Refusing the Right to Refuse: Coerced Treatment of Mentally Disabled Persons

Grant H Morris
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Chapter 1

Refusing the Right to Refuse: An Introduction

The United Nations estimates that 852 million people worldwide are
undernourished,\(^1\) and the World Health Organization estimates that more than
3.7 million people die each year from malnutrition and other weight deficiency
problems.\(^2\) In contrast, the Surgeon General reports that overweight and obesity
“have reached epidemic proportions in the United States.”\(^3\) The Food and Drug
Administration reports that almost two-thirds (yes, two-thirds) of American
adults are overweight or obese.\(^4\) A major study tracking 4117 normal-weight

\(^1\) Food and Agriculture Organization of the United Nations, State of Food Insecurity in the World 2004, at 6,

\(^2\) Id. at 9. Additionally, deficiencies in iron, vitamin A, and zinc each
cased an additional 750,000 to 850,000 deaths. Id.

\(^3\) Office of the Surgeon General, U.S. Dep’t of Health & Human Services, The Surgeon General’s Call to Action to Prevent and
Decrease Overweight and Obesity 2001, at xiii (2001). See also Ali H. Mokdad et al., The Spread of the Obesity Epidemic in the United States, 1991-
1998, 282 JAMA 1519, 1520 (1999) (noting that obesity is a chronic condition
that has “spread with the speed and dispersion characteristic of a communicable
disease epidemic”).

\(^4\) Food and Drug Administration Obesity Working Group, Public
amost two-thirds of all Americans are overweight.”). The Surgeon General
estimated that in the year 1999, sixty-one percent of Americans were
overweight or obese. Office of the Surgeon General, supra note 3. In
contrast, in 1988 through 1992, less than fifty-six percent of American adults
were overweight or obese. Food and Drug Administration Obesity Working
Group, supra.

In a publication entitled F as in Fat: How Obesity Policies Are
Failing in America 2005, The Trust for America’s Health reported that
obesity rates continued to rise in 2004 in every state but Oregon, and asserted
adults over a thirty-year period found “that 9 of 10 young to middle-aged adults are likely to be or to develop overweight or more and that 1 of 2 individuals is likely to have or to develop obesity.” One might say, in the language of the street, fat is phat!

Overweight and obesity, however, are no joking matter. Citing epidemiological studies, the Surgeon General asserted that obese individuals “have a 50 to 100 percent increased risk of premature death from all causes compared to [nonobese] individuals . . . .” Overweight and obesity significantly increase a person’s risk of coronary heart disease, type II diabetes, various cancers, and certain musculoskeletal disorders.\(^6\)

When an overweight person, even a morbidly obese individual, orders a Monster Thickburger at Hardee’s—a burger containing 1410 calories, 107 grams of fat (including 45 grams of saturated fat), 229 milligrams of cholesterol, and


\(^{6}\)In a dictionary of slang expressions, the word “phat” is defined as “cool.” \textit{Urban Dictionary}, http://www.urbandictionary.com/define.php?term=phat (last visited Sept. 4, 2006).

\(^{7}\)Office of the Surgeon General, \textit{supra} note 3, at 8. The Surgeon General estimated that 300,000 American deaths each year are attributable to overweight and obesity, and asserted that “overweight and obesity may soon cause as much preventable disease and death as cigarette smoking.” \textit{Id.} at xiii. In the year 2000, the economic cost of treating the preventable diseases attributable to obesity was estimated to be $117 billion. \textit{Id.} at 10.

\(^{8}\)\textit{Id.} at 8. According to the epidemiological studies cited by the Surgeon General, even a modest weight gain of ten to twenty pounds increases a person’s risk of coronary heart disease 1.25 times in women and 1.6 times in men; a weight gain of eleven to eighteen pounds doubles a person’s risk of developing type II diabetes. \textit{Id.} According to the Centers for Disease Control’s National Diabetes Fact Sheet (for the year 2005), 20,800,000 people—i.e., seven percent of the population of the United States—have diabetes. Of that number, 6,200,000 are undiagnosed cases of diabetes. \textit{Centers for Disease Control \& Prevention, U.S. Dep’t of Health \& Human Services, National Diabetes Fact Sheet 3}(2005), http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2005.pdf.
2740 milligrams of sodium—does anyone interfere with that person’s decision to consume what Hardee’s hails as “a monument to decadence”? Of course not. After all, it’s a free country, and each of us can choose how we want to live our own lives. As former Chief Justice Burger once observed, the right to be let alone—to be free of government intrusion—is not limited only to those who hold sensible beliefs, valid thoughts, reasonable emotions, or well-founded sensations. The right extends to those who hold foolish, unreasonable, and even absurd ideas and who make decisions based on such beliefs.

9Hardee’s provides the “nutritional” breakdown of its Monster Thickburger on its website. Hardee’s, http://www.hardees.com/nutrition (select “Monster Thickburger” under “Quick Item View”). The Monster Thickburger consists of two one-third pound slabs of Angus beef, four strips of bacon, three slices of American cheese and mayonnaise on a buttered sesame seed bun.


Hardee’s, of course, is not alone in offering such “monuments” to its customers. The nutritional breakdown of the Country Sausage Bowl on Denny’s breakfast menu contains 1680 calories, 108 grams of fat (including 33 grams of saturated fat), 540 milligrams of cholesterol, and 3750 milligrams of sodium. Denny’s informs us that to this total, one needs to add the customer’s choice of fruit topping or syrup, and margarine. http://www.dennys.com/LiveImages/enProductImage_409.pdf. If the Denny’s customer waits until lunch—or returns for lunch—he or she may order mini-burgers (six) with onion rings, containing 2044 calories, 122 grams of fat (including 38 grams of saturated fat), 145 milligrams of cholesterol, and 3834 milligrams of sodium. Id.

11Application of President & Directors of Georgetown Coll., 331 F.2d 1010, 1017 (D.C. Cir. 1964) (Burger, J., dissenting) (discussing the opinion of Justice Brandeis in Olmstead v. United States, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting)).

12Georgetown Coll., 331 F.2d at 1017. Justice Burger specifically identified “refusing medical treatment at great risk” as an example of a foolish decision that should not be disturbed by government intervention. Id.
Suppose, however, that a doctor prescribes Zyprexa®\textsuperscript{13} to a mental patient to treat his or her schizophrenia. Will the doctor inform the patient that a fifteen to twenty-five pound weight gain is a common side effect of this medication\textsuperscript{14} and that such weight gain will significantly increase the patient’s risk for coronary heart disease, diabetes, and cancer? If the doctor does disclose this risk, and the patient refuses the medication, or if the patient takes the medication but wishes to discontinue its use after experiencing the unwanted weight gain, will the patient’s decision be accepted? Or will that decision be overruled by the patient’s doctor who believes that the medication’s benefit—controlling the patient’s psychotic symptoms—outweighs the detriment of the medication’s side effects—weight gain with concomitant increased risk for coronary heart disease, diabetes, and cancer? And if the issue is contested, will society uphold the doctor’s medical judgment over the patient’s right to decide? In other words, this book asks whether mental patients, especially involuntary mental patients, possess the same decisionmaking authority that nonmentally ill persons possess concerning their own bodies and their own health.

In Chapter 2, I discuss the right of any patient to decide whether to accept or reject proposed medical treatment under the common law doctrine of informed consent. In Chapter 3, I discuss the application of the informed consent doctrine, at least in theory, to involuntary mental patients who refuse treatment. Nevertheless, as I discuss in Chapters 4 through 7, the mental patient’s right to refuse has, in reality, been refused. Court decisions and legislation, influenced both by the medical profession’s desire to provide treatment to the mentally disordered unfettered by judicial oversight and by the economic cost to the state of detaining mentally disordered persons in hospitals

\textsuperscript{13}Zyprexa® is the Eli Lilly brand of the atypical antipsychotic medication olanzapine. PHYSICIANS’ DESK REFERENCE 1899 (59th ed. 2005).

\textsuperscript{14}Research reveals that the mean increase in weight gain for patients taking olanzapine for one year is 6.8 to 11.8 kilograms, that is, 15 to 26 pounds. Donna A. Wirshing & Jonathan M. Meyer, Obesity in Patients with Schizophrenia, in MEDICAL ILLNESS AND SCHIZOPHRENIA 35, 38 (Jonathan M. Meyer & Henry A. Nasrallah, ed. 2003) (citing studies). The authors also note that many patients gain more than twenty percent of their initial body weight in the first year of therapy. Id.
or treatment facilities when they refuse treatment, have so weakened the right to refuse treatment that in most situations medication may be administered over the mental patient’s objection. In Chapter 8, I explore other justifications for refusing the right to refuse that have recently emerged and explain why they should be rejected. Nevertheless, I conclude by suggesting that the continued viability of the mental patient’s right to refuse treatment is jeopardized by the current trend of public opinion, legislative activity, and judicial decisionmaking.
Chapter 2

The Common Law Basis for a Patient’s Right to Medical Self-Determination

A. Battery: The Requirement of Consent

It is an elementary principle of tort law that an intended harmful or offensive contact with another constitutes the tort of battery.\(^{15}\) This tort, the American Law Institute tells us, specifically protects the individual’s interest in freedom from harmful or offensive bodily contact.\(^{16}\) Battery, of course, is not a new tort. It has existed since the middle of the thirteenth century.\(^{17}\) Even at the time of its historic beginning, the mere touching of a person without consent was considered a breach of the King’s peace sufficient to justify a tort action for battery under the common law writ of trespass \textit{vi et armis}.\(^{18}\)

Surprisingly, more than six hundred years elapsed before the tort of battery was used to champion the patient’s right to medical self-determination. In \textit{Schloendorff v. Society of New York Hospital},\(^{19}\) Justice Benjamin Cardozo declared: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is

\(^{15}\) \textit{Restatement (Second) of Torts} §§13, 18 (1965).
\(^{16}\) Chapter 2 of the Restatement (Second) of Torts is entitled “Intentional Invasions of Interests in Personality,” and Topics 1 and 2 of that chapter are respectively entitled “The Interest in Freedom from Harmful Bodily Contact” and “The Interest in Freedom from Offensive Bodily Contact.” \textit{Id.} at 21.
\(^{18}\) \textit{Id.} at 50.
\(^{19}\) 105 N.E. 92 (N.Y. 1914).
liable in damages.”20 This early twentieth century quotation is often cited as the starting point for the law’s recognition of the patient’s right to control physician decisionmaking.21 In Schloendorff, and in two earlier twentieth century cases22 cited as authority by Justice Cardozo in Schloendorff,23 the patient either specifically prohibited any operation,24 or authorized an operation different than the one performed by the surgeon.25 Under such circumstances, it was easy for the courts to find that a battery had been committed. That tort protects the inviolability of one’s person, described by writers of the day as the first and greatest right of a free citizen, one that underlies all other rights.26 An operation

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20Id. at 93.


22Pratt v. Davis, 79 N.E. 562 (Ill. 1906); Mohr v. Williams, 104 N.W. 12 (Minn. 1905).

23Schloendorff, 105 N.E. at 93.

24Plaintiff consented to exploratory surgery only. While she was anesthetized, the surgeon removed a tumor in her stomach. Id.

25In Pratt, the husband of an incompetent woman consented to an operation for diseased conditions of her uterus and rectum. In a second operation performed without consent, the surgeon removed the wife’s ovaries and uterus. Pratt, 79 N.E. at 564. In Mohr, the patient consented to an operation on her right ear. While she was unconscious, the surgeon examined her left ear and performed surgery on the patient’s left ear. Mohr, 104 N.W. at 13.

26See Mohr, 104 N.W. at 14. As the United States Supreme Court noted in 1891: “No right is held more sacred, or is more carefully guarded, by the
performed without permission on an anesthetized patient\(^{27}\) violates the patient’s bodily integrity. The tort is committed by the unauthorized contact,\(^{28}\) no matter how medically appropriate the surgery and no matter how skillfully it is performed.\(^{29}\) Neither an intent to harm the patient, nor negligence in the operation itself, are required for the tort of battery, only knowledge that the contact is made without the patient’s consent.\(^{30}\) Actual physical harm to the patient is not a prerequisite for tort liability; battery is a dignitary tort, protecting individuals from offensive as well as harmful contact.\(^{31}\)

When a surgical operation, or any other medical treatment requiring

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\(^{27}\)Although the tort of battery can be committed on a patient who is not anesthetized, Jay Katz, M.D., suggested that the use of anesthesia in the early twentieth century concerned judges, such as Cardozo, who were unwilling to allow doctors to render their patients unconscious and then to operate on them without even informing them of what they intended to do. See Jay Katz, The Silent World of Doctor and Patient 62 (1984).

\(^{28}\)Restatement (Second) of Torts §18 cmt. d, illus. 1 (1965). In Mohr, the court noted that in an emergency when a patient is unconscious, the consent of the person is implied, and the surgeon may operate to preserve the patient’s life or health without further consent. The Mohr facts, however, did not involve a medical emergency. See Mohr, 104 N.W. at 15.

\(^{29}\)See Dan B. Dobbs, The Law of Torts 654 (2000) (“The wrong done is not a negligent operation but a failure to respect the patient’s right of choice.”); W. Page Keeton et al., Prosser and Keeton on the Law of Torts 190 (W. Page Keeton gen. ed., 5th ed. 1984) (asserting that if the patient was not adequately informed, the physician may be held liable for an adverse consequence even if the operation was skillfully performed).

\(^{30}\)Restatement (Second) of Torts §§ 16, 18 (1965). The intent required to commit the tort of battery is not the intent to make a harmful contact. The requisite intent is found if the actor “intends to bring about an offensive contact.” Id. § 16 cmt. a.

\(^{31}\)Id. §§ 16, 18. “[T]he essence of the plaintiff’s grievance consists in the offense to the dignity involved in the unpermitted and intentional invasion of the inviolability of his person and not in any physical harm done to his body . . . .” Id. § 18 cmt. c.
contact with the patient, is performed without any consent, the tort of battery is well-suited to protect the patient’s autonomy interest. Over the years, however, patients demanded more for their autonomy right. Self-determination meant more than simply accepting or rejecting the doctor’s decision; it meant the right for patients to decide for themselves. And to make that decision, patients needed information about the proposed treatment or surgery that only their doctors could provide to them. Responding to patient need, courts imposed upon physicians a duty to disclose the risks, benefits, and alternatives to the proposed procedure. Although courts could have incorporated this expanded disclosure duty within the tort of battery, requiring physicians to obtain not merely their patients’ consent but their “informed”\textsuperscript{32} consent to contact, courts chose instead to do so within the tort of negligence.\textsuperscript{33} The tort of battery—with its possibility of an award of punitive damages—was rejected by courts as too harsh for the typical case involving a physician’s failure to disclose risks and alternatives to the proposed procedure.\textsuperscript{34} Battery was...


\textsuperscript{33}See Dobbs, supra note 29, at 654 (2000) (asserting that most courts construe the patient’s informed consent claim as negligence, not battery); Keeton et al., supra note 29, at 190 (asserting that negligence has generally displaced battery as the tort used for informed consent claims).

\textsuperscript{34}See Marjorie Maguire Shultz, From Informed Consent to Patient Choice: A New Protected Interest, 95 YALE L.J. 219, 225 (1985) (asserting that courts rejected battery as an appropriate cause of action because “actions for battery . . . threatened to yield unacceptably harsh results.”). In choosing negligence instead of battery as the appropriate tort claim for failure of the physician to obtain the patient’s informed consent, courts focused on the surgeon’s good faith affirmative conduct in performing the unauthorized surgery or other medical treatment. Nevertheless, courts also claimed that the failure to disclose was not affirmative conduct that constitutes either an intentional act or a touching required for the tort of battery. In my opinion, the courts cannot have it both ways, relying on the surgery or other medical treatment to show the defendant’s good faith and ignoring the surgery or other medical treatment to find no intentional act or touching. The surgery or other medical treatment is intentionally performed, and it is a touching. The absence of plaintiff’s consent to that intentional touching properly characterizes the
relegated to cases in which the physician either operated on the patient or otherwise made contact with the patient’s body without obtaining any consent from the patient or cases in which the patient specifically declined the operation or contact.\textsuperscript{35}

\textbf{B. Negligence: The Requirement of Informed Consent}

The doctrine of informed consent imposes a duty on physicians to disclose to the patient the risks of and alternatives to the proposed treatment and to accept the patient’s decision to authorize or refuse that treatment. In \textit{Canterbury v. Spence},\textsuperscript{36} a leading case on the doctrine, the United States Court of Appeals for the District of Columbia Circuit declared: “[I]t is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie.”\textsuperscript{37} “In our view,” wrote the court, “the patient’s right of self-decision shapes the boundaries of the duty to reveal.”\textsuperscript{38} The adequacy of the physician’s disclosures to the patient “must be measured by the patient’s need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient’s decision: all risks potentially affecting the decision must be

\textsuperscript{35}See Cobbs v. Grant, 502 P.2d 1, 7-8 (Cal. 1972) (holding that battery is appropriate only when the doctor obtains consent to one type of treatment but performs another). \textit{But see} Gouse v. Cassel, 615 A.2d 331 (Pa. 1992) (holding that informed consent is included within the scope of consent). The Pennsylvania Supreme Court stated: “Lack of informed consent is the legal equivalent to no consent; thus, the physician or surgeon who operates without his patient’s informed consent is liable for damages which occur, notwithstanding the care exercised.” \textit{Id.} at 334. To prevent the physician from being held liable for insignificant risks that were not disclosed, the court departed from a traditional battery analysis by limiting the physician’s disclosure obligation to “those material facts, risks, complications and alternatives to surgery that a reasonable person in the patient’s situation would consider significant in deciding whether to have the operation.” \textit{Id.}

\textsuperscript{36}464 F.2d 772 (D.C. Cir. 1972).

\textsuperscript{37}\textit{Id.} at 781.

\textsuperscript{38}\textit{Id.} at 786.
unmasked."\(^39\) Other courts articulated the patient’s right to medical self-determination in similar terms. The California Supreme Court, for example, declared:

Unlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected. . . . The weighing of [the] risks [inherent in the procedure and the risks of a decision not to undergo the treatment] against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgment reserved to the patient alone.\(^40\)

\(^{39}\) *Id.* at 786-87 (footnote omitted).

\(^{40}\) Cobbs v. Grant, 502 P.2d 1, 10 (Cal. 1972). Although courts now use the tort of negligence to protect the patient’s right to medical self-determination, that tort deflects the courts’ attention from the conduct of the doctor, i.e., did he or she wrongfully deprive the patient of the right to decide what shall be done with his or her body, to the narrow issue of whether the patient’s body was injured by a breach of that duty. *See* Joseph Goldstein, *For Harold Lasswell: Some Reflections on Human Dignity, Entrapment, Informed Consent, and the Plea Bargain*, 84 *YALE L.J.* 683, 685-86, 690-91 (1975) (suggesting that the attention of decisionmakers should be focused on the conduct of the doctor, not on the state of mind of the patient). In the typical case, the patient undergoes surgery that produces an injurious result and claims that he or she would have rejected the proposed surgery if the undisclosed information about risks and alternatives had been revealed. *See generally* Grant H. Morris, *Dissing Disclosure: Just What the Doctor Ordered*, 44 *ARIZ. L. REV.* 313, 317-43 (2002) (explaining why the torts of battery and negligence fail to adequately protect a patient’s right to medical self-determination). Several authors have proposed that the patient’s dignitary interest in medical self-determination should no longer be viewed through the myopic lenses of battery and negligence. They assert that a new tort is needed to replace the doctrine of informed consent, a tort that would truly value the patient’s right to informed decisionmaking. *See, e.g.*, Alexander Morgan Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 *U. PA. L. REV.* 340, 350, 404 (1974) (proposing that breach of the physician’s disclosure duty should be reconstituted as a new tort, “with its own rules of conduct, causation, and damages.” The new tort would be “a hybrid of negligence and battery theories that is controlled by its own logic and is not confined by the rules which attach
Courts, however, recognize exceptions to patient autonomous judgment. If, for example, the patient is unconscious or in such pain that he or she is incapable of considering information about the proposed treatment or making a decision as to whether to consent, and if treatment is immediately necessary to prevent either death or a serious injury to the patient, the physician is privileged to proceed in order to prevent that disastrous consequence.41 In this emergency situation, the law presumes, in the absence of information to the contrary, that the patient would consent to treatment.42 As the Canterbury court stated, the emergency exception to the requirement of informed consent to either of its parent causes of action.

See Alan Meisel, The “Exceptions” to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking, 1979 Wis. L. Rev. 413, 434-38 (discussing the emergency exception).

Meisel notes that the patient’s implied consent to emergency treatment is premised on the presumption that a reasonable person would consent to emergency treatment and therefore that this patient would also consent. Id. at 434. Meisel suggests that such reasoning is “not so much a rationale as it is a restatement of the exception.” Id.
comes into play when the patient is unconscious or otherwise incapable of consenting, and harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment. When a genuine emergency of that sort arises, it is settled that the impracticality of conferring with the patient dispenses with need for it.\footnote{Canterbury, 464 F.2d at 788-89.}

In deciding whether a situation constitutes an emergency, courts consider whether an urgent need exists for immediate medical care to prevent the threatened harm.\footnote{Meisel, supra note 41, at 437.} Although, typically, the threatened harm is death or serious injury to the patient, in some cases—for example, a patient infected with a highly contagious and deadly disease—the qualifying harm may be to other persons.\footnote{Id. Typically, however, if a person was infected with a highly contagious disease, the remedy was to isolate the individual from society, so that he or she would not infect others. In the early twentieth century, for example, a person with tuberculosis was placed in a sanitarium. The only treatment he or she was required to accept was milk, fresh air, and sunlight. See, e.g., Evelyn Boswell, Fear Led to Montana’s Sanitarium for TB Patients, MSU U. News, Jan. 6, 2002, http://www.montana.edu/news/1041734340.html.}

Even in nonemergency situations, courts recognize an exception to the informed consent requirement for incompetent persons.\footnote{Id. Even in no emergency situations, courts recognize an exception to the informed consent requirement for incompetent persons. If an individual has been adjudicated incompetent and a guardian has been appointed to make personal decisions for that individual, the guardian may give informed consent to medical treatment as the incompetent ward’s substitute decisionmaker. Even without a court adjudication of incompetence, minor children are conclusively presumed to be incompetent, and their parents, as their legal guardians, may do so.}

\footnote{43 Canterbury, 464 F.2d at 788-89.}
\footnote{44 Meisel, supra note 41, at 437.}
\footnote{45 Id.}
\footnote{46 See Meisel, supra note 41, at 439-53 (discussing the incompetency exception).}
\footnote{47 Traditionally, a guardian is appointed for either the person or the estate of the incompetent person. A guardian of the person is authorized to make personal decisions for the incompetent person, including providing for basic necessities of life, such as food, clothing, and housing as well as deciding whether to consent to medical treatment. A guardian of the estate is authorized to make decisions concerning the property of the incompetent person. Sometimes a guardian is appointed for both the person and the estate of the incompetent person.}
give informed consent to medical treatment for them.\textsuperscript{48} Courts have also recognized a therapeutic exception to the duty to disclose.\textsuperscript{49} If the disclosure would harm the patient, the physician is not required to inflict such harm by making the disclosure. As explained by the California Supreme Court, the therapeutic privilege may be invoked if “the disclosure would . . . so seriously upset the patient that the patient would not [be] able to dispassionately weigh the risks of refusing to undergo the recommended treatment.”\textsuperscript{50} The court cited as an example the difficulty of informing a dying patient.\textsuperscript{51} Similarly, the \textit{Canterbury} court stated that a physician may withhold information if the patient would “become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient.”\textsuperscript{52} The \textit{Canterbury} court cautioned, however, that the therapeutic privilege must be “carefully circumscribed” so that it does not “devour the disclosure rule itself.”\textsuperscript{53} The court specifically rejected the paternalistic notion that the physician may avoid disclosure simply because he or she thinks that the patient, upon such disclosure, might reject the proposed treatment that the physician believes is medically needed.\textsuperscript{54}

\footnotesize
\textsuperscript{48} \textit{See}, e.g., \textit{Cobbs v. Grant}, 502 P.2d 1, 10 (Cal. 1972) (declaring that if the patient is a minor, “the authority to consent is transferred to the patient’s legal guardian”).
\textsuperscript{49} \textit{See} Meisel, \textit{supra} note 41, at 460-70.
\textsuperscript{50} \textit{Cobbs}, 502 P.2d at 12.
\textsuperscript{51} \textit{Id}.
\textsuperscript{53} \textit{Id}. Alan Meisel, in his definitive study of the exceptions to the informed consent doctrine, expressed concern that “[t]he danger that the therapeutic privilege poses to self-determination in medical decisionmaking is so great that we should seriously consider its abolition.” Meisel, \textit{supra} note 41, at 467. Meisel urged that the therapeutic privilege exception should be eliminated. \textit{Id}. at 467-70.
\textsuperscript{54} \textit{Canterbury}, 464 F.2d at 789.
Chapter 3

The Mental Patient’s Right to Medical Self-Determination

The first court decision to fully recognize a mental patient’s right to medical self-determination was *Rogers v. Okin*, decided by a federal district court in 1979. During the seventy-two-day trial, more than fifty witnesses—most of whom were psychiatrists, psychologists or other professionals—testified. The trial transcript was over 8000 pages in length and post-trial briefs numbered over 2300 pages. District Judge Joseph Tauro ruled that involuntarily confined mental patients—just as any other patients—have a right to make decisions about their treatment and may not be forcibly medicated. Just as with other patients, this right is not absolute, and the patient’s informed consent is not required in an emergency or if the patient is incompetent.

The judge narrowly defined an emergency as “circumstances in which a failure to [medicate] would bring about a substantial likelihood of physical harm to the patient or others.” If no emergency exists justifying treatment, the involuntarily committed mental patient—just as any other patient—has a right to make his or her own analysis of the risks and benefits of, and alternatives to the proposed treatment that the physician is required to communicate to the patient, and to make his or her own decision to accept or reject that treatment.

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56 478 F. Supp. at 1353.

57 Id. at 1366.

58 Id. at 1371.

59 Id.

60 Id. at 1367. Judge Tauro noted that establishing a therapeutic alliance between psychiatrist and patient is fundamental for successful treatment. Such
physician may disagree with the patient’s decision to refuse treatment—the physician may believe the patient’s analysis is “wrong” and that the patient is making a “bad” decision—but the patient’s decision, if competently made, must be accepted. The state’s legitimate interest in protecting the public from dangerous mentally ill persons has been achieved through the involuntary commitment decision—the patient has been quarantined by his or her placement in the hospital. If no emergency exists in the hospital, involuntary treatment of the patient can not be justified by danger to the hospital community.\textsuperscript{61}

The judge refused to equate the decision to involuntarily commit a person with an adjudication of incompetence.\textsuperscript{62}

The weight of evidence persuades this court that, although committed mental patients do suffer at least some impairment of their relationship to reality, most are able to appreciate the benefits, risks, and discomfort that may reasonably be expected from receiving psychotropic medication. This is particularly true for patients who have experienced such medication and, therefore, have some basis for assessing comparative advantages and disadvantages.\textsuperscript{63}

The presumption that the patient is competent to make medication decisions prevails, said the court, unless the patient has been adjudicated incompetent by an alliance requires the patient to understand and willingly accept the prescribed treatment. \textit{Id.} at 1361. The judge noted that the American Psychiatric Association accepts the requirement that informed consent for treatment be obtained from the mental patient except in emergency situations. \textit{Id.} at 1370, n.37 (citing American Psychiatric Association Task Force on the Right to Treatment, 134 \textit{Am. J. Psychiatry} 3 (Mar. 1977)). The quoted material from the American Psychiatric Association Task Force is actually located at 134 \textit{Am. J. Psychiatry} 354, 355 (Mar. 1977).

\textsuperscript{61}\textit{Id.} at 1369.

\textsuperscript{62}\textit{Id.} at 1359. In so ruling, the judge relied on a Department of Mental Health regulation, codified in substance in a state statute, which provides that no person admitted to or committed to a mental health facility shall lose the right to manage his or her affairs, to contract, to hold a driver’s license, to make a will, to marry, to hold or convey property, or to vote except if the person has been adjudicated incompetent. \textit{Id. See} \textit{Mass. Gen. Laws Ann.} ch. 123, § 24 (West 2003).

\textsuperscript{63}Rogers v. Okin, 478 F. Supp. at 1361.
a court after a hearing on that issue.\textsuperscript{64} Although the state has an obligation to make treatment available to involuntary patients, the state’s interest in providing that treatment does not override the competent patient’s fundamental right to refuse treatment in nonemergency situations.\textsuperscript{65}

Even if a patient is adjudicated incompetent, the hospital is not automatically authorized to impose treatment over the patient’s objection. The patient, whether competent or not, has a right to be free from unwarranted governmental intrusion into fundamentally personal matters—including medication decisions.\textsuperscript{66} Therefore, a guardian appointed for an incompetent patient protects that freedom by acting in the place of the patient, i.e., deciding whether to accept or refuse treatment as the patient would have decided if the patient was competent to make the decision. The guardian does not act as a third person, i.e., deciding whether treatment is in the patient’s best interest.\textsuperscript{67}

Judge Tauro rejected the therapeutic exception to informed consent. Even if disclosure of potential side effects of medication might frighten the patient and therefore might be considered as “not in the patient’s best interest,” failure to provide the patient with sufficient information to make an informed treatment decision is not justified.\textsuperscript{68}

In reaching his judgment, Judge Tauro relied upon two constitutional rights. The right of a competent mental patient to accept or refuse psychotropic medication in nonemergency situations is protected by the patient’s right to

\textsuperscript{64} Id. The court scoffed at the defendant’s argument that a person who was statutorily presumed to be competent to manage his or her affairs and dispose of his or her property might not be presumed competent to decide whether to follow his or her doctor’s advice regarding medication. “Such an argument would make a doubter of even the most credulous.” Id. at 1361 n.12. Although the rights to hold and dispose of one’s property are fundamental to any concept of ordered liberty, such rights “pale in comparison to the intimate decision as to whether to accept or refuse psychotropic medication—medication that may or may not make the patient better, and that may or may not cause unpleasant and unwanted side effects.” Id. at 1366.

\textsuperscript{65} Id. at 1367, 1370.

\textsuperscript{66} Id. at 1362 (citing Eisenstadt v. Baird, 405 U.S. 438, 453 (1972)).

\textsuperscript{67} See id.

\textsuperscript{68} Id. at 1387.
An individual’s right to prohibit an unwanted infringement of his or her bodily integrity is fundamental to ordered liberty, more so, said the court, than the right to own and dispose of property.\textsuperscript{60} Forced medication of competent mental patients in nonemergency situations also violates the First Amendment’s protection of the individual’s ability to produce ideas.\textsuperscript{71} Even if treatment with psychotropic medication is medically indicated, such treatment may affect a patient’s mood, attitude, and capacity to think.\textsuperscript{72} Involuntary mind control is not a power granted to the government, absent extraordinary circumstances.\textsuperscript{73}

Following Judge Tauro’s decision, the Rogers case experienced a legal odyssey. The United States Court of Appeals for the First Circuit affirmed the judgment in part and reversed in part;\textsuperscript{74} the United States Supreme Court reversed and remanded to the First Circuit for a determination of whether a case decided by the Massachusetts Supreme Judicial Court\textsuperscript{75} while certiorari was pending in Rogers could determine the rights and duties of the parties entirely under state law.\textsuperscript{76} The First Circuit certified nine questions of state law to the Massachusetts Supreme Judicial Court.\textsuperscript{77} The Massachusetts court provided

\textsuperscript{60}Id. at 1366.
\textsuperscript{70}Id. See supra note 64.
\textsuperscript{71}Rogers v. Okin, 478 F. Supp. at 1367.
\textsuperscript{72}Id. at 1366.
\textsuperscript{73}Id. at 1367.
\textsuperscript{75}In re Guardianship of Roe, 421 N.E.2d 40 (Mass. 1981). In Roe, the Massachusetts Supreme Judicial Court upheld the right of a noninstitutionalized, mentally incompetent person to refuse antipsychotic medication absent an emergency. Id. at 51-52. Further, the court required that any nonemergency judgment to accept treatment must be made by a judge, not by the guardian of the person. Id. The judge’s “substituted judgment” must consider the subjective values and preferences of the ward. Id. at 56. The court identified various factors that must be considered by the judge in making the substituted judgment so that the judge’s decision approximates the decision that would have been made by the incompetent person. Id. at 56-59.
\textsuperscript{76}Mills v. Rogers, 457 U.S. 291, 305-06 (1982).
\textsuperscript{77}See Rogers v. Okin, 738 F.2d 1, 3 (1st Cir. 1984).
detailed answers, and the First Circuit, relying on those answers, held that Massachusetts recognized substantive and procedural rights for involuntary mental patients that created for them a liberty interest protected under the Fourteenth Amendment’s Due Process Clause.

Under Massachusetts law, as articulated by the Supreme Judicial Court of Massachusetts, the involuntary commitment decision is not a determination that the committed person’s is incompetent to make treatment decisions. The patient retains the right to make treatment decisions unless and until a judge adjudicates the patient incompetent to make treatment decisions in proceedings to establish the patient’s incompetence. Even if the patient is adjudicated incompetent, treatment may not be imposed unless a judge, making a substituted judgment decision for the patient, decides that the patient would have consented to the treatment if he or she were competent to make the decision.

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78 Rogers v. Comm’r of Dep’t of Mental Health, 458 N.E.2d 308, 310-11, 322-23 (Mass. 1983). The questions certified by the First Circuit to the Massachusetts Supreme Court and answered by that court appear at Rogers, 458 N.E.2d at 312 n.8 (questions 1-3), 315 n.13 (questions 4 & 5), 319 n.23 (questions 6 & 7), 322 n.27 (questions 8 & 9).

79 Rogers, 738 F.2d at 9. The First Circuit concluded that “the full panoply of rights set forth [by the Massachusetts Supreme Judicial Court] equal or exceed the rights provided in the federal Constitution.” Id.

80 Rogers, 458 N.E.2d at 312-14. The court noted that the standard for involuntary commitment, i.e., that the person is mentally ill and that the failure to commit would create a likelihood of serious harm, is a commitment “for public safety purposes and does not reflect lack of judgmental capacity. [The commitment standard] says nothing concerning [the patient’s] competence to make treatment decisions.” Id. at 313.

81 Id. at 314. The court rejected the argument that doctors should be able to make treatment decisions for involuntarily committed mental patients, even if such patients are competent. Competent adults have the right to refuse treatment even if the medical profession views their sense of values as unwise. Id. (quoting Harnish v. Children’s Hosp. Med. Ctr., 439 N.E.2d 240, 242 (Mass. 1982)). The right to refuse treatment has constitutional and common law origins that protect the individual’s “strong interest in being free from nonconsensual invasion of his bodily integrity.” Id. (quoting Superintendent of Belchertown State School v. Saimkewicz, 370 N.E.2d 417, 424 (Mass. 1977).
decision. The state’s *parens patriae* power may be used to override a patient’s refusal of medication only in those rare circumstances in which such medication is necessary to prevent the “immediate, substantial, and irreversible deterioration of a serious mental illness.” The state’s police power may be used to override a patient’s refusal of medication only in an emergency situation in which the “patient poses an imminent threat of harm to himself or others, and only if there is no less intrusive alternative to antipsychotic drugs.”

In many states, the highest appellate court has adopted right to refuse treatment principles substantially identical to those announced in the *Rogers* case by Judge Tauro in his 1979 District Court decision or by the Supreme Judicial Court of Massachusetts four years later. Some, such as the Colorado Supreme Court decision rendered two weeks before Judge Tauro’s decision, rely on the patient’s common law right to give or withhold informed consent to medical treatment and a statute, commonly found in many states, declaring that mental patients do not forfeit any legal rights solely by reason of their involuntary commitment. Six years later, the Colorado Supreme Court, citing

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82 *Id.* at 315-16. According to the court, the right to refuse medical treatment extends to incompetent as well as competent patients because both are entitled to human dignity. *Id.* at 315 (quoting *Saikewicz*, 370 N.E.2d at 427). The court rejected decisionmaking determined by what doctors perceive as the patient’s best medical interest. Because the patient bears the risks of treatment, treatment decisions are solely the prerogative of the patient—even for incompetent patients. *Id.* at 316.

Although the judge makes the original substituted judgment treatment decision for the patient, the judge may delegate the power to monitor the treatment process to the patient’s guardian. The guardian is responsible for ensuring that the substituted judgment treatment plan, which must be approved by the judge, is followed. *Id.* at 318.

83 *Id.* at 322 (quoting *In re Guardianship of Roe*, 421 N.E.2d 40, 55 (Mass. 1981)). In *Roe*, the court added that when such an emergency situation arises, “even the smallest of avoidable delays would be intolerable.” *Roe*, 421 N.E.2d at 55.

84 *Rogers*, 458 N.E.2d at 321.

85 *Goedecke v. State*, 603 P.2d 123, 125 (Colo. 1979). The court specifically stated that because Colorado law protects involuntarily committed mental patients from forced medication, “we need not reach the constitutional issues raised.” *Id.* at 124.
the Supreme Judicial Court of Massachusetts’ decision in Rogers, specifically extended the prohibition against forced treatment to incompetent mental patients. Even if an involuntarily committed mental patient is determined to be incompetent, that patient does not lose the right to refuse treatment unless the judge, after conducting a separate inquiry into the patient’s capacity to make an informed treatment decision, determines that the patient’s refusal lacks any reasonable basis in fact and that “the proposed treatment is necessary either to prevent a significant and likely long-term deterioration in the patient’s mental condition or to prevent the likelihood of the patient’s causing serious harm to himself or others in the institution.”

Some courts, such as the Supreme Court of Oklahoma, rely on the constitutional right to privacy, also relied upon by Judge Tauro, to uphold an involuntary mental patient’s right to refuse treatment. As that court noted, the decision to impose treatment on a patient is not a medical decision. “Physicians are not legislators. . . . [I]n a society ruled by laws, social actions that infringe or control individual freedoms must be judged by legal standards.”

The Supreme Court of Minnesota ruled that the involuntary administration of psychotropic medication is “intrusive” treatment that seriously infringes upon the mental patient’s right to privacy protected by the state constitution.

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86 People v. Medina, 705 P.2d 961, 971 (Colo. 1985).
87 Id.
88 At the treatment refusal hearing: (1) the patient is entitled to the benefit of counsel, including court-appointed counsel if the patient is indigent, (2) the patient must be accorded the right to cross-examine adverse witnesses and to present evidence to support his or her refusal, and (3) the physician seeking to administer nonconsensual treatment must prove by clear and convincing evidence a justification for the administration of such treatment. Id. at 972.
89 Id. at 970 n.5.
90 Id. at 973.
91 In re K.K.B., 609 P.2d 747, 749, 751 (Okla. 1980). The Oklahoma Supreme Court specifically cited and discussed Judge Tauro’s opinion in Rogers. Id. at 751 (citing Rogers, 478 F. Supp. 1342 (D. Mass. 1979)). See supra text accompanying notes 69-70.
92 In re K.K.B., 609 P.2d at 751.
93 Jarvis v. Levine, 418 N.W.2d 139, 144-45 (Minn. 1988).
Involuntary commitment does not eliminate this fundamental right to the integrity of one’s own body and to consent–or withhold consent–to invasions or alterations of one’s own body.94 Competent, though involuntarily committed patients possess the same right to refuse intrusive treatment as possessed by other patients in a free and open society. “To deny mentally ill individuals the opportunity to exercise that right is to deprive them of basic human dignity by denying their personal autonomy.”95 Even if a court finds that the patient is legally incompetent, forced medication is not warranted unless the court also determines that treatment is necessary and reasonable.96

The Wisconsin Supreme Court relied on the Equal Protection Clause of the state and federal constitutions to uphold an involuntary mental patient’s right to refuse treatment.97 The court found beyond a reasonable doubt that no rational basis existed for the Wisconsin legislature to grant the right to give or withhold informed consent to precommitment detainees but to deny that same right to involuntarily committed individuals.98 Although a finding of dangerousness is a prerequisite for involuntary commitment, that finding does not establish the incompetence of the patient to accept or refuse psychotropic medication.99 Merely because the person’s detention is involuntary does not mean that he or she is incapable of accepting treatment voluntarily that may lead to release from confinement.100 Under Wisconsin law, involuntary

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94Id. at 148.
95Id.
96Id. n.7.
97State ex rel. Jones v. Gerhardstein, 416 N.W.2d 883, 892-93 (Wis. 1987) (superceded by repeal of statute and subsequent legislation). The Fourteenth Amendment to the United States Constitution provides that no state shall “deny to any person within its jurisdiction the equal protection of the laws.” U.S. CONST. amend. XIV, § 1. The Wisconsin Constitution begins with the following declaration of rights: “All people are born equally free and independent, and have certain inherent rights; among these are life, liberty and the pursuit of happiness . . . .” Wis. STAT. CONST. art. 1, § 1.
98Gerhardstein, 416 N.W.2d at 892-93.
99Id. at 894. The court noted that no corollary exists between dangerousness and mental incompetence to make treatment decisions. Id. at 895.
100Id. at 894.
commitment does not result in a mental patient’s loss of the right to manage his or her affairs, to hold professional, occupational, and motor vehicle operator’s licenses, to marry or divorce, to vote, to make a will or to exercise any other civil right. To deny involuntary patients the right to refuse treatment without a judicial determination of incompetence is arbitrary and unreasonable.

Although the Wisconsin Supreme Court based its equal protection decision on an impermissible distinction drawn by a statute between precommitment detainees and involuntarily committed individuals, the court also suggested that a broader equal protection analysis might be appropriate. The court intimated that competent mental patients have the same right to autonomous decisionmaking—i.e., the right to give or to withhold informed consent—that all other patients possess. The court noted that “outside the field of mental competency” the doctrine of informed consent has developed to recognize the patient’s right to make decisions on whether to accept or reject treatment.

Medical doctors advise the patient on available alternative courses of treatment, but it is the patient who ultimately consents to the treatment. As long as a person is competent to make such choices which do not affect others, then that individual should be allowed to decide whether to receive such a drastic form of treatment. Although, historically, mental patients were generally presumed to be legally incompetent for all purposes, the court declared, “This presumption of incompetency has been reversed.”

Surprisingly, courts have not used an equal protection analysis to equate

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102 Gerhardstein, 416 N.W.2d at 895. The equal protection guarantee that all competent individuals are entitled to make treatment decisions “may not be replaced by professional judgment, and their protection and enforcement cannot be considered to be judicial interference.” Id. at 896.
103 The court also found a similar disparity between the law’s handling of voluntary patients and involuntary patients. The court ruled that the presumption of competence, which is extended to both precommitment detainees and voluntary patients, “cannot be denied to involuntarily committed individuals.” Id. at 895.
104 Id.
105 Id.
106 Id.
In his treatise, Michael Perlin asserted that the Gerhardstein case is of special significance because the Wisconsin Supreme Court relied on the “rarely used” equal protection clause. 2 Michael L. Perlin, Mental Disability Law—Civil and Criminal 280 (2d ed. 1999). Neither the treatise, or the 2004 supplement to the treatise, cites a case since Gerhardstein that uses an equal protection analysis. It should be noted that the Gerhardstein decision, with its narrowly focused equal protection distinction between precommitment detainees and involuntarily committed individuals, was superceded when the statute interpreted in the court’s decision was repealed and legislation was subsequently enacted that addressed post-commitment rights of patients. See State v. Anthony D.B., 614 N.W.2d 435, 439 (Wis. 2000) (noting that the statute interpreted in Gerhardstein was repealed and recreated and that separate involuntary medication laws were subsequently enacted for precommitment detainees and for other involuntarily committed individuals). A broader equal protection analysis equating mental patients with other, nonmental patients would not have suffered a similar fate.

The American Psychiatric Association admits that the term “mental disorder” unfortunately implies a distinction between ‘mental’ disorders and ‘physical’ disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much ‘physical’ in ‘mental’ disorders and much ‘mental’ in ‘physical’ disorders.”108 As with physical illnesses, physicians

107 In his treatise, Michael Perlin asserted that the Gerhardstein case is of special significance because the Wisconsin Supreme Court relied on the “rarely used” equal protection clause. 2 Michael L. Perlin, Mental Disability Law—Civil and Criminal 280 (2d ed. 1999). Neither the treatise, or the 2004 supplement to the treatise, cites a case since Gerhardstein that uses an equal protection analysis. It should be noted that the Gerhardstein decision, with its narrowly focused equal protection distinction between precommitment detainees and involuntarily committed individuals, was superceded when the statute interpreted in the court’s decision was repealed and legislation was subsequently enacted that addressed post-commitment rights of patients. See State v. Anthony D.B., 614 N.W.2d 435, 439 (Wis. 2000) (noting that the statute interpreted in Gerhardstein was repealed and recreated and that separate involuntary medication laws were subsequently enacted for precommitment detainees and for other involuntarily committed individuals). A broader equal protection analysis equating mental patients with other, nonmental patients would not have suffered a similar fate.

108 American Psychiatric Ass’n, Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) xxx (4th ed. Text Revision 2000) (emphasis in original). The American Psychiatric Association admits that the term “mental disorder” persists “because we have not found an appropriate substitute.” Id. Schizophrenia, for example, is characterized today as a brain-based illness. See Douglas Mossman, Unbuckling the “Chemical Straitjacket”: The Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis, 39 San Diego L. Rev. 1033, 1048 (2002) (“By the end of the twentieth century, scientific evidence had shown overwhelmingly that schizophrenia was a brain-based illness . . . .”). Mossman also noted that psychiatrists’ and psychologists’ current theories about schizophrenia “all share the view that schizophrenia is not fundamentally a syndrome of irrational perceptions, beliefs, or actions.” Id. at 1058. The core pathological process that scientists are currently investigating is “malfunctioning brain circuitry” rather than impairments in thinking, behavior,
(psychiatrists) use a medical model to classify and diagnose mental disorders and prescribe medication to treat mental disorders. Although the standard manual used by psychiatrists to diagnose mental disorders distinguishes between the terms “mental disorder” and “general medical condition,” the American Psychiatric Association cautioned:

[T]hese are merely terms of convenience and should not be taken to imply that there is any fundamental distinction between mental disorders and general medical conditions, that mental disorders are unrelated to physical or biological factors or processes, or that general medical conditions are unrelated to behavioral or psychosocial factors or processes.\(^{109}\)

Some courts, such as the New York Court of Appeals, rely on the state constitution’s due process clause to uphold an involuntary mental patient’s right to refuse treatment.\(^{111}\) In Rivers v. Katz, the court, quoting Justice Cardozo’s statement in the Schloendorff case decided by that same court seventy-two years earlier,\(^{112}\) held that the fundamental common law right of a competent individual to make decisions concerning his or her own body “is coextensive with the patient’s liberty interest protected by the due process clause of our State Constitution.”\(^{113}\) “This right,” said the court, “extends equally to mentally ill persons who are not to be treated as persons of lesser status or dignity because of their illness.”\(^{114}\) Neither the presence of mental illness nor a

\(^{109}\)See generally American Psychiatric Ass’n, supra note 108 (providing an official nomenclature for the classification of mental disorders in the United States). By definition, individuals with mental disorder suffer “distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning)” or have “a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.” Id. at xxxi.


\(^{112}\)“It is a firmly established principle of the common law of New York that every individual ‘of adult years and sound mind has a right to determine what shall be done with his own body’ . . . .” Id. (quoting Schloendorff v. Soc’y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914)). See supra text at notes 19-21.

\(^{113}\)Rivers, 495 N.E.2d at 341.

\(^{114}\)Id. (citation omitted).
decision to involuntarily commit the mentally ill person is sufficient, in and of itself, to conclude that the person lacks the mental capacity to comprehend the consequences of a decision to refuse medication.\textsuperscript{115}

This ruling is particularly significant because involuntary civil commitment in New York requires proof by clear and convincing evidence\textsuperscript{116} that care and treatment in a hospital is essential to the person’s welfare and that the person’s judgment is so impaired that he or she is unable to understand the need for such care and treatment.\textsuperscript{117} Despite the impaired judgment criterion for commitment, the Rivers court required a judicial determination of the patient’s incapacity to make a reasoned decision regarding the proposed treatment before the state may exercise its \textit{parens patriae} power to impose treatment over the patient’s objection.\textsuperscript{118} The court also noted that the state’s police power can be exercised to impose treatment in an emergency situation when the patient presents an imminent danger to a patient or others in the immediate vicinity.\textsuperscript{119} However, the court cautioned that forced treatment in an emergency situations is permitted only until the emergency abates.\textsuperscript{120}

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\begin{itemize}
\item \textsuperscript{115}Id. at 341-42, 344.
\item \textsuperscript{116}In re Dionne D., 774 N.Y.S.2d 167, 168 (N.Y. App. Div. 2004); see also Addington v. Texas, 441 U.S. 418, 431-33 (1979) (holding that in a civil commitment proceeding, the Due Process clause of the Fourteenth Amendment requires that the state prove by clear and convincing evidence that the individual to be committed meets the commitment criteria).
\item \textsuperscript{117}Rivers, 495 N.E.2d at 339 (quoting N.Y. MENTAL HYG. LAW §9.01 (2002) (defining “in need of involuntary care and treatment”)).
\item \textsuperscript{118}Id. at 343-44.
\item \textsuperscript{119}Id. at 343.
\item \textsuperscript{120}Id.
\end{itemize}
Chapter 4

Wronging a Right: Substituting Less than Due Process for Due Process

The authors of a leading coursebook on mental health law report that “virtually every court that has considered the matter now recognizes a ‘right to refuse’ psychotropic medication for institutionalized populations, in the process constitutionalizing a version of the informed consent doctrine in that context.” Michael Perlin, citing three United States Supreme Court decisions, asserts that the Court has clearly recognized a qualified right to refuse treatment in the Fourth Amendment’s Due Process Clause. “[T]he game,” he tells us, “for all practical purposes, is over.” Why then, do I claim that the right to refuse—i.e., the supposedly fundamental right to autonomous decisionmaking—has been refused? Despite Rogers and other court decisions discussed above, some courts have defined the right so narrowly or have approved such inadequate procedural protection for those who assert the right, that the right exists on paper, but not in reality. The game is not over. It has merely moved to a different playground. As noted psychiatrist Loren Roth,

121 RALPH REISNER ET AL., LAW AND THE MENTAL HEALTH SYSTEM—CIVIL AND CRIMINAL ASPECTS 923 (4th ed. 2004); see also Michael L. Perlin, “May You Stay Forever Young”: Robert Sadoff and the History of Mental Disability Law, 33 J. AM. ACAD. PSYCHIATRY & L. 236, 242 (2005) (asserting that after the Supreme Court’s decision in Mills v. Rogers, 457 U.S. 291 (1982), “every state high court that has considered [the question of whether a civilly committed mental patient has a right to refuse treatment] has ruled that there is such a right.”).
123 Id.
M.D., acknowledged: “No matter what the law does, we’ll always treat all the people we want. I hate to say that, but that’s my experience. By hook or by crook, most of the patients will continue to be treated.”

If Rogers v. Okin\(^{125}\) is the seminal case for full recognition of an involuntary mental patient’s right to refuse treatment, Rennie v. Klein\(^{126}\), its contemporary counterpart,\(^{127}\) is the seminal case for limiting that right.\(^{128}\) Rennie began as an action by an involuntarily confined mental patient seeking to enjoin the hospital psychiatrists from forcibly medicating him in the absence of an emergency. After considering various federal constitutional bases for a

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\(^{124}\)Conference Report, Refusing Treatment in Mental Health Institutions: Values in Conflict, 32 Hosp. & Community Psychiatry 255, 258 (1981). Dr. Roth is currently Senior Vice President and Chief Medical Officer, University of Pittsburgh Medical Center. At the time he made the statement, quoted above, Dr. Roth was Director of the Law and Psychiatry Program at the Western Psychiatric Institute and Clinic at the University of Pittsburgh. Id. at 256.


\(^{127}\)The Rogers case commenced on April 27, 1975, when patients filed an action seeking to enjoin seclusion and medication practices at Boston State Hospital and to recover damages for those practices. Rogers, 478 F. Supp. at 1353. The final opinion in Rogers was issued on June 14, 1984, more than nine years later. Rogers v. Okin, 738 F.2d 1 (1st Cir. 1984). The Rennie case commenced on December 22, 1977, nearly two years after Rogers commenced. Rennie, 462 F. Supp. at 1134. However, the first court decision in Rennie was issued on November 9, 1978, nearly one year (October 29, 1979) before the first court decision was issued in Rogers. Rennie, 462 F. Supp. at 1131.

\(^{128}\)For a thorough discussion of the Rogers and Rennie decisions, and of the impact of those decisions on judicial and legislative decisionmaking on procedural protections accorded to mental patients asserting a right to refuse treatment, see Perlin, supra note 107, at 189-294.
mental patient’s right to refuse treatment,129 Judge Stanley Brotman, as did Judge Tauro in the Rogers case,130 held that a mental patient’s right to refuse treatment is based on the right to privacy.131 “Individual autonomy,” wrote Judge Brotman, “demands that the person subjected to the harsh side effects of psychotropic drugs have control over their administration. . . . Whether the potential benefits are worth the risks is a uniquely personal decision which, in the absence of a strong state interest, should be free from state coercion.”132 Although involuntary commitment authorizes the patient’s detention, it alone does not authorize the state to treat the detained patient involuntarily.133 Nevertheless, the state’s interest in protecting other patients in the hospital from harm may authorize the state to exercise its police power to override the dangerous patient’s decision to refuse treatment.134 Although mental illness alone does not equate with incompetency to make an informed decision whether to accept or reject treatment, the state may exercise its parens patriae power to make treatment decisions for those mentally ill patients who are incapable of making such decisions.135 Because forced medication is a major change in the patient’s condition of confinement, due process requires that a hearing be held to determine the patient’s competency before the state may exercise its parens patriae authority to impose treatment.136 At that hearing, the patient is entitled

129 The court specifically discussed the First Amendment right to avoid the involuntary administration of medications that affect the person’s mental processes, the Due Process clause requirement of notice and a hearing, the Eighth Amendment’s prohibition against cruel and unusual punishment, and the right to bodily privacy. Rennie, 462 F. Supp. at 1142-45. The court noted that these constitutional bases for the right to refuse treatment had been suggested previously in Scott v. Plante, 532 F.2d 939, 946-47 (3d Cir. 1976). See Rennie, 462 F. Supp. at 1142.
130 Rogers, 478 F. Supp. at 1366. See supra text accompanying notes 69-70.
131 Rennie, 462 F. Supp. at 1144.
132 Id. at 1145. Judge Brotman noted that “only the patient can really know the discomfort associated with side effects of particular drugs.” Id.
133 Id.
134 Id.
135 Id. at 1145-46.
136 Id. at 1147.
to legal counsel and to an independent psychiatrist—an outside consultant of the patient’s choice.\textsuperscript{137} If the patient is financially unable to pay the attorney or the psychiatrist, the state must supply them.\textsuperscript{138}

In this first \textit{Rennie} case, Judge Brotman considered the evidence and made specific findings and decisions concerning the patient, John Rennie. The court found that Mr. Rennie’s decisionmaking powers were “somewhat impaired.”\textsuperscript{139} The court found that his refusal of lithium without an antidepressant and his refusal of prolixin were rational decisions.\textsuperscript{140} The court announced that if the state again sought to medicate Mr. Rennie without his consent, that it—the court—would decide whether forced medication was appropriate under the framework that it established.\textsuperscript{141}

Four months later, Judge Brotman allowed the plaintiff to expand the lawsuit into a class action composed of all voluntary and involuntary mental patients in five state-operated mental facilities.\textsuperscript{142} Because a New Jersey statute specifically confers to voluntary patients a right to refuse treatment,\textsuperscript{143} the court prohibited the forced medication of voluntary patients in nonemergency situations.\textsuperscript{144} This absolute right to refuse treatment, said the court, precluded

\begin{thebibliography}{144}
\bibitem{137} Id. at 1147-48.
\bibitem{138} Id. at 1148. Additionally, the court required the hospital to provide access to the patient’s hospital records to the patient’s lawyer and psychiatrist. \textit{Id.}
\bibitem{139} Id. at 1146.
\bibitem{140} Id.
\bibitem{141} Id. Nevertheless, Judge Brotman expressed his intent not to conduct multiple hearings. To avoid a cyclical situation in which the prohibition of treatment causes the patient to be incompetent, which then allows the patient’s doctors to override the patient’s refusal and treat him with medication that restores his competency and his right to refuse treatment, Judge Brotman indicated he would consider “the proper treatment over the long term” including an analysis of the least restrictive treatment alternative. \textit{Id.} at 1146-47.
\bibitem{143} N.J. STAT. ANN. 30:4-24.2(d)(1) (West 1997) provides: “Voluntarily committed patients shall have the right to refuse medication.”
\bibitem{144} Rennie, 476 F. Supp. at 1308. Indeed, the court noted that “all parties recognize that voluntary patients have an absolute right to refuse treatment
the need for a due process hearing for such patients. Judge Brotman stated that the privacy and due process rights that he recognized in Mr. Rennie’s case apply to all involuntary patients.

Although Judge Brotman previously ruled that if the state sought to medicate Mr. Rennie without his consent, the court would conduct the medication refusal hearing and that due process entitled Mr. Rennie to legal counsel and to an independent psychiatrist/consultant at that hearing, Judge Brotman asserted in his class action opinion that those statements were merely dictum. Judge Brotman ruled that an informal hearing, conducted by an independent psychiatrist, outside the hospital structure, appointed by the Commissioner of the New Jersey Department of Human Services, satisfied the due process review of a patient’s refusal rights. Instead of a court hearing, a psychiatrist would conduct an informal review. Instead of a right to legal counsel at the hearing, a patient advocate—who could be an attorney, psychologist, social worker, registered nurse, paralegal, or other person with equivalent experience—would serve as the patient’s “informal counsel.” Instead of an independent psychiatrist/consultant of the patient’s choosing to assist legal counsel in the court hearing, the independent psychiatrist was now the decisionmaker, not the patient’s consultant.

Judge Brotman asserted that informal review by independent psychiatrists rather than by judges, lawyers or laypersons “would provide the most accurate analyses of patient interests.” He did not explain what he meant by the words “patient interests.” When a patient asserts the right to refuse medication, he or she has only one interest: the interest in exercising the individual’s autonomy under state law.”

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145 Id. at 1307.
146 Id. at 1308.
147 See supra text accompanying notes 136-41.
148 Rennie, 476 F. Supp. at 1297.
149 Id. at 1306.
150 Id. at 1312. Judge Brotman held that review by a psychiatrist, rather than by a judge or administrative hearing officer, was “constitutionally adequate.” Id. at 1310.
151 Id. at 1311-13.
152 Id. at 1306.

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over his or her own body. Even Judge Brotman acknowledged that weighing the risks and benefits of psychotropic medication “is a uniquely personal decision” and that “[i]ndividual autonomy demands that the person subjected to the harsh side effects of psychotropic drugs have control over their administration.” The only question in the hearing or independent review is whether the patient had the competency to make that decision.

Judge Brotman’s use of the plural word “interests” suggests that the reviewing authority is considering something other than the patient’s mental capacity to exercise autonomous judgment. It suggests that the doctor’s medical judgment in prescribing the medication is also an appropriate issue for consideration, and perhaps, even determinative of whether treatment should be imposed involuntarily on the patient. In fact, in the sentence immediately following the “patient interests” sentence, Judge Brotman wrote, “Review within the profession would also create far less resentment among physicians and staff whose decisions are questioned.” The decision in question, however, is not that of the physician who proposed treating the patient with a particular medication. Rather, the decision in question is that of the patient. The issue to be determined is whether the patient is competent to refuse what the physician is proposing. If the physician feels resentment from this inquiry, such resentment stems from the physician’s misunderstanding or rejection of the competent patient’s right to exercise autonomous judgment.

A decision to prescribe a particular medication for the patient is a medical judgment. The physician uses his or her training and experience to evaluate the risks, benefits, and alternatives and exercises his or her expertise to decide whether the medicine is appropriate to treat the patient’s medical problem. However, a decision to override a competent person’s refusal of treatment is not essentially medical in character. The patient is not claiming that the physician who prescribed the medication for the patient erred in his or her medical judgment. Rather, the patient is claiming that despite the physician’s

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153 Rennie, 462 F. Supp. at 1145.
154 Id. Although these statements appear in the individual lawsuit brought by Mr. Rennie, in the class action lawsuit, Judge Brotman held that the due process and privacy rights accorded to Mr. Rennie in the individual lawsuit applied to all other involuntary patients. Rennie, 476 F. Supp. at 1307.
155 Rennie, 476 F. Supp. at 1306.
recommendation, the patient, as a competent person, is entitled to reject that recommendation. An evaluation of the patient’s competence to make that decision—does he or she have a rational reason for rejecting the physician’s recommendation—is a legal decision, not a medical decision. In essence, a decision on competence to refuse treatment is no different than a decision on a person’s competence to manage his or her estate, to enter into contracts, to execute a will, to marry, to drive a car, or to vote. Such decisions are made by courts, not physicians.

Physicians not only lack expertise in making legal decisions, they are also biased decisionmakers. Physicians are trained to diagnose and treat diseases in order to restore their patients’ health. The physician-patient relationship demands the physician’s unqualified fidelity to his or her patient’s health. The physician may not do anything to impair the patient’s health and must do everything within his or her ability to promote the patient’s health. The Hippocratic Oath obligates the physician to “follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.” The American Medical Association’s Principles of Medical Ethics echo that same categorical imperative: “A physician shall, while caring for a patient, regard responsibility to the patient as paramount.”

156KATZ, supra note 27, at 225-26.
15814 ENCYCLOPEDIA AMERICANA 218 (int’l ed., deluxe libr. ed. 1993) (quoting the Hippocratic Oath); see also Hippocrates, Oath, in 1 HIPPOCRATES 299, 299 (W.H. Jones trans. 1962) (quoting the Hippocratic Oath as containing this statement: “I will use treatment to help the sick according to my ability and judgment . . .”).
159AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS, PRINCIPLE VIII, (adopted by the AMA’s House of Delegates, June 17, 2001). The physician’s fidelity to the patient assures the patient’s trust in the physician. With trust, the patient is willing to share sensitive and confidential information, to be confident in the physician’s clinical judgment, and to comply with the physician’s recommended treatment. M. Gregg Bloche, Clinical Loyalties and the Social Purposes of Medicine, 281 JAMA 268, 272 (1999). Thus, trust is vitally important for therapeutic purposes. “Trust is the core,
interest—as perceived by the physician who is an expert on that medical interest—sometimes conflicts with the patient’s legal rights—including the right to make an autonomous judgment as to whether to accept or reject the physician’s proposed course of action. From the physician’s perspective, the medical imperative of restoring the patient’s health supercedes the patient’s decision to refuse the physician’s advice. As one author phrased it, “patient autonomy is simply not a primary value of the medical profession.” And if the patient is mentally disordered and is involuntarily committed to a mental hospital, the physician is far less likely to consider and accept a refusal of treatment than the refusal of a “normal” patient who is in a voluntary doctor/patient relationship.

If a psychiatrist serves as the decisionmaker in the informal treatment refusal review process, what assures the patient—indeed, what assures society—that the psychiatrist will even consider the patient’s competence to refuse treatment as the issue to be reviewed? If, as Judge Brotman asserts, psychiatrists, rather than judges, lawyers, or laypersons will “provide the most accurate analyses of patient interests,” then isn’t it far more likely that the reviewing psychiatrist will assess the patient’s medical interest and whether that interest was appropriately evaluated by the treating psychiatrist? Physicians, after all, are experts on making medical determinations, not on making legal determinations. Legal determinations are ordinarily made by judges.

For example, will the reviewing psychiatrist assure himself or herself that the treating psychiatrist informed the patient of the risks and alternatives to the

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defining characteristic of the doctor-patient relationship—the ‘glue’ that holds the relationship together and makes it possible.” Mark A. Hall, Law, Medicine, and Trust, 55 Stan. L. Rev. 463, 470 (2002). See also Frances H. Miller, Trusting Doctors: Tricky Business When It Comes to Clinical Research, 81 B.U. L. Rev. 423, 426-27 (2001) (asserting that a patient’s trust in his or her physician is a critical component in the healing process).


prescribed medication so that the patient has a rational basis for refusing the proposed treatment? If the patient denies having a mental disorder, is it appropriate for the treating psychiatrist to immediately conclude that the patient is incompetent to evaluate the therapeutic benefit of the proposed medication, thus justifying the psychiatrist’s failure to disclose the risks and alternatives to that treatment? Is it possible that the patient who denies having a mental disorder has a rational reason for doing so? The patient may be denying mental disorder in order to maintain control over his or her life and to avoid being thrust into the dependent role of a mental patient. The patient knows that the psychiatrist’s authority to prescribe medication to treat the patient’s condition is strengthened if the patient acknowledges that the problem is a mental disorder within the psychiatrist’s medical expertise. Or perhaps the patient’s denial of mental disorder is a reaction to his or her involuntary detention or to

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162 When treating psychiatrists are asked whether they inform patients of the potential risks and benefits of, and alternatives to, the proposed treatment, they typically answer in the affirmative. However, in many right to refuse treatment hearings that I conducted as a mental health hearing officer, when I specifically asked psychiatrists what they informed patients, their answers frequently did not support their claims of disclosure. Information about side effects was usually inadequate; information about alternatives to medication was usually nonexistent. *See* Grant H. Morris, *Judging Judgment: Assessing the Competence of Mental Patients to Refuse Treatment*, 32 SAN DIEGO L. REV. 343, 425-28 (1995); *see also infra* text accompanying notes 606-16.

163 In the right to refuse treatment hearings I conducted, the most frequently cited reason given to support the treating psychiatrist’s assertion that the patient was incompetent to make medication decisions—mentioned in over ninety percent of cases—was the patient’s refusal to acknowledge his or her mental disorder. Morris, *supra* note 162, at 399, 400 tbl.6. Nevertheless, in the hearings I conducted, patients testified that they refused medication because they had no mental disorder in fewer than thirty percent of the cases. *Id.* at 406, 403 tbl.7.


165 Morris, *supra* note 162, at 408.
the lack of communication between the treating psychiatrist and the patient.\textsuperscript{166}

A patient’s seemingly irrational objections to medication may, in fact, be rationally based. Even a patient who denies having a mental disorder may be refusing medication, not because the patient really believes that he or she has no mental disorder, but rather, because the patient has a rational concern about side effects that he or she experienced when the drug was administered previously.\textsuperscript{167} These issues need to be considered if the patient’s competence to refuse medication—i.e., the very issue that is to be reviewed—is, indeed, the focus of the inquiry.\textsuperscript{168}

Judge Brotman, however, transforms a mental patient’s legal right to refuse medication into a medical issue. If the reviewing psychiatrist confirms the treating psychiatrist’s judgment that a particular medication is medically appropriate for treating the patient’s mental disorder and that the risk of side effects is an acceptable cost in view of the benefit that may be gained, treatment will be ordered. In one study, when independent psychiatrists reviewed medication refusal decisions, they approved the administration of medication in 98.9 percent of the cases.\textsuperscript{169} When a psychiatrist reviews the treatment

\textsuperscript{166}Id.

\textsuperscript{167}In the right to refuse treatment hearings I conducted, the most frequently cited reason given by patients for refusing medication was side effects experienced from previous administration of medication, mentioned in over sixty percent of cases. Additionally, some patients expressed concern about potential side effects from a prescribed medication even if they had not previously suffered them. Id. at 403 tbl.7, 404.

\textsuperscript{168}See id. at 407-08 (asserting that the reviewing decisionmaker should consider whether a patient’s seemingly irrational objections to medication are rationally based). In 	extit{In re Virgil D.}, 524 N.W.2d 894, 898 (Wis. 1994), the Wisconsin Supreme Court ruled that a patient’s competence to refuse medication is determined by whether the patient understands the risks, benefits, and alternatives to the medication and not by whether the patient accepts a diagnosis of mental illness.

\textsuperscript{169}William A. Hargreaves et al., \textit{Effects of the Jamison-Farabee Consent Decree: Due Process Protection for Involuntary Psychiatric Patients Treated With Psychoactive Medication}, 144 AM. J. PSYCHIATRY 188, 192 (1987). The researchers found: “The reviews did not reduce the average dose of antipsychotic medication received by involuntary patients, did not make it easier for patients to successfully refuse medication, and did not seem to be
refusal decision, the weighing of risks and benefits of the proposed treatment is no longer measured by the patient’s competence to weigh risks and benefits, but rather, by whether the patient’s physician weighed them in accordance with accepted medical practice. 170 As psychiatrist Paul Appelbaum acknowledged, “When physicians act as judges, they still tend to think like physicians.” 171

In ruling that an informal review by an independent psychiatrist satisfies due process, Judge Brotman cited and relied upon a United States Supreme Court case decided earlier that year. 172 In Parham v. J.R., 173 the Supreme Court acknowledged that children have a substantial liberty interest in avoiding unnecessary confinement for treatment. 174 Nevertheless, the Court ruled that parents retain plenary authority to seek and obtain treatment for their children in a mental health facility subject to a physician's independent examination and medical decision. 175 If the staff physician agrees with the parent’s judgment that the child is mentally ill and can benefit from treatment in the institution, the child will be admitted as a “voluntary” patient, regardless of the child’s protest. 176 Because the commitment decision was deemed “essentially medical in character,” 177 due process did not require the state to provide either a preadmission or a postadmission adversarial hearing before a law-trained

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170Ironically, in John Rennie’s individual lawsuit, Judge Brotman specifically found that Mr. Rennie refused lithium because he correctly determined that it caused him to suffer depression, and the hospital would not provide him with an antidepressant along with the lithium to combat this side effect. Rennie v. Klein, 462 F. Supp. 1131, 1139 n.4 (D.N.J. 1978).


174Id. at 600.

175Id. at 604.

176Id. at 609.

177Id.
judicial or administrative officer.\footnote{For a critique of Parham, see Grant H. Morris, The Supreme Court Examines Civil Commitment Issues: A Retrospective and Prospective Assessment, 60 Tul. L. Rev. 927, 946-52 (1986), asserting that children who do not freely choose to enter the hospital should not be regarded as “voluntary” patients; that a parent’s decision to seek inpatient mental hospitalization of a child disrupts the ongoing family relationship and is not a routine, child-rearing decision and thus permission for such detention should be obtained from a court, not a psychiatrist; that psychiatrists overpredict the presence of mental illness and the need for inpatient hospitalization; that a hearing may have therapeutic benefits for the child; that less restrictive alternatives to inpatient commitment were not considered; and that valid reasons exist for distinguishing state wards from other children and providing them with hearings—the natural bonds of affection existing—or supposedly existing—in a parent/child relationship. See also Michael L. Perlin, An Invitation to the Dance: An Empirical Response to Chief Justice Warren Burger’s “Time-Consuming Procedural Minuets” Theory in Parham v. J.R., 9 Bull. Am. Acad. Psychiatry & L. 149 (1981) (critiquing the Supreme Court for failing to consider data, submitted in an amicus brief by the New Jersey Division of Mental Health Advocacy, demonstrating that preadmission civil commitment hearings for juveniles, with full due process safeguards including legal counsel, are “necessary, effective and ameliorative”).} \footnote{Id. at 613.}

The Parham precedent, however, is not directly applicable to the right to refuse treatment issue. Arguably, it is not even pertinent. Children, because of their youth and immaturity, are considered to be incompetent to make medical decisions. Because of this incapacity, parents are authorized to make medical decisions for them. If little Johnny is ill and his parents believe he needs an appendectomy or a tonsillectomy, Johnny’s parents need no one’s approval to seek such surgery.\footnote{Id. at 604.} In such a situation, the examining physician makes a medical judgment as to the propriety of the surgery and thus serves as an appropriate reviewer of the parents’ judgment. If the physician concurs, the surgery proceeds, despite any objections that Johnny may have.\footnote{Id. at 604.} Adults, however, even if involuntarily committed to a mental hospital, are presumed to be competent. No one is authorized to force treatment upon them unless they...
are determined to be incompetent. That decision is a legal decision, not a medical decision.

Judge Brotman’s decision in the Rennie class-action lawsuit was appealed, and the United States Court of Appeals for the Third Circuit modified and remanded the District Court’s judgment. The Court of Appeals acknowledged that involuntary civil commitment subjects the person to “a massive curtailment of liberty,” but ruled that commitment plus forced medication with psychotropic medication is an additional intrusion on the person’s liberty that warrants protection under the Due Process Clause of the Fourteenth Amendment. The court specifically discussed the serious side effects that can result from such medication, including akinesia, akathesia, and tardive dyskinesia, and declared that such side effects were “a critical factor in our determination that a liberty interest is infringed by forced medication.”

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181 The parties cross-appealed the District Court’s order. The defendants challenged the District Court’s recognition of a constitutional right to refuse treatment. In the alternative, the defendants asserted that the state’s administrative procedures adequately protected any such right. The plaintiffs contended that use of independent psychiatrists as neutral decisionmakers did not satisfy due process. Plaintiffs also attacked the permitted use of patient advocates as informal counsel to patients who refuse treatment. Rennie v. Klein, 653 F.2d 836, 840 (3d Cir. 1981).


183 Id. at 843 (quoting Humphrey v. Cady, 405 U.S. 504, 509 (1972)).

184 Id. at 844. The court also noted that an equal protection argument might be lurking as well, but the parties did not address the issue, and the court, other than in its footnote comment, did not do so either. “If there is a constitutional right to be free from overly intrusive medication, and prima facie, involuntarily confined patients are as competent as voluntarily admitted persons, there would seem to be some question about excluding the former from the benefits of the statute.” Id. at 842 n.7. The New Jersey statute referred to by the court specifically provided that voluntary patients have a right to refuse medication but contained no similar provision for involuntary patients. Id. at 842 (citing N.J. STAT. ANN. 30:4-24.2(d)(1) (West 1997)). The court noted that the statute implies that involuntary patients do not have a right to refuse medication under state law. Id.

185 Id. at 843.

186 Id. at 844 n.8.
Although medical judgment is involved in deciding what medication is desirable to treat a patient’s mental condition, the patient’s liberty interest in refusing medication, said the court, is not abdicated to medical judgment and cannot be defeated by medical judgment.\textsuperscript{187} However, in its determination of applicable procedural due process protections to review patient treatment refusal decisions, the court so emasculated the patient’s right to refuse that abdication to medical judgment is accomplished. The Court of Appeals ruled that the informal procedures established in an administrative regulation met the requirements of procedural due process\textsuperscript{188} and that Judge Brotman erred in establishing an independent review mechanism that went beyond the procedures prescribed by that regulation.\textsuperscript{189} The administrative regulation merely required that the attending psychiatrist’s treatment recommendation be reviewed by the medical director or his designee.\textsuperscript{190} Gone is the requirement imposed by Judge Brotman that a hearing—even an informal hearing—be held to determine whether the patient can be medicated over his or her objection. Gone is the requirement that the state provide a patient advocate to represent the patient at the hearing. Gone is the requirement that the state retain independent psychiatrists to make the ultimate determination at the hearing.\textsuperscript{191} If the District Court’s due process requirements constituted “due process lite,” the Third Circuit’s due process requirements constituted less than due process.

At three points in the Third Circuit’s decision, the court specifically identified the due process protection of the patient’s liberty interest as a medical decision to be made by hospital medical staff. Such staff are appropriate decisionmakers, said the court, because their experience with the patient in the weeks or months of his or her hospitalization “should provide a more accurate and reliable basis for the . . . judgment as to whether the patient . . . is capable of making a rational treatment decision”\textsuperscript{192} than the judgment of an independent psychiatrist. But what assures the patient, and what assures society, that the

\textsuperscript{187}Id. at 847.
\textsuperscript{188}Id. at 838, 851.
\textsuperscript{189}Id.
\textsuperscript{190}Id. at 853. The medical director, or his designee was required to conduct a personal examination of the patient and to review the record. Id.
\textsuperscript{191}See supra text accompanying notes 149-51.
\textsuperscript{192}Rennie, 653 F.2d at 850.
due process issue, i.e., whether the patient is capable of making a rational treatment decision, is the issue that is considered when hospital medical staff make their medical decision? Isn’t it far more likely that the issue that will be considered by the medical staff is whether the proposed medication is medically appropriate to treat the patient’s diagnosed condition? That is the medical decision involved here, not the legal decision of whether the patient possesses the mental capacity necessary to exercise his or her liberty interest by rejecting the proposed medication.

According to the Third Circuit, an adversary contest—even an informal hearing required by Judge Brotman—“is ill-suited to the type of medical determination that must be made.”193 To support this assertion, the court relied upon the Supreme Court’s Parham decision.194 “If an informal investigation by an admitting physician satisfies due process” in the civil commitment context, said the Third Circuit, “such informal procedures meet constitutional standards in the present context.”195 Despite this analysis—or lack thereof—the two contexts are different and the legally protected interests involved are different. As discussed above,196 children are conclusively presumed to be incompetent, and parents are authorized to seek treatment for them. The Supreme Court in Parham ruled that physicians are qualified to serve as a check on the parents’ judgment by making the medical decision as to whether treatment is warranted for the child’s mental condition.197 Civilly committed adults are presumed competent to refuse treatment, and the question of the patient’s competence to refuse medication is a legal question that cannot be answered by a psychiatrist who makes a medical decision that proposed medication is appropriate for the patient’s condition.

Finally, the Third Circuit asserted that “[t]he New Jersey regulations provide a series of informal consultations and reviews to determine from a medical standpoint whether administration of the drugs is necessary.”198 The

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193 Id. (emphasis added).
194 Id. (citing Parham v. J.R., 442 U.S. 584, 607 (1979)).
195 Id.
196 See supra text accompanying notes 173-80.
197 But see supra note 178, critiquing the Parham decision and asserting that due process should require a pre-admission, court hearing for juveniles.
198 Rennie, 653 F.2d at 851 (emphasis added).
court added that “[t]he participants in the procedure are mental health professionals, rather than judges who have doffed their black robes and donned white coats.” But the court failed to explain why mental health professionals who have doffed their white coats and donned black robes are qualified to make legal decisions. Simply stated, the assessment of a patient’s competency is a legal decision, not a medical decision.

In a most egregious omission, the Third Circuit failed to address Judge Brotman’s concern that a review of the physician’s decision to forcibly medicate the patient, if conducted by the hospital director, failed to meet the requirements of due process. Evidence presented at trial, and relied upon and cited by Judge Brotman in the District Court opinion, established that physicians in state hospitals were under institutional pressures to medicate patients unnecessarily. One state hospital director “candidly admitted that drugs are still systematically forced on patients.” When patients refused medication orally, they were often subjected to injections of long-acting prolixin, a medication which not only had a longer effect but also had more immediate adverse side effects. As a result, many patients were intimidated into accepting medication they did not want. Credible experts testified that if state hospital directors reviewed the forced treatment recommendations of hospital physicians, “the directors would inevitably be caught in a conflict between patients’ interests and pressures from their staff.” Judge Brotman concluded that “institutional pressures–similar to the pressures that have created the unfortunate legacy of overdrugging in state mental hospitals–make it impossible for anyone in the medical director’s position to have sufficient independence, much less the appearance of fairness which due process requires.” How did the Third Circuit respond to Judge Brotman’s finding? The court simply stated: “We are satisfied that the state’s procedures, if

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199 Id.
201 Id. at 1304.
202 Id.
203 Id.
204 Id. at 1310.
205 Id.
carefully followed, pose only a minor risk of erroneous deprivation”\(^{206}\) of the patient’s liberty interest.

I have questioned the competence of independent psychiatrists to assess the legal question of a patient’s competence to refuse treatment.\(^{207}\) Psychiatrists are experts in making medical judgments—i.e., the proposed treatment appropriate for the patient—not legal judgments—is the patient competent to refuse medication even if it may benefit him or her. Psychiatrists are committed to restoring their patients’ health—a pro-treatment bias. Substituting medical directors for independent psychiatrists contributes an additional source of decisionmaker bias. If, as Judge Brotman asserts, medical directors are inclined to support their staff physician decisions, they do not serve as impartial decisionmakers. They serve as rubber stamps.

\(\text{Rennie}\) was appealed to the United States Supreme Court, which vacated the Third Circuit’s judgment and remanded the case for further consideration in light of the Supreme Court’s decision in \(\text{Youngberg v. Romeo}\).\(^{208}\) \(\text{Youngberg}\) was also appealed from the Third Circuit and decided by the Supreme Court two weeks prior to the Supreme Court’s remand in \(\text{Rennie}\).\(^{209}\) In \(\text{Youngberg}\), the Supreme Court acknowledged that involuntarily committed mentally retarded persons have liberty interests in freedom and safety from restraint and that the state must provide minimally adequate or reasonable training to assure that those interests are protected.\(^{210}\) In determining whether the state adequately protected the confined person’s rights, the Court merely required that judgment be exercised by a qualified professional.\(^{211}\)

\(^{206}\) \(\text{Rennie v. Klein}, 653 F.2d 836, 850 (3d Cir. 1981) (en banc).\) The court added: “We also are convinced that this risk will not be significantly reduced by superimposing the district court’s own requirements on those already required by the state.” \(\text{Id.}\) Judge Gibbons dissented, chastising the majority for disregarding Judge Brotman’s evidence-based findings of patient abuse and substituting its own intuitive judgment that review of patient refusals by the hospital director would pose only a minor risk of error. \(\text{Id.}\) at 865-70 (Gibbons, J., dissenting).

\(^{207}\) \(\text{See supra}\) text accompanying notes 155-80.


\(^{209}\) \(\text{Rennie v. Klein}, 458 U.S. 1119 (1982).\)

\(^{210}\) \(\text{Youngberg}, 457 U.S. at 314-19.\)

\(^{211}\) \(\text{Id.}\) at 321-22.
In *Youngberg*, the Supreme Court focused primarily on the extent of the state’s affirmative obligation to provide habilitation services to an institutionalized mentally retarded person. That issue is comparable to the state’s affirmative obligation to provide adequate treatment to an institutionalized mentally ill person, i.e., a “right to treatment” issue. The Court also deferred to professional judgment on the question of whether physical restraints should be imposed in individual cases, i.e., a “right to refuse treatment” issue. The *Youngberg* Court, however, did not consider the right of a *competent* mental patient to refuse treatment or the due process protections necessary to assure that right. Romeo was a profoundly retarded person with the mental capacity of an eighteen-month old child. Obviously he lacked the mental capacity necessary to make treatment decisions. The Court did not discuss or decide whether a professional’s judgment that the proposed treatment is appropriate for the patient’s condition provides adequate due process protection of a competent mental patient’s right to refuse treatment. Obviously, an incompetent patient is not able to make a rational judgment on whether to accept or refuse treatment. Someone must be substituted to decide for the patient. Deferring to a professional’s judgment on what treatment may be appropriate is an acceptable choice. Competent patients, however, have a right to accept or refuse treatment. A professional’s judgment that certain treatment is appropriate for the patient’s mental condition does not address the question—and, indeed, is irrelevant to the question—of whether the patient is

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212 *See infra* text accompanying notes 256-60 (discussing the legal development of the state’s obligation to provide adequate treatment to involuntarily committed mental patients—i.e., that mental patients have a legally enforceable right to treatment—and explaining why such right does not impose any obligation on the patient to accept such treatment—i.e., that the patient retains the right to refuse treatment).

213 *Youngberg*, 457 U.S. at 321-22.

214 In *Cruzan* v. Director, Missouri Dep’t of Health, 497 U.S. 261 (1990), the Supreme Court acknowledged: “*Youngberg* . . . did not deal with decisions to administer or withhold medical treatment.” *Id.* at 280. *See also* Rennie v. Klein, 720 F.2d 266, 269 n.7 (3d Cir. 1983) (stating that the Supreme Court in *Youngberg* expressly declined to deal with the issue of the forcible administration of antipsychotic medication).

215 *Youngberg*, 457 U.S. at 309.
competent to refuse the proposed treatment.\footnote{See generally Stefan, supra note 160, at 646-67 (strongly critiquing use of the professional judgment standard in cases, such as right to refuse treatment cases, in which the individual is asserting a negative right against invasive state action). In comparing “right to treatment” cases with “right to refuse treatment” cases, Professor Stefan asserted: The professional judgment standard should be limited to cases in which the plaintiff claims an affirmative entitlement to professional services, and has received inadequate services or none at all. The professional judgment standard is appropriate to guide courts or juries in determining the level of professional services that the state must provide to individuals in its custody; the standard is inappropriate and harmful in cases where the individual seeks to resist state restrictions on his or her privacy imposed in the name of professional judgment. Id. at 646; see also Jarvis v. Levine, 418 N.W.2d 139, 147 (Minn. 1988) (asserting that Youngberg, which involved an incompetent, severely retarded individual’s right to safe physical conditions, “furnishes little guidance” to the case before the court involving a competent mental patient’s right to refuse psychotropic medication, and holding that Youngberg’s professional judgment standard would not be applied).}

By remanding \textit{Rennie} for further consideration in light of \textit{Youngberg},\footnote{Rennie v. Klein, 458 U.S. 1119 (1982), \textit{vacating} 653 F.2d 836 (3d Cir. 1981) (en banc).} the Supreme Court may have been inviting the Third Circuit to consider whether deference to professional judgment might satisfy due process requirements in right to refuse treatment cases.\footnote{In R.A.J. v. Miller, 590 F. Supp. 1319 (N.D. Tex.1984), the court, after acknowledging that Youngberg “specifically addressed only the right of an involuntarily committed \textit{mentally retarded} individual to be free from \textit{physical} bodily restraint,” asserted that the Supreme Court’s remand of the \textit{Rennie} decision in light of the \textit{Youngberg} decision “evidences an intent to apply the guidelines of \textit{Youngberg} to the right of an involuntarily committed \textit{mentally ill} patient to refuse \textit{administration of psychotropic drugs}.” \textit{Id.} at 1321 (emphasis in original).} If that was the invitation, then on remand, the Third Circuit readily accepted.\footnote{Rennie v. Klein, 720 F.2d 266 (3d Cir. 1983).} Although five different opinions were written
by the ten judges sitting on remand, all but one judge agreed that the Supreme Court’s decision in Youngberg did not require any change in the result of the previous Third Circuit decision. The state’s administrative regulation requiring that the medical director or his designee informally review the treating psychiatrist’s treatment recommendation satisfied Youngberg’s professional judgment standard and constituted due process.

States have divided almost equally on the question of what procedural protections are necessary to enforce a patient’s right to refuse treatment. Nearly half have rejected the Rogers v. Okin requirement that the involuntarily committed mental patient’s competence to refuse treatment be determined in a formal hearing before a judge or other law-trained decisionmaker. They follow the professional review model of Rennie v.

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220 Although nine judges agreed in the result, no more than three judges joined in any one opinion. In the various concurring opinions, the judges expressed disagreement as to whether the Supreme Court’s decision in Youngberg precluded reliance by the Third Circuit on a requirement that the treatment ordered be the least intrusive of the patient's liberty. Compare Judge Garth’s opinion (with which two judges joined), id. at 269 (asserting that the “least intrusive means” test cannot be applied), with Judge Weis’s concurring opinion (with which two judges joined), id. at 275-77 (asserting that the “least intrusive means” test can and should be applied).

221 Id. at 277 (Gibbons, J., dissenting). In a one paragraph opinion, Judge Gibbons dissented for the same reasons he discussed in his prior Rennie opinion— that the majority improperly substituted its own intuitive judgment that review of patient refusals by the hospital director would pose only a minor risk of error, disregarding Judge Brotman’s evidence-based finding that it would not. See supra note 206.

222 See Catherine E. Blackburn, The “Therapeutic Orgy” and the “Right to Rot” Collide: The Right to Refuse Antipsychotic Drugs Under State Law, 27 Hous. L. Rev. 447, 479 & n.101, 493 & n.147 (1990) (citing fourteen states that use a medical decisionmaker model and eighteen states that use a judicial decisionmaker model to decide whether an involuntarily committed mental patient’s treatment refusal will be upheld).


224 Id. at 1361. See supra text accompanying notes 64-84.
allowing an informal review by a staff psychiatrist or hospital committee to suffice.226 State courts, often relying on state constitutional provisions or statutes, have generally required Rogers-type procedures;227 federal courts, relying on the United States Constitution as interpreted in Youngberg, have generally upheld Rennie-type procedures.228

Writers have characterized the Rogers approach as an expanded due process model.229 In contrast, the Rennie approach has been characterized as


226 See, e.g., Md. Code Ann., Health—Gen. §10-708(b) (West Supp. 2006) (using a medical review panel composed of a psychiatrist, a physician, and a non-physician mental health professional); N.C. Gen. Stat. § 122C-57(e) (2003) (using a second physician to review the professional judgment of the treating physician). For court decisions upholding state statutes and regulations that use a medical review model, see infra note 228.

227 See supra text accompanying notes 85-120.

a limited due process model. But due process can not be so parsed. It is the process that is due, i.e., the process that is necessary to assure adequate protection of the asserted right. Unless foxes have suddenly become qualified to adequately guard the henhouse, psychiatrists–especially psychiatrists employed by the treating facility–are not qualified to decide whether the patient is competent to refuse treatment.

Indeed, the professional review model assures that the patient’s competence is not the measure of whether treatment will be imposed. The District Court decision in *R.A.J. v. Miller* is illustrative. In *R.A.J.*, the court approved a rule proposed by the Commissioner of the Texas Department of Mental Health and Mental Retardation governing the administration of psychotropic medications to involuntarily committed mental patients who refuse to give their informed consent. Under that rule, for the first fourteen days of the patient’s commitment, the decision to administer psychotropic medication is within the discretion of the treating physician. Thereafter, if the patient objects, the medication may be continued, but the clinical director of the mental health facility or the director’s physician designee reviews the decision and determines whether the administration of such medication is medically appropriate treatment. In determining whether the prescribed medication is medically

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230 *Perlin*, supra note 107, at 260-61; *Perlin*, supra note 121, at 242; *Perlin & Dorfman*, supra note 229, at 122-23.


232 *Id.* at 1325. The Proposed Commissioner’s Rule on Administration of Psychotropic Medications is reprinted in full as an appendix to the District Court’s decision. *Id.* at 1323-26.

233 *Id.* at 1325. The term “medically appropriate treatment” was defined in the rule as:

Treatment with psychotropic medication based on a professional judgment that without such medication the patient’s condition cannot realistically be expected to improve within a reasonable period of time; or that without such medication deterioration of the patient’s condition cannot be prevented; or that without such medication deterioration of the patient’s condition cannot be prevented; or that without such medication there is a significant possibility that the patient’s
appropriate treatment, the clinical director or physician designee is required to consider four factors: “(A) the accuracy of the diagnosis; (B) indications for the medication; (C) probable benefits and risks of the medication; and (D) the existence and value of alternative forms of treatment, if any.”\textsuperscript{234} As a separate issue, the clinical director or physician designee is also required to determine “whether the patient’s ability to understand the consequences of his decision to object to the administration of such medication is impaired as a result of his mental illness.”\textsuperscript{235} If the clinical director or physician designee determines that the administration of psychotropic medication is medically appropriate treatment but also determines that the patient’s ability to understand the consequences of his decision to object to its administration has not been impaired as a result of mental illness, then a consultant psychiatrist is employed to conduct a review and to determine the appropriateness of treatment with psychotropic medication.\textsuperscript{236} Under this rule—approved by the court in \textit{R.A.J.}—professional judgment is exercised, first by the treating physician and then by the clinical director or a physician designee, to determine whether the prescribed medication is appropriate. Although the patient’s competence to refuse treatment is also assessed, it is not determinative of whether treatment is imposed. A competent, but objecting, patient only receives another review by an independent, consultant psychiatrist, who again exercises his or her professional judgment to determine whether the prescribed medication is appropriate. Regardless of whether the patient is competent to understand the risks, benefits, and alternatives to treatment, under the rule approved in \textit{R.A.J.}, no involuntarily committed patient is allowed to refuse treatment.\textsuperscript{237} The right to refuse is refused.

In applying the \textit{Youngberg/Rennie} professional judgment model, some courts require even less. To those courts, the question is not whether due process requires a formal court review of the treating physician’s decision to

\begin{itemize}
\item mental condition will not be stabilized in time to prevent injury to himself or other persons.
\end{itemize}

\textit{Id.} at 1323-24.

\textsuperscript{234}\textit{Id.} at 1325.

\textsuperscript{235}\textit{Id.}

\textsuperscript{236}\textit{Id.} at 1326.

\textsuperscript{237}\textit{Id.} at 1320.
impose treatment to a patient who refuses treatment or whether an informal professional review process suffices. To those courts, no review is required. Due process, they say, is satisfied when the treating physician makes a professional judgment and orders the patient treated over his or her objection. For example, in **Dautremont v. Broadlawns Hospital**,\(^{238}\) the United States Court of Appeals for the Eighth Circuit, quoting **Youngberg**,\(^{239}\) stated that the patient’s liberty interest in refusing medication is “‘protected by the Due Process Clause from arbitrary governmental action.’”\(^{240}\) A treating physician’s decision to administer psychotropic medication to a patient is the exercise of professional judgment and is not arbitrary action.\(^{241}\) The patient’s liberty interest in refusing treatment, wrote the Eighth Circuit, is outweighed “by the government’s legitimate objective [of returning] Dautremont’s behavior to that which is acceptable to society and by the professionals’ reasonable judgment here that that objective can best be accomplished by the administration of certain types and levels of psychotherapeutic drugs.”\(^{242}\) Even though an Iowa statute specifically declared that involuntary hospitalization “does not constitute a finding of nor equate with nor raise a presumption of incompetency, nor cause a person so hospitalized to be deemed a person of unsound mind nor a person under a legal disability for any purpose,”\(^{243}\) the patient’s competence to refuse treatment was not evaluated. In fact, it was not an issue.\(^{244}\) A competent

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\(^{238}\)827 F.2d 291 (8th Cir. 1987).

\(^{239}\)In **Youngberg**, the Supreme Court, quoting Justice Powell’s opinion in **Greenholtz v. Nebraska Penal Inmates**, 442 U.S. 1, 18 (1979) (Powell, J., concurring in part and dissenting in part) wrote: “Indeed, ‘[l]iberty from bodily restraint always has been recognized as the core of the liberty protected by the Due Process Clause from arbitrary governmental action.’” **Youngberg v. Romeo**, 457 U.S. 307, 316 (1982).

\(^{240}\)**Dautremont**, 827 F.2d at 300 (emphasis in original).

\(^{241}\)**Id.**

\(^{242}\)**Id.**

\(^{243}\)**Id.** at 296, quoting **Iowa Code Ann.** §229.27. The Iowa statute exists today without substantial alteration. **Iowa Code Ann.** §229.27(1) (West Supp. 2006).

\(^{244}\)The decision in **Dautremont** is not unique. For example, in **Stensvad v. Reivitz**, 601 F. Supp. 128 (W.D. Wis. 1985), the District Court considered whether an involuntarily confined mental patient, who had been committed
patient’s right to refuse treatment? It does not exist.

Under the professional judgment model, Dr. Roth’s assertion is surely accurate: “No matter what the law does, we’ll always treat all the people we want.”245 I am reminded of the words of a Bob Dylan lyric. In describing the ease with which a scoundrel named Diamond Joe circumvented the law, Dylan wrote: “He never took much trouble/With the process of the law.”246

245Conference Report, supra note 124, at 258. A pro-treatment bias also undermines the professional judgment model when a determination of the patient’s dangerousness is in issue. See infra text accompanying notes 525-603 (discussing the finding of dangerousness by medication review panels in cases involving mentally disordered offenders).

246BOB DYLAN, Diamond Joe, on Good as I Been to You (Columbia 1992).
Chapter 5

Wronging a Right:
Substituting the Commitment Decision
for a Finding of Incompetency

In the Rennie remand decision, Chief Judge Collins Seitz, in his concurring opinion, asserted that a decision to involuntarily commit a patient transfers to the state authority to make certain decisions that affect the patient’s welfare.\textsuperscript{247}

Even when the sole justification offered for a patient’s confinement is that he is dangerous to himself or others, as in New Jersey, and not that he is incompetent, there is the inescapable fact that such confinement is a benefit to the patient as well as to society—a benefit which the patient is incapable of securing for himself. . . . The State is not restricted to helping the patient only if he wishes to be helped.\textsuperscript{248}

Under Judge Seitz’s analysis, the commitment decision itself empowers the state to make treatment decisions that may improve the patient’s condition and return the patient to the community.\textsuperscript{249} Within a year of the Rennie remand decision, the federal district court in R.A.J., quoting Judge Seitz’s concurring opinion, held that competent, but involuntarily committed, patients may not refuse psychotropic medication that has been prescribed for them.\textsuperscript{250}

Should the involuntary commitment decision, in and of itself, justify depriving the involuntary mental patient of the right to refuse treatment? Judge Seitz’s position assumes that because an involuntarily committed person loses

\textsuperscript{247}Rennie v. Klein, 720 F.2d 266, 273 (3d Cir. 1983) (Seitz, C.J., concurring).
\textsuperscript{248}Id.
\textsuperscript{249}Id.
his or her liberty—i.e., his or her physical freedom—that the person also loses other rights, such as the right to refuse treatment.

The exercise of the state’s authority to confine a person, however, does not deprive the person of other rights. For example, in Thor v. Superior Court,251 an inmate of a state prison was pushed or fell from a ledge, fractured cervical vertebrae, and was rendered quadriplegic.252 A staff physician at the facility sought to perform a life-saving surgical procedure to permit the prisoner to be artificially fed and medicated through an opening in his stomach, but the prisoner refused to consent.253 In a unanimous decision, the California Supreme Court upheld the prisoner’s right to refuse, saying: “[W]e conclude that a competent, informed adult, in the exercise of self-determination and control of bodily integrity, has the right to direct the withholding or withdrawal of life-sustaining medical treatment, even at the risk of death, which ordinarily outweighs any countervailing state interest.”254 Prisoners do not suffer “civil death,” but rather, retain all rights of free persons except as necessary to maintain security in the institution or to protect the public.255 If prisoners, who have been convicted of crimes and who are confined for punishment, do not lose the right to refuse treatment—even treatment necessary to preserve their lives—then mentally disordered persons who are civilly committed do not, by

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251 855 P.2d 375 (Cal. 1993).
252 Id. at 379.
253 Id. The physician petitioned the court for an order allowing him to perform a gastrojejunostomy or a gastrostomy. For a description of these procedures, see id. at n.1.
254 Id. at 387.
255 Id. (quoting CAL. PENAL CODE § 2600 (West 2000)). The Thor court quoted directly from the statute as originally enacted in 1975. Act of Sept. 29, 1975, ch. 1175, § 3, 1975 Cal. Stat. 2897, 2897. The year following the Thor decision, the legislature amended the statute to provide that prisoners may only be deprived of such rights that are “reasonably related to legitimate penological interests.” CAL. PENAL CODE § 2600 (West 2000). The change in language did not diminish the right of prisoners to refuse treatment. The legislature added a sentence to the amended statute, declaring: “Nothing in this section shall be construed to overturn the decision in Thor v. Superior Court, 5 Cal. 4th 725.” Id.
that commitment decision alone, lose the right to refuse treatment.

A mental patient, however, is not placed in a prison to be punished. He or she is placed in a mental treatment facility to be treated. The state has an obligation to provide that treatment. Nevertheless, the state’s obligation to provide treatment—sometimes referred to as the patient’s right to treatment—imposes no obligation on the patient to accept the treatment that the state is required to provide. Citizens in our society have the right to vote. But if they

\[256\] The idea that an involuntary mental patient possesses a right to treatment was first articulated in 1960. Morton Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960). In that article, Dr. Birnbaum asserted that if the state that takes away a person’s liberty by involuntarily confining that person in a mental hospital, then the state has an obligation to make that involuntary commitment as short as possible by providing adequate treatment to the patient. If the state fails in that obligation, the patient should be released from confinement, even if his or her mental condition still meets the criteria for involuntary commitment. *Id.* at 503. This principle was first accepted in *Rouse v. Cameron*, 373 F.2d 451, 453-55, 458 (D.C. Cir. 1966) in which the court found that statutes enacted by Congress created a right to treatment cognizable in habeas corpus, and subsequently in *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), aff’d sub nom. Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). *Wyatt* was a class action lawsuit brought on behalf of all the patients at one of Alabama’s state mental hospitals alleging inadequate treatment. *Id.* at 782. The court ruled that the treatment programs were scientifically and medically inadequate and that they deprived patients of their constitutional rights. *Id.* at 784. The court specifically held that civilly committed mental patients “unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition.” *Id.* The court issued a decree establishing and ordering the implementation of standards necessary to meet medical and constitutional minimums. *Id.* at 785-86. The decision in the *Wyatt* case resulted in the release of many patients from that facility and was instrumental in the deinstitutionalization of many state hospitals throughout the United States.

\[257\] See, e.g., U.S. Const. amend. XV, § 1 (“The right of citizens of the United States to vote shall not be denied or abridged by the United States or by any State on account of race, color, or previous condition of servitude.”); *id.* amend. XIX, cl. 1 (“The right of citizens of the United States to vote shall not be denied or abridged by the United States or by any State on account of sex.”); *id.* amend. XXVI, § 1 (“The right of citizens of the United States, who are
eighteen years of age or older, to vote shall not be denied or abridged by the United States or by any State on account of age.”).  

\[ Id. \text{ amend. V (“No person . . . shall be compelled in any criminal case to be a witness against himself . . . .”); id. amend. VI (“In all criminal prosecutions, the accused shall enjoy the right . . . to have the Assistance of Counsel for his defence.”). In Miranda v. Arizona, 384 U.S. 436 (1965) the Supreme Court interpreted the Fifth Amendment to require that:}

Prior to any questioning, the person must be warned that he has a right to remain silent, that any statement he does make may be used as evidence against him, and that he has a right to the presence of an attorney, either retained or appointed. The defendant may waive effectuation of these rights, provided the waiver is made voluntarily, knowingly and intelligently. If, however, he indicates in any manner and at any stage of the process that he wishes to consult with an attorney before speaking there can be no questioning.

\[ Id. \text{ at 444-45.}

\[ U.S. \text{ Const. art. III, § 2, cl. 3 (“The Trial of all Crimes . . . shall be by Jury . . . .”); id. amend. VI (“In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury . . . .”).} \]
[including nontreatment] and of the dangers inherently and potentially involved in each.” The competent adult patient’s ‘informed refusal’ supersedes and discharges the obligation to render further treatment. 260

In 1990, the United States Supreme Court ruled that mentally ill, sentence-serving prisoners possess “a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs.” 261 If mentally ill prisoners have a right to refuse treatment, mentally ill nonprisoners surely do. In fact, because civilly committed patients have been confined without a criminal trial and without a criminal conviction, special deference should be paid to their decisions to refuse treatment. The state has exercised its authority to detain them because of their predicted dangerousness or inability to provide for themselves. The state’s legitimate interest in protecting them, and in protecting others from them, is achieved by the confinement itself—without coerced treatment. If the confined individual competently chooses to refuse treatment, even if such decision may prolong his or her confinement, the individual’s constitutionally protected liberty interest in refusing treatment should outweigh any claimed governmental interest in coercing treatment.

Some, however—especially psychiatrists and other hospital professionals who wish to treat involuntarily committed patients even if those patients refuse that treatment—assert that the decision to involuntarily commit a patient determines—or should determine—that the patient is incompetent to make

260 Thor, 855 P.2d at 383 (quoting Cobbs v. Grant, 502 P.2d 1, 10 (1972)).
medical decisions. The patient has a diagnosable mental disorder and has been placed in a mental treatment facility as an involuntary patient. The patient may not even realize that he or she has a problem. If the patient did realize it, he or she would—or if competent, the patient should—be willing to accept the physician’s recommendation as to the appropriate treatment. If the patient is unwilling to accept treatment voluntarily, the patient must be incompetent. After all, the physician is better able than the resisting patient to determine what treatment should be utilized to alleviate the condition that led to the patient’s involuntary confinement in the first instance. That’s the argument.

The issue, however, is not what is the best treatment, or the most efficacious treatment, or the medically appropriate treatment. The issue is not whether, from a medical perspective, the patient is making a bad decision, or exercising poor judgment. Rather, the issue is whether the patient is competent to make the judgment to accept or reject the proposed treatment. Although the physician may dispassionately weigh the risks and benefits of a medication and determine that its use is medically appropriate and desirable, nevertheless, the patient’s refusal, while it may be characterized as a bad judgment—like stuffing oneself with a Monster Thickburger—may not be an incompetent judgment. Especially for a patient who has experienced the side effects of psychotropic medication—akinesia, akathesia, tardive dyskinesia, or obesity with its increased risk of coronary heart disease and type II diabetes—a refusal of medication to avoid such side effects can hardly be called irrational.

Competence to accept or reject proposed treatment with psychotropic medication is determined by whether the individual can rationally assess the risks and benefits of, and the alternatives to, that medication. That is the

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262 The hospital psychiatrist tends to view a patient’s refusal of medications as irrationally self-destructive, a product of such influences as anger at the therapist or family, tensions in the hospital ward, and the like. . . . Hospital psychiatrists tend to perceive reasons for refusing medications as unworthy.” Alexander Brooks, The Constitutional Right to Refuse Antipsychotic Medications, 8 BULL. AM. ACADEMY PSYCH. & L. 179, 214-15 (1980).

263 See supra note 8.

264 See, e.g., In re Virgil D., 524 N.W.2d 894, 898 (Wis. 1994) (holding that, under the Wisconsin statute, the only standard applied to evaluate a
same test that is used to determine whether any person is competent to accept or reject any proposed treatment under the common law doctrine of informed consent.265

Proof that a mentally disordered individual meets the civil commitment criteria and is subject to involuntary detention does not establish that the individual is incompetent to refuse proposed treatment. In most states, the commitment laws do not presume or require incompetence as a criterion for civil commitment.266 Merely because the person has been found to be mentally disordered and dangerous to self or others, or unable to provide for basic necessities—the typical criteria for commitment267—does not mean that the person is unable to understand the risks, benefits, and alternatives to the medication patient’s competency to refuse medication is “whether the patient is able to express an understanding of the advantages and disadvantages of, and the alternatives to, accepting medication or treatment”).

265 See supra text accompanying notes 36-54.
266 See Blackburn, supra note 222, at 472 n.88, for statutes declaring that civil commitment neither raises a presumption of, nor constitutes a finding of, the patient’s incompetence; see also Dennis E. Chicon, The Right to “Just Say No”: A History and Analysis of the Right to Refuse Antipsychotic Drugs, 53 LA. L. REV. 283, 350 n.435 (1992), for court decisions separating the commitment and competence issues. As the Alabama Supreme Court stated: “[A] person involuntarily committed to a mental hospital is not ipso facto barred from the invocation of the ‘informed consent’ doctrine.” Nolen v. Peterson, 544 So. 2d 863, 867 (Ala. 1989). As of 1985, only eight states even allowed the issues of civil commitment and competency to be determined in the same proceeding. John Parry, Incompetency, Guardianship, and Restoration, in SAMUEL J. BRACKETT ET AL., THE MENTALLY DISABLED AND THE LAW 369, 374 n.35, 405-07 (3d ed. 1985).
267 See, e.g., CAL. WELF. & INST. CODE §§ 5150 (West 1998) (detention, without court order, for seventy-two hours to evaluate and treat mentally disordered persons who are a danger to self or others or gravely disabled), 5200 (court-ordered detention for seventy-two hours to evaluate and treat persons who are a danger to self or others or gravely disabled), 5250 (certification for fourteen days of intensive treatment for persons who are a danger to self or others or gravely disabled), 5260 (certification for an additional fourteen days of intensive treatment for imminently suicidal persons ), 5300 (postcertification 180-day detention for persons who present a demonstrated danger of inflicting substantial physical harm upon others).
that the physician is prescribing to treat his or her condition. A mentally disordered person’s dangerousness or inability to provide for basic necessities may justify a deprivation of liberty, but without a separate determination of incompetence, such condition does not justify a deprivation of the patient’s right to refuse treatment or other rights. Only when a person’s incompetence to make the treatment decision is established can another’s judgment be substituted.

Thirty years ago, when the right of mental patients to refuse treatment was first emerging in the courts, Alan Stone, M.D., a noted Harvard psychiatrist and former President of the American Psychiatric Association, proposed, and the American Psychiatric Association subsequently endorsed the proposal, that civil commitment be conditioned upon a finding of incompetence to make treatment decisions. Under the proposal, competent mentally disordered people would neither be civilly committed nor involuntarily treated. In essence, the right to refuse treatment survives, but it is not a right enjoyed by involuntarily committed mental patients. For such patients, the right to refuse treatment is restored only when they are released from confinement.

The proposal has been severely criticized for forcing a decision that may be premature. At the time of the initial civil commitment hearing, information regarding the proposed patient’s competence to make treatment decisions may not be available. The proposed patient’s mental disorder may not have been finally diagnosed and a treatment plan may not have been developed. How can a proposed patient’s competence to make an informed decision be measured when the treatment has not yet been prescribed and the risks, benefits, and alternative treatments have not been explained?

The proposal has also been criticized for eliminating any meaningful

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269 In 1982, the American Psychiatric Association approved a model civil commitment law. The model law is presented and discussed in Clifford D. Stromberg & Alan A. Stone, A Model State Law on Civil Commitment of the Mentally Ill, 20 Harv. J. on Legis. 275, 333-34 (1983).

270 Chicon, supra note 266, at 389.
opportunity for an involuntary mental patient to challenge the doctor’s treatment decisions.\textsuperscript{271} Loss of the right to refuse treatment seems particularly inappropriate for a patient who was unable to make reasoned treatment decisions at the time he or she was initially committed but who has regained competence to make such decisions during the period of involuntary commitment.\textsuperscript{272}

Additionally, a focus on the patient’s competence at the time of the commitment decision may well contaminate the competence inquiry.\textsuperscript{273} If the other criteria for commitment have been proven, i.e., the person is mentally disordered and either dangerous or unable to provide for basic needs, the judge is likely to make a \textit{pro forma} finding of incompetence if such finding is required in order to involuntarily commit the person.

In a few states, statutes condition involuntary commitment upon a finding that the person “lacks sufficient judgment to make responsible decisions with

\textsuperscript{271}Historically—prior to the development of the doctrine of informed consent—physicians believed that they alone were qualified by education, training, and experience to make treatment decisions. Any involvement by the patient in the decisionmaking process was resented as an unwarranted intrusion into the physician’s professional prerogatives. \textit{See} Morris, \textit{supra} note 40, at 314-15 (discussing the Hippocratic Oath); \textit{see also} Loren H. Roth, \textit{The Right to Refuse Psychiatric Treatment: Law and Medicine at the Interface}, 35 \textit{Emory L.J.} 139, 143 (1986) (quoting \textit{American Medical Ass’n Code of Medical Ethics}, ch. 1, art. 1, § 2 (1847), \textit{reprinted in Percival’s Medical Ethics} 218 (Leake ed. 1927). The 1847 Code of Ethics of the American Medical Association included a statement of “Obligations of Patients to Their Physicians,” which provided: “The obedience of a patient to the prescriptions of his physician should be prompt and implicit. He should never permit his own crude opinions as to their fitness, to influence his attention to them.” \textit{Id.}

\textsuperscript{272}Chicon, \textit{supra} note 266, at 388.

\textsuperscript{273}Perhaps in recognition of the possible contamination of issues if both are considered in the same proceeding, an Illinois statute expressly requires that a hearing on the issue of whether psychotropic medication may be administered involuntarily to a patient “shall be separate from a judicial proceeding held to determine whether a person is subject to involuntary admission.” 405 Ill. Comp. Stat. Ann. 5/2-107.1(a)(2) (West 2005). The Illinois Supreme Court has ruled that this statute precludes a joint hearing on the two issues. \textit{In re Barbara H.}, 702 N.E.2d 555, 562 (Ill. 1998).
respect to the person’s hospitalization or treatment”274 or that the person’s “judgment is so impaired that he or she is unable to understand his or her need for treatment”275 or that the person “lacks sufficient insight or capacity to make responsible decisions with respect to his treatment.”276 Nevertheless, in those states, other statutes typically clarify that, despite such language, the involuntary commitment decision does not equate to a finding of incompetency that eliminates the patient’s right to refuse treatment.277

277 See IOWA CODE ANN. § 229.27(1) (West Supp. 2006) (providing that involuntary hospitalization does not equate with incompetency); MICH. COMP. LAWS ANN. § 330.1489(1) (West 1999) (providing that a determination that a person requires treatment or an order of a court authorizing hospitalization does not give rise to a presumption of, constitute a finding of, or operate as an adjudication of legal incompetence); S.C. CODE ANN. § 44-22-140(B) (West 2002) (providing that competent patients may not receive treatment or medication in the absence of their express and informed consent).

In Wisconsin, for most patients, the involuntary commitment decision does not equate with a finding of incompetency. See supra text accompanying notes 97-106 (discussing State ex rel. Jones v. Gerhardstein, 416 N.W.2d 883 (Wis. 1987)). Nevertheless, eight years after the Jones decision, the legislature created a new category of patient for whom the commitment criteria includes a requirement that the person is either incapable of understanding the advantages, disadvantages, and alternatives of the proposed medication or is incapable of applying that understanding in order to make an informed choice as to whether to accept or refuse the prescribed medication. WIS. STAT. ANN. § 51.20(1)(a)(2)(e) (West 2003). In In re Dennis H., 647 N.W.2d 851 (Wis. 2002), the Wisconsin Supreme Court upheld the constitutionality of the new commitment standard. Id. at 864. Although the court did not specifically decide whether involuntarily-committed patients in this new category lose the right to refuse treatment by the commitment decision itself, the court’s language certainly suggests that the right to refuse is lost. For example, the court states that this new commitment standard:

- applies to mentally ill persons whose mental illness renders them incapable of making informed medication decisions . . .
- It allows the state to intervene with care and treatment before the deterioration reaches an acute stage . . . . There is a rational basis for distinguishing between a mentally ill person

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who retains the capacity to make an informed decision about medication or treatment and one who lacks such capacity. Id. at 861-62.

Division 5 of the California Welfare and Institutions Code, entitled Community Mental Health Services, was added by the California Mental Health Act of 1967, ch. 1667, § 36, 1967 Cal. Stat. 4053, 4074. Division 5 consists of two parts: the Lanterman-Petris-Short Act, CAL. WELF. & INST. CODE §§ 5000-5550 (West 1998 and Supp. 2006), and the Bronzan-McCorquodale Act (formerly the Short-Doyle Act), id. §§ 5600-5781, which provides the legislative framework for the organizing and financing of “community mental health services for the mentally disordered in every county through locally administered and locally controlled community mental health programs.” Id. § 5600 (West 1998).


See, e.g., Frank W. Miller et al., The Mental Health Process xvi (2d ed. 1976) (characterizing the California experiment as “innovative” and declaring that LPS “must be considered throughout any discussion of mental health programs”).

See, e.g., David Bazelon, Implementing the Right to Treatment, 36 U. Chi. L. Rev. 742, 753 (1969) (asserting that LPS “promises virtually to
other state legislatures. With only some minor tinkering over the years, LPS remains the law today in California. Under LPS, if a person, as a result of mental disorder, is believed to be a danger to others, or to himself or herself, or gravely disabled, he or she may be detained for an initial seventy-two-hour treatment and evaluation period. ‘Thereafter, the person may be certified for a fourteen-day intensive treatment period if he or she is determined to be dangerous or gravely disabled.

A key component of LPS is the elimination of indeterminate commitment of nondangerous, mentally ill persons and the use of conservatorships to provide continuing assistance in managing the affairs of gravely disabled patients who need such assistance after they have been treated in a mental hospital for seventeen days or less. For an LPS conservator to be appointed, the court must find that the patient is gravely disabled—defined as “[a] condition in which [the] person, as a result of mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter.” The LPS

eliminate involuntary hospitalization except for short term crisis situations. . . . The procedural protections it promises are impressive indeed when compared with commitment proceedings in other states.

See, e.g., WASH. REV. CODE ANN. §§ 71.05.010-71.05.940 (West 2002).

CAL. WELF. & INST. CODE §§ 5150 (West 1998) (detention, without court order, for seventy-two hours to evaluate and treat mentally disordered persons who are a danger to self or others or gravely disabled) & 5200 (West 1998) (court-ordered detention for seventy-two hours to evaluate and treat persons who are a danger to self or others or gravely disabled).

Id. § 5250 (certification for fourteen days of intensive treatment for persons who are a danger to self or others or gravely disabled).

The California legislative subcommittee that recommended revision of California’s civil commitment statutes issued a report that served as a resource document for the LPS legislation. That report recommended the creation of LPS conservatorships to provide continuing assistance in managing the affairs of those gravely disabled patients who needed such assistance following treatment during a fourteen-day certification. SUBCOMM. ON MENTAL HEALTH SERVICES, ASSEMBLY INTERIM COMM. ON WAYS AND MEANS, CAL. LEGIS., THE DILEMMA OF MENTAL COMMITMENTS IN CALIFORNIA—A BACKGROUND DOCUMENT 133 (1966).

conservatorship is established for a one-year period, but it may be renewed upon proof of continuing grave disability.\textsuperscript{287}

At the time an LPS conservatorship is established, the court may grant the conservator\textsuperscript{288} the authority to place his or her conservatee in a mental hospital\textsuperscript{289} and to require the conservatee to receive treatment to remedy or prevent the recurrence of the conservatee’s condition of grave disability.\textsuperscript{290} Although the court, in appointing a conservator for a gravely disabled person, has discretion to grant or to withhold the placement authority, the court almost always grants this authority to the conservator.\textsuperscript{291}

\textsuperscript{287}Id. § 5361.

\textsuperscript{288}A statute provides that the selection of a conservator shall be subject to the following list of priorities: (1) the nominee of the proposed conservatee if the proposed conservatee has sufficient capacity to make an intelligent preference; (2) the spouse or domestic partner of the proposed conservatee; (3) an adult child of the proposed conservatee; (4) a parent of the proposed conservatee; (5) a brother or sister of the proposed conservatee; (5) any other person or entity eligible for appointment as a conservator. However, the statute also provides that appointment of a conservator is subject to this list of priorities “unless the officer providing conservatorship investigation recommends otherwise to the superior court.” Id. § 5350(b)(1) (incorporating by reference the list of priorities in CAL. PROB. CODE 1812(b) (West 2002)). In practice, the conservatorship investigator almost invariably recommends the appointment of a public agency—such as the Department of Public Welfare—as conservator, and the court almost invariably accepts the recommendation. See Grant H. Morris, \textit{Conservatorship for the “Gravely Disabled”: California’s Nondeclaration of Nonindependence}, 15 SAN DIEGO L. REV. 201, 226-27 (1978) (finding that relatives or friends were selected as conservator in only three of the 461 cases in which LPS conservatorships were established in San Diego County over a nine-month period).

\textsuperscript{289}CAL. WELF. & INST. CODE § 5358(a)(2) (West 1998).

\textsuperscript{290}Id. § 5358(b).

\textsuperscript{291}Eight years after LPS was enacted into law, students in my seminar in Law and Mental Disorder observed LPS conservatorship proceedings in the San Diego County Superior Court and gathered data on those proceedings. See Morris, \textit{supra} note 288, at 225. In each and every one of the sixty-three cases that my students observed, the court granted the conservator the authority to place his or her conservatee in a mental hospital and to require the conservatee to receive treatment for his or her condition. Id. at 228.
California statutes provide that a person may apply for voluntary admission to a mental treatment facility when he or she is mentally competent to apply, or if he or she is an LPS conservatee, when his or her conservator applies if the court has granted the conservator the authority to place the conservatee in a mental treatment facility.  However much the conservatee protests, he or she is admitted to that facility as a voluntary patient.  However much the conservatee protests, he or she may be required to take psychotropic medication that his or her doctor prescribes and the conservator, exercising a substituted judgment for the conservatee, authorizes.

Elsewhere, I characterize these conservatorship statutes as “California’s nondeclaration of nonindependence,” laws that allow civil commitment and coerced treatment without the crunch. For LPS conservatees, there is no involuntary civil commitment hearing. For LPS conservatees, there is no right

The students also reported that the LPS conservatorship proceedings were performed in a perfunctory fashion. Eight hearings were one minute or less in duration. Nineteen hearings were between one and two minutes in duration. Nine hearings were between two and three minutes in duration. Thus, more than half the hearings—a total of thirty-six of the sixty-three that were observed—were completed in three minutes or less. Id. at 232. Only nine hearings were more than eight minutes in duration. Id. at 232 n.173.

In forty-two of the sixty-three cases, counsel representing a proposed conservatee asked no questions of the reporting psychiatrist. In most of the remaining twenty-one cases, the lawyer asked only one question. In only one case did the proposed conservatee’s counsel request either the assistance of a psychiatrist or the examination of the proposed conservatee by another psychiatrist. There was not a single case in which counsel for the proposed conservatee offered testimony of an independent psychiatrist. In fifty-six of the sixty-three cases, no questions were asked of the proposed conservatee. In fifty-eight of the sixty-three cases, counsel for the proposed conservatee neither proposed alternatives to conservatorship nor even suggested that others explore these possibilities. Id. at 233.

292 CAL. WELF. & INST. CODE §§ 6000(a) & 6002 (West 1998). Additionally, although other voluntary patients may depart the facility by giving notice of a desire to do so, LPS conservatees may depart only if notice is given by their conservators. Id.

293 Morris, supra note 288, at 201.

294 Id. at 215.
to refuse treatment hearing. Under California’s so-called “Magna Carta of the mentally ill,” LPS conservators are given carte blanche control over LPS conservatees.

The use of LPS conservatorships to assure involuntary detention and coercive treatment is the option of choice for civilly committed patients deemed worthy of long-term control. In the most current report available, the California Department of Mental Health reveals that in the 2002-2003 fiscal year, 139,880 adults were detained on seventy-two-hour evaluation holds as dangerous to self, dangerous to others, or gravely disabled. Of that number, 60,637 were detained on fourteen-day intensive treatment certifications, using the same commitment criteria. Thereafter, only twenty-seven were detained for a 180-day period as dangerous to others. Do we really believe that after only seventeen days or less of inpatient hospitalization, there were only twenty-seven dangerously mentally ill people in the entire state of California? Highly doubtful! But many of those who were initially detained as dangerous to others were suddenly found to be gravely disabled and processed through the LPS conservatorship route. For fiscal year 2002-2003, a total of 14,518 LPS conservatorships were established. Thus, LPS conservatorships were used

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296 Id. at 5 tbl.3.

297 Id. at 8 tbl.6. See Cal. Welf. & Inst. Code § 5300 (West 1998) (establishing the criteria for 180-day involuntary commitment of dangerous persons). Although the danger criteria of section 5300 is rarely used to involuntarily commit patients in California, the criteria is frequently used to impose involuntary treatment on patients already committed as mentally disordered offenders. See infra text accompanying notes 525-603.

298 Statistics & Data Analysis, supra note 295, at 9 tbl.7. In its statistical report, the Department of Mental Health listed these conservatorships as “permanent conservatorships.” However, LPS conservatorships are established for a one-year period. Cal. Welf. & Inst. Code §5361 (West 1998). The conservatorship may be re-established for successive one-year periods upon a finding that the conservatee continues to be gravely disabled. Id. In addition to the 14,518 one-year conservatorships, 6,492 temporary conservatorships were established during fiscal year 2002-03. Statistics &
in 99.8 percent of cases (i.e., 14,518 LPS conservatorships out of 14,545 total cases) in which long-term control (i.e., 180 days or longer) was deemed appropriate.

This grant of authority to conservators to involuntarily commit their conservatees as “voluntary” patients and to impose treatment upon them over their objection cannot be justified. In *Riese v. St. Mary’s Hospital & Medical Center*,299 a class action lawsuit brought on behalf of mental patients involuntarily committed pursuant to California’s seventy-two hour treatment and evaluation hold100 or subsequently certified for fourteen days pursuant to California’s intensive treatment hold,301 the California Court of Appeal held that such patients could not be required to take psychotropic medication against their will in nonemergency situations.302 “It is one of the cardinal principles of

**Data Analysis, supra** note 295, at 9 tbl.7. Temporary conservatorships are established for thirty days pending a determination of whether a one-year conservatorship is appropriate. **Cal. Welf. & Inst. Code § 5352.1** (West 1998).


301**Id. § 5250.**

302*Riese*, 271 Cal. Rptr. at 201 (holding that involuntarily committed patients have the right to exercise informed consent). The *Riese* court relied upon numerous statutory provisions to support the requirement of informed consent by involuntarily committed mental patients. See **id.** at 204-10. The court specifically rejected the argument that the failure of LPS to explicitly grant to involuntary patients the right to refuse psychotropic medication constitutes a basis for denying them that right. **Id.** at 208. Although the court withheld judgment on whether constitutional bases also support informed consent in this context, **id.** at 201, it noted that the right of persons not adjudicated incompetent to give or withhold consent to medical treatment—including treatment with psychotropic medication—is protected both by the common law and by the constitutional right to privacy. **Id.** at 207-08. California courts uphold decisions by competent adults to refuse life-sustaining treatment. **Id.** at 208 (discussing *Bartling v. Superior Court*, 209 Cal. Rptr. 220,
LPS,” said the court, “that mental patients may not be presumed incompetent solely because of their hospitalization.” 303 The individual’s right to give or withhold consent to medical treatment—including treatment with psychotropic medication—“does not disappear upon involuntary commitment.” 304

Before treatment can be imposed on an involuntary patient without his or her consent, the Riese court required that “there must be an evidentiary hearing directed to the question whether the patient is able to understand and knowingly and intelligently act upon information required to be given regarding the treatment.” 305 The court conducting that hearing must determine the patient’s incapacity by clear and convincing evidence. 306 If the court determines that the involuntary patient possesses the capacity to give informed consent to psychotropic medication and the patient refuses to do so, “the patient may not be required to undergo the treatment.” 307 In 1991, two years after the Riese decision was republished, the California Legislature enacted statutes that confirm and codify, with some modifications, 308 Riese’s competency hearing requirement. 309 The legislation specifically declares that involuntarily committed mental patients have a right to refuse treatment with psychotropic

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225 (Cal. Ct. App. 1984)). Logically, they can not reject non-life threatening medication-refusal decisions by competent mental patients.

303 Id. at 206.
304 Id. at 213.
305 Id. at 211. In so ruling, the court adopted LPS statutory provisions governing the determination of a patient’s capacity to consent to electroconvulsive therapy, saying that those provisions were “equally appropriate” to the determination of a patient’s capacity to consent (or refuse consent) to psychotropic medication. Id.
306 Id.
307 Id. at 212.
308 For example, instead of judicial hearings to determine a patient’s capacity to give or withhold informed consent, the statute uses administrative hearings, conducted by a superior court judge, a court-appointed commissioner or referee, or a court-appointed hearing officer. Cal. Welf. & Inst. Code § 5334(c) (West 1998). At such hearings, patients are represented by counsel or by an advocate. Id. § 5333(a).
medication. Even if a patient is determined to lack the capacity to refuse treatment, the legislation provides that such incapacity remains in effect only for the duration of the seventy-two hour or fourteen day detention period that the patient is being detained.

If a finding of grave disability is not sufficient, in and of itself, to warrant coerced treatment of an involuntarily detained mental patient, then is a finding of grave disability, made in a hearing to establish an LPS conservatorship, sufficient to warrant coerced treatment of an LPS conservatee? The answer, according to the California statutes is: Yes. Although the Riese court ruled that mental patients are not presumed incompetent solely because of their hospitalization, and although the establishment of an LPS conservatorship is not an adjudication that the LPS conservatee is incompetent or is incapable of making treatment decisions, nevertheless, in reality, LPS conservatees are

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310 Cal. Welf. & Inst. Code § 5325.2 (West 1998). The right to refuse medication is not absolute; it is subject to statutory limitations. Id.

311 Riese, 271 Cal. Rptr. at 206.

312 Id. at 204 (“Appointment of a conservator under LPS . . . does not involve an adjudication of incompetence . . . .”). In Board of Regents v. Davis, 533 P.2d 1047 (Ca. 1975), the California Supreme Court noted that LPS conservatorships, which are established for persons who are gravely disabled as a result of mental disorder or impairment by chronic alcoholism, are identical to Probate Code conservatorships established for other reasons. Id. at 1053. Probate Code conservatorships were created statutorily in 1957 as an alternative to guardianship in order to avoid the stigma of the label “incompetency.” Id. at 1051. Conservatorship law should not be interpreted to strip the competent conservatee of his or her decisionmaking authority. See id. at 1054. See generally Morris, supra note 288, at 208-14 (discussing similarities and differences in Probate Code guardianships, Probate Code conservatorships, and LPS conservatorships in California).

313 Riese, 271 Cal. Rptr. at 204 (“Appointment of a conservator under LPS . . . does not involve an adjudication of . . . incapacity to make treatment decisions about one’s own body.”). See also Keyhea v. Rushen, 223 Cal. Rptr. 746, 751 (Cal. Ct. App. 1986) (“LPS conservatees have a right to refuse involuntary long-term psychotropic medication absent a judicial determination of their incompetency to do so.”); 60 Ops. Cal. Att’y Gen. 375, 377 (1977) (“[T]he conservatee is not divested of the right to make his or her own medical decisions absent a specific determination by the court that the conservatee cannot make those decisions.”).
presumed incompetent solely because of their status as gravely disabled conservatees. Although the Riese court ruled that an individual’s right to withhold consent to psychotropic medication “does not disappear upon involuntary commitment,” that right does disappear for LPS conservatees when their conservators order them to undergo treatment as “voluntary” patients.

Surely, one would assume that the judge establishing the conservatorship is required to make some new finding of fact that the conservatee is incapable of making rational treatment decisions before the judge grants authority to the conservator to place the conservatee in a mental hospital and require the conservatee to accept treatment. In dicta, the Riese court suggested that conservatees retain the right to refuse medical treatment “unless the court, after making appropriate findings, specifically denies the conservatee this right in its order and authorizes the conservator to make informed consent decisions.”

LPS conservatorship legislation, however, imposes no obligation on the court that establishes a conservatorship to make “appropriate findings” before granting the conservator placement and treatment authority over the conservatee. LPS conservatorship legislation imposes no obligation on the court to determine that the conservatee is incompetent—that he or she lacks the mental capacity to give or withhold informed consent—before it grants the conservator the authority to order that treatment be imposed over the conservatee’s objection. In fact, LPS conservatorship legislation does not even require that the court make any additional determination beyond a finding of grave disability. Rather, an LPS conservatorship statute merely provides that the conservatorship investigator’s report to the court “shall contain his or her recommendations concerning the powers to be granted to . . . the

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314 Riese, 271 Cal. Rptr. at 213.
315 Id. at 204 (emphasis added). See also Keyhea, 223 Cal. Rptr. at 755 (asserting that under LPS, a court determination of incompetency is required before long-term psychotropic medication may be administered without a patient’s consent); 60 Ops. Cal. Att’y Gen. 375 (1977) (asserting that the court should not divest the conservatee of the right to make medical decisions “unless it finds that the conservatee lacks the mental capacity to rationally understand the nature of the medical problem, the proposed treatment and the attendant risks”).
conservator.”316 The next statute provides that the conservatorship investigator’s report shall recommend for or against the imposition of various disabilities on the conservatee, specifically mentioning as one such disability, the right to refuse or consent to treatment related to the conservatee’s condition of grave disability.317 The following statute merely provides that the conservator “shall . . . have the right, if specified in the court order, to require his or her conservatee to receive treatment related specifically to remedying or preventing the recurrence of the conservatee’s being gravely disabled.”318 Apparently, the finding of grave disability is sufficient, in and of itself, to warrant the court authorizing the conservator to place the conservatee in a mental hospital and to require the conservatee to accept treatment. A study of LPS conservatorships in San Diego County revealed that in every case in which the conservatorship investigator petitioned the court to establish a conservatorship, the investigator recommended that the conservator be so empowered, and in every such case, the court in establishing the conservatorship, accepted the recommendation and so empowered the conservator.319

One need only examine the facts of the Riese case to realize that LPS conservatees, despite their inability to provide for their basic necessities of food, clothing, and shelter, can be competent to make treatment decisions regarding their mental disorder. On June 12, 1985, Eleanor Riese, the named

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317 I d. § 5357.
318 I d. § 5358. The statutory language empowering the conservator to require the conservatee to receive treatment to prevent the recurrence of the conservatee’s grave disability seems inappropriate. An LPS conservatorship is established for a person who is gravely disabled. If the conservatee is no longer gravely disabled, the conservatorship should terminate. Mere concern that the condition of grave disability might recur is insufficient to continue the conservatorship and to continue the conservator’s power to require the conservatee to receive treatment. See C A L. W E L F. & I N S T. C O D E § 5364 (W est 1998) (authorizing the conservatee, at six-month intervals, to petition for a rehearing on his or her status as a conservatee).
319 Morris, supra note 288, at 228. See supra note 291 (discussing the San Diego County study and the inadequacy of counsel for proposed LPS conservatees).
plaintiff in the class action suit, entered St. Mary's Hospital as a voluntary patient. Prior to this admission, she had been treated for chronic schizophrenia with Mellaril,\textsuperscript{320} a psychotropic medication. As a result of that earlier treatment, her bladder had been severely damaged. Nevertheless, the treating doctor prescribed Mellaril, and she consented to its use. Although she complained of dizziness and dry mouth and stated that she was receiving too much medication, the dosage was not reduced. When she protested and refused medication, she was forcibly injected and, on June 19, 1985, she was committed as an involuntary patient. The basis for involuntary commitment was that Ms. Riese became violent when she refused medication. On June 26, 1985, a conservatorship was recommended on the ground that Ms. Riese was unable to provide for her own food, clothing, and shelter. A temporary conservator was appointed on July 2, 1985, and a conservator was appointed on August 5, 1985. The court authorized the conservator to place Ms. Riese in a mental hospital and to require her to accept treatment over her objection. When she refused to ingest medication orally, she was forcibly medicated intramuscularly.\textsuperscript{321} According to the \textit{Riese} court, Ms. Riese “continued to suffer from swollen feet, urinary problems, shaking, memory loss and seizures.”\textsuperscript{322} Ms. Riese died on April 6, 1991. She was forty-seven years old. Although no autopsy was performed, her death was attributed to renal failure resulting from the cumulative effects of medication she had received over her lifetime.\textsuperscript{323}

Was Ms. Riese’s refusal to take psychotropic medication a competent decision based on rational reasons? Yes. Was her decision accepted by the treating

\textsuperscript{320}Mellaril® is the Sandoz Pharmaceuticals Corporation brand of thioridazine HCL. \textsc{Physicians’ Desk Reference} 2168 (49th ed. 1995). Today, physicians receive a “black box” warning that thioridazine has the “potential for significant, possibly life-threatening proarrhythmic effects” and “should be reserved for use in the treatment of schizophrenic patients who fail to show an acceptable response to adequate courses of treatment with other antipsychotic drugs.” \textsc{Physicians’ Desk Reference} 2122 (60th ed. 2006).


\textsuperscript{322}\textit{Id.} at 202.

\textsuperscript{323}Telephone Interview with Colette Hughes, Protection and Advocacy, Inc., co-counsel for Eleanor Riese in \textit{Riese v. St. Mary’s Hosp. & Med. Ctr.} (July 11, 1994).
physicians, by her conservator, and by the court? No. One could easily conclude that LPS conservatorships are not established to provide needed assistance to a conservatee who is unable to provide for food, clothing, and shelter. Rather, LPS conservatorships are established in order to subject conservatees to long-term treatment with psychotropic medication despite their protests.
Chapter 6

Wronging a Right:
Substituting Generalized Danger
for the Requirement of an Emergency

As previously discussed, one exception to the requirement of obtaining a patient’s informed consent arises in an emergency situation when the individual is incapable of considering information about the proposed treatment or making a decision as to whether to consent, and treatment is immediately necessary to prevent either death or a serious injury to the patient. In an emergency, the physician is privileged to proceed to prevent the disastrous consequence from occurring. The emergency exception is applicable to all patients, including involuntary mental patients. California, for example, has enacted legislation that specifically provides that in an emergency, a protesting mental patient may be treated with antipsychotic medication that is necessary to treat the emergency condition. The legislature narrowly defined “emergency” as “a situation in which action to impose treatment over the person’s objection is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient or others, and it is

324 See supra text accompanying notes 41-45.
325 Although the legislature used the term “anitpsychotic medication” instead of the broader term “psychotropic medication,” the legislature broadly defined antipsychotic medication so as to include psychotropic medications that are not antipsychotic medications. “Antipsychotic medication” was defined statutorily as “any medication customarily prescribed for the treatment of symptoms of psychoses and other severe mental and emotional disorders.” CAL. WELF. & INST. CODE § 5008 (l) (West 1998).
326 CAL. WELF. & INST. CODE § 5332(e) (West Supp. 2006).
impracticable to first gain consent.”\textsuperscript{327} Additionally, even when forced treatment with antipsychotic medication is authorized, the statute limits the permitted treatment to that which “is required to treat the emergency condition . . . .”\textsuperscript{328}

Recently, however, the limited emergency exception to the requirement of informed consent has been undermined by court decisions and legislation authorizing treatment of dangerous patients–without requiring that an emergency situation exists. If the conservatorship/guardianship device has been the option used to assure that civilly committed patients are medicated despite their refusal, the dangerousness device has been the option used to assure that mentally disordered, sentence-serving prisoners and other mentally disordered individuals who are not prisoners but who are either currently involved in the criminal process, or who were “specially” civilly committed after their release from penal confinement, are medicated despite their refusal.

\textbf{A. Prisoners}

\textit{Washington v. Harper}\textsuperscript{329} was the first United States Supreme Court case that directly considered whether competent mental patients have a right to refuse treatment. The case did not involve a civilly committed mental patient, but rather, involved a mentally disordered prisoner. In \textit{Harper}, the Supreme Court held that a prison inmate possesses a significant liberty interest in avoiding the unwanted administration of psychotropic medication.\textsuperscript{330} That liberty interest, said the Court, was conferred by an administrative policy of the

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\textsuperscript{327}\textit{Id.} § 5008(m) (West 1998). Another California statute authorizes the denial of a patient’s rights “for good cause” and orders the Director of Mental Health to “adopt regulations specifying the conditions under which [a patient’s rights] may be denied.” \textit{Id.} § 5326. The regulation promulgated pursuant to that statute permits psychotropic medication to be administered in an emergency but imposes an additional limitation on the definition of emergency: “An emergency exists when there is a sudden marked change in the patient’s condition so that action is immediately necessary . . . .” \textit{Cal. Code Regs.} tit. 9, § 853 (2006).


\textsuperscript{329}494 U.S. 210 (1990).

\textsuperscript{330}\textit{Id.} at 221-22.
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Special Offender Center at which the prisoner and other convicted felons with serious mental disorders were diagnosed and treated, and was entitled to protection under the Fourteenth Amendment’s Due Process Clause.\textsuperscript{331}

The Court, however, rejected the prisoner’s contention that this liberty interest prevented the state from overriding his treatment refusal decision without a judicial finding that he was incompetent to make treatment decisions.\textsuperscript{332} Under the challenged regulation, a prisoner could be subjected to involuntary treatment–without a judicial finding of incompetence–if a psychiatrist determined that the prisoner posed a “likelihood of serious harm” to himself or herself, others, or their property.\textsuperscript{333} The prisoner’s right to refuse treatment, said the Court, “must be defined in the context of the inmate’s confinement.”\textsuperscript{334} Even if a more rigorous standard of review would ordinarily be required to measure the alleged infringement of a nonprisoner’s fundamental constitutional right, a prison regulation that infringes on a prisoner’s constitutional right–even a prisoner’s fundamental constitutional right–will be

\textsuperscript{331}Id. However, after considering the state’s administrative policy, the Court concluded that the Due Process Clause did not confer any greater right upon the prisoner than was recognized under state law. Id. at 222.

\textsuperscript{332}Id. at 222, 228.

\textsuperscript{333}Id. at 215. The Court, however, read into the regulation a requirement that the treatment that is imposed be in the prisoner’s medical interest. Id. at 227. In a concurring and dissenting opinion, three justices noted that the state’s policy did not require a determination that involuntary treatment would advance the prisoner’s medical interest. Id. at 244 (Stevens, J., concurring and dissenting). Thus, in their judgment the policy inappropriately “sacrifices the inmate’s substantive liberty interest to refuse psychotropic drugs, regardless of his medical interests, to institutional and administrative concerns.” Id. at 245-46.

The prison regulation also authorized the involuntary administration of psychotropic medication on prisoners who were both mentally disordered and gravely disabled. Id. at 215. In a subsequent opinion, Justice Kennedy, author of the majority opinion in Harper, clarified that Harper addressed only the situation in which involuntary medication is administered to a prisoner “to insure that the incarcerated person ceased to be a physical danger to himself or others.” Riggins v. Nevada, 504 U.S. 127, 140 (1992) (Kennedy, J., concurring).

\textsuperscript{334}Harper, 494 U.S. at 222.
upheld if the regulation is “reasonably related to legitimate penological interests.”335 In the Court’s judgment, the state’s legitimate interest in prison safety and security warranted involuntary treatment of mentally disordered prisoners who were dangerous to themselves or others without the requirement of a full court hearing. The Court noted: “There are few cases in which the State’s interest in combating the danger posed by a person to both himself and others is greater than in a prison environment . . . ”336 Because prisoners have “a demonstrated proclivity for antisocial criminal, and often violent, conduct,”337 the state’s interest in combating danger posed by prisoners—both to themselves and to others—is greater in the prison environment than elsewhere.338 The Court specifically held: “[G]iven the requirements of the prison environment, the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate’s medical interest.”339

After disposing of the prisoner’s substantive claim, the Court addressed the adequacy of the prison regulation’s procedural protections. The regulation provided for a prisoner-initiated hearing to review the treating psychiatrist’s decision.340 A committee consisting of a psychiatrist, a psychologist, and the facility’s associate superintendent—none of whom can be involved in the prisoner’s current treatment or diagnosis—conducts the hearing. If the committee determines that the prisoner suffers from a mental disorder and is dangerous, the prisoner may be medicated involuntarily.341 The Supreme Court

335 Id. at 223 (citing Turner v. Safley, 482 U.S. 78, 89 (1987); O’Lone v. Estate of Shabazz, 482 U.S. 342, 349 (1987)).
336 Id. at 225.
337 Id. (quoting Hudson v. Palmer, 468 U.S. 517, 526 (1984)).
338 Id.
339 Id. at 227.
340 Id. at 215.
341 Id. at 215-16. Under the regulation, the committee decides by majority vote, provided that if forced medication is approved, the psychiatrist on the committee must vote in the majority. Id.
upheld this regulation as satisfying procedural due process requirements.\textsuperscript{342} 

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\textsuperscript{342}Id. at 231-35. The Court suggested two reasons why the state may defer to the judgment of an internal professional review committee. First, the Court noted that the intentions (i.e., judgments) of a mentally disordered person are difficult to assess and are changeable. \textit{Id.} at 231. Those intentions can be better determined by frequent and ongoing clinical observations of mental health professionals than by a judge in a single judicial hearing. \textit{Id.} at 231-32. The Court’s assertion is most curious. Under the procedure that the Court approved, the internal review committee is not required to hold multiple hearings at which the prisoner’s intentions are discerned. In fact, under the Court’s ruling, the prisoner's judgment, whether competent or incompetent, is irrelevant. Second, the Court was concerned about the costs of a judicial hearing. Financial resources and staff time would be diverted from patient care. \textit{Id.} at 232. The Court cited studies indicating that patient refusals of psychotropic medications are upheld infrequently, whether the decisionmaker is a judge or a mental health professional, internal or external to the facility. \textit{Id.} at 234 n.13. Thus, because the regulation approved in \textit{Harper} requires the hearing committee to review the treating staff’s medical decisions regarding the type and dosage of medication, the state could legitimately conclude that an administrative review using medical decisionmakers would be more effective than a judicial review. \textit{Id.} at 233. The Court ignored studies cited in \textit{amicus curiae} briefs demonstrating that a judicial review model that provides therapeutic benefits to patients could be implemented without seriously burdening the mental health system. One amicus brief noted that judicial oversight increased the doctor’s attention to medication side effects and increased the doctor’s willingness to accommodate patient needs. An effective therapeutic alliance resulted in therapeutic benefit. Patients who refused treatment were not adversely affected by any delay from scheduling a competency hearing. They did not become violent and disruptive. Brief of the National Association of Protection and Advocacy Systems et al. as \textit{Amici Curiae} at 24-27, Washington v. Harper, 494 U.S. 210 (1990) (No. 88-599). Another amicus brief reported that in Massachusetts, using a judicial review model, patients who refused treatment were not hospitalized for longer periods than similarly situated patients who accepted treatment. Accidents and injuries to patients and staff did not increase. Use of restraints to control violent and destructive behavior did not increase. Because hearings were conducted at the mental health facilities, staff time spent away from the facilities was small, and document preparation time was minimized. Brief for the Mental Health Legal Advisors Committee of the Massachusetts Supreme Judicial Court et al. as \textit{Amici Curiae} at 16-18, Washington v. Harper, 494 U.S. 210 (1990) (No. 88-
The “danger” exception, allowing the forced medication of prisoners, is a significant departure from the “emergency” exception that is traditionally required for forced medication without a patient’s consent. In the typical emergency situation, the patient’s life or health is threatened by harm from an external source, the threatened harm is imminent if the doctor fails to act, and the patient is incompetent to make a decision. This situation differs greatly from one in which the patient’s mental condition is the source of danger to others, and the patient is competent to make a decision to weigh the risks and benefits of proposed treatment and to decide whether to accept or reject such treatment.

The substitution of a “dangerous” criterion for an “emergency” criterion eliminates the requirement of proving an immediate necessity to act in order to prevent the loss of life or the infliction of serious bodily harm to the patient or to others. In fact, a standard of dangerousness requires far less certainty that the adverse event will ever occur, even if the medication intervention is not pursued. For example, the administrative policy considered in Harper allowed forced medication if the mentally disordered prisoner posed a “likelihood of serious harm” to himself, others or their property. The dictionary defines “likelihood” as “[t]he quality or fact of being likely or probable.” “Likely” is defined as “[h]aving an appearance of truth or fact; that looks as if it would happen, be realized, or prove to be what is alleged or suggested; probable.” However, the administrative policy defined “likelihood of serious harm” as “a substantial risk” that physical harm will be inflicted by an individual upon his own person or another or upon the property of others, words that suggest less than a mathematical probability. How great a risk is “a substantial risk”? 

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343 Harper, 494 U.S. at 215. The Court specifically held that the Due Process Clause permits involuntary medication of mentally disordered prisoners who are dangerous to themselves or others. Id. at 227. The Court did not consider whether danger to property also suffices.


345 Id. at 949.

346 See also Cross v. Harris, 418 F.2d 1095, 1102 (D.C. Cir. 1969) (Chief Judge Bazelon construed the words “likely to . . . inflict injury” to require “a high probability of serious harm.”); Millard v. Harris, 406 F.2d 964,
Fifty percent? Twenty-five? How about ten or even five? If, prior to their actions, Andrea Yates presented a one percent risk of drowning her children, or Timothy McVeigh presented a one percent risk of bombing the Oklahoma City Federal Building, or the 9/11 terrorists presented a one percent risk of hijacking airplanes and crashing them into the twin towers of the World Trade Center, would that risk be viewed as substantial?

It is easy to envision a prison professional review committee concluding that even a one percent risk that a mentally disordered prisoner might physically assault another patient or a staff member is a substantial risk warranting forced medication to ensure the safety of the institution and that such medication would be in the prisoner’s medical interest. Without judicial review of the “substantial risk” criterion, the standard is unlikely to be applied consistently. As the American Psychiatric Association acknowledged more than thirty years ago, “[D]angerousness is neither a psychiatric nor a medical diagnosis, but involves issues of legal judgment and definition, as well as issues of social policy.”

Use of a “dangerous” standard not only expands the criteria for involuntary treatment, it expands the length of time that involuntary treatment may be

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971-78 (D.C. Cir. 1968) (same). How high a probability is high enough? How serious a harm is serious enough? Judge Bazelon’s interpretation provides no answer.

Elsewhere, I assert that “civil commitment is justified only if, in the absence of confinement, the person will engage in the harmful conduct. Proposals to declare a person dangerous and to allow confinement without such proof are unacceptable.” Grant H. Morris, Defining Dangerousness: Risking a Dangerous Definition, 10 J. CONTEMP. LEGAL ISSUES 61, 88 (1999). I also reject proposals to replace a prediction that the person will actually commit the harmful act with data indicating that the person has characteristics that place him or her in a group of individuals who are at an increased risk of violent behavior. See id. at 85-95. The same analysis should be applied to the question of whether coerced treatment is warranted for a person who has been involuntarily committed. Unless the evidence establishes that the person will more likely than not engage in the harmful conduct, that person should not be labeled as “dangerous” and subjected to involuntary treatment.

imposed. Unlike emergency treatment, which when authorized is limited to that which is required to end the emergency situation, treatment of a dangerous prisoner is not so circumscribed. For example, once Walter Harper was determined to be dangerous, he was involuntarily medicated for a full year.\textsuperscript{349}

In \textit{Harper}, the Supreme Court ruled that due process does not require that the state accord a prisoner a judicial hearing on the prisoner’s competence before it may administer medication over the prisoner’s objection. The Court did not consider Harper’s claims, made to the state trial court, that forced medication of competent prisoners also violated the equal protection and free speech clauses of both the federal and state constitutions, as well as state tort law which requires a competent patient’s informed consent to medical treatment.\textsuperscript{350} If, as the Court ruled, due process can be satisfied by a prison regulation that is reasonably related to the state’s legitimate penological interest in prison safety and security even when it infringes on a prisoner’s fundamental constitutional rights, it is unlikely that equal protection and free speech claims, even if independently and fully considered by the Court, would have succeeded. Nevertheless, an equal protection claim may be meritorious. Although Walter Harper was a sentence-serving prisoner, at the time psychotropic medication was administered to him involuntarily, he was not housed in a regular

\textsuperscript{349}\textit{Harper}, 494 U.S. at 217. After being involuntarily medicated for one year, Harper was transferred from the Special Offender Center to the Washington State Reformatory. After one month without medication, his condition deteriorated, and he was retransferred to the Special Offender Center, where he was again treated involuntarily for a period of two years before he was transferred to the Washington State Penitentiary. \textit{Id.}

\textsuperscript{350}\textit{Id.} The state trial court merely decided that the procedures that were employed to administer treatment involuntarily met due process requirements. On appeal, the Washington Supreme Court reversed the trial court decision and ruled that to administer psychotropic medication to a mentally disordered prisoner who refuses such medication, due process requires a judicial proceeding at which the state proves by clear and convincing evidence that the administration of the medication is both necessary and effective for furthering a compelling state interest. Harper v. State, 759 P.2d 358, 364 (Wash. 1988). The United States Supreme Court granted certiorari, \textit{Washington v. Harper}, 489 U.S. 1064 (1989), and considered only the due process issue, reversing the judgment of the Washington Supreme Court. \textit{Harper}, 494 U.S. at 236.

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Department of Corrections’ state prison. Because his manic depressive disorder could not be adequately treated in a state prison, Harper had been transferred to a special facility established to diagnose and treat serious mental disorders.\textsuperscript{351} He was not transferred to the Special Offender Center as punishment for misconduct, but rather, in order to provide appropriate treatment for his mental disorder so that he could be returned to prison to resume his punishment. In essence, Harper could be viewed as similarly situated with any other mental patient involuntarily committed to a mental hospital. If an involuntarily committed patient is competent and presents no emergency danger to others, coerced treatment is inappropriate, whether the patient is a prisoner or a nonprisoner.

In evaluating the state’s interest in preventing dangerous behavior in prison, one can also question the Court’s characterization of prison inmates. While each prisoner has been convicted of a crime, not all prisoners have what the Court described as “a demonstrated proclivity for antisocial criminal, and often violent, conduct.”\textsuperscript{352} Many convicts are in prison for their first crime and may never reoffend. To suggest that they have a natural inclination toward committing antisocial conduct exaggerates their wrongdoing and our knowledge about their motivation. Similarly, to suggest that prisoners have a proclivity not just for antisocial conduct, but for violent conduct, is counterintuitive, especially for those prisoners who have never committed or been convicted of a violent crime and who are confined in minimum security penal institutions. The state’s interest in combating danger posed by such prisoners is no greater in the prison environment than elsewhere. Arguably, they are similarly situated with involuntarily-committed, civil patients. If competent, civilly-committed mental patients cannot be treated without their consent in nonemergency situations, equal protection demands the same for competent, prisoner mental patients. Indeed, only four years before the Supreme Court’s Harper decision, the California Court of Appeal equated state prisoners to nonprisoner mental patients under the LPS statutory scheme, and ruled that prisoners are entitled to a judicial determination of their incompetence to refuse treatment before they

\textsuperscript{351}Harper, 494 U.S. at 214.
\textsuperscript{352}Id. at 225 (quoting Hudson v. Palmer, 468 U.S. 517, 526 (1984)).
could be involuntarily medicated. The court expressed its disdain for coerced medication—even of prisoners—declaring: “Forced drugging is one of the earmarks of the gulag. It should be permitted in state institutions only after adherence to stringent substantive and procedural safeguards.”

**B. Criminal Defendants**

In 2003, the Supreme Court considered whether the government may administer psychotropic medication to an incompetent criminal defendant against his or her will in order to render the defendant competent to stand trial for a nonviolent crime or whether forced medication unconstitutionally deprives the defendant of his or her liberty interest to reject medical treatment. In *Sell v. United States*, the Court upheld involuntary administration of psychotropic medication provided three conditions were met. First, the treatment must be medically appropriate, second, the treatment must be substantially unlikely to have side effects that could undermine the fairness of the trial, and third, the treatment must be necessary to significantly further important governmental, trial-related interests. Justice Breyer, writing for the Court’s six-justice majority, discussed these requirements in detail and opined that instances of permissible forced medication solely to restore trial competence “may be

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354 *Id.* at 756.
356 *Id.* at 179.
357 *Id.* at 168. Justice Scalia, in a dissenting opinion joined by Justice O’Connor and Justice Thomas, asserted that the Supreme Court lacked jurisdiction because the District Court’s order was neither a final decision nor an interlocutory order specified by statute that would permit an appeal and a decision on the merits. *Id.* at 186-87 (Scalia, J., dissenting). The dissenters expressed concern that by allowing the appeal, the majority would enable criminal defendants “to engage in opportunistic behavior” by voluntarily taking medication until partway through trial and then abruptly refusing it while demanding an interlocutory appeal from an order that the medication be continued on an involuntary basis. *Id.* at 191 (Scalia, J., dissenting).
358 *Id.* at 180-81.
rare." Nevertheless, the *Sell* majority held that the requirements that limit forced medication to restore trial competence need not be considered if forced medication is warranted for a different purpose—such as when the defendant is dangerous either to others or to himself or herself. At two separate places in his opinion, Justice Breyer emphasized that these alternative grounds should be considered before the issue of forced medication to restore trial competence is considered.

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359 *Id.* at 180. Despite Justice Breyer’s observation, post-*Sell* orders of forcible medication solely to restore trial competence may not be rare. Within months of the *Sell* decision, a federal district court in Connecticut, applying the three *Sell* requirements, authorized the involuntary medication of an incompetent defendant solely to restore trial competency, and the district court’s decision was affirmed by the Court of Appeals for the Second Circuit. United States v. Gomes, 305 F. Supp. 2d 158, 169 (D. Conn. 2004), aff’d, 387 F.3d 157, 160-63 (2d Cir. 2004) (discussing the *Sell* requirements), cert. denied, 543 U.S. 1128 (2005). See infra note 362 (discussing both the district court and the court of appeals decisions in *Gomes* applying the *Sell* requirements). Within two weeks of the district court decision in *Gomes*, another district court in Virginia, applying the *Sell* requirements, ordered the involuntary medication of an incompetent defendant solely to restore trial competency. United States v. Mackie, 2004, No. Crim. 7:03CR00007, 2004 WL 368477 (W.D. Va. Feb. 26, 2004). In another federal district court case, the judge ruled that any offense—including a mere misdemeanor—for which the defendant could be sentenced to more than six months imprisonment is a “serious” crime against person or property that, in appropriate circumstances, could be used to satisfy the *Sell* condition that involuntary medication to restore trial competency be necessary to significantly further important governmental, trial-related interests. United States v. Evans, 293 F. Supp. 2d 668, 673-74 (W.D. Va. 2003).

360 *Sell*, 539 U.S. at 181-82. In addition to the dangerousness justification, the Court also stated that forced medication can be justified when the individual’s “refusal to take drugs puts his health gravely at risk.” *Id.* at 182. This second justification can be construed as an emergency justification for treatment. Clearly, the Court has differentiated the dangerousness justification from the emergency justification.

361 *Id.* at 181-83.

362 *Id.* Justice Breyer noted that if medication is authorized on alternative grounds, there may be no need to consider authorization to medicate to restore competency to stand trial. *Id.* at 183. Even if medication is not authorized on alternative grounds, the findings that underlie that decision will
The *Sell* majority asserted that two prior Supreme Court precedents—*Riggins v. Nevada* and *Washington v. Harper*—“set forth the framework” for the *Sell* decision. Justice Breyer, however, misstated and misapplied those cases, perverting their precedential value. In *Riggins*, the Court reversed the conviction of a mentally competent defendant who was involuntarily medicated during his criminal trial. The record failed to inform expert opinion and judicial decisionmaking on whether medication should be authorized to restore competency to stand trial. For example, is it medically appropriate to administer medication to a defendant who is not dangerous and who is competent when the sole purpose for such medication is to bring the defendant to trial? See *id*.

One may question whether trial court judges are performing in good faith the Supreme Court’s required exploration of alternative grounds for forced medication of incompetent criminal defendants. For example, in *United States v. Gomes*, 305 F. Supp. 2d 158 (D. Conn. 2004), *aff’d*, 387 F.3d 157 (2d Cir. 2004), *cert. denied*, 543 U.S. 1128 (2005), the district court discussed at length the applicability of the *Sell* factors to the facts before it and concluded that the requirements for involuntary medication of the incompetent criminal defendant were met. *Id.* at 163-68. As an apparent afterthought, the court devoted only one paragraph to a discussion of whether alternative grounds for involuntary treatment existed, and found that the defendant was not dangerous to others in the prison population, that his refusal to take medication would not put his health gravely at risk, and that appointing a conservator to make medical decisions on his behalf was not appropriate. *Id.* at 168-69. In affirming the district court’s decision, the Court of Appeals for the Second Circuit also focused its discussion on whether the *Sell* requirements were met for involuntarily medicating the incompetent criminal defendant. *United States v. Gomes*, 387 F. 3d 157, 160-63 (2d Cir. 2004). In fact, the appellate court devoted only two sentences to alternative grounds for forced medication. Alternative grounds for involuntary treatment did not exist, said the court, because a staff psychiatrist and a staff psychologist at the Medical Center for Federal Prisoners testified that Gomes was not a danger in the prison population, and no evidence was introduced to indicate that Gomes was a danger to himself or that he faced a serious health risk absent medical treatment. *Id.* at 160.

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539 U.S. at 177-78.  
504 U.S. at 138.
establish that the administration of psychotropic medication was necessary to accomplish an essential state policy that would permit the state to override the defendant’s liberty interest in freedom from unwanted medication and his Sixth and Fourteenth Amendment rights to a fair trial.

Because Riggins did not involve an incompetent defendant, the case did not establish the substantive standards that govern the forced medication of incompetent defendants. In fact, the Riggins majority specifically acknowledged that “we have not had occasion to develop substantive standards for judging forced administration of [psychotropic] drugs in the trial or pretrial settings.” The Riggins majority did, however, suggest a standard that, in its words, “certainly would satisfy[ ] due process.” Due process would be satisfied if the trial court finds that the compelled treatment is “medically appropriate and, considering less intrusive alternatives, essential for the sake of [the defendant’s] own safety or the safety of others.” Additionally, the Riggins majority opined that due process “might” be satisfied if the compelled treatment is medically appropriate and an adjudication of guilt or innocence cannot be obtained using less intrusive means. These gratuitous comments involved speculation on a question that was not before the Court for decision. Nevertheless, with little more consideration of the issue, the Sell majority adopted dicta from a case involving a competent defendant as its holding for incompetent defendants.

The Sell majority’s reliance on Washington v. Harper is even more dubious. Harper involved a sentence-serving convict, not an incompetent defendant awaiting trial. The Harper Court, relying upon the state’s legitimate

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367 Id. at 137-38.
368 See id. at 138.
369 Id. at 135. In his dissenting opinion, Justice Thomas asserted that the Riggins’ majority “appears to adopt a standard of strict scrutiny.” Id. at 156 (Thomas, J., dissenting). The majority denied the assertion. Id. at 136.
370 Id. at 135.
371 Id.
372 Id.
interest in reducing danger posed by prisoners in the prison environment, specifically distinguished sentence-serving prisoner mental patients from all other involuntarily confined mental patients. According to the Court, prisoners have “a demonstrated proclivity for antisocial criminal, and often violent, conduct.” Such proclivity means that the state’s interest in combating danger posed by prisoners is greater in the prison environment than the danger posed by others in nonprison environments.

Two years after Harper, Justice O’Connor, writing for the Court’s majority in Riggins, explained that “the unique circumstances of penal confinement” were crucial to the Harper Court’s decision to allow the state to involuntary administer psychotropic medication to dangerous, mentally disordered, sentence-serving prisoners. Charles Sell, however, was not a sentence-
serving prisoner. This dentist was an incompetent criminal defendant charged with mail fraud, Medicaid fraud, and money laundering.\textsuperscript{379} Because he had not yet been convicted of those crimes, he could not be subjected to the unique circumstances of penal confinement. He may be innocent of those crimes, and, in fact, the law presumes his innocence.\textsuperscript{380} For the Sell majority to rule that Harper’s holding and rationale for forced medication of sentence-serving prisoners is equally applicable to Charles Sell and to other criminal defendants is ludicrous.

Additionally, the Sell decision conflicts with Jackson v. Indiana,\textsuperscript{381} a venerable and frequently cited\textsuperscript{382} Supreme Court case decided more than thirty years ago. In Jackson, the Court held that incompetent criminal defendants are denied equal protection of the laws when they are subjected to a more lenient commitment standard (i.e., incompetence to stand criminal trial) and to a more stringent release standard (i.e., restoration of trial competence) than is applicable to all other persons who are not charged with crimes and who could

\textsuperscript{379}Sell v. United States, 539 U.S. 166, 170 (2003).

\textsuperscript{380}Because the incompetent defendant has not been tried for the crime charged against him or her, the defendant retains the status of any accused, but not convicted, criminal defendant. Criminal defendants are presumed innocent until they are convicted. As Justice Stevens noted: “Prior to conviction every individual is entitled to the benefit of a presumption . . . that he is innocent of prior criminal conduct . . . .” Bell v. Wolfish, 441 U.S. 520, 582 (1979) (Stevens, J., dissenting); see Estelle v. Williams, 425 U.S. 501, 503 (1976) (“The presumption of innocence, although not articulated in the Constitution, is a basic component of a fair trial under our system of criminal justice.”); Coffin v. United States, 156 U.S. 432, 453 (1895) (“The principle that there is a presumption of innocence in favor of the accused is the undeniable law, axiomatic and elementary, and its enforcement lies at the foundation of the administration of our criminal law.”).

\textsuperscript{381}406 U.S. 715 (1972).

only be detained under the state’s civil commitment laws.\textsuperscript{383} The incompetent criminal defendant in \textit{Jackson} was a mentally retarded, deaf-mute person who was not likely to be restored to trial competence.\textsuperscript{384} The Supreme Court invalidated a statute that permitted Jackson to be committed for an indeterminate period of time—potentially a lifetime—until he was restored to trial competence.

Although the finding of incompetence to stand trial may justify a brief period of detention designed to restore the defendant’s competence, due process requires that incompetent defendants who cannot soon be restored to competency either must be released or be subjected to “the customary civil commitment proceeding that would be required to commit indefinitely any other citizen.”\textsuperscript{385} The Court noted that detention of incompetent defendants is appropriate only for those who “probably soon will be able to stand trial.”\textsuperscript{386} And even for those defendants, the Court required that commitment “must be justified by progress toward that goal.”\textsuperscript{387}

Thus, under \textit{Jackson}, mentally incompetent criminal defendants who cannot be restored quickly to stand trial cannot be separately categorized for commitment purposes. The civil commitment process used to involuntarily detain any other citizen must be used to involuntarily detain such individuals.\textsuperscript{388} If the incompetent defendant is committed, he or she is a civil patient. If long-term, incompetent criminal defendants are civil patients, then criminal defendants whose incompetence is not long-term are also civil patients. Both are accused, but not convicted, of crime. Although their potential for restoration to trial competence may differ, their nonconvict, nonprisoner status

\footnote{\textit{Jackson}, 406 U.S. at 730.}
\footnote{\textit{Id.} at 717-19, 738.}
\footnote{\textit{Id.} at 738.}
\footnote{\textit{Id.} at 717-19, 738.}
\footnote{An incompetent defendant can only be held for a “reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future.” \textit{Id.} If such probability does not exist, the defendant must either be released or civilly committed. If such probability does exist, the defendant may be detained for a limited time to attempt to restore his or her competency. \textit{Id.}}
\footnote{\textit{Id.} at 724, 730, 738.}

\footnote{\textit{Id.}}
is identical.

The *Sell* Court did not consider the implications of the *Jackson* precedent on the patient status of incompetent criminal defendants. *Jackson* was not even discussed or cited.\textsuperscript{389} In 1999, Charles Sell was institutionalized in the United States Medical Center for Federal Prisoners at Springfield, Missouri, as incompetent to stand trial.\textsuperscript{390} He remained in that institution and in that patient status in 2003, when the Supreme Court decided the *Sell* case. Although *Jackson* forbids the lengthy confinement of incompetent defendants as incompetent defendants,\textsuperscript{391} the *Sell* Court did not question the propriety of Charles Sell’s four-year confinement as an incompetent defendant and his continued confinement in that patient status.\textsuperscript{392} The *Sell* majority simply

\textsuperscript{389} *Jackson*, however, was cited and discussed in the Petitioner’s Brief to the Supreme Court. Petitioner’s Brief at 38, Sell v. United States, 539 U.S. 166 (2003) (No. 02-5664).


\textsuperscript{391} *Jackson*, 406 U.S. at 738. See supra text accompanying notes 386-87.

\textsuperscript{392} A review of legislation in the fifty states and the District of Columbia, conducted twenty years after *Jackson* was decided, revealed that the Supreme Court’s decision has been ignored or circumvented in a majority of jurisdictions. See Grant H. Morris and J. Reid Meloy, *Out of Mind? Out of Sight: The Uncivil Commitment of Permanently Incompetent Criminal Defendants*, 27 U.C. DAVIS L. REV. 1, 13-33 (1993). Some states ignore *Jackson* by continuing to allow incompetent defendants to be detained until their competence has been restored. *Id.* at 13. Others evade *Jackson* by imposing a lengthy period of treatment before acknowledging that the defendant is permanently incompetent, i.e., that there is no substantial probability that the defendant will become competent to stand trial in the foreseeable future. *Id.* at 15-18. Several states tie the maximum length of the treatment period to the maximum sentence that could have been imposed if the defendant was convicted of the crime charged. *Id.* at 17-18. In California, permanently incompetent criminal defendants can be placed on mental health conservatorships using different criteria than are used to establish mental health conservatorships for all other mentally disordered people. *Cal. Welf. & Inst. Code §§ 5350, 5008(h)(1)(A)-(B)* (West 1998). By law, other conservatees must be placed in the least restrictive placement. *Cal. Welf. & Inst. Code § 5358(a)(1)(A).* In contrast, by law, permanently incompetent criminal defendant conservatees must be placed in a facility “that achieves the purposes of
acknowledged that Sell had already been confined “for a long period of time, and that his refusal to take antipsychotic drugs might result in further lengthy confinement”\textsuperscript{393}—factors that would diminish the importance of the government’s interest in prosecuting Sell.\textsuperscript{394} One might well ask whether \textit{Jackson} has been overruled \textit{sub silencio}.\textsuperscript{395}

If incompetent criminal defendants are civil patients, then they are entitled to the same right to medical self-determination that other civil patients possess. In many states, courts have ruled that civilly committed patients have a right to refuse treatment with psychotropic medication unless they lack the capacity to make treatment decisions—i.e., to weigh the risks, benefits, and alternatives to the proposed medication.\textsuperscript{396}

Civilly committed patients—including incompetent criminal defendants—are not similarly situated with mentally disordered, sentence-serving prisoners. The

\textit{treatment of the conservatee and protection of the public.”} \textsc{cal. welf. \\& inst. code} § 5358(a)(1)(B).

The failure to individualize placement may violate a patient’s right to placement in the least restrictive appropriate treatment setting. See Michael L. Perlin, “\textit{For the Misdemeanor Outlaw}”: The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities, 52 \textsc{ala. l. rev.} 193, 231-34 (2000) (asserting that the Supreme Court’s decision in \textit{Olmstead v. L.C.}, 527 U.S. 581 (1999), interpreting the Americans with Disabilities Act, may require individualized placement decisionmaking for permanently incompetent criminal defendants and other forensic patients, rather than uniform placement in maximum security institutions).

\textsuperscript{393}Sell, 539 U.S. at 186.

\textsuperscript{394}See id. at 180, 186 (requiring that important governmental interests be at stake and suggesting that lengthy pretrial detention diminishes the importance of the government’s interest in prosecuting the defendant).

\textsuperscript{395}In mentioning the possibility that Charles Sell might be subjected to “further lengthy confinement,” perhaps the majority only meant to suggest that if Sell was not medicated, he would be found permanently incompetent to stand trial, and, pursuant to \textit{Jackson}, could confined thereafter through the civil commitment process. Nevertheless, the majority failed to consider: (1) whether detention for four years as an incompetent criminal defendant is permissible under \textit{Jackson}, and (2) whether detention beyond four years as an incompetent criminal defendant is permissible under \textit{Jackson}.

\textsuperscript{396}See supra text accompanying notes 85-120.
right of civilly committed patients to refuse treatment in nonemergency situations is governed by their capacity to understand the consequences of the proposed therapy. In contrast, the right of sentence-serving prisoners to refuse treatment is governed by the danger they present to themselves and others. The Supreme Court characterized the circumstances of penal confinement as “unique.”

They are unique because, according to the Supreme Court, prisoners have “a demonstrated proclivity for antisocial criminal, and often violent, conduct.”

Because of such proclivity and the state’s legitimate interest in reducing danger posed by prisoners in the prison environment, the state may adopt a prison regulation authorizing the administration of psychotropic medication on competent, but dangerous, prisoners even when such regulation infringes on a prisoner’s fundamental constitutional right to avoid coerced treatment.

If the presumption of innocence has any meaning whatsoever, then incompetent criminal defendants cannot be subjected to the unique circumstances of penal confinement. Unless and until they are convicted of the crimes charged against them, they have not demonstrated a proclivity for antisocial or violent conduct. They simply cannot be equated to sentence-serving prisoners.

One cannot assume that a criminal defendant who is incompetent to stand trial is necessarily incompetent to make treatment decisions. The issue for competence to stand trial is whether the defendant is able to understand the criminal proceedings and to assist in his or her defense. The issue for competence to refuse psychotropic medication is whether the individual can weigh the risks, benefits, and alternatives to the proposed medication. Because

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399 Id. at 221-22.
400 Id. at 227.
401 Id. at 221-22; see supra text accompanying notes 330-42.
402 See, e.g., N.Y. CRIM. PROC. LAW § 730.10(1) (McKinney 1995); see also Grant H. Morris et al., Competency to Stand Trial on Trial, 4 Hous. J. HEALTH L. & POL’Y 193, 205 n.66 (2004) (citing representative statutes from nine states).
the issues are different, a defendant who is incompetent for one purpose may be competent for another.403

Criminal defendants, just as other civilly committed patients, do not have an absolute right to refuse treatment with psychotropic medication. The state does have a legitimate interest in protecting other patients and staff from dangerous mental patients. This danger, however, is far less in a mental hospital than it is in a prison.404 Unlike prisons, mental hospitals have professional and support staff trained in dealing with problems of potential violence. Hospital staff may respond to threatening situations using alternative approaches such as segregation, physical restraints, psychotherapy, and behavior therapy.405 At most, all that is needed is authority to involuntarily sedate the patient in an emergency situation, when the patient presents an immediate danger to himself or herself or to others.406 Nevertheless, this exercise of the state’s police power must end when the emergency that warranted this exercise of authority ends. Even if the patient was civilly committed as being too dangerous to live in society, and even if he or she presents a generalized danger to other patients or staff in the institution, such facts do not warrant nonemergency, coerced treatment if the patient is competent to make a treatment refusal decision.

In Sell, however, the Supreme Court eschews this analysis. Justice Breyer correctly notes that involuntary medical treatment is typically addressed as a civil matter, and that every state provides for the appointment of a guardian who may make a medication decision for a patient who has been found

403 See Godinez v. Moran, 509 U.S. 389, 413 (1993) (Blackmun, J., dissenting) (asserting: “A person who is ‘competent’ to play basketball is not thereby ‘competent’ to play the violin. . . . Competency for one purpose does not necessarily translate to competency for another purpose.”).


405 Id.

406 See, e.g., CAL. WELF. & INST. CODE § 5332(e) (West Supp. 2006) (authorizing coerced treatment in an emergency); see supra text accompanying notes 324-28.
incompetent to make that decision.\footnote{Sell v. United States, 539 U.S. 166, 182 (2003).} But then he adds that “courts, in civil proceedings, may authorize involuntary medication where the patient’s failure to accept treatment threatens injury to the patient or others.”\footnote{Id. (citing 28 C.F.R. § 549.43 (2003); 18 U.S.C. § 4246 (2000)).} As authority for this proposition, Justice Breyer does not cite any state statutes or state court decisions. Rather, he cites a federal regulation that implements a federal statute.\footnote{18 U.S.C. § 4246(a)(2000).} The statute is a federal civil commitment law, authorizing the detention of dangerous, prisoners whose criminal sentences are about to expire and dangerous, incompetent criminal defendants against whom all criminal charges have been dismissed.\footnote{See supra text accompanying notes 381-88.} The statute was not applicable to Charles Sell because the criminal charges against him had not been dismissed. Even if the statute was valid and was applicable to Sell, the statute says nothing about the government’s authority to coerce treatment on those who are confined.

The federal regulation cited as authority by Justice Breyer does not implement or even pertain to the special commitment process established by the cited statute, but rather, to forced medication of patients after they have been committed. The regulation provides for a hearing by a psychiatrist to determine
whether coerced treatment “is necessary because the inmate is dangerous to self or others.”

And yet, the Sell majority uncritically accepts this arguably inappropriate regulation as its sole authority to support its ruling that a court may grant permission, on “Harper-type grounds” to forcibly medicate dangerous criminal defendants who are competent to make treatment decisions in nonemergency situations.

Ignoring the criminal defendant’s liberty interest in refusing medication, the majority simply notes that “the inquiry into whether medication is permissible . . . to render an individual nondangerous is usually more ‘objective and manageable’ than the inquiry into whether medication is permissible to render a defendant competent.”

The majority adds that “medical experts may find it easier” to express an informed opinion on whether particular medications “are medically appropriate and necessary to control a patient’s potentially dangerous behavior . . . than to try to balance harms and benefits related to the more quintessentially legal questions of trial fairness and competence.”

Through the Sell decision, a criminal defendant’s significant liberty interest in refusing psychotropic medication is lost. Objectivity and manageability of the inquiry plus ease of adjudication—in other words, expediency—trumps an individual’s supposedly constitutionally protected liberty interest.

In the Harper case, Justice Stevens, joined by Justices Brennan and Marshall, wrote an opinion, concurring in part and dissenting in part, that criticized the majority for authorizing the forced medication of mentally disordered, sentence-serving convicts. Justice Stevens asserted that imposing psychotropic medication on prisoners to serve institutional concerns and “institutional convenience eviscerates the inmate’s substantive liberty interest in the integrity of his body and mind.”

And yet, the Harper precedent was used by the Sell majority to justify forced medication of nonprisoner, criminal defendants.

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Sell, 539 U.S. at 183.
Id. at 182 (quoting Riggins v. Nevada, 504 U.S. 127, 140 (1992) (Kennedy, J., concurring)).
Id.
C. Sentence-expiring prisoners

Forty years ago, in *Baxstrom v. Herold*, the Supreme Court held unconstitutional a New York statute that authorized, through administrative decision, the civil commitment of mentally ill, sentence-expiring prisoners and their continued confinement in a maximum security mental institution operated by the Department of Correction. Under the invalidated statute, sentence-expiring prisoners were the only persons subject to civil commitment who were denied a jury review on the question of whether their mental condition met the civil commitment criteria. They were also the only persons who were denied court hearings on the question of whether they were dangerously mentally ill, a prerequisite for confinement in a maximum security mental institution.

Writing for a unanimous Court, Chief Justice Warren rejected the assertion that a person’s criminal tendencies or dangerous propensities are established by his or her past criminal record. Equal protection “demands” that sentence-expiring prisoners receive the same procedural safeguards that all others receive in the civil commitment process; they cannot be specially classified to avoid the standard procedural roadblocks to civil commitment. Equal protection also demands that they receive the same procedural safeguards that all other civilly committed patients receive before they may be placed in maximum security confinement; they cannot be specially classified to avoid the standard roadblocks to such placement. “[T]here is no conceivable basis,” wrote the Chief Justice, “for distinguishing the commitment of a person who is nearing the end of a penal term from all other civil commitments.”

Although the *Baxstrom* Court considered only a sentence-expiring prisoner’s right to procedural protections in the civil commitment process and

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417 *Id.* at 110-11.
418 *Id.* at 110-13.
419 Justice Black concurred in the result but wrote no opinion. *Id.* at 115.
420 *Id.* at 114.
421 “Demands” is the word choice of the Chief Justice. *Id.* at 115.
422 *Id.* at 110, 114-15.
423 *Id.* at 110.
424 *Id.* at 111-12.
See also Humphrey v. Cady, 405 U.S. 504 (1972). In Humphrey, the Supreme Court applied its Baxstrom precedent to an individual convicted of the misdemeanor of contributing to the delinquency of a minor. In lieu of a one-year maximum sentence, he was committed pursuant to the Wisconsin Sex Crime Act to the sex deviate facility in the state prison for a potentially indefinite period, i.e., initial commitment for a period equal to the maximum sentence followed by renewable five-year commitment periods. Id. at 506-07. The Court ruled that petitioner’s contention that he was denied equal protection in the renewal commitment, which did not accord him a jury trial accorded other persons undergoing civil commitment, was substantial enough to warrant an evidentiary hearing in a federal habeas corpus proceeding. Id. at 508.

425 See also Humphrey v. Cady, 405 U.S. 504 (1972). In Humphrey, the Supreme Court applied its Baxstrom precedent to an individual convicted of the misdemeanor of contributing to the delinquency of a minor. In lieu of a one-year maximum sentence, he was committed pursuant to the Wisconsin Sex Crime Act to the sex deviate facility in the state prison for a potentially indefinite period, i.e., initial commitment for a period equal to the maximum sentence followed by renewable five-year commitment periods. Id. at 506-07. The Court ruled that petitioner’s contention that he was denied equal protection in the renewal commitment, which did not accord him a jury trial accorded other persons undergoing civil commitment, was substantial enough to warrant an evidentiary hearing in a federal habeas corpus proceeding. Id. at 508.


427 Id. at 727 (emphasis added).

428 As a result of the Baxstrom decision, 992 sentence-expiring prisoners were discharged from confinement under the unconstitutional law that mandated their placement in maximum security mental hospitals administered by the New York State Department of Correction. Almost all of the 992 Baxstrom patients were civilly committed—using the criteria and procedures applicable to all others who were civilly committed—and placed in mental hospitals administered by the New York State Department of Mental Hygiene. Within a six-month period, 79 were discharged to the community, 22 were conditionally released on convalescent care, 273 were reclassified to voluntary patient status, and 24 were reclassified to informal patient status. Only six had to be retransferred to maximum security hospitals operated by the Department of Corrections as dangerously mentally ill. Within the following six months, an additional sixty-eight Baxstrom patients were discharged and only one was retransferred to a maximum security hospital. Grant H. Morris, “Criminology”
prisoner’s sentence expires, his or her debt to society has been paid, and the
prisoner is no longer subject to further punishment. *Baxstrom* remains not just
a viable precedent, it is a venerable precedent. *Baxstrom* has been cited in 521
court decisions, including eighteen Supreme Court decisions.429

If civilly committed ex-prisoners are truly civil patients—if as *Baxstrom* tells
us, they cannot be separately categorized for civil commitment purposes—then
they are entitled to the same right to medical self-determination—including the
right to refuse treatment—that other civil patients possess. Upon the completion
of their criminal sentences, ex-prisoners may no longer be punished. They are
no longer subject to the unique circumstances of penal confinement. If other
civilly committed patients have a right to make a competent decision to refuse
treatment in nonemergency circumstances, civilly committed ex-prisoners,
being similarly situated with other civilly committed patients, have the same

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strongly suggest that psychiatrists in the Department of Mental Hygiene: (1)
overpredicted dangerous mental illness, (2) were unwilling to accept and treat
as mental patients those who were identified as “dangerous” or labeled as
“criminals,” and (3) had the ability to treat such patients when they were
integrated with and given treatment indistinguishable from that provided to
other civilly committed mental patients. *Id.* at 796. *See also* HENRY J.
STEADMAN & JOSEPH J. COCOZZA, CAREERS OF THE CRIMINALLY INSANE 55-
161 (1974) (finding that the *Baxstrom* patients were not very dangerous and
were successfully treated in civil mental hospitals, *id.* at 108, and that when
released to the community, few displayed dangerous behavior, *id.* at 158); Grant
H. Morris, *The Confusion of Confinement Syndrome: An Analysis of the
Confinement of Mentally Ill Criminals and Ex-Criminals by the Department of
Correction of the State of New York*, 17 BUFF. L. REV. 651, 670-75 (1968)
[hereinafter Morris, *Confusion of Confinement*].

(examined on April 17, 2006). The Supreme Court most recently cited
Thomas, who wrote the Court’s majority opinion in *Hendricks*, cited *Baxstrom*,
as did Justice Kennedy, who wrote a concurring opinion. *Id.* at 369, 372
(Kennedy, J., concurring); *see infra* text accompanying notes 437-77
discussing and critiquing *Hendricks*.
right to refuse.\textsuperscript{430} A logical application of equal protection analysis compels this result.

Nevertheless, the result today is not so certain. Although prisoners cannot be punished once their term of imprisonment expires, in recent years, several states have enacted statutes that allow sentence-expiring prisoners to be civilly committed using criteria that differ from the criteria applicable to those who are not about to be released from penal incarceration and imposing more stringent conditions upon sentence-expiring civil patients. California, for example, has enacted a Mentally Disordered Offenders (MDO) statute.\textsuperscript{431} Despite its title, the statute is applicable, not to sentence-serving offenders, but rather, to ex-offenders whose sentence is about to expire and who are about to be discharged from prison. If a court or jury finds that the person has a severe mental disorder that is not in remission or cannot be kept in remission without treatment, and that the person represents a substantial danger of physical harm to others because of that disorder, the person can be committed for renewable one-year periods.\textsuperscript{432} In contrast, regular civilly committed patients, who suffer from the same mental disorders and who represent the same substantial danger of physical harm to others, can only be confined for renewable 180-day periods.\textsuperscript{433}

In fact, “regular” civilly committed patients may present an even greater danger than do “special” civilly committed, sentence-expiring convicts. To be subjected to a 180-day commitment hold, the nonprisoner must have attempted, inflicted, or made a serious threat of substantial physical harm upon the person of another either during confinement on a short-term evaluation or treatment hold or leading to that hold, and must continue to present a demonstrated

\textsuperscript{430} See, e.g., State v. Anthony D.B., 614 N.W.2d 435, 438-39 (Wis. 2000). In Anthony, the Wisconsin Supreme Court ruled that the patients’ rights provisions applicable to civilly committed patients apply to patients committed pursuant to the state’s Sexually Dangerous Persons Act. Such rights include the right to exercise informed consent to medication unless the person is not competent to decide or an emergency exists in which medication is necessary to prevent serious physical harm to the person or others. \textit{Id.} (interpreting Wis. Stat. Ann. § 51.61(1)(g)(3) (West 2003)).
\textsuperscript{431} Cal. Penal Code § 2972 (West Supp. 2006).
\textsuperscript{432} \textit{Id.} § 2972(c).
danger of inflicting substantial physical harm upon others. No such demonstration of danger is required to confine sentence-expiring prisoners to a confinement period that is twice as long. Clearly, Baxstrom’s promise of equal protection for sentence-expiring prisoners has been broken.

One group of sentence-expiring prisoners has been of particular interest to state legislatures. Beginning in the 1990s, several states enacted Sexually Violent Predator (SVP) statutes. Unlike the discredited sexual psychopath legislation that it replaced, SVP statutes did not merely substitute

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434 Id.


436 Forty years ago, sexual psychopath legislation had been enacted in more than half the states. Barbara A. Weiner, Mental Disability and the Criminal Law, in The Mentally Disabled and the Law, supra note 266, at 693, 739. Through such legislation, criminal defendants charged with or convicted of sex crimes and facing a determinate sentence could be detained indefinitely for treatment until they were no longer dangerous. See id. at 740-41. Sexual psychopath legislation was discredited, however, by the inability of
psychiatrists and other mental health professionals to identify a specific mental disorder experienced by individuals who should be included within the targeted group and by the lack of successful treatment methodologies to improve their condition. *Id.* at 741-43. The absence of treatment destroyed any valid basis for distinguishing sexual psychopath prisoners from other prisoners in order to subject them to indeterminate commitment. *Millard v. Cameron*, 373 F.2d 468, 473 (D.C. Cir. 1966).

Sexual psychopath legislation was also challenged as violating procedural due process. For example, in *Specht v. Patterson*, 386 U.S. 605 (1967), a unanimous Supreme Court ruled that the possibility of indeterminate confinement based on a new finding of fact—that the person constitutes a threat of bodily harm to the public, or is a habitual offender and mentally ill—entitled the person subjected to commitment under Colorado’s Sex Offenders Act to the full panoply of due process protections, including the right to counsel, to have an opportunity to be heard, to be confronted with witnesses, to cross-examine, to offer evidence of his own, and to have findings adequate to make a meaningful appeal. *Specht*, 386 U.S. at 609-10.

In 1997, in a five-to-four decision, the Supreme Court upheld the constitutionality of Kansas’s SVP Act against three claims of constitutional infirmity. Under the Kansas statute, a sentence-expiring prisoner could be civilly committed as an SVP if he had a “mental abnormality” or a “personality disorder” that made him “likely to engage in predatory acts of sexual violence.” In *Kansas v. Hendricks*, the Court held that the Act satisfied

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substantive due process requirements.\textsuperscript{441} Justice Thomas, writing for the Court’s five-justice majority, noted that civil commitment statutes have been sustained when they limit the class of persons eligible for confinement to those who, because of mental illness, are dangerous and who are unable to control their dangerousness.\textsuperscript{442}

The majority also found that the Act did not violate the Constitution’s prohibition against double jeopardy\textsuperscript{443} or \textit{ex post facto} lawmaking.\textsuperscript{444} The Court accepted as true the legislature’s stated intention to create a new civil commitment scheme for SVPs, rather than to inflict additional punishment for past criminal acts.\textsuperscript{445} Hendricks failed to prove that the legislation was punitive

\textsuperscript{441}\textit{Id.} at 356-60. The Fourteenth Amendment to the United States Constitution provides that no state “shall deprive any person of . . . liberty without due process of law.” U.S. \textit{Constitution} amend. XIV.

\textsuperscript{442}\textit{Hendricks}, 521 U.S. at 358. Although the Kansas statute used the term “mental abnormality” rather than “mental illness,” Justice Thomas dismissed the importance of the distinction, declaring that “the term ‘mental illness’ is devoid of any talismanic significance.” \textit{Id.} at 359. Justice Thomas used, without attribution, language employed by the Supreme Court of Wisconsin two years earlier. In a decision upholding the constitutionality of Wisconsin’s SVP statutes, that court stated: “[T]here is no talismanic significance that should be given to the term ‘mental illness.’” \textit{State v. Post}, 541 N.W.2d 115, 122 (1995). As Justice Thomas explained, the legislature may define terms of a medical nature for legal purposes and need not mirror the definitions of the medical profession. \textit{Hendricks}, 521 U.S. at 359.

\textsuperscript{443}\textit{Hendricks}, 521 U.S. at 360-70. The Fifth Amendment of the Constitution, made applicable to the states through the Fourteenth Amendment, provides that no person shall “be subject for the same offense to be twice put in jeopardy of life or limb.” U.S. \textit{Constitution} amend. V, XIV.

\textsuperscript{444}\textit{Hendricks}, 521 U.S. at 370-71. Article I of the Constitution, made applicable to the states through the Fourteenth Amendment, provides that no “\textit{ex post facto} Law shall be passed.” U.S. \textit{Constitution} art. 1, § 9, cl. 3; U.S. \textit{Constitution} amend. XIV.

\textsuperscript{445}\textit{Hendricks}, 521 U.S. at 361. \textit{But see} \textit{State v. Post}, 541 N.W.2d 115, 135 (1995) (Abrahamson, J., dissenting). In dissenting from a \textit{pre-Hendricks} Wisconsin Supreme court decision upholding the constitutionality of that state’s SVP statutes, Justice Abrahamson asserted: “If reference to treatment were sufficient to render a statute civil, [Wisconsin’s statutes that govern] prisons and jails, would be transmogrified into a civil statute.” \textit{Id.} at 137.
either in purpose or effect. In finding that the SVP Act was not proven to have a punitive purpose, the majority noted that, unlike a criminal statute, the Act did “not affix culpability for prior criminal conduct,” and did not require scienter for commitment. Id. at 362. The Act did not function as a deterrent because individuals committed as SVPs are unable to exercise control over their behavior and are “unlikely to be deterred by the threat of confinement.” Id. at 362-63. Additionally, SVPs experience essentially the same conditions experienced by other civilly committed persons, not the more restrictive conditions experienced by prisoners. Id. at 363. The Act’s use of criminal process-type procedural safeguards to identify those who are civilly committable did not convert the proceedings into criminal proceedings. Id. at 364; see infra text accompanying notes 467-70 (discussing procedural safeguards provided by the Kansas SVP Act).

446 Hendricks, 521 U.S. at 361. In finding that the SVP Act was not proven to have a punitive purpose, the majority noted that, unlike a criminal statute, the Act did “not affix culpability for prior criminal conduct,” and did not require scienter for commitment. Id. at 362. The Act did not function as a deterrent because individuals committed as SVPs are unable to exercise control over their behavior and are “unlikely to be deterred by the threat of confinement.” Id. at 362-63. Additionally, SVPs experience essentially the same conditions experienced by other civilly committed persons, not the more restrictive conditions experienced by prisoners. Id. at 363. The Act’s use of criminal process-type procedural safeguards to identify those who are civilly committable did not convert the proceedings into criminal proceedings. Id. at 364; see infra text accompanying notes 467-70 (discussing procedural safeguards provided by the Kansas SVP Act).

447 Id. at 365.
448 Id. at 363.
449 Id. at 365-66.
450 Id. at 366-67.
451 Id. at 369.
452 Id.
453 Id. at 371. Although Justice Kennedy joined in the Court’s majority, he wrote a short concurring opinion expressing his concern about the use of civil commitment laws to confine those who have already been punished through the criminal process. Id. at 371-72 (Kennedy, J., concurring). He cautioned that if civil confinement is used to achieve retribution or general deterrence rather than mere incapacitation, it cannot be validated. Id. at 373. If “mental abnormality” proves too uncertain a category to justify civil
In Hendricks, the Supreme Court did not consider whether special civil commitment legislation for SVPs violates the Constitution’s Equal Protection Clause. But given the Court’s rejection of Hendricks’s substantive due commitment, its use cannot be condoned. Id.

Writing on behalf of the four dissenting justices, Justice Breyer focused on Hendricks’s *ex post facto* claim. To the dissenters, the statutes impermissibly imposed punishment by delaying treatment until Hendricks completed his prison sentence. Id. at 381 (Breyer, J., dissenting). Under the Kansas statute, diagnosis, evaluation, and commitment proceedings—prerequisites for treatment—did not occur until the prisoner’s criminal sentence was about to expire. Id. at 387.

In fact, the words “equal protection” do not appear even once in Justice Thomas’s majority opinion, in Justice Kennedy’s concurring opinion, or in Justice Breyer’s dissenting opinion. Ironically, Leroy Hendricks did raise an equal protection claim in his cross-petition to the Supreme Court. Conditional Cross-Petition at 16-18, Kansas v. Hendricks (No. 95-1649), *microformed on* U.S. Supreme Court Records and Briefs (Microform, Inc.). However, in his brief as cross-petitioner, Hendricks did not argue the equal protection claim. In a footnote, the cross-petitioner stated: “Mr. Hendricks’ cross-petition also sought review of his equal protection challenge to the statute. This claim will be subsumed in his substantive due process argument, and will not be separately briefed.” Brief for Leroy Hendricks Cross-Petitioner at *2 n.1, Hendricks (Nos. 95-1649, 95-9075), 1996 WL 450661. In its brief as cross-respondent, Kansas asserted that Hendricks abandoned his equal protection claim by failing to argue its merits in his cross-petitioner’s brief and requested that the Court so rule. Brief of Cross-Respondent, at *4, *39-40. Hendricks (No. 95-9075), 1996 WL 509502. The state characterized this failure as an apparent attempt to evade the page-limit requirements established by Supreme Court rule “or to manipulate the briefing process” by forcing the state either to address first the equal protection claim that Hendricks alone had raised or to wait until the state’s final reply brief to respond. Id. at *40. In his reply brief for cross-petitioner, Hendricks did not address the state’s argument. See Reply Brief for Cross-Petitioner, Hendricks (Nos. 95-1649, 95-9075), 1996 WL 593579.

The Supreme Court did not discuss the question of whether Hendricks’s equal protection claim could be appropriately subsumed within his substantive due process argument and did not comment on the state’s request for a ruling that Hendricks had abandoned his equal protection claim. The Court merely noted that Hendricks’s cross-petition asserted double jeopardy and *ex post facto* claims. Hendricks, 521 U.S. at 350.
process argument, it is unlikely that the Court would have accepted an equal protection argument that equated SVPs with other civilly committed mental patients. The *Hendricks* majority found that the legislature may identify for civil commitment purposes “a limited subclass of dangerous persons.” The Kansas SVP Act met that requirement by restricting SVP commitments to individuals who have a mental abnormality or personality disorder that they are unable to control and that renders them likely to engage in predatory acts of sexual violence. SVPs are more dangerous as a group than are other civilly committed mental patients. An equal protection argument that SVPs are no more dangerous than, and therefore are similarly situated with, other civilly committed patients is likely to fail.

Nevertheless, because SVP legislation is applicable, not to all persons who can be categorized as SVPs, but only to some, such legislation may be vulnerable to an equal protection attack. Typically, SVP legislation does not authorize civil commitment of all those who suffer from a mental disorder and who are likely to engage in predatory acts of sexual violence. Rather, SVP commitment is targeted at prisoners whose criminal sentence is about to expire. 

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455 See Grant H. Morris, *The Evil That Men Do: Perverting Justice to Punish Perverts*, 2000 U. ILL. L. REV. 1199, 1213-17 (asserting that an equal protection argument that SVPs are similarly situated with other civilly committed patients is not likely to succeed).

456 *Hendricks*, 521 U.S. at 357.

457 After the decision in *Hendricks*, the Kansas legislature amended the statute to require a likelihood of “repeat” acts of sexual violence instead of “predatory” acts of sexual violence. See supra note 439.

458 *Id.* at 358.

459 Even three of the four dissenting justices agreed that Kansas was not constitutionally prohibited from adopting two separate civil commitment statutes “each covering somewhat different classes of committable individuals.” *Id.* at 377 (Breyer, J., dissenting).

460 See Morris, *supra* note 455, at 1217-27 (asserting that an equal protection claim may be successful if it demonstrates that sentence-expiring prisoners and others who may be identified as SVPs and subjected to SVP commitment are similarly situated with other persons identifiable as SVPs but not subject to SVP commitment).
In some states, SVP legislation also identifies individuals in other narrowly-defined classes for inclusion as SVP candidates. Kansas, for example, includes persons found mentally incompetent to stand criminal trial who are about to be released from confinement and persons acquitted of crimes by reason of insanity who are about to be released from confinement. See KAN. STAT. ANN. § 59-29a03, -29a04, -29a07 (Supp. 2005). In Kansas, an insanity acquittee is not released from confinement as an insanity acquittee until he or she is no longer dangerous, i.e., is not likely to cause harm to himself or herself or to others. Id. §§ 22-3428(3) & 22-3428(7)(b). Kansas is not alone. In many states, insanity acquittees may not be released until a court finds that they are no longer dangerous to others. See, e.g., CAL. PENAL CODE § 1026.2(e) (West Supp. 2006). Thus, an insanity acquittee who currently suffers from a mental abnormality or personality disorder that makes him or her likely to engage in repeat acts of sexual violence—the definitional criteria for SVP adjudication—is unlikely to be released from insanity acquittee commitment as not dangerous. In reality, insanity acquittees who are not too dangerous to be released from insanity acquittee confinement but who are dangerous enough to be confined as SVPs do not exist. Insanity acquittees, therefore, are not a special category for SVP commitment purposes; they are a noncategory.

Other individuals are not subject to SVP commitment even if they are equally likely to engage in sexually violent conduct and are equally unable to control their dangerousness due to mental disorder. Thus, for example, ex-prisoners who were punished for sexually violent crimes and who could be predicted to perform additional sexually violent crimes are not subject to SVP commitment if they already served their criminal sentences and were released from confinement before the SVP legislation was enacted. Criminal defendants who are charged with, but not yet convicted of, sexually violent crimes and who could be predicted to commit additional sexually violent crimes are not subject to SVP commitment. Criminal defendants who are charged with violent crimes, but not sexually violent crimes, are not subject to SVP commitment. Individuals who have not yet been charged with sexually violent crimes, and indeed, individuals who have not yet committed such crimes, are not subject to SVP commitment. And yet, in each case, their mental disorders and their difficulty in controlling their sexual urges may make them equally dangerous.
with sentence-expiring prisoners who are subject to SVP commitment.\textsuperscript{462} Although the Supreme Court permits the legislature “to recognize degrees of harm, and it may confine its restrictions to those classes of cases where the need is deemed to be clearest,”\textsuperscript{463} the Equal Protection Clause prohibits the legislature from discriminating between individuals when the danger that they pose is equal. The state has no compelling interest to so discriminate.

\textit{Baxstrom v. Herold}\textsuperscript{464} tells us that sentence-expiring prisoners cannot be specially classified for civil commitment purposes. Nevertheless, sentence-expiring prisoners are separately categorized for commitment by MDO and SVP legislation. \textit{Baxstrom} tells us that the same civil commitment standards and procedures must be applied to sentence-expiring prisoners that are applied to any other nonprisoners.\textsuperscript{465} MDO and SVP legislation, however, apply different civil commitment standards and procedures to sentence-expiring prisoners. If sentence-expiring prisoners can only be involuntarily confined as are other civilly committed patients, then they are civilly committed patients,

\textsuperscript{462}Consider, for example, the case of \textit{In re Diestelhorst}, 716 N.E.2d 823 (Ill. App. Ct. 1999). A pedophile, who was released after serving a ten-year prison term for sexually molesting children, attempted to lure a young girl into his car. He was apprehended and pled guilty to the crime of child abduction. \textit{Id.} at 824. As his sentence was expiring, the state petitioned for SVP commitment. \textit{Id.} at 825. Despite expert testimony that he had a “lingering penchant for children,” the appellate court ruled that the petition should have been dismissed. \textit{Id.} at 825, 829. Child abduction is not a sexually violent offense, and under Illinois law, only those who are completing confinement for a sexually violent offense are subject to SVP commitment. \textit{Id.} at 827. The court rejected the state’s argument that SVP commitment is appropriate because the crime, although not specifically defined as violent, was sexually motivated. \textit{Id.} at 827-29. The perpetrator, according to the state, sought to gratify “an aberrant sexual preference. He wanted to sexually molest his prey.” \textit{Id.} at 826. If, as the court assumed, the state correctly assessed the criminal’s motivation, would anyone believe that this individual is less sexually dangerous than another pedophile who was not apprehended until after he sexually molested a child and who was therefore subject to SVP commitment?

\textsuperscript{463}Minnesota \textit{ex rel.} Pearson v. Probate Court, 309 U.S. 270, 275 (1940).

\textsuperscript{464}383 U.S. 107 (1966).

\textsuperscript{465}\textit{Id.} at 114-15.
and cannot be morphed into MDOs or SVPs or any other special hybrid class of patient with “criminal” as well as “civil” features. As civilly committed patients, they are entitled—or should be entitled—to the same right to refuse treatment that other civilly committed patients possess.

The Supreme Court has yet to consider an equal protection challenge to MDO or SVP commitment statutes or to consider whether patients committed under such statutes possess the same right to refuse treatment that other civilly committed patients possess. Nevertheless, our current Supreme Court—far more conservative than the Warren Court that decided Baxstrom and far more deferential to the legislative judgment to enact such laws—may be able to finesse the Baxstrom precedent in order to uphold MDO and SVP legislation and limit the right of patients committed under such legislation to refuse treatment. In Baxstrom, the Supreme Court invalidated a statute that permitted the Commissioner of Mental Hygiene to order that a sentence-expiring prisoner be placed in a maximum security mental hospital administered by the Department of Correction.466 MDO and SVP statutes do not authorize civil commitment through administrative fiat. Extensive due process protections are afforded in the commitment process. For example, the Kansas SVP statute requires a judge to determine whether probable cause exists to believe that the person is an SVP;467 entitles the person to the assistance of counsel, and if indigent, appointed counsel, at all stages of SVP proceedings;468 permits the person to demand a jury trial;469 and requires proof beyond a reasonable doubt to adjudicate the person an SVP.470 The Court could narrowly construe Baxstrom to be applicable only to situations in which civil commitment is achieved for a special class of individuals through administrative judgment or without due process procedures at least as protective as those employed for regular civil commitment.

466 See supra text accompanying notes 416-24; see also Morris, Confusion of Confinement, supra note 428, at 665-67 (quoting and discussing the statute found unconstitutional in Baxstrom).
468 Id. § 59-29a06(b).
469 Id. § 59-29a06(c). The statute also permits the prosecutor to demand a jury trial. Id.
470 Id. § 59-29a07(a).
Although MDO and SVP statutes establish separate civil commitment classifications, *Hendricks* allows such separate categorization if the statutes provide for “somewhat different classes of committable individuals.”

Kansas’s SVP legislation begins with a legislative finding that distinguishes SVPs from others subjected to civil commitment. According to the Kansas Legislature, SVPs are “an extremely dangerous group” of individuals “who have a mental abnormality or personality disorder and who are likely to engage in repeat acts of sexual violence if not treated for their mental abnormality or personality disorder.” The legislature also found that the existing civil commitment procedures were “inadequate to address the special needs of sexually violent predators and the risks they present to society” and that “a separate involuntary civil commitment process for the potentially long-term control, care and treatment of sexually violent predators is necessary.”

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471 *Hendricks*, 521 U.S. at 377 (Breyer, J., dissenting); see supra text accompanying notes 456-59.

472 KAN. STAT. ANN. § 59-29a01 (Supp. 2005).

473 *Id.* The Kansas Legislature also determined “that because of the nature of the mental abnormalities or personality disorders from which sexually violent predators suffer, and the dangers they present, it is necessary to house involuntarily committed sexually violent predators in an environment separate from persons involuntarily committed” pursuant to other civil commitment statutes. *Id.*

California’s MDO legislation also begins with a legislative finding that distinguishes MDOs from others subjected to civil commitment. According to the California Legislature, MDOs are prisoners who have a treatable, severe mental disorder that was one of the causes of, or was an aggravating factor in the commission of the crime for which they were incarcerated [. ] . . . that if the severe mental disorders of those prisoners are not in remission or cannot be kept in remission at the time of their parole or upon termination of parole, there is a danger to society, and the state has a compelling interest in protecting the public . . . [and] that in order to protect the public from those persons it is necessary to provide mental health treatment until the severe mental disorder which was one of the causes of or was an aggravating factor in the person's prior criminal behavior is in remission and can be kept in remission.

CAL. PENAL CODE § 2960 (West 2000).
Although MDO and SVP statutes target sentence-expiring prisoners, the Supreme Court may rule that such targeting does not violate the Equal Protection Clause. After all, the Court in Harper declared that prisoners have “a demonstrated proclivity for antisocial criminal, and often violent, conduct,” and that such proclivity permits a state to involuntarily medicate dangerous prisoners without having to prove they are incompetent to refuse medication. To support its judgment, the Harper Court relied upon the state’s legitimate interest in prison safety and security. This interest, according to the Court, differentiates prisoners from others who may refuse treatment unless they are incompetent to do so. But the state also has a legitimate interest in the public’s safety and security when prisoners are released at the end of their criminal sentences. Incapacitation of the dangerously mentally ill, according to the Hendricks Court, is a “legitimate nonpunitive governmental objective.” MDO and SVP legislation merely targets a small group of sentence-expiring prisoners for an inquiry into their potential for further acts of violence if they are released. The Court may permit such targeting because, according to the Court, prisoners have a proclivity for antisocial and often violent conduct. Such proclivity differentiates prisoners—even sentence-expiring prisoners—from others in society.

If MDO and SVP legislation survives an equal protection challenge, and if MDOs and SVPs are, by definition, dangerous individuals, does the Sell precedent apply to permit forced medication of these specially committed civil patients? In my opinion, it should not. Consider, for example, a typical SVP—such as Leroy Hendricks—whose mental disorder is pedophilia. The danger from such a person is that he will sexually assault a child if released to society. That is why society is justified in incapacitating—i.e., preventively detaining—pedophiles by placing them in secure facilities. But children are not found in such facilities. Confinement itself satisfies society’s legitimate interest in protecting its young. If the pedophile presents no risk of violence to

\[475\] See supra text accompanying notes 329-42.
\[476\] Harper, 494 U.S. at 225.
the staff members and other patients he is likely to encounter within the facility, and if he is competent to decide whether to accept or reject treatment to improve his condition, society cannot justify imposing treatment on him against his will.

Although an individual’s danger to society does not—or at least should not—equate to danger to others in the facility in which the individual is placed, the Sell decision allows a state to forcibly medicate a patient who is dangerous to other patients and staff in the facility.\textsuperscript{478} Although Sell involved a criminal defendant patient, the Sell precedent is likely to be expanded to other special commitment classifications, such as MDOs and SVPs. In Sell, the Court wrote that forced medication to restore competence to stand trial need not be considered “if forced medication is warranted for a different purpose, such as the purposes set out in Harper related to the individual’s dangerousness.”\textsuperscript{479} If a patient’s danger to other patients and to staff can justify coerced treatment not only of mentally disordered prisoners—as the Supreme Court held in Harper—but criminal defendants as well—as the Supreme Court held in Sell—it is unlikely that the Supreme Court will apply a different rule to MDOs and SVPs. The emergency exception to the common law requirement of informed consent no longer applies to patients subjected to special civil commitment. For them, coerced treatment is permissible if they are a danger—i.e., if they present a generalized risk of harm\textsuperscript{480}—to other patients or staff at the facility in which they are involuntarily detained.\textsuperscript{481}

D. Insanity Acquittees

A successful insanity defense precludes criminal responsibility. A seriously mentally disordered person who engages in criminal behavior but who

\textsuperscript{479} Id. (citing Harper, 494 U.S. at 225-26).
\textsuperscript{480} See supra text accompanying notes 343-48 (discussing the Washington administrative regulation applicable to mentally ill prisoners).
\textsuperscript{481} Additionally, the Supreme Court is also likely to uphold an administrative regulation, such as the one it upheld in Harper for mentally disordered prisoners, allowing the question of a specially civilly committed patient’s dangerousness to be determined by an internal professional review committee. See supra text accompanying notes 340-42.
is found not guilty of the crime because of that disorder is not blameworthy and is not subject to criminal punishment.

Relying upon Baxstrom’s prohibition against the special classification of sentence-expiring criminals for civil commitment purposes, the Court of Appeals for the District of Columbia Circuit in 1968, and the highest appellate courts in several states in the 1960s and 1970s, held that an insanity verdict could not by itself justify the indeterminate detention of a person acquitted of a crime by reason of insanity, i.e., an insanity acquittee. Although a finding of insanity at the time of the criminal act warrants a post-trial evaluation of the acquittee’s current mental condition, once that evaluation is completed, the acquittee should not be distinguished from other nonprisoner mentally disordered persons in either the criteria applied to the commitment decision or to the procedures employed in the commitment process.

Nevertheless, in its 1983 decision in Jones v. United States, a narrowly divided Supreme Court held that “insanity acquittees constitute a special class

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482 See supra text accompanying notes 416-29.
483 Bolton v. Harris, 395 F.2d 642 (D.C. Cir. 1968). Chief Judge Bazelon, writing for the court, relied on Baxstrom as establishing the principle that “the commission of criminal acts does not give rise to a presumption of dangerousness which, standing alone, justifies substantial difference in commitment procedures and confinement conditions for the mentally ill.” Id. at 647. To confine an insanity acquittee without affording him the standard civil commitment procedural protections denies him equal protection. Id. at 651. The court rejected the argument, which the Supreme Court also rejected in Baxstrom, that expeditious commitment of nonconvict mentally ill persons is justified because of their dangerous or criminal propensities. Id. at 649.
485 See generally Grant H. Morris, Dealing Responsibly with the Criminally Irresponsible, 1982 Ariz. St. L.J. 855 (asserting that although insanity acquittees can be subjected to a post-trial evaluation to assess their current mental condition, they should not be distinguished from other mentally disordered nonprisoners in commitment, release, and treatment decisions).
that [can] be treated differently from other candidates for commitment. As a special class, insanity acquittees can be subjected to automatic, indeterminate commitment without first undergoing the civil commitment process. For civil commitment generally, the state is required to prove, by clear and convincing evidence, that the person is both mentally ill and dangerous. According to the five-judge *Jones* majority, the state has no such burden for insanity acquittee commitment. In his criminal trial, Michael Jones pleaded insanity as a defense to the crime charged against him. The insanity verdict established beyond a reasonable doubt that he committed a criminal act and did so because of mental illness. The legislature may determine that the insanity verdict supports an inference of continuing mental illness and continuing dangerousness. Thus, insanity acquittees can be distinguished from others, such as incompetent criminal defendants, about whom such proof is lacking.

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487 *Id.* at 370.
488 The District of Columbia statute interpreted in the *Jones* case provided, and continues to provide, that within fifty days of commitment, a judicial hearing shall be held at which the insanity acquittee can prove his or her eligibility for release. D.C. CODE ANN. § 24-501(d)(2)(A) (2001). At that hearing, the burden is placed on the insanity acquittee to prove by a preponderance of the evidence that he has recovered his sanity and will not in the reasonable future be dangerous to himself or others. *Id.* § 24-501(d)(2)(B), (e).
490 *Jones*, 463 U.S. at 359-60.
491 *Id.* at 363.
492 *Id.* at 366.
493 *Id.* at 364. The *Jones* majority reasoned that proof of the commission of a criminal act is “concrete evidence” that “may be at least as persuasive as any predictions about dangerousness that might be made in a civil-commitment proceeding.” *Id.*
494 The Court distinguished insanity acquittees from persons subjected to the regular civil commitment process without any criminal charges brought against them and from criminal defendants found incompetent to stand trial. Incompetent criminal defendants cannot be committed indefinitely because no affirmative proof has been offered that they committed criminal acts or were dangerous. *Id.* at 364 n.12 (discussing *Jackson v. Indiana*, 406 U.S. 715 (1972)).

Justice Brennan, joined by Justices Marshall and Blackmun, wrote a
Because *Jones* allows insanity acquittees to be specially categorized for civil commitment purposes, then logically, their right to refuse treatment should be governed by the principles applicable to other patients who have been specially civilly committed as both mentally disordered and dangerous. After *Sell*, proof of danger to other patients or staff will be deemed sufficient to authorize forced treatment, even when no emergency exists.

**E. Regular Civilly Committed Patients**

In *Washington v. Harper*, the Supreme Court distinguished prisoners from civilly committed patients in ruling that due process does not require a judicial finding of incompetence before treatment may be involuntarily imposed on dangerous prisoner-patients. In *Sell v. United States*, the Supreme Court, relying on its *Harper* precedent, distinguished criminal defendants from civilly committed patients in ruling that treatment may be involuntarily imposed...
on dangerous criminal defendants. I have suggested that the Supreme Court is likely to apply the dangerousness standard to permit coerced treatment of other specially categorized civil patients—i.e., sentence-expiring prisoners (MDOs and SVPs) and insanity acquittees. But if generalized danger to self or others is sufficient to warrant coerced treatment for prisoners and specially committed civil patients—even in the absence of an emergency and despite the protest of a competent patient—will that standard also be applied to regular civil patients? In other words, if prisoners and specially committed civil patients are not equated to regular civil patients for the purpose of according them the regular civil patient’s right to refuse treatment, will regular civil patients be equated to prisoners and specially committed civil patients for the purpose of denying them the right to refuse treatment?

In Harper, the Supreme Court recognized the state’s legitimate interest in

\[\text{\footnotesize \textsuperscript{498}See supra text accompanying notes 355-414 (discussing and critiquing the Sell decision).}\]

\[\text{\footnotesize \textsuperscript{499}See supra text accompanying notes 416-94.}\]

\[\text{\footnotesize \textsuperscript{500}See, e.g., State v. Barker, No. 20417, 2005 WL 187392 (Ohio Ct. App. 2d Dist. Jan. 28, 2005). In Barker, the court ruled that the Constitution does not require that the procedures for forcibly medicating a civilly committed patient be identical to those for forcibly medicating an incompetent to stand trial criminal defendant. The court reasoned that an incompetent criminal defendant "needs to be restored to competence in order to defend himself against the charges raised against him. A civilly committed individual would not have a similar sufficient need to be restored to competency justifying overriding his free choice" regarding his own healthcare. Id. at *3. However, in State v. Rowe, No. 14-05-31, No. 14-05-46, 2006 WL 988532 (Ohio Ct.App. 3d Dist. Apr. 17, 2006), the court refused to apply the Barker precedent to distinguish insanity acquittees from civilly committed patients. Unlike incompetent criminal defendants, insanity acquittees and civilly committed patients are committed because they are dangerous to themselves or to others. Under Ohio law, a civilly committed patient cannot be involuntarily medicated unless a judge determines that the person lacks the capacity to give or withhold informed consent. At the hearing on the patient’s capacity, the patient is entitled to the assistance of an attorney and to an evaluation by an independent psychiatrist or psychologist. The court held that insanity acquittees are entitled to the same procedural protections against coerced treatment as are accorded civilly committed patients. Id. at *7.}\]
ensuring the safety of prisoners, prison staff, and administrative personnel. As the Court stated, when a prisoner’s mental disorder “is the root cause of the threat he poses to the inmate population, the State’s interest in decreasing the danger to others necessarily encompasses an interest in providing him with medical treatment for his illness.” In *Sell*, the Court specifically cited “the purposes set out in *Harper* related to the individual’s dangerousness” as a justification for permitting coerced treatment of nonprisoner, criminal defendants in nonpenal settings.

The state, however, has a legitimate interest, not only in the safety of prisoners and specially committed civil patients, but also in the safety of regularly civilly committed patients. Although the Supreme Court asserted that the state’s interest in combating danger is greater in the prison environment than elsewhere, the state’s interest in protecting civilly committed patients in mental treatment facilities from attacks by their dangerous colleagues is at least equally as great. In California, for example, a person can be civilly committed if, because of mental disorder, he or she is dangerous to self or others, or gravely disabled, i.e., unable to provide for food, clothing, or shelter. Upon initial admission, gravely disabled patients are often placed in wards with patients who are dangerous to others. If the state has a legitimate interest in protecting presumably dangerous prisoners from other dangerous prisoners, it must have an equal, if not greater, interest in protecting innocent, helpless mental patients from dangerous mental patients.

In some states, legislation has been enacted to specifically authorize the involuntary administration of psychotropic medication to dangerous patients in

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502 Id.
503 *Sell*, 539 U.S. at 182.
505 *Cal. Welf. & Inst. Code* §§ 5150 (West 1998) (detention, without court order, for seventy-two hours to evaluate and treat mentally disordered persons who are a danger to self or others or gravely disabled), 5200 (court-ordered detention for seventy-two hours to evaluate and treat persons who are a danger to self or others or gravely disabled), 5250 (certification for fourteen days of intensive treatment for persons who are a danger to self or others or gravely disabled); *see supra* text accompanying notes 267, 283-84, 286.
nonemergency situations. In Maryland, for example, a clinical review panel is empowered to order the patient medicated in nonemergency situations\textsuperscript{506} if the medication is prescribed by a psychiatrist to treat the patient’s mental disorder and the patient is at substantial risk of continued hospitalization because without the medication the patient will remain seriously mentally ill: (1) with no significant relief in the symptoms that cause the patient to be a danger to self or to others, or (2) for a significantly longer period of time with symptoms that cause the patient to be a danger to self or to others.\textsuperscript{507} Under the statute, nonemergency treatment may be imposed on a dangerous patient without any assessment of the patient’s competence to refuse treatment.\textsuperscript{508} Simply put, the right to refuse treatment is refused. Nevertheless, in rejecting a patient’s claim that due process requires a determination of the patient’s incompetence before he or she may be involuntarily medicated, the Maryland Court of Appeals characterized the statute as “a narrow legislative exception to the common law rule that a physician cannot administer treatment of any kind to a patient without that patient’s consent, absent emergency circumstances.”\textsuperscript{509}

Iowa does not even accord its dangerous mental patients the limited due process protection of a clinical review before denying them the right to make treatment decisions. By statute, a person who is “seriously mentally impaired” is subject to involuntary commitment.\textsuperscript{510} “Serious mental impairment” is defined as lacking “sufficient judgment to make responsible decisions with respect to the person’s hospitalization or treatment” and either “likely to physically injure the person’s self or others if allowed to remain at liberty

\begin{itemize}
\item \textsuperscript{506}Md. Code Ann., Health–Gen. §10-708(b)(2) (West Supp. 2006).
\item \textsuperscript{507}Id. § 10-708(g)(3)(i)-(ii).
\item \textsuperscript{508}Beeman v. Dep’t of Health & Mental Hygiene, 666 A.2d 1314, 1325-26 (Md. 1995). In Beeman, the court stated that the presumption of competency “does not disappear upon an involuntary admission to a mental health facility for psychiatric treatment” and thus rejected the patient’s assertion that a determination of the patient’s mental capacity to understand and exercise appeal rights is constitutionally required. \textit{Id.} at 1325. Nevertheless, this presumption of the patient’s competency did not preclude the administration of medication without the patient’s consent in a nonemergency situation.
\item \textsuperscript{509}Id.
\item \textsuperscript{510}Iowa Code Ann. §§ 229.13, 229.14 (West Supp. 2006).
\end{itemize}
without treatment,” or “likely to inflict serious emotional injury on members of
the person’s family or others . . . if . . . allowed to remain at liberty without
treatment” or “unable to satisfy the person’s needs for nourishment, clothing,
essential medical care or shelter.” 511 Another Iowa statute provides that a
seriously mentally impaired patient’s right to refuse treatment by chemotherapy
does not apply during any period of custody authorized by a court pursuant to
the involuntary commitment statutes. 512 Even though Iowa law does not equate
involuntary commitment with incompetency, or raise a presumption of
incompetency, or cause the committed person to be under a legal disability for
any purpose, 513 a person committed as seriously mentally impaired loses the
right to refuse treatment. Without any formal adjudication of the patient’s
incompetency to make medication decisions and without an emergency
situation necessitating that the patient be medicated, the commitment decision
itself authorizes psychotropic medication to be administered without the
patient’s consent. 514
A Georgia statute accords mental patients the right to refuse medication
“except in cases where a physician determines that refusal would be unsafe to
the patient or others.” 515 As interpreted, the “unsafe” standard is far broader
than the “dangerous” standard it replaces. For example, in a class action suit
brought by patients at a Georgia state mental hospital to enjoin doctors from
medicating them without their consent, 516 a treating doctor found one patient to

511 Id. § 229.1(16).
512 Id. § 229.23(2) (West 2000).
513 Id. § 229.27(1) (West Supp. 2006).
514 In Dautremont v. Broadlawns Hosp., 827 F.2d 291, 297 (8th Cir. 1987), the United States Court of Appeals for the Eighth Circuit, applying Iowa law, ruled that the involuntary medication of a patient committed as seriously mentally impaired did not deny him due process. In the court’s view, the patient’s liberty interest was outweighed by the government’s legitimate objective of making the patient’s behavior acceptable to society and accomplishing that objective through the administration of psychotropic medication prescribed by medical professionals. Id. at 300. See supra text accompanying notes 238-44.
515 GA. CODE ANN. § 37-3-163(b) (1995).
be unsafe simply because she was delusional and did not believe she was mentally ill. Even though she was not determined to be incompetent, and was not violent or threatening to herself or others, she was forcibly injected with Haldol of a strength sufficient to last for four to six weeks. A federal district court ruled that the patients’ procedural and substantive due process rights were not violated and refused to issue the injunction. As to the delusional patient, it was reasonable for the physician to believe the patient was unsafe, said the court, because she had “not presented any medical testimony stating that she was not delusional at the time she was involuntarily medicated.” By this measure, a patient who is determined by a treating doctor to be delusional is, , unsafe, regardless of whether that delusional state causes the patient to act in a way that is dangerous to the patient or to others. Apparently, if the doctor believes the patient is mentally ill, and the patient refuses to accept the doctor’s diagnosis, the court allows the doctor to medicate the patient involuntarily because, under the Georgia statute, the patient is unsafe.

In the Georgia case, the federal district court relied heavily upon the Supreme Court’s Harper decision to justify the limitations placed on the patients’ right to refuse treatment. The court noted that the state possessed “a significant interest, indeed a significant duty, to provide a safe and effective environment within state-run institutions and to preserve the safety of Plaintiff’s themselves.” Although the court acknowledged that Harper was a prisoner and that the plaintiffs in this case were not, the court noted that “the administration of psychotropic drugs in Harper took place not merely in a prison environment, but in a special treatment center for mentally ill prisoners. . . . As such, the state interests in Harper are analogous to those in the present case.” As in Harper, the state’s interest is to provide patients with medical treatment consistent not only with his or her own medical interests, but also

517 Id. at 1556-57.
518 Id. at 1571.
519 Id. at 1562.
520 Id. at 1562 n.6. The court also noted that the purpose of placing a mentally ill prisoner in a special treatment center was to treat the prisoner’s mental illness so that the prisoner could be returned to the general prison population. Id.
with the needs of the institution in which the patient is confined.\footnote{Id. at 1563.} Although prisoners are not equated to civilly committed patients to assure prisoners their right to refuse treatment, this case clearly equates civilly committed patients to prisoners in order to deny civilly committed patients their right to refuse treatment.

An Illinois statute expands the “danger” criterion even further by combining a finding that the patient is incompetent to make treatment decisions--and an exercise of the state’s \textit{parens patriae} power to care for the incompetent person--with a broadly worded danger standard--and an exercise of the state’s police power to protect others from the dangerous patient. In Illinois, involuntary treatment may be administered to a mental patient if the patient lacks the capacity to make a reasoned decision about the proposed treatment and the patient exhibits a deterioration of his or her ability to function, suffering, or threatening behavior.\footnote{Id. at 358.} The Supreme Court of Illinois upheld the statute against a patient’s claim that the term “threatening behavior” was unconstitutionally vague.\footnote{Id. at 358.} One can anticipate that any patient who refuses medication and communicates a threat will be determined to lack the capacity to make a reasoned decision about the proposed treatment. After all, from the doctor’s perspective, the reasoned decision is to accept the medication prescribed by the doctor that will treat the patient’s mental condition and eliminate, or at least diminish, the patient’s threatening behavior. Thus, the incapacity requirement is unlikely to be a meaningful deterrent to the involuntary administration of medication to patients who satisfy the “threatening behavior” requirement.

A recent California Supreme Court decision seemingly authorizes coerced treatment of patients civilly committed for 180 days as dangerous\footnote{405 ILL. COMP. STAT. ANN. 5/2-107.1(a-5)(4)(B), (E) (West 2005).}--without proof of incompetence or an emergency situation. Ironically, the case involved an MDO, not a regular civilly committed patient.

\footnote{405 ILL. COMP. STAT. ANN. 5/2-107.1(a-5)(4)(B), (E) (West 2005).}
\footnote{In re C.E., 641 N.E.2d 345, 357-58 (Ill. 1994). At the time of the court’s decision, the statute also authorized involuntary treatment of a patient who exhibited “disruptive behavior.” See id. at 349. The court also ruled that the term “disruptive behavior” was not unconstitutionally vague. Id. at 358.}
\footnote{CAL. WELF. & INST. CODE §§5300, 5304 (West 1998).}
In *In re Qawi*, the court, citing the United States Supreme Court’s *Sell* decision, acknowledged that “a regime of forced medication based on a vague and generalized suspicion of dangerousness would likely violate the state, if not the federal, Constitution.” The court acknowledged that under the MDO commitment statute, MDOs are considered to be involuntary mental patients and are entitled to the rights of other civilly committed mental patients. The court also acknowledged that the California Constitution’s right of privacy and the common law guarantee the right to refuse medical treatment—including the right of competent individuals to refuse psychotropic medication—and that civilly committed mental patients are presumed competent unless proven otherwise. The *Qawi* court discussed, approvingly, the California Court of Appeals decision in *Riese v. St. Mary’s Hospital & Medical Center*. In *Riese*, the court held that mental patients initially detained for seventy-two hours for evaluation and treatment, and mental patients subsequently certified for fourteen days of intensive treatment, have a right to refuse treatment in nonemergency situations. Thus, unless a court determines that the patient lacks the capacity to give or withhold informed consent to treatment, the patient may not be treated involuntarily. The *Qawi* court noted that “*Riese’s* recognition

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525 81 P.3d 224 (Cal. 2004).
526 *Id.* at 234.
527 *Id.* at 230 (citing CAL. PENAL CODE §2972(g) (West Supp. 2006)).
528 *Id.* at 230-31 (citing CAL. CONST. art. I, § 1 (West 2002), Conservatorship of Wendland, 28 P.3d 151 (Cal. 2001), and Riese v. St. Mary’s Hosp. & Med. Ctr., 271 Cal. Rptr. 199 (Cal. Ct. App. 1987)). In *Qawi*, the California Supreme Court accepted language contained in a court of appeals decision, that the right of privacy in the California Constitution “guarantees to the individual the freedom to choose to reject, or refuse to consent to, intrusions of his bodily integrity.” *Id.* at 231 (citing Wendland, 28 P.3d at 159, which quoted Bartling v. Superior Court, 209 Cal. Rptr. 220, 225 (Cal. Ct. App. 1984)).
529 *Id.* at 230-32.
530 *Id.* at 232-33.
531 *Id.*
533 *Riese*, 271 Cal. Rptr. at 201.
of the right to refuse medication if competent has been codified in the LPS Act.” In the *Qawi* court added: “[T]he reasoning of *Riese* makes clear that the right does not apply solely to short-term LPS patients.” In its dictum, the *Qawi* court stated that individuals placed on one-year renewable conservatorships as gravely disabled also possess the right to refuse psychotropic medication absent a judicial determination of their incompetence to make treatment decisions.

In contrast to short-term LPS patients and LPS conservatees, the *Qawi* majority asserted that “the LPS Act implicitly addresses state interests in institutional security in nonemergency situations by not including patients committed under Welfare and Institutions Code section 5300 . . . among those patients with the right to refuse medication.” At the expiration of the fourteen-day certification for intensive treatment, section 5300 authorizes a post-certification commitment for an additional 180-day period for persons who are dangerous. As explained in *Qawi*, in order to subject a person to a 180-day commitment hold, section 5300 requires two types of findings of dangerousness. The patient must have attempted, inflicted, or made a serious threat of substantial physical harm upon the person of another either while the patient was in custody on a seventy-two hour or fourteen-day evaluation or

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534 *Qawi*, 81 P.3d at 233.
535 *Id.*
536 *Id.* at 233-34. Because the *Qawi* case involved an MDO, not an LPS conservatee, the court’s statement about the right of LPS conservatees to refuse treatment is dictum. See infra text accompanying notes 560-75.
537 *Id.* at 234.
538 The statutes containing the standards and criteria for the 180-day commitment are found in *Cal. Welf. & Inst. Code* §§ 5300-5309 (West 1998), which are entitled “Postcertification Procedures for Imminently Dangerous Persons.” Nevertheless, the characterization of a person as an “imminently dangerous person” does not mean that an emergency exists warranting immediate treatment to alleviate the situation. The *Qawi* court specifically distinguished emergency treatment situations from the general authority to impose involuntary treatment on patients committed on 180-day postcertification holds. *Qawi*, 81 P.3d at 235, 240. See infra text accompanying notes 543-44.
539 *Id.* at 235.
treatment hold, or prior to being taken into custody and that act resulted in the patient being taken into custody.\textsuperscript{540} In addition to this finding of a recent act or threat of violence, the statute also requires a generalized finding of current dangerousness, i.e., that the patient "presents a demonstrated danger of inflicting substantial physical harm upon others."\textsuperscript{541} A patient committed pursuant to section 5300 may be recommitted for an additional 180 days if he or she attempted, inflicted, or made a serious threat of substantial physical harm upon another during the 180-day postcertification treatment period, and the patient continues to present a demonstrated danger of inflicting substantial physical harm upon others.\textsuperscript{542}

The LPS civil commitment statutes, said the \textit{Qawi} court, balance the individual’s constitutional and common law right to refuse psychotropic medication with the state’s interests in caring for individuals who cannot care for themselves and in providing security in institutional settings. Thus, a patient may refuse treatment unless he or she is determined to be incompetent, or medication is administered in an emergency, or the patient is committed as a dangerous person under section 5300.\textsuperscript{543} The court distinguished emergency situations in which action is immediately necessary to preserve life or prevent serious bodily harm to the patient or others—which limits involuntary treatment

\begin{itemize}
\item \textsuperscript{540} \textit{Cal. Welf. \\ & Inst. Code} § 5300 (West 1998).
\item \textsuperscript{541} \textit{Id. See also id.} § 5304(a) (authorizing the court to remand the patient to the custody of the State Department of Mental Health or to a county mental health facility for a period of intensive treatment not to exceed 180 days if the patient meets the criteria of $§ \ 5300$). A statute provides that an assessment of “demonstrated danger” may consider “past behavior of the person within six years prior to the time the person attempted, inflicted, or threatened physical harm upon another.” \textit{Id.} § 5300.5. Despite this statute, one can legitimately question whether an evaluation of an individual’s current dangerousness should appropriately consider behavior of the individual that occurred six years prior to the evaluation.
\item \textsuperscript{542} \textit{Id.} § 5304(b). The patient may be recommitted for additional 180-day periods if he or she is proven to meet the two-part dangerousness test of § 5300. \textit{Id.}
\item \textsuperscript{543} \textit{Qawi}, 81 P.3d at 235, 240.
\end{itemize}
only to that which necessary to resolve the emergency from the 180-day commitment of dangerous persons—which permits the patient to be treated involuntarily for the full 180-day commitment period.

Although a one-year commitment as an MDO requires a finding that the sentence-expiring prisoner “represents a substantial danger of physical harm to others,” the Qawi court noted that the term “substantial danger of physical harm to others” is not defined, although, in context, the language “appears to mean a prediction of future dangerousness by mental health professionals.”

The MDO commitment criteria focuses solely on the prisoner’s future dangerousness and, unlike section 5300, does not require a finding that the prisoner committed a recent, dangerous act, i.e., that the prisoner attempted, inflicted, or made a serious threat of substantial physical harm upon the person of another. Because a person can be adjudicated an MDO without a finding of recent dangerousness, the court concluded that MDOs do not lose the right to refuse psychotropic medication merely by being adjudicated MDOs, but only if they are proven to meet the two-part dangerousness test of section 5300.

In dissenting, Justice Janice Rogers Brown rebuked the majority for ranging well outside the designated boundaries of the MDO-commitment statute and for formulating an opinion “that is at best a patchwork of extraneous and irrelevant statutory and decisional law.” Justice Brown viewed the MDO commitment laws as “an entirely different statutory scheme” from LPS, and she rejected the majority’s attempt to provide MDOs with an LPS-generated right to refuse treatment. She declared the majority’s discussion of section 5300 to be

545 Cal. Penal Code § 2972(c) (West Supp. 2006).
546 Qawi, 81 P.3d at 237.
547 Id.
548 Id. at 238.
549 Id. at 240 (Brown, J., dissenting).
550 Id. at 241.
551 Id. at 240-42. Justice Brown characterized the majority’s discussion as “a free-ranging and circuitous foray well outside the designated confines of [the patient rights provisions] of the LPS Act.” Id. at 242.
“equally off point.”

Although I, too, am troubled by the Qawi majority opinion, I do not agree with Justice Brown’s conclusion that individuals committed as MDOs lose the right to refuse treatment based solely on that commitment decision—even if they are competent to make treatment decisions and even if no emergency exists warranting treatment over their objection. I also reject the majority’s finding that individuals civilly committed as dangerous pursuant to section 5300 also lose the right to refuse treatment based solely on that commitment decision—even if they are competent to make treatment decisions and even if no emergency exists warranting treatment over their objection.

Although California legislation does not specifically provide a right to refuse treatment for MDOs or for dangerous persons civilly committed for 180 days, in the absence of such legislation, such patients retain their common law right to refuse treatment. In 1972, the California Supreme Court held that a patient has a “basic right . . . to make the ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected. . . . Such evaluation and decision is a nonmedical judgment reserved to the patient alone.” The Riese court specifically cited this Supreme Court precedent for the principle that “the right of persons not adjudicated incompetent . . . to give or withhold consent to medical treatment is protected by the common law of this state.” Riese also held that because mental patients are not presumed incompetent solely because they are involuntarily committed, their right to give or withhold consent to treatment with psychotropic medication “does not disappear upon involuntary commitment.” At common law, both MDOs and dangerous civil committees have a right to refuse treatment.

The Riese court specifically rejected the argument that legislative silence could serve “as a basis upon which to deprive mentally ill persons not

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552 Id. at 242.
555 Id. at 206.
556 Id. at 213.
adjudicated incompetent of any right enjoyed by others.” Although the Qawi court repeatedly relies upon the Riese decision as authority for a mental patient’s right to refuse psychotropic medication, the majority ignores this aspect of the Riese decision when it claims that “the LPS Act implicitly addresses state interests in institutional security in nonemergency situations by not including patients committed under Welfare and Institutions Code section 5300 . . . among those patients with the right to refuse medication.” Although Kanuri Qawi argued that the absence of a statutory grant of a right to refuse medication in section 5300 should not be construed as a denial of that right, the Qawi majority concluded that because section 5300 patients are “the only class of LPS patients not afforded the right makes such an inference unavoidable.”

The inference, however, is avoidable. In fact, there is no such inference. Prior to the Riese decision, the LPS statutes did not specifically address the question of whether involuntary mental patients possess a right to refuse psychotropic medication. The Riese case was a class action lawsuit brought on behalf of mental patients involuntarily committed pursuant to California’s seventy-two hour treatment and evaluation hold or subsequently certified for fourteen days pursuant to California’s intensive treatment hold. The Riese court ruled that such patients have a right to exercise informed consent to the use of psychotropic medication in nonemergency situations absent a judicial determination of their incapacity to make treatment decisions. The Riese court appropriately limited its holding to patients in the two commitment categories that formed the plaintiff class and did not consider whether dangerous patients detained on a 180-day post-certification hold or patients placed on an LPS conservatorship also possessed the same right.

Two years after the Riese litigation ended, the California Legislature,

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557 Id. at 207. The Riese court also stated that “throughout the statutory scheme the Legislature repeatedly admonishes that the failure of LPS to explicitly confer a particular right upon mentally ill persons cannot provide a basis upon which to deny it.” Id.
558 In re Qawi, 81 P.3d 224, 234 (Cal. 2004).
559 Id.
561 Id. § 5250.
562 Riese, 271 Cal. Rptr. at 201.
responding directly to the *Riese* decision, codified the right of patients on seventy-two-hour holds and fourteen-day holds to refuse treatment with psychotropic medication\(^563\) and provided for administrative hearings to determine whether such patients possess the capacity to give or withhold informed consent.\(^564\) Because the legislature was responding to the *Riese* decision, it did not consider whether dangerous patients detained on a 180-day post-certification hold or patients placed on an LPS conservatorship also possess a right to refuse treatment and whether a judicial hearing is required, or whether an administrative hearing is sufficient, to determine whether such patients possess the capacity to give or withhold informed consent. In essence, the right of post-certification patients and LPS conservatees to refuse treatment is unaffected by the *Riese* decision or the legislative activity that responded to that decision. Neither the court, nor the legislature, addressed those patient categories. In the absence of legislation specifically addressing their right to refuse treatment, their common law right to give or withhold consent in nonemergency situations remains intact.

Although the legislature has not specifically addressed the right of postcertification patients and conservatees to refuse treatment, it has addressed their rights in general terms. A patients’ rights statute enacted in 1967 as a part of the original LPS Act—a statute that is conspicuously unmentioned by the *Qawi* court—provides that any person involuntarily detained, including a person detained either as dangerous under a 180-day postcertification commitment or detained as an LPS conservatee, “shall be entitled to all rights set forth in this part and shall retain all rights not specifically denied him under this part.”\(^565\) Another patients’ rights statute provides that persons with mental illness have the same legal rights as all other persons “unless specifically limited by federal or state law or regulations.”\(^566\) Because the legislature has not specifically denied or limited the common law right of postcertification patients and conservatees to refuse treatment, the inference that can and should be drawn from the existing statutes is that these patients retain that right.

\(^564\) *Id.* §§ 5332(b), 5334(c) (West 1998 & West Supp. 2006).
\(^565\) *Id.* § 5327 (West 1998).
\(^566\) *Id.* § 5325.1.
Even if one rejects this obvious conclusion, the *Qawi* court’s assertion that section 5300 patients are “the only class of LPS patients” that are not afforded the right to refuse treatment is not supportable. As previously discussed, a court establishing an LPS conservatorship may–and routinely does–grant the conservator the authority to hospitalize his or her conservatee and to require the conservatee to undergo treatment. The finding of “grave disability,” necessary to establish and LPS conservatorship, is not, per se, an adjudication of general incompetence, or of specific incapacity to make treatment decisions. Nevertheless, the LPS conservatorship statutes impose no obligation on the court to determine whether an LPS conservatee is incompetent to make treatment decisions before the court grants authority to the LPS conservator to make treatment decisions for the conservatee—including ordering that psychotropic medication be administered involuntarily to the conservatee. Thus, as the law currently stands, LPS conservatees as a class are not afforded the right to refuse treatment.

The *Qawi* court cites approvingly the California Court of Appeal decision in *Keyhea v. Rushen* for the proposition that “LPS conservatees have a right to refuse involuntary long-term psychotropic medication absent a judicial determination of their incompetency to do so.” But neither *Qawi*, which

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567 *In re* Qawi, 81 P.3d 224, 234 (Cal. 2004).
568 See *supra* text accompanying notes 288-94.
569 CAL. WELF. & INST. CODE § 5358(a)(2) (West 1998).
570 *Id.* § 5358(b).
571 See Board of Regents v. Davis, 533 P.2d 1047, 1054 (Cal. 1975) (holding that a conservatee who has not been adjudicated incompetent does not lose the right to enter into valid contracts); Riese v. St. Mary’s Hosp. & Med. Ctr., 271 Cal. Rptr. 199, 204 (Cal. Ct. App. 1987) (“Appointment of a conservator under LPS . . . does not involve an adjudication of incompetence . . .”).
572 See *Riese*, 271 Cal. Rptr. at 204 (“Appointment of a conservator under LPS . . . does not involve an adjudication of . . . incapacity to make treatment decisions about one’s own body.”).
573 See *supra* text accompanying notes 311-23.
575 *In re* Qawi, 81 P.3d 224, 234 (Cal. 2004) (quoting *Keyhea*, 223 Cal. Rptr. at 751). The *Qawi* court also cited *Keyhea* for recognizing that a
involved an MDO, nor Keyhea, which involved a mentally ill prisoner, directly considered whether individuals placed on an LPS conservatorship retain the right to refuse treatment unless they are adjudicated incompetent. Neither Qawi nor Keyhea considered whether, in the absence of legislation specifically mandating a competency hearing, the court establishing the conservatorship is precluded from authorizing the conservator to make treatment decisions for the conservatee without first conducting such a hearing. No other California Supreme Court or California Court of Appeal case has considered or decided those issues. These issues remain for future determination.

The Qawi decision suggests that the California Supreme Court is likely to hold that LPS conservatees retain the right to refuse treatment unless they are determined to be incompetent and that a hearing on a conservatee’s competency to make treatment decisions must be conducted before a court grants a conservator authority to make treatment decisions for the conservatee. However, at least currently, dangerous patients committed pursuant to section 5300 cannot be accurately described as uniquely alone in not being accorded the right to refuse treatment.

The Qawi majority’s attempt to use the section 5300 criteria to determine when MDOs lose their right to refuse treatment creates other difficulties. To be subjected to a 180-day postcertification commitment, section 5300 requires that the person must have attempted, inflicted, or made a serious threat of substantial physical harm upon another either while the person was in custody on a seventy-two hour or fourteen-day evaluation or treatment hold or prior to being taken into custody and that act resulted in the person being taken into custody. 576 Recommitment for an additional 180-day period requires that the patient engage in the same type of conduct during the 180-day hold. 577 If an MDO loses the right to refuse treatment not because he or she was adjudicated an MDO, but rather, only if he or she is determined to be a danger to others within the meaning of section 5300, then the time constraints imposed by...
section 5300 for establishing a recent dangerous act should be equally applicable to MDOs. But not so. In a final footnote to the majority’s opinion, the court stated, “[W]e do not believe an exact adherence to the time frames set forth in section 5300 is necessary.” The court ruled that in considering whether medication may be administered involuntarily to an MDO, the judge should consider whether the MDO committed the violent or threatening acts specified in section 5300 within one year prior to commitment or recommitment.

And what of Kanuri Qawi himself? The majority acknowledges that in the ten-year period since he was adjudicated an MDO in 1995, “none of the petitions or supporting evaluations identify any specific incidents of violence, threats of violence, or property damage that have occurred.” At worst, evaluators described him as “clearly delusional and grandiose” and noted that he “expressed some persecutory beliefs regarding his continued incarceration,” including that “the State of California had no intention of ever letting him out of the hospital.” Despite the absence of any evidence that Qawi committed a violent act or made a threat of violence during the ten-year period prior to the court’s decision, the California Supreme Court remanded the case for further consideration. One might well suggest that Qawi’s belief that the State of California had no intention of ever letting him out of the hospital was not a persecutory belief, but rather, was an accurate assessment.

In her Qawi dissent, Justice Brown expressed her judgment that MDOs do not possess a right to refuse treatment. As authority for her position, Justice Brown simply quoted a clause in the MDO commitment statute that imposes “an affirmative obligation on the treatment facility to provide treatment for the underlying causes of the person’s mental disorder.” However, as I have

578 *Qawi*, 81 P.3d at 240 n.7.
579 *Id.* Without further explanation or justification for its decision, the majority simply expressed its view that this ruling was “a reasonable translation of LPS rights into the context of the MDO Act.” *Id.*
580 *Id.* at 228.
581 *Id.*
582 *Id.* at 240.
583 *Id.* at 241 (Brown, J., dissenting) (quoting *Cal. Penal Code* § 2972(f) (West Supp. 2006)).
previously discussed, the state’s obligation to provide adequate treatment to the patients it involuntarily confines imposes no concomitant obligation on patients to accept that treatment. In the absence of an emergency situation warranting a short-term intervention to prevent imminent injury, the individual patient’s right to refuse treatment should prevail over the state’s claimed duty to impose treatment. Although sentence-expiring prisoners are not subject to MDO commitment unless they present “a substantial danger of physical harm to others,” the risk—i.e., the danger—may not be so great that it rises to an emergency situation. Perhaps the endangered person is a witness who testified against the prisoner at his or her criminal trial or some other person living outside the prison or mental hospital. If so, involuntary commitment itself—i.e., the security provided by the institution itself—provides sufficient protection against the threatened danger without forced treatment. Even if the patient presents a risk of harm to other patients or staff in the facility, the risk of attack may not be so imminent that it warrants emergency intervention.

The Riese case holds that civilly committed patients who have been certified for fourteen days of intensive treatment because they are dangerous to others cannot be forcibly medicated if they are competent to refuse treatment and no emergency exists warranting coerced treatment. Other civilly committed patients who have been detained for 180 days as dangerous or for one year as MDOs cannot be distinguished from them. Although their continuing danger—and our inability to make valid predictions about the risk of short-term violence from such persons—may justify a lengthier commitment period, it justifies no diminution of their right to refuse treatment. The state’s legitimate interest in protecting the public from the danger they present is achieved by the involuntary commitment decision. Whether they should be subjected to coerced treatment requires—or at least should require—an assessment of their competency to make treatment decisions and an assessment of whether there is an emergency need to impose treatment. Unless a patient is incompetent or an emergency exists, the competent patient’s right to refuse

\footnotesize{\textsuperscript{584} See supra text accompanying notes 251-67.\\ \textsuperscript{585} CAL. PENAL CODE § 2972(c) (West Supp. 2006).\\ \textsuperscript{586} Riese v. St. Mary’s Hosp. & Med. Ctr., 271 Cal. Rptr. 199, 201 (Cal. Ct. App. 1987).}
treatment outweighs any claimed governmental interest in coercing treatment.

Even the limited right to refuse treatment accorded MDOs by the Qawi decision has been subverted through post-Qawi administrative action. In Qawi, the California Supreme Court required that for psychotropic medication to be involuntarily administered in a nonemergency situation, the MDO must be “determined by a court to be incompetent to refuse medical treatment” or must be “determined by a court to be a danger to others.” The Qawi court noted, however, that an MDO’s right to refuse medication may also be limited through Department of Mental Health regulations that modify the MDO’s rights “as is necessary in order to provide for the reasonable security of the inpatient facility in which the patient is being held.” Identical language appears in the MDO commitment statute. In response to the Qawi decision, the California Department of Mental Health issued a “Special Order” establishing procedures to be followed to involuntarily medicate MDO patients. A Psychotropic Medication Review panel, consisting of a presiding psychiatrist, a second psychiatrist, and a clinical psychologist, determine the necessity for psychotropic medication. No panel member can be directly involved in the patient’s treatment. A social worker or nurse acts as the patient’s advocate at the hearing and assists the patient in filing a writ with the court if the patient desires that a writ be filed. If at least two members of the panel find that the

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587 Qawi, 81 P.3d at 240 (emphasis added); see also id. at 227-28.
588 Id. at 240 (emphasis added); see also id. at 227-28.
589 Id. at 240. The court noted that no such regulations had been issued as of the date of the Qawi decision. Id. at 240 n.8.
590 CAL. PENAL CODE § 2972(g) (West Supp. 2006). In Qawi, the California Supreme Court, citing this statute, noted that the California Legislature had delegated to the Department of Mental Health the authority to impose limitations on the right of MDOs to refuse treatment if the Department’s experience in administering institutions in which MDOs were housed established that such regulations were necessary to provide for institutional safety. Qawi, 81 P.3d at 238-39.
591 Cal. Dep’t Mental Health, Special Order No. 336.01, Subject: Involuntary Administration of Psychotropic Medication to Mentally Disordered Offenders (PC 2962 and 2972) Patients (effective Nov. 15, 2004) (on file with the author). The Special Order was signed by John Rodriguez, Deputy Director, Long Term Care Services, Department of Mental Health.
patient meets the criteria for involuntary psychotropic medication, such medication may be ordered for fourteen days. Thereafter, the panel conducts another hearing and may order continued treatment for up to 180 days. Another hearing is required to continue treatment beyond this 180-day period. Thus, the MDO’s right to a court determination of dangerousness before medication may be involuntarily administered is replaced, under the Special Order, by an in-house, medication review panel’s informal determination of dangerousness. The Special Order declares that this panel provides “interim authority” for involuntary medication but that “long term authority” for involuntary medication is determined by a court. Nevertheless, under the Special Order, the court only determines whether involuntary medication is permissible in those few instances in which a patient, with the assistance of his or her social worker or nurse advocate, files a writ to the court.

At Atascadero State Hospital, in the period of July 6, 2004 through

592 The Special Order states: “The panel will again review the treatment outcome in 14 days and may order continued treatment for up to 180 days.” Id. Note, however, that “the treatment outcome” was not previously reviewed. Rather, at the original hearing, the panel was supposed to determine whether the patient met the criteria for dangerousness. Supposedly, the patient’s continued dangerousness is also being assessed in the hearing to authorize continued treatment for up to 180 days. The “treatment outcome” issue is only relevant, if at all, to indicate that with medication the patient is not dangerous but would be dangerous if medication was terminated.

593 The Special Order states: “After 180 days a new hearing is required to consider the need for continued treatment.” Id. Note, however, that “need for continued treatment” is not the standard for ordering additional involuntary treatment. Supposedly, the patient’s continued dangerousness is being assessed to determine whether involuntary treatment is permissible. Note also, the Special Order does not specify the maximum length of permissible continued treatment beyond the original 180-day period.

594 Atascadero State Hospital is one of four state hospitals operated by the California Department of Mental Health. The other three state hospitals are Metropolitan, Napa, and Patton. The total in-hospital population of all four hospitals, as of June 30, 2001, was 4,347 patients. Statistics & Data Analysis, Ca. Dep’t of Mental Health, State Hospitals for the Mentally Disabled Inpatient, In-Hospital Plus Short-Term Leave, and In-Hospital Populations Hospital by Funding Source June 30, 2001, at
August 10, 2006, medication review panels conducted 254 “initial” hearings to determine whether individual MDO patients were dangerous and could be medicated involuntarily for fourteen days. In all 254 cases, those panels found that the patient was dangerous. During that same period of time, Atascadero State Hospital medication review panels also conducted 341 “extension” hearings to determine whether individual MDO patients continued to be dangerous and could be medicated involuntarily for an additional 180 days. In all 341 cases, those panels found that the patient was dangerous. Thus, in the 595 in-house hearings conducted at Atascadero State Hospital, the patient was determined to be dangerous and involuntary medication authorized in all 595 hearings–a truly remarkable one hundred percent!

Reasons exist, however, to suggest that the hospital’s one hundred percent “success” rate is not so remarkable, and, perhaps, could even have been anticipated. For example, as established by the Special Order, medication review panels are utilized to review the patient’s dangerousness for all nonemergency situations involving MDO patients who refuse treatment. The Qawi court’s requirement that a court determine the patient’s dangerousness was subject to modification through Department of Mental Health regulation only “as is necessary to provide for the reasonable security of the inpatient

1 (Nov. 2001) http://www.dmh.ahwnef.gov/SADA/ docs/benchmark/ FY% 2000-01.pdf. Atascadero’s in-hospital population, as of June 30, 2001 was 1,011 patients (23.3% of the total). Id. The total number of MDOs at all four hospitals on June 30, 2001, was 759 patients, which was 17.3% of the 4,347 patients at all four hospitals. Id. at 5.

595 Letter from Barrie Hafler, Public Relations Officer, Atascadero State Hospital, to author (Aug. 24, 2006) (on file with author).
596 E-mail from Barrie Hafler, Public Relations Officer, Atascadero State Hospital, to author (Aug. 25, 2006) (on file with author).
597 Letter from Barrie Hafler, supra note 595. The number of “extension” hearings exceeds the number of “initial” hearings because some MDO patients have had more than one “extension” hearing to continue their involuntary treatment beyond the 180-day treatment period authorized in the first “extension” hearing.
598 E-mail from Barrie Hafler, supra note 596.
facility in which the patient is being held."599 Does reasonable security of the inpatient facility require the use of in-house administrative panels for all hearings, or are in-house administrative panels warranted only in exceptional cases in which greater security is required than is generally appropriate? Because these hearings are held for patients who are not an imminent danger to themselves or others, i.e., there is no emergency situation warranting treatment without a hearing, it is difficult to justify use of in-house panels for all MDO treatment refusal hearings. Conducting hearings in the hospital without transporting MDOs to court for hearings may be administratively convenient, but in-house hearings are not necessary in all cases in order to provide for the reasonable security of the inpatient facility.

Who are the psychiatrists that serve on the in-house Psychotropic Medication Review panels? Atascadero reports that “most of the panel psychiatrists have MDO’s within their caseload.”600 Some might assert that such psychiatrists are best qualified to serve as panel members. After all, such psychiatrists are familiar with the characteristics and needs of these patients and have expertise in assessing the dangerousness criteria as it relates to these patients. Their neutrality, it can be argued, is assured because the Special Order precludes psychiatrists from serving as panel members if they are directly involved in the patient’s treatment. However, because these psychiatrists may have MDO patients who they wish to treat despite their patients’ refusal of treatment, then these psychiatrists know that they will have to bring their claims of danger before the very psychiatrists they are judging in the case presently before them. This reality biases psychiatrists who serve on medication review panels to find patients dangerous. How else can they assure that their colleagues will return the favor and allow them to treat their treatment-refusing patients? According to Webster’s, the colloquial meaning of “rubber stamp” is “a person . . . that approves or endorses something in a routine manner, without thought.”601 How better to explain why medication review panels find

599 In re Qawi, 81 P.3d 224, 240 (Cal. 2004); Cal. Penal Code § 2972(g) (West Supp. 2006); see supra text accompanying notes 589-90.
600 E-mail from Barrie Hafler, Public Relations Officer, Atascadero State Hospital, to Grant Morris (Sept. 7, 2006) (on file with author).
the patient dangerous in one hundred percent of the cases? Just as a pro-
treatment bias undermines the judgment of psychiatrists when they determine
a patient’s competence, the same bias undermines their judgment when they
determine a patient’s dangerousness.

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602 As previously discussed, of the thousands of mentally disordered
individuals who were detained initially for seventy-two hours in California
mental hospitals as dangerous to others, only twenty-seven such patients during
a one-year period were subsequently committed for 180 days as meeting the
two-part danger criteria of section 5300. See supra text accompanying notes
295-97. And yet, for one small category of mental patient—MDOs—several
hundred patients—one hundred percent of those who have “initial” or
“retention” hearings—are determined to meet that criteria and are subjected to
involuntary treatment. Such disparity is suspect.

603 See supra Chapter 4. Atascadero State Hospital’s 100% rate of
finding dangerousness in MDO patients compares closely to the 98.9% rate of
finding incompetence in medical review decisions involving other patients. See
Hargreaves et al., supra note 169, at 192.
Chapter 7

Wrangling a Right:
Substituting Uninformed or Involuntary Acquiescence
for Informed and Voluntary Consent

A. Uninformed Acquiescence

A patient’s right to medical self-determination, whether one is referring to a physically ill patient’s right to give or withhold informed consent to a proposed surgical intervention, or a mental patient’s right to accept or refuse the administration of psychotropic medication to treat the patient’s mental disorder, requires physicians to disclose the risks of and alternatives to the proposed treatment and to accept the patient’s judgment to authorize or refuse that treatment. However, one popular device to refuse a mental patient’s right to refuse treatment is either to withhold information that the patient needs to make an informed decision or to coerce the patient into accepting treatment in lieu of an even less desirable alternative. For example, the California right to refuse treatment statute, enacted in response to the Riese decision, assures mental patients that their right to refuse treatment will be disclosed to them as well as information about the probable effects and side effects of the prescribed medication and reasonable alternatives to that medication.\(^{604}\) However, the statute provides that psychotropic medication may be administered to a patient “if that person does not refuse that medication following [such disclosures].”\(^{605}\) The statute replaces the physician’s affirmative obligation to obtain the patient’s voluntary, knowing, and informed consent to the proposed treatment.


\(^{605}\) Id.
with the physician’s authority to administer treatment if the patient acquiesces in that treatment. No duty is imposed on the physician or the facility to assure that the patient understands the required disclosures. No duty is imposed to determine whether any lack of understanding is a consequence of the patient’s mental disorder or some other unrelated cause, such as inability to understand English, or a physical problem, such as deafness. If the patient accepts medication without refusing, no hearing is held to determine whether the patient’s acquiescence is a rational decision of a competent mind. Although informed consent remains the requirement for physically ill people, acquiescence suffices for the mentally disordered.

If the “goal” of disclosure is not to provide needed information so that the patient can make his or her own decision whether to accept or reject treatment, but rather, to induce the patient into accepting the prescribed medication without objecting, then the disclosure requirement is no longer a protection of patient autonomy. Rather, it is a subterfuge to deceive the patient. A standard of patient acquiescence encourages nondisclosure, or at most, limited and biased disclosure. I base this assertion on my experience as a mental health hearing officer in California who has conducted numerous hearings to determine a patient’s competence to refuse psychotropic medication. Even though California law requires disclosure of the risks, benefits, and alternatives to the prescribed medication, the testimony I heard as a decisionmaker in right to refuse treatment hearings reveals that nondisclosure or, at most, inadequate disclosure of risks was the norm; full disclosure was the rare exception. Often psychiatrists informed patients only about medication benefits. For example, in one case, the psychiatrist testified that he told the patient “that haloperidol would help reduce her feelings of anxiety and would

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606 See generally Morris, supra note 162, at 384-431 (reporting on my experience as a mental health hearing officer in seventy-seven right to refuse treatment cases).
608 Morris, supra note 162, at 426.
reduce some or all of her hostility. In another case, the psychiatrist testified that he informed the patient that “she would feel less agitated and that her thinking would improve if she agreed to medications.” In another case, the psychiatrist simply stated: “I informed the patient that medication would be necessary to help her with her distress and encouraged her to take it.

Even when psychiatrists did discuss risks, they did not divulge “all information relevant to a meaningful decisional process—the test of disclosure imposed by the California Supreme Court. To obtain a patient's informed consent, that test requires the psychiatrist to divulge all risks that are material to the patient's decision. Sometimes psychiatrists spoke about risks in general terms, informing patients that any medication can have detrimental as well as beneficial effects. At other times, psychiatrists discussed some side effects but not others. Typically, the psychiatrist would inform the patient of non-neurological side effects such as sedation or anticholinergic side effects, i.e., dry mouth, blurred vision, urinary retention, and constipation, but would omit any discussion of neurological side effects such as dystonia, Parkinsonism, akathisia, akinesia, and tardive dyskinesia. Obviously, if the risk of non-neurological side effects is material to a patient's decision, the risk of neurological side effects is likely to be even more so.

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609 Id.
610 Id.
611 Id.
612 Cobbs v. Grant, 502 P.2d 1, 10 (1972).
613 The California Supreme Court summarized the physician's disclosure duty as follows:
In sum, the patient's right of self-decision is the measure of the physician's duty to reveal. That right can be effectively exercised only if the patient possesses adequate information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is whatever information is material to the decision. Thus the test for determining whether a potential peril must be divulged is its materiality to the patient's decision.
Id. at 11.
614 Morris, supra note 162, at 426-27.
When psychiatrists disclosed the risk of neurological side effects, they usually sugar-coated the information. I deliberately chose the word “sugar-coated.” In one hearing, in response to my question: “Did you treat the patient with antipsychotic medication during this admission?,” the psychiatrist testified: “No and yes. I managed to sweet talk him into taking Navane a couple of times–three days in a row.”

Sometimes psychiatrists testified that they used a written advisement to inform patients about medication side effects. Typically, those so-called consent forms contained no information about risks but merely asserted that the prescribing physician had provided information about medication risks and benefits. Often those forms were used ritualistically to substitute for the process of obtaining informed consent rather than as evidence that informed consent was, in fact, obtained.

Clearly, my experience as a hearing officer assessing patient capacity to give or withhold informed consent reveals that physician disclosure of the risks, benefits, and alternatives to the proposed medication was not intended to provide the patient with the information necessary for the patient to make an informed judgment about whether to accept or reject that medication. Information, to the extent it was provided at all, was provided with the specific intent of securing the patient’s acceptance of the doctor’s medical judgment. Informed consent? Patient autonomy? Medical self-determination? For doctors, these were not legal requirements to be obeyed, but evils to be avoided.

What if a patient accepts medication without receiving any disclosure of the risks, benefits, and alternatives? Does uninformed acquiescence substitute for informed consent? At least some federal appellate courts have so ruled. For example, in Benson v. Terhune, a criminal defendant who requested medication to treat various physical ailments also received and ingested psychotropic medication which was dispensed in the treatment envelope that contained all medications received by the defendant. A staff psychiatrist had

615 Id. at 427 n.295.
616 Id. at 428.
617 304 F.3d 874 (9th Cir. 2002).
618 Id. at 877. The envelope was marked only with the time for the scheduled administration of the medication and the defendant’s name. Id. If the defendant wanted to refuse a particular medication, the defendant would
have to be able to pick out the specific pill from the group of pills contained in
the envelope. \textit{Id.} at 877 \textit{n.2}.

\textit{Id.} at 878. During the eighty-seven days she spent in custody, she
also received two other psychotropic medications, Valium and Vistaril, which
were administered to her without disclosure or informed consent.

\textit{Id.} at 877. The defendant was convicted of second degree murder
and sentenced to a term of seventeen years to life. She sought habeas corpus
relief but was denied by the district court. \textit{Id.} at 876-77.

\textit{Id.} at 882. The court noted that the patient “had some personal
knowledge of drugs from her own usage (and abuses) as well as from her
training as a practical nurse.” \textit{Id.}

\textit{Id.} at 884. It was voluntary, said the court, because the patient “made a free and deliberate
choice to ingest the drugs in the absence of intimidation and coercion.”\textit{Id.} It
was knowing, said the court, because she was mentally capable of seeking
information about the nature, dosage, and effects of the medication prescribed
for her if she wanted it,\textit{Id.} and “in this context, the jail staff had no affirmative
duty to volunteer information about the drugs.”\textit{Id.}

Incredibly, the doctor’s duty to inform the patient of the risks and
alternatives to the medication being prescribed and to obtain the patient’s
informed consent to its administration was transformed into a patient’s duty to
inquire about the medication before ingesting it. Imposing such a duty on the
patient seems unreasonable, especially here, in a situation in which the patient
requested medication only for physical ailments and was confined in the
coercive environment of a jail prior to and during her criminal trial. No one
alerted the patient that psychotropic medication was included in the envelope
of medications given to her. No one informed her that she could refuse one, or

\textit{Id.} at 885.
some, of her medications but still receive the rest. Can a patient give a voluntary and knowing informed consent to psychotropic medication when the patient has no information about the medication and, in fact, is unaware that the medication is being administered to her? Obviously, the answer is, or should be, no.

In another case, a doctor prescribed Thorazine to an involuntarily committed mental patient to relieve the patient’s feelings of anxiety. The doctor did not inform the patient of the dosage level, warn him of the potential side effects, or prescribe a companion medication to minimize any side effects. The patient suffered severe side effects—slurred speech, dizziness, and blurred vision. The following day he “sat insensible in a chair, dazed and disoriented.” A second doctor discontinued Thorazine and prescribed Serentil. Although that doctor informed the patient that Serentil is an antidepressant, the drug is classified as an antipsychotic medication. The patient experienced dehydration, anxiety, shallow breathing, and a tight chest. The patient brought a Section 1983 action against the doctors, claiming that his due process rights were violated by the failure of the defendants to provide him with dosage and side effect information, by the failure of defendants to

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625 The court noted that despite the jail’s formal policy that would have allowed the patient to refuse a specific medication when it was dispensed, “there is some evidence individual staff members would take back the entire packet of pills if an inmate objected to any of them.” Id. at 883.

626 Kulak v. City of New York, 88 F.3d 63, 69 (2d Cir. 1996).

627 Id.

628 Id.

629 Id.

630 The statute provides:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

properly monitor him for adverse side effects, and for giving him medications that were not indicated for his illness.\textsuperscript{631}

The United States Court of Appeals for the Second Circuit, in affirming the district court’s decision to grant summary judgment to the defendants, ruled that the doctors were shielded from liability by a qualified immunity.\textsuperscript{632} The court applied the “professional judgment” model adopted by the Supreme Court in \textit{Youngberg v. Romeo}\textsuperscript{633} to immunize the defendants for treatment decisions that are not a substantial departure from the accepted judgment, practice, or standards of the profession.\textsuperscript{634} The doctors were not liable, said the court, because “[n]o clear line of federal law establishes that it is a ‘substantial departure’ from accepted practice for a physician to fail to inform a patient of the risks of psychotropic medication.”\textsuperscript{635}

Hippocrates rejected the idea that physicians were required to obtain the informed consent of their patients to the treatments they were about to administer. He specifically counseled physicians that they should perform their calling “calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and serenity . . . revealing nothing of the patient’s future or present condition.”\textsuperscript{636} But Hippocrates lived 2400 years ago.\textsuperscript{637} Can failure to inform the patient of the risks, benefits, and alternatives of proposed therapy be acceptable practice in medicine today? What ever happened to the doctrine of informed consent—a doctrine that has been accepted in all fifty states?\textsuperscript{638} If state law requires

\begin{itemize}
  \item \textsuperscript{631}Kulak, 88 F.3d at 75.
  \item \textsuperscript{632}Id.
  \item \textsuperscript{633}457 U.S. 307 (1982); see supra text accompanying notes 210-16.
  \item \textsuperscript{634}Kulak, 88 F.3d at 75.
  \item \textsuperscript{635}Id. at 76. Although the plaintiff’s federal claim failed, the court noted that the plaintiff might succeed on a state law cause of action for the doctors’ failure to inform. \textit{Id.}
  \item \textsuperscript{636}Hippocrates, \textit{Decorum}, in 2 HIPPOCRATES 297 (W.H.S. Jones trans. 1962).
  \item \textsuperscript{637}Hippocrates is believed to have lived from 460 B.C. to 377 B.C. 5 \textsc{The New Encyclopaedia Britannica} (Micropaedia) 939 (15th ed. 1998).
  \item \textsuperscript{638}In 2000, Georgia became the fiftieth state to accept the common law doctrine of informed consent. Ketchup v. Howard, 543 S.E.2d 371 (Ga. Ct. App. 2000). In an appendix, the court summarized the law in the other forty-
doctors to obtain their patients’ informed consent, as New York’s law clearly does, then can it be acceptable professional practice to ignore the state law’s requirement? It would be no more acceptable than a decision by the medical profession to allow doctors, upon completion of medical school, to engage in medical practice without obtaining a license to practice, ignoring the state law’s requirement that they obtain a license before practicing.

According to Youngberg, which the Court of Appeals for the Second Circuit cites for support, a doctor who conforms to professional standards in choosing what treatment to prescribe will not be held liable for that choice. However, Youngberg provides no support for the proposition that a doctor who fails to obtain a patient’s informed consent to the prescribed treatment in violation of state law will be absolved from liability if he or she conforms to professional standards in imposing that treatment upon the patient. Washington v. Harper, not Youngberg, is the Supreme Court case that is most on point. Harper acknowledges that mental patients possess a significant liberty interest in avoiding the unwanted administration of psychotropic medication. That liberty interest is recognized through the state’s common law doctrine of informed consent and is entitled to protection under the Fourteenth Amendment’s Due Process Clause. Although Harper held that the right to refuse treatment might be lost if the patient presented a danger to others or to
himself or herself, there was no indication in the Second Circuit’s opinion that the patient in that case was dangerous when Thorazine and Serentil were administered to him.

**B. Involuntary Acquiescence**

Fifty years ago, the patient census of state-operated or state-funded mental hospitals in the United States exceeded 500,000 people. For example, the largest psychiatric facility in the world was Pilgrim State Hospital, located on Long Island, New York, with a patient census of 13,875 in 1954. In the 1960s and 1970s, these large asylums were depopulated in response to: media criticism of patient abuse and neglect—i.e., the warehousing of patients,—court decisions and legislation that restricted the criteria for involuntary civil commitment and expanded procedural protections in the civil commitment process, and the development of psychotropic medications that enabled

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645 See id. at 227.
646 See Kulak, 88 F.3d at 69 (discussing the administration of Thorazine and Serentil to the patient).
650 See, e.g., O’Connor v. Donaldson, 422 U.S. 563, 575 (1975) (“A finding of ‘mental illness’ alone cannot justify a State’s locking a person up against his will and keeping him indefinitely in simple custodial confinement.”); Lessard v. Schmidt, 349 F. Supp. 1078, 1088 (1972) (“Even a brief examination of the effects of civil commitment upon those adjudged mentally ill shows the importance of strict adherence to stringent procedural requirements and the necessity for narrow, precise standards.”).
symptoms of mental disorder to be effectively treated without hospitalization. 651 On October 31, 1963, the Community Mental Health Centers Act was enacted, through which the federal government promised funding to assist states in providing for the care and treatment of discharged mental patients. 652

But the promise was not kept. Community mental health centers were not adequately financed. Some patients whose mental condition had been stabilized in a hospital experienced a deterioration of their mental condition when they were released to the community that was unprepared to care for them. 653 But the inadequacy or unavailability of community resources is not what people saw. Rather, they saw mentally disordered people, often homeless, living on the streets of their cities. 654 And the conduct of mentally disordered people—their disorganized thinking, their impaired judgment—was disturbing and sometimes truly frightening. And so, the logical response was to confine the mentally disordered, or at least to require them to take their psychotropic medication so that their conduct in society would be appropriate.

Reconfinement, however, often occurs in local jails and prisons, rather than in mental hospitals. The Department of Justice estimates that 283,800 mentally disordered persons are incarcerated in the nation’s prisons and jails. 655

651 See Telson, supra note 647, at 42.
653 See Telson, supra note 647, at 43.
654 Michael Perlin notes that deinstitutionalization is not the sole cause of homelessness, citing various other factors that have contributed to the increase in homelessness. See Michael L. Perlin, Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization, 28 Hous. L. Rev. 63, 68, 74-79 (1991). Professor Perlin also asserts that the misexecution of deinstitutionalization rather than the clinically sound concept of deinstitutionalization has exacerbated the problem of homelessness. See id. at 68, 94-112.
Mentally disordered persons are frequently charged with petty crimes—e.g., sleeping, sitting, or storing personal belongings in public spaces; loitering, aggressive panhandling or even begging in general—and processed through the criminal justice system. Think of it. The three largest hospitals in the United States for the treatment of serious mental illness are not hospitals at all. Rather, they are the three largest jails in the country: Riker’s Island in New York City, the Cook County Jail in Chicago, and the Los Angeles County Jail. Some individuals, who are fortunate enough to avoid the criminal process and criminal incarceration, are readmitted into short-term mental health treatment facilities, stabilized on psychotropic medication, and released to the


657 See generally Paul F. Stavis, Why Prisons Are Brim-Full of the Mentally Ill: Is Their Incarceration a Solution or a Sign of Failure?, 11 Geo. Mason U. Civ. Rts. L.J. 157 (2000); see also Marc F. Abramson, supra note 279, at 103 (asserting that mentally disordered individuals are often arrested and prosecuting for nuisance offenses as a convenient and more reliable alternative to assure their involuntary detention than the LPS civil commitment process).

In fact, Professor Kress identifies this phenomenon as the “revolving-door syndrome.” Kress, supra note 656, at 1293-95.

The first four mental health courts were established in Broward County (Fort Lauderdale), Florida; King County (Seattle), Washington; Anchorage, Alaska; and San Bernardino, California. Each is discussed in John S. Goldkamp & Cheryl Irons-Guynn, U.S. Dep’t of Justice, Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage 9-56 (2000), http://www.ncjrs.gov/pdffiles1/bja/182504.pdf.

There are variations between courts. In some courts, the defendant is required to plead guilty to the charges as a condition for participating in the mental health court program. But the court does not adjudicate guilt and if the defendant successfully completes the treatment program, the court dismisses the criminal charges. In some courts, the charges remain unresolved until the defendant completes the treatment program. In some courts, the prosecutor agrees to a deferred prosecution or a deferred sentence pending the defendant’s participation in the treatment program. Bruce J. Winick, Outpatient Commitment: A Therapeutic Jurisprudence Analysis, 9 Psychol. Pub. Pol’y & L. 107, 126 (2003); see also Goldkamp & Irons-Guynn, supra note 660, at xix. After reviewing twenty mental health courts, the Bazelon Center for Mental Health Law concluded: “There is no single ‘model’ of a mental health court; each court operates under its own, mostly unwritten, rules and procedures.

(i) Mental Health Courts

In recent years, various strategies have developed to address society’s failure to adequately fund deinstitutionalization. Unfortunately, the strategies typically involve involuntary medication of mentally disordered persons—even when such persons are not incompetent to make medication decisions and when they are not currently dangerous to themselves or others. For example, mental health courts have emerged to divert mentally disordered individuals charged with nonviolent, nuisance offenses from the criminal process and into community treatment. After the individual enters into a court-ordered course of treatment and demonstrates satisfactory progress, he or she may withdraw a plea of guilty, and criminal charges are dismissed. Proponents of mental
health courts note that the individual can choose either to accept diversion into treatment or face criminal charges.\textsuperscript{662} There is no coercion, they assert, because the individual makes the decision to participate or not. At most, the mental health court judge attempts “to persuade the individual to accept treatment and motivate him or her to participate effectively in it.”\textsuperscript{663}

Critics, however, note that mental health courts require the participating individual to adhere to a treatment plan. Often that plan offers little more than medication and very occasional therapy. As such, the plan does “nothing to address the factors associated with the criminal [conduct] or the individual’s need for housing or other healthcare or vocational services.”\textsuperscript{664} The authors of a Department of Justice study asserted that mental health courts have been created, at least in part, “because existing institutions and services in the community . . . have failed to serve this population. There is some irony, then, in designing a program that uses the court to place mentally ill and disabled participants in those very systems.”\textsuperscript{665} Each of the four mental health courts that was studied “found that treatment resources and funding are insufficient for the populations they are serving and plan to serve in the near future.”\textsuperscript{666} If the lack of community resources means that the only “deal” that the mental health court is able to offer the defendant is psychotropic medication in lieu of jail, then the mental health court movement has truly failed.

Mental health courts frequently use jail time as a sanction for an individual’s noncompliance with the treatment program.\textsuperscript{667} Especially when a

\begin{itemize}
  \item Winick, supra note 661, at 127.
  \item Id. at 126.
  \item Bernstein & Seltzer, supra note 661, at 151.
  \item Goldkamp & Irons-Guynn, supra note 660, at 76.
  \item Id.
  \item One recent study revealed that ninety-two percent of mental health courts were willing to use jail as a sanction for an individual’s noncompliance with the treatment program. Allison D. Redlich et al., Patterns of Practice in Mental Health Courts: A National Survey, 30 Law & Hum. Behav. 347, 358 (2006). In another study of twenty mental health courts, sixty-four percent of those reporting used jail time as a sanction for noncompliance with treatment.
\end{itemize}
full range of community treatment options is not available, punitive sanctions should not be imposed against the individual who volunteers for, but does not receive, needed treatment.

Because the individual can freely choose whether to undergo treatment or continue with the criminal trial, the decision to undergo treatment is considered to be his or her voluntary and uncoerced choice. Of course, the individual must be competent to make that decision, i.e., he or she must understand the choices being offered and the consequences of his or her choice. Competency, therefore, is a threshold issue to be determined before the defendant can be accepted for diversion through the mental health court. Concern has been expressed that defense counsel, fearing a finding of guilt in a criminal trial, or the mental health court judge, seeking to assist a mentally disordered individual, may make decisions that they perceive to be in the defendant’s best interest when, in fact, the defendant is thoroughly confused and afraid. A paternalistic motive for coercing consent does not substitute for voluntary, informed, and competent consent.

At a more fundamental level, one can ask whether the Hobson’s choice afforded the defendant—jail (after an almost certain criminal conviction) or unwanted treatment—permits him or her to make a voluntary and uncoerced decision. Although the mental health court is not responsible for the defendant’s initial arrest, in a very real sense, society is responsible. Society failed to keep its promise to adequately fund community services to assist mentally disordered individuals when they were deinstitutionalized. If a homeless, mentally disordered individual urinates in the street because no

The authors asserted: “If the goal is to lessen the incarceration of people with mental illnesses, then using incarceration as punishment is a perversion of the whole idea of mental health courts.” Bernstein & Seltzer, supra note 661, at 158.

In those mental health courts that require the defendant to plead guilty to the charge before entering the treatment program, the defendant—just as any other defendant who wishes to plead guilty—must also be competent to plead guilty. This separate finding of competence must be made in addition to a finding of competence to decide whether to undergo mental health court-prescribed treatment.

GOLDKAMP & IRONS-GUYN, supra note 660, at 73.
public bathroom is available to him and no store will welcome him as a potential customer and allow him to use their bathroom, is it appropriate to arrest him for public urination or some similar nuisance crime? Would drunken college students engaging in the same conduct face a similar fate? To say that the individual can freely choose whether to participate in mental health court-ordered treatment or undergo trial for an easily-provable minor crime fails to consider that the individual has been placed in this predicament by society’s shortcoming. The very real threat of jail coerces him to accept treatment that he would not voluntarily choose if he was not charged with a crime—a crime that a caring and humane society would not have charged him with initially.

(ii) Outpatient Commitment

To address the problem of revolving door mental patients, some states have expanded the criteria for outpatient commitment. Traditionally, outpatient commitment is a form of conditional release or convalescent leave status for

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670 See People v. McDonald, 40 Cal. Rptr. 3d 422, 433-37 (Cal. Ct. App. 2006) (holding that even though urinating in public is not specifically identified as a crime under California state law, it satisfies the statutory definition of “public nuisance” under the criminal nuisance statute). Urinating in public was held to be a prescribed act because it is injurious to health, indecent, and offensive to the senses. Id. at 434-35. Public urination interferes with the comfortable enjoyment of life or property. Id. at 435-37. Public urination, which in this case occurred on a busy commercial street in a populated area, affects a considerable number of people. Id. at 437. The court also held that public urination did not qualify as “littering” under the statute prohibiting littering. Id. at 430-32. But see Jones v. City of Los Angeles, 444 F.3d 1118, 1138 (9th Cir. 2006) (“[T]he Eighth Amendment prohibits the City from punishing involuntary sitting, lying, or sleeping on public sidewalks that is an unavoidable consequence of being human and homeless without shelter in the City of Los Angeles.”). Quaere: If a city fails to provide public toilets, is urinating in public an involuntary act that cannot be criminalized if it is committed by a homeless person?

671 Michael Perlin wrote: “It is our social attitudes—attitudes born in bias, honed by the thoughtless acceptance of stereotypes, and perpetuated by the cognitive error of heuristics—that resonate in the discourse on the homeless mentally ill.” Perlin, supra note 654, at 138.
civilly committed mental patients. In essence, the hospital releases a patient
to the community on condition that the patient continues to receive treatment.
A patient who succeeds in community treatment is discharged from the hospital.
Outpatient commitment can also be used at the time a court determines that the
person’s mental condition meets the involuntary civil commitment criteria. If
some less restrictive alternative to hospital confinement is available—for
example, treatment at a community mental health center—then this lesser
restriction of the person’s liberty should be ordered in lieu of involuntary
confinement. These traditional forms of outpatient commitment apply only
to individuals whose mental condition meets the criteria for inpatient
commitment. A mentally disordered person who would otherwise be
institutionalized either gains liberty by conditional release from a mental
hospital or retains liberty by remaining in the community instead of being
placed in a mental hospital.

In contrast, some states have adopted a form of outpatient commitment that
restricts the liberty of mentally disordered persons who do not currently meet
the criteria for inpatient commitment but whose mental condition can be
predicted to deteriorate without treatment. Proponents of this approach, and
some state legislatures, refer to this form of outpatient commitment as “assisted
outpatient treatment,” perhaps, in part, because it assists the person in
avoiding inpatient commitment in the future. Opponents of this approach refer

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672 See Winick, supra note 661, at 111 (discussing the two traditional
models of outpatient commitment).

district court should not have allowed a psychotropic medication to be
involuntarily administered to a criminal defendant to restore his competency to
stand trial without any determination of reasonable alternatives); Wyatt v.
Stickney, 344 F. Supp. 373, 379 (M.D. Ala. 1972), aff’d in part, rev’d in part
and remanded by Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974) (holding
that involuntarily civilly committed mental patients “have a right to the least
restrictive conditions necessary to achieve the purposes of commitment”).

674 See, e.g., The Assisted Outpatient Treatment Demonstration Project
N.Y. Mental Hyg. Law § 9.60 (McKinney Supp. 2006) (defining “assisted
outpatient treatment” and establishing the criteria and procedures for such
treatment).
to this form of outpatient treatment as “preventive outpatient commitment”\textsuperscript{675} because it targets for state control individuals who are not subject to civil commitment. Preventive outpatient commitment has been characterized as compelled preventive treatment that is imposed in order to avoid preventive detention of the individual that occurs through civil commitment if and when the individual’s condition deteriorates to the extent that civil commitment criteria are met.\textsuperscript{576}

In 1990, North Carolina became the first state to enact preventive outpatient commitment statutes.\textsuperscript{677} The court may order outpatient commitment if it determines that the individual is mentally ill, is capable of surviving safely in the community with supervision, is in need of treatment to prevent further disability or deterioration that would predictably result in dangerousness to self or others that would satisfy the criteria for involuntary civil commitment, and that the individual’s “current mental status or the nature of his illness limits or negates his ability to make an informed decision to seek voluntarily or comply with recommended treatment.”\textsuperscript{678}

In 1994, New York enacted its first involuntary outpatient treatment law,\textsuperscript{679} creating a pilot project through Bellevue Hospital in New York City.\textsuperscript{680} The criteria for outpatient commitment was similar to that used in North Carolina, and specifically included a statement that the involuntary administration of psychotropic medication could be ordered as a part of the treatment program only if the court determined that the individual lacked the capacity to make a


\textsuperscript{675}Stefan, \textit{supra} note 675, at 289.


\textsuperscript{678}See Amy Allbright et al., \textit{Outpatient Commitment Laws: An Overview}, 26 \textit{Mental \& Physical Disability L. Rep.} 179, 179 (2002) (stating that prior to 1994, New York was the only state that statutorily prohibited outpatient commitment).

\textsuperscript{680}N.Y. L. 1994, ch. 560, §3 (effective until June 30, 1998).
treatment decision.\textsuperscript{681} Unlike North Carolina, however, the pilot project was limited to patients who were hospitalized at Bellevue and who had a history of lack of compliance with treatment that necessitated involuntary hospitalization at least twice within the previous eighteen months.\textsuperscript{682} The pilot program was used infrequently. During the pilot program’s three and one-half year existence, only 247 initial outpatient commitment orders were granted.\textsuperscript{683}

On January 3, 1999, Andrew Goldstein, a chronically mentally ill individual with a history of repeated hospitalizations and failure to comply with prescribed medication on an outpatient basis, pushed Kendra Webdale to her death in front of a New York City subway train.\textsuperscript{684} The event was the subject of intense media attention,\textsuperscript{685} and a frightened and angry public demanded legislative action. In response, “Kendra’s Law” was enacted to compel mentally disordered individuals to comply with court-ordered community treatment so that they would not be dangerous in society.\textsuperscript{686} Ironically, Goldstein had voluntarily sought inpatient treatment and supervised living several times prior to his attack on Webdale, but he was repeatedly discharged and denied assistance.\textsuperscript{687} If he had received the assistance he sought, the tragic event that led to the enactment of Kendra’s Law may never have occurred.

Kendra’s Law broadens considerably the outpatient commitment criteria.

\textsuperscript{681}Id.  
\textsuperscript{682}Id.  
\textsuperscript{683}Telson, supra note 647, at 59. Only two initial petitions for outpatient commitment were denied. Id. For a discussion and assessment of the New York pilot program, see id. at 47-76.  
\textsuperscript{684}John Kip Cornwell & Raymond Deeney, Exposing the Myths Surrounding Preventive Outpatient Commitment for Individuals with Chronic Mental Illness, 9 PSYCHOL. PUB. POL’Y & L. 209, 209 (2003).  
\textsuperscript{686}N.Y. MENTAL HYG. LAW § 9.60 (McKinney Supp. 2006). Although the statute is entitled “Assisted outpatient treatment,” the New York Legislature, in enacting the law, specifically provided “This act shall be known and may be cited as ‘Kendra’s Law’.” 1999 N.Y. Sess. Laws 859 (McKinney).  
The pilot program requirement that the person be hospitalized at the time he or she is placed on outpatient treatment was eliminated. The pilot program requirement that “the patient has a history of lack of compliance with treatment that has necessitated involuntary hospitalization at least twice within the last eighteen months” was modified to merely require that

the patient has a history of lack of compliance with treatment for mental illness that has . . . at least twice within the last thirty-six months been a significant factor in necessitating hospitalization . . . or . . . resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months . . . .

Think of it. One threat of self-harm—even without any attempt at a harmful act—within a four-year period and a history of noncompliance with psychotropic medication can subject the individual to court-ordered treatment.

Unlike the pilot program, Kendra’s Law has been used frequently. Through December 2004, there were 4041 petitions for outpatient treatment, of which ninety-three percent were granted. Over ninety percent of those who were ordered into outpatient treatment—3493 persons—were ordered into treatment for the six-month maximum initial period allowed by Kendra’s Law. In almost two-thirds of the cases, these initial outpatient commitment orders were renewed—for additional one-year periods as permitted by Kendra’s Law. The average length of time that a person remained on an order of outpatient treatment was sixteen months.

Although Kendra’s Law is denominated as “assisted outpatient

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689 N.Y. MENTAL HYG. LAW § 9.60(c)(4) (McKinney Supp. 2006).
691 Id.
693 Geller, supra note 690, at 240.
695 Geller, supra note 690, at 240.
In enacting Kendra’s Law, the New York Legislature made a specific finding “that assisted outpatient treatment as provided in this act is compassionate, not punitive, will restore patients’ dignity, and will enable mentally ill persons to lead more productive and satisfying lives.” 1999 N.Y. Sess. Laws 860 (McKinney). In extending the provisions of the statute in 2005, the New York Legislature stated that Kendra’s Law was enacted with the intent to establish “a statewide court-ordered assisted outpatient treatment (AOT) program to ensure that persons with mental illness who are capable of living in the community with the help of family, friends or others, along with routine care and treatment on an outpatient basis, are provided this opportunity.” 2005 N.Y. Sess. Laws 780 (McKinney).

Unlike North Carolina’s outpatient commitment legislation and New York’s pilot project legislation, Kendra’s Law authorizes the court to order medication—either self-administered or administered by authorized personnel—as a part of the outpatient treatment program, without any finding that the patient is incompetent to make treatment decisions.

Twenty years ago, in Rivers v. Katz, the New York Court of Appeals held that neither mental illness, nor involuntary civil commitment of a person because of that mental illness, is sufficient to deprive the person of his or her right to refuse psychotropic medication. Even if a person is civilly committed, he or she may be competent to comprehend the consequences of a medication refusal decision, and thus, said the court, a judicial determination of the patient’s incapacity to make a medication decision is required before treatment may be imposed over the patient’s objection.

If a civilly committed patient retains the right to refuse medication unless and until he or she is judicially determined to be incompetent to do so, then is it logical to say that a person whose mental condition is not so serious as to

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696 In enacting Kendra’s Law, the New York Legislature made a specific finding “that assisted outpatient treatment as provided in this act is compassionate, not punitive, will restore patients’ dignity, and will enable mentally ill persons to lead more productive and satisfying lives.” 1999 N.Y. Sess. Laws 860 (McKinney). In extending the provisions of the statute in 2005, the New York Legislature stated that Kendra’s Law was enacted with the intent to establish “a statewide court-ordered assisted outpatient treatment (AOT) program to ensure that persons with mental illness who are capable of living in the community with the help of family, friends or others, along with routine care and treatment on an outpatient basis, are provided this opportunity.” 2005 N.Y. Sess. Laws 780 (McKinney).

697 N.Y. MENTAL HYG. LAW § 9.60(j)(4) (McKinney Supp. 2006). The court order of outpatient treatment includes a treatment plan. That plan includes all categories of services—including medication—that the examining physician recommends that the patient receive. Id. § 9.60(i)(1) & (j)(2).

698 495 N.E.2d 337 (N.Y. 1986).

699 Id. at 342-43. See supra text accompanying notes 111-20 (discussing Rivers).

700 Rivers, 495 N.E.2d at 341-42, 344.

701 Id. at 343-44.
permit civil commitment is, nevertheless, subject to involuntary medication without a judicial determination of his or her incompetence to make a medication decision? I doubt it. Nevertheless, the New York Court of Appeals was able to avoid answering this question in upholding the constitutionality of Kendra’s Law.

In In re K.L.,\footnote{806 N.E.2d 480 (N.Y. 2004).} the court ruled that in mandating that outpatients comply with a court-ordered treatment plan, Kendra’s Law did not violate due process because the law “neither authorizes forcible medical treatment in the first instance nor permits it as a consequence of noncompliance with court-ordered [outpatient treatment].”\footnote{Id. at 484.} “The restriction on a patient’s freedom effected by a court order authorizing assisted outpatient treatment is minimal,” said the court, “inasmuch as the coercive force of the order lies solely in the compulsion generally felt by law-abiding citizens to comply with court directives. [Although a court order] increases the likelihood of voluntary compliance with necessary treatment, a violation of the order, standing alone, ultimately carries no sanction.”\footnote{Id. at 485.} Similarly, the K.L. court held that Kendra’s Law does not violate the Equal Protection Clause because a court-ordered outpatient treatment plan does not authorize forcible medical treatment, and therefore, patients on outpatient commitment are not similarly situated with persons placed on a guardianship or civilly committed who must be judicially determined to be incompetent to make medication decisions before medication may be forced upon them.\footnote{Even if the New York Court of Appeals decision in In re K.L. is logical

\footnote{806 N.E.2d 480 (N.Y. 2004).}\footnote{Id. at 484.}\footnote{Id. at 485.} Bruce Winick argues persuasively that neither the government’s police power interest nor the government’s parens patriae interest justifies the imposition of involuntary psychotropic medication on persons who are under an order of preventive outpatient commitment. Because the individual is not presently dangerous and civilly committable, the government can not claim that a compelling necessity exists for coerced treatment in order to protect the public. Because the individual has not been proven to be incompetent to make treatment decisions, the government can not claim that a compelling necessity exists for coerced treatment in order to protect the individual. Winick, \textit{supra} note 661, at 113-18.\footnote{In re K.L., 806 N.E.2d at 486.}
--which I doubt--it contradicts reality. What is the purpose of a court order of outpatient treatment--an order that includes a specific provision that the patient self-administer psychotropic medication or accept the administration of such medication by authorized personnel? Obviously, it is to require the individual to comply with the terms of that order, including accepting medication that the patient would not have accepted voluntarily in the absence of the court order. As R. B. Friedman stated, “[T]he point of claiming that an imperative comes from authority is to put a person under an obligation to obey it . . . .”

What is the effect of such an order? The K.L. court acknowledges that court-ordered outpatient treatment is coercive in that law-abiding citizens feel compelled to comply with court directives. As Joseph Raz observed, “It is common to regard authority over persons as . . . correlated with an obligation to obey on the part of those subject to the authority.” If, as Rivers v. Katz tells us, a person—even a mentally disordered person—possesses a fundamental liberty interest in making decisions concerning his or her own body—including decisions to accept or reject psychotropic medication—then should a court be permitted to order the person to accept psychotropic medication—either self-administered or administered by others—in violation of that right, even if the court order “ultimately carries no sanction”? If a person accepts medication because the court ordered it, when he or she would not have accepted it without the court order, the restriction on that person’s freedom is significant. The freedom to choose whether to accept or refuse proposed treatment is the very

707 See Ronald L. Wisor, Jr., Community Care, Competition and Coercion: A Legal Perspective on Privatized Mental Health Care, 19 AM. J.L. & MED. 145, 169 (1993) (“Indeed, the key to preventive commitment is forced medication.”).
708 R.B. Friedman, On the Concept of Authority in Political Philosophy, in Authority 56, 65 (Joseph Raz ed. 1990).
709 In re K.L., 806 N.E.2d at 485.
711 See supra text accompanying notes 698-701 (discussing Rivers).
712 In re K.L., 806 N.E.2d at 485 (acknowledging that a patient’s noncompliance with court-ordered outpatient treatment “ultimately carries no sanction”). See supra text accompanying notes 702-05 (discussing K.L.).
essence of individual autonomy. As Joel Dvoskin and Erin Spiers asserted, “[F]reedom matters. . . . There is nothing necessarily crazy about not wanting to be told what to do.”\textsuperscript{713} For the \textit{K.L.} court to claim that the restriction on a person’s freedom effected by court ordered medication “is minimal”\textsuperscript{714} is absurd.

The Oxford English Dictionary defines a voluntary action as one “[p]erformed or done of one’s own free will, impulse, or choice; not constrained, prompted, or suggested by another.”\textsuperscript{715} For the \textit{K.L.} court to claim that the court order merely “increases the likelihood of voluntary compliance with necessary treatment”\textsuperscript{716} is disingenuous. For the court to acknowledge that “the coercive force of the order lies solely in the compulsion generally felt by law-abiding citizens to comply with court directives,”\textsuperscript{717} but to claim that the patient’s compliance is “voluntary,” is ludicrous. “[O]utpatient treatment,” wrote Michael Hoge and Elizabeth Grottole, “is being mandated precisely because it is not being accessed voluntarily.”\textsuperscript{718} Can it be that when the court uses the word “voluntary,” then like Humpty Dumpty in Alice in Wonderland, it means just what the court chooses it to mean–neither more nor less?\textsuperscript{719} If so, then the rule of law is not merely jeopardized, it is nullified.

Let there be no doubt: Patient compliance with psychotropic medication is

\textsuperscript{714}\textit{In re K.L.}, 806 N.E.2d at 485.
\textsuperscript{716}\textit{In re K.L.}, 806 N.E.2d at 485.
\textsuperscript{717}Id. (emphasis added).
\textsuperscript{719}“When I use a word,” Humpty Dumpty said in rather a scornful tone, ‘it means just what I choose it to mean–neither more nor less.’” \textit{Lewis Carroll, Alice’s Adventures in Wonderland, and Through the Looking-Glass} 188 (New York, Hartsdale House n.d.).
the indispensable component of outpatient treatment. As one author noted: “[T]he vast majority of patients in community programs rely on some form of medication to control the symptoms of their illnesses. Indeed, all programs successful at keeping patients out of the hospital have discovered that medication compliance is the single most important factor for community tenure.” Wisor, supra note 707, at 161.

Let there be no doubt: Most patients who have been placed on outpatient commitment believe that the court order requires them to take the psychotropic medication that the doctor has prescribed in the court-approved treatment plan. In one study, 82.7 percent of the 306 outpatients who were questioned expressed that belief. If the “aggressive measures” advocated in the American Psychiatric Association’s resource document to achieve medication compliance include efforts to create this mistaken belief in patients—whether by a failure to inform patients that medication cannot be compelled on them if they refuse to follow the court order or by affirmative misstatements suggesting that the court order requires them to accept the prescribed medication—then these acts of deception negate any claim that patient consent to medication was voluntary.

Kendra’s Law permits a treating physician to seek involuntary commitment of a noncompliant outpatient if, in the physician’s clinical judgment, the patient’s mental condition has deteriorated to the extent that he or she meets the

720 As one author noted: “[T]he vast majority of patients in community programs rely on some form of medication to control the symptoms of their illnesses. Indeed, all programs successful at keeping patients out of the hospital have discovered that medication compliance is the single most important factor for community tenure.” Wisor, supra note 707, at 161.


722 Randy Borum, Consumer Perceptions of Involuntary Outpatient Commitment, 50 PSYCHIATRIC SERVICES 1489, 1490 (1999). An additional 6.2 percent of the outpatients stated that they did not know whether the court order required them to take the prescribed medication. Id.
criteria for involuntary civil commitment. Upon the physician’s request, peace officers may be directed to take into custody and transport the outpatient to an authorized hospital where he or she can be detained for up to seventy-two hours for an evaluation to determine whether involuntary, inpatient commitment is warranted. However, if the “aggressive measures” advocated in the American Psychiatric Association’s resource document to achieve medication compliance include threatening the patient with such arrest and detention when the physician cannot or does not make a clinical judgment that the patient is currently civilly committable, then this subterfuge negates any claim that the patient’s consent to medication was voluntary. Some writers assert that the strategy being suggested by the resource document “is to hassle individuals . . . to achieve compliance with medications that cannot be forcibly administered by law.”

The New York Court of Appeals’ redefinition of “voluntary” to include unenforceable court orders that are used to coerce and compel a patient’s consent may signal that courts will uphold the “aggressive measures” suggested above to achieve a patient’s compliance with medication. After all, as Susan Stefan charges, preventive outpatient commitment “operates as a kind of judicial intimidation, which can only work if the respondent mistakenly assumes that the judge’s order must be obeyed.” If the physician deceives the patient into believing that the court order must be obeyed, then the physician’s

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723 N.Y. MENTAL HYG. LAW § 9.60(n) (McKinney Supp. 2006).
724 Id.
725 Hoge & Grottole, supra note 718, at 167. Ironically, warnings to outpatients concerning the consequences of treatment noncompliance may deter individuals from seeking treatment voluntarily. See Marvin S. Swartz et al., Does Fear of Coercion Keep People Away from Mental Health Treatment? Evidence from a Survey of Persons with Schizophrenia and Mental Health Professionals, 21 BEHAV. SCI. & L. 459, 469-70 (2003) (reporting that thirty-six percent of consumers in the study reported fear of coerced treatment as a barrier to voluntarily seeking help for a mental problem).
726 Stefan, supra note 675, at 295; see also Wisor, supra note 707, at 171 (characterizing preventive commitment as a form of judicial intimidation and asserting that “[c]ompliance is achieved only if the person fears rehospitalization or mistakenly believes that the court’s order must be obeyed.”).
act supports the judicial intimidation necessary to achieve medication compliance. In essence, the physician and the court are co-conspirators in this endeavor.

Consent obtained by deception is not voluntary and is not valid. Intentionally deceiving a person to induce that person to give up a right constitutes fraud. 727 “Fraud,” wrote Justice Marcel Poché for the California Court of Appeal, “evokes almost universal repugnance expressed with near-Biblical fervor. . . . The hostility to fraud is evident in judicial attempts to define it in such a manner as not to exclude any of its infinite possible permutations.” 728 As the Supreme Court of Oklahoma explained:

Fraud is a generic term, which embraces all the multifarious means which human ingenuity can devise and which are resorted to by one individual to gain an advantage over another by false suggestions or by the suppression of truth. [Fraud] includes all surprise, trick, cunning, dissembling, and any unfair way by which another is cheated. 729 Fraudulent conduct, according to the Ohio Supreme Court is “the very essence of wrong; conduct that has always been and always will be wrong, according to the common judgment of mankind; conduct that cannot be dressed up or manipulated or associated so as to invest it with any element of right.” 730

Fraud is typically used against a person to gain some financial advantage by cheating the deceived person. Fraud, however, is no less repugnant and no less wrong when it is employed by a physician paternalistically to benefit a person who does not seek that benefit or by a court that issues an unenforceable order requiring a competent patient to comply with treatment that the patient

727 Webster’s New World Dictionary of the American Language, supra note 601, at 555.
730 Morton v. Petitt, 177 N.E. 591, 593 (Ohio 1931) (describing fraudulent conduct through destruction of a valid will, fabrication and forgery of another will to substitute for the valid will, and having the substituted will probated through perjured testimony).
does not want. Eliminating a competent person’s right to make a voluntary choice to refuse medical treatment is an affront to that person’s human dignity; it is “a demeaning and pernicious form of paternalism.” If a court, through its misdefinition of “voluntary,” condones such conduct, then the court’s decision is equally repugnant and equally wrong. In fact, given the court’s role as arbiter of right and wrong, the court’s condonation of such fraud is even more abhorrent.

Winick, supra note 661, at 121-22.
Chapter 8

Conclusion: Death Knell for the Right to Refuse?

Through the common law doctrine of informed consent, our society recognizes the right of the individual to decide for himself or herself whether to accept or reject treatment that a physician is proposing for the individual’s medical condition. The physician’s role is to diagnose the patient’s condition, propose a medically acceptable course of action to treat that condition, and inform the patient of the risks, benefits, and alternatives of the physician’s proposed course of action. The ultimate decisionmaker, however, as to whether that treatment option will be utilized, is the patient, not the physician.\textsuperscript{732} The patient’s consent to treatment is required unless an emergency exists requiring immediate action to prevent harm to the patient or to others, or the patient is incompetent and a substitute decisionmaker, who has been appointed to make decisions for the patient, gives informed consent.\textsuperscript{733}

If no emergency exists, and if the patient is competent, then the requirement of informed consent should apply equally to all patients—including involuntarily committed mental patients who choose to refuse treatment with psychotropic medication. As the New York Court of Appeals acknowledged in \textit{Rivers v. Katz},\textsuperscript{734} the common law right to make decisions concerning one’s own body is a fundamental liberty interest that “extends equally to mentally ill persons who are not to be treated as persons of lesser status or dignity because of their

\textsuperscript{732}See \textit{supra} text accompanying notes 36-40.

\textsuperscript{733}See \textit{supra} text accompanying notes 41-48. Courts also recognize a therapeutic privilege not to disclose when the disclosure itself would either harm the patient or so upset the patient that he or she would not be able to make a rational judgment about the information that would be conveyed by the physician. \textit{See supra} text accompanying notes 49-54.

\textsuperscript{734}495 N.E.2d 337 (N.Y. 1986).
More than two decades ago, the right of mental patients to refuse treatment became well-established through numerous court decisions. Nevertheless, various devices have emerged to weaken or eliminate that right. Some courts have converted the legal decision of the patient’s competence to make a treatment decision into a medical judgment of whether the physician-prescribed medication is medically appropriate to treat the patient’s condition. Some courts have ruled that the decision to involuntarily commit a person or to establish a conservatorship for the person is justification enough to impose treatment without a separate consideration of whether the patient is competent to make a rational judgment about the proposed treatment. In essence, these decisions replace the patient’s right to refuse treatment with the patient’s obligation to accept treatment. Some courts—including the United States Supreme Court in cases involving prisoners and criminal defendants—have ruled that a patient’s dangerousness to self or others is sufficient to impose treatment, even if such treatment is not immediately necessary to prevent the perceived harm. In essence, these decisions replace the emergency exception to the requirement of informed consent with a general dangerousness exception. In some states, the common law duty of the physician to obtain the patient’s informed consent to treatment has been replaced with a duty imposed on the patient to specifically refuse treatment if he or she objects to that treatment. Even if the patient has not been informed of the risks and alternatives to the treatment or of the patient’s right to refuse treatment, the patient’s voluntary, but uninformed, acquiescence allows that treatment to proceed. In some states, preventive outpatient commitment has emerged as a device to ensure that mentally disordered individuals take prescribed psychotropic medication while

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735 *Id.* at 341. *See supra* text accompanying notes 107-10 (discussing the distinction between physical and mental illness).
736 *See supra* Chapter 3.
737 *See supra* Chapter 4.
738 *See supra* Chapter 5.
741 *See supra* Chapter 6.
742 *See supra* text accompanying notes 604-46.
they are living in the community.\textsuperscript{743} Through a court order requiring the individual to comply with an outpatient treatment plan, individuals are coerced into accepting medications that they would not otherwise accept. Such individuals are not informed that the court is powerless to enforce its order. Voluntary and informed consent is replaced by involuntary and uninformed acquiescence.

Why has the right to refuse treatment come under continuing attack? The idea that an involuntarily committed mental patient should have a right to refuse psychotropic medication that has been prescribed to improve his or her condition has always been controversial.\textsuperscript{744} The debate between proponents of this right, mostly lawyers, and opponents of this right, mostly psychiatrists, was fueled by two early, and often-cited,\textsuperscript{745} articles—one asserting that the right to refuse psychiatric treatments is necessary to inhibit a “therapeutic orgy,”\textsuperscript{746} the other asserting that patients who are allowed to refuse needed medication are permitted to “rot with their rights on.”\textsuperscript{747} Although the rhetoric of subsequent

\textsuperscript{743} See supra text accompanying notes 672-731.

\textsuperscript{744} See, e.g., Jonathan Brant, Pennhurst, Romeo, and Rogers: The Burger Court and Mental Health Law Reform Litigation, 4 J. LEGAL MED. 323, 345 (1983) (“The question of whether patients have a right to refuse treatment is probably the most controversial issue in forensic psychiatry today.”); William M. Brooks, A Comparison of a Mentally Ill Individual's Right to Refuse Medication Under the United States and the New York State Constitutions, 8 TOURO L. REV. 1, 1 (1991) (“The right of a mentally ill and involuntarily hospitalized individual to refuse medication prescribed by a psychiatrist has divided the legal and psychiatric professions more than any other recent issue.”); Winick, supra note 404, at 206 (“[T]he issues surrounding the availability and dimensions of such a right remain mired in controversy.”).


publications has been somewhat less polemic, legal and psychiatric commentators remain intensely interested in the subject.\textsuperscript{748}

In recent years, attacks on the right to refuse treatment have not merely continued, they have intensified. Psychiatrists and others question whether mental patients–especially involuntarily committed mental patients–should have a right to refuse psychotropic medication that is an effective means for improving patient functioning, for reducing the risk of harm patients’ pose to themselves and others, for reducing the need to use physical restraints, and for reducing the length of hospitalization.\textsuperscript{749} And today, their arguments seem more appealing as new psychotropic medications–called “novel” or “atypical” medications–have been introduced that offer these benefits without the same risk of serious neuroleptic side effects that accompany treatment with the older, “conventional” medications.\textsuperscript{750}

137 Am. J. Psychiatry 720 (1980); Thomas G. Gutheil, \textit{In Search of True Freedom: Drug Refusal, Involuntary Medication, and “Rotting With Your Rights On”}, 137 Am. J. Psychiatry 327 (1980) (editorial). The “rotting with their rights on” language may have been paraphrased from a well-known letter to the editor, published six years earlier, in which the psychiatrist-writer charged that legal reforms to the civil commitment process might enable mental patients to die with their rights on. Darold A. Treffert, \textit{Dying With Their Rights On}, 130 Am. J. Psychiatry 1041 (1973).


\textsuperscript{748}See, e.g., Mossman, supra note 108, at 1126.

\textsuperscript{750}Id. at 1039-40. Mossman acknowledged that when patients were treated with conventional psychotropic medications, the risk of serious neuroleptic side effects was “a nearly inevitable consequence of treatment.” \textit{Id.} at 1040.
In an recent article, Douglas Mossman, M.D., asserts that the introduction of atypical medications beginning in 1994 should result in the unbuckling of the conceptual straitjacket that has prevented judges, legal scholars, and lawyers from recognizing the need for and value of psychotropic medications. According to Dr. Mossman, the assessment of psychotropic medication as found in court decisions and legal scholarship is “distorted and increasingly outdated.” In right to refuse treatment litigation that involved conventional psychotropic medication, judges and scholars barely acknowledged that such drugs were effective – “sometimes only in passing” – and emphasized instead the serious side effects that the medications may cause. Those side effects, writes Dr. Mossman, “rather than a principled opposition to nonconsensual medical treatment per se, . . . gave force to a patient’s constitutionally based right to refuse treatment.”

When atypical medications are used instead of conventional medications, the level of neurological side effects—such as akathesia (a distressing urge to move), akinesia (a reduced capacity for spontaneity), pseudo-Parkinsonism (causing retarded muscle movements, masked facial expression, body rigidity, tremor, and a shuffling gait)—is lower. Additionally, atypical medications

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751 *Id.* at 1043.
752 *Id.*
753 *Id.* at 1126.
756 *See In re Qawi*, 81 P.3d 224, 231 (Cal. 2004) (discussing side effect characteristics of conventional psychotropic medications).
757 Mossman, *supra* note 108, at 1074. *See Chicon, supra* note 266, at 300-04 (explaining and discussing extrapyramidal side effects). As two psychiatrist authors explain: “Unlike typical antipsychotics, the novel agents clozapine, risperidone, olanzapine, quetiapine, and ziprasidone are weaker dopamine D2 antagonists, and therefore have very favorable extrapyramidal side-effect profiles compared with conventional antipsychotic agents.”
reduce the risk of the patient developing tardive dyskinesia\(^{758}\) —“an irreversible neurological disorder characterized by involuntary, rhythmic and grotesque movements of the face, mouth, tongue, jaw and extremities.”\(^{759}\) Atypical medications have replaced conventional medications as the drugs of choice for the treatment of schizophrenia.\(^{760}\)

Dr. Mossman states that despite the advantages of atypical medications, courts are not likely to eliminate the involuntary mental patient’s right to refuse treatment or the procedures employed to determine when medication can be administered despite the patient’s refusal.\(^{761}\) He notes that atypicals “still carry some risk of the neurological side effects that alarmed courts in the 1970s and 1980s.”\(^{762}\) Additionally, Dr. Mossman acknowledges that atypicals “appear to place patients at more risk than [conventional medications] of developing troublesome metabolic conditions, including obesity, alterations in lipid metabolism, and diabetes mellitus.”\(^{763}\) He even suggests that apart from the side effects issue, the right to refuse treatment “probably should” be preserved because it serves a valuable ethical purpose of respecting the personhood of patients.\(^{764}\) But Dr. Mossman asserts that the development of atypical medications will make judges “more inclined to accept physicians’ generally pro-treatment position and less persuaded by the antimedication views of some patient advocates.”\(^{765}\) In essence, the right to refuse treatment remains—at least as a theoretical right—but when a patient exercises that right and refuses treatment, a court is likely to rule that the patient is incompetent, and therefore, that treatment may be imposed despite the patient’s protest. After all, if the patient was competent, wouldn’t he or she choose the benefits of the proposed atypical medication over the risks of that medication—described by Dr.


\(^{758}\)Mossman, *supra* note 108, at 1074-75.


\(^{760}\)Mossman, *supra* note 108, at 1077-78.

\(^{761}\)Id. at 1148.

\(^{762}\)Id.

\(^{763}\)Id.

\(^{764}\)Id.

\(^{765}\)Id. at 1149.
Mossman as a “relatively benign side effect profile.”

The answer is, or should be, no. A competent patient can rationally decide to refuse atypical medications. Even Dr. Mossman admits that atypical medications “still carry some risk of . . . neurological side effects.” Is a patient—especially a patient who previously suffered neurological side effects from the administration of conventional medications—incompetent simply because he or she fears the possibility of neurological side effects—even a diminished risk of such side effects—from a proposed atypical medication? I think not. As the California Supreme Court stated: “The weighing of these risks against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgment reserved to the patient alone.”

And what of the metabolic side effects of atypical medications? Can obesity, hyperlipidemia (i.e., an elevation of cholesterol, triglycerides and other lipids (fats) in the bloodstream), and type II diabetes mellitus be summarily dismissed as merely “troublesome”? If obesity, cardiovascular disease, and diabetes are risks—very real risks—of atypical medications, is it appropriate for Dr. Mossman or any other psychiatrist to characterize the side effect profile of atypical medications as “relatively benign”?

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766 Id. at 1144.
767 Id. at 1148.
770 Mossman, supra note 108, at 1148. Ironically, Dr. Mossman, who criticizes judges and scholars for emphasizing the side effects of psychotropic medications while minimizing their effectiveness, see supra text accompanying notes 752-55, is guilty of overemphasizing the benefits of atypical medications while minimizing their side effects. Dr. Mossman devotes only one brief paragraph in his 131-page law review article to the discussion of metabolic side effects associated with atypicals. Id. at 1084.
771 Id. at 1144. Dr. Mossman acknowledges that “psychiatrists do not yet know what will be the long-term consequences of atypical induced weight gain.” Id. at 1084. How can one assert definitively that the side effect profile
While the metabolic side effects of atypical medications may be less
graphic than the neurological side effects of conventional medications, they
counteract significantly to increased patient morbidity and mortality. In a book
written by psychiatrists for psychiatrists, and published by the American
Psychiatric Association, the authors of a chapter on excessive morbidity and
mortality associated with schizophrenia concluded: “Avoiding adverse
metabolic side effects . . . is . . . critical in reversing the trend toward higher
mortality in patients with schizophrenia.” 772 The authors of a chapter on obesity
in patients with schizophrenia asserted: “The first step in the battle against
obesity and novel antipsychotic medication-associated weight gain is to
appreciate the severity of this ubiquitous problem.” 773 Obesity prevalence
among patients with schizophrenia is one-and-one-half to two times higher than
among the general population. 774 The author of a chapter on cardiovascular
illness in patients with schizophrenia reported that metabolic side effects of
atypical medications were “significant contributors to cardiovascular risk.” 775
For a twenty-six-year old male patient treated with the atypical medication
olanzapine, the risk of a major coronary event occurring over the next decade
quadruples. 776 The authors of a chapter on glucose intolerance and diabetes in
patients with schizophrenia reported that the risk for the development of type
II diabetes in mildly obese individuals is twice that of normal-weight
individuals, is five times as high in moderately obese individuals, and is ten

772 Daniel E. Casey & Thomas E. Hansen, Excessive Mortality and
Morbidity Associated with Schizophrenia, in Mental Illness and
Schizophrenia, supra note 14, at 13, 31.
773 Wirshing & Meyer, supra note 14, at 42.
774 Johnathan M. Meyer, Cardiovascular Illness and Hyperlipidemia in
Patients with Schizophrenia, in Mental Illness and Schizophrenia, supra
note 14, at 53, 60 (citing studies).
775 Id. at 55.
776 Id. at 70. If the patient was forty-six years old instead of twenty-six,
the risk of a major coronary event increases 100 percent, giving the patient a
twenty percent chance of a major coronary event over the next decade. Id.
times as high in severely obese individuals. Additionally, patients treated with atypical medications were found to be at an increased risk of developing type II diabetes even if they were of normal weight. Ironically, a growing body of research suggests that people with type II diabetes have an increased risk of certain mental disorders, specifically dementia and Alzheimer’s disease.

Are psychiatrists so enamored by the benefits of atypical medications in the treatment of their patients’ mental illnesses that they neglect the risks to their patients’ physical health from such medications? Apparently so. As one psychiatrist-author, writing about cardiovascular illness and hyperlipidemia associated with the use of atypical medications, stated:

During therapy of patients with schizophrenia, mental health practitioners are not primarily focused on the substantial cardiovascular risk imposed by hyperlipidemia, and they may therefore be disinclined to perform lipid monitoring in patients prescribed antipsychotics associated with hyperlipidemia or to refer patients for lipid-lowering therapy. Given the immediately observable psychiatric benefits of antipsychotic therapy, the health risks imposed by hyperlipidemia become a secondary issue.

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778 Henderson & Powers, supra note 777, at 109; see also Meyer, supra note 774, at 63 (asserting that the development of glucose intolerance and new-onset diabetes mellitus associated with the use of atypical medications occurs “at times not associated with significant increases in weight”) (citing studies). Meyer also reported that diabetes mellitus prevalence among patients with schizophrenia is two times higher than among the general population. *Id.*


780 Meyer, supra note 774, at 55. Incredibly, Meyer seems to excuse the current failure of psychiatrists to perform such monitoring, asserting that “[m]ental health providers should not feel unduly chastened in this regard,
But the health risks of atypical medications may well be a primary issue to patients who are, or who should be, informed of those risks, and who have, or should have, the right to accept or refuse treatment with such medications after weighing the benefits of the medications against those risks. The doctrine of informed consent assures them that they will make that ultimate judgment. Even Dr. Mossman acknowledges that “one must wonder how many patients might prefer a drug with a higher risk of tardive dyskinesia to a drug that had a good chance of making them fat.”

A patient’s decision to refuse treatment with an atypical medication may not only be a rational decision, it may be a wise decision. A recent study comparing patients with schizophrenia treated with conventional psychotropic medications and those treated with atypical psychotropic medications concluded, rather surprisingly, that after one year of treatment, there was “no disadvantage in terms of quality of life, symptoms, or associated costs of care” in the use of conventional medications. In commenting on this study, Columbia University psychiatrist Jeffery Lieberman, M.D., declared:

[T]he claims of superiority for [atypical antipsychotics] were greatly exaggerated. This may have been encouraged by an overly expectant community of clinicians and patients eager to believe in the power of new medications. At the same time, the aggressive marketing of these drugs may have contributed to this enhanced perception of their effectiveness in the absence of empirical evidence.

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because data indicate that even among patients with documented CHD [coronary heart disease] seen by primary care providers, only 14% receive lipid-lowering therapy when indicated, and only 18% ever achieve their target serum lipid goals . . . .” Id. (citing studies). Quaere: Does malpractice by primary care physicians excuse malpractice by psychiatrists? In concluding his chapter, Meyer specifically recommends regular lipid monitoring of patients who are treated with atypical medications. Id. at 73-74.

781 Mossman, supra note 108, at 1084.

782 Peter B. Jones et al., Randomized Controlled Trial of the Effect on Quality of Life of Second-vs First-Generation Antipsychotic Drugs in Schizophrenia, 63 ARCHIVES GEN. PSYCHIATRY 1079, 1086 (2006).

783 Jeffery A. Lieberman, Comparative Effectiveness of Antipsychotic Drugs: A Commentary on Cost Utility of the Latest Antipsychotic Drugs in Schizophrenia Study (CUtLASS I) and Clinical Antipsychotic Trials of
According to Dr. Lieberman, atypical medications “are not the great breakthrough in therapeutics they were once thought to be.” 784

An individual’s competence to make a treatment decision concerning his or her own body should determine whether he or she is entitled to make that decision. That competence should be determined by whether the individual is weighing rationally the risks and the benefits of the proposed treatment. If a person’s competence is measured by how a physician or other third person would decide, then that physician or other third person is, in essence, the decisionmaker, not the individual in question. 785 Even if atypical medications are more effective and less risky than conventional medications 786—an issue that is in considerable doubt today—the decision of an individual who makes a competent judgment should be honored. 787

Although I am confident that this analysis is correct, I am far less confident that this analysis will prevail. In those jurisdictions that use a professional judgment model to review a patient’s treatment refusal, the ultimate decision of whether coerced treatment will be authorized is likely to depend on whether the reviewing professional agrees with the treating doctor that the prescribed psychotropic medication is medically appropriate to treat the patient’s mental

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784 Id. at 1071.


786 It should be noted that most atypical medications are not available in long-term injectable form. Thus, even if a doctor wants to treat a patient with an atypical medication, a patient who refuses that treatment may be required to accept treatment with a conventional medication. In In re K.L., 806 N.E.2d 480, 482 (N.Y. 2004), for example, the outpatient treatment plan required K.L. to orally self administer Zyprexa, an atypical medication. If he did not comply, the plan required him to “voluntarily submit himself to the administration of Haldol Decanoate by medical personnel.” Id. In my view, a person who is competent to refuse treatment with an atypical medication should not be coerced into accepting treatment with a conventional medication that poses more risks and is less effective in treating his or her mental condition. See supra text accompanying notes 711-31.

787 Slobogin, supra note 785, at 235.
condition, not on whether the patient is competent and is refusing medication for rational reasons.\textsuperscript{788} Even in jurisdictions that require a judicial review of the patient’s competence to refuse medication, judges are likely to be influenced by the testimony of psychiatrists who claim that atypicals have a “relatively benign side effect profile.”\textsuperscript{789}

Judges are also likely to be influenced by psychiatric testimony about research linking anosognosia—a biologically-based inability of a person to appreciate that he or she has an illness\textsuperscript{790}—with schizophrenia. Until the mid-

\textsuperscript{788} See supra Chapter 4.

\textsuperscript{789} Mossman, supra note 108, at 1044. In Riggins v. Nevada, 504 U.S. 789 (1992), Justice Kennedy discussed side effects of conventional psychotropic medications that could affect a criminal defendant’s ability to receive a fair trial by creating a prejudicial, negative demeanor. For example, the defendant may be restless and unable to sit still. Parkinsonism could diminish the range of a defendant’s facial expression or slow movements and speech. Conventional psychotropic medications may produce a sedation-like effect. The side effects of conventional psychotropic medications may impair the defendant’s ability to cooperate with counsel or to testify on his or her own behalf. Id. at 142-45 (Kennedy, J. concurring). For these reasons, Justice Kennedy was not willing to allow psychotropic medication to be administered over the objection of the defendant unless the state could prove that involuntary treatment would not cause those side effects. Id. at 145. However, in recent cases involving coerced treatment of criminal defendants found mentally incompetent to stand trial, some courts, relying on the testimony of psychiatrists, have authorized the involuntary administration of atypical psychotropic medication because the “more favorable side effect profile” of such medications indicates they would not affect adversely the defendant’s demeanor and appearance before a jury or the defendant’s ability to cooperate with counsel or testify at trial. See, e.g., United States v. Gomes, 387 F.3d 157, 162 (2d Cir. 2004); United States v. Weston, 255 F.3d 873, 882-87 (D.C. Cir. 2001). It should be noted that the government’s interest in bringing a criminal defendant to trial does not exist in situations involving civilly committed patients. For civilly committed patients, competence of the individual to make medication decisions should be determinative.

1970s, anosognosia was a condition usually associated with individuals who suffered strokes or brain tumors. However, in the last thirty years, several studies have reported that approximately half the individuals with schizophrenia have moderate to severe impairment in their awareness of their illness. A psychiatric expert might testify that if an individual does not appreciate that he or she has a mental disorder, obviously, the individual is unable to perceive the need for treatment of that disorder and to consider the benefits of such treatment, and therefore, the individual should be found incompetent. And it is likely that the judge will so rule.

Judges, however, should not rush to judgment. The MacArthur Treatment Competence Study—the definitive study measuring mental patients’ legally relevant abilities to make decisions about treatment—reported that although approximately one-third of patients with schizophrenia tended not to acknowledge some aspect of their mental disorder and thus were impaired in

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791 Id. at 32-35.
792 See id. at 35-39 (discussing studies).
794 Bruce Winick described the MacArthur Treatment Competence Study as “exceedingly important research of the highest quality” and added that “its implications for mental health law are profound.” Bruce J. Winick, The MacArthur Treatment Competence Study: Legal and Therapeutic Implications, 2 PSYCHOL. PUB. POL’Y & L. 137, 138 (1996).
795 The MacArthur Treatment Competence Study measured three components of competence—the individual’s ability: (1) to understand information that is disclosed to the individual about mental disorder and treatment options, (2) to appreciate the existence of the mental disorder with which the individual has been diagnosed and the potential value of treatment for that disorder, and (3) to reason rationally about information in deciding whether to accept or reject treatment. Grisso & Appelbaum, supra note 793, at 154-56. The principal authors of the study cautioned, however, that the research instruments used in the study “were not intended for use in the clinical assessment of individual cases, and they were not conceptualized as ‘measures of competence.’” Thomas Grisso & Paul S. Appelbaum, Values and Limits of the MacArthur Treatment Competence Study, 2 PSYCHOL. PUB. POL’Y & L. 167, 168 (1996) [hereinafter Grisso & Appelbaum, Values and Limits].
their appreciation of their disorder, nevertheless, only about thirteen percent of patients with schizophrenia tended not to acknowledge the potential value of treatment. Thomas Grisso, M.D. and Paul Appelbaum, M.D., the principal authors of the MacArthur Treatment Competence Study, wrote: “Clearly, mere nonacknowledgment of one’s disorder or of the realistic consequences of treatment is not enough to constitute incompetence; it must also be related to delusional thinking or other medical or psychological conditions that are responsible for a serious distortion of reality . . .”

In the MacArthur Treatment Competence Study, the most frequent reason given by patients with schizophrenia for devaluing treatment was the belief that such treatment, especially medication, was intended to harm them in some way. Is such a belief due to delusional thinking that the treating psychiatrist is an evil person who seeks to poison the patient? Or is such belief merely an ambiguous, but completely rational, expression of the patient’s concern about possible side effects that may be experienced from the medication? Perhaps the more important question is whether the psychiatrist will inquire further into the basis for the patient’s answer, or whether the psychiatrist will simply assume that the patient’s answer is due to delusional thinking.

In my experience as a mental health hearing officer conducting right to

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796 Grisso & Appelbaum, supra note 793, at 162-63.
797 Id. at 163-64.
798 Grisso & Appelbaum, Values and Limits, supra note 795, at 172.
799 Grisso & Appelbaum, supra note 793, at 164.
800 Similarly, one could ask whether the psychiatrist will be willing to repeat the disclosure of risks and benefits, breaking down the information into smaller pieces—a procedure that Drs. Grisso and Appelbaum found improves patient understanding of the disclosed information. See Grisso & Appelbaum, supra note 793, at 173; Grisso & Appelbaum, Values and Limits, supra note 795, at 179. Bruce Winick asserted that to avoid an unnecessary determination of incompetence, the MacArthur Treatment Competence Study “suggests that therapists should explain or ‘teach’ the information to the patient bit by bit and in more than one session.” Winick, supra note 794, at 150. Drs. Grisso and Appelbaum declared that the idea of characterizing informed consent as a process both of teaching patients and of listening to them “has much to recommend it.” Grisso & Appelbaum, Values and Limits, supra note 795, at 179.
refuse treatment hearings, I found that most psychiatrists equated a patient’s incompetence with either the psychiatrist’s finding that the patient had a mental disorder or with the patient’s unwillingness to acknowledge that disorder. When psychiatrists made a professional judgment that a particular medication was medically appropriate to treat the patient’s disorder, they often viewed any patient objections as irrational. From the psychiatrist’s perspective, the choice of treatment was a medical decision within the psychiatrist’s expertise and his or her authority. Patient objection to the psychiatrist’s judgment—particularly the objection of an involuntarily committed patient—was not acceptable. Did the person deny mental illness simply to avoid the stigmatization that surely follows from that label? Did the person deny mental illness in an attempt to avoid involuntary commitment? Did the person deny mental illness because he or she did not feel ill? Can these reasons for denying illness be universally characterized as a lack of insight produced by delusional thinking? Perhaps, as Elyn Saks suggests, the individual is merely expressing a reasoned preference—a value choice—for the symptoms rather than the cure. Denial “may be the patient’s way of saying that she, who knows her state of mind better than anyone else, is satisfied with the way she is and does not want to change with the help of psychotropic agents.”

When nonacknowledgment of one’s disorder occurs because of a difference in values, rather than delusional thinking, “the proper response,” say Drs. Grisso and Appelbaum, “is to respect the patient’s choice.” Consider, for example, the eating habits of American adults. Despite the fact that 64.5 percent of American adults are overweight, 30.5 percent are obese, and 4.7

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801 Morris, supra note 162, at 432. See supra text accompanying notes 162-68 (discussing potentially rational reasons for patients refusing to acknowledge a mental disorder) and text accompanying notes 606-16 (discussing the failure of psychiatrists to fully inform patients of the risks of medication that they are prescribing).


803 Id.

804 Id. at 991.

805 Grisso & Appelbaum, Values and Limits, supra note 795, at 172.
percent are morbidly obese, \(^{806}\) in a recent survey of 12,000 American adults, 82.6 percent of respondents characterized their eating habits as very healthy or somewhat healthy. \(^{807}\) Even among those respondents who were morbidly obese, 64.9 percent characterized their eating habits as very healthy or somewhat healthy. \(^{808}\) The authors of the study concluded: “[S]everal high risk behaviors have combined to become part of the average American’s weekly routine. . . . Americans are rationalizing themselves into ever-expanding waistlines.” \(^{809}\)

While we may encourage morbidly obese people—and, in fact, all American adults—to develop healthy eating habits, we do not force them to do so. And if they continue to overeat, significantly increasing their risk of suffering coronary heart disease, diabetes, and cancer, we, nevertheless, continue to respect their decision. The authors of an article recently published in the New England Journal of Medicine acknowledged that progressive public policy laws to deal with obesity “are unlikely to be implemented until the dominant cultural mores are sufficiently favorable.” \(^{810}\) They concluded that, at present, the public policy approach to obesity is “one that focuses primarily on informing personal choices rather than restricting them.” \(^{811}\)

But not so for mentally disordered people. Although the MacArthur

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\(^{807}\)Id. at 1-2. Of all respondents, 27.7 percent characterized their eating habits as very healthy and 54.9 percent characterized their eating habits as somewhat healthy. Id. at 2. Only 2.9 percent of all respondents characterized their eating habits as not healthy. Id.

\(^{808}\)Id. at 2. Of morbidly obese respondents, 16.3 percent characterized their eating habits as very healthy and 48.6 percent characterized their eating habits as somewhat healthy. Id. Only 11.2 percent of morbidly obese respondents characterized their eating habits as not healthy. Id.

\(^{809}\)Id. at 4. The high risk factors that have become part of the average American’s weekly routine are: “a combination of occasional fast food meals, moderate snacking, not quite enough exercise and the belief that these habits are ‘somewhat healthy’.” Id.


\(^{811}\)Id.
Treatment Competence Study confirmed that “a blanket denial of the right to consent to or refuse treatment for persons hospitalized because of mental illness cannot be based on the assumption that they uniformly lack decision-making capacity,”


nevertheless, our society—and the psychiatrists and judges who are decisionmakers for our society—continues to believe the myth that mentally disordered people who refuse treatment for their disorders are incompetent to make those decisions. Even when laws require that a judge make an individualized determination of a mental patient’s competence, the judge, relying on testimony from the treating psychiatrist that the side effect profile of the prescribed atypical medication that the patient is refusing is relatively benign or that the patient suffers from anosognosia and lacks insight into his or her mental illness, is likely to find the patient incompetent.

To the myth of incompetency, we must also add the myth of dangerousness. Drs. Grisso and Appelbaum assert that the most stigmatizing aspect of mental illness is not the connection between mental illness and incompetence to make treatment decisions, but rather, the connection between mental illness and dangerousness. Bruce Winick pleads: “It is not appropriate to associate mental illness with moral weakness, dangerousness, or incompetence. We must see these associations as antiquated and pernicious stereotyping that should be disposed of root and branch.”

For example, Jeffrey Swanson and his associates compared the prevalence of self-reported violence by mentally disordered individuals living in the community with others living in the community who had no mental disorder. Approximately two percent of nonmentally disordered persons reported engaging in violent behavior in the past year compared with approximately ten to twelve percent of mentally disordered persons. Although mentally disordered persons were five to six times more violent than nonmentally disordered persons, eighty-eight to ninety percent of mentally disordered persons were not violent. Jeffrey S. Swanson et al., Violence and
Bruce Link and his associates found that although the prevalence of arrests/violence was consistently higher for mental patients than for community residents—sometimes two to three times higher—only patients who were actively experiencing psychotic symptoms had elevated rates. Bruce G. Link et al., *The Violent and Illegal Behavior of Mental Patients Reconsidered*, 57 *Am. Soc. Rev.* 275, 283, 290 (1992). Bruce Link and Ann Stueve found that only three of thirteen psychotic symptoms studied were strongly associated with violent behavior. Apparently not all actively psychotic persons are dangerous, only those experiencing threat/control override symptoms. Bruce G. Link & Ann Stueve, *Psychotic Symptoms and the Violent/Illegal Behavior of Mental Patients Compared to Community Controls*, in *Violence and Mental Disorder* 137, 151 (John Monahan & Henry J. Steadman eds., 1994).

Bruce Link and his associates found that the risk of violence from mentally disordered persons currently experiencing psychotic symptoms is “comparable to the risks associated with common social statuses [e.g., male gender, young age, limited education] and a trivial contribution to the overall level of violent/illegal behavior in American society.” Link et al., *supra* note 814, at 290. In the study conducted by Jeffrey Swanson and his associates, 16.09 percent of males aged 18-24 of low socioeconomic status reported violent behavior—a higher rate of violence than reported by mentally disordered individuals. Swanson, *supra* note 814, at 764 tbl.1. Violent behavior was reported by 24.57 percent of the respondents who abused or were dependent on alcohol and 34.74 percent of the respondents who abused or were dependent on other drugs—a far higher rate of violence than reported by mentally disordered individuals. In a subsequent analysis of the same data, Swanson found that “the absolute risk of violence in the presence of mental illness remained low—about 7% in the course of a year—even while the relative risk was about three times as high as in the nondisordered population.” Jeffrey W. Swanson, *Mental Disorder, Substance Abuse, and Community Violence: An Epidemiological Approach*, in *Violence and Mental Disorder*, *supra* note 814, at 101, 112. By Swanson’s analysis, ninety-three percent of mentally disordered persons were not violent. Substance abuse continued to be associated with a far higher risk of violence than mental disorder in both absolute and relative terms. *Id.* See Morris, *supra* note 347, at 92-95 (discussing studies of mental disorder as a risk factor for violence).
two in the public mind seems unshakable.\textsuperscript{816}

The public is not convinced by—in fact, is not even interested in learning about—studies, such as the massive MacArthur Violence Risk Assessment Study, which found that the prevalence of violence among ex-mental patients without symptoms of substance abuse and others living in the same neighborhoods without symptoms of substance abuse was statistically indistinguishable.\textsuperscript{817} We would rather obtain our knowledge of how mentally disordered people act by watching them on television committing violent acts. A content analysis of television programming revealed that the incidence of violence by mentally disordered people in television programs is grossly distorted. Television characters with mental disorder are highly likely to be shown committing acts of violence—they are portrayed as ten times more violent than the general population of television characters.\textsuperscript{818}

Those who advocate for coerced treatment of mentally disordered persons have exploited the public’s fear of the mentally disordered in order to achieve their objective. D. J. Jaffe, a co-founder of the Treatment Advocacy Center and vigorous proponent of Kendra’s Law,\textsuperscript{819} informed the audience at the 1999 convention of the National Alliance for the Mentally Ill:

\begin{quote}
Laws change for a single reason, in reaction to highly publicized incidents of violence. People care about public safety. I am not saying it is right, I am saying this is the reality. . . . So if you’re changing your laws in your states, you have to understand that. Now once you understand that, it
\end{quote}

\begin{footnotes}
\item[817] Henry J. Steadman et al., \textit{Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods}, 55 Archives Gen. Psychiatry 393, 400 (1998). The MacArthur Violence Risk Assessment Study compared prevalence of violent conduct by 1136 recently discharged mental patients with a community sample of 519 people living in the same neighborhoods as the discharged patients. \textit{Id.} at 394-95.
\item[818] American Psychiatric Association, \textit{Psychiatric Effects of Media Violence}, \textit{at} http://www.healthyminds.org/mediaviolence.cfm (last visited August 15, 2006). The American Psychiatric Association asserted: “Nowhere is the media’s distortion of reality greater than in the portrayal of individuals with mental illness.” \textit{Id.}
\item[819] See supra text accompanying notes 684-731.
\end{footnotes}
means that you have to take the debate out of the mental health arena and put it in the criminal justice/public safety arena.\textsuperscript{820} The strategy of vilifying the mentally disordered in order to force treatment upon them is succeeding. New York is not alone in enacting preventive outpatient commitment laws. In the “new tradition”\textsuperscript{821} of naming outpatient commitment statutes after a victim who died from a violent act of a mentally disordered person, California, for example, has enacted “Laura’s Law,”\textsuperscript{822} Michigan has enacted “Kevin’s Law,”\textsuperscript{823} and Ontario has enacted “Brian’s Law.”\textsuperscript{824}

In post-9/11 America, we are obsessed with the need to prevent violence at any cost. We have declared war, not against a country, but against a concept—terrorism—and have changed the rules of war. We claim a right to make preemptive strikes against foreign dictators who might harbor weapons of mass destruction that might be used against us.\textsuperscript{825} Regime change, at our discretion, is a viable foreign policy option.\textsuperscript{826} Those who are captured in this “war” are not accorded prisoner of war status. Rather, they are declared to be

\begin{itemize}
\item \textsuperscript{820}Mattison, \textit{supra} note 656, at 155.
\item \textsuperscript{821}Geller, \textit{supra} note 691, at 241.
\item \textsuperscript{822}The Assisted Outpatient Treatment Demonstration Project Act of 2002, \textit{Cal. Welf. & Inst. Code} §§ 5345-5349.5 (West Supp. 2006). A statute specifically provides: “This article shall be known, and may be cited as Laura’s Law. \textit{Id.} § 5345(a).”
\item \textsuperscript{823}\textit{Mich. Comp. Laws Ann.} §§ 330.1401(d), 1433, 1469a(3-5) (West Supp. 2006). \textit{See} Geller, \textit{supra} note 691, at 242 (stating that Michigan’s outpatient commitment law is known as Kevin’s Law).
\item \textsuperscript{824}Mental Health Act, R.S.O. 1990, ch. M.7, §§ 33.1-33.9 (2006) (Can.). \textit{See} Cornwell & Deeney, \textit{supra} note 685, at 231 (stating that Ontario’s outpatient commitment statute, “commonly known as ‘Brian’s Law,’ was named for the victim of a high-profile crime perpetrated by a mentally ill person.”).
\item \textsuperscript{825}In a speech made less than six months before the start of hostilities against Iraq, President Bush, in outlining the Iraqi threat, mentioned Iraq’s “weapons of mass destruction”—seven times—as the basis for American military action. \textit{Address to the Nation on Iraq, 38 Weekly Comp. Pres. Doc.} 1716 (Oct. 7, 2002).
\item \textsuperscript{826}President Bush stated that “regime change in Iraq is the only certain means of removing a great danger to our Nation.” \textit{Id.} at 1719.
\end{itemize}
“enemy combatants” who are imprisoned indefinitely at Guantanamo Bay, or Abu Ghraib.\(^\text{827}\) The Geneva Convention? Sorry, it just doesn’t apply to this war.\(^\text{828}\) Prisoners of this war are subjected to cruel, humiliating, and degrading treatment.\(^\text{829}\) Amnesty International’s describes several instances in which detainees have been tortured to death while being interrogated and asserts that


\(^{828}\) But see Hamdan v. Rumsfeld, 126 S. Ct. 2749, 2796-98 (2006). In Hamdan, the Supreme Court held that Common Article 3 of the Geneva Convention applies to trials of enemy combatant prisoners detained in Guantanamo Bay. Article 3 requires that such combatants be tried by a “regularly constituted court affording all the judicial guarantees which are recognized as indispensable by civilized peoples.” Id. at 2796. Ordinary military courts are regularly constituted courts; special military commissions are not. Id. at 2796-97. Additionally, absent an express statutory provision to the contrary, the accused must be present for his trial and must be privy to the evidence against him. Id. at 2798.

\(^{829}\) To punish detainees for failing to cooperate or to “soften them up” for interrogation, the following practices have been utilized: “waterboarding,” hooding, stripping and shackling of detainees in painful positions, use of military dogs to intimidate blindfolded detainees, prolonged isolation, deprivation of food and sleep, and exposure of detainees to extremes of temperature. AMNESTY INTERNATIONAL, USA: AMNESTY INTERNATIONAL’S SUPPLEMENTARY BRIEFING TO THE UN COMMITTEE AGAINST TORTURE, http://www.amnestyusa.org/news/document.do?id=ENGAMR510612006.
the interrogation techniques had been officially sanctioned.830

In these troubled times, we are not interested in understanding those who are different from us or in tolerating those differences. We demand protection from those who we perceive—or misperceive—as dangerous. Just as we changed the rules of war for dealing with terrorists, we change the rules of engagement for our interaction with mentally disordered persons. To those we label “dangerous,” we reject a right to refuse treatment—despite their competence to make treatment decisions and despite the absence of an emergency situation necessitating treatment. We will not wait until their condition deteriorates and they act out violently. We declare our right to preemptive action—a right superior to their claim of a right to refuse treatment. We rationalize our decision to coerce treatment as beneficial to those we involuntarily treat. We are not punishing or torturing them. We are merely requiring them to take psychotropic medication prescribed by a physician that will improve their mental condition so that they will not be dangerous to us.

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830 Id. (discussing the deaths of Dilwar, Habibullah, Abdul Jaleel, Iraqi Major-General Abed Hamad Mowhoush, and an unnamed twenty-seven year old Iraqi male); see also Jordan J. Paust, Executive Plans and Authorizations to Violate International Law Concerning Treatment and Interrogation of Detainees, 43 COLUM. J. TRANSNAT’L L. 811, 838-55 (2005) (discussing illegal, but officially approved, interrogation methods).

On October 5, 2005, the United States Senate passed the McCain Detainee Amendment to the Department of Defense Authorization Bill, prohibiting inhumane treatment of prisoners. President Bush issued a signing statement declaring his intent to construe the amendment “in a manner consistent with the constitutional authority of the President to supervise the unitary executive branch and as Commander in Chief and consistent with the constitutional limitations on the judicial power, which will assist in achieving the shared objective of the Congress and the President . . . of protecting the American people from further terrorist attacks.” Statement on Signing the Department of Defense, Emergency Supplemental Appropriations to Address Hurricanes in the Gulf of Mexico, and Pandemic Influenza Act, 2006, 41 WEEKLY COMP. PRES. DOC. 1918, 1919 (Dec. 30, 2005). In other words, the President asserted his authority as Commander in Chief to disregard this amendment. See Charlie Savage, Bush Could Bypass New Torture Ban, BOSTON GLOBE, JAN. 4, 2006, http://www.boston.com/news/nation/washington/articles2006/01/04bush_could_bybass_new_torture_ban/.
Surely, there are other sources of danger that impose a higher risk of harm to us than that posed by mentally disordered persons. A study published in the New England Journal of Medicine almost ten years ago revealed that when the driver of a motor vehicle uses a cellular phone while driving, the risk of having collision was four times higher for those same drivers than when they were not using a cellular phone. The risk of collision while driving using a cellular phone is comparable to the risk of driving while under the influence of alcohol. But have we changed our driving habits since that report? If anything, in the last ten years, the rate of cellular phone use while driving has increased exponentially.

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831 See Morris, supra note 347, at 95-101 (discussing examples of various sources of danger in our society and our unwillingness to confront them).


833 Id. A recent study comparing cell phone drivers with drunk drivers confirmed that “impairments associated with using a cell phone while driving can be as profound as those associated with driving with a blood alcohol level at 0.08%.” David L. Strayer et al., A Comparison of the Cell Phone Driver and the Drunk Driver, 48 HUMAN FACTORS 381, 390 (2006).

834 On September 15, 2006, California became only the fourth state (joining Connecticut, New York, and New Jersey) to ban handheld cell phone use by motor vehicle drivers. 2006 Cal. Stat. 290. The California statute becomes effective on July 1, 2008 and will be codified as CAL. VEH. CODE § 23123. Violation of the California statute is an infraction punishable by a fine of twenty dollars for a first offense and fifty dollars for each subsequent offense. 2006 Cal. Stat. 290 § 4. Violations, however, will not be reflected on the driver’s record. Id. § 3. In enacting statutes that bar only handheld cell phones, legislatures have ignored scientific studies establishing that driving impairments associated with handheld cell phone conversations are not significantly different than driving impairments associated with hands-free cell phone conversations. See, e.g., Redelmeier & Tibshirani, supra note 832, at 456 (“We observed no safety advantage to hands-free as compared with hand-held telephones. . . . [O]ur data do not support the policy followed in some countries of restricting hand-held cellular telephones but not those that leave the hands free); Strayer et al., supra note 833, at 388 (“[L]egislative initiatives that restrict handheld devices but permit hands-free devices are not likely to
In 1972, almost thirty-five years ago, the Surgeon General, in releasing a report of his Scientific Advisory Committee on Television and Social Behavior, informed us: “[T]he study shows for the first time a causal connection between violence shown on television and subsequent behavior by children.” But have television programs become less violent? No, they are even more so. And today, our technology has taken us another step. Now our children are more than mere witnesses of violence; they are active participants in violence. Through point-and-shoot video games, children are conditioned by the same brutalization and desensitization techniques that are used to train soldiers to kill in combat. One such game, legally sold to children of any age, claims to be so realistic that “your victims actually beg for mercy and scream for their lives.” How many more Columbine massacres will we have to endure before we stop teaching our children how to kill?

We appear oblivious to the real sources of danger in our society. We do not eliminate the problems associated with using cell phones while driving.”).
want to be deprived of our cellular phones as we drive down the highway, or our violent television shows or violent video games as we entertain ourselves at home. These are our pursuits, and we enjoy them. In our search for safety, we have developed an “us versus them” mentality. The inconvenient truth is that in our war on violence, mentally disordered individuals are a convenient scapegoat. They are the witches that we hunt. It is difficult to deny Michael Perlin’s pronouncement that our irrational fear of the mentally disordered—i.e., our sanist attitude—incites us to dehumanize them, to use dangerousness as a pretext to impose treatment upon them. They, too, must learn to love Big Brother. And if they refuse our offering, we will use the involuntarily commitment process to exorcize “them” from “our” midst.

What is the future of the right to refuse psychotropic medication? If a patient’s refusal of medication can, without more, establish his or her danger to society, and if such generalized danger replaces the imminent danger/emergency requirement as the standard for treating the patient involuntarily, then the right to refuse treatment is not merely undermined, it is emasculated. If a patient’s refusal of medication can, without more, establish his or her incompetence to make treatment decisions, then the right to refuse treatment is not merely subverted, it is eviscerated. If determinations of a patient’s competence or dangerousness are medicalized—i.e., subject to a psychiatrist’s judgment that the treatment is appropriate rather than a court’s judgment that the patient is incompetent or dangerous—then the right to refuse treatment is not merely marginalized, it is extinguished. While the right to

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840 See George Orwell, Nineteen Eighty-Four (Oxford Univ. Press 1984) (1949). The book ends: “But it was all right, everything was all right, the struggle was finished. He had won the victory over himself. He loved Big Brother.” Id. at 416.
refuse may continue to exist, it will remain a right in theory only. In reality, 

841 For the mental patient’s right to refuse treatment to be effective, to be changed from a “paper” right, as Michael Perlin characterizes it, into a right with a real remedy, Professor Perlin recommends that organized and regularized counsel be appointed—lawyers who are specifically trained to represent individual mental patients who assert a right to refuse treatment. Michael L. Perlin, “And My Best Friend, My Doctor/ Won’t Even Say What It Is I’ve Got”:
The Role and Significance of Counsel in Right to Refuse Treatment Cases, 42 S AN D I E GO L. REV. 735, 736-37, 748 (2005). “[T]he presence of adequate counsel,” Perlin asserts, “is of critical importance in the disposition of right to refuse treatment cases.” Id. at 746. Just as with civil commitment cases, the quality of counsel is “the single most important factor” in the decisions that are reached in those cases. Id. (quoting Michael L. Perlin, Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases, 16 LAW & HUM. BEHAV. 39, 49 (1992)). From Professor Perlin’s perspective, a mentally disabled person will be fully valued as a member of our society only if a competent lawyer vigorously advocates for him or her in any legal proceeding in which that person is involved.

In my opinion, competent and zealous lawyer advocacy by patients’ attorneys in individual right to refuse treatment cases will have, at best, only a marginal impact in securing an effective right to refuse treatment for mentally disordered persons. See Grant H. Morris, Pursuing Justice for the Mentally Disabled, 42 S AN D I E GO L. REV. 757, 769-77 (2005). In states that use a medical decisionmaker model, the patient’s liberty interest—his or her legal interest—in avoiding unwanted psychotropic medication is converted into a determination of the patient’s medical interest as that interest is measured by the patient’s physician or a hospital committee reviewing that physician’s decision. In these states, there is no zealous lawyer advocacy because there are no court hearings on the competence issue. Id. at 770-71. Even in states that utilize a formalized hearing process to determine a patient’s competency for those few patients who refuse treatment, no hearings are conducted for patients who obediently accept—or are coerced into accepting—medication that their psychiatrists prescribe. No advocates are appointed to assure that psychiatrists fully disclosed the risks of the medication to these patients or that these patients understood those disclosures and made competent judgments to accept medication. Id. at 771-74. For those relatively few patients whose refusal of treatment is upheld in court proceedings, the hospital is likely to show them the door. But when they are next apprehended, they are likely to be processed through the criminal justice system or placed on preventive outpatient commitment with a court order requiring them to take psychotropic medication.
it will have become a meaningless formality. If legal impediments to coerced treatment no longer impede such treatment, then, as Loren Roth, M.D., acknowledged, “by hook or by crook” doctors will continue to treat all the patients they want.\footnote{See Conference Report, supra note 124, at 258.}

\textit{Id.} at 774-75, 776 n.89. “Our sanist society will continue to find ways to require the mentally disabled to act as obedient children and take their medicine.” \textit{Id.} at 776.
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