or withhold medical treatment."⁹²⁵ However, the Court's application of *Turner's* "reasonableness" standard of review differs little from the professional judgment standard as applied by the Fourth and Eighth Circuits. Under the *Turner* standard, a prison regulation which infringes upon an inmate's constitutional rights, regardless of the nature of those rights and the type of infringement presented, is valid if it is "reasonably related to legitimate penological interests."⁹²⁶

This article maintains that the *Harper* rationale is limited to situations involving a convicted individual confined in a penal setting and determined to be a danger to himself or others due to a mental illness. However, even the minimal, if not meaningless, protections afforded such prisoners go beyond those provided to a pretrial detainee in *Charters II* and an involuntarily committed civil patient in *Dautremont*.⁹²⁷ The *Harper* opinion indicates that the Court will consider only certain governmental interests as being sufficiently legitimate to justify forced medication under the "reasonableness" standard. The Court's specific holding makes it clear that absent a finding of a mental disorder resulting in a danger of physical violence, the state cannot force antipsychotic drugs on a competent individual in the prison environment.⁹²⁸ Involuntary treatment must also be directly related to controlling dangerous behavior and cannot be used solely to treat aspects of a mental disorder unrelated

924. *United States v. Charters*, 863 F.2d 302, 305 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016, 110 S. Ct. 1317 (1990) (citations omitted). *Accord Dautremont v. Broadlawns Hosp.*, 827 F.2d 291, 300 (8th Cir. 1987).

925. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2852 (1990).

926. *Washington v. Harper*, 494 U.S. 210, 223, 110 S. Ct. 1028, 1037 (1990).

927. The substantive restrictions placed on a pretrial detainee's right to refuse antipsychotic drugs by the Fourth Circuit in *Charters II* would appear to be in serious question after the Supreme Court suggested a heightened standard of review for these individuals in *Riggins*.

928. *Harper*, 494 U.S. at 227, 110 S. Ct. at 1039-40.

to the dangerous behavior.⁹²⁹ Moreover, the Court's holding requires that any such treatment be medically beneficial.⁹³⁰

The *Harper* decision also overrules the procedural components of cases such as *Charters II* and *Dautremont* which adopt an approach of unqualified deference to professional judgment. The Supreme Court required that there be "procedural safeguards to ensure the prisoner's interests are taken into account."⁹³¹ The Court upheld an informal, in-house review with certain accompanying procedures.⁹³² As minimal as these procedures are, they are something more than an unqualified deference to the judgment of a treating professional. Unfortunately, due to the conflicting interests and bias inherent to such in-house review systems, any additional protection perceived is, in reality, quite illusory.⁹³³

The extensive qualifications placed on the right to refuse in *Harper* are the result of a standard of review developed specifically for individuals with a demonstrated proclivity for criminal conduct confined in the inherently violent atmosphere of the prison environment. In other circumstances, the Court indicated that the state "would have been required to satisfy a more rigorous standard of review."⁹³⁴ When subsequently presented with different circumstances in *Riggins*—involving a pretrial detainee—the Court went on to suggest a more rigorous standard of review. This article maintains that any such standard must recognize that involuntarily hospitalized individuals with mental disabilities are not *per se* dangerous or incompetent. These individuals have not been convicted of criminal conduct and are confined in therapeutic rather than penal settings. As such, these citizens should be accorded the same rights to self-determination and bodily integrity that all enjoy as members of a civilized society.

929. The Court stated that "[w]here 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." *Id.*, 110 S. Ct. at 1039. See generally Parry, *supra* note 874, at 202.

930. *Harper*, 494 U.S. at 227, 110 S. Ct. at 1040.

931. *Id.* at 233, 110 S. Ct. at 1043.

932. See *supra* notes 845-872 and accompanying text. The Maryland Court of Appeals has indicated that these procedures are the minimum necessary to satisfy procedural due process requirements. See *supra* notes 908-909 and accompanying text.

933. It must be emphasized that the Court did not address the procedures necessary in a competency determination. See *supra* note 920 and accompanying text.

934. *Harper*, 494 U.S. at 223, 110 S. Ct. at 1037.