
FURTHER DEVELOPMENTS ON PREVIOUS SYMPOSIA

OUTPATIENT CIVIL COMMITMENT IN NORTH CAROLINA: CONSTITUTIONAL AND POLICY CONCERNS

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I

INTRODUCTION

The Summer 1982 issue of *Law and Contemporary Problems*, entitled *Mental Health*, contained eight articles covering a broad range of mental health issues facing the United States in the early 1980s.¹ The 1960s and 1970s had witnessed sweeping reforms in state management of the mentally ill, and the symposium participants addressed, among other things, the new (narrower) civil commitment criteria² and the problems associated with the resulting deinstitutionalization of the mentally ill.³ While there were hints by 1982 that these reforms were drawing to a close,⁴ the direction subsequently taken in several states (including North Carolina, the publishing home of this journal) was not predicted in our 1982 issue. This important development in the care of the mentally ill has been the expansion of outpatient care.

Involuntary civil commitment of the mentally ill is typically thought of as an inpatient arrangement: court-ordered 24-hour confinement at a facility that provides a structured living environment and services that might include care, treatment, habilitation, or rehabilitation. Another civil commitment option, however, now available in most states, is "outpatient commitment." Outpatient

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1. See generally David L. Bazelon, *Introduction*, 45 LAW & CONTEMP. PROBS. 1 (Summer 1982). See *infra* text accompanying notes 11-25 for a review of the civil commitment reforms spanning the last three decades.

2. See, e.g., George E. Dix, *Major Current Issues Concerning Civil Commitment Criteria*, 45 LAW & CONTEMP. PROBS. 137 (Summer 1982).

3. See, e.g., Bruce Ledewitz, *Foreseeing is Believing: Community Imposition of Liability for the Acts of "Dangerous" Former Mental Patients*, 45 LAW & CONTEMP. PROBS. 67 (Summer 1982).

4. See Alan Meisel, *The Rights of the Mentally Ill Under State Constitutions*, 45 LAW & CONTEMP. PROBS. 7 (Summer 1982) (suggesting, accordingly, that advocates for the mentally ill turn to state constitutional provisions for enforceable rights).

commitment is court-ordered treatment in the community and is usually characterized by short, recurring visits to a mental health clinic that provides treatment such as medication, individual or group therapy, day or part-day activities, or supervision of living arrangements.⁵

There are presently three types of outpatient civil commitment.⁶ The first is traditional outpatient commitment, in which someone who would otherwise be an inpatient is assigned to a community setting.⁷ The individual is adjudicated committable to an inpatient facility, but then is simply assigned to an outpatient program. A familiar analogy would be probation, where, rather than serving his or her prison sentence, a convicted criminal will live in the community, subject to certain standards of conduct. The second type of outpatient commitment is "conditional release" from an inpatient facility,⁸ which is analogous to parole, where a convicted criminal leaves prison early, subject again to certain behavioral standards. The third type, which is known as "preventive commitment," differs from the first two in that it targets those not ill or dangerous enough to be committed to inpatient facilities under state commitment laws.⁹

Preventive commitment, specifically the North Carolina scheme, is the focus of this note. Part II describes the history and design of the North Carolina preventive commitment scheme. Part III explores possible constitutional difficulties with the implementing statute.¹⁰ Part IV identifies practical

5. Susan Stefan, *Preventive Commitment: The Concept and Its Pitfalls*, 11 MENTAL & PHYSICAL DISABILITY L. REP. 288, 290 (1987).

6. *Id.* at 288. Nearly every state authorizes outpatient commitment, either explicitly or implicitly. For recent surveys of state outpatient commitment statutes, see AMERICAN PSYCHIATRIC ASSOCIATION TASK FORCE ON INVOLUNTARY OUTPATIENT COMMITMENT, INVOLUNTARY COMMITMENT TO OUTPATIENT TREATMENT 3-4 (1987) [hereinafter APA REPORT]; Geraldine A. McCafferty & Jeanne Dooley, *Involuntary Outpatient Commitment: An Update*, 14 MENTAL & PHYSICAL DISABILITY L. REP. 277 (1990). For a thorough overview of the primary two types of outpatient commitment, see Jillane T. Hinds, *Involuntary Outpatient Commitment for the Chronically Mentally Ill*, 69 NEB. L. REV. 346 (1990).

7. Some states authorize or require placement in the least restrictive environment, thereby implicitly authorizing outpatient placement; others explicitly refer to outpatient treatment. For examples of statutes that authorize outpatient placement as a less restrictive alternative to involuntary hospitalization, see ARK. CODE ANN. § 20-47-214(c) (Michie 1991) (implicit); IDAHO CODE § 66-329(k) (1989) (implicit); MINN. STAT. ANN. § 253B.09 (West 1990) (implicit); PA. STAT. ANN. tit. 50, § 7304(f) (Supp. 1994) (explicit).

8. For examples of inpatient civil commitment schemes authorizing conditional release to outpatient status, see ALA. CODE § 22-52-57 (1990); KY. REV. STAT. § 202A.181 (1992); OR. REV. STAT. § 426.130 (1987).

9. For examples of outpatient commitment using broadened substantive criteria, see GA. CODE ANN. § 37-3-81 (1982); HAW. REV. STAT. §§ 334-121 to -134 (1991 & Supp. 1994); N.C. GEN. STAT. § 122C-271 (1994). See also APA REPORT, *supra* note 6, at 19-20 (proposed guidelines for outpatient commitment).

10. While the U.S. Supreme Court has not ruled on outpatient commitment of any sort, this note analyzes other cases, including a variety of inpatient civil commitment cases, and concludes that preventive commitment probably satisfies substantive due process. Although the outpatient statutes differ procedurally from the inpatient commitment statutes, a procedural due process analysis of outpatient civil commitment in North Carolina would be well beyond the scope of this note. Moreover, while the outpatient statutes differ in significant ways (for example, they provide no right to counsel and no explicit right to confront or cross-examine witnesses, see N.C. GEN. STAT. § 122C-267 (1994)),

problems with the current administration of the scheme, reviewing, for example, problems with noncompliance and enforcement. Part V, the conclusion, briefly addresses the prospect of forcible medication, and argues that individualized case management through local mental health clinics is the more effective and humane way of serving the interests of both the individual and the state.

II

BACKGROUND

A. History of the 1983 Statute

In the 1960s and early 1970s, as the civil rights movement spread to the treatment of mental patients, public support of expansive civil commitment schemes was replaced by a desire to restrain the state's commitment authority.¹¹ Commentators have linked this shift in public opinion to such factors as a growing recognition that involuntary hospitalization involves a serious loss of liberty, increasing awareness of the stark conditions in mental hospitals, and the U.S. Supreme Court's rulings on privacy.¹² The change in public attitude manifested itself in, among other things, community mental health workers and civil rights groups working for deinstitutionalization of inpatients.¹³

It was against this background, in 1973, that the North Carolina General Assembly enacted its first outpatient civil commitment law, using the same substantive criteria for outpatient commitment as were then in place for inpatient commitment (specifically, that the patient be "mentally ill" and "imminently dangerous to others").¹⁴ Almost immediately after this legislative

from a practical perspective, this distinction may matter little. Outpatient and inpatient hearings are effectively the same in North Carolina courts; judges tend to provide the inpatient procedures in both instances. Interview with Marvin Swartz, M.D., Duke Hospital, in Durham, N.C. (Jan. 12, 1995) [hereinafter Swartz Interview]. The inpatient statutes also have been found to satisfy procedural due process. See *French v. Blackburn*, 428 F. Supp. 1351 (M.D.N.C. 1977).

11. Mary L. Durham & John Q. LaFond, *The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment*, 3 YALE L. & POL'Y REV. 395, 397 (1985); Virginia Aldigé Hiday & Teresa L. Scheid-Cook, *The North Carolina Experience with Outpatient Commitment: A Critical Appraisal*, 10 INT'L J. L. & PSYCHIATRY 215, 215 (1987) [hereinafter Hiday & Scheid-Cook, *Critical Appraisal*].

12. Durham & LaFond, *supra* note 11, at 397; see also Hinds, *supra* note 6, at 346-47 ("Public awareness of abuse and neglect of the mentally ill in large, isolated state and county institutions, new antipsychotic medications, and increasing involvement of the legal system in the care of the mentally disabled provided the impetus for the policies of deinstitutionalization and community care" (citations omitted)); Stacy E. Seicshnaydre, Comment, *Community Mental Health Treatment for the Mentally Ill—When Does Less Restrictive Treatment Become a Right?*, 66 TUL. L. REV. 1971, 1971-72 (1992) (linking deinstitutionalization to the discovery of large, overcrowded hospitals plagued with neglect and brutality and to the influence of writings by Thomas Szasz (citing THOMAS SZASZ, *MANUFACTURE OF MADNESS* (1970); THOMAS SZASZ, *MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT* (1961))).

13. APA REPORT, *supra* note 6, at 1.

14. 1973 N.C. Sess. Laws, ch. 726, § 1; 1973 N.C. Sess. Laws, ch. 1408, § 1. In 1979 the North Carolina General Assembly rewrote the second substantive criterion, deleting the word "imminently." 1979 N.C. Sess. Laws, ch. 915, §§ 8, 15, 16.

initiative in North Carolina, the U.S. Supreme Court decided *O'Connor v. Donaldson*,¹⁵ which is usually cited for the proposition that inpatient civil commitment of an adult requires a showing of mental illness and dangerousness.¹⁶ In response to this ruling, or simply to explore less restrictive alternatives, many states tightened their substantive criteria for inpatient commitment.¹⁷ In the wake of the resulting flood of released inpatients,¹⁸ a large portion of the chronically mentally ill population became known as "revolving door patients."¹⁹

Revolving door patients are those chronically mentally ill who will not seek treatment on their own and who have a pattern of regularly relapsing and becoming dangerous.²⁰ As the *O'Connor* decision has been interpreted, the state may not commit such individuals until they become dangerous. Once they do, the state hospitalizes and medicates them, at which point they cease to be dangerous and must be released. Once released, they stop taking their medication and the cycle resumes.²¹ The revolving door syndrome inheres in state management of the mentally ill; it is a byproduct of combining a substantive threshold for triggering state intervention with chronic mental illness that responds to medication.

With the 1980s, however, came a newly expanded view of the state's role in management of the mentally ill²² and advocacy by mental health patients for lower standards of commitment.²³ In 1983, the North Carolina legislature passed new outpatient commitment statutes,²⁴ expanding the criteria so as to embrace patients not yet committable to an inpatient facility under either North

15. 422 U.S. 563 (1975).

16. The Court's holding is actually considerably narrower than this. See *infra* text accompanying notes 81-96.

17. APA REPORT, *supra* note 6, at 1. This transition has been described as a shift from a "medical" model to a "legal" model of civil commitment. See Virginia Aldigé Hiday, *Civil Commitment: A Review of Empirical Research*, 6 BEHAVIORAL SCI. & L. 15, 16 (1988) ("A basic assumption in these reforms was that a legal standard, 'dangerousness,' as opposed to a medical standard, 'need for treatment,' coupled with formal legal procedures as opposed to informal medical practices, would provide necessary scrutiny of the mental health establishment and would, thus, remove the cloak of paternalism responsible for past abuses."); Virginia A. Hiday & Teresa L. Scheid-Cook, *A Follow-up of Chronic Patients Committed to Outpatient Treatment*, 40 HOSP. & COMMUNITY PSYCHIATRY 52, 52 (1989) [hereinafter Hiday & Scheid-Cook, *Follow-up*] ("In most jurisdictions the law has rejected the medical model of commitment, which allowed involuntary hospitalization of the mentally ill when they needed treatment, and has substituted a legal model that emphasizes due process and permits involuntary hospitalization only of the mentally ill who are judged to be dangerous.").

18. See APA REPORT, *supra* note 6, at 1 (noting "massive depopulation of the public mental hospital system"); *id.* ("75% reduction in inpatient censuses in public mental hospitals" over the 30-year period between 1957 and 1987); see also Hinds, *supra* note 6, at 348 n.9.

19. See generally Hiday & Scheid-Cook, *Critical Appraisal*, *supra* note 11; Stefan, *supra* note 5.

20. See APA REPORT, *supra* note 6, at 1 (defining revolving door as "repeated brief hospitalizations followed by relapse after discharge").

21. Hiday & Scheid-Cook, *Critical Appraisal*, *supra* note 11, at 215.

22. Durham & LaFond, *supra* note 11, at 398 (noting return to expanded role for the state in the mid-1980s).

23. See *id.* at 396-99; Hiday & Scheid-Cook, *Critical Appraisal*, *supra* note 11, at 216.

24. 1983 N.C. Sess. Laws, ch. 638, § 14; see N.C. GEN. STAT. §§ 122C-263(d)(1), -267(h) (1994).

Carolina law or *O'Connor*, as interpreted.²⁵ The new outpatient commitment scheme was designed to prevent the otherwise inevitable periodic inpatient commitment of revolving door patients. Accordingly, it is called "preventive commitment."

B. Description of the Statute

In the first step of preventive commitment in North Carolina, anyone may petition a magistrate or clerk of a superior court for issuance of an order to take the respondent (the individual named in the petition) into custody.²⁶ The magistrate or clerk may then issue a "custody order."²⁷ To issue a custody order for outpatient commitment, the magistrate must have reasonable grounds to believe that the person is mentally ill²⁸ and, based on his psychiatric history, in need of treatment to prevent further disability or deterioration that would predictably result in future dangerousness.²⁹ If the petition is filed by a nonphysician, the respondent is taken into custody for examination by a physician or eligible psychologist.³⁰ The respondent is then given a date and a time at which to appear for treatment, and is transported home and released³¹ pending a commitment hearing.³² If the petition is instead filed by a physician who recommends outpatient commitment, and if the magistrate finds probable cause to believe that the respondent meets the criteria for outpatient commitment, then the magistrate simply issues an order for the hearing.³³

Most persons placed on outpatient status in North Carolina, however, are not initially considered to be candidates for preventive commitment; instead

25. See Hiday & Scheid-Cook, *Follow-up*, *supra* note 17, at 53 ("[T]he North Carolina state legislature, after a decade under reformed civil commitment laws, made outpatient commitment criteria less restrictive than involuntary hospitalization criteria, provided a mechanism for enforcing outpatient commitment, gave facilities and staff immunity from liability, and allocated funds to community mental health centers for each patient they treated on outpatient commitment.").

26. N.C. GEN. STAT. § 122C-261 (1994).

27. *Id.* § 122C-261(b).

28. When applied to an adult, "mental illness" means an illness that lessens an adult's ability to use self-control, judgment, and discretion, such that it is necessary or advisable that he be under treatment, care, supervision, guidance, or control. *Id.* § 122C-3(21).

29. *Id.* § 122C-261(b). A person is "dangerous" if he is dangerous to himself or to others. A person is dangerous to himself if, absent treatment, (1) he is unable to care for himself and likely to suffer serious physical debilitation in the near future, (2) he has attempted suicide or threatened suicide and is likely to commit it, or (3) he has mutilated himself or threatened to mutilate himself, and is likely to do so. A person is dangerous to others if (1) he has engaged in the extreme destruction of property and there is a reasonable probability he will do so again, or (2) he has threatened to inflict, attempted to inflict, inflicted, or created a substantial risk of serious bodily harm to another, and there is a reasonable probability he will do so again. *Id.* § 122C-3(11); see APA REPORT, *supra* note 6, at 20 ("North Carolina [has] operationalized [its] definition of deterioration to the point of dangerousness by requiring that determinations be based on past treatment records. This approach has the virtue of providing specific evidence of past behavior, the best basis for prediction of human behavior.").

30. N.C. GEN. STAT. § 122C-261(b) (1994) (setting forth the criteria pursuant to which the physician may recommend outpatient commitment); *id.* § 122C-263(c).

31. *Id.* § 122C-263(f).

32. *Id.* § 122C-264(a).

33. *Id.* § 122C-261(d).

outpatients tend to have been inpatients "stepped down" to outpatient status at some point during the inpatient commitment process.³⁴ An inpatient might be stepped down to outpatient status either at the hospital or at the district court hearing.

By and large, most patients are stepped down at the hospital.³⁵ If a petition for inpatient commitment is filed by a nonphysician (for example, by a family member), the respondent is taken into custody for a first examination. If the examining physician instead recommends outpatient commitment, she identifies the proposed treatment physician or center, and the respondent is released pending a district court hearing.³⁶ The respondent is also directed to appear at the treatment center at a specified date and time.³⁷ A second examination of candidates for inpatient commitment takes place within twenty-four hours of arrival at a facility,³⁸ if this physician finds only the criteria for outpatient commitment satisfied, then she sets an appointment for the respondent with an outpatient physician and releases him pending a district court hearing.³⁹

A respondent recommended for outpatient commitment (either at a magistrate's behest based on a petitioning physician or as a "step-down") is ordered to appear for examination by the proposed treatment provider at a particular date and time, and slated for a civil commitment hearing. In the meantime, the proposed physician or treatment center may prescribe reasonable and appropriate medication and treatment.⁴⁰ However, the respondent can be neither physically forced to take the medication nor forcibly detained.⁴¹

In such a situation, a civil commitment hearing must be held within ten days of the beginning of custody.⁴² The order for outpatient commitment must be supported by clear, cogent, and convincing evidence that the person is mentally ill, capable of surviving safely in the community with available supervision, in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness, and limited in his ability to make or simply unable to make an informed decision to seek voluntary treatment or to comply with recommended treatment.⁴³ At this stage, of course, a candidate for inpatient commitment could be rerouted to outpatient status.

34. Swartz Interview, *supra* note 10.

35. *Id.*

36. N.C. GEN. STAT. § 122C-263(d)(1) (1994).

37. *Id.* § 122C-263(f).

38. *Id.* §§ 122C-266, -285.

39. *Id.* § 122C-266(a)(2).

40. *Id.* § 122C-265(b).

41. *Id.* § 122C-265(c).

42. *Id.* §§ 122C-267(a) (outpatient), -268(a) (inpatient).

43. *Id.* §§ 122C-267(h), -263(d)(1). There must also be a finding of fact as to the actual availability of outpatient treatment. *Id.* § 122C-271(b)(4). By way of contrast, an inpatient commitment order must be supported by clear, cogent, and convincing evidence that the person is mentally ill and dangerous. *Id.* § 122C-268(j).

III

DUE PROCESS ANALYSIS OF THE STATUTES

A. Due Process

The notion underlying the Due Process Clause of the Fourteenth Amendment is that certain interests of the individual (life, liberty, and property) are so fundamental that they cannot be taken away by the state without "due process."⁴⁴ Identifying a constitutionally protected interest is, thus, the first step of due process analysis. The guarantee of substantive due process is that only sufficiently weighty interests justify any encroachment on a liberty interest.⁴⁵ The procedural component of the Due Process Clause is the guarantee of certain procedures to accompany such an intrusion. Thus, due process analysis includes both a substantive question (under what circumstances, if any, infringement of this interest would be permissible) and a procedural question (how the state is to determine if the infringement is justifiable in the particular situation).⁴⁶

The outpatient commitment statutes of North Carolina give the state a new role in management of the mentally ill. While they may be susceptible to a due process challenge, none has yet been brought.

B. Preventive Commitment and Substantive Due Process

1. *The Reasonable Relation Rule.* A threshold question for substantive due process analysis is the level of scrutiny to which the state's preventive commitment scheme will be subjected by a reviewing court. In general, the U.S. Supreme Court has afforded substantial latitude to the states in the area of civil commitment.⁴⁷ While the Due Process Clause places some procedural and substantive constraints on state regulation in matters of health and general

44. The Fourteenth Amendment provides that "[no] State [shall] deprive any person of life, liberty, or property, without due process of law." U.S. CONST. amend. XIV.

45. Some interests (for example, freedom of contract) have low weight and can be regulated on the basis of a minimum rationality justification. Regulation of other liberty interests requires a compelling state interest.

46. See *Mills v. Rogers*, 457 U.S. 291, 299 (1982) ("[T]he substantive issue involves a definition of th[e] protected constitutional interest, as well as identification of the conditions under which competing state interests might outweigh it. The procedural issue concerns the minimum procedures required by the Constitution for determining that the individual's liberty interest is actually outweighed in a particular instance.").

47. See *Youngberg v. Romeo*, 457 U.S. 307, 322 (1982) ("[W]e emphasize that courts must show deference to the judgment exercised by a qualified professional. By so limiting judicial review of challenges to conditions in state institutions, interference by the federal judiciary with the internal operations of these institutions should be minimized."); *id.* at 317 ("[A] State necessarily has considerable discretion in determining the nature and scope of its responsibilities."); *Addington v. Texas*, 441 U.S. 418, 431 (1978) ("The essence of federalism is that states must be free to develop a variety of solutions to problems and not be forced into a common, uniform mold. As the substantive standards for civil commitment may vary from state to state, procedures must be allowed to vary so long as they meet the constitutional minimum.").

welfare, the Court's tendency has been to articulate a constitutional minimum and then leave substantial room for state-by-state experimentation.⁴⁸

Substantive due process requires a reasonable relationship between the nature and duration of commitment, and its purpose and basis. The Court articulated this "reasonable relation" rule in *Jackson v. Indiana*,⁴⁹ when it held unconstitutional the involuntary commitment of a criminal defendant who had been found incompetent to stand trial. Although Jackson's recovery was unlikely, the trial court had committed him until the hospital could certify his sanity.⁵⁰ This confinement was tantamount to permanent institutionalization on a mere showing that Jackson was incompetent to stand trial ("mere" because the state had a lesser burden than it would have had for civil commitment⁵¹). In finding a due process violation, the Court explained that no reasonable relationship existed between the permanent duration of commitment and its stated purpose of helping Jackson regain competence for trial.⁵² Instead, such a defendant could be held only for a reasonable time, meaning the time necessary to determine his chances of regaining the capacity to stand trial. If the chances were slim, the state would have to initiate civil commitment proceedings or release him.⁵³

2. *Liberty Interests.* Identifying a constitutionally protected interest is the first step of due process analysis.

a. *Physical freedom.* North Carolina's preventive commitment scheme implicates a liberty interest in freedom, though to a considerably lesser extent than any inpatient civil commitment scheme. In writing that "civil commitment for any purpose constitutes a significant deprivation of liberty,"⁵⁴ the U.S. Supreme Court was addressing the strength of this liberty interest in physical

48. See *Parham v. J.R.*, 442 U.S. 584, 608 n.16 (1979) ("As the scope of governmental action expands into new areas creating new controversies for judicial review, it is incumbent on courts to design procedures that protect the rights of the individual without unduly burdening the legitimate efforts of the states to deal with difficult social problems.").

49. 406 U.S. 715 (1972).

50. *Id.* at 719.

51. Specifically, the state showed only that Jackson "lack[ed] comprehension sufficient to make his defense." *Id.* The state's burden to commit him civilly as mentally ill would have been a showing of (1) mental illness, (2) need for care, and (3) dangerousness. *Id.* at 727-29. The Court also found an equal protection violation: Insofar as the state subjected Jackson to "a more lenient commitment standard and to a more stringent standard of release than those . . . others not charged with offenses," Indiana condemned him "to permanent institutionalization without the showing required for commitment or the opportunity for release afforded by [the statutes for commitment of the mentally ill and the feeble minded]." *Id.* at 730.

52. *Id.* at 738.

53. In dicta, the Court approved the federal provisions for commitment of incompetent criminal defendants, which the federal courts have construed to require precisely this. *Id.* at 731-33 (discussing 28 U.S.C. §§ 4244-4246).

54. *Addington v. Texas*, 441 U.S. 418, 425 (1979); see also *O'Connor v. Donaldson*, 422 U.S. 563, 580 (1975) (Burger, C.J., concurring) ("There can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the state cannot accomplish without due process of law.").

freedom in the context of inpatient commitment; the Court has not yet identified the extent to which outpatient commitment (of any sort) similarly entrenches on it. By and large, commentators assume that outpatient commitment intrudes less on this liberty interest than does inpatient placement,⁵⁵ an assumption that finds support in the Court's treatment of parole and probation vis-à-vis incarceration,⁵⁶ at least with respect to nonpreventive schemes. That is, reconfinement of convicted criminals released on parole or probation requires due process, because release (re)created a protected liberty interest. So outpatient commitment schemes analogous to parole (that is, conditional release schemes) and probation (that is, community placement schemes) return to those patients some of the "liberty" interest in physical freedom deprived at the original inpatient civil commitment hearing.⁵⁷

Preventive commitment, by way of contrast, is more akin to placing someone on probation without a criminal conviction. Rather than depriving a person of his liberty and then returning some (a lesser portion), it deprives him of less to begin with. The net result is not the same, given the conspicuous absence of a threat of comparatively swift reincarceration and rehospitization.⁵⁸ Thus, preventive commitment results in at most the same net deprivation of liberty as do other outpatient commitment schemes, and arguably it effects a lesser deprivation.

b. Reputation. Although the Court has not been receptive to viewing damage to reputation alone as a deprivation of either liberty or property,⁵⁹ there is some basis for inferring that a deprivation of liberty that also affects reputation might be treated as more invasive than a deprivation of liberty alone. In 1970, the Court found that due process requires notice and a hearing before the state may post a notice in retail liquor outlets forbidding sale of alcohol to

55. See, e.g., Lynn E. Gunn, *Outpatient Commitment for the Mentally Ill*, POPULAR GOV'T., Spring 1987, at 18.

56. See *Gagnon v. Scarpelli*, 411 U.S. 778, 782 (1973) ("Petitioner does not contend that there is any difference relevant to the guarantee of due process between the revocation of parole and the revocation of probation, nor do we perceive one."); *Morrissey v. Brewer*, 408 U.S. 471, 483 (1972) (Revocation of *parole* does not require the procedural safeguards of a criminal trial, "given the previous conviction and the proper imposition of conditions.").

57. See *Morrissey v. Brewer*, 408 U.S. 471 (1972) (requiring procedural safeguards for reconfinement of parolees); *C.R. v. Adams*, 649 F.2d 625, 628 (8th Cir. 1981) (noting that "lower federal courts . . . have uniformly found that the conditional liberty interest of a mental patient . . . on outpatient status cannot be summarily terminated without notice and the opportunity for a hearing"); *Birl v. Wallis*, 619 F. Supp. 481, 490 (M.D. Ala. 1985) (extending rule from parole revocation cases to reconfinement of conditionally released mental health patients); *Meisel v. Kremens*, 405 F. Supp. 1253 (E.D. Pa. 1975) (equating the liberty interest created by conditional release to the liberty interest created by parole).

58. While reincarceration of parolees requires due process of law, it does not require a full-fledged criminal trial. Similarly, the state need not repeat the full civil commitment hearing in order to rehospitalize conditionally released inpatients.

59. See, e.g., *Paul v. Davis*, 424 U.S. 693 (1976) (holding mere injury to reputation alone not a deprivation of "liberty").

an individual on account of her excessive drinking.⁶⁰ While the Court held six years later that injury to reputation alone is not of its own accord a deprivation of liberty, the Court distinguished its earlier ruling by noting that posting had "significantly altered [the person's] status as a matter of state law" and concluded that the "alteration of legal status, . . . combined with the injury resulting from the defamation, justified the invocation of procedural safeguards."⁶¹ So, while the imposition of stigma by the state may not in itself trigger the Due Process Clause, a state action that deprives the individual of liberty and imposes a stigma may thereby be a greater deprivation of constitutionally protected liberty. In other words, stigma imposed is a factor in due process analysis.

Preventive commitment unquestionably implicates an interest in "reputation." First, some stigma arises when one is not treated, despite serious mental illness.⁶² Although being "free" of stigma is arguably a sort of "liberty," it is very different from the liberty interest in being free of physical restraint. The state does not impose the stigma as it might the restraint, and the state action constituting deprivation could only be its failure to remove the stigma through medical treatment. A mentally ill person would have to allege that the state's failure to commit him constituted a deprivation of a protected liberty interest in a stigma-free reputation. Ordinarily, however, the government has no duty to prevent others from working a deprivation of liberty or property.⁶³ It is thus unlikely that the individual has a constitutionally protected liberty interest in being stigma-free that can, of its own impetus, give rise to a state duty to prevent or remove the stigma.⁶⁴ Second, the state may impose a stigma when it erroneously commits a person who is not mentally ill.⁶⁵ One so confined would likely bring a suit for the erroneous deprivation of liberty, that is, confinement without satisfying the minimum substantive requirements. Third,

60. *Wisconsin v. Constantineau*, 400 U.S. 433 (1971).

61. *Paul v. Davis*, 424 U.S. 693, 708-09 (1976).

62. Thus, the Court once noted that a child has some sort of interest in avoiding the stigma of abnormal behavior in public. *Parham v. J.R.*, 442 U.S. 584, 601 (1979) ("[W]hat is truly 'stigmatizing' is the symptomatology of a mental or emotional illness. . . . A person needing, but not receiving, appropriate medical care may well face even greater social ostracism . . .").

63. See, e.g., *DeShaney v. Winnebago County Dep't. of Social Serv.*, 489 U.S. 189, 196 (1989) ("[T]he Due Process clauses generally confer no affirmative right to government aid, even where such aid may be necessary to secure life, liberty, or property interests of which the government itself may not deprive the individual.").

64. Damage to reputation accompanied by a loss in future education or employment opportunities could be a deprivation of liberty. See, e.g., *Goss v. Lopez*, 419 U.S. 565, 574-75 (1975) (disciplinary action in school setting constituted deprivation of liberty because it would damage student's future educational and employment opportunities). Absent affirmative action taken by the state to impose such additional damage, though, it is unlikely that failure to commit and treat is a deprivation of reputational liberty.

65. See *Parham v. J.R.*, 442 U.S. 584, 601 (1979) ("protectible interest . . . in not being labeled erroneously by some persons because of an improper decision" (emphasis added)); *S.H. v. Edwards*, 860 F.2d 1045, 1050 (11th Cir. 1988) (per curiam) ("[T]he right not to be *inappropriately stigmatized* by hospitalization is a protectible interest under the Fourteenth Amendment due process clause." (district court's order appended to Court of Appeals opinion, relying on *Parham*) (emphasis added)).

and critically, even a correct adjudication of mental illness so severe that it warrants state intervention (on the person's own behalf or for the protection of society) has a profound impact on the individual's status in the community. The Court made precisely this point in 1979, noting that "commitment to a mental hospital 'can engender adverse social consequences to the individual' and that '[w]hether we label this phenomena 'stigma' or choose to call it something else, . . . we recognize that it can occur and that it can have a very significant impact on the individual.'"⁶⁶ And while commitment to outpatient status may engender less severe "social consequences," it unquestionably engenders some.

c. Conclusion. The North Carolina outpatient commitment scheme implicates a liberty interest in freedom, though to a lesser extent than any inpatient civil commitment scheme, and possibly to a lesser extent than other outpatient commitment schemes. This infringement is enhanced, at least to some extent, by the "stigma" of the commitment process. Critically, though, the deprivation of liberty involved here is considerably less than in the inpatient schemes reviewed by the Court.

3. *The State's Interest.* Identifying the liberty interests infringed upon by preventive commitment, and the extent to which they are infringed, is only the first step of substantive review. Only sufficiently weighty state interests will justify the infringement. North Carolina's interest seems fairly clear: The scheme is designed to, and does, prevent hospitalization of revolving door patients, effect lesser deprivations, and reduce state expenses.⁶⁷ And its power to enact such a scheme is not in doubt: This is an exercise of both its police power (because outpatients are, by definition, on the very brink of dangerousness) and its role as *parens patriae* (because outpatients are, by definition, limited in their ability to make treatment decisions).⁶⁸

Both the police power and the *parens patriae* role are legitimate premises for state action. However, a police power justification is more convincing in the inpatient setting than in the outpatient setting, as inpatients have been adjudicated dangerous, while outpatients have not. The *parens patriae* rationale

66. *Vitek v. Jones*, 445 U.S. 480, 492 (1980) (quoting *Addington v. Texas*, 441 U.S. 418, 425-26 (1979)).

67. See *Gunn*, *supra* note 55, at 19-20.

68. To be sure, the state's interest is preventive and, as such, deprives the individual of liberty on the basis of the possibility that he would become dangerous absent treatment. To the extent that it works from possibility rather than certainty, the North Carolina scheme will be overbroad (though not necessarily unconstitutionally so). That is, some of those deprived would not, in fact, have become dangerous. Still, similarly broad juvenile curfews have been justified on preventive grounds and sustained at the court of appeals level. See, e.g., *Qutb v. Strauss*, 11 F.3d 488 (5th Cir. 1993). In fact, the *Qutb* court sustained a juvenile curfew even while applying "strict scrutiny." The state's interests were deemed unusually compelling, since the persons affected were minors "whose immaturity, inexperience, and lack of judgment may sometimes impair their ability to exercise their rights wisely." *Id.* at 492 (citing *Hodgson v. Minnesota*, 497 U.S. 417, 444 (1990)). This analysis suggests that preventive commitment in North Carolina will survive the less rigorous scrutiny to which it must be subjected. See *supra* text accompanying notes 47-53.

may, thus, take on greater significance in the outpatient setting. This is entirely consistent with the *Jackson* reasonable relationship rule: The state's authority to commit to outpatient status is largely *parens patriae*—precisely what one would expect of a scheme that is primarily about treatment.⁶⁹

4. *No Right to Least Restrictive Means.* If due process requires that the state merely design a reasonable commitment scheme, then “least restrictive means” analysis (a hallmark of strict scrutiny, the least deferential form of judicial review) is unwarranted. Still, plaintiffs arguing for training and habilitation⁷⁰ in the inpatient setting, as well as plaintiffs seeking outpatient placement (instead of inpatient confinement) have couched their arguments in terms of a least restrictive means requirement,⁷¹ and several U.S. courts of appeals have applied that standard. The Supreme Court has not spoken directly on the topic,⁷² however, and the courts of appeals using least restrictive means analysis have misapplied the analogous precedent.

While some lower courts have relied on *Youngberg v. Romeo*⁷³ for a definitive answer on the appropriateness of least restrictive means analysis in the civil commitment setting,⁷⁴ their reliance on the case is misplaced. The *Youngberg* Court simply did not address the question. Rather, the Court held only that a committed mentally retarded individual is entitled to the training reasonably required by his constitutionally protected interests in reasonably safe conditions of confinement and freedom from unreasonable bodily restraints.⁷⁵ The Court recognized that some training of the patient by the state might be logically necessary in order to prevent deprivation of identified constitutional interests, but it construed this as an application of the *Jackson* reasonable

69. See APA REPORT, *supra* note 6, at 21 (suggesting outpatient commitment “be based on a need for treatment rather than on protection of the patient or others from dangerous behavior”). The *parens patriae* power finds its origin in the sovereign's authority to act as the “general guardian of all infants, idiots, and lunatics.” *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 257 (1972). The Court has suggested that this power inheres in the modern state, and the power has been invoked to justify civil commitment since at least 1845. See Comment, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1207-10 (1974).

70. The Court uses “habilitation” and “training” interchangeably; each refers to the “development of needed skills.” See *Youngberg v. Romeo*, 457 U.S. 307, 316-17 (1982).

71. See, e.g., *S.H. v. Edwards*, 860 F.2d 1045 (11th Cir. 1988) (mentally retarded persons arguing for community placement on the basis of a least restrictive environment requirement).

72. See *Foucha v. Louisiana*, 504 U.S. 71, 118 n.12, 119 (1992) (Thomas, J., dissenting) (noting that the Court has never applied strict scrutiny to state laws involving involuntary civil confinement).

73. 457 U.S. 307 (1982).

74. See, e.g., *S.H. v. Edwards*, 860 F.2d 1045, 1046 (11th Cir. 1988) (per curiam) (“[O]n the one issue of whether the [mentally retarded] plaintiffs have a substantive due process right, under the federal constitution, to habilitation in a community setting[,] . . . [a]ll agree that *Youngberg v. Romeo* is the guiding light but reasonable litigants, attorneys, and judges disagree on its application.” (citations omitted)); *Association for Retarded Citizens v. Olson*, 561 F. Supp. 473, 486 (D.N.D. 1982) (“While the *Youngberg* decision does not directly address this specific right, the Court's analysis indicates that it would reject an absolute right to the least restrictive alternatives.”).

75. *Youngberg*, 457 U.S. at 322 (choosing “reasonable” standard so as not to burden state institutions unduly and so as not to restrict the exercise of professional judgment).

relation rule.⁷⁶ The Court did not explicitly endorse a substantive entitlement to training.⁷⁷ Nor did it endorse a substantive entitlement to commitment in the least restrictive setting. Instead, as several courts of appeals have correctly interpreted the case, *Youngberg* requires the state only to provide habilitation consistent with prevailing standards of practice.⁷⁸

By and large, courts ruling recently have not applied least restrictive means analysis to due process challenges of state schemes of civil commitment,⁷⁹ and the traditional deference generally accorded to the states and to mental health professionals in this context strongly suggests that strict scrutiny of North Carolina's preventive commitment statutes would be inappropriate. This conclusion, combined with the premise that "mental illness" and "dangerous-

76. See *id.* at 324; *Olson*, 561 F. Supp. at 486 (Pursuant to *Youngberg*, a "constitutional right to the least restrictive method of care or treatment exists only insofar as professional judgment determines that such alternatives would measurably enhance the resident's enjoyment of basic liberty interests."); see also *Clark v. Cohen*, 794 F.2d 79 (3d Cir. 1986) (ordering community placement for a particular individual for precisely this reason); Bruce A. Arrigo, *The Logic of Identity and the Politics of Justice: Establishing a Right to Community-Based Treatment for the Institutionalized Mentally Disabled*, 18 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 1, 6-9 (1992) (dividing post-*Youngberg* decisions into two groups, those that "[dismiss] all claims to a constitutionally-based right to community-situated treatment for the psychiatrically disabled" and those that "[equate] minimally adequate treatment with community-based services," consistent with "the consensus of the medical profession"); Seicshnaydre, *supra* note 12, at 1981-83 (arguing that there may be a right to community placement consistent with *Youngberg* if professional judgment deems outpatient placement the better course of treatment).

77. Although three concurring justices were prepared to consider the possibility of an independent constitutional claim to the training or habilitation needed to preserve self-care skills, they reasoned from a perceived *additional* loss of liberty. See *Youngberg*, 457 U.S. at 327 (Blackmun, J., with whom Brennan, J., and O'Connor, J., joined, concurring).

78. See, e.g., *S.H. v. Edwards*, 860 F.2d 1045, 1046 (11th Cir. 1988); *Society for Good Will to Retarded Children v. Cuomo*, 737 F.2d 1239, 1248 (2d Cir. 1984); *Philips v. Thompson*, 715 F.2d 365, 368 (7th Cir. 1983). The *Youngberg* decision addressed the issue with respect to commitment of the mentally retarded, not the mentally ill, but the distinction has not been explored in the cases pertaining to either. The framework of analysis should not differ. But see Mary C. McCarron, Comment, *The Right to Refuse Antipsychotic Drugs: Safeguarding the Mentally Incompetent Patient's Right to Procedural Due Process*, 73 MARQ. L. REV. 477, 509 (1990) (arguing that there are relevant differences between the mentally ill and the mentally retarded, such as the permanence of the impairment, such that, for example, *Youngberg*'s deferential professional judgment standard for treatment of the mentally retarded might not translate to the context of the mentally ill).

79. Compare *Lynch v. Baxley*, 744 F.2d 1452, 1459 (11th Cir. 1984) (noting that "the least restrictive alternative consistent with the legitimate purposes of a commitment inheres in the very nature of civil commitment" (quoting *Covington v. Harris*, 419 F.2d 617, 623 (D.C. Cir. 1969))) and *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966) (noting that court should consider alternative courses of treatment for "insane" petitioner who posed no danger to others) with *Lelsz v. Kavanagh*, 807 F.2d 1243, 1251 (5th Cir. 1987) (noting that "the federal constitution does not confer on [the mentally retarded] a right to habilitation in the least restrictive environment") and *Society for Good Will to Retarded Children v. Cuomo*, 737 F.2d 1239, 1249 (2d Cir. 1984) ("More generally, post-*Youngberg* courts have held that there is no constitutional right to a 'least restrictive environment.'") and *Johnson v. Brejle*, 701 F.2d 1201, 1210 (7th Cir. 1983) ("Due process . . . does not guarantee [criminal defendants found unfit to stand trial and assigned to a mental health center] the right to be treated in the least restrictive environment that money can buy.") and *Rennie v. Klein*, 720 F.2d 266, 269-271 (3d Cir. 1983) (en banc) (plurality and concurring opinions) (noting that a "least intrusive means" test should not be applied to an examination of New Jersey's regulations for treating the mentally ill). See also *Clark v. Cohen*, 794 F.2d 79, 87 (3d Cir. 1986) (ordering community placement of mentally retarded plaintiff because of the "unanimous professional opinion that she should be placed in a far less restrictive environment" (emphasis added)).

ness" may not always be required for inpatient hospitalization, suggests that preventive commitment treatment providers may have more flexibility under the federal Constitution than they currently exercise in North Carolina. Perhaps, for example, the Constitution would permit them to move a noncompliant outpatient, who is rapidly spiralling toward dangerousness, into an inpatient facility, at least briefly.⁸⁰

5. *The Reasonable Relationship Rule.* While the Court has not ruled on outpatient commitment of any sort, it applied the reasonable relationship rule to inpatient civil commitment in *O'Connor v. Donaldson*.⁸¹ The *O'Connor* holding, when combined with a subsequent pair of cases on the commitment of criminal defendants found "not guilty by reason of insanity" ("NGRI"), strongly suggests that North Carolina's preventive commitment scheme would satisfy the reasonable relationship rule and, accordingly, be sustained against a due process challenge.

a. *Inpatient commitment.* Although he was not dangerous, Kenneth Donaldson had been confined for "custodial care" alone (not for treatment)⁸² for fifteen years. He was clearly capable of surviving in a community setting, and several persons had offered to assume custody. Indeed, there was even some doubt as to whether he was mentally ill. Putting aside that question, and applying *Jackson*, the Court held that if he were not dangerous, he could not be confined for custodial care alone. Specifically, there was no rational link between the basis of his commitment (at most, mental illness) and its nature (custodial).

While *O'Connor* is cited for the broad rule that involuntary inpatient civil commitment of an adult requires a showing of mental illness and dangerousness,⁸³ subsequent rulings by the Court on the commitment of criminal defendants found NGRI⁸⁴ suggest that the case should be read more narrowly. In the first case, *Jones v. United States*,⁸⁵ a narrow majority of the Court held that a criminal defendant committed in the District of Columbia on a finding of NGRI need not be released at the end of what would otherwise have been his sentence. An individual found NGRI, presumably both mentally ill and dangerous, is committed as any other committee would be, both for his own treatment and for the protection of society. As the duration of commitment

80. This detention would almost certainly have to be brief. See *Barrera-Echavarria v. Rison*, 21 F.3d 314, 316 (9th Cir. 1994) ("In sustaining statutes in the very few and limited situations in which preventive detention is permissible in the United States, the U.S. Supreme Court has stressed the crucial role of time.").

81. 422 U.S. 563 (1975).

82. See *id.* at 569 ("Donaldson's confinement was a simple regime of enforced custodial care, not a program designed to alleviate or cure his supposed illness.").

83. See, e.g., *Jones v. United States*, 463 U.S. 354, 374 (1983) (Brennan, J., dissenting) (writing of the "Addington burden of proof" and the "*O'Connor* elements").

84. *Foucha v. Louisiana*, 504 U.S. 71 (1992); *Jones v. United States*, 463 U.S. 354 (1982).

85. 463 U.S. 354 (1982).

must be reasonably related to its purpose,⁸⁶ the individual may be confined until one of these criteria is no longer satisfied.

The problem that fractured the Court in *Jones* was that after a criminal defendant is found NGRI, the D.C. Code mandates inpatient civil commitment without mention of the substantive criteria enunciated in *O'Connor*.⁸⁷ The majority and dissent disagreed about how (and even whether) a leap from NGRI to "mentally ill and dangerous" was made. Indeed, because it considered the *O'Connor* elements controlling, the dissent raised concerns about the rationality of the leap at all. Specifically the dissent noted that a person found NGRI is found to have been mentally ill and dangerous only at a particular moment in the past. Civil commitment hearings, by way of contrast, are "forward looking."⁸⁸ Moreover, the criminal law in the District of Columbia requires a finding that the mental illness "caused" the act; although the majority viewed this as supporting an inference of an illness so serious it is likely to continue,⁸⁹ the dissent viewed the finding of causation in the criminal context as a social judgment, not a medical judgment, and thus inappropriate in the context of civil commitment.⁹⁰

Very recently the Court revisited the issue. Ten years had passed since *Jones*, and the scale now tipped in the other direction. This time, in *Foucha v. Louisiana*, the Court invalidated a Louisiana scheme under which a person found NGRI would remain committed until he proved he was no longer dangerous, even if he regained his sanity.⁹¹ The four justices dissenting in *Foucha* (Kennedy, Rehnquist, Thomas, and Scalia) emphasized that both *Jones* and *Foucha* were criminal proceedings and contended that a criminal defendant found NGRI is more like a convicted criminal than a candidate for civil commitment.⁹² Indeed, in *Foucha*, the state had already proved the criminal act beyond a reasonable doubt.⁹³ In other words, the *O'Connor* elements would be inappropriate. These justices construed *Jones* as an endorsement of

86. *Jackson v. Indiana*, 406 U.S. 715 (1972).

87. See D.C. CODE ANN. § 24-301(j) (1981) (criminal defendant may be acquitted by reason of insanity if insanity established by preponderance of the evidence); *id.* § 24-301(d)(1) ("If any person . . . is acquitted solely on the ground that he was insane . . . he shall be committed to a hospital for the mentally ill."). *Jones* pleaded not guilty by reason of insanity, which the government did not contest, and the parties stipulated to the facts. *Jones*, 463 U.S. at 360. The Court's holding must be narrowly construed to apply only when the burdens of proof and elements proven match those of the D.C. Code; as the dissent pointed out, "[i]n some jurisdictions, . . . an acquittal by reason of insanity may mean only that a jury found a reasonable doubt as to a defendant's sanity and as to the causal relationship between his mental condition and his crime." *Id.* at 377 (Brennan, J., dissenting).

88. See *Jones*, 463 U.S. at 377 (Brennan, J., dissenting).

89. *Id.* at 366 (majority opinion).

90. *Id.* at 381 (Brennan, J., dissenting).

91. 504 U.S. 71 (1992).

92. *Id.* at 90, 94-95, 108. See also the majority opinion in *Jones*, 463 U.S. at 367 (noting "important differences between the class of potential civil-commitment candidates and the class of insanity acquittees that justify differing standards of proof").

93. On the other hand, the state did not contend that *Foucha* was criminally responsible or that it was entitled to punish him as a criminal. Nor did the Louisiana NGRI statute so provide. See *Foucha*, 504 U.S. at 74 n.1.

the distinction between civil and criminal commitment, and viewed the *Foucha* rule (that commitment of a person found NGRI must still be—at all times—predicated on both mental illness and dangerousness) as effectively overruling *Jones*.⁹⁴

So, while the dissent in *Jones* had expressed concern about *any* commitment premised solely on a finding of NGRI, what is thought of as the “conservative bloc” in the Court (dissenting in the more recent *Foucha* case) would sustain a statutory scheme confining a criminal defendant after a finding of NGRI, possibly even indefinitely and for dangerousness alone.⁹⁵ To be sure, the dissent in *Foucha* is precisely that—a dissent. But it underlines a fundamental point about the *Jackson* holding, which remains good law: What constitutes a “reasonable relationship” necessarily varies from scheme to scheme. As the state’s purpose and basis for action change, the nature and duration of commitment may also change. The narrow interpretation of *O’Connor* (that if an adult is not *dangerous*, he cannot be confined for custodial care alone) is thus more consistent with the *Jackson* reasonable relation rule, as well as with the deference usually accorded to state-by-state experimentation in mental health matters.⁹⁶

b. Preventive commitment. North Carolina’s preventive commitment scheme falls within an area the *O’Connor* Court explicitly left unexplored. That is, the *O’Connor* Court did not address (1) whether a *dangerous* mentally ill person has a right to treatment upon compulsory confinement (whether Donaldson’s “custodial” commitment would have been constitutional if he had also been dangerous) and (2) whether the state can confine a *nondangerous* mentally ill person simply for the purpose of treatment (whether Donaldson’s commitment would have been constitutional if they had been treating him).⁹⁷ If the state could have kept Donaldson by treating him, even though he was not dangerous, then even some forms of inpatient commitment may not require a showing of mental illness and dangerousness. And that suggests the lower

94. See *id.* at 90, 94-95 (Kennedy, J., dissenting). Pursuant to *Foucha*, commitment of a person found NGRI must terminate as soon as he is either sane or not dangerous. In other words, both prongs (mental illness and dangerousness) must at all times be satisfied for continuing commitment to be constitutional. The *Foucha* Court qualified this by noting that it had previously approved pretrial detention premised on dangerousness alone, provided the crime was serious, the government’s interests were overwhelming, detention followed a full-blown adversary hearing with a neutral decisionmaker, and a finding by clear and convincing evidence that no conditions of release would assure the safety of the detainee or the community, the duration was strictly limited, and the detainee was kept separately from persons awaiting or serving sentences. *Id.* at 80-83 (citing *United States v. Salerno*, 481 U.S. 739 (1987)).

95. See *id.* at 87-88 (O’Connor, J., concurring) (“[I]t might . . . be permissible for Louisiana to confine an insanity acquittee who has regained sanity if . . . the nature and duration of detention were tailored to reflect pressing public safety concerns related to the acquittee’s continuing dangerousness.”).

96. See Karen Matteson, Comment, *Involuntary Civil Commitment: The Inadequacy of Existing Procedural and Substantive Protections*, 28 U.C.L.A. L. REV. 906, 918-21 (1981) (narrow reading of *O’Connor*).

97. The Court did not address these questions because the questions were not before the Court.

threshold of preventive commitment may well pass constitutional muster. It remains to be seen, however, exactly how the *Jackson* rule will apply to the North Carolina scheme.

Again, due process requires a reasonable relationship between (1) the nature and duration of commitment and (2) its purpose and basis. The purpose of the North Carolina scheme is to treat a portion of the mentally ill population—those who are not yet dangerous—in order to prevent their otherwise inevitable dangerousness. In other words, in North Carolina, the individual's need for treatment is the statutory justification for preventive commitment. So, in North Carolina, a constitutionally protected right to treatment might be a logical extension of the reasonable relationship rule.

The Supreme Court has noted that, "as a general matter, a state is under no constitutional duty to provide substantive services for those within its border."⁹⁸ Thus, ordinarily there is no right to treatment by the state. Some lower courts, however, have reasoned that treatment must be provided on account of an implicit *quid pro quo* in the Due Process Clause. In this view, the state, in return for the liberty deprivation, must offer treatment as compensation. Thus, as one lower court reasoned, "[i]f an individual, adult or child, healthy or ill, is confined by the government for some reason other than his commission of a criminal offense, the state must provide some benefit to the individual in return for the deprivation of his liberty."⁹⁹

While fundamentally different in its view of the relationship between state and individual, the more commonly articulated view of due process—that any deprivation of liberty requires a sufficiently weighty countervailing state interest—results in this instance in the same outcome. The state interest justifying a deprivation of liberty might be punishment, deterrence, and the safety of others (as in the exercise of police power to incarcerate a convicted criminal), or it might be the individual's need for treatment (under the *parens patriae* power). If the state's interest is the latter, application of the *Jackson* reasonable relationship rule would result in a "right to treatment." In other words, whether or not one applies a *quid pro quo* analysis, treatment is the only reasonable option in North Carolina since the nature of confinement must be reasonably related to its purpose.¹⁰⁰ The North Carolina statute does require

98. *Youngberg v. Romeo*, 457 U.S. 307, 317 (1982).

99. *Gary v. Louisiana*, 437 F. Supp. 1209, 1216 (E.D. La. 1976); see also *S.H. v. Edwards*, 860 F.2d 1045, 1059 (11th Cir. 1988) (Clark, J., dissenting); *Wyatt v. Aderholt*, 503 F.2d 1305, 1314 (5th Cir. 1974).

100. See *Youngberg v. Romeo*, 457 U.S. 307, 326 (1982) (Blackmun, J., concurring) ("If a state [commits] a mentally retarded person . . . for 'care and treatment,' . . . due process might well bind the state to ensure that the conditions of his commitment bear some reasonable relation to . . . those goals. . . . [C]ommitment without any 'treatment' . . . would not bear a reasonable relation to the purposes of the person's confinement."); see also *Woe v. Cuomo*, 729 F.2d 96, 105 (2d Cir. 1984) (noting that if the justification for commitment rests on the patient's need for care, the reasonable relationship rule provides a right to treatment); David W. Burgett, Comment, *Substantive Due Process Limits on the Duration of Civil Commitment for the Treatment of Mental Illness*, 16 HARV. C.R.-C.L. L. REV. 205, 215-16 (1981) (substantive due process requires that treatment be provided and effective, for therapeutic

the district court judge to make a finding at the preventive commitment hearing that outpatient treatment is, in fact, available.¹⁰¹ The state has thus taken steps to address the possibility that, without medical treatment, preventive commitment might be irrational.

At the same time, however, preventive commitment usually entails an involuntary medication order (albeit "coerced" instead of "forced" medication), which raises the question of whether or to what extent the patient may refuse precisely that medication to which he has a "right." Ordinarily, the individual has a liberty interest in avoiding the unwanted administration of psychotropic drugs.¹⁰² Administration of psychotropic drugs to prison inmates and inpatients, for example, impairs a liberty interest beyond the deprivation effected by the original conviction or commitment.¹⁰³

custody to satisfy *Jackson*).

Similarly, a mentally ill but easily curable criminal defendant committed (pending trial) on a finding of incompetence might successfully argue that the *Jackson* rule mandated precisely that treatment necessary to restore his competence. On the other hand, although the state may not confine the nondangerous for custodial purposes alone (*O'Connor*), once a mentally ill person is dangerous, conceivably the *Jackson* rule could be satisfied by custodial care. See *Youngberg v. Romeo*, 457 U.S. 306, 325-26 (1982) (Blackmun, J., concurring) ("Under [the *Jackson*] standard, a State could accept a person for 'safekeeping,' then constitutionally refuse to provide him treatment. In such a case, commitment without treatment would bear a reasonable relation to the goal for which the person was confined."); see also *Association for Retarded Citizens v. Olson*, 561 F. Supp. 473, 488 (D.N.D. 1982) ("[I]t is reasonable to believe that the state may have a compelling interest in just safekeeping—rather than habilitating—[the] mentally retarded . . . from injuries that would result to themselves, and others, if the mentally retarded were not so confined."). Each of these very different propositions (for different situations) flows equally from the *Jackson* reasonable relation rule.

101. N.C. GEN. STAT. § 122C-271(b)(4) (1994).

102. *Washington v. Harper*, 494 U.S. 210, 221 (1990) ("[R]espondent possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs."); see also *Vitek v. Jones*, 445 U.S. 480, 491-94 (1980). "Psychotropic drugs" includes medications for depression ("anti-depressants") and medications for psychosis such as schizophrenia ("anti-psychotics"). See McCarron, *supra* note 78, at 480 n.22 (reviewing the various psychotropic drugs).

103. Even though criminal conviction involves the most rigorous process the state can provide, the new action of administering drugs implicates a liberty interest not adequately protected by the original process (i.e., the substantive constitutional limitations on the new intrusion are wholly different from those on the old), so the Due Process Clause requires additional substantive and procedural protections. See *Washington v. Harper*, 494 U.S. 210 (1990) (applying due process analysis to prison regulation regarding the administration of antipsychotic drugs to prisoners); *Montanye v. Haymes*, 427 U.S. 236, 242 (1976) ("As long as the conditions or degree of confinement to which the prisoner is subjected is within the sentence imposed upon him and is not otherwise violative of the Constitution, the Due Process Clause does not in itself subject an inmate's treatment by prison authorities to judicial oversight.").

Transfer to a prison hospital would be another example of a totally new "type" of intrusion. See, e.g., *Vitek v. Jones*, 445 U.S. 480 (1980) (transfer from prison to prison hospital requires administrative process that complies with due process); *Baugh v. Woodard*, 604 F. Supp. 1529 (E.D.N.C. 1985) (state prisoner has liberty interest in not being involuntarily transferred to mental health facility and due process requires pre-transfer notice and hearing as well as an adviser and an impartial decisionmaker), *vacated in part*, 808 F.2d 333 (4th Cir. 1987) (hearing can be *after* transfer and *before* admission, but only because psychiatric treatment does not commence until after admission).

By way of contrast, administrative segregation and transfer to a different penal facility may not require new process. See, e.g., *Olim v. Wakinekona*, 461 U.S. 238 (1983) (transfer from state prison in Hawaii to state prison in California); *Montanye v. Haymes*, 427 U.S. 236 (1976) (transfer to a different prison facility); *Meachum v. Fano*, 427 U.S. 215 (1976) (transfer to maximum security prison). To be sure, in these situations, the state might have *created* a new liberty interest, thus triggering a

While there is unquestionably an interest in avoiding unwanted medication, the U.S. Court of Appeals for the Fourth Circuit shed some light on the limits of that interest in the 1980s.¹⁰⁴ In 1987, the court held that forcible medication of a defendant institutionalized after a finding of incompetence to stand trial requires an initial finding of “medical incompetence” and a procedure pursuant to which the state can decide if and how to treat the defendant. Such a procedure might be substituted judgment (where the decisionmaker determines what the patient would do if he were competent), deference to professional judgment, or some sort of “best interests” test.¹⁰⁵ On rehearing in 1988, however, a different panel of the Fourth Circuit concluded that any distinction between competence to stand trial and competence to make treatment decisions “must certainly be one of such subtlety and complexity as to tax perception by the most skilled medical or psychiatric professionals.”¹⁰⁶ To require a preliminary finding of medical incompetence would be to “pose an unavoidable risk of completely anomalous, perhaps flatly inconsistent, determinations of mental incompetence by different judicial tribunals.”¹⁰⁷ Thus the court approved a process, proposed by the government, that construed the decision to medicate as essentially “medical” and that placed decisional responsibility in the hands of medical personnel at the custodial institution.¹⁰⁸

While the Supreme Court denied *certiorari* on the Fourth Circuit case, it implicitly aligned itself with the second panel and cast doubts on any widespread applicability of a notion of “medical incompetence.”¹⁰⁹ In *Washington v. Harper*, an inmate who had become mentally ill while incarcerated argued that the state “[could] not override his choice to refuse antipsychotic drugs unless he ha[d] been found to be incompetent, and then only if the factfinder makes a substituted judgment that he, if competent, would consent to drug treatment.”¹¹⁰ The Court disagreed.¹¹¹ Instead, according to the Court, “given the requirements of the prison environment, the Due Process Clause permits the state to treat a prison inmate who has a serious mental illness with antipsychotic

requirement of procedural protections. See, e.g., *Hewitt v. Helms*, 459 U.S. 460 (1983) (if a state by statute or administrative action declares prisoners to be entitled to a hearing before transfer into administrative segregation or to another penal facility, the state has given those prisoners an interest protected by the due process clause).

104. See *United States v. Charters*, 829 F.2d 479 (4th Cir. 1987), *reheard and remanded*, 863 F.2d 302 (4th Cir. 1988), *cert. denied*, 494 U.S. 1016 (1990).

105. See *id.* at 494-97 (explaining medical incompetence); *id.* at 495 (“In almost every state the mentally disabled person is considered competent unless there is a *separate hearing* declaring him incompetent.” (quoting S. BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* 341 n.167 (3d ed. 1985) (emphasis added))); *id.* at 488 (“Mentally ill patients, though incapacitated for particular purposes, can be competent to make decisions concerning their medical care.”).

106. 863 F.2d at 310.

107. *Id.*

108. *Id.* at 307; see also *id.* at 312 (“We do not believe that adequate protection here requires substitution of the pre-medication adjudication regime proposed by *Charters*.”).

109. See *Washington v. Harper*, 494 U.S. 210 (1990).

110. *Id.* at 222.

111. *Id.*

drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest."¹¹² The Court thus required no finding of incompetence. For forcible medication in the prison environment, at least, a lesser showing by the state will suffice.

North Carolina requires the state district court judge, working from the recommendations of examining physicians, to find the patient limited in his ability to make, or simply unable to make, an informed decision to seek voluntary treatment or to comply with recommended treatment.¹¹³ While "incompetent to stand trial" is not the same thing as "incompetent to make treatment decisions," arguably "limited in the ability to make (or flatly unable to make) treatment decisions" is. Moreover, to require an additional finding of incompetence to make treatment decisions might be to ask the wrong question.¹¹⁴ Insofar as the mentally ill share as a symptom of their disease a tendency not to take their medicine,¹¹⁵ the appropriate question might be medical and diagnostic rather than legal (and, specifically, constitutional). In other words, if this subset of the population is prone, by virtue of their disease, to passivity, a rigorous interpretation of "incompetence" may well be conceptually inappropriate for them.¹¹⁶

With respect to the procedure pursuant to which the state makes a treatment decision, it remains unclear if any of the three options outlined by the first Fourth Circuit panel would be appropriate in the context of preventive commitment. Several courts of appeals have applied least restrictive means analysis, required an overwhelming state interest, or otherwise closely

112. *Id.* at 227.

113. Indeed, district court judges in North Carolina uphold physicians' recommendations in 96% of all civil commitment cases. Swartz Interview, *supra* note 10.

114. See Joseph T. Carney, Comment, *America's Mentally Ill: Tormented Without Treatment*, 3 GEO. MASON U. CIV. RTS. L.J. 181 (1992) ("Dr. Thomas Szasz and civil liberties attorneys . . . argue that, in a society where people are free to smoke, drink, climb mountains or race cars, people should be free to do as they wish with their bodies as long as nobody else is harmed."). For thoughtful review of tension between liberty and the need for treatment, see Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 EMORY L.J. 375 (1982).

115. Swartz Interview, *supra* note 10 (suggesting this is a symptom of the mental illnesses common to outpatients). *But see* Gerard R. Kelly et al., *Utility of the Health Belief Model in Examining Medication Compliance Among Psychiatric Outpatients*, 25 SOC. SCI. MED. 1205, 1209 (1987) ("[W]hile there has been an inclination on the part of many researchers to view psychiatric patients as unreliable, incompetent, and unable to hold rational views and beliefs concerning their illnesses and disabilities, [we have concluded that] psychiatric outpatients do hold distinct and even realistic beliefs and perceptions regarding the extent of their illnesses and the ways in which they are viewed by others around them.").

116. Swartz Interview, *supra* note 10. Joseph Carney makes the same point:

In protecting the patient's procedural and substantive due process rights, [civil libertarians] are protecting his right to choose treatment or not. However, the affected individual is unable to make a rational decision. . . . The unfortunate irony is that the illness' symptomatology, irrational or distorted thinking, allows the disease to perpetuate itself because the law requires society to respect the patient's irrational decisions.

Carney, *supra* note 114.

scrutinized decisions to medicate the inpatient and the inmate forcibly.¹¹⁷ The Supreme Court, however, has suggested this heightened standard of review might not be necessary. For example, in 1981, the Massachusetts Supreme Judicial Court held that a noninstitutionalized but mentally ill person had a protected liberty interest in refusing treatment with antipsychotic drugs and, applying rigorous scrutiny, required a countervailing “overwhelming state interest” in order to medicate forcibly.¹¹⁸ The U.S. Supreme Court noted in a case the same year that this decision was based on the common law of Massachusetts as well as the federal constitution, and suggested that the rigorous scrutiny applied by Massachusetts might be more than the federal constitution requires.¹¹⁹

More importantly, in the preventive commitment setting, psychotropic medication is not *per se* forced. That is to say, in the paradigm due process involuntary medication case, the institutionalized or incarcerated individual is physically administered psychotropic medication, by force if necessary. By way of contrast, North Carolina outpatients are merely ordered to take their medicine, and then psychologically coerced.¹²⁰ Arguably, the liberty interest in avoiding coerced treatment with psychotropic drugs is weaker than the liberty interest in avoiding forced administration of psychotropic drugs. To be sure, the drugs mandated by the state, whether forced or coerced, are equally mentally and physically intrusive.¹²¹ The coercion process, however, leaves available the choice of noncompliance (and concomitant penalty). Combined with the

117. See *United States v. Charters*, 829 F.2d 479, 497 (4th Cir. 1987) (opting for “substituted judgment” approach for forcible medication of mentally ill pretrial detainee); *id.* (forcible medication of incompetent pretrial detainee sufficiently intrudes into fundamental liberties that the state must explore less restrictive alternatives); *Bee v. Greaves*, 744 F.2d 1387, 1396 (10th Cir. 1984) (“[L]ess restrictive alternatives . . . should be ruled out before resorting to antipsychotic drugs.”), *cert. denied*, 469 U.S. 1214 (1985).

118. See *In re Guardianship of Roe*, 421 N.E.2d 40, 51 (Mass. 1981).

119. See *Mills v. Rogers*, 457 U.S. 291, 303 (1982) (“Especially in the wake of *Roe*, it is distinctly possible that Massachusetts recognizes liberty interests of persons adjudged incompetent that are broader than those protected directly by the Constitution of the United States.”). *But see Bee v. Greaves*, 744 F.2d 1387, 1396 (10th Cir. 1984) (expressing caution about application of deferential standard to forcible medication), *cert. denied*, 469 U.S. 1214 (1985); *Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983) (same).

120. See Virginia Aldigé Hiday, *Coercion in Civil Commitment: Process, Preferences, and Outcome*, 15 INT’L J. L. & PSYCHIATRY 359, 363 (1992) (“[C]linicians pointed out to patients the likelihood of getting sick again and being rehospitalized if they failed to take their medicine or come to therapy. Many clinicians called these tactics ‘threats,’ and thought them important in obtaining compliance.” (citations omitted)). The threat of contempt sanctions would be another coercive measure. See *infra* text accompanying notes 136-43.

121. The mind-altering nature and potential long-term effects of psychotropic drugs suggest that they may be at least as intrusive as inpatient commitment. Cf. *United States v. Charters*, 829 F.2d 479, 489 (4th Cir. 1987) (“There is . . . no principled distinction between the chemical invasion of drug therapy and the mechanical invasion of surgery.”); *In re Guardianship of Roe*, 421 N.E.2d 40, 60 (Mass. 1981) (At least if public safety is the reason for the treatment, “antipsychotic drugs function as chemical restraints forcibly imposed upon an unwilling individual who, if competent, would refuse such treatment. Examined in terms of personal liberty, such an infringement is at least the equal of involuntary commitment to a State hospital. Accordingly, we think that the same standard of proof is applicable in both involuntary commitment and involuntary medication proceedings.”).

fact that the basic concept of the scheme seems quite reasonable (revolving door patients are, by definition, safe if they take their medicine), this less intrusive medication process probably satisfies substantive due process.

IV

APPLICATION OF THE STATUTES

A. Noncompliance

Although a respondent under an outpatient commitment order has been ordered to receive outpatient treatment, the statute does not permit forced medication or detention for treatment.¹²² Noncompliance thus poses the greatest practical challenge to North Carolina's preventive commitment scheme.¹²³ Quite a few researchers evaluating the North Carolina preventive commitment scheme have distinguished between "situational" and "contumacious" noncompliance,¹²⁴ defining the former as noncompliance "due to social and illness factors,"¹²⁵ and finding it much more common. That is, "patients could not get transportation to the mental health center, could not afford the cost of medicine and treatment, had little family support in pursuing care and staying on medication regimes, denied their illnesses and/or lacked understanding of their need for medicine and care."¹²⁶ This distinction between "contumacious" noncompliance and "situational" noncompliance may be artificial, as mentally ill individuals often share, as a symptom of their disease, a tendency not to take their medicine.¹²⁷ Noncompliance with treatment regimens is a universal problem, common to all diseases (mental and otherwise) as well as to all demographic and social groups.¹²⁸ But it is quite unclear to what extent patients with chronic mental diseases are more prone than other patients to fail

122. The outpatient statutes explicitly forbid forcible medication. N.C. GEN. STAT. § 122C-273(a)(3) (1994). The legislature had determined that a provision for forcible medication would be unnecessary, because noncompliance tends to result from "situational" factors such as transportation. APA REPORT, *supra* note 6, at 11. While the North Carolina mental health statutes allow emergency forced medication of involuntarily committed clients, N.C. GEN. STAT. § 122C-57(e) (1994), and the accompanying regulations both define "emergency" and explain the procedures, N.C. ADMIN. CODE tit. 10, 14J .0400 (Mar. 1990) ("Refusal of Psychotropic Medication"), these provisions cannot be read as authorizing forcible medication of outpatients. The language is simply inconsistent with the outpatient context. *See, e.g., id.* ("When a client *in a state facility* refuses psychotropic medication. . . ." (emphasis added)).

123. APA REPORT, *supra* note 6, at 12 (in a six-month period, 50% of 295 respondents either refused medication or otherwise failed to comply (citing Hiday & Scheid-Cook, *Critical Appraisal*, *supra* note 11, at 215)).

124. Gustavo A. Fernandez & Sylvia Nygard, *Impact of Involuntary Outpatient Commitment on the Revolving-Door Syndrome in North Carolina*, 41 HOSP. & COMMUNITY PSYCHIATRY 1001, 1002 (1990); Hiday & Scheid-Cook, *Critical Appraisal*, *supra* note 11, at 218.

125. Hiday & Scheid-Cook, *Critical Appraisal*, *supra* note 11, at 218.

126. *Id.*

127. Swartz interview, *supra* note 10.

128. Kelly et al., *supra* note 115, at 1205. Indeed, the average rate of noncompliance with medical regimens is 50% across all chronic disorders (psychiatric and other). *Id.*

to comply, or to what extent this noncompliance should be considered part of the disease itself.¹²⁹

The statutory mechanism for dealing with refusals draws the distinction between contumacious and situational noncompliance, but ultimately provides little in the way of statutory teeth. In fact, the only thing that can be forced on a noncompliant outpatient under North Carolina law is his presence at an appointment for the purposes of evaluation. By statute, if a mentally ill person "fails to comply" or "clearly refuses to comply" with outpatient treatment, his treatment physician or center must make reasonable efforts to elicit compliance and then may request a supplemental hearing.¹³⁰ The procedures for this hearing are the same as for outpatient civil commitment hearings.¹³¹ The court determines whether and why the respondent has failed to comply, and may then find probable cause for inpatient commitment and order an examination, alter the outpatient commitment order, or discharge the respondent.¹³² If the respondent "fails to comply" but does not "clearly refuse to comply," the center can request a clerk (not a magistrate) to issue a custody order.¹³³ The respondent is then brought before the outpatient physician or treatment center, examined, and released.¹³⁴ The physician will presumably try to cajole compliance. If the respondent meets the criteria for inpatient commitment, proceedings for a new commitment order may be started.¹³⁵ In short, noncompliant outpatients are divided into those who refuse and those whose failure is instead situational. A custody order cannot be issued for refusals.

Coercive civil contempt is, at least in theory, an obvious tool for enforcing the outpatient treatment order, but conceptual problems arise when one tries to apply the statutory requirements in the context of the mentally ill. In North Carolina, failure to comply with a valid court order is continuing civil contempt so long as the order remains in force, the purpose of the order would still be served by compliance, and the person subject to the order is still "able to comply."¹³⁶ Significantly, disobedience must be willful¹³⁷ and the party held

129. Swartz interview, *supra* note 10.

130. N.C. GEN. STAT. § 122C-273 (1994).

131. *See id.* § 122C-274.

132. *Id.*

133. *Id.* § 122C-273(a).

134. *Id.*

135. *Id.*

136. *Id.* § 5A-21. The outpatient doctor or treatment center would swear out an affidavit before a clerk of court, who would find probable cause (that the respondent will be found in contempt) and then issue a show cause order and a notice to appear. At the subsequent civil contempt hearing, the court would determine if the respondent were capable of compliance (taking his medicine) and, if so, would place him in jail until he complied or sufficiently deteriorated to be committed as an inpatient. If the respondent failed to appear for the contempt hearing, the court would order arrest, set bond, and calendar another hearing. *See id.* § 5A-23.

137. *Jones v. Jones*, 278 S.E.2d 260 (N.C. Ct. App. 1981); *Cox v. Cox*, 179 S.E.2d 194 (N.C. Ct. App. 1971).

in civil contempt must be able to comply.¹³⁸ One assumes, first, that this mechanism could be used only in the few situations of noncompliance that are "contumacious refusal." To the extent that the distinction between "contumacious" and "situational" refusals is artificial,¹³⁹ the appropriateness of civil contempt seems doubtful. More importantly, it is unclear what relationship exists between the ability to comply with a valid court order for contempt purposes and the earlier finding at the outpatient commitment hearing that the respondent was limited in his ability to make or simply unable to make an informed decision to seek voluntary treatment or comply with recommended treatment. Quite possibly, the condition supporting the limited-ability finding, to the extent that it suffices for a state-imposed involuntary medication order, precludes the contempt. At the very least, while he waits in prison on contempt charges, the patient may well spiral toward the complete relapse that will justify inpatient hospitalization by North Carolina statute; thus, at some point, he may cross a threshold into "unable to comply" for contempt purposes.

The court's contempt power also may be inappropriate in this setting because it threatens to undermine the therapeutic relationship. In fact, a recent study of compliance and enforcement in North Carolina concluded that, for essentially this reason, clinicians even tend not to use the weaker enforcement procedures provided in the civil commitment statutes.¹⁴⁰ Rather, they employ "softer means" such as phone calls and letters.¹⁴¹ And, apparently, these more "traditional means of persuasion"¹⁴² are effective. Thus the North Carolina Mental Health Study Commission may well have been correct when it concluded that "social and illness factors, as opposed to recalcitrance, could be overcome and compliance obtained by the authority of a court order, the

138. *Glesner v. Dembrosky*, 327 S.E.2d 60 (N.C. Ct. App. 1985).

139. See *supra* text accompanying note 127.

140. Virginia Aldigé Hiday & Theresa L. Scheid-Cook, *Outpatient Commitment for "Revolving Door" Patients: Compliance and Treatment*, 179 J. NERVOUS & MENTAL DISEASE 83, 87 (1991) [hereinafter Hiday & Scheid-Cook, *Compliance*].

141. *Id.*

142. *Id.* In a 1992 study, researchers noted:

At the first "No Show" these softer methods were relatively effective, for only 38.7% failed to show a second time. Again phoning and sending letters were the major methods of handling this situation and were relatively effective: failure to show a third time was reduced to 22.6%. At the third "No Show" clinicians employed more forceful methods: calling the sheriff, threatening to call the sheriff, and taking out a new petition for civil commitment. In the course of outpatient commitment (OPC), clinicians pointed out to patients the likelihood of getting sick again and being rehospitalized if they failed to take their medicine or come to therapy. Many clinicians called these tactics "threats," and thought them important in obtaining compliance.

Hiday, *supra* note 120, at 363 (citations omitted). To threaten civil contempt (or rather, to warn that it may become necessary) is to tell the patient that he is deteriorating and that he may deteriorate sufficiently to justify inpatient hospitalization. While such a "threat" may introduce an adversarial element to the doctor-patient relationship, it does so considerably less than would a threat of contempt sanctions (which might well be an empty, and thus deceptive, threat, precisely since drastic deterioration may preclude application of the contempt statutes).

strength of a sheriff's pick up and custody, and the extra effort and attention required of mental health personnel."¹⁴³

Several commentators have further argued that preventive commitment without judicial enforcement through the contempt power is inappropriately coercive for a therapeutic relationship. For example, several write that "chronically mentally ill individuals who are the likely candidates for involuntary outpatient commitment are generally alienated individuals who perceive the world as hostile and uncaring" and argue that placing them "into a situation where their acceptance of treatment becomes another instance in which the larger society is willing to penalize them for being unattached to regular social structures will merely perpetuate the cycle of alienation."¹⁴⁴ Another commentator notes that "many providers feel that such coercion is inherently antithetical to the therapeutic process and believe that serious questions exist regarding the clinical utility of mandatory outpatient treatment."¹⁴⁵

B. Preventive Commitment: The Results

Several studies of outpatient commitment in North Carolina have concluded that the scheme has not been used much.¹⁴⁶ A variety of explanations have been proffered for this fact, including "ideological resistance" on the part of community clinicians, that is, less concern for chronic patients as compared with crisis patients, more obligation felt to the voluntarily committed, and wariness about the value of psychotropic medication.¹⁴⁷ Some reluctance also can be attributed to awareness of inappropriate placements,¹⁴⁸ as well as to concerns that the scheme cannot be enforced.¹⁴⁹ The extent to which the scheme is

143. Hiday & Scheid-Cook, *Critical Appraisal*, *supra* note 11, at 218; see Hiday & Scheid-Cook, *Follow-up*, *supra* note 17, at 58 (noting that community mental health centers successful with obtaining compliance had to encourage compliance through aggressive case management).

144. Edward P. Mulvey et al., *The Promise and Peril of Involuntary Outpatient Commitment*, AM. PSYCHOLOGIST, June 1987, at 571, 577.

145. KATHLEEN A. MALOY, CRITIQUING THE EMPIRICAL EVIDENCE: DOES INVOLUNTARY OUTPATIENT COMMITMENT WORK? 3 (1992).

146. The earliest outpatient commitment statutes in North Carolina, which directly paralleled the inpatient statutes, were rarely used in the 1970s and accounted for a mere 2.6% of all civil commitment decisions. Hiday & Scheid-Cook, *Critical Appraisal*, *supra* note 11, at 216; see also Fernandez & Nygard, *supra* note 124, at 1002. A study covering the period between July 1984 and June 1985 concluded that the new statutes were "not being used much" and that 8.3% of respondents were ordered to outpatient commitment. Most of this group were brought in under inpatient procedures and then "stepped down" to outpatient status after the district court hearing. Hiday & Scheid-Cook, *Critical Appraisal*, *supra* note 11, at 219-21. As late as 1992, a study indicated outpatient commitment "still is receiving only limited use." Hiday, *supra* note 120, at 368.

147. APA REPORT, *supra* note 6, at 6-7; see also Robert D. Miller & Paul B. Fiddleman, *Outpatient Commitment: Treatment in the Least Restrictive Environment*, 35 HOSP. & COMMUNITY PSYCHIATRY 147 (1984).

148. See APA REPORT, *supra* note 6, at 6 (noting that a "significant proportion of the commitments was the result of negotiation between the patient's attorney and the judge, analogous to plea bargaining in criminal cases").

149. Stefan, *supra* note 5, at 290 ("Some judges and mental health professionals in North Carolina refuse to use preventive commitment because they perceive that it cannot be enforced effectively."); Hiday & Scheid-Cook, *Critical Appraisal*, *supra* note 11, at 218.

used also varies tremendously from county to county across North Carolina,¹⁵⁰ at least partly because it requires cooperation between independent entities, such as the community mental health clinic and the local sheriff's department. This relationship is clearly critical, and the quality of interaction varies considerably.¹⁵¹

In addition to the fact that preventive commitment is not used much, conclusions about its effect and effectiveness have been mixed.¹⁵² To be sure, many studies of preventive commitment in North Carolina have been optimistic.¹⁵³ In their 1987 study, for example, researchers concluded that "most OPC [preventive outpatient commitment] respondents had no dangerous behavior during the follow-up period after their OPC orders," that "results attest to the success of OPC in obtaining compliance with medication and treatment," and that "[w]hen respondents show up and begin treatment, OPC works in terms of keeping patients in treatment and on medication, increasing compliance, permitting residence outside an institution and social interaction outside the home, and maintaining patients in the community with few dangerous episodes."¹⁵⁴ In their 1990 study, these same researchers concluded that "close to half of these patients . . . never failed to show for their appointments without giving an acceptable excuse and rescheduling during the three months of their OPC."¹⁵⁵

In another 1990 study, researchers concluded that

[i]f the trend of sharp reductions in admission rates, coupled with less dramatic decreases in the number of inpatient days, is sustained by further research, one could then argue that patients clearly experience substantial reduction in admission rates after involuntary outpatient commitment, even though a few who are admitted after outpatient commitment remain in the hospital for lengthy periods. Regardless of that trend, both reductions were statistically significant. Clearly, even under the most conservative estimates for measuring institutionalization, the impact of involuntary outpatient commitment on the revolving-door syndrome is strong.¹⁵⁶

However, in her 1992 review of the empirical studies to date (studies of outpatient commitment in North Carolina, as well as the District of Columbia, Nebraska, Tennessee, New Mexico, and Arizona) Kathleen Maloy vigorously criticized the researchers' methodology and concluded that "these studies provide almost no valid empirical evidence in support of the effectiveness of

150. Swartz interview, *supra* note 10.

151. *Id.*

152. See generally MALOY, *supra* note 145.

153. Studies of North Carolina's outpatient commitment statutes (before the expansion of the substantive criteria) were also generally positive. See *id.* at 6-8. The American Psychiatric Association has also been optimistic, concluding that outpatient commitment (of any sort) is the best solution for "those with psychotic illnesses which respond well to antipsychotic medication, but who have a demonstrated pattern of noncompliance with medication after inpatient discharge," and "those patients who need externally imposed structure in order to function as outpatients but who are not capable of requesting the establishment of such structure on their own." APA REPORT, *supra* note 6, at 16.

154. See Hiday & Scheid-Cook, *Critical Appraisal*, *supra* note 11, at 224, 226, 229.

155. Hiday & Scheid-Cook, *Compliance*, *supra* note 140, at 87.

156. Fernandez & Nygard, *supra* note 124, at 1004.

[involuntary outpatient commitment] laws vis-à-vis treatment compliance, success in the community for people with severe and persistent mental illness, or amelioration of the problems associated with 'revolving door' patients."¹⁵⁷ Most of the empirical studies, she concludes, "have serious flaws in their study design and research methodology."¹⁵⁸ Thus, the jury is still out on the effectiveness of outpatient commitment.

C. Problems

The North Carolina scheme is noteworthy for its expansion of the state's power over a much broader portion of the population and for its failure to provide for supervision of mental health professionals. While preventive commitment orders are not "enforceable" in the sense that they envision forcible medication, and while they are not enforced by the legally available method of contempt, they do, practically speaking, place a great deal of unsupervised power in the hands of community mental health care providers. In particular, treatment options are left to the clinic by the assigning district court judge. Thus, noncompliance is usually handled at the clinic level, informally, and sometimes with threats of inpatient placement that is not actually an option under the statute, though the patient may not realize this. So while preventive commitment in North Carolina probably passes muster under the federal constitution, the question for policymakers and legislators must be broader than constitutionality.¹⁵⁹

Ordinarily, outpatient arrangements provide advantages to both the state and the families of mental health patients. From the point of view of the family, outpatient placement provides the advantages of state intervention (notably treatment and psychological coercion) without the disruption of hospitalization.¹⁶⁰ It also introduces the patient to the experience of living in the community in a nonpsychotic state¹⁶¹ (something rarely possible when he is a revolving door patient). And from the state's point of view, service in a community mental health clinic is considerably less expensive than inpatient hospitalization.¹⁶² But when the state's role expands with the use of more

157. MALOY, *supra* note 145, at 1. For example, she argues that the 1987 Hiday and Scheid-Cook study may not have had reliable controls, and may not have eliminated bias inherent in their process of selecting groups to study. *Id.* at 15-16. She writes: "one cannot conclude, as the authors did, that the results of their study indicate that outpatient commitment 'was successful.'" *Id.* at 16.

158. *Id.* at 22. For a more recent (but less critical) review of the research to date, see Marvin S. Swartz et al., *New Directions in Research on Involuntary Outpatient Commitment*, PSYCHIATRIC SERVICES (forthcoming 1995).

159. For a well-balanced review of the arguments for and against involuntary outpatient commitment (not preventive commitment *per se*), see Mulvey et al., *supra* note 144, at 571, 579 (acknowledging that treatment providers need to be monitored and discretion needs to be checked, and that an "absolutist stance that does not allow for any coercive element connected to the treatment of this group seems to preserve an ideal at the expense of human suffering").

160. McCafferty & Dooley, *supra* note 6, at 277-78.

161. Mulvey et al., *supra* note 144, at 578.

162. Stefan, *supra* note 5, at 288.

relaxed commitment criteria, these factors play out differently. To be sure, there is support for the expanded state role of preventive commitment from parent and family advocacy groups, as well as mental health patients ("consumers"),¹⁶³ because the state now provides treatment for persons who would otherwise be a burden at home and not be treated. But when it expands the number of persons under the umbrella of its civil commitment powers (in one form or the other), the state may not actually reduce its own expenses.¹⁶⁴ The state runs the risk of increasing the total number of involuntary committees at the expense, perhaps, of funding for involuntary inpatient facilities or of funding for voluntary committees.¹⁶⁵ In fact, to the extent that studies suggest inadequate resources at community mental health clinics and unequal funding across the state of North Carolina, the state may already face precisely this problem.

Another danger of this unchecked power is the specter of "social monitoring."¹⁶⁶ One group of researchers, for example, predicted in 1987 that "[i]f injections can be given and blood drawn, then arguments can be made from a treatment perspective for reviewing, programming, and monitoring situational aspects of a patient's life (for example, drinking behavior, peer associations, family life)."¹⁶⁷ This danger inheres, however, in the legislative decision to defer to the judgment of medical professionals. And to some extent, medical treatment might be "greatly enhanced when it can be directed broadly at several spheres of the patient's life, rather than myopically focused on intrapersonal dynamics or biologic underpinnings."¹⁶⁸ It is open to advocacy groups to point out abuse of this broad ranging power, and open to the legislature to revamp the statutes. None of the empirical studies suggests yet that such abuse is taking place.

V

CONCLUSION

While North Carolina's present preventive commitment scheme probably satisfies substantive due process, noncompliance problems have aroused the interest of reformers. One suggested reform has been a statutory option for

163. *Id.*; McCafferty & Dooley, *supra* note 6, at 277.

164. Indeed, a recent study concluded that a major factor contributing to compliance problems in North Carolina was a shortage of funding for Community Mental Health Clinics. Hiday & Scheid-Cook, *Compliance*, *supra* note 140, at 88.

165. See, e.g., Durham & LaFond, *supra* note 11, at 444 (noting that in Washington outpatient commitment increased the number of involuntary committees at the expense of voluntary committees); see also Hiday & Scheid-Cook, *Critical Appraisal*, *supra* note 11, at 230 (describing the tremendous variation in community mental health clinic knowledge, dedication, commitment, and resources); Seicshnaydre, *supra* note 12, at 1974-75 (noting concern that funding shortages lead to a "nonsystem" of community treatment, acknowledging the unmet treatment needs of mentally ill homeless).

166. Mulvey et al., *supra* note 144, at 575.

167. *Id.* at 576.

168. *Id.* at 578.

forcible medication of outpatients.¹⁶⁹ Without a doubt, such a provision would raise serious substantive due process concerns. Moreover, this suggestion, and the larger controversy over noncompliance, highlights the fundamental problem with the present scheme: While constitutional, it is unnecessarily and inappropriately coercive.

A. Forcible Medication and Substantive Due Process

The two most recent U.S. Supreme Court opinions on forcible medication, while not endorsing strict scrutiny of such provisions, suggest that a statutory option to medicate noncompliant outpatients forcibly would not satisfy due process. First, in *Washington v. Harper*,¹⁷⁰ despite noting that “forcible injection of medication into a nonconsenting person’s body represents a substantial interference with that person’s liberty,”¹⁷¹ the Court held that states may forcibly medicate a mentally ill inmate if the state establishes first that the inmate poses a danger to himself or to others and then that forcible medication is in his medical interests.¹⁷² The Court later recharacterized the *Harper* prongs as, first, an overriding justification, and, second, medical appropriateness.¹⁷³ Subsequently, in *Riggins v. Nevada*,¹⁷⁴ the Court held that forcible medication in the trial setting would require “at least” as much justification as it had in the setting of a prison inmate.¹⁷⁵ The language in *Riggins* could be construed as an endorsement of rigorous review; indeed, the dissent believed the Court had applied strict scrutiny.¹⁷⁶ However, it had not. While it wrote of “overriding justifications” and “less restrictive alternatives,” the Court was not establishing a constitutional *floor*. Justice O’Connor, writing for the Court, was quite clear on this point. By writing that “Nevada certainly would have satisfied due process” if it had found forcible medication medically appropriate and if, after considering less intrusive alternatives, it had found the procedure essential for the safety of the defendant (or of others), the Court declared what would be *sufficient* to satisfy due process not what would be *necessary*.¹⁷⁷ Thus, wrote the Court, “we have no occasion to finally prescribe such substantive standards as mentioned above.”¹⁷⁸

Critically, forcible medication of outpatients is as intrusive as forcible medication of inmates or inpatients; “forcible injection of medication into a nonconsenting person’s body”¹⁷⁹ is not less intrusive simply because the state’s

169. Swartz interview, *supra* note 10.

170. 494 U.S. 210 (1990).

171. *Id.* at 229.

172. *Id.* at 227.

173. *Riggins v. Nevada*, 504 U.S. 127, 135 (1992).

174. *Id.*

175. *Id.*

176. *Id.* at 156 (“The Court today, for instance, appears to adopt a standard of strict scrutiny.”).

177. *Id.* at 135-36.

178. *Id.* at 136.

179. *Washington v. Harper*, 494 U.S. 210, 229 (1990).

control of the person otherwise is less sweeping. Under *Harper* and *Riggins*, the state must articulate concerns about an imminent threat to the safety of the patient or of others, and it cannot do that when it is administering preventive medicine.

B. Implications of the Noncompliance Controversy

The empirical work on North Carolina's preventive commitment scheme¹⁸⁰ suggests that a forcible medication provision might not be the wisest approach and that the present scheme might be unnecessarily coercive.

Several factors suggest that forcible medication is exactly the wrong solution. First, noncompliance problems may only seem significant; quite possibly, noncompliance with outpatient orders is no more common than noncompliance with other treatment regimes.¹⁸¹ Second, coercive solutions may be inappropriate to the extent that a tendency to noncompliance is part of the disease itself.¹⁸² Third, experience has shown that noncoercive measures are quite effective in obtaining compliance. Clinicians are often successful when they use informal means, such as phone calls and letters, to induce compliance.¹⁸³ Finally, concerns about the detrimental effect of introducing adversarial processes and coercion into the therapeutic relationship suggest that a cooperative solution, such as community-based individualized case management, might be the better, and more humane, option.

While the practice and definition of "case management" vary nationwide, it offers the beneficial aspects of outpatient commitment (treatment in the community, in particular) without the introduction of a judicial hearing and court order. Roughly speaking, case management involves the following: detailed attention to the individual client; provision of services where the client is located (rather than in a clinic); a low staff-to-client ratio; frequency of services (even once a day); basic functions such as client outreach, service planning, and client advocacy; and more extended services viewed in the broader context of community resources, such as local libraries, friends, or the YMCA. Case management is also envisioned as an indefinite arrangement.¹⁸⁴

A five-year study presently underway in North Carolina may well prove that case management could adequately replace the present scheme. The Duke Mental Health Study, which will conclude in 1998, covers nine counties in the central part of the state (Chatham, Durham, Franklin, Granville, Guilford, Orange, Person, Vance, and Warren). Researchers are studying the relationship between the existence of a court order and compliance, and the effectiveness of

180. See *supra* text accompanying notes 146-58.

181. See *supra* text accompanying notes 128-29.

182. See *supra* text accompanying note 127.

183. See *supra* text accompanying notes 141-42.

184. Gail K. Robinson & Gail Toff-Bergman, *Choices in Case Management: Current Knowledge & Practice for Mental Health Programs* 5 (Mental Health Policy Resource Center 1990). For a thorough overview of case management practices, see generally *id.*

active case management at local community mental health centers as an alternative to court order. Specifically, they offered active case management to persons ordered to receive outpatient commitment. Fifty percent of the randomly selected participants were released from court order. The primary goal of the study is to examine whether court-ordered treatment has an effect over and above case management and optimal community treatment.¹⁸⁵

The Duke Mental Health Study should answer whether coercion is necessary in the care of revolving door patients. If, as the empirical evidence to date suggests will be the case, active case management adequately ensures compliance, then it may well be the remedy for problems inherent in requiring active compliance with a court order from a subset of the population inherently prone to passivity. In the meantime, reforms to strengthen the coercive nature of the present scheme are unwarranted. Any reforms pending the outcome of the Duke Mental Health Study should decrease coercion and emphasize cooperation. To the extent that the present scheme is already unnecessarily and inappropriately coercive, it may be constitutional, but from a public policy standpoint, it is a "bad idea."

185. See DUKE MENTAL HEALTH STUDY 13 (unpublished bound booklet available from the Duke University Medical Center Department of Psychiatry), which presents the issue as:

In a number of studies in N.C., OPC has been shown to be effective in reducing rates of rehospitalization and lengths of stay. However, by and large, those counties which use OPC tend to provide more aggressive treatment in general, and those counties which use little OPC generally provide less aggressive treatment. This raises an important question about the effectiveness of OPC over and above the effectiveness of community treatment. Does coerced outpatient treatment add anything once community-based treatment has been optimized?

