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THE RIGHT TO CHOOSE AND REFUSE MENTAL HEALTH CARE: A HUMAN RIGHTS BASED APPROACH TO ENDING COMPULSORY PSYCHIATRIC INTERVENTION

COURTNEY A. BERGAN*

Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. It would be better to live under robber barons than under omnipotent moral busybodies. The robber baron's cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience.¹

Abstract

American laws carve out startling exceptions to the bodily autonomy rights of people with psychosocial disabilities, allowing states to forcibly confine and medicate people labeled with mental illness. Recently, many states renewed efforts to expand forced treatment invoking ableist, sanist, and paternalistic rhetoric suggesting that mentally disabled people are incapable of knowing their own needs, precluding them from making competent health care decisions and putting them at perceived risk of future harm.

This Article will explore the historical trends of misusing psychiatric constructs to pathologize marginalized groups, along with the longstanding pattern of depriving people with psychosocial disabilities of appropriate care.

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1. C.S. LEWIS, *The Humanitarian Theory of Punishment*, in *GOD IN THE DOCK: ESSAYS ON THEOLOGY AND ETHICS* 220, 223–24 (1971).

Through exploring why people refuse psychiatric care, this Article will promote the right to choose and refuse care and suggest policy interventions to enhance access to desired resources, including culturally responsive mental health supports that are accountable to meeting individual needs.

INTRODUCTION

American law distinguishes psychosocial disabilities² from physical disabilities, both in the rights afforded and restrictions imposed.³ Throughout the nation's history, American courts consistently condone depriving people deemed mentally disabled of their human rights, permitting forced medical treatment, physical abuse, neglect, and torture.⁴ Ensuring that the right to choose and refuse mental health and substance use care is on par with the right to choose and refuse somatic care is essential to health justice and shoring up guarantees to bodily autonomy.

Most notably, American laws carve out startling exceptions to the bodily autonomy rights of people with psychosocial disabilities, allowing states to forcibly confine, medicate, and even operate on people with psychosocial disabilities against their consent. Simultaneously, these laws limit access to and reimbursement for culturally responsive, person centered, community based mental health care.⁵ Narratives that civil commitment is necessary to protect the public reinforce rhetoric that both stigmatizes mental illness and jeopardizes bodily autonomy. Paternalism also underpins justifications for involuntary treatment, suggesting that people labeled with mental illness are incapable of determining their own needs and fuels epistemic injustice that pervades mental health law and policy, by assuming the state is better suited to determine the treatment needs of individuals. Consequently, mental illness labels are too often misused to silence people in distress, rather than to listen to people's human experiences or remedy underlying structural inequality. The sociopolitical origins of America's existing legal framework require interrogation to further social progress and ensure psychosocial disability is not misused to disenfranchise marginalized groups.

Thus, in opinions often fueled by broader social stigma, courts limit the rights of psychosocially disabled people to refuse unwanted medical

2. *A note on language*: This Article uses psychosocial disability to respect the diversity and preferences of those who have been deprived autonomy based on their perceived mental state. Psychosocial disability includes people labeled with mental illness, people who use drugs, and people with other types of disabilities that may present to those around them as impacting mentation. Psychosocial disability better captures the broad range of factors that can impact assumptions about mental state and experiences of distress. Identity-first (disabled person) and person-first language (person with a disability) is alternated to reflect differing experiences and preferences within the disability community.

3. *See, e.g., Cummings v. Premier Rehab Keller, P.L.L.C.*, 142 S. Ct. 1562, 1571 (2022) (finding emotional distress damages are not compensable injuries in contract law); *Buck v. Bell*, 274 U.S. 200, 207 (1927) (holding that state has a legitimate interest in forcibly sterilizing people with psychosocial disabilities); *Stouffer v. Reid*, 965 A.2d 96 (Md. Ct. Spec. App. 2009) (holding in part that lack of insight in context of somatic illness does not justify compulsory care).

4. *See, e.g., Buck*, 274 U.S.

5. *See, e.g., Colleen L. Barry et al., A Political History of Federal Mental Health and Addiction Insurance Parity*, 88 *MILBANK Q.* 404, 404–33 (2010).

intervention, consequently sanctioning state violence.⁶ At the same time, American law fails to guarantee people's rights to choose mental health resources appropriate to each individual's unique needs,⁷ which could mitigate the need for forced treatment in restrictive and often dangerous psychiatric institutions.⁸ Failure to guarantee access to voluntary, culturally responsive, community based mental health supports created a mental health system that is largely segregated in both the quality and quantity of services available to different communities, likely violating the sweeping integration mandate dictated by Congress in the Americans with Disabilities Act ("ADA") and infringing upon basic Constitutional guarantees.⁹

The right to choose mental health and substance use care is supported by a broad base of coalitional support from disability rights activists, health care providers, and mental health advocacy organizations. On the other hand, the right to refuse mental health and substance use care is perceived as adverse to the interests of some stakeholders.¹⁰ Contrary to many common assertions that suggest allowing people with psychosocial disabilities to refuse care is dangerous, this Article will demonstrate that the right to refuse unwanted mental health intervention is not only in the interest of people with psychosocial disabilities, but also in the interest of public safety and human rights.¹¹ Instead of imposing forced mental health treatment, American law must focus on

6. See *Allmond v. Dep't of Health & Mental Hygiene*, No. 1570, 2017 WL 5172631 (Md. Ct. Spec. App. Nov. 8, 2017) (upholding forced medication order based on patient's ambivalence about accepting medical intervention); cf. *Stouffer*, 965 A.2d at 105 (Md. 2009) (upholding a prisoner's right to refuse medical intervention, even when prisoner deemed to lack insight into decision and refusal would likely result in death); see also *Morgan v. Rabun*, 128 F.3d 694 (8th Cir. 1997); *Dep't of Health & Mental Hygiene v. Kelly*, 918 A.2d 470 (Md. 2007); *In re Commitment of Dennis H.*, 647 N.W.2d 851 (Wis. 2002).

7. See, e.g., *Youngberg v. Romeo*, 457 U.S. 307, 319 (1982) (finding no right to treatment); Erin C. Fuse Brown, *Developing a Durable Right to Health Care*, 14 MINN. J.L. SCI. & TECH. 439, 448–55 (2013) (stating that United States Constitution generally only grants negative rights, creating no affirmative constitutional right to health care, although statutory rights to health care exist in specific situations).

8. See Rep. of the High Comm'r for Human Rights, *Mental Health and Human Rights* at 10, U.N. Doc. A/HRC/34/32 (Jan. 31, 2017) [hereinafter *Mental Health and Human Rights*] (concluding sufficient psychiatric institutionalization puts people at increased risk of "violence and abuse, including sexual exploitation and trafficking"); see also *id.* at 15 (finding provision of appropriate community based mental health resources prevents unnecessary hospital admissions).

9. See generally 42 U.S.C. § 12101 et seq. (mandating elimination of discrimination against individuals with disabilities in all aspects of society); U.S. CONST. amend. XIV.

10. See, e.g., FRANKIE BERGER ET AL., TREATMENT ADVOC. CTR., GRADING THE STATES: AN ANALYSIS OF INVOLUNTARY PSYCHIATRIC LAWS 4–14 (2018); NAT'L ALL. ON MENTAL ILLNESS, NAMI PUBLIC POLICY PLATFORM 2 (12th ed. 2016); Brief for Md. Psychiatric Soc'y et al. as Amici Curiae Supporting Respondent, *Allmond v. Dep't of Health & Mental Hygiene*, 448 Md. 592 (2015) (No. 34) (supporting Department of Health and Mental Hygiene by asking Court of Appeals to sustain constitutionality of forced medication statute); Brief for Treatment Advoc. Ctr. as Amicus Curiae Supporting Appellee, *Allmond v. Dep't of Health & Mental Hygiene*, 448 Md. 592 (2015) (No. 34) (requesting similar outcome).

11. See *infra* Parts I–III.

guaranteeing unequivocal rights to both choose and refuse health care.¹² These rights to choose and refuse care are inextricably linked and essential to guaranteeing equal rights for all.

Part I will discuss the origins of the right to refuse unwanted medical intervention, the relationship between constitutional liberty guarantees, and common law informed consent doctrine.¹³ The Fourteenth Amendment's guarantees of bodily autonomy and the First Amendment's rights to freedom of thought imply treatment choice is a necessary component of the right to refuse medical interventions, but choice is often overlooked in psychiatric care.¹⁴ Through case law addressing the right to refuse, Part I also will look at the logical fallacies used to distinguish the right to refuse unwanted somatic medical intervention from unwanted psychiatric intervention and question whether a state's interests justify the broad use of compulsory psychiatric treatment, in light of advancements in scientific research.¹⁵

Part II will evaluate the right to choose care, identifying the role of disability rights laws in creating a right to choose mental health care and evaluating discriminatory biases that impede access to appropriate care, often depriving patients with psychosocial disabilities of necessary somatic and mental health resources when seeking care voluntarily.¹⁶ Finally, Part III will identify the role of compulsory mental health treatment laws in upholding discrimination based on psychosocial disability and artificially reducing treatment choices.¹⁷ By suggesting pragmatic policy interventions that focus on needs identified by people with psychosocial disabilities, Part III will also suggest that promoting choice in mental health care, could mitigate the need for compulsory mental health treatment.¹⁸ Lawyers can play a powerful role in furthering inclusion and reducing the use of unnecessary and often harmful compulsory treatments by listening to the lived experiences of people with psychosocial disabilities and holding systems accountable to their legal obligations to provide appropriate disability supports.

I. THE RIGHT TO REFUSE MEDICAL INTERVENTION

Based in the common law right to self-determination and the Fourteenth Amendment's liberty guarantees, American courts have long recognized the

12. *See infra* Parts I–II.

13. *See infra* Part I.

14. *See infra* Section I.A.1.

15. *See infra* Part I.

16. *See infra* Part II.

17. *See infra* Part III.

18. *See infra* Part III.

right to refuse unwanted somatic medical intervention.¹⁹ The right to self-determination, constitutional liberty guarantees, principles of medical ethics, and international human rights covenants all proscribe the provision of medical treatment without a patient's informed consent.²⁰ While legal, ethical, and public health principles permit limited exceptions for involuntary medical interventions when the failure to treat an individual poses a threat to the public, American courts are extremely judicious in allowing the state to compel somatic medical care only for public health benefits, carefully weighing the risks and benefits to the individual against the risks and benefits to society.²¹

Importantly, public health benefits alone generally do not suffice to justify compulsory somatic medical intervention, particularly when an individual does not directly benefit from a medical intervention or an individual's refusal of care does not directly harm innocent third parties.²² Thus, American jurisprudence generally forbids overriding an individual's express refusal of somatic medical interventions if declining the proposed intervention would only risk harm to the individual, even if declining treatment might result in that individual's death.²³ Nonetheless, on several occasions American courts stripped people with psychosocial disabilities of these basic constitutional guarantees in decisions so violent and egregious, that Nazi's even cited one Supreme Court decision during the Nuremberg trials in defense of Holocaust war crimes.²⁴ Yet, such decisions remain good law to this day, despite numerous opportunities to overturn what

19. See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990) (citing *Jacobson v. Massachusetts*, 197 U.S. 11, 28, 38–39 (1905)) (noting Court needed to balance State's interest in preventing disease with an individual's interest in declining an unwanted smallpox vaccine).

20. See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11, 28, 38–39 (1905); *Thor v. Superior Ct.*, 855 P.2d 375, 383 (Cal. 1993) (identifying right to reasonable disclosure of available choices with respect to proposed therapy, including nontreatment, and of dangers inherently involved in each); G.A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948).

21. See, e.g., *Nat'l Fed'n of Indep. Bus. v. Dep't of Lab.*, 595 U.S. 109, 116–17 (2022) (finding that OSHA was not justified in enacting its vaccine or test requirement in absence of COVID-19 specific workplace risks); cf. *Buck v. Bell*, 274 U.S. 200, 207 (1927) (“The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes”).

22. See, e.g., *Stouffer v. Reid*, 965 A.2d 96, 105 (Md. Ct. Spec. App. 2009) (finding no valid state interest in forcible medical intervention when there is not a significant risk to innocent third parties); *McFall v. Shimp*, 10 Pa. D. & C.3d 90, 92 (Pa. Ct. Com. Pl. 1978) (prohibiting compulsory bone marrow donation even when necessary to save another's life).

23. See, e.g., *Stouffer*, 993 A.2d at 113 (identifying a prisoner's right to refuse unwanted medical intervention, even if refusal would result in death and refusal does not impose a direct threat of harm to third parties); *Cruzan*, 497 U.S. at 288–89 (recognizing right to refuse medical intervention under Fourteenth Amendment).

24. Nazi lawyers defending SS Officer, Otto Hofmann, defended Germany's Hereditary Health Courts that oversaw mass sterilization of people with disabilities and Jewish people by citing the laws in so-called “enlightened countries,” and directly quoting Justice Oliver Wendell Holmes's majority opinion in *Buck v. Bell*, which sums up the rationale for permitting compulsory sterilization in the United States by stating that “three generations of imbeciles are enough.” See PAUL A. LOMBARDO, THREE GENERATIONS, NO IMBECILES: EUGENICS, THE SUPREME COURT, AND *BUCK V. BELL* 202–03 (Johns Hopkins Univ. Press 2008).

should be anticanonical caselaw.²⁵ Consequently, people with psychosocial disabilities are dehumanized and deemed unworthy of basic dignity, respect, and autonomy.

The use of involuntary mental health treatment also contravenes the rights enumerated in the United Nations Convention on the Rights of Persons with Disabilities and may even amount to torture.²⁶ Furthermore, deprivation of choice in accessing mental health resources and informed consent contravene the right to health identified in Article 12 of the International Covenant on Economic, Social and Cultural Rights, which encompasses the right to autonomous, informed consent in choosing and refusing mental health treatment.²⁷ Presuppositions in American law depriving people with psychosocial disabilities of basic human rights, fail to consider that existing mental health diagnoses and treatments developed largely to reinforce the values and behaviors deemed normative by those in power.

Historically, psychiatry pathologizes Black people, indigenous communities, people living in poverty, queer communities, trans people, women, religious minorities, ethnic minorities, and people with disabilities.²⁸ Despite long time use of forced psychiatric care as a tool for social control, political repression, systemic deprivation, overt violence, and even genocide of

25. *E.g.*, *Buck*, 274 U.S.; *cf.* *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 538 (1942) (striking down Oklahoma sterilization law that applied to justice involved individuals, distinguishing Oklahoma law from Virginia law in *Buck v. Bell*, by stating that Virginia Sterilization Act was narrowly tailored and that Virginia demonstrated a compelling state interest); *see also* *Vaughn v. Ruoff*, 253 F.3d 1124, 1129 (8th Cir. 2001) (stating sterilization laws are not unconstitutional if they are narrowly tailored and sufficient due process protections are in place).

26. *See Mental Health and Human Rights*, *supra* note 8, at 10–11 (maintaining that involuntary mental health treatment violates articles 12, 15, 16 and 17 of Convention on the Rights of Persons with Disabilities, including solitary confinement, forced sterilization, use of restraints, forced medication and overmedication, all of which may amount to torture); *see also* G.A. Res. 39/46, Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, at 197 (Dec. 10. 1984) (“[T]orture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person ... for any reason based on discrimination of any kind, when such pain or suffering is inflicted ... with the consent or acquiescence of a public official or other person acting in an official capacity.”).

27. *See Mental Health and Human Rights*, *supra* note 8, at 4. *But see* Philip Alston, *U.S. Ratification of the Covenant on Economic, Social and Cultural Rights: The Need for an Entirely New Strategy*, 84 AM. J. INT’L L. 365, 365–93 (1990) (stating that United States has signed, but has not ratified International Covenant on Economic, Social and Cultural Rights).

28. *See generally, e.g.*, *Marable v. Ala. Mental Health Bd.*, 297 F. Supp. 291 (M.D. Ala. 1969) (holding that discrimination based on race by Alabama officials in mental health system violated plaintiff’s Fourteenth Amendment equal protection rights); Samuel Cartwright, *Diseases and Peculiarities of the Negro Race*, 11 DEBOW’S REV. 331, 331 (1851) (asserting racist ideology that pathologizes and justifies forced institutionalization of Black people, especially those who were formerly enslaved); Jack Drescher, *Out of DSM: Depathologizing Homosexuality*, 5 BEHAV. SCIS. 565, 565–75 (2015); Jane M. Ussher, *Diagnosing Difficult Women and Pathologising Femininity: Gender Bias in Psychiatric Nosology*, 23 FEMINISM & PSYCH. 63, 63–69 (2013); Helena Hansen et al., *Pathologizing Poverty: New Forms of Diagnosis, Disability, and Structural Stigma Under Welfare Reform*, 103 SOC. SCI. & MED. 76, 76–83 (2014).

marginalized communities, American law continues to justify forced mental health treatment to this day.²⁹ In contrast, American courts largely agree that forced somatic care is unlawful, recognizing the atrocities caused by historical allowances for forced medical interventions, even when an individual's life is at stake. One such example is the Nazi's use of experimental interventions on people imprisoned in concentration camps, which prompted the adoption of the Nuremberg Code.³⁰ Still, forced mental health treatment is a widely accepted and largely unquestioned practice in the United States, mostly ignoring the similar human rights violations that arose out of historical abuses of compulsory mental health treatment.³¹

However, the medical and legal professions often reason that people labeled with mental illness and people who use drugs lack the capacity to understand the implications of refusing medical intervention. As a result, courts permit states to legislate statutory exceptions to the right to refuse, largely based upon antiquated assumptions about psychosocial disabilities rooted in paternalism, prejudice, and fear. Accordingly, American law largely permits forced psychiatric intervention when individuals are diagnosed with a mental illness and deemed dangerous to themselves or others or gravely disabled, assuming due process is guaranteed.³² Courts upheld overly permissive compulsory treatment laws largely based upon discriminatory stereotypes of psychosocial disabilities,³³ rather than critical evaluations of the risks and benefits to the individual weighed in contrast to the

29. See generally ROBERT WHITAKER, *MAD IN AMERICA: BAD SCIENCE, BAD MEDICINE, AND THE ENDURING MISTREATMENT OF THE MENTALLY ILL* (2001) (discussing Nazis' involuntary confinement of people with psychosocial disabilities, pathologizing and hospitalization of escaped and former enslaved people, and former USSR's involuntary confinement and forcible medication of political dissidents); see also Richard Bonnie, *Political Abuse of Psychiatry in the Soviet Union and in China: Complexities and Controversies*, 30 J. AM. PSYCHIATRY & L. 136, 138–39 (2002).

30. See, e.g., *Stouffer v. Reid*, 965 A.2d 96, 111 (Md. Ct. Spec. App. 2009) (prohibiting a prison warden from forcing life-saving medical intervention on a prisoner merely because state deemed prisoner as lacking insight into his somatic illness).

31. Before Nazis rounded up and murdered millions of German Jews, Roma, and LGBT individuals in death camps, Nazi Germany's first step in carrying eugenicist policies involved incarcerating and exterminating people deemed mentally ill. Similarly, in Soviet Russia, doctors abused their authority and violated ethical codes when they incarcerated and forcibly medicated political dissidents under the guise of treating mental illness. See Rael D. Strous, *Psychiatry During the Nazi Era: Ethical Lessons for the Modern Professional*, 6 ANNALS GEN. PSYCHIATRY (2007) (discussing need to reflect on role psychiatrists played in Nazi era eugenics practices and consider that any doctor is susceptible to such egregious acts without sufficient ethical training).

32. Tina Minkowitz, *Positive Policy to Replace Forced Psychiatry, Based on CRPD* (2019), https://www.academia.edu/39229717/Positive_policy_to_replace_forced_psychiatry_based_on_CRPD.

33. See, e.g., *Buck v. Bell*, 274 U.S. 200, 208 (1927) (finding compulsory sterilization constitutional); *Kansas v. Hendricks*, 521 U.S. 346, 357–59 (1997) (finding involuntary confinement of “sexually violent predators” constitutional even after serving criminal sentence imposed for “dangerous” behavior); *Kanuszewski v. Michigan Dep't of Health & Hum. Servs.*, 927 F.3d 396, 423–26 (6th Cir. 2019) (holding compulsory newborn screening constitutional even when a parent wants to refuse testing).

risks and benefits to society.³⁴ As a result, prejudicial legal analyses of the right to refuse mental health interventions contributed to mental health legal doctrine that eroded the civil and human rights of people with psychosocial disabilities.

*A. The Right to Make and Communicate Autonomous Decisions
Underlies the Right to Refuse Unwanted Medical Intervention*

Autonomy is foundational to the United States Constitution and a cornerstone of medical ethics, dating back to fifth century B.C.E and defined as a patient's right to make their own informed decisions about their care. Health care providers are generally barred from imposing their own decisions upon patients.³⁵ When autonomy is taken together with beneficence, nonmaleficence, and justice, very few circumstances allow clinicians to ethically override a patient's express refusal of care.³⁶ Intervening over an individual's express refusal, merely based on a clinician's belief that a given treatment is in a patient's best interests encroaches on a patient's dignity, autonomy, and self-determination.³⁷ Despite these clear ethical mandates, the medical profession throughout history has continually violated the bodily autonomy of marginalized groups—abuses often sanctioned by lawyers, judges, and legislators.³⁸ In this context, unwanted medical intervention requires critical evaluation to assess whether the decision is congruent with medical ethics or a potential abuse of a state's police powers.

34. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 288–89 (1990) (O'Connor, J., concurring) (discussing invasiveness of nasogastric feeding tube in an unconscious patient and restraint on a patient's dignity, liberty, and autonomy when used in absence of consent).

35. Benjamin D. Pirotte & Scarlet Benson, *Refusal of Care*, STATPEARLS (July 24, 2023), <https://scholarlycommons.hcahealthcare.com/emergency/76/> (defining beneficence, as principle that medical treatment should only be performed for benefit of patient; nonmaleficence, as principle that physicians have a duty to not provide treatment that could harm individual patient or society; and, justice, as principle that benefits of medical care should be equitable).

36. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 12 (5th ed. 2001); *see also* *Sard v. Hardy*, 379 A.2d 1014, 1019 (Md. 1977) (forbidding physicians from substituting their judgment for that of an otherwise competent adult patient in deciding risks and benefits to disclose for informed consent).

37. *Sard*, 379 A.2d at 1019.

38. *See generally* *In Re Guardianship of Mary Moe*, 960 N.E.2d 350 (Mass. App. Ct. 2012) (authorizing compulsory abortion of person with a mental disability over their express refusal while overturning trial court's sua sponte forced sterilization order); *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. 1969) (holding a court of equity has the authority to order an incompetent person to donate their kidney to save a sibling's life); *Amended Complaint & Demand for Jury Trial, Kowalski v. Johns Hopkins All 'Child.'s Hosp.*, No. 2018 CA 005321 NC (Fla. Cir. Ct. Jan. 24, 2023), (DIN No. 2816) (alleging hospital falsely imprisoned, battered, and denied appropriate medical care for a child's diagnosed somatic condition based on the child's perceived psychosocial disability while also intentionally inflicting emotional distress that caused the wrongful death of the child's mother).

1. *The Fourteenth Amendment Guarantees a Fundamental Right to Refuse Unwanted Medical Intervention*

The Fourteenth Amendment provides that no state shall “deprive any person of life, liberty, or property, without due process of law.”³⁹ The Supreme Court first expressly discussed the Fourteenth Amendment’s right to bodily autonomy in *Jacobson v. Commonwealth of Massachusetts*, when it assessed whether a state could involuntarily inoculate an individual against smallpox amidst an outbreak of the deadly disease.⁴⁰ The Court affirmed the state’s ability to impose “reasonable regulations” that compel an individual to submit to medical treatment, when doing so is necessary for the safety of the community.⁴¹ However, the Court also cautioned against the abuse of the state’s police powers to coerce medical intervention, when doing so may impose an undue risk to an individual or is not necessary for the safety of the community.⁴² Over a century of jurisprudence relies on the discussion in *Jacobson* to evaluate when a public health regulation compelling medical intervention may interfere with longstanding legal and ethical obligations to respect individuals’ rights to liberty and self-determination.⁴³

The Supreme Court further clarified the constitutional right to refuse unwanted medical intervention in *Cruzan by Cruzan v. Director, Missouri Department of Health*, stating that the Court’s prior decisions support the “principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment.”⁴⁴ The Court made clear that an individual’s right to refuse care exists even when the consequence of refusing

39. U.S. CONST. amend. XIV, § 1.

40. See generally *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (holding Massachusetts law mandating vaccination was constitutional).

41. *Id.* at 24–25 (holding that states may enact laws mandating medical treatment when they are reasonably expected to protect public safety).

42. *Id.* at 28, 38–39 (specifying that courts are compelled to interfere with “arbitrary, unreasonable” and “oppressive” public health regulations that contravene Constitution, including those that are otherwise valid, but cruel and inhumane when applied in context of an individual’s particular condition).

43. In assessing people with psychosocial disabilities’ right to refuse care, courts have largely abandoned their duty to carefully apply strict scrutiny when assessing an individual’s fundamental liberty interest versus the state’s interest. See, e.g., *Washington v. Harper*, 494 U.S. 212, 229 (1990) (explaining that prisoners’ liberty interest is “not insubstantial” and policy is narrowly tailored to a compelling state interest); *Sell v. United States*, 539 U.S. 166, 181 (2003) (requiring involuntary medication to qualify as medically necessary, “significantly further” concomitant government interest at stake, and serve as a no less intrusive means to achieve same result to forcibly medicate a pretrial detainee). Many trial courts fail to assess the validity of the scientific evidence presented by physicians using the evidentiary standard announced in *Daubert v. Merrell Dow Pharmaceuticals Inc.*, 509 U.S. 579 (1993). See *Kansas v. Crane*, 534 U.S. 407, 409 (2002) (requiring “proper procedures and evidentiary standards” in civil commitment proceedings); see also Michael L. Perlin, *The ADA and Persons with Mental Disabilities: Can Sanist Attitudes Be Undone?*, 8 J.L. & HEALTH 15, 33–34 (1993) (finding that psychiatrists admit to dishonesty in mental health proceedings and judges acknowledge noncompliance with procedures).

44. 497 U.S. 261, 278 (1990).

care could lead to death.⁴⁵ In a concurring opinion, Justice O'Connor more explicitly defined this right to refuse unwanted medical intervention, referring to the Court's decisions in *Washington v. Harper* and *Parham v. J.R.*,⁴⁶ which discuss the right to refuse unwanted psychiatric care:⁴⁷

The State's imposition of medical treatment on an unwilling competent adult necessarily involves some form of restraint and intrusion. A seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions. Such forced treatment may burden that individual's liberty interests as much as any state coercion.⁴⁸

2. *The Common Law Right to Refuse Unwanted Medical Intervention Is Anchored in the Rights of Informed Consent and Self-Determination*

The common law recognizes an individual's right to freedom from nonconsensual bodily invasion and right to make informed choices, essentially protecting patients from the provision of unwanted medical care.⁴⁹ In fact, the common law regarded the provision of nonconsensual medical treatment as battery.⁵⁰ As described by the Maryland Court of Appeals, the tort of medical battery is an intentional, unconsented physical invasion of a patient's bodily integrity.⁵¹ If such an invasion rises to an intentional infliction of a serious physical injury, then forced medical intervention may even rise to the level of criminal battery.⁵² Watching an individual succumb to a treatable medical condition is excruciating for most, particularly medical professionals trained to save lives. However, forcibly imposing unwanted medical treatment is its own form of torture, as defined under the United Nations Commission on Human

45. *Id.* at 276.

46. 442 U.S. 584 (1979).

47. *Harper*, 494 U.S. at 221; *Parham*, 442 U.S. at 600.

48. *Cruzan*, 497 U.S. at 288 (O'Connor, J., concurring) (citing *Harper*, 494 U.S. at 221); *Parham*, 442 U.S. at 600.

49. *See, e.g.*, *McQuitty v. Spangler*, 976 A.2d 1020, 1037–38 (Md. 2009); *Thor v. Superior Ct.*, 855 P.2d 375, 378 (Cal. 1993); *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626, 633 (Mass. 1986).

50. *See McQuitty*, 976 A.2d at 1037–38 (explaining that tort of medical battery is an intentional, unconsented physical invasion of a patient's bodily integrity); *Lamb v. State*, 613 A.2d 402, 413 (Md. Ct. Spec. App. 1992) (defining criminal battery as any intentional or reckless use of force against person of another no matter how slight, including offensive bodily contact); MD. CODE ANN., CRIM. LAW §§ 3-201–3-209 (establishing that criminal assault encompasses common law battery, defined as intentionally causing serious physical injury including protracted impairment of any bodily function).

51. *See McQuitty*, 976 A.2d at 1037.

52. *Lamb*, 613 A.2d at 413 (defining criminal battery as any intentional or reckless use of force against person of another no matter how slight, including offensive bodily contact); MD. CODE ANN., CRIM. LAW §§ 3-201–3-209 (encompassing criminal assault in common law battery and defining such assault as intentionally causing serious physical injury, including protracted impairment of any bodily function).

Rights.⁵³ Throughout history, forced and coerced medical treatment led to reprehensible human rights abuses, emphasizing the importance of guaranteeing the right to refuse unwanted medical care.⁵⁴

3. *The First Amendment Protects Autonomy in Thought, Preventing the State from Infringing Upon the Communication of Ideas in the Absence of an Imminent Risk of Harm to Others*

The First Amendment to the United States Constitution plainly enumerates the right to communicate freely, stating that “Congress shall make no law ... abridging the freedom of speech.”⁵⁵ The Supreme Court interprets the free speech clause as providing broad protections to free expression, preventing the state from inhibiting one’s right to generate knowledge,⁵⁶ verbally communicate information, receive information,⁵⁷ or engage in nonverbal expressive conduct.⁵⁸ First Amendment protections to free expression also prevent the government from compelling individual expression of any specific beliefs, ideology, or opinion.⁵⁹ Thus, the government can neither abridge one’s right to free

53. G.A. Res. 39/46, *supra* note 26, at 197.

54. Forced medical treatment was a notable component of racial violence and exploitation in the United States, violence towards people with disabilities, and a core component of Nazi concentration camps. *See generally* U.S. DEP’T OF HEALTH & HUM. SERVS., NAT’L COMM’N FOR THE PROT. OF HUM. SUBJECTS OF BIOMED. & BEHAV. RSCH., THE BELMONT REPORT: ETHICAL PRINCIPLES AND GUIDELINES FOR THE PROTECTION OF HUMAN SUBJECTS OF RESEARCH (1979) (describing medicine’s long history of using disenfranchised populations for benefit of powerful, such as when Tuskegee Experiment intentionally deprived poor Black men of treatment for syphilis); *Records of the United States Nuremberg War Crimes Trials: U.S. v. Brandt*, [November 21, 1946—August 20, 1947] Nat. Archives and Records Servs., (1974) (describing proceedings against Nazi physicians for unconsented medical experiments, euthanasia of mentally ill, and murder of concentration camp prisoners for medical research).

55. U.S. CONST. amend. I, § 3 (incorporated by the U.S. CONST. amend. XIV, in *Gitlow v. New York*, 268 U.S. 652, 666 (1925)).

56. *See, e.g.*, *Meyer v. Nebraska*, 262 U.S. 390 (1923) (holding that a state may not pass laws limiting fund of available knowledge).

57. *E.g.*, *Bd. of Educ. v. Pico*, 457 U.S. 853, 872 (1982) (holding that government may not censor content available merely due to disagreement with a specific viewpoint).

58. *E.g.*, *Texas v. Johnson*, 491 U.S. 397, 404–06 (1989) (protecting right to express beliefs via burning an American flag, stating nonverbal expressive conduct requires both an intent to convey a specific message and that conduct can be reasonably interpreted as displaying some sort of message); *Hurley v. Irish-Am. Gay, Lesbian, & Bisexual Grp. of Boston*, 515 U.S. 557, 569 (1995) (protecting right to express beliefs via marching in a parade; stating a message need not be succinctly articulable to gain First Amendment protections); *Tinker v. Des Moines Indep. Cmty. Sch. Dist.*, 393 U.S. 503, 505–06 (1969) (finding that wearing a black armband to protest Vietnam War is protected conduct).

59. *See W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 631–33 (1943) (holding unconstitutional to compel declaration of a specific belief by requiring students to partake in the pledge of allegiance); *see also id.* at 642 (“[No state official] can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein.”).

expression, nor compel expression of specific opinions or beliefs, absent an imminent threat to public welfare.⁶⁰

Any meaningful freedom to express ideas also requires the right to form beliefs based on one's own mind and conscience.⁶¹ In fact, this country's founders believed freedom of thought was foundational to a free society, stating, "freedom to think as you will and to speak as you think are means indispensable to the discovery and spread of political truth; that without free speech and assembly, discussion would be futile."⁶² Thus, freedom of thought is a necessary corollary to the First Amendment guarantee of free expression and the Supreme Court interprets the First Amendment's "liberty of the mind" guarantees as foundational to "nearly every other form of freedom."⁶³ While the Court permits states to limit the public dissemination of ideas in accordance with their police powers, states "cannot constitutionally premise legislation on the desirability of controlling a person's private thoughts."⁶⁴ Accordingly, the First Amendment provides absolute protections to think and believe free from government intrusion.⁶⁵

In contrast, the freedom to express one's thoughts is a fundamental right, generally subject to a strict scrutiny analysis, with government interference only permitted when a state demonstrates a compelling interest and the regulation on speech is narrowly tailored to achieve that interest.⁶⁶ In determining the contours of free expression, the Supreme Court deems limited categories of speech

60. *Wooley v. Maynard*, 430 U.S. 705, 714–16 (1977) (holding that First Amendment freedom of speech includes "right to speak freely and the right to refrain from speaking at all").

61. *Abood v. Detroit Bd. of Educ.*, 431 U.S. 209, 235 (1977) ("[I]n a free society one's beliefs should be shaped by his mind and his conscience rather than coerced by the State."), *overruled by* *Janus v. AFSCME, Council 31*, 138 S. Ct. 2448 (2018).

62. *Whitney v. California*, 274 U.S. 357, 375 (1927), *overruled by* *Brandenburg v. Ohio*, 395 U.S. 444 (1969).

63. *Palko v. Connecticut*, 302 U.S. 319, 326–27 (1937) (stating freedom of thought and freedom of speech from "indispensable condition, of nearly every other form of freedom"); *see also* *Adler v. Bd. of Educ.*, 342 U.S. 485, 492 (1952) (finding school employees have right to "think and believe as they will").

64. *See generally* *Stanley v. Georgia*, 394 U.S. 557 (1969) (protecting one's right to view obscene material in privacy of one's own home). *But see* *Paris Adult Theater I v. Slaton*, 413 U.S. 49, 67 (1973) (determining that government regulations which only incidentally affect thoughts are not unconstitutional).

65. *Am. Comm'n Ass'n v. Douds*, 339 U.S. 382, 393 (1950) ("Beliefs are inviolate.") (citing *Cantwell v. Connecticut*, 310 U.S. 296, 303 (1940)).

66. Government restrictions of protected speech based on content or viewpoint are subject to a strict scrutiny analysis, while content neutral laws and laws restricting the secondary effects of speech are subject to intermediate scrutiny. *See* *Ashcroft v. ACLU*, 535 U.S. 564, 573 (2002) ("[A]s a general matter, the First Amendment means that government has no power to restrict expression because of its message, its ideas, its subject matter, or its content."); *Ashcroft v. ACLU*, 542 U.S. 656, 666 (2004) (requiring government to use "least restrictive means among available, effective alternatives" when regulating protected speech); *Williams-Yulee v. Fla. Bar*, 575 U.S. 433, 454 (2015) (noting that strict scrutiny's "narrowly tailored" requirement does not require law to be "perfectly tailored").

unprotected under the First Amendment, including obscenity,⁶⁷ incitement,⁶⁸ defamation,⁶⁹ “fighting words,”⁷⁰ child pornography,⁷¹ true threats,⁷² and speech used in the commission of criminal conduct.⁷³ Importantly, all of these categorical restrictions on individual speech represent limitations likely to survive a strict scrutiny analysis, because these restrictions satisfy a compelling state interest to restrict speech and are narrowly tailored to fulfill such an interest. The government may also impose other reasonable restrictions on the time, place, and manner of protected speech to promote general welfare, so long as such restrictions do not discriminate based on viewpoint or content and leave open alternative methods for communication.⁷⁴ Otherwise, the First Amendment generally prohibits the government from imposing content or viewpoint based restrictions on individual expression merely because the topic of conversation or messaging conveyed is forbidden or unpopular.⁷⁵

67. See *Miller v. California*, 413 U.S. 15, 23–24 (1973) (holding that government may impose regulations limiting obscenity: “works which, taken as a whole, appeal to the prurient interest in sex, which portray sexual conduct in a patently offensive way, and which, taken as a whole, do not have serious literary, artistic, political, or scientific value”).

68. See *Brandenburg v. Ohio*, 395 U.S. 444, 447 (1969) (explaining that First Amendment restricts government restraint on speech unless speech is intended to provoke imminent unlawful danger and speech is likely to induce such action).

69. *N.Y. Times Co. v. Sullivan*, 376 U.S. 254, 279–80 (1964) (holding that limiting speech based upon defamation requires demonstrating a knowing and reckless false statement).

70. *Cohen v. California*, 403 U.S. 15, 20 (1971) (quoting *Chaplinsky v. New Hampshire*, 315 U.S. 568 (1942)) (“[P]ersonally abusive epithets which, when addressed to the ordinary citizen, are, as a matter of common knowledge, inherently likely to provoke violent reaction” in a public setting.).

71. *E.g.*, *United States v. Williams*, 553 U.S. 285, 299 (2008) (holding child pornography is not protected under First Amendment).

72. *Virginia v. Black*, 538 U.S. 343, 359 (2003) (finding communication must be a serious expression of intent to commit unlawful physical violence against a specific person or group); *cf.* *Watts v. United States*, 394 U.S. 705, 708 (1969) (noting political hyperbole, vague threats, and verbal attacks are protected speech).

73. *E.g.*, *Williams*, 553 U.S. at 299 (holding solicitation of child pornography is not protected under First Amendment); *Va. State Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc.*, 425 U.S. 748, 771 (1976) (finding speech used to intentionally effect fraud is not protected); *cf.* *United States v. Alvarez*, 567 U.S. 709, 719 (2012) (“[F]alsity alone may not suffice to bring the speech outside the First Amendment.”); *see also id.* at 725 (requiring government to show a false statement presents some direct causal link between restriction imposed and legally cognizable harm prevented by regulating protected speech).

74. See *Ward v. Rock Against Racism*, 491 U.S. 781, 791 (1989) (“[G]overnment may impose reasonable restrictions on the time, place, or manner of protected speech, provided the restrictions ‘are justified without reference to the content of the regulated speech, that they are narrowly tailored to serve a significant governmental interest, and that they leave open ample alternative channels for communication of the information.’”); *Renton v. Playtime Theaters, Inc.*, 475 U.S. 41, 46–47 (1986) (finding that if government proves restriction intends to limit secondary effects of speech, challenged regulation is subject to intermediate scrutiny).

75. *Wollschlaeger v. Governor of Fla.*, 848 F.3d 1293, 1307 (11th Cir. 2017) (citing *Reed v. Town of Gilbert*, 576 U.S. 155, 164 (2015)) (noting government imposed, content-based restrictions on speech that apply merely because of topic, idea, or message communicated by speaker are generally prohibited).

The First Amendment's enumerated free speech protections generally insulate the expression of one's internal thought processes against state retaliation, as described by Judge Tauro in *Rogers v. Okin*:

The First Amendment protects the communication of ideas. That protected right of communication presupposes a capacity to produce ideas. As a practical matter, therefore, the power to produce ideas is fundamental to our cherished right to communicate and is entitled to comparable constitutional protection. 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.⁷⁶

Consequently, the First Amendment restricts the government from imposing involuntary intervention based on an individual's mere expression of their thoughts, unless there is other conduct that sufficiently justifies restraint under the states' police powers.⁷⁷ Admittedly, many communications about medical decisions likely fall outside the First Amendment's protections⁷⁸ or implicate valid restrictions.⁷⁹ However, any statutorily prescribed restraint on one's right to refuse medical treatment may not discriminate based on the content of a

76. 478 F. Supp. 1342, 1367 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291 (1982). The First Amendment to the Constitution restricts government restraint on speech unless the speech is intended to provoke imminent unlawful danger and the speech is likely to induce such action. *See Brandenburg v. Ohio*, 395 U.S. 444, 447 (1969).

77. *Okin*, 478 F. Supp. at 1367.

78. The Supreme Court has created several tests to identify state action including the "public function test," "state compulsion test," "nexus test," and "joint action test," while also recognizing a functional approach that assesses whether the specific action in question is performed under the guise of state authority which the Court terms the "abuse of authority doctrine." *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 939–40 (1982); *see also Rubenstein v. Benedictine Hosp.*, 790 F. Supp. 396, 405–06 (N.D.N.Y. 1992) (holding that because New York's civil commitment scheme was part of the state's comprehensive scheme to provide services to mentally ill individuals and the commitment of individuals is a public function, involuntary treatment satisfied both "public function" and "close nexus" tests); *Jensen v. Lane Cnty.*, 222 F.3d 570, 575 (9th Cir. 2000) (finding state action occurred when physicians involuntarily hospitalized mentally ill individuals at a private psychiatric hospital and state statute's legal framework limited professional discretion); *West v. Atkins*, 487 U.S. 42, 52 n.10 (1988) (noting despite acting in accordance with professional discretion and judgment, "private party's challenged decisions could satisfy the state-action requirement if they were made on the basis of some rule of decision for which the State is responsible."). *Contra S.P. v. City of Takoma Park*, 134 F.3d 260, 269–70 (4th Cir. 1998) (citing *Spencer v. Lee*, 864 F.2d 1376, 1379 (7th Cir. 1989)) (holding community physician's choice to involuntarily hospitalize patient was not state action because state emergency petition law was not to "encourage" doctors to hospitalize patients).

79. *Dall. Ass'n of Cmty. Orgs. for Reform Now v. Dall. Cnty. Hosp. Dist.*, 656 F.2d 1175, 1180 (5th Cir. 1981) ("[W]hile performing public functions public hospitals are akin to jails and may impose reasonable time, place, and manner restrictions on First Amendment activities.").

medical decision or the patient's viewpoint, even if physicians or politicians may otherwise disagree with a patient's medical decision making.⁸⁰

The absolute protections conferred to freedom of thought under the First Amendment suggest that statutorily compelled mental health treatment directly targeting an individual's thoughts or beliefs implicates grave constitutional concerns, regardless of the state's rationale for intervention.⁸¹ Thus, any limitations on the right to refuse psychiatric drugs or therapies which intentionally target cognitive and emotional processes likely violate the First Amendment's freedom of thought protections.⁸² Some commentators suggest that disordered thoughts and expression of disordered thoughts are exempt from protections under the First Amendment,⁸³ but the absolute protection conferred to freedom of thought raises significant questions about such assertions.⁸⁴ Furthermore, the broad proscription on disability discrimination enumerated in the ADA suggests that both the state and private physicians must accommodate any disabilities impairing an individual's ability to effectively communicate, including mental disabilities that may limit communication of treatment choice.⁸⁵

As a result, relying on compulsory treatment to control an individual's thoughts, without first furnishing auxiliary aids and services that may be necessary to facilitate effective communication of treatment choice, risks violating an individual's First Amendment rights.⁸⁶ Moreover, the ADA requires that states grant primary consideration to the auxiliary aids and services

80. Wollschlaeger, 848 F.3d at 1307–08 (citing *Reed*, 576 U.S. at 169).

81. See, e.g., *Kaimowitz v. Mich. Dep't of Mental Health*, No. 73-19434-AW (Mich. Cir. Ct., July 10, 1973), reprinted in A.D. BROOKS, LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM 902, 918 (1974) (distinguishing freedom of thought from right to disseminate ideas); *Am. Comm'n Ass'n v. Douds*, 339 U.S. 382, 392–93 (1950) (stating that government may regulate conduct, but “[b]eliefs are inviolate”); *Jones v. Opelika*, 316 U.S. 584, 618 (1942), *vacated*, 319 U.S. 103 (1943) (“Freedom to think is absolute of its own nature; the most tyrannical government is powerless to control the inward workings of the mind.”).

82. Compare *Mackey v. Procunier*, 477 F.2d 877, 878 (9th Cir. 1973) (holding that involuntary use of succinylcholine as part of an aversive conditioning program would raise serious constitutional questions concerning “impermissible tinkering with the mental processes”), with *Paris Adult Theater I v. Slaton*, 413 U.S. 49, 67 (1973) (noting government regulation limiting location of adult entertainment venue incidental effect on “utterances” or “thoughts” does not bar State from acting to protect legitimate state interests).

83. *Rennie v. Klein*, 462 F. Supp. 1131, 1144 (D.N.J. 1978) (“The court need not reach the question of whether insane or disordered thought is within the scope of [F]irst [A]mendment protection.”), *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 (1982), *on remand*, 720 F.2d 266 (3d Cir.1983) (en banc).

84. See *supra* note 81 and accompanying text.

85. See 42 U.S.C. § 12132 (prohibiting public entities from discriminating on basis of disability in programs, services, and activities); *Id.* § 12182(a) (banning discrimination in places of public accommodation operated by private entities).

86. See 28 C.F.R. § 35.160(b)(2) (“In determining what types of auxiliary aids and services are necessary, a public entity shall give primary consideration to the requests of individuals with disabilities. In order to be effective, auxiliary aids and services must be provided in accessible formats, in a timely manner, and in such a way as to protect the privacy and independence of the individual with a disability.”).

requested by disabled individuals, indicating the importance of autonomy in identifying effective disability supports.⁸⁷ First Amendment case law also requires that any restrictions on speech represent the least intrusive form of government restraint necessary to achieve the identified state interest, further impugning commentators' ideas that disordered thoughts are merely exempt from the First Amendment's protections.⁸⁸ Accordingly, the First Amendment should preclude the use of compulsory treatment to target thoughts, even those deemed "disordered." Instead, states must ensure people are supported when making autonomous medical decisions.

B. Courts Distinguished the Right to Refuse Unwanted Mental Health Care from the Right to Refuse Somatic Medical Interventions

State police powers generally permit legislatures to create narrow exceptions to the overall right to refuse treatment when a patient's refusal of medical intervention may endanger the general health and welfare of others and the need for medical intervention is narrowly tailored to further a compelling state interest.⁸⁹ States traditionally use these exceptions to overcome an individual's right to refuse mental health care when deemed a danger to themselves or others.⁹⁰ Moreover, the state's *parens patriae* authority may also justify forcible mental health treatment when an individual is gravely disabled or otherwise deemed lacking insight to make decisions about their care. However, the constitutionality of these statutory exceptions is ambiguous under the standard identified in *O'Connor v. Donaldson*.⁹¹

87. *Id.*

88. *E.g.*, *Bee v. Greaves*, 744 F.2d 1387, 1396 (10th Cir. 1984) ("[L]ess 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."); *see also* *McCullen v. Coakley*, 573 U.S. 464, 486 (2014) (noting content-based restrictions on protected speech subject to the least intrusive restrictions necessary to achieve compelling state interest).

89. *See, e.g.*, *Washington v. Glucksberg*, 521 U.S. 702, 728–32 (1997) (identifying a fundamental right to refuse life sustaining care); *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975) ("[A] State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.").

90. *See generally* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM: HISTORICAL TRENDS AND PRINCIPLES FOR LAW AND PRACTICE 4–5 (2019).

91. *See generally* *O'Connor*, 422 U.S. While many states require a dangerousness standard for involuntary inpatient treatment, courts tend to uphold state statutes reliant upon the *parens patriae* authority to order outpatient civil commitment. *See, e.g.*, *Wetherhorn v. Alaska Psychiatric Inst.*, 156 P.3d 371, 376 (Alaska 2007) (citing *O'Connor v. Donaldson*, 422 U.S. 563, 575–76 (1975)) (invalidating Alaska statutory provision permitting civil commitment based on grave disability to avoid substantial deterioration of functioning), *overruled by* *In re Necessity for the Hospitalization of Naomi B.*, 435 P.3d 918 (Alaska 2019); *Winters v. Miller*, 446 F.2d 65, 70–71 (2d Cir. 1971) (finding a *parens patriae* relationship is only created when a person is legally adjudicated incompetent). *But see* *In re Dennis H.*, 647 N.W.2d 851, 862 (Wis. 2002); *Ilissa L. Watnik, A Constitutional Analysis of Kendra's Law: New*

A grave disability standard imposes forced mental health interventions when individuals are struggling to meet their basic needs for food, shelter, or medical care, often leading to the medicalization of one's social conditions and compulsory mental health interventions that deprive individuals of their liberty in the name of "public welfare."⁹² Thus, courts rely on state police powers and *parens patriae* authority to grant wide latitude in overriding the health care decisions of patients with psychosocial disabilities, often permitting states to order forced mental health treatment, including confinement to hospitals and involuntary psychiatric medication, based on the health care providers' allegations that such interventions are in the patient's best interests.⁹³ Consequently, compulsory mental health interventions are often ordered without meaningfully evaluating the risks or consideration for whether interventions are likely to confer any direct benefits on the impacted individual.⁹⁴

1. *Maryland Affords No Meaningful Right to Refuse Unwanted Mental Health Intervention*

In Maryland, health care providers can involuntarily hospitalize and forcibly medicate people with little oversight, as the law permits frontline health care workers to make initial determinations on emergency petitions and forced

York's Solution for Treatment of the Chronically Mentally Ill, 149 U. PA. L. REV. 1181, 1182–83 (2001) (arguing outpatient civil commitment represents a valid use of state's *parens patriae* authority).

92. See *Addington v. Texas*, 441 U.S. 418, 425–26, 427 (1979) (holding that "the individual should not be asked to share equally with society the risk of error when the possible injury to the individual is significantly greater than any possible harm to the state," especially because "it is indisputable that involuntary commitment to a mental hospital . . . can engender adverse social consequences to the individual").

93. See *Parham v. J.R.*, 442 U.S. 584, 608 n.16 (1979) (ruling that courts may not "unduly burden" state efforts to address "difficult social problems").

94. Courts have upheld numerous permissive state laws that permit involuntary medication interventions over the express refusal of a patient, relying only upon a physician's opinions without meaningfully evaluating whether the constitutional requirements are satisfied or whether involuntary medication is necessary, appropriate, and the least restrictive intervention. See, e.g., *Stensvad v. Reivitz*, 601 F. Supp. 128, 131 (W.D. Wis. 1985) (upholding statute that provided involuntarily committed patients no right to refuse medication without further procedural protections, assuming prescribed medication was presumptively administered based upon professional judgment of prescribing physician); *R.A.J. v. Miller*, 590 F. Supp. 1319, 1322 (N.D. Tex. 1984) (noting that involuntarily hospitalized patients have no right to refuse medication, if medication is ordered in accordance with professional judgment standard identified in *Rennie v. Klein*); *In re Rob W.*, 197 N.E.3d 796, 809–10 (Ill. 2021) (finding involuntary medication permitted when person has a history of dangerous behavior due to psychosis merely because he could potentially be dangerous again without medication); *In re Mental Health of L.R.*, 231 P.3d 594, 597 (Mont. 2010) (holding constitutional rights not violated when patient involuntarily medicated prior to any involuntary civil commitment proceedings); *In re L.R.*, 497 A.2d 753, 755 (Vt. 1985) (finding involuntary medication permitted when patient is labeled a danger to self or others in absence of medication, despite no evidence of any recent dangerous act); see also WHITAKER, *supra* note 29 (explaining history of violence in inpatient psychiatric care and psychiatric medications, including neurotoxic effects of antipsychotic medications, increased risk of chronic psychiatric illness from their use, and lack of efficacy in reducing psychotic symptoms).

medication without judicial oversight.⁹⁵ Even when judges get involved in these disputes, they frequently give unquestioning deference to the decisions of health care providers, with little consideration for a patient's legitimate concerns about violations of bodily autonomy or treatment side effects.⁹⁶ Maryland, along with many other states, continues to broaden the circumstances of when medical professionals may forcibly administer medical interventions to people with psychosocial disabilities, even suggesting that the refusal of unwanted somatic medical intervention justifies forced psychiatric medication administration to gain compliance with medical care.⁹⁷

Overriding patient refusal of mental health care is especially concerning in light of historical abuses of state authority in the context of involuntary mental health intervention.⁹⁸ Psychiatric institutions historically are home to egregious human rights violations that contravene the most basic medical ethics, including forced lobotomies, electroshock treatment, intentional induction of insulin comas, and bloodletting.⁹⁹ Furthermore, physical and sexual abuse are common in institutional settings, especially in psychiatric institutions, where patients are perceived as lacking credibility by virtue of their mental illness diagnoses.¹⁰⁰ Thus, it is no surprise that the risk of suicide is heightened immediately following psychiatric hospitalization.¹⁰¹ While many clinicians initially attributed the increased post hospital suicide risk to heightened preexisting risk of suicide in

95. Emergency petition and emergency involuntary medication procedures vary significantly throughout the United States, from states such as Virginia that require judicial review prior to intervention, to states that allow emergency detention for three to fourteen days based only on medical professionals' concerns for potential dangerousness. Federal courts have provided minimal guidance. *See generally* Richard C. Boldt, *Emergency Detention and Involuntary Hospitalization: Assessing the Front End of the Civil Commitment Process*, 10 DREXEL L. REV. 1 (2017); *see also* MD. CODE. ANN., HEALTH-GEN §§ 10-622, 10-708(b)(1).

96. *See* Perlin, *supra* note 43, at 33–34 (stating judges often apply a “best interest” standard and dismiss patients concerns as symptoms of their mental illness).

97. *See* Allmond v. Dep't of Health & Mental Hygiene, No. 1570, 2017 WL 5172631 (Md. Ct. Spec. App. Nov. 8, 2017) (finding patient could be forcibly medicated to resolve ambivalence about undergoing somatic medical intervention).

98. *See generally* *Civil Rights of Institutionalized Persons: Hearings on H.R. 10 Before the Subcomm. on Cts., C.L. & the Admin. of Just. of the H. Comm. on the Judiciary*, 96th Cong. 9, 13 (1979) (testimony of Drew S. Days, III, Asst. Att'y Gen., C.R. Div.) [hereinafter *Civil Rights of Institutionalized Persons*].

99. *See, e.g.*, Manfred Sakel, *The Origin and Nature of the Hypoglycemic Therapy of the Psychoses*, 13 BULL. N.Y. ACAD. MED. 97 (1937); David Impastato, *The Story of the First Electroshock Treatment*, 116 AM. J. PSYCHIATRY 1 (1960); Walter Freeman, *History of Development of Psychosurgery*, 17 DIG. NEUROLOGY & PSYCHIATRY 412, 426–28 (1949); WHITAKER, *supra* note 29, at 13–16, 73–77.

100. *See* *Civil Rights of Institutionalized Persons*, *supra* note 98, at 12.

101. *See* Joshua T. Jordan & Dale E. McNeil, *Perceived Coercion During Admission into Psychiatric Hospitalization Increases Risk of Suicide Attempts After Discharge*, 50 J. SUICIDE & LIFE-THREATENING BEHAV. 180, 187 (2020) (finding increased risk of suicide after involuntary hospitalization); Daniel Thomas Chung et al., *Suicide Rates After Discharge from Psychiatric Facilities: A Systematic Review and Meta-Analysis*, 74 JAMA PSYCHIATRY 694, 704 (2017) (finding suicide rate to be 100 times higher after discharge from hospital).

those who are hospitalized, recent studies suggest that suicide risk following hospitalization may arise independent of a patient's preexisting suicide risk.¹⁰² Moreover, evidence also suggests involuntary hospitalization may increase one's risk for psychosis and traumatic stress disorders, while discouraging people from seeking voluntary help.¹⁰³ Psychiatric hospitalization is undoubtedly cited by some as lifesaving, but imposing involuntary psychiatric hospitalization as the primary solution for mitigating mental health crises fails to assess the interventional factors perceived as helpful and to root out those that may be unnecessary or even harmful.¹⁰⁴ Furthermore, the beneficial components of hospitalization may be reproduceable sans the high risk of harm, if we chose to reimagine alternative supports without stripping people of their dignity, autonomy, and respect.¹⁰⁵ Accordingly, suggesting that hospitalization is necessary to mitigate suicide—by and far the most common justification for involuntary admission—fails to acknowledge and address the significant harms associated with the practice.¹⁰⁶

102. See, e.g., Erin F. Ward Ciesielski & Shireen L. Rizvi, *The Potential Iatrogenic Effects of Psychiatric Hospitalization for Suicidal Behavior: A Critical Review and Recommendations for Research*, 28 *CLINICAL PSYCH.: SCI. & PRAC.* 60, 60–71 (2021) (noting that involuntary hospitalization increases risk of suicide and has other adverse consequences including significant social and economic effects); Rebecca Musgrove et al., *Suicide and Other Causes of Death Among Working Age and Older Adults in the Year After Discharge From In-Patient Mental Healthcare in England: Matched Cohort Study*, 221 *BRIT. J. PSYCHIATRY* 468, 474 (2022) (finding that psychiatric hospitalization is associated with increased risk of suicide post discharge when compared with non-hospitalized individuals without mental illness).

103. Daniel Thomas Chung et al., *Commentary: Adverse Experiences in Psychiatric Hospitals Might Be the Cause of Some Postdischarge Suicides*, 80 *BULL. MENNINGER CLINIC* 371, 373–74 (2016) (finding that suicide risk increased even amongst those not suicidal upon admission and was linked to adverse hospital experiences); Nev Jones et al., *Investigating the Impact of Involuntary Psychiatric Hospitalization on Youth and Young Adult Trust and Help-Seeking in Pathways to Care*, 56 *SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY* 2017, 2024–25 (2021) (arguing that involuntary treatment deterred future help seeking); Aditya Sareen et al., *Trauma from Involuntary Hospitalization and Impact on Mental Illness Management*, 24 *PRIMARY CARE COMPANION* (2022) (elucidating that involuntary hospitalization experiences are traumatic); Antonio Iudici et al., *Implications of Involuntary Psychiatric Admission: Health, Social, and Clinical Effects on Patients*, 210 *J. NERVOUS MENTAL DISEASE* 290, 308 (2022) (asserting that involuntary or coerced treatment led to worse outcomes relative to those seeking voluntary treatment).

104. Iudici et al., *supra* note 103, at 307.

105. See, e.g., LEGIS. ANALYSIS & PUB. POL'Y ASS'N, *PEER RESPITES AS AN ALTERNATIVE TO HOSPITALIZATION 2* (2021) (noting that use of peer respites as opposed to hospitalization may be more cost efficient); Ellen E. Bouchery et al., *The Effectiveness of a Peer-Staffed Crisis Respite Program as an Alternative to Hospitalization*, 69 *PSYCHIATRIC SERVS.* 1069, 1072 (2018) (noting that use of crisis respite services led to fewer hospitalizations and lower Medicaid expenditures).

106. PAMELA L. OWENS ET AL., AGENCY FOR HEALTHCARE RSCH. & QUALITY, *STATISTICAL BRIEF #249: INPATIENT STAYS INVOLVING MENTAL AND SUBSTANCE USE DISORDERS 9* (2019) (citing suicide or suicidal ideation as most common justification for psychiatric hospital admission).

2. *Limitations on the Right to Refuse Psychiatric Hospitalization*

In Maryland, the legal standards for involuntary admission are defined in the Maryland Code Health-General, Section 10-617, requiring that a person (1) has a mental illness (2) that is susceptible to treatment, (3) currently poses a “danger” to themselves or others, (4) is unwilling to be admitted voluntarily, and (5) lacks access to a less restrictive setting where the individual could receive treatment.¹⁰⁷ Decision makers demonstrate inconsistent compliance with existing statutory and constitutional requirements for involuntary treatment, with many judges and physicians justifying involuntary psychiatric treatment when individuals may not satisfy dangerousness standards or cite to medical rationale that is inconsistent with the current evidence base.¹⁰⁸ Moreover, the legislative and executive branches are continually seeking to expand the circumstances under which an individual is subjected to involuntary treatment.¹⁰⁹ However, these existing proposals to expand involuntary hospitalization rest on faulty legal footing, with proposed revisions to the “dangerousness” standard descriptive of disability more generally. Such proposals substantially risk arbitrarily hospitalizing individuals who may coincidentally have a “mental disorder,” but present no danger to the life or safety of themselves or others.¹¹⁰ If anything, current calls to expand involuntary intervention demonstrate a need for additional voluntary, community based supports, not more coercion.¹¹¹

Proposals to extend involuntary hospitalization to non-dangerous individuals potentially infringe upon the constitutional rights the United States Supreme Court identified in *O’Connor v. Donaldson*, where the Court proscribed confining non-dangerous individuals *without more* when an individual can survive safely in the community with or without support.¹¹² Commentators disagree on the meaning of the “without more” language identified in *O’Connor*, with some suggesting “without more” refers to a mental illness, while others

107. MD. CODE ANN., HEALTH-GEN. § 10-617.

108. See generally Letter from Carroll McCabe, Chief of the Mental Health Div., Md. Pub. Def.’s Off., to Rutherford K. Boyd, Lieutenant Governor of Md. (Oct. 1, 2021).

109. See, e.g., 49 Md. Reg. 801-02 (Aug. 12, 2022) (proposing to revise Maryland Department of Health’s dangerousness standard for emergency petitions codified at MD. CODE REGS. 10.21.01.04); 49 Md. Reg. 989-1018 (Nov. 4, 2022) (updating Sept. 12, 2022 notice to acknowledge how proposed action impacts people with disabilities and may result in increased involuntary hospitalizations); H.B. 1160, 444th Gen. Assemb. (Md. 2022) (proposing revision to emergency petition criteria definition for “dangerousness” in involuntary psychiatric treatment).

110. Supreme Court jurisprudence on compulsory treatment requires state laws to be narrowly tailored and a compelling state interest to curtail individual’s most basic freedoms. See, e.g., *O’Connor v. Donaldson*, 422 U.S. 563, 576 (1975); *Washington v. Harper*, 494 U.S. 210, 221 (1990).

111. Morgan C. Shields & Ari Ne’eman, *Expanding Civil Commitment Laws Is Bad Mental Health Policy*, HEALTH AFFS. FOREFRONT (April 6, 2018), <https://www.healthaffairs.org/content/forefront/expanding-civil-commitment-laws-bad-mental-health-policy>.

112. *O’Connor*, 422 U.S. at 576 (holding that a non-dangerous individual capable of surviving safely in freedom with support of family or friends cannot be involuntarily hospitalized).

suggest the phrase may justify civil commitment in circumstances where an individual is not immediately dangerous.¹¹³ However, the Court's language harkening back to *Shelton v. Tucker* identifies that "incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom."¹¹⁴ Thus, prioritizing restrictive hospital care over meeting the needs of disabled individuals in the most integrated setting available deprives people with disabilities of the meaningful community inclusion, which they are entitled to.¹¹⁵ Such actions fail to recognize the cognizable harm that broadening involuntary hospitalization standards could create for disabled individuals and ignores the State of Maryland's obligations to treat individuals with disabilities with the dignity and respect that all human beings deserve.¹¹⁶

3. *Limitations on the Right to Refuse Psychiatric Medications*

States may also utilize their police powers to authorize involuntary administration of psychiatric medications.¹¹⁷ State laws permitting involuntary medication vary significantly throughout the country, relying upon differing substantive standards and offering varying procedural protections.¹¹⁸ In Maryland, psychiatric medication may be administered over an individual's

113. Interpretations of "without more" in *O'Connor* vary, with some suggesting "without more" broadens the dangerousness standard to include a deterioration standard, while others suggest "without more" merely refers to the need for an individual to have a mental illness susceptible to treatment and be dangerous, but not allowing for broader dangerousness requirements. See Donald H. Stone, *Confine Is Fine: Have the Non-Dangerous Mentally Ill Lost Their Right to Liberty? An Empirical Study to Unravel the Psychiatrist's Crystal Ball*, 20 VA. J. SOC. POL'Y & L. 323, 325 (2012) (arguing *O'Connor* does not permit civil commitment without a finding of dangerousness). But see Sara Gordon, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness*, 66 CASE W. RES. L. REV. 657, 671 (2016) (arguing holding should allow for involuntary treatment of non-dangerous individuals but conceding that most courts interpret *O'Connor* as requiring a finding of dangerousness).

114. *O'Connor*, 422 U.S. at 575 (citing *Shelton v. Tucker*, 364 U.S. 479, 488–90 (1960)).

115. See *Olmstead v. L.C.*, 527 U.S. 581, 597–98 (1999) (recognizing and deferring to Department of Justice's determination that "undue institutionalization qualifies as discrimination"); see also *United States v. Mississippi*, 400 F. Supp. 3d 546, 551 (S.D. Miss. 2019) (affirming recognition that any treatment professional can be used to show community placement is appropriate).

116. MD. JUDICIARY HUMAN RES. DEP'T, NOTICE OF COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT (2019), <https://www.courts.state.md.us/sites/default/files/import/hr/ada/adanoticeofcompliance.pdf>.

117. Gary G. Cooper, *Civil Commitment of Mentally Ill; Right to Treatment; Parens Patriae Power; Right to Liberty; Donaldson v. O'Connor*, 9 AKRON L. REV. 374, 378 (1975) (arguing that police power justifies treatment for protection of others and *parens patriae* authority to provide treatment when one is not capable of caring for oneself).

118. See, e.g., N.Y. COMP. CODES R. & REGS. tit. 14, § 27.8 (2022) (providing significant procedural protections for forced medication, affording a right to counsel and judicial hearing); ARIZ. REV. STAT. ANN. § 36-513 (2022) (allowing for involuntary medication as part of a written treatment plan or when necessary for patient safety); MASS. GEN. LAWS ANN. ch. 123, § 8B (permitting involuntary medication with antipsychotics only when a person is civilly committed to hospital, deemed incompetent to make treatment decisions, and would accept treatment if competent).

express refusal in two circumstances: (1) in an emergency, where an individual poses a danger to self or others, or (2) in a nonemergency, when the individual is involuntarily hospitalized and medication is necessary to relieve serious mental illness symptoms that cause an individual to be dangerous to self or others while confined to the facility.¹¹⁹ Institutional abuses of authority regarding the use of forced psychiatric medications are well documented, yet the practice continues to this day.¹²⁰ What is more, many psychiatric medications pose significant risks while demonstrating inconsistent benefits, raising the question of whether states may still permit compulsory psychiatric medication in light of evolving evidence.¹²¹ Research suggests that only one-third of people experiencing psychosis require and benefit from psychiatric medication and only one-fifth of patients may need ongoing medication treatment.¹²² The medications most commonly ordered involuntarily, atypical antipsychotics and neuroleptic medications, carry significant risks of morbidity and mortality with inconsistent efficacy at ameliorating experiences of psychosis that patients report as most distressing.¹²³ When recommending psychiatric medications, physicians lack

119. MD. CODE ANN., HEALTH-GEN §10-708; *Dep't of Health & Mental Hygiene v. Kelly*, 397 Md. 399, 918 A.2d 470 (2007) (clarifying that involuntary psychiatric medication may only be ordered when an individual is dangerous to themselves or others within the confines of a facility).

120. *Drugs in Institutions: Hearings Before the Subcommittee to Investigate Juvenile Delinquency of the S. Comm. on the Judiciary*, 94th Cong. (1975) (noting common practice of forced drugging in educational, hospital, penal, and other settings); David Ferleger, *Evolutions in Advocacy, a Brief History: The Bible to Bedlam to Bill Johnson*, MINN. GOVERNOR'S COUNCIL ON DEVELOPMENTAL DISABILITIES (June 23, 2011), <https://mn.gov/mnddc/disability-litigation/evolution-in-advocacy-history.html>.

121. Ira R. Katz et al., *Lithium Treatment in the Prevention of Repeat Suicide-Related Outcomes in Veterans with Major Depression or Bipolar Disorder: A Randomized Clinical Trial*, 79 JAMA PSYCHIATRY 24 (2022) (finding that lithium treatment did not reduce suicides or suicide attempts in people with depression and bipolar disorder); Erick H. Turner et al., *Selective Publication of Antidepressant Trials and Its Influence on Apparent Efficacy*, 358 NEW ENG. J. MED. 252, 256-58 (2008) (showing that antidepressant medications have no significant treatment effect when compared to placebo); Jose Luis Turabian, *Psychotropic Drugs Originate Permanent Biological Changes That Go Against of Resolution of Mental Health Problems. A View from the General Medicine*, J. ADDICTIVE DISORDERS & MENTAL HEALTH 1, 4 (2021) (noting that psychiatric medications can "chronify" mental illnesses that would have resolved without medication and worsen public mental health).

122. See Jakkó Seikkula et al., *Five-Year Experience of First-Episode Nonaffective Psychosis in Open-Dialogue Approach: Treatment Principles, Follow-Up Outcomes, and Two Case Studies*, 16 PSYCHOTHERAPY RSCH. 214, 223-24 (2006) (determining that when psychotherapy was used as a primary intervention and antipsychotics only administered as an adjunct for those unresponsive to primary intervention, only 33% of the cohort required anti-psychotic medication and only 20% required regular anti-psychotic medication); see also Brett J. Deacon, *The Biomedical Model of Mental Disorder: A Critical Analysis of Its Validity, Utility, and Effects on Psychotherapy Research*, 33 CLINICAL PSYCH. REV. 846, 852-53 (2013) (finding only 23% of patients with bipolar disorder who received treatment in line with best practices remained well and continuously enrolled in study).

123. Jeffrey A. Lieberman et al., *Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia*, 353 NEW ENG. J. MED. 1209, 1218 (2005) (noting that newer, atypical antipsychotics are not significantly more effective or well tolerated than older neuroleptics); Beng-Choon Ho et al., *Long-Term Antipsychotic Treatment and Brain Volumes: A Longitudinal Study of First-Episode Schizophrenia*, 68 ARCHIVES GEN. PSYCHIATRY 128, 135 (2011) (documenting long term antipsychotic use associated

reliable means to predict whether antipsychotic medications will benefit any particular patient or which medication, if any, will prove most effective.¹²⁴ Thus, even when medications do help improve symptoms, identifying beneficial medication regimens with manageable side effects often requires significant trial and error.

Forcibly medicating people with inconsistent benefits and at significant risk to the impacted individual necessarily questions the professional judgment of medical professionals ordering compulsory medications.¹²⁵ Analyses of scientific literature suggest conflicts of interests contribute to biased research and publication practices, likely contributing to prescribing practices and policies based upon inflated expectations of psychotropic medications.¹²⁶ Furthermore, psychiatric prescribers often fail to disclose the significant variance in drug efficacy and side effects to patients or judges, indicating a failure in the judiciary's role of advisement to ensure involuntary medication satisfies both

with longitudinal dose-dependent decreases in global brain volume that is not explained by symptom severity or drug use); Martin Harrow et al., *A 20-Year Multi-Follow Up Longitudinal Study Assessing Whether Antipsychotic Medications Contribute to Work Functioning in Schizophrenia*, 256 *PSYCHIATRY RSCH.* 267, 269–71 (2017) (discerning that long term antipsychotic treatment is associated with worse vocational outcomes when compared with those not prescribed antipsychotic medications); Stefan Weinmann et al., *Influence of Antipsychotics on Mortality in Schizophrenia: Systematic Review*, 113 *SCHIZOPHRENIA RSCH.* 1, 3–7 (2009) (finding that antipsychotic medication is associated with a higher risk of mortality); Katherine Jonas et al., *Two Hypotheses on the High Incidence of Dementia in Psychotic Disorders*, 78 *JAMA PSYCHIATRY* 1305, 1305 (2021) (reporting that antipsychotic medications are associated with an increased risk of dementia); Nikolai Albert et al., *Cognitive Functioning Following Discontinuation of Antipsychotic Medication. A Naturalistic Sub-Group Analysis from the OPUS II Trial*, 49 *PSYCH. MED.* 1138, 1143 (2019) (finding that people diagnosed with psychosis demonstrate improved cognitive functioning after discontinuing antipsychotic medications).

124. See Deacon, *supra* note 122, at 854.

125. See *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982) (articulating professional judgment standard used to determine one's right to be free from unwanted treatment); see also Susan Stefan, *Leaving Civil Rights to the "Experts": From Deference to Abdication Under the Professional Judgment Standard*, 102 *YALE L.J.* 639, 679–81 (1992) (arguing professional judgement standard violates Fourteenth Amendment's due process protections when applied to negative rights).

126. See, e.g., James H. Baraldi et al., *A Cross-Sectional Examination of Conflict-of-Interest Disclosures of Physician-Authors Publishing in High-Impact US Medical Journals*, 12 *BMJ OPEN* 1, 6–8 (2022) (discussing role of conflicts of interests in publication bias); Y.A. de Vries et al., *The Cumulative Effect of Reporting and Citation Biases on the Apparent Efficacy of Treatments: The Case of Depression*, 48 *PSYCH. MED.* 2453, 2453 (2018) (showing that publication bias in reporting results of psychiatric drug trials inflates perceived efficacy of psychiatric medications); Roy H. Perlis et al., *Industry Sponsorship and Financial Conflict of Interest in the Reporting of Clinical Trials in Psychiatry*, 162 *AM. J. PSYCHIATRY* 1957, 1958–59 (2005) (noting that conflicts of interests lead to underreporting of adverse events and overreporting of treatment effects); Joel Lexchin & Adriane Fugh-Berman, *A Ray of Sunshine: Transparency in Physician-Industry Relationships Is Not Enough*, 36 *J. GEN. INTERNAL MED.* 3194, 3195 (2021) (noting that transparency has not resulted in a change in behavior for physicians declaring conflicts of interests); Michelle Chen, *For-Profit Medicine Incentivizes Overmedicating Our Elderly Rather Than Caring for Them*, *NBC NEWS* (Feb. 20, 2018, 4:25 AM), <https://www.nbcnews.com/think/opinion/profit-medicine-incentivizes-overmedicating-our-elderly-rather-caring-them-ncna848491>.

legal and ethical requirements.¹²⁷ Thus, involuntary psychiatric medication raises the question of whether the state possesses a legitimate interest in compelling patient use of these medications, when only one-third of patients are likely to gain a meaningful benefit, while all are exposed to significant risks.¹²⁸

If the state intends to use its power to ameliorate public health risks associated with mental illness, the state should focus its efforts on interventions that confer direct benefits and outweigh any potential risk of harm. For example, states could focus their efforts on offering alternative interventions for those who do not benefit from psychiatric medications, rather than continuing to amplify the use of force and coercion. Additionally, if a patient opposed medications on any grounds, the state could seriously consider the harms involved in medicating someone over their express objection and the reasons why that individual may oppose taking the drugs, before reverting to forcible medication. In addition to the constitutional implications, experiencing the violation of one's bodily integrity creates lasting trauma, with many patients describing the experience as akin to the violation experienced during sexual assault, which causes understandable reluctance to seek future support from the health care system.

4. *Coercion Further Limits the Right to Refuse Within the Mental Health System*

The power disparities present between people with psychosocial disabilities, medical providers, and the courts further limit any meaningful right to refuse mental health care, even when patients are not legally compelled to engage in treatment.¹²⁹ Outpatient civil commitment represents one version of this, in which the judiciary is employed to coerce treatment compliance.¹³⁰ Here,

127. Lex Wunderink et al., *Recovery in Remitted First-Episode Psychosis at 7 Years of Follow-up of an Early Dose Reduction/Discontinuation or Maintenance Treatment Strategy*, 70 JAMA PSYCHIATRY 913, 917 (2013) (finding that early discontinuation of antipsychotic medication is associated with better outcomes); Nancy Sohler et al., *Weighing the Evidence for Harm from Long-Term Treatment with Antipsychotic Medications: A Systematic Review*, 86 AM. J. ORTHOPSYCHIATRY 477, 483 (2016) (reporting that long term treatment with anti-psychotic medication is not supported by evidence); J. Moilanen et al., *Characteristics of Subjects with Schizophrenia Spectrum Disorder with and Without Antipsychotic Medication – A 10-Year Follow-Up of the Northern Finland 1966 Birth Cohort Study*, 28 EUR. PSYCHIATRY 53, 58 (2013) (iterating that people diagnosed with schizophrenia who were not taking medication were equally likely to relapse, but had better long term outcomes); Martin Harrow et al., *Does Treatment of Schizophrenia with Antipsychotic Medications Eliminate or Reduce Psychosis? A 20-Year Multi-Follow-Up Study*, 44 PSYCH. MED. 3007, 3013 (2014) (stating that antipsychotic medication does not reduce symptoms of psychosis or improve long term prognosis for people diagnosed with schizophrenia).

128. See, e.g., Deacon, *supra* note 122, at 852–53.

129. See, e.g., David Cohen, *It's the Coercion, Stupid!*, MAD IN AMERICA (Oct. 21, 2014), <https://www.madinamerica.com/2014/10/coercion-stupid/>.

130. See Richard C. Boldt, *Perspectives on Outpatient Civil Commitment*, 49 NEW ENG. L. REV. 39, 68–69 (2014) (noting that half of state outpatient civil commitment laws do not identify enforcement for noncompliance).

judges compel compliance with involuntary medication orders, relying “only” upon the apparent authority of the courts, as many states lack a statutorily designated enforcement mechanism to impose upon noncompliance with court ordered treatment.¹³¹ Instead, inducing treatment compliance relies solely on the apparent authority of the judge and court process.¹³² The absence of designated enforcement mechanisms leads many to argue that involuntary outpatient treatment is not actually involuntary treatment at all, instead implying it is a more benign and beneficial form of coercion, using the euphemism “assisted outpatient treatment” to deflect from negative connotations that are associated with the term “civil commitment.”¹³³ Benefits of involuntary outpatient treatment remain unclear, yet euphemisms ignore the significant harm of “mere coercion,” even in the absence of formal punitive mechanisms to compel compliance. Involuntary outpatient treatment programs subject marginalized individuals to increased law enforcement involvement and ongoing threats of involuntary institutionalization for noncompliance, putting people with psychosocial disabilities at an increased risk of abuse and even death.¹³⁴

131. See, e.g., N.Y. MENTAL HYG. LAW § 9.60I (McKinney 2023) (stating that Kendra’s Law allows for “assisted outpatient treatment” without designated enforcement); see also Boldt, *supra* note 130, at 68–69; Betsy Johnson, AOT Pol’y Advisor, Treatment Advoc. Ctr., *The Fundamentals of Assisted Outpatient Treatment (AOT)* (Oct. 13, 2022) (distinguishing lack of enforcement authority in assisted outpatient treatment laws to “consequences for non-compliance” suggesting noncompliance will not result in jail or fines but could lead to extended assisted outpatient treatment orders and involuntary hospitalization).

132. Many commentators cite the “power of the robe” or the “black robe effect” to describe the efficacy of formalized court processes and judicial authority to coerce ongoing compliance with involuntary medication orders under outpatient civil commitment schemes. See Boldt, *supra* note 130, at 70 n.170, 81–82 (citing TREATMENT ADVOCACY CENTER BACKGROUND: NO RELEVANCE TO ASSISTED OUTPATIENT TREATMENT (AOT) IN THE OCTET STUDY OF ENGLISH COMPULSORY TREATMENT (2014), <http://treatmentadvocacycenter.org/storage/documents/Research/may2013-octet-study.pdf>).

133. Advocates for outpatient civil commitment argue the laws do not actually impose “involuntary” outpatient treatment but are more akin to “assisted outpatient treatment,” suggesting that a mentally ill patient’s refusal of care is a symptom of a neurological illness impairing capacity for informed consent, and thus grants the state authority, under its *parens patriae* power, to coerce compliance with medication even if it goes against a patient’s stated interests. See Boldt, *supra* note 130, at 45–47 (citing John Monahan et al., *Reply to Erik Roskes, Letter to the Editor, “Assisted Outpatient Treatment”: An Example of Newspeak?*, 64 PSYCHIATRIC SVCS. 1179, 1179 (2013)). But see Rosanna Esposito et al., *A Guide for Implementing Assisted Outpatient Treatment*, TREATMENT ADVOCACY CENTER (June 2012), <https://www.treatmentadvocacycenter.org/storage/documents/aot-implementation-guide.pdf> (identifying consequences for noncompliance and involvement of law enforcement as necessary to effective implementation of outpatient civil commitment schemes).

134. Many outpatient civil commitment laws threaten hospitalization for noncompliance with outpatient civil commitment. Significant racial and class disparities amongst individuals subjected to outpatient civil commitment orders also indicate disparate application of the law demonstrating a significant risk of outpatient civil commitment. See MARVIN S. SWARTZ ET AL., *NEW YORK STATE ASSISTED OUTPATIENT TREATMENT PROGRAM EVALUATION* vii (Duke Univ. Sch. of Med. ed., 2009) (suggesting that NY Outpatient Civil Commitment program is only discriminatory if it causes harm and that overrepresentation of Black people is attributable to their “higher likelihood of being poor, higher likelihood of being uninsured, and higher likelihood of being treated by the public mental health system”).

In the confines of institutions, the coercive power of mental health care is even stronger, as a health care provider's authority is largely unchecked outside of involuntary admission hearings and nonemergency forced medication orders. This leads to practices where the patient's ability to access certain privileges or avoid punishment may be contingent upon engagement in certain prescribed treatments.¹³⁵ In fact, patient refusal of care itself often gets pathologized as evidence of "anosognosia" and justifies forced or coercive mental health intervention.¹³⁶ In addition to overt coercion from health care providers, a patient's limited financial resources may further impede their right to refuse mental health care in any meaningful way, as insurance coverage may define the care options that the patient can access.¹³⁷ Many models of inpatient psychiatric treatment also inherently limit patient's access to alternative treatment options, further inhibiting opportunities for meaningful informed consent. Such restrictions create uniquely coercive conditions when captive populations are desperate to escape institutional violence.¹³⁸

Some physicians even capitalize on patient vulnerability in psychiatric institutions by enrolling patients in research studies without notifying them of the study's purpose or disclosing the material risks of harm involved in participation.¹³⁹ Physician-researchers often justify experimentation without informed consent based on inappropriate applications of a "best interests" standard, rationalizing that disclosing research risks causes harm to patients.¹⁴⁰

135. See Awas Aftab, *Reconsidering Care and Coercion in Psychiatry: Kathleen Flaherty, JD*, PSYCHIATRIC TIMES (Apr. 21, 2021) (discussing coercive nature of inpatient environment and backlash from refusing treatment); see also *Grimes v. Kennedy Krieger Inst.*, 782 A.2d 807, 853 (Md. 2001) (explaining risks of researchers deciding "best interests" of study participants in hazardous, nontherapeutic research, the Court of Appeals states "to turn over human and legal ethical concerns solely to the scientific community, is to risk embarking on slippery slopes, that all too often in the past, here and elsewhere, have resulted in practices we, or any community, should be ever unwilling to accept").

136. Aftab, *supra* note 135 (describing how minor unwillingness to consent to psychiatric care gets labeled as anosognosia).

137. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 90, at 7–8, 13–14 (citing managed care and changes in public payment structures as contributing to changes in availability of services); see also Aftab, *supra* note 135 (discussing role of poverty in limiting access to treatment choices and need to fund more voluntary, community based interventions).

138. Tina Minkowitz, *Why Mental Health Laws Contravene the CRPD – An Application of Article 14 with Implications for the Obligations of States Parties*, CTR. FOR HUM. RTS. OF USERS & SURVIVORS OF PSYCHIATRY (2011); Cindy Brach, *Making Informed Consent an Informed Choice*, HEALTH AFFS. FOREFRONT (Apr. 4, 2019), <https://www.healthaffairs.org/content/forefront/making-informed-consent-informed-choice> (noting that patients do not get informed consent without informed choices which are often curtailed due to perverse incentives within health care system).

139. See ROBERT WHITAKER, ANATOMY OF AN EPIDEMIC: MAGIC BULLETS, PSYCHIATRIC DRUGS, AND THE ASTONISHING RISE OF MENTAL ILLNESS IN AMERICA 239–47 (Crown Publishers 2010) (discussing how parents and patients generally do not know risks of bipolar disorder and other mental health issues that often arise from treating hyperactive and depressed children with depressants and stimulants).

140. See *Grimes*, 782 A.2d at 816–17 (providing examples of coercive human subjects research with minimal benefit); see also *id.* at 816 n.6 (citations omitted) ("Indeed, the literature on the law and ethics

Worse, many research studies enrolled psychiatric inpatients not only without an intent to provide a treatment effect, but actually intending to exacerbate psychiatric symptoms for experimental purposes.¹⁴¹ Thus, researchers effectively claimed patients possessed the capacity to consent to research that afforded no direct benefit and often exacerbated the very symptoms patients sought relief from, but simultaneously claimed patients lacked the capacity to refuse unwanted psychiatric care.¹⁴² Accordingly, by applying inconsistent standards to patient rights, informed consent and refusal of psychiatric intervention, physicians, policymakers, and judges often compromise the civil and human rights of disabled individuals. While the Department of Health and Human Services recognizes the danger of performing research on individuals in carceral settings, these same protections do not apply to people in psychiatric hospitals.¹⁴³ Furthermore, internally inconsistent applications of patient rights raise significant ethical questions about whether the “professional judgment” standard announced in *Youngberg v. Romeo*¹⁴⁴ can meaningfully incorporate and respect a patient’s independent interests and rights.¹⁴⁵ These concerns highlight the need to ensure patients labeled with mental illness are afforded the same rights to choose and refuse care as those with somatic illnesses.

of human experimentation is replete with warnings that all subjects, but especially vulnerable subjects, are at risk of abuse by inclusion as research subjects.”).

141. *Major Reforms Are Urgently Needed to Protect Human Subjects in Research: Hearing Before the S. Comm. on Health, Educ., Lab. & Pension*, 107th Cong. 3–4 (2002) (statement of Michael A. Susko, President & Adil E. Shamoo, Cofounder, Citizens for Responsible Care & Rsch.), <http://www.circare.org/submit/230402Shamoo.pdf>.

142. The Nuremberg Code requires voluntary, informed consent, limits experimentation in vulnerable situations, and requires experimenters to limit unnecessary suffering. NICHOLAS H. STENECK, U.S. DEP’T OF HEALTH & HUM. SERVS., INTRODUCTION TO THE RESPONSIBLE CONDUCT OF RESEARCH, NUREMBERG CODE: DIRECTIVES FOR HUMAN EXPERIMENTATION 36–37 (2007); *see also* WORLD MED. ASS’N., DECLARATION OF HELSINKI – ETHICAL PRINCIPLES FOR MEDICAL RESEARCH INVOLVING HUMAN SUBJECTS (1964) (outlining principles of informed consent in research in post World War II era); *cf.* T.D. v. N.Y. State Off. of Mental Health, 650 N.Y.S.2d 173 (1996) (noting the State could not perform psychiatric research deemed “more than minimal risk” and offering “no therapeutic benefit” on psychiatric inpatients deemed incompetent to make treatment decisions without due process protections); *Rivers v. Katz*, 495 N.E.2d 337 (N.Y. 1986) (citations omitted) (“[I]t is well accepted that mental illness often strikes only limited areas of functioning, leaving other areas unimpaired, and consequently, that many mentally ill persons retain the capacity to function in a competent manner.”).

143. 45 C.F.R. § 46.303(c) (“Prisoner means any individual involuntarily confined or detained in a penal institution.”); *cf.* DEP’T OF HEALTH & HUM. SERVS., OFF. FOR HUM. RSCH. PROTS., PRISONER RESEARCH FAQs (2022) (noting people involuntarily hospitalized due to mental illness are not protected under regulations protecting prisoners). *But see* Lisa E. Smilan, *The Revised Common Rule and Mental Illness: Enduring Gaps in Protections*, 46 AM. J.L. & MED. 413, 417 n.26 (2020) (citing 45 C.F.R. § 46 (2019)) (noting that people who are involuntarily hospitalized are not explicitly addressed, but should be protected as vulnerable subjects under original and revised common rules, “because of the inherently coercive nature of that environment and the relationship between institutionalized patient and mental health provider”).

144. 457 U.S. 307 (1982).

145. *Id.* at 323 (holding that right to refuse mental health treatment is assessed based upon whether intervention is a substantial departure from professional judgement, standards, or practice).

C. State Interests Do Not Justify Overriding an Individual's Right to Refuse Psychiatric Treatment Since Involuntary Psychiatric Treatment Fails to Reliably Further Public Health or Safety

Using state police powers to sanction violence and perpetuate harm runs afoul of the United States Constitution. Yet, legislators use public safety to justify forcibly confining, treating, and medicating people who are labeled as mentally ill to control behavior that is deemed dangerous.¹⁴⁶ However, the extent of a state's authority to order compulsory mental health treatment when individuals do not pose an imminent risk of harm remains unclear. The Supreme Court decisively found states hold an "unqualified interest in preserving human life," by eliminating the possibility of a right to suicide.¹⁴⁷ The Court also found a fundamental right to refuse unwanted life sustaining care.¹⁴⁸ In evaluating the tension between the state's interest in preserving life and an individual's right to refuse care, the Court discussed state interest in preventing coercive medical interventions, stating that the "[s]tate's interest here goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and 'societal indifference.'"¹⁴⁹ Thus, states must carefully consider the Court's guidance in examining an individual's right to refuse mental health care, particularly with interventions that may increase the risk of suicide¹⁵⁰ and hasten death.¹⁵¹ Given that forced mental health treatment overrides the fundamental right to refuse medical treatment, the state must demonstrate a compelling interest to override a patient's constitutionally protected interest in refusing care, with statutes that are narrowly tailored to achieve that end.¹⁵² Moreover, recent Supreme Court

146. See *infra* note 165.

147. *Washington v. Glucksberg*, 521 U.S. 702, 720–21, 728 (1997) (citing *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 162, 278–79).

148. *Id.*

149. *Id.* at 732.

150. See, e.g., *Ward-Ciesielski & Rizvi*, *supra* note 102, at 8–9 (noting that involuntary hospitalization increases risk of suicide and has other adverse consequences including significant social and economic effects); *Chung et al.*, *supra* note 103, at 373–74 (finding that suicide risk increases even among those not suicidal upon admission and is linked to adverse hospital experiences).

151. See, e.g., *Turabian*, *supra* note 121, at 4 (asserting that psychiatric medications can "chronify" mental illnesses that would have resolved without medication and worsen public mental health); *Weinmann et al.*, *supra* note 123, at 1–11 (arguing that antipsychotic medication is associated with a higher risk of mortality); *Jonas et al.*, *supra* note 123 (alleging that antipsychotic medications are associated with an increased risk of dementia); *Albert et al.*, *supra* note 123, at 1138–47 (finding that people diagnosed with psychosis demonstrate improved cognitive functioning after discontinuing antipsychotic medications).

152. *Prince v. Massachusetts*, 321 U.S. 158, 166–67 (1944) (discussing that threat of a child or community's safety from illness and death overrides one's freedom of religious liberty as a parent); *Winters v. Miller*, 446 F.2d 65, 70 (2nd Cir. 1971) (contrasting a state's compelling interest to protect a community from infectious disease through mandatory vaccinations in *Jacobson* with involuntarily committing a patient who is not a threat to the state into a psychiatric facility); *People v. Pierson*, 68 N.E.

decisions emphatically state that “fundamental rights need not be free of “controversial public safety implications.”¹⁵³

I. Maryland Courts Distinguish Rights to Refuse Care for Patients with Somatic Illness Relative to Patients with Mental Illness Based Upon Discriminatory Stereotypes

The Maryland Court of Appeals further distinguishes valid state interests, suggesting even when a competent adult lacks insight into a treatable somatic condition, they maintain the right to refuse unwanted somatic medical intervention.¹⁵⁴ In *Stouffer v. Reid*, the Maryland Court of Appeals examined whether a prisoner could refuse life sustaining dialysis treatments for his end stage kidney disease.¹⁵⁵ The prison warden wanted to compel treatment in the name of the state’s penological interests, but the prisoner wished to refuse treatment even though he was deemed lacking insight into his need for treatment.¹⁵⁶ The Court of Appeals determined the State may not override a patient’s express refusal of care absent a compelling risk to innocent third parties or the public.¹⁵⁷ Nonetheless, the Court of Appeals continues to permit the State to override the express refusal of psychiatric care when patients are deemed “mentally ill,” even when the individual has not otherwise been adjudicated incompetent.¹⁵⁸

Moreover, in *Stouffer*, the Maryland Court of Appeals criticized the Iowa Supreme Court’s decision in *Polk County Sheriff v. Iowa District Court for Polk County*,¹⁵⁹ which condoned the forcible provision of unwanted medical care to prisoners.¹⁶⁰ The *Stouffer* court criticized the reasoning in *Polk*, because ordering forced medical treatment “fundamentally undervalue[s] the liberty interest of the Fourteenth Amendment” and “recognize[s] the [s]tate’s interests as supreme

243, 246–47 (N.Y. 1903) (discussing cases where courts held a substantial state interest outweighed individual interests, court found state interests were only upheld upon demonstrating a clear interest, either on part of society as a whole or at least in relation to a third party, which would be substantially affected by permitting individuals to assert their rights to refuse unwanted mental health care).

153. *McDonald v. City of Chicago*, 561 U.S. 742, 783 (2010).

154. *See Stouffer v. Reid*, 993 A.2d 104, 111 (Md. 2010) (holding that preserving life is not sufficient to override a patient’s right to refuse care of a treatable condition even when that refusal is fatal).

155. *Id.*

156. *Id.*

157. *Id.* at 119–20.; *see, e.g., Winters*, 446 F.2d at 70 (finding no evidence to suggest that forcing unwanted medication on patient “was in any way protecting the interest of society or even any third party”).

158. *See Allmond v. Dep’t of Health & Mental Hygiene*, 141 A.3d 57, 71–72 (Md. 2016) (noting neither diagnoses of mental illness, nor confinement in a psychiatric hospital, render an adjudication of incompetence).

159. 594 N.W.2d 421 (Iowa 1999).

160. *Stouffer*, 993 A.2d at 112–14 (citing *Polk Cnty. Sheriff v. Iowa Dist. Ct. for Polk Cnty.*, 594 N.W.2d 421, 431 (Iowa 1999)).

even though they are totally unsupported by the evidence.”¹⁶¹ Citing these criticisms of *Polk*, the *Stouffer* Court bolstered an individual’s right to refuse unwanted medical intervention, validating that a patient’s distrust of medical professionals is legitimate when physicians fail to disclose information about their medical condition or accurately portray the risks and benefits of refusing treatment.¹⁶² Moreover, the Court of Appeals did not label the patient, Mr. Reid, as paranoid or delusional for refusing a lifesaving somatic medical intervention, as is often done to rationalize compulsory care for patients with psychosocial disabilities.¹⁶³ Instead, the *Stouffer* court empathized with Mr. Reid, finding his constitutional right to refuse unwanted medical intervention outweighed the State’s legitimate penological interests.¹⁶⁴

The only distinction the Court of Appeals draws to distinguish the refusal of life sustaining somatic medical care from the right to refuse psychiatric medication is the legislature’s “justifiable” exception to the right to refuse care when it enacted Maryland Code Health-General, Section 10-708.¹⁶⁵ The court attempts to distinguish the patient’s behavior and thought processes from those relied upon by the legislature to justify compulsory psychiatric intervention, such as validating the causes for Mr. Reid’s lack of insight and mistrust of medical professionals.¹⁶⁶ Though, arguably, the only meaningful difference is the court’s capacity to relate to and its willingness to understand Mr. Reid’s rationale for refusing care. Accordingly, the court upholds his right to refuse unwanted medical intervention, standing in stark contrast to cases where courts undermine the rights of people with mental illness.¹⁶⁷ Thus, the Court of Appeals’ inconsistent application of the right to refuse between patients with mental illnesses versus those with somatic illnesses suggests that the state’s use of compulsory psychiatric care violates the state’s obligation to refrain from discriminating against and inaccurately stereotyping people with psychosocial disabilities.¹⁶⁸

161. *Id.* at 113 (quoting *Polk Cnty. Sheriff*, 594 N.W.2d at 434 (Snell, J., dissenting)).

162. *Id.*

163. *Id.* at 113.

164. *Id.* at 120.

165. MD. CODE ANN., HEALTH-GEN. § 10-708. Compare *Stouffer*, 993 A.2d at 114–15 (citing *Williams v. Wilzack*, 573 A.2d 809, 820 (Md. 1990)), with *Kansas v. Crane*, 534 U.S. 407, 413 (2002) (citing *Foucha v. Louisiana*, 504 U.S. 71 (1992)) (finding states may confine people convicted of criminal conduct beyond their sentence only upon findings that an individual has a mental illness or “mental defect” that impairs volitional control and poses a danger to self or others).

166. *Stouffer*, 993 A.2d at 113.

167. *Id.* at 120.

168. *Id.* at 115; see also *Washington v. Glucksberg*, 521 U.S. 702, 732 (1997).

2. *Patients' Express Refusal of Life Sustaining Medical Intervention Does Not Compromise the Ethics or Integrity of the Medical Profession*

In addition, courts generally recognize that a patient's right to refuse treatment does not conflict with or compromise the integrity of the medical profession.¹⁶⁹ In the setting of meaningful informed consent, physicians do not possess a duty to treat patients who decline treatment after disclosing the risks and benefits of the proposed medical intervention, possible alternatives, and no treatment.¹⁷⁰ In fact, both the common law doctrine of informed consent and medical ethics require that doctors refrain from imposing their beliefs on patients.¹⁷¹ Despite these requirements to provide informed consent, physicians rarely satisfy these obligations, limiting any meaningful justification that a patient's refusal of treatment alone compromises the integrity of the medical profession or permits state intervention.¹⁷² Thus, arguments suggesting a state interest in "preserving the medical profession" to justify "medical treatment" over a patient's express refusal of care are incompatible with the law and basic ethical principles of autonomy, beneficence, nonmaleficence, and justice that are foundational to the medical profession, especially when an individual is not otherwise rendered incapable of medical decision making.¹⁷³

3. *Determinations That an Individual Has a Mental Illness and Poses a Danger to Self or Others are Often Arbitrary and Pretextual, Failing to Support a Valid State Interest in Promoting Public Health or Safety*

In order to constitutionally compel treatment, the Supreme Court requires that states identify findings of mental illness and dangerousness.¹⁷⁴ The Court

169. See *Stouffer*, 993 A.2d at 119 (maintaining ethical integrity of medical profession is insufficient to override an incarcerated individual's right to refuse unwanted medical treatment).

170. See *McQuitty v. Spangler*, 976 A.2d 1020, 1031 (Md. 2009) (quoting *Sard v. Hardy*, 379 A.2d 1014, 1020 (Md. 1977)) (noting informed consent requires physician disclosure of "the nature of the proposed treatment, the probability of success of the contemplated therapy and its alternatives, and the risk of unfortunate consequences associated with such treatment"); see also *Thor v. Superior Ct.*, 855 P.2d 375 (Cal. 1993).

171. *McQuitty*, 976 A.2d at 1031 (quoting *Sard*, 379 A.2d at 1020) ("[T]he law does not allow a physician to substitute his judgment for that of the patient in the matter of consent to treatment.").

172. See *Brach*, *supra* note 138.

173. See *id.*; see also *Pirotte & Benson*, *supra* note 35. Moreover, if private hospitals or representatives of health care providers are arguing these state interests in lieu of the state itself, it may conflict with their duties to their patients. See *Matter of Dubreuil*, 629 So. 2d 819, 823, 828 (Fla. 1993) (holding that a health care provider may not act on behalf of state to assert state interests or satisfy state's burden of proof required to override a patient's refusal of care, as "a health care provider must not be forced into the awkward position of having to argue zealously against wishes of its own patient, seeking deference to wishes or interests of nonpatients").

174. See *O'Connor v. Donaldson*, 422 U.S. 563, 575–76 (1975). *But see* *Kansas v. Hendricks*, 521 U.S. 346, 357–59 (1997) (stating mental illness has no "talismanic significance" and granting legislatures broad discretion by stating that a "mental abnormality" need not be a defined medical condition and suggesting, instead, that involuntary confinement is limited to those with "volitional impairments rendering them dangerous beyond their control"); *Kansas v. Crane*, 534 U.S. 407, 412–15 (2002) (holding

treats these factors as distinct criteria that should be assessed based upon independent variables, stating that potential dangerousness alone is not sufficient to confine a person without a mental illness or mental defect.¹⁷⁵ However, some mental illness labels are applied to describe past “dangerous” behavior,¹⁷⁶ while perceptions of dangerousness are imputed to other diagnostic labels based only on stereotypes.¹⁷⁷ Either way, once an individual is labeled as mentally ill, clinicians are more likely to perceive a patient as dangerous, leading to presumptions of dangerousness that may or may not persist.¹⁷⁸ Confining people with mental illness based on concern for future dangerousness risks infringing on ideas of liberty otherwise guaranteed by the Fourteenth Amendment and criminal procedural due process requirements enumerated in the Fifth Amendment.¹⁷⁹ Justifying confinement in the name of public safety, absent any finding to support an imminent or specific danger, necessarily raises questions about the methods used to assess risk and provide treatment in the least restrictive setting available.¹⁸⁰

that post sentence civil commitment of individuals convicted of sexual offenses requires a judicial finding that an individual has a “mental illness, abnormality, or disorder” impairing volitional control).

175. *Hendricks*, 521 U.S. at 357–59 (holding that potential for future dangerousness must be linked to “proof of some additional factor, such as a ‘mental illness’ or ‘mental abnormality’” that makes it difficult or impossible for an individual to control future dangerous behavior); *see also id.* at 358 (limiting confinement to people with a mental abnormality or personality disorder who are unable to control their dangerousness).

176. *See, e.g., In Brief: The Stigma of Borderline Personality*, HARV. MENTAL HEALTH LETTER (2007) (reporting that women demonstrating “sudden rage, suicidal thoughts, self-injury, and inappropriate attempts at intimacy followed by sudden rejection” are disproportionately labeled with borderline personality disorder); Deirdre M. Smith, *Dangerous Diagnoses, Risky Assumptions, and the Failed Experiment of “Sexually Violent Predator” Commitment*, 67 OKLA. L. REV. 619, 696–701 (2014) (pathologizing “sexually violent predators” based on past behavior is a moral construct that leads to faulty assumptions about future dangerousness).

177. *See, e.g., Bernice A. Pescosolido et al., Evolving Public Views on the Likelihood of Violence from People with Mental Illness: Stigma and Its Consequences*, 38 HEALTH AFFS. 1735, 1735 (2019) (explaining how symptoms of mental illness are often inappropriately stereotyped as dangerous); Lynn M. Servais & Stephen M. Saunders, *Clinical Psychologists’ Perceptions of Persons with Mental Illness*, 38 PRO. PSYCH. 214, 216–17 (2007) (describing how people with borderline personality disorder and people with schizophrenia are perceived as significantly more dangerous).

178. Leslie Zun, *Care of Psychiatric Patients: The Challenge to Emergency Physicians*, 17 W.J. EMERGENCY MED. 173–76 (2016) (noting that societal attitudes, personal biases, and safety concerns contribute to health care providers’ perceptions that people with mental health and substance use diagnoses are problems or nuisances); Smith, *supra* note 176, at 700–01 (finding that inappropriate pathologizing leads to faulty assessments of dangerousness, depriving people of due process rights).

179. Smith, *supra* note 176, at 700–01 (questioning Supreme Court’s reasoning in upholding indefinite detention of people deemed “sexually violent predators” in *Kansas v. Crane* and *Kansas v. Hendricks*).

180. *See, e.g., Hendricks*, 521 U.S. at 358 (1997) (upholding Kansas statute permitting detention of those deemed “sexually violent predators” based on state’s police power authority to detain people “who are unable to control their behavior and who thereby pose a danger to the public health and safety”); *Kansas v. Crane*, 534 U.S. 407, 415 (2002) (permitting post sentencing confinement of people convicted of sexual offenses based on supposed “mental defect”).

Psychiatric diagnoses often lack the scientific reliability and validity required to form other medical diagnostic criteria.¹⁸¹ Such assertions are not to suggest that mental distress and mental illness are not real, but that uncertain diagnostic classifications require dynamic patient-provider relationships that rely heavily upon patient feedback and adapt to a patient's stated needs. Mental health professionals often label people with mental health diagnoses in isolation without critically evaluating patient symptoms or behaviors in the context of their unique lived experience.¹⁸²

Furthermore, predictions of dangerousness are often tautological, lacking the sensitivity, specificity, and reliability to accurately predict the risk of future danger.¹⁸³ Risk assessments have been shown to be inaccurate, as clinicians' assessments of dangerousness fail to accurately stratify people at low risk of future dangerous behavior, posing substantial risks of arbitrarily depriving people of liberty and all of the accompanying risks of harm.¹⁸⁴ Thus, involuntarily confining and treating people based on unreliable and invalid labels of mental illness and dangerousness raises the question of whether the civil commitment laws are merely pretextual bases to confine and silence people as a proxy for protected status or protected speech.¹⁸⁵ The Court's civil commitment decisions dehumanize people subject to these laws, implying that people who lack the "free will" necessary to control certain behaviors fail to satisfy the requisite definition of humanity in order to retain their rights to liberty.¹⁸⁶

181. Kenneth S. Kendler, *Potential Lessons for DSM from Contemporary Philosophy of Science*, 79 JAMA PSYCHIATRY 99, 100 (2021) (explaining that psychiatric diagnoses are working descriptive constructs, but that it is not appropriate to draw conclusions about etiology or objective reality from these labels).

182. Justin Karter & Sarah Kamens, *Toward Conceptual Competence in Psychiatric Diagnosis: An Ecological Model for Critiques of the DSM*, in CRITICAL PSYCHIATRY 17, 36, 51–54 (Sandra Steingard ed., 2019).

183. Edwin D. Boudreaux et al., *Predictive Utility of an Emergency Department Decision Support Tool in Patients with Active Suicidal Ideation*, 15 PSYCHIATRIC SERVS. 270, 271 (2018) (finding that a tool assessing suicide risk had high sensitivity and low specificity, but that assessment relies on past suicide attempts as strongest correlate of risk, along with suicidal intent or plan; diagnosis of mental health and substance use conditions; and irritability, agitation or aggression).

184. See *Heller v. Doe*, 509 U.S. 312, 323–24 (1993) (acknowledging psychiatric predictions of future violent behavior by people with mental illness are inaccurate); Rob Hicks, *Emphasis on Suicide Risk Prediction Is Misplaced and Potentially Dangerous*, MEDSCAPE UK (Aug. 9, 2022), <https://www.medscape.co.uk/viewarticle/emphasis-suicide-risk-prediction-misplaced-and-potentially-2022a100214z> (stating that clinical predictions of suicide are unreliable).

185. See Michael L. Perlin, *Their Promises of Paradise: Will Olmstead v. L.C. Resuscitate the Constitutional "Least Restrictive Alternative" Principle in Mental Disability Law?*, 37 HOUSTON L. REV. 1032, 1028 (2000) (citing H.R. REP. NO. 101-485 (II), at 56–57 (1990)); see also WHITAKER, *supra* note 29, at 171 (discussing the pretextual use of civil commitment to confine Black people during Reconstruction).

186. Smith, *supra* note 176, at 700–01; David L. Faigman, *Making Moral Judgments Through Behavioural Science: The 'Substantial Lack of Volitional Control' Requirement in Civil Commitments*, 2 L. PROBABILITY & RISK 309, 314 (2003) (criticizing volitional control requirement that "there is no

4. *Compulsory Mental Health Care Based Solely Upon an Individual's Speech or Thoughts, in the Absence of An Imminent Risk of Unlawful Harm, Infringes Upon First Amendment Rights*

Mental health diagnoses developed to maintain normative social structures by labeling people as pathological, and individualizing social problems, without fully examining the sociopolitical ramifications of these diagnostic constructions.¹⁸⁷ Consequently, mental health diagnoses are used to ostracize, confine, and silence those who challenge social and political norms, acting as a vehicle to “lawfully” infringe upon exercises of First Amendment rights. In *Rogers v. Okin*, Judge Tauro reminds us that “[t]he patient is in an institution only because he is unable to function safely in society, and so there is a public interest in civil commitment. The state may not involuntarily commit a person merely because of bizarre or unorthodox behavior.”¹⁸⁸

Nonetheless, a recent string of legislative and regulatory enactments seeks to do just that.¹⁸⁹ In New York City, Mayor Eric Adams announced a policy that justifies forced psychiatric hospitalization of any individual “who refuses voluntary assistance, ... appears to be mentally ill,” and is unable to care for themselves.”¹⁹⁰ New York City’s training materials implementing the policy explicitly state that involuntary hospitalization is justified “*even when there is no recent dangerous act.*”¹⁹¹ The city identifies that mere beliefs and speech alone may warrant involuntary hospitalization.¹⁹² Then, the city lists factors such as “illogical statements,” “firmly held beliefs not congruent with cultural ideas,” and “refusal to engage in discussion” as indicia that may authorize involuntary hospitalization.¹⁹³ Using forced mental health treatment in response to diverging

empirical/scientific basis for determining when an act was a product of ‘free will’” because “[f]ree will is a normative construct that has no corresponding operational definition that can be tested”).

187. See Karter & Kamens, *supra* note 182, at 36 (2019).

188. 478 F. Supp. 1342, 1367 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom.* Mills v. Rogers, 457 U.S. 291 (1982). The First Amendment of the United States Constitution restricts government restraint on speech, unless the speech is intended to provoke imminent unlawful danger and the speech is likely to induce such action. See *Brandenburg v. Ohio*, 395 U.S. 444 (1969).

189. *E.g.*, OFF. OF THE MAYOR OF NEW YORK, MENTAL HEALTH INVOLUNTARY REMOVALS (Nov. 28, 2022), <https://www.nyc.gov/assets/home/downloads/pdf/press-releases/2022/Mental-Health-Involuntary-Removals.pdf>; Community Assistance, Recovery, and Empowerment (“CARE”) Act, S.B. 1338, 2021–2022 Sess. (Cal. 2022) (codified in scattered sections of CAL. CODE).

190. *Transcript: Mayor Eric Adams Delivers Address on Mental Health Crisis in New York City and Holds Q-and-A*, CITY OF NEW YORK (Nov. 29, 2022), <https://www.nyc.gov/office-of-the-mayor/news/871-22/transcript-mayor-eric-adams-delivers-address-mental-health-crisis-new-york-city-holds>.

191. *9.58 Evaluation, Removal and Placement Refresher Training for Clinicians*, N.Y.C. HEALTH & N.Y. STATE OFF. OF MENTAL HEALTH (Nov. 9, 2022), <https://www.politico.com/f/?id=00000186-3caad37d-a7e7-3fea7a100000> [<https://perma.cc/XRS3-JGHJ>].

192. *Id.*

193. *Id.*

beliefs and unwanted speech necessarily questions whether such policies impermissibly burden disabled people's rights to free expression.

While a patient's explicit refusal of medical interventions generally must be respected, even amongst patients who are otherwise deemed incompetent to make medical decisions,¹⁹⁴ the right to refuse unwanted medical interventions often does not apply to people labeled with mental illnesses.¹⁹⁵ Unlike when an individual refuses invasive or uncomfortable somatic care, refusal of psychiatric treatment is pathologized largely because mental health professionals cannot fathom a patient's rationale for refusing psychiatric medications; third party interests tend to focus on quickly reducing "disruptive" behavior rather than treating underlying symptoms that are causing patient distress.¹⁹⁶ An examination of decisions limiting the right to refuse mental health treatment reveals reasoning that is largely pretextual.¹⁹⁷

The violent history and profound uncertainty surrounding diagnostic classifications for mental disorders further brings into question whether states are validly exercising their police power authority when enacting and enforcing mental health laws.¹⁹⁸ Thus, legislators must be cognizant of the power the state imbues on private citizens in their capacity as mental health professionals, ensuring individuals' rights to refuse care are not infringed upon based on a professional inappropriately pathologizing a patient's cultural, social, religious, or political beliefs.¹⁹⁹ The history of psychiatry is replete with examples of clinicians using mental illness as a pretext to discriminate against Black, Indigenous, LGBTQIA+ people, women, political dissidents, and people living in poverty, offering a cautionary tale about compulsory mental health care in the United States.²⁰⁰ The use of mental health care to silence and scapegoat those deemed "deviant" emphasizes that meaningful choice is necessary to guarantee

194. See *Stouffer v. Reid*, 965 A.2d 96, 111 (Md. Ct. Spec. App. 2009).

195. See, e.g., *Winters v. Miller*, 446 F.2d 65, 70 (2d Cir. 1971) (describing how patients are confined and forcibly medicated based on social behavior that demonstrated no harm to others).

196. See generally NAT'L COUNCIL ON DISABILITY, FROM PRIVILEGES TO RIGHTS: PEOPLE LABELED WITH PSYCHIATRIC DISABILITIES SPEAK FOR THEMSELVES 9–29 (Jan. 20, 2000); Michael Perlin, *On Sanism*, 46 SMU L. REV. 373, 391–98 (1992).

197. See, e.g., *Winters*, 446 F.2d at 69 (discussing that mental illness was only raised to justify compulsory care).

198. See generally Owen Whooley, *Measuring Mental Disorders: The Failed Commensuration Project of DSM-5*, 166 SOC. SCI. & MED. 33 (2016) (finding that diagnostic classifications in DSM-5 lack construct validity, failing to reflect a causal mechanism of mental disorders necessary to be referent of an underlying reality).

199. See, e.g., Olivia Ensign & John Raphling, HUM. RTS. WATCH, *Human Rights Watch's Opposition to CARE Court (CA SB 1338)* (June 16, 2022), <https://www.hrw.org/news/2022/06/24/opposition-care-court-sb-1338-amended-june-16-2022> (discussing risk of California's CARE court proposal in disproportionately targeting racially marginalized populations for forced treatment).

200. See Karter & Kamens, *supra* note 182, at 35–36.

First Amendment rights.²⁰¹ Thus, states have an interest in expanding access to culturally responsive, community based mental health supports, rather than relying upon involuntary confinement.²⁰²

5. *Exercising State Power to Authorize Compulsory Psychiatric Care Causes Lifelong Social and Economic Harm to Impacted Individuals*

Invoking the power of the state and the judiciary to impose unwanted mental health care also leads to lifelong legal and employment consequences, such as impeding opportunities to obtain professional licensure, own a firearm, obtain documentation in FBI background checks, and gain security clearances.²⁰³ These public disclosures of an individual's private mental health treatment, via the civil commitment process, risk perpetuating discrimination and limiting representation in professions that may perform background checks as part of their professional licensure.²⁰⁴ In addition, these sweeping restrictions may contravene the ADA's protections, particularly for those without a demonstrated recent history of conduct that compromises their capacity to safely satisfy the requirements of gun ownership, serve in a professional capacity, or otherwise manage their personal rights and privileges as citizens.²⁰⁵ Nonetheless, despite the questionable legal footing of laws that discriminate based upon past mental health treatment, they remain in place, harming individuals and communities.²⁰⁶ Rather than promoting safety, these practices risk provoking mental health crises by increasing the stress on vulnerable individuals and deterring people from seeking voluntary support.²⁰⁷

In fact, the practices of many professional licensing bodies mandate compliance with mental health and substance use treatment, which are similar to outpatient civil commitment regimes. Licensing boards often use their authority as an arm of the state to compel lawyers, physicians, nurses, social workers, and

201. Bruce J. Winick, *The Right to Refuse Mental Health Treatment: A First Amendment Perspective*, 44 U. MIAMI L. REV. 1, 59–60 (1989).

202. See generally TINA MINKOWITZ, REIMAGINING CRISIS SUPPORT: MATRIX, ROADMAP AND POLICY (2021).

203. See McCabe, *supra* note 108, at 11 (discussing lifelong legal and employment limitation imposed upon people who are involuntarily committed to psychiatric hospitals).

204. See *id.* (discussing Maryland laws which disclose civil commitment, even if other privacy protections may protect process).

205. Perlin, *supra* note 185, at 1049.

206. See generally Katrine Gren Voldby et al., *Structural Discrimination Against People with Mental Illness: A Scoping Review*, SOC. SCI. & MED. – MENTAL HEALTH, Dec. 2022, at 2.

207. See, e.g., Jerome M. Organ et al., *Suffering in Silence: The Survey of Law Student Well-Being and the Reluctance of Law Students to Seek Help for Substance Use and Mental Health Concerns*, 66 J. LEGAL EDUC. 116, 121 (2016) (discussing law student reluctance to seek mental health support due to concerns about how it will affect licensure); James T.R. Jones et al., *Medical Licensure Questions About Mental Illness and Compliance with the Americans with Disabilities Act*, 46 J. AM. ACAD. PSYCHIATRY & L. 458, 460–61 (2018) (noting that licensing questions about physician mental health deter physicians from seeking support).

other professionals to engage in mental health treatment as a condition of licensure,²⁰⁸ even when such recommendations may contradict the guidance of an individual's personal clinician.²⁰⁹ Licensing boards' use of compulsory mental health and substance use treatment often causes significant harm, vis-a-vis due process violations, financial burdens associated with required treatment programs, and trauma caused by coerced treatments that obtain compliance by threatening career and economic stability.²¹⁰

II. THE RIGHT TO CHOOSE HEALTH CARE

In the context of mental health, the right to choose health care is often perceived as in tension with the right to refuse unwanted medical intervention, yet the right to choose health care is an essential component of informed consent.²¹¹ After all, can patients give meaningful informed consent if one cannot obtain a second opinion, choose an alternative intervention to the suggested approach, or refuse intervention altogether?²¹² In the United States, the right to choose medical interventions is complicated by the lack of any right to health care access.²¹³ Managed care models often limit coverage for mental health outpatient care to short term interventions or require that patients try less expensive interventions before gaining access to the most appropriate intervention.²¹⁴ Moreover, people with disabilities are disproportionately impacted by poverty, leaving many with psychosocial disabilities struggling to meet their most basic needs.²¹⁵ Poverty, unmet health care needs, and compulsory care perpetuate structural violence and trauma imposed upon people

208. Jennifer Poole et al., *The Professional Regulation of Madness in Nursing and Social Work*, in THE ROUTLEDGE INTERNATIONAL HANDBOOK OF MAD STUDIES 177, 177–78, 184 (Peter Beresford & Jasna Russo eds., 2022).

209. *E.g.*, Doe v. Sup. Ct. of Ky., 482 F. Supp. 3d 571, 576–78 (W.D. Ky. 2020) (noting Kentucky bar applicant diagnosed with bipolar disorder was presented with conditional licensing requirements that conflicted with recommendations of applicant's own physician and precluded from practicing law).

210. *E.g.*, Beth A. Wood, *Performance Audit: North Carolina Physicians Health Program* (Apr. 2014), <https://www.auditor.nc.gov/documents/reports/performance/per-2013-8141-0/open> (noting audit of North Carolina's Physicians Assistance Program revealed that its procedures lacked objectivity and due process); PJ Randhawa et al., *Doctors Fear Controversial Program Made to Help Them*, KSDK-TV (Feb. 14, 2019, 5:51 PM), <https://www.ksdk.com/article/news/local/doctors-fear-controversial-program-made-to-help-them/63-ac167fca-a312-4464-a315-de5ba712698f> (discussing expensive mental health and substance use treatment centers which employers may require doctors to visit with prospect of losing their license and career if they do not comply, but which often leads to misdiagnoses and an increased risk of physician suicide).

211. Brach, *supra* note 138.

212. *See id.*

213. Brown, *supra* note 7, at 448–55.

214. *See, e.g.*, Nicole Rapfogel, *The Behavioral Health Care Affordability Problem*, CTR. FOR AM. PROGRESS (May 26, 2022), <https://www.americanprogress.org/article/the-behavioral-health-care-affordability-problem/>.

215. *See generally* NANETTE GOODMAN ET AL., NAT'L DISABILITY INST., FINANCIAL INEQUALITY: DISABILITY, RACE AND POVERTY IN AMERICA (2019).

labeled as mentally ill, exacerbating mental distress, while limiting an individual's ability to choose care that suits unique needs.²¹⁶

Yet, evidence from communities around the world evaluating mental health outcomes suggests the answer may not need to come at great expense, therapeutic advance, or state force.²¹⁷ The answer may come from promoting communities of care, ensuring access to basic needs, and enhanced peer support.²¹⁸ Disparities in mental health outcomes between high income and low income countries suggest that the mental health systems in resource restricted communities that rely less on coercive medicalized mental health care and more on community based supports result in better quality of life and reduced mortality.²¹⁹

A. *Cultivating a Right to Choose Care*

The United States should consider information from other countries, as well as communities throughout the United States, to identify strategies to increase access to voluntary, culturally responsive, person centered, and community based care. Many who argue for increased civil commitment speak to ensuring the availability of services or increased supervision via judicial power and outpatient civil commitment.²²⁰ However, involving the judiciary in treatment frequently impedes access to care and prevents people from following their clinician's recommendations as judicial decisions are often guided by stigma and bias, rather than evidence.²²¹ Moreover, even the threat of forced treatment or confinement leads to coerced health care decisions, causing lasting trauma, depriving people of access to appropriate care, and even risking death.²²² People

216. See Gloria L. Krahn et al., *Persons with Disabilities as an Unrecognized Health Disparity Population*, 105 AM. J. PUB. HEALTH S198, S201–02 (2015).

217. See T.V. Padma, *The Outcomes Paradox*, 508 NATURE S14, S14–S15 (2014) (finding that improved outcomes among schizophrenia patients in India can be attributed to factors such as less rigid nature of society and greater social inclusion).

218. See MINKOWITZ, *supra* note 202, at 15–16; see also LEWIS BOSSING ET AL., BAZELON CTR. FOR MENTAL HEALTH L., A NEW DAY OR MORE OF THE SAME?: OUR HOPES AND FEARS FOR 988 (AND 911) 10–14 (Susan Stefan ed., 2022).

219. See, e.g., Kim Hopper & Joseph Wanderling, *Revisiting the Developed Versus Developing Country Distinction in Course and Outcome in Schizophrenia: Results from ISoS, the WHO Collaborative Followup Project*, 26 SCHIZOPHRENIA BULLETIN 835, 836 (2000); RECOVERY FROM SCHIZOPHRENIA: AN INTERNATIONAL PERSPECTIVE (Kim Hopper et al. eds., Oxford U. Press 2007); Bonnie, *supra* note 29, at 138–39.

220. See E. Fuller Torrey, OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS 152 (1997).

221. See Complaint at 4–9, United States v. Unified Jud. Sys. of Pa., No. 22-cv-00709 (E.D. Pa. filed Feb. 24, 2022). In an ADA complaint filed by the United States Department of Justice, the Department alleges that the Pennsylvania drug court required participants to cease taking prescribed, evidence-based medications to treat opioid use disorders to successfully graduate from the state's drug court program and avoid incarceration.

222. *Id.* at 5–6; MINKOWITZ, *supra* note 202.

should not experience pressure to either choose or refuse care because of a state official's discriminatory threats of involuntary intervention.²²³

1. *Mental Health Provider Shortages Limit Meaningful Rights to Choose and Refuse Mental Health Care*

Realizing the mental health resources required for creating meaningful choice often is a daunting task for states, particularly as shortages of medical and mental health professionals plague our society.²²⁴ These devastating workforce shortages create significant limits in the availability of mental health services, often requiring people to be in crisis before they can access mental health resources.²²⁵ Such shortages create perverse incentives that do not just deprive people of care until they are in crisis, but also deprive individuals of choice because of their mental health status.²²⁶ People should not need to be in crisis just to get their basic support needs met; increasing coercive care only inflicts additional trauma.²²⁷

2. *The Mental Health System Increasingly Relies on Medication Only Treatment, Despite Limited Evidence of Success*

Workforce shortages of human resources and the desire for a quick fix to solve our mental health system has led to a medication centered approach to mental health care despite inadequate knowledge of the risks of these medications or their efficacy.²²⁸ The public health benefits of involuntary psychiatric medication often do not outweigh the risks, especially when a patient's refusal of treatment does not pose a direct threat to third parties, raising questions about whether states have a legitimate interest in compelling involuntary psychiatric treatment.²²⁹ Moreover, even when individuals do pose a

223. See generally SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 90.

224. See JOHN CACCAVALE ET AL., AM. BD. OF BEHAV. HEALTHCARE PRAC., *THE IMPACT OF PSYCHIATRIC SHORTAGE ON PATIENT CARE AND MENTAL HEALTH POLICY: THE SILENT SHORTAGE THAT CAN NO LONGER BE IGNORED* 2–5 (2012), <http://www.abbhp.org/survey.pdf>.

225. *Id.*

226. See, e.g., Amelia Winger, *Healing or Dehumanizing: Experts Explore the Rise in '302' Involuntary Psychiatric Commitment Petitions*, PUBLICSOURCE (Oct. 31, 2022), <https://www.publicsource.org/allegheeny-county-302-involuntary-outpatient-treatment-western-psych-mental-health-pa/> (describing an overall rise in Civil Commitment Petitions and a young adult's experience with involuntary hospitalization that disrupted her plans to access more appropriate, less restrictive care).

227. See generally Morgan Shields & Rinad S. Beidas, *The Need to Prioritize Patient-Centered Care in Inpatient Psychiatry as a Matter of Social Justice*, 3 JAMA HEALTH F. 1 (2022).

228. See, e.g., WHITAKER, *supra* note 29, at 146–47 (describing rise of psychiatric medications to support transition from institutional care to community care, stating, “America would need to believe that a medical treatment was available that would enable the seriously mentally ill to function in the community.”).

229. See, e.g., Roman Cath. Diocese of Brooklyn v. Cuomo, 141 S. Ct. 63, 67 (2020) (finding that COVID-19 regulations limiting attendance at religious services were not narrowly tailored, as commented

risk of physical harm to others, evidence suggests psychiatric medications do not consistently reduce risks of violence.²³⁰ Changes to the sociological understandings of psychosocial distress²³¹ and evolutions in caselaw²³² beg the question of whether some theoretical future risk of harm is sufficient to justify compulsory intervention. Thus, instead of forcibly confining or medicating people with psychosocial disabilities, communities must increase access to other types of mental health resources and require clinicians to educate patients about the risks and benefits of various forms of mental health care, independent of the clinicians' interests and ideology.²³³

B. Deprivation of Care Limits Meaningful Choice in Health Care

The right to choose mental health care is essential to health equity. However, people with psychosocial disabilities are more likely to be deprived of health care relative to those without disabilities, particularly impacting multiply marginalized people from Black and Brown communities, LGBTQIA+ communities, and people living in poverty.²³⁴

1. Doctors Often Deprive People with Psychosocial Disabilities of Medications to Treat Mental and Physical Disabilities

Deprivation of care is particularly prevalent in the context of controlled substances used to treat certain types of mental health and substance use diagnoses, as well as somatic conditions that disproportionately impact people

on by the Court, “[n]ot only is there no evidence that the applicants have contributed to the spread of COVID-19, but there are many other less restrictive rules that could be adopted to minimize the risk to those attending religious services”).

230. See, e.g., Jerome Schulte, *Homicide and Suicide Associated with Akathisia and Haloperidol*, 6 AM. J. FORENSIC PSYCHIATRY 3, 3–7 (1985); Eric Shaw et al., *A Case of Suicidal and Homicidal Ideation and Akathisia in a Double-Blind Neuroleptic Crossover Study*, 6 J. CLINICAL PSYCHOPHARMACOLOGY 196, 196–97 (1986); John Herrera et al., *High-Potency Neuroleptics and Violence in Schizophrenia*, 176 J. NERVOUS & MENTAL DISEASE 558, 558–61 (1988); Theodore van Putten & Stephen Marder, *Behavioral Toxicity of Antipsychotic Drugs*, 48 J. CLINICAL PSYCHIATRY 13, 18 (1987).

231. See, e.g., Stone, *supra* note 113, at 326 (discussing increased use of compulsory medication is not consistent with current evidence base regarding dangerousness and people with serious mentally illness who choose not to take medication); see generally MINKOWITZ, *supra* note 202, at 83 (discussing harm of compulsory intervention and benefits of implementing a positive model of crisis supports); LEGIS. ANALYSIS & PUB. POL’Y ASS’N, *supra* note 105 (illustrating evidence that suggests voluntary community based peer respites are an effective alternative to involuntary hospitalization for people with serious mental illness).

232. See, e.g., Sell v. United States, 539 U.S. 166, 181 (2003) (finding that to involuntarily medicate a person held incompetent to stand trial, states must demonstrate medication is in individual’s medical interests, substantially furthers a government interest, and is least intrusive means of achieving government interest); Stouffer v. Reid, 993 A.2d 104, 111 (Md. 2010) (holding that a prisoner can refuse medical treatment even if refusal presents a threat to his own life).

233. See Brach, *supra* note 138 (stating that patients do not get informed consent without informed choices, which are often curtailed due to perverse incentives within health care system).

234. See *infra* Sections II.B.1–3.

with disabilities.²³⁵ Health care providers may feel inclined to deprive individuals of certain treatments based on stereotypes about psychosocial disabilities, rather than medical evidence and individual need.²³⁶ For example, health care providers often perceive people with psychosocial disabilities as more likely to misuse or become dependent on pain medications. Consequently, providers under treat or completely deprive these patients of care, rather than considering the risks and benefits of appropriate pain treatment, gaining informed consent, or discussing accommodations based on individual needs to support the receipt of pain relief that every human being deserves.²³⁷ Deprivation of medication is particularly concerning when held in contrast to forced medication; many of the psychiatric medications that are forcibly administered lead to severe risks of physical dependence and severe withdrawal symptoms that patients are not informed about, furthering the concern that mental health care decisions are made based upon stereotypes rather than valid and reliable evidence.²³⁸

2. *Biases About Psychosocial Disabilities Contribute to Limitations on Access to Somatic Medical Care*

Deprivation of care is not limited to medications, as medical professionals often withhold care from individuals subjected to compulsory treatment.²³⁹ Medical professionals are known to openly express their disdain and resentment

235. See Tamar Ezer et al., *The Problem of Torture in Health Care*, in TORTURE IN HEALTHCARE SETTINGS: REFLECTIONS ON THE SPECIAL RAPPORTEUR ON TORTURE'S 2013 THEMATIC REPORT 19, 33 (2021) (discussing torture in health care caused by depriving marginalized populations of controlled substances, including those required for pain management and to treat substance use); see also Amended Complaint & Demand for Jury Trial, *supra* note 38 (alleging hospital falsely imprisoned, battered, and denied appropriate medical care for a diagnosed somatic condition based on plaintiff's perceived psychosocial disability).

236. Ezer et al., *supra* note 235, at 34 (stating that physicians often deprive people of pain relief based on prejudice, patently false beliefs, or even to punish patients they deem unworthy of treatment).

237. See, e.g., HUM. RTS. WATCH, "PLEASE DON'T MAKE US SUFFER ANYMORE...": ACCESS TO PAIN TREATMENT AS A HUMAN RIGHT 6–7 (2009), <http://www.hrw.org/reports/2009/03/02/please-do-not-make-us-suffer-any-more> (reporting that deprivation of pain treatment increases risk of suicide); Verdict Form, *Kowalski v. Johns Hopkins All Children's Hospital*, No. 2018 CA 005321 NC (Fla. Cir. Ct. Nov. 9, 2023) (DIN No. 3629) (finding hospital liable for false imprisonment, battery, malpractice, and intentional infliction of emotional distress, when the hospital detained plaintiff and deprived her of appropriate medical care for a diagnosed chronic pain condition based on plaintiff's prior use of prescribed Ketamine and perceived mental disability).

238. See, e.g., Ezer et al., *supra* note 235, at 24–28 (documenting a history of forced medical procedures on socially excluded and marginalized populations); Claire Sibonney, *With a Diagnosis at Last, Black Women with ADHD Start Healing*, KFF HEALTH NEWS (July 20, 2021), <https://kffhealthnews.org/news/article/black-women-adhd-attention-deficit-hyperactivity-disorder-underdiagnosed/>.

239. See, e.g., Maggi A. Budd et al., *Biases in the Evaluation of Self-Harm in Patients with Disability Due to Spinal Cord Injury*, 6 SPINAL CORD SERIES & CASES 1, 1–6 (2020).

for treating patients who sustain injuries from drug use, suicide attempts, or self-harm, suggesting people who need somatic care as a result of such injuries are less deserving of care than those with other medical needs.²⁴⁰ Consequently, medical professionals often deny appropriate anesthesia, somatic medications, or unduly delay medical treatment on account of mental health diagnoses.²⁴¹ Even outside of acute crises, people with psychosocial disabilities are almost three times as likely to experience harm resulting from a deprivation of access to appropriate medical care.²⁴² Thus, despite psychosocial disabilities increasing the likelihood one may experience chronic medical conditions, many with psychosocial disabilities get dismissed by physicians suggesting physical symptoms are “psychosomatic” in nature.²⁴³ Even when people with psychosocial disabilities are taken seriously by the medical profession, they are often denied lifesaving treatment, including exclusion from organ donation and denials of lifesaving interventions when crisis standards of care are in effect, as the medical profession continues to devalue some lives.²⁴⁴

240. See, e.g., Carmen Black & Amanda Calhoun, *How Biased and Carceral Responses to Persons with Mental Illness in Acute Medical Care Settings Constitute Iatrogenic Harms*, 24 AMA J. ETHICS 781, 781–83 (2022); Bantale Ayisire & Kristen R. Choi, *When Experiencing Inequitable Health Care Is a Patient’s Norm, How Should Iatrogenic Harm Be Considered?*, 24 AMA J. ETHICS 729, 729–30 (2022).

241. Diagnostic overshadowing is a common issue in somatic medical care for people with psychosocial disabilities that leads to deprivation of appropriate medical diagnosis of somatic health issues and subsequent denial of appropriate treatment, likely contributing to poor outcomes that patients labeled with mental illness experience. See, e.g., Guy Shefer et al., *Diagnostic Overshadowing and Other Challenges Involved in the Diagnostic Process of Patients with Mental Illness Who Present in Emergency Departments with Physical Symptoms—A Qualitative Study*, 9 PLOS ONE 1, 1–8 (2014) (finding that 77% of emergency room physicians surveyed could identify instances of diagnostic overshadowing in patients with psychiatric diagnoses resulting in patient harm); Sarah Hamilton et al., *Qualitative Analysis of Mental Health Service Users’ Reported Experiences of Discrimination*, 134 ACTA PSYCHIATRICA SCANDINAVICA 14, 14–22 (2016) (reporting, in qualitative assessment of patient experiences of health care provider discrimination based on mental illness, that providers dismissed somatic health concerns as symptoms of mental illness, resulting in neglect or delay in provision of appropriate medical treatment).

242. Gail L. Daumit et al., *Patient Safety Events and Harms During Medical and Surgical Hospitalizations for Persons with Serious Mental Illness*, 67 PSYCHIATRIC SERVS. 1068, 1072–73 (2016) (finding that people with serious mental illness experienced 142 physical harms per 100 medical hospitalizations, largely a consequence of deprivation of care and nearly three times rate of those without mental illness).

243. See, e.g., Camille Noe Pagan, *When Doctors Downplay Women’s Health Concerns*, N.Y. TIMES (May 3, 2018), <https://www.nytimes.com/2018/05/03/well/live/when-doctors-downplay-womens-health-concerns.html>; Clare Henderson et al., *Mental Health-Related Stigma in Health Care and Mental Health-Care Settings*, 1 LANCET PSYCHIATRY 467, 472 (2014); John S. Brekke et al., *Reducing Health Disparities for People with Serious Mental Illness*, 9 BEST PRACS. IN MENTAL HEALTH 62, 63 (2013).

244. See, e.g., Sara Reardon, *Push Is On for States to Ban Organ Transplant Discrimination*, KFF HEALTH NEWS (Mar. 8, 2021), <https://kffhealthnews.org/news/article/organ-transplant-discrimination-disabilities-state-legislation/>; NAT’L COUNCIL ON DISABILITY, ORGAN TRANSPLANT DISCRIMINATION AGAINST PEOPLE WITH DISABILITIES: PART OF THE BIOETHICS AND DISABILITY SERIES 14 (2019) (discussing discrimination against people with mental health disabilities); Natalie M. Chin & Jasmine Harris, *Examining How Crisis Standards of Care May Lead to Intersectional Medical Discrimination Against COVID-19 Patients*, ARC (Feb. 11, 2021), https://thearc.org/wp-content/uploads/2021/02/Intersectional-Guide-to-Crisis-Care_FINAL.pdf.

3. *Inequitable Allocations of Community Based Mental Health Resources Deprive Individuals of Community Based Support*

The systemic devaluation of certain populations is further evidenced through the inequitable allocations of mental health resources that invariably results in denials of appropriate mental health care. Black and Brown communities have significantly less access to community based mental health resources than White communities, despite Black people being more than twice as likely to receive a diagnosis of schizophrenia.²⁴⁵ Moreover, because the mental health system fails to provide culturally sensitive, trauma-informed care, common cultural beliefs within Black communities are too often mislabeled as “psychotic” or “delusional,” leading to mental health treatment that seeks to expunge Black experiences rather than understand them in the appropriate context.²⁴⁶ Psychiatry’s medicalization of Black, Brown, and indigenous experiences serves as a means of repressing social and political opposition to White supremacy, historically silencing those who dared to question structural oppression.²⁴⁷ This pattern of social control and political repression repeated itself with the LGBTQIA+ community, reifying societal stereotypes that suggested merely being queer or trans posed a “danger” to society, necessitating state intervention.²⁴⁸

Similarly, psychiatry perpetuated misogynistic violence by pathologizing people who courageously spoke out about sexual and domestic violence, again, using the mental health system to discredit and oppress those harmed by violence and protect those who perpetrated it.²⁴⁹ While many people impacted by misogynistic violence willingly sought support from mental health professionals, the inability to access care from a clinician who understands distress in the context of trauma more often endangers victims, rather than offering genuine support.²⁵⁰

Importantly, oppressive mental health practices are not limited to America’s past. Overwhelming evidence suggests these practices continue to this day, particularly when culturally competent, person centered support is not

245. See Robert C. Schwartz & David M. Blankenship, *Racial Disparities in Psychotic Disorder Diagnosis: A Review of Empirical Literature*, 4 *WORLD J. PSYCH.* 133, 139–40 (2014).

246. See Sirry M. Alang, *Mental Health Care Among Blacks in America: Confronting Racism and Constructing Solutions*, 54 *HEALTH SERVS. RSCH.* 346, 346–55 (2019).

247. See, e.g., JONATHAN METZL, *THE PROTEST PSYCHOSIS: HOW SCHIZOPHRENIA BECAME A BLACK DISEASE* xix–xxi (2009).

248. See Leslie Margolin, *The Third Backdoor: How the DSM Casebooks Pathologized Homosexuality*, 70 *J. HOMOSEXUALITY* 291, 292 (2021).

249. See Amy Biancolli, *Pathologized Since Eve: Jessica Taylor on Women, Trauma, and “Sexy but Psycho,”* *MAD IN AMERICA* (June 29, 2022), <https://www.madinamerica.com/2022/06/jessica-taylor-sexy-but-psycho/>.

250. *Id.*

accessible.²⁵¹ Thus, equitable access to self-determined, culturally responsive mental health resources are essential to ensuring marginalized communities retain autonomy and receive care that aligns with each individual's unique needs.

Because effective mental health care relies on adequate personnel resources, affordable community based mental health services are often limited to certain populations, such as those deemed to have a "serious mental illness."²⁵² Thus, while all people should undoubtedly gain expedient access to the community based resources needed for discharge from institutions, as required by the Supreme Court's decision in *Olmstead v. L.C.*, many do not gain access to outpatient support until after they are hospitalized.²⁵³ Moreover, hospitalization itself often deprives individuals of care options.²⁵⁴ The trauma caused by involuntary care prevents people from seeking future care and medication is often the only treatment offered within the confines of inpatient facilities.²⁵⁵ Thus, the adverse effects of involuntary hospitalization warrant shifting society's focus to increasing community based resources to prevent the harm of hospitalization and improve the quality of life for people with psychosocial disabilities, particularly those living with severe or persistent mental health conditions.²⁵⁶

C. Increasing Access to Voluntary, Community Based Resources Can Be as Effective as Involuntary Care, But with Reduced Risks of Harm

Instead of relying on compulsory mental health treatment that fails to achieve any rational public health goals, communities must increase access to

251. See, e.g., Morgan C. Shields, *Patient Characteristics Associated with Admission to Low-Safety Inpatient Psychiatric Facilities in Massachusetts: Evidence for Racial Inequities*, 72 PSYCHIATRIC SERVS. 1151, 1151 (2021).

252. Serious mental illness ("SMI") is a heterogeneous population often classified based upon previous experiences with hospitalization, suicidality, or other functional impairment. See, e.g., Doris A. Fuller, *What is "Serious Mental Illness"?*, TREATMENT ADVOC. CTR. (Feb. 15, 2017), <https://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/3771-research-weekly-what-is-qserious-mental-illnessq>.

253. Alex Clarke & Ira D. Glick, *The Crisis in Psychiatric Hospital Care: Changing the Model to Continuous, Integrative Behavioral Health Care*, 71 PSYCHIATRIC SERVS. 165, 165–66 (2020); see generally Nicholas C. Coombs et al., *Barriers to Healthcare Access Among U.S. Adults with Mental Health Challenges: A Population-Based Study*, 15 SSM POPULATION HEALTH 1 (2021) (explaining that scarce allocation of medical resources and affordability issues limit care in adults with mental health issues); Hemangi Modi et al., *Exploring Barriers to Mental Health Care in the U.S.*, ASS'N OF AM. MED. COLLS. (Oct. 10, 2022), <https://www.aamc.org/advocacy-policy/aamc-research-and-action-institute/barriers-mental-health-care>.

254. Sareen et al., *supra* note 103.

255. *Id.*

256. See, e.g., Chung et al., *supra* note 103, at 373–74 (finding that suicide risk increased even amongst those not suicidal upon admission and was linked to adverse hospital experiences); Jones et al., *supra* note 103 (determining that involuntary treatment deterred future help seeking); Sareen et al., *supra* note 103 (asserting that involuntary hospitalization is a traumatic experience).

voluntary care and support that can achieve the benefits sought through civil commitment, without adding to the harm caused by coercive care. By increasing and diversifying the types of mental health and substance use supports, and ensuring all mental health resources are affordable and accessible, the United States can confirm that support is available to everyone with a psychosocial disability.²⁵⁷ Arguments writing off possibilities to increase community based resources based on costs or shortages of mental health providers ignore the wisdom, creativity, and ingenuity amongst mental health service users who devise alternative mechanisms for support, out of necessity.²⁵⁸ By exploring and implementing alternative care delivery options, such as peer led respite programs, harm reduction approaches to drug use, suicide and self-harm, and culturally responsive, community based supports, individuals with psychosocial disabilities can access mental health and substance use support without experiencing the trauma of coercive care that too often accompany these services.²⁵⁹ Not only do these methods avoid state coercion, but they provide effective care at significantly lower costs than hospitalization.²⁶⁰

D. States Lack a Compelling Interest to Involuntarily Confine People for the Provision of Mental Health Care When Such Services Can Be Provided Safely in the Community

States lack a legitimate interest in depriving people with mental illness of the constitutionally protected liberty in freedom of unwarranted restraint and bodily intrusion when voluntary, community based mental health treatment is more effective at achieving the stated public health interests, with reduced risks of harm.²⁶¹ States may argue that the financial impact of furnishing choices to access differing types of voluntary, community based mental health treatment outweighs the potential benefit of providing such services; however, when

257. MINKOWITZ, *supra* note 202, at 52–53.

258. *See, e.g., id.*; *see also* PROJECT LETS, <https://projectlets.org/about> (last visited Dec. 11, 2023).

259. *See* BOSSING ET AL., *supra* note 218, at 11–12.

260. *See, e.g., Emily Cutler & Caroline Mazel-Carlton, Introducing Alternatives to Suicide: An Interview with Caroline Mazel-Carlton About a New Approach to Crisis*, CMTY. PSYCH., <https://www.communitypsychology.com/new-approach-to-suicide/> (last visited Oct. 26, 2023) (explaining basis for Alternatives to Suicide peer support model); LOREN R. MOSHER ET AL., *SOTERIA: THROUGH MADNESS TO DELIVERANCE* 254–66 (2004) (discussing success of Soteria model and other similar types of noncoercive community based supports that successfully treated psychosis at significantly reduced costs); SERA DAVIDOW, *PEER RESPITE HANDBOOK: A GUIDE TO UNDERSTANDING, DEVELOPING AND SUPPORTING PEER RESPITES* 14–16 (2018) (explaining peer respites).

261. *See, e.g., Mercer v. Thomas B. Finan Ctr.*, 265 A.3d. 1044, 1078 (Md. 2021) (holding that individuals have a constitutionally protected liberty interest in being free from arbitrary administration of involuntary psychiatric medication and that Maryland law provides an unequivocal statutory right to representation by counsel in administrative hearings appealing such determinations); *see also id.* (finding State has no legitimate public health interest in arbitrarily depriving an individual of their statutory right to representation given high risk of erroneously depriving an individual of their Constitutionally protected liberty interest to be free of forced medication under Fourteenth Amendment).

private health care providers act on behalf of the state to confine or forcibly medicate an individual, the state remains responsible for guaranteeing the constitutional rights of people who are subject to the jurisdiction of its laws.²⁶² Thus, while the Supreme Court admittedly declared that “disability” is not a “quasi-suspect” class subject to heightened scrutiny under the Equal Protection Clause,²⁶³ the Court also identified that the financial costs incurred to guarantee the statutory rights of similarly situated individuals are not a rational basis to deprive citizens of their right to equal protection under the law.²⁶⁴

Considering the significant risks of harm associated with compelled mental health interventions, the state has a compelling interest in providing patients access to alternative, less intrusive forms of treatment in order to guarantee the constitutional and human rights of all people with disabilities.²⁶⁵ Additionally, the provision of choice is necessary to ensure the availability of less restrictive alternatives,²⁶⁶ and voluntary care itself is less restrictive than coerced or forced intervention.²⁶⁷ Judge Bazelon first identified the least restrictive alternative doctrine in *Lake v. Cameron*, stating that “[d]eprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection.”²⁶⁸ The Supreme Court gave renewed credence to the least restrictive alternative doctrine in *Olmstead v. L.C. ex rel. Zimring*, holding unnecessary institutionalization constituted segregation in violation of the ADA.²⁶⁹ Finally, choice is necessary to meaningfully guarantee procedural due

262. See, e.g., *Lugar v. Edmonson Oil*, 457 U.S. 922, 936–40 (1982) (identifying the abuse of authority doctrine, which occurs when a private entity acts “under color of state law” to deprive an individual of life, liberty, or property without due process, as a means of satisfying state action under Fourteenth Amendment); see also *Matter of Dubreuil*, 629 So.2d 819, 823, 828 (Fla. 1993) (holding that a health care provider may not validly act on behalf of state to assert state interests or the state’s burden of proof required to override a patient’s refusal of care due to inherent conflicts involved in asserting interests contrary to their patients’ expressed wishes).

263. See *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 442–43 (1985) (suggesting “legislators guided by qualified professionals,” not the judiciary, should determine how law should treat people with disabilities because “[people with intellectual disabilities] are thus different, immutably so, in relevant respects, and the States’ interest in dealing with and providing for them is plainly a legitimate one”).

264. See *Plyler v. Doe*, 457 U.S. 202, 216–25 (1982) (holding that “undocumented aliens” are not a suspect class and education is not a fundamental right, but that financial costs are not a rational basis to deny undocumented children equal access to education, when doing so imposes broader costs on the nation). But see *Olmstead v. L.C.*, 527 U.S. 592, 603 (1999) (noting that a fundamental-alteration defense “allow[s] the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities”).

265. BOSSING ET AL., supra note 218, at 10–15.

266. See, e.g., *Olmstead*, 527 U.S.; *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966).

267. See, e.g., *Osgood v. D.C.*, 567 F. Supp. 1026, 1033 (D.D.C. 1983) (specifying involuntary medication permitted only when there is no infliction of unnecessary pain).

268. *Lake*, 364 F.2d at 660.

269. *Olmstead*, 527 U.S. at 607.

process rights, such as ensuring access to neutral decision makers and independent advocates.²⁷⁰

III. SOLVING AMERICA'S "MENTAL HEALTH CRISIS" REQUIRES INCREASING TREATMENT CHOICE

Discourse around civil commitment and forced treatment laws invariably lead to suggestions for reform.²⁷¹ However, procedural reforms to civil commitment laws largely fail to create more just outcomes when imposed in the absence of broader systemic reforms to address underlying stigma and power disparities often present in mental health law proceedings.²⁷² Recent procedural reforms correlate with increased instances of forced treatment under the guise of strengthened protections, rather than decreases in such practices.²⁷³ Moreover, the presence of civil commitment laws explicitly permit the curtailment of some people's rights based on who they are. Limited due process protections often fail to serve any meaningful purpose when courts deem people with psychosocial disabilities as lacking credibility to even define their own experiences.²⁷⁴ Thus, civil commitment effectively results in confinement without the due process protections afforded with comparable deprivations of liberty.²⁷⁵ Worst of all,

270. See, e.g., *Williams v. Wilzack*, 573 A.2d 809, 820–21 (Md. 1990); *Washington v. Harper*, 494 U.S. 210, 235 (1990).

271. See, e.g., David D. Doak, *Theorizing Disability Discrimination in Civil Commitment*, 93 TEX. L. REV. 1589, 1591–92 (2015) (suggesting some applications of civil commitment may violate ADA).

272. See, e.g., Christyne E. Ferris, *The Search for Due Process in Civil Commitment Hearings: How Procedural Realities Have Altered Substantive Standards*, 61 VANDERBILT L. REV. 959, 979–81 (2019) (illustrating that when right to counsel relies on a “best interest standard,” rather than advocating for a client’s stated interest, it fails to guarantee substantive protections and thus, fails to protect client’s constitutional due process rights); Tina Minkowitz, *The Abolition of Forced Psychiatric Interventions*, MAD IN AMERICA: RETHINKING MENTAL HEALTH (Mar. 10, 2018) (available on Spotify) (discussing how attempts to reform, rather than eliminate, civil commitment in France was associated with increased instances of involuntary hospitalization); Jonathan J. Marz & Richard M. Levinson, *Statutory Change and ‘Street-Level’ Implementation of Psychiatric Commitment*, 27 SOC. SCI. & MED. 1247, 1253 (1988) (describing how “rather than being passive objects of statutory changes, participants in the mental health system may actively adapt to the changes and look for ways to cope within the framework to obtain desired outcomes”).

273. See Gi Lee & David Cohen, *Incidences of Involuntary Psychiatric Detentions in 25 U.S. States*, 72 PSYCHIATRIC SERVS. 61, 61 (2021) (demonstrating psychiatric detention increased in United States with rises in civil commitment from 2011–2018, outpacing changes in population); cf. Stone, *supra* note 113, at 326 (indicating that states began making it easier to involuntarily commit people following media coverage of local mass violence incidents in 2007); see also *id.* at 328 (showing that civil commitment is highest in states where psychiatrists report it is subjectively “easiest” to commit people, suggesting both procedural and substantive protections are necessary to prevent abuse of civil commitment process).

274. See, e.g., *Bolmer v. Oliveira*, 594 F.3d 134, 137–38 (2d Cir. 2010) (describing a patient accused of inventing a sexual relationship with a staff member who was civilly committed as a result of a staff member gaslighting a patient); Ferris, *supra* note 272, at 971–78.

275. See Donald Stone, *There Are Cracks in the Civil Commitment Process: A Practitioner’s Recommendations to Patch the System*, 43 FORDHAM URB. L.J. 789, 793, 797 (2016) (showing how criminal defendants are afforded more protections than persons subject to involuntary civil commitment).

compulsory treatment laws perpetuate stigma and discrimination by messaging to the public that a class of citizens (those labeled as “mentally ill”) require confinement to ensure public safety.²⁷⁶ Such arguments are often premised on the “failures” of deinstitutionalization in the 1970s, which neglect to recognize that deinstitutionalization itself did not fail; the government failed to fund community based resources for those previously confined to institutions.²⁷⁷ Politicians irrationally expected psychiatric medications to resolve longstanding social problems and failed to acknowledge their responsibility to create lasting structural change.²⁷⁸

A. Disability Rights Laws Create a Framework for Establishing the Right to Choose Care

The ADA²⁷⁹ and Section 504 of the Rehabilitation Act²⁸⁰ prohibit discrimination on the basis of disability. Yet, by their very nature, civil commitment laws stereotype and target people with psychosocial disabilities, as without a diagnosis of mental illness or “mental defect,” the legal system could not constitutionally confine these individuals, without evidence of conduct actually violating the law.²⁸¹ By tying dangerousness and forced treatment with mental illness, civil commitment laws contribute to structural stigma, dehumanize people with psychosocial disabilities, and reinforce ideas that people with mental illnesses are dangerous beings that must be tamed.²⁸²

hearings, despite having same fundamental liberty interests at stake); Stone, *supra* note 113, at 325 (describing how forty-two states use standards allowing civil commitment of non-dangerousness of individuals, such as grave disability and need for treatment, which are inconsistent with constitutional liberty guarantees).

276. See Rebecca Morin, *Trump Calls for Reviving Mental Institutions*, POLITICO (Feb. 26, 2018) (discussing former President Donald Trump’s calls for increasing civil commitment in response to 2018 mass shooting at Parkland High School).

277. E. Fuller Torrey, *Stop the Madness*, WALL ST. J. (July 18, 1996) (arguing deinstitutionalization was a failed social experiment).

278. Thomas Szasz, *Psychiatric Fraud and Force: A Critique of E. Fuller Torrey*, 44 J. HUMANISTIC PSYCH. 416, 418 (2004).

279. Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101–12213.

280. Rehabilitation Act of 1973 § 504, Pub. L. No. 93-112, 87 Stat. 394 (codified as amended at 29 U.S.C. § 794).

281. See generally THOMAS S. SZASZ, PSYCHIATRIC SLAVERY 9–10 (1st ed. 1977) (arguing that all civil commitment is invalid); Keith Cheng, *Civil Commitment Considerations in California*, 144 W. J. MED. 497, 498 (1986) (“Persons who are found to be dangerous or gravely disabled but not as a result of a mental illness do not qualify for civil commitment.”); see also Stone, *supra* note 275, at 793 (stating confinement based on mental illness alone is not sufficient to justify confinement).

282. Structural stigma “refers to the inequities and injustices inherent in social structures that arbitrarily restrict the means and freedoms of a specific population.” TRACY PUGH ET AL., STRUCTURAL STIGMA AND MENTAL ILLNESS 2–3 (2015); see also Stone, *supra* note 113, at 329 (“The addition of ‘need for treatment’ provisions to civil commitment laws reflects a troubling supposition that persons with mental illness who are not on medication are inherently dangerous.”).

Mental health laws largely fail to consider why people might reject mental health treatment, assuming people with psychosocial disabilities are incapable of knowing their own needs.²⁸³ Policymakers' failures to even consider that people experiencing serious mental illness may have a valid reason for refusing medical intervention show the epistemic injustice that pervades mental health research, care, and policymaking.²⁸⁴ Epistemic injustice manifests in scientific literature about mental illness, as researchers often exclude people with psychosocial disabilities when studying mental health treatment or fail to integrate the knowledge of disabled people when devising frameworks for understanding psychic distress, fueling both social and structural stigma.²⁸⁵ Testimonial injustice,²⁸⁶ a type of epistemic injustice, pervades policymaking as legislators often rely on information provided by mental health providers and family members of people with psychosocial disabilities to justify segregating and forcibly medicating people labeled with mental illness, while ignoring concerns expressed by people who have experienced psychiatric institutionalization.²⁸⁷ As a result, mental health laws continue to focus on forced treatment while failing to address the underlying societal issues known to cause psychological distress, such as systemic violence, poverty, and health inequity.²⁸⁸

The ADA proscribes discriminatory overgeneralizations that result in the unnecessary segregation of people with disabilities, requiring the provision of mental health services in the "most integrated setting appropriate to the needs of qualified individuals with disabilities."²⁸⁹ To balance concerns for public health, individual liberty, and access to care, the United States must establish diverse care options with sufficient access for all so that people with psychosocial disabilities can receive supports needed to thrive in their communities.

283. See, e.g., Anna Saya et al., *Criteria, Procedures, and Future Prospects of Involuntary Treatment in Psychiatry Around the World: A Narrative Review*, 10 FRONTIERS PSYCHIATRY 1, 10 (2019) (suggesting refusal of treatment is a symptom of mental illness and involuntary treatment laws propose to restore autonomy).

284. Epistemic injustice describes when people are discriminated against and disempowered as knowers based on prejudices about their identity. See, e.g., Karen Newbigging & Julie Ridley, *Epistemic Struggles: The Role of Advocacy in Promoting Epistemic Justice and Rights in Mental Health*, 218 SOC. SCI. & MED. 36, 37–38 (2018).

285. Katarina Grim et al., *Legitimizing User Knowledge in Mental Health Services: Epistemic (In)justice and Barriers to Knowledge Integration*, 13 FRONTIERS PSYCHIATRY 1, 1–2 (2022).

286. Testimonial injustice is a type of epistemic injustice used to describe discounting the "value and legitimacy" of people's lived experiences. *Id.* at 5.

287. See Newbigging & Ridley, *supra* note 284, at 37.

288. *Id.* at 38.

289. *Olmstead v. L.C.*, 527 U.S. 581, 592 (1999) (holding public entities must provide community based services to people with disabilities when such services are clinically appropriate, not opposed by disabled individual, and can be reasonably accommodated, considering all available resources).

1. *Expanding Voluntary Community Crisis Services Reduces the Need for Coercive Interventions*

States are required to provide care in the most integrated settings available.²⁹⁰ Thus, a lack of community based crisis services puts people at risk for unnecessary hospitalization in violation of the ADA.²⁹¹ Accordingly, states must expand community based crisis services so that they serve all communities at all times, ensuring a diverse array of crisis services are available to meet each individual's unique needs.²⁹² The nationwide roll out of the 988 suicide hotline was intended to expand mental health crisis response.²⁹³ However, without a corresponding increase in community based crisis services and follow up mental health supports, 988 risks increasing hospitalizations or becoming a dead end for people in need of longer term support.²⁹⁴ Moreover, existing crisis supports often rely on involuntary intervention to manage the distress of those in proximity to people experiencing crises, rather than meaningfully addressing the distress of individuals experiencing crisis.²⁹⁵ Crisis supports that emphasize bodily autonomy and harm reduction, such as the "Alternatives to Suicide" approach, seek to meaningfully reduce the distress of people struggling by understanding their distress, rather than imposing unwanted and traumatizing interventions.²⁹⁶ Reducing involuntary crisis intervention not only reduces the likelihood of unintended consequences such as criminalization, police violence, and social alienation, but also helps ensure people in distress retain autonomy and self-determination when accessing mental health treatment.

2. *Peer Respite Houses are An Effective Alternative to Hospitalization That Preserves Dignity and Autonomy*

Community based peer respite programs were initially developed in the 1970s as people realized neither hospitals, nor medication sufficiently addressed the support needs of people with psychosocial disabilities living in the community.²⁹⁷ Peer respite houses proved an effective means of providing

290. *Id.* at 607.

291. *See, e.g.,* Pashby v. Delia, 709 F.3d 307, 324 (4th Cir. 2013) (illustrating that a lack of community based services creates a serious risk of unnecessary institutionalization).

292. *See* Letter from Assistant Attorney General Kristen Clarke, U.S. Dep't of Just., to Maine Governor Janet Mills and Attorney General Aaron Frey (Jun. 22, 2022) (on file with U.S. Dept. of Just.) (communicating *Olmstead* violations in Maine's mental health services, specifically mentioning lack of crisis services).

293. National Suicide Hotline Designation Act of 2020, Pub. L. No. 116-172, 134 Stat. 832 (codified at 47 U.S.C. § 251).

294. *See generally* BOSSING ET AL., *supra* note 218.

295. Irit Shimrat, *Ending Coercive "Help": A Review of "Reimagining Crisis Support,"* MAD IN AMERICA (Apr. 21, 2022), <https://www.madinamerica.com/2022/04/reimagining-crisis-support/>.

296. *See, e.g.,* Cutler & Mazel-Carlton, *supra* note 260.

297. Jeremy T. Holman & Elizabeth Reardon Hinkley, *Nothing for Us Without Us: Peer-Based Recovery Is the Latest in a Long History of Consumer-Driven Movements*, HEALTH RES. IN ACTION (Dec.

voluntary, community based care without relying upon forced psychiatric treatment.²⁹⁸ These houses continue to cost significantly less than hospital care.²⁹⁹ Additionally, peer respites do not rely upon medical professionals, which is an additional benefit in times where medical professionals are in short supply, and make peer respite a viable option to expand mental health crisis services.³⁰⁰ Peer respites use integrated models to provide support, utilizing the wisdom of those with lived experience and respecting the autonomy of the clients they serve.³⁰¹ Peers work to provide guidance and emotional support, working to understand resident's delusions, hallucinations, and other distress, rather than pathologizing psychic distress.³⁰²

In studies that compared peer respite houses to inpatient care, voluntary peer respite houses demonstrated better short and long term outcomes than hospital based care.³⁰³ Nevertheless, peer respites and peer services are not a panacea for emotional distress, social inequality, and community violence. If peer respites simply supplant professional services without any attention to the power structures that permit abuse, neglect, and trauma within our existing medical care models, they risk recreating the same problems under the guise of a different name. Thus, creating and implementing alternative models of care requires not just attention to who is providing what services and where they are provided, but also evaluating how mental health supports are provided and to whom. Successfully transforming the mental health system requires continually examining the purpose for providing supports and evaluating the power disparities that inevitably arise when serving vulnerable populations.

B. The United States Must Strengthen Patient Rights and Accountability in All Mental Health Services

America's mental health system is inherently motivated by capitalism. Thus, proposing increased mental health support requires an acknowledgment that increasing access to support comes with the consequences of sustaining increased demand, an issue common to all market based systems.³⁰⁴ Sustainably expanding care requires ensuring patients receive unequivocal rights to refuse mental health interventions in conjunction with the right to select alternative forms of care, ensuring the health care market is not incentivized to supplant

18, 2018), <https://hria.org/2018/12/18/nothing-for-us-without-us-peer-based-recovery-is-the-latest-in-a-long-history-of-consumer-driven-movements/>.

298. See LEGIS. ANALYSIS & PUB. POL'Y ASS'N, *supra* note 105.

299. See *id.*; see also Bouchery et al., *supra* note 105.

300. CACCAVALE ET AL., *supra* note 224, at 3 (discussing shortages of mental health professionals).

301. See MOSHER ET AL., *supra* note 260, at 11–14 (explaining treatment methods peers use in Soteria peer respites, seeking to understand rather than pathologize).

302. *Id.*

303. LEGIS. ANALYSIS & PUB. POL'Y ASS'N, *supra* note 105.

304. Shields & Beidas, *supra* note 227, at 2.

patient rights.³⁰⁵ Left unchecked, merely increasing access to mental health care could result in expanded efforts to medicalize the human experience or subordinate individuals impacted by trauma, leading to unwanted labeling with mental illnesses to justify payment for and access to services.³⁰⁶ Thus, expanding mental health support offerings while reducing the risks of over pathologizing requires mindfulness of power disparities and historical trends that continually circle back to involuntary medical interventions and segregation of marginalized communities under the guise of mental illness.³⁰⁷ To address the ongoing risks of involuntary intervention, states must consider revising legislation that allows for the confinement of those labeled with mental illness, instead of enforcing an unequivocal right to refuse unwanted mental health intervention.

Importantly, creating an unequivocal right to refuse unwanted mental health intervention may also provide an important violence intervention strategy. Notably, research shows that mental illness is not significantly correlated with acts of violence.³⁰⁸ Targeting people labeled with mental illnesses for involuntary treatment in the name of public safety is not only an ineffective public health policy; it may unintentionally increase violence.³⁰⁹ Therefore, guaranteeing the rights of all to refuse unwanted mental health intervention is likely more effective at reducing violence, in light of existing data.³¹⁰ Importantly, eliminating involuntary care is not synonymous with condoning suicide or standing by while someone is violent to others. Instead, the right to refuse unwanted mental health care eliminates discrimination and state sanctioned violence based on psychosocial disability.³¹¹ Rather than imposing unwanted mental health treatment, states must be creative and consider how to provide support consistent with impacted population's stated needs.

1. Using Patient-Centered Outcomes in Mental Health Treatment May Reduce Discriminatory Attitudes in Health Care

Part of reducing discrimination based on psychosocial disability requires using patient centered outcomes. In all other areas of medical care, the Center

305. Shields, *supra* note 251, at 1151, 1158.

306. Shields & Beidas, *supra* note 227, at 2–3.

307. *Id.*

308. See John S. Rozel & Edward P. Mulvey, *The Link Between Mental Illness and Firearm Violence: Implications for Social Policy and Clinical Practice*, 13 ANN. REV. CLINICAL PSYCH. 445, 448 (2017) (“[E]ven if all of the association between mental illness and violence could somehow be eliminated, we would still have to confront 96 percent of the violence in the United States.”).

309. Herrera et al., *supra* note 230, at 558–61; Van Putten & Marder, *supra* note 230, at 13–19.

310. Musgrove et al., *supra* note 102 (finding that psychiatric hospitalization is associated with increased risk of suicide post discharge when compared with non-hospitalized individuals without mental illness); Jones et al., *supra* note 103 (noting that involuntary treatment deterred future help seeking).

311. Cf. Doak, *supra* note 271, at 1591–92 (arguing civil commitment laws are often discriminatory as applied, but that reform rather than abolition is appropriate).

for Medicare and Medicaid Services requires administration of the Hospital Consumer Assessment of Healthcare Providers and Systems (“HCAHPS”) and reporting of HCAHPS outcomes.³¹² Psychiatry is not required to administer or report HCAHPS outcomes, raising the question of whether this disparity is discriminatory.³¹³ Notably, CMS is not the only entity that fails to rely on patient centered outcomes when assessing the quality of care in psychiatry.³¹⁴ Well-known health care rankings, such as U.S. News and World Reports, rank the top hospitals in psychiatry simply based on local psychiatrists’ perceptions of care at the psychiatric hospital in question, rather than considering either patient satisfaction or outcomes of care.³¹⁵ Failure to assess or value patient perceptions of their own mental health care evidences the epistemic injustice pervasive in the mental health system.

2. *Health Care Payment Must Shift to Incentivize Payment for Preferred Mental Health Supports*

To address the vulnerability associated with mental illness and substance use disorder labels in health care, states must consider how mental health services and other social supports are funded. Policymakers must ask who should pay for mental health care, substance use supports, and the basic needs of those marginalized by our communities.³¹⁶ Placing mental health costs on the private sector may disincentivize the social change required to prevent much of the trauma and social inequality underlying mental health spending.³¹⁷ At the same time, failing to address social needs, such as housing, increases risks for psychic and somatic distress. Thus, all payors should care about increasing access to effective community based supports for all as part of their corporate responsibility. Afterall, one night in the hospital costs more than the average monthly rent, highlighting the economic impact of relying on forced inpatient psychiatric care, in lieu of providing holistic mental health supports to all.³¹⁸ The

312. Shields & Beidas, *supra* note 227, at 1.

313. *Id.*

314. See, e.g., Ben Harder, *FAQ: How and Why We Rank and Rate Hospitals*, U.S. NEWS & WORLD REP. (Aug. 1, 2023) <https://health.usnews.com/health-care/best-hospitals/articles/faq-how-and-why-we-rank-and-rate-hospitals> (noting that in psychiatry “ranking is determined entirely by expert opinion” whereas other inpatient specialties included patient experiences, and outcomes comprise over 40% of ranking calculations).

315. *Id.*

316. See, e.g., Peggy L. O’Brien et al., *Residential Treatment and Medication Treatment for Opioid Use Disorder: The Role of State Medicaid Innovations in Advancing the Field*, 4 DRUG & ALCOHOL DEPENDENCE REPS., 2022, at 1.

317. Morgan C. Shields et al., *Increases in Inpatient Psychiatry Beds Operated by Systems, For-Profits, and Chains, 2010–2016*, 73 PSYCHIATRIC SERVS. 561, 564 (2021).

318. Cost of room and care for one night in a psychiatric hospital in Baltimore County, Maryland, is about \$1,300 per day whereas the average rent for a one bedroom apartment in the same region is \$1,124 per month. See, e.g., Sheppard Pratt Health System, *CMS Price Transparency Shoppable Services* (July

Housing First model demonstrates the efficacy of guaranteeing access to basic needs in reducing overall health care costs, suggesting spending on basic needs and community supports is more efficient than continuing to rely upon unwanted psychiatric interventions.³¹⁹

Furthermore, states must evaluate whether payors should be able to require a diagnosis for the provision of mental health services, considering the social repercussions and limitations to access when mental health and substance use diagnoses gatekeep access to care for individuals and communities.³²⁰ Rather than allocating funds based on individual utilization of services, policymakers should evaluate the feasibility of allocating mental health funding based on community need, developing equitable payment structures that allocate funds based on holistic needs assessments that consider both basic needs and mental health support. While such mechanisms are not without their own risks, community allocation of funding could allow individuals to seek support without imposition of a diagnosis that pathologizes common human distress, while also requiring accountability to both individuals and communities. Furthermore, diagnostic categories often limit access to specific types of care, even if the intervention is deemed unhelpful by the impacted individual.³²¹ Thus, facilitating access to mental health care independent of diagnoses opens up access to differing types of support based on an individual's choices and needs.

The Mental Health Self-Direction Model seeks to foster this type of autonomy and self-determination by granting program participants the opportunity to select the supports that best suit their unique mental health, somatic, and social needs.³²² Participants in self-directed mental health services work with a support planner to develop an individualized recovery plan and then utilize an allocation of state funds to achieve their recovery goals. Self-directed services afford participants access to a diverse array of supports, including private therapists that may better meet unique cultural or clinical needs, housing

2023) <https://www.sheppardpratt.org/cms-price-transparency/> (explaining that a fee for inpatient room and care for an adult is listed as \$1,304 per day, but that this fee does not include professional fees, fees for medications, or fees for evaluations or procedures); cf. U.S. DEP'T OF HOUSING & URB. DEV., *FY 2022 Fair Market Rent Documentation System* (last visited Oct. 20, 2023), https://www.huduser.gov/portal/datasets/fmr/fmrs/FY2022_code/2022state_summary.odn (reporting fair market monthly rent for a one bedroom apartment in Baltimore-Columbia-Towson, MD as \$1,124).

319. See *Housing First*, NAT'L ALL. TO END HOMELESSNESS (Mar. 20, 2022), <https://endhomelessness.org/resource/housing-first>.

320. Suggesting that access to care should not rely upon a diagnosis does not imply that clinicians should deny access to diagnoses, when a person meets criteria for a specific diagnosis and an impacted individual deems it helpful to understanding themselves or participating in their community. Rather, diagnoses should not be required to access care or be documented without the impacted individual's informed consent. Karter & Kamens, *supra* note 182, at 17–69.

321. *Id.* at 35.

322. NAT'L RESOURCE CTR. FOR PARTICIPANT-DIRECTED SERVS., *SELF-DIRECTION IN MENTAL HEALTH 2–4* (2019).

support, educational opportunities, and technology to enhance communication access.³²³ Recent research illustrates the efficacy of self-directed mental health services, finding that participants in self-directed services reported greater perceived autonomy and competence in managing their care, enhanced employment outcomes, and a reduction in the impact of psychiatric symptoms relative to individuals using traditional mental health services.³²⁴

If individuals are given the autonomy to select supports based on their unique needs and reimbursement is contingent on service user satisfaction, systems are more likely to reorient to serving the needs of impacted individuals, rather than the interests of clinicians or family members.³²⁵ Likewise, focusing on patient experience shifts the goal of treatment from eliminating external disruption to alleviating distress, which leads to mental health services that create long term benefits and mitigate risks of harm.³²⁶

3. *Service Users Must Be Included in Codesigning Mental Health Supports*

Service user narratives about interventions experienced as coercive versus those experienced as supportive further validates the social, legal, and moral imperative to empower service users to choose supports based on their unique experience and guarantee autonomy in treatment.³²⁷ Coercive treatment may result in short term changes in externalized behavior that complies and conforms to expectations, but often does not benefit the impacted individual.³²⁸ The failure to offer a direct benefit to impacted individuals alone should lead to immediate

323. *Id.* at 9–10.

324. Judith A. Cook, Ph.D. et al, *Randomized Controlled Trial of Self-Directed Care for Medically Uninsured Adults With Serious Mental Illness*, 74 *PSYCHIATRIC SERVS.* 1027, 1032–34 (Oct. 2023).

325. Shields & Beidas, *supra* note 227, at 1–2.

326. *See, e.g.*, Cook et al., *supra* note 324, at 1027 (explaining that self-directed mental health services improve participant satisfaction and functional outcomes at no greater cost than traditional mental health services); Iudici et al., *supra* note 103, at 309 (iterating that involuntary or coerced treatment led to worse outcomes relative to those seeking voluntary treatment).

327. *See, e.g.*, Mary Chambers et al., *The Experiences of Detained Mental Health Service Users: Issues of Dignity in Care*, 15 *BMC MED. ETHICS* 1, 1–8 (2014) (finding that service users describe involuntary care as harmful due to a lack of dignity, respect, and therapeutic choice); David Palmer et al., *'No One Knows Like We Do'—The Narratives of Mental Health Service Users Trained as Researchers*, 8 *J. PUB. MENTAL HEALTH* 18, 18–29 (2009); Jenny Logan & Justin M. Karter, *Psychiatrization of Resistance: The Co-Option of Consumer, Survivor, and Ex-Patient Movements in the Global South*, 7 *FRONTIERS SOCIO.*, Mar. 2022, at 1, 2.

328. Involuntary hospitalization and involuntary antipsychotic medication are prime examples of treatments that result in short term reductions of externalized symptoms, but often this comes at a great cost to the impacted individual. *See, e.g.*, Harrow et al., *supra* note 127, at 3007–16 (explaining that antipsychotic medication does not reduce symptoms of psychosis or improve long term prognosis for people diagnosed with schizophrenia); Jones et al., *supra* note 103; Caleb M. Adler et al., *Comparison of Ketamine-Induced Thought Disorder in Healthy Volunteers and Thought Disorder in Schizophrenia*, 156 *AM. J. PSYCHIATRY* 1646, 1648 (1999) (“[O]ur clinical experience is that while the intensity of thought disorder may decrease with medication treatment, the profile of the thought disorder is not altered.”).

shifts away from forced intervention. Though, more importantly, such interventions are not just unhelpful, but may actively harm impacted individuals. Compulsory care fails to respect a service user's self-determination and insults their dignity, ignoring that the individual is best suited to identify their own unique support needs.³²⁹

Many express concerns about the potential unintended outcomes of “deprofessionalizing” mental health that could coincide with providing services based on individual experiences, rather than exclusively based upon clinical diagnoses. But, disentangling treatment from mental health diagnoses does not eliminate the role of mental health clinicians who can serve as guides and supporters, rather than as the ultimate arbiters of care. Furthermore, expanding access to supports independent of diagnoses can enhance holistic conceptions of mental health support, expanding the definitions of who and what may qualify as a valid form of support. Increasing the pool of people that can provide mental health support is necessary in this time of medical scarcity, as well as to disrupt the concentrated power of mental health professionals. Accordingly, separating diagnoses from access to mental health support and incentivizing beneficial, service user centered care, may create a secondary effect of diversifying mental health supports, expanding the types of services available, and enhancing overall access to meaningful support.

4. *Laws Must Protect the Rights of People with Psychosocial Disabilities*

Finally, policymakers must consider enacting laws that specifically protect against discrimination on the basis of mental health or substance use diagnosis or utilization of supports. While the ADA reduced discrimination on the basis of disability, it did not go far enough to address discrimination against those with psychosocial disabilities, perhaps one of the most vulnerable and stigmatized populations in our society. Enacting specific protections against discrimination based on psychosocial disability and eliminating laws that target people with psychosocial disabilities will expand opportunities to access support when experiencing emotional distress without fear that doing so may adversely impact future educational or employment prospects. Moreover, prohibitions against discrimination based on psychosocial disability are essential to ensuring representation of people with psychosocial disabilities in all aspects of life and guaranteeing impacted people have direct input in societal decision making.³³⁰ Therefore, eliminating discrimination on the basis of psychosocial disability, without exception, is essential to facilitating meaningful change.

329. Logan & Karter, *supra* note 327; Shields & Beidas, *supra* note 227.

330. Shields & Beidas, *supra* note 227.

IV. CONCLUSION

Ensuring people with psychosocial disabilities are afforded the same rights, dignity, and respect as those with physical disabilities is essential to guarantee human rights. Moreover, protecting patient rights is an essential component of social progress that avoids repeating the atrocities of the past.³³¹ Thus, expanded voluntary community resources that provide access to varying types and levels of support are necessary to ensure each individual's right to choose and refuse health care.³³² In addition, patients must be empowered to refuse any and all forms of mental health care that are not beneficial to them, based on their own assessment of risks and benefits after the provision of informed consent.³³³ Hiding certain risks breaches professional obligations to provide informed consent, while also removing critical opportunities for people with psychosocial disabilities to understand and engage in their treatment.³³⁴ Failure to disclose side effects of a medication may lead patients to ignore early warning signs of a severe adverse reaction, while failing to disclose realistic treatment limitations may lead health care providers to inappropriately label patients as treatment resistant rather than the more accurate reality that the treatment failed the patient.³³⁵ Thus, realistic expectations of treatment are necessary to mitigate patient blaming when a treatment does not work.³³⁶ Health care providers must also inform people with psychosocial disabilities of alternative treatment options that may be available to them, empowering people to seek out different supports.³³⁷ Providing realistic information is not only necessary to prevent coercion and abuse, but to uphold ethical expectations that promote long term trust.³³⁸

Adequate and diverse mental health supports are necessary to promote health justice and community well-being.³³⁹ At the same time, allowing individuals to determine the supports that do or do not work for them preserves autonomy and prevents harm that often arises from compulsory treatment.³⁴⁰ Policymakers must separate mental health and substance use supports from the legal system, which only serves to coerce, and impose collateral consequences from seeking health care.³⁴¹

331. *See supra* Part I.

332. *See supra* Section II.C.

333. *See supra* Section III.B.

334. *See supra* Section II.B.

335. *See supra* Section II.B.1.

336. *See supra* Section II.B.2.

337. *See supra* Section I.B.4.

338. *See supra* Section III.B.1.

339. *See supra* Section II.C.

340. *See supra* Section III.B.1.

341. *See supra* Section III.B.