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2017]

UNCOMFORTABLY NUMB: THE THIRD CIRCUIT CHECKS STATE'S
FORCED MEDICATION POLICY IN *DISABILITY RIGHTS*
NEW JERSEY v. COMMISSIONER, NEW JERSEY
DEPARTMENT OF HUMAN SERVICES

MICHAEL WALKER*

“And if the band you’re in starts playing different tunes, I’ll see you on
the dark side of the moon.”¹

I. HAVE A CIGAR . . . WHILE ADDRESSING QUESTIONS SURROUNDING
THE TREATMENT OF MENTALLY ILL PATIENTS

In 1935, a Portuguese doctor named Antonio Egas Moniz performed the first prefrontal leukotomy operation, also known as a lobotomy.² This revolutionary procedure, which became popular in the United States in the 1930s to the 1950s, was executed by shocking the patient into a coma and hammering an icepick-like instrument through the top of each eye socket, thus severing the nerves connected to the emotional sensors of the brain.³ Often, lobotomies were administered whether or not the patient consented.⁴ Despite the brutality of this procedure, doctors saw it as a

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1. PINK FLOYD, *Brain Damage*, (Capitol Records 1973). This is a vague lyric that many have attempted to interpret over the years. See PHIL ROSE, ROGER WATERS AND PINK FLOYD: THE CONCEPT ALBUMS 37–38 (2015). However, according to Roger Waters, the line

‘I’ll see you on the dark side of the moon’ is me speaking to the listener saying: I know you have these bad feelings and impulses because I do too and one of the ways I can make direct contact with you is to share with you the fact that I feel bad sometimes.

Id. at 38 (emphasis omitted). “The dark side of the moon” seems to represent the insane side of all of us as people, and Waters saying he will see us there means he identifies with that side of us in himself. See *id.* In that way, we can all identify with what we commonly refer to as “insanity.”

2. See Brengt Jansson, *Controversial Psychosurgery Resulted in a Nobel Prize*, NOBEL-PRIZE.ORG (Oct. 29, 1998), https://www.nobelprize.org/nobel_prizes/medicine/laureates/1949/moniz-article.html [<https://perma.cc/LH5F-DMW>] (discussing research that led to Moniz’s Nobel Prize in 1949).

3. See Allison M. Foerschner, *The History of Mental Illness: From Skull Drills to Happy Pills*, 2 *INQUIRIES J.* no.9, 2010, at 1, 4 (discussing history of mental illness treatment and lobotomies).

4. See Elizabeth Day, *He Was Bad, So They Put an Icepick in His Brain . . .*, *GUARDIAN* (Jan. 13, 2008, 6:40 PM), <https://www.theguardian.com/science/2008/jan/13/neuroscience.medicalscience> [<https://perma.cc/9ZE3-PWJF>] (stating “[h]e had undergone a lobotomy and no one, not his parents, not the medical commu-

successful way to calm uncontrollably violent and emotional patients to enhance their standard of living.⁵ The procedure proved to be something of a revolution for the medical field, and Moniz was even awarded the 1949 Nobel Prize for Physiology or Medicine for his work on lobotomies.⁶

Medical practices, specifically the treatment of mentally ill patients, have come a long way since the days of the last lobotomy.⁷ The process as a whole was abandoned in favor of the application of psychoactive drugs.⁸ Today, medication is overwhelmingly the most popular way to treat mental illness in the United States.⁹ Odds are, we all know at least one person who has been diagnosed with some form of mental illness or disorder and has been prescribed some form of medication, such as Xanax or Adderall, to name a couple of the more common ones.¹⁰ But while medication and other treatments such as counseling have been widely adopted, courts continue to take on constitutional and other legal questions such as, “is consent always required to medicate mentally ill patients?” and, “if consent is not always required, what kinds of patients can be forcibly medicated?”¹¹ Courts hold that, while a patient’s constitutional rights play a role in decid-

nity or the state authorities, had intervened to stop it,” and noting he had undergone operation “without his knowledge”). The article goes on to mention the story of Rose Kennedy, sister of John F. Kennedy, who also underwent a lobotomy when she was twenty-three years old for which only her father’s consent was given. *See id.*

5. *See* Foerschner, *supra* note 3, at 4 (discussing perceived value of lobotomies to medical professionals).

6. *See* Jansson, *supra* note 2 (discussing Nobel Prize Moniz was awarded for his work in lobotomies).

7. *See* Foerschner, *supra* note 3, at 4 (“Although significant advances have been made in this field of study that greatly benefit many individuals suffering from psychopathology, there remains much room for improvement.”).

8. *See id.* (stating lobotomies were “quickly abandoned” for drug treatment).

9. *See* Disability Rights N.J., Inc. v. Comm’r N.J. Dept. of Human Servs., 796 F.3d 293, 295–96 (3d Cir. 2015) (noting witness testimony that “‘psychotropic medications are almost universally a part of successful treatment for patients in psychiatric hospitals’”); *see also* *Treatments for Mental Disorders*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/treatment/mental-disorders> [<https://perma.cc/E4G2-GJQJ>] (last visited Jan. 10, 2017) (discussing how many common mental illnesses are treated with medication including anxiety, depression, bipolar disorder, schizophrenia, and post-traumatic stress disorder (“PTSD”)).

10. *See* *Treatments for Mental Disorders*, *supra* note 9 (“43.6 million adults ages 18 and older experienced some form of mental illness in the past year, or about 18.1% of the adult population.”); *see also* *Drugs & Medications: Adderall*, WEBMD, <http://www.webmd.com/drugs/2/drug-63163/adderall-oral/details> [<https://perma.cc/2T3J-WWG9>] (last visited Mar. 10, 2017) (describing uses of Adderall); *Drugs & Medications: Xanax*, WEBMD, <http://www.webmd.com/drugs/2/drug-9824/xanax-oral/details> [<https://perma.cc/67Q3-2482>] (last visited Mar. 10, 2017) (describing uses of Xanax).

11. *See* *Disability Rights*, 796 F.3d at 294 (addressing issue of whether mentally ill patients can be forcibly medicated in non-emergency situations without judicial process); *see also* *Rennie v. Klein*, 653 F.2d 836, 848–49 (3d Cir. 1981) [hereinafter *Rennie I*] (addressing issue of whether civilly committed patients can be forcibly medicated).

ing to medicate, a patient's consent is not always required.¹² However, there is no uniform judicial standard for who can be forcibly medicated and under what circumstances that forced medication can take place.¹³

In 2015, the Third Circuit addressed that precise issue in *Disability Rights New Jersey, Inc. v. Commissioner of New Jersey Department of Human Services*.¹⁴ In *Disability Rights*, a New Jersey policy that allowed state-run mental hospitals to forcibly medicate certain patients once procedural requirements were met was challenged on multiple grounds by a national nonprofit organization.¹⁵ *Disability Rights* was the second Third Circuit decision to address constitutional challenges to a state policy on the forced medication of mental patients in the civil, rather than the prison, context.¹⁶

Opinions on *Disability Rights'* outcome will likely differ depending on the association of the medical professional, attorney, or policy maker.¹⁷ In the more specific context of medicating the mentally ill, this opinion established that some patients could be forcibly medicated in some situations, while others cannot be forcibly medicated at all.¹⁸ However, *Disabil-*

12. See, e.g., *Washington v. Harper*, 494 U.S. 210, 227 (1990) (holding sufficient due process for forced medication of mentally ill state prisoner existed).

13. See, e.g., *Disability Rights*, 796 F.3d at 310 (finding conditional extension pending placement (CEPP) patients cannot be forcibly medicated under New Jersey policy); *Riese v. St. Mary's Hospital*, 209 Cal.App.3d 1303, 1320 (Cal. Ct. App. 1987) (finding "antipsychotic drugs cannot be administered to involuntarily committed patients in non-emergency situations without their informed consent"). There is no single, uniform judicial standard for addressing forced medication policies in the civil context namely because few courts have addressed them and the Supreme Court has yet to consider the issue. For further discussion, see *infra* notes 14–16 and accompanying text.

14. 796 F.3d 293 (3d Cir. 2015); see *id.* at 294 (stating issue at hand was "whether mentally ill residents of New Jersey who have been committed to state custody are entitled to judicial process before they may be forcibly medicated in non-emergency situations").

15. See *id.* at 296 (discussing facts and parties to case).

16. See *id.* ("Unlike the Supreme Court, we have squarely addressed the right of civilly committed psychiatric patients to refuse psychotropic drugs."); see also *Rennie v. Klein*, 720 F.2d 266, 267–68 (3d Cir. 1983) [hereinafter *Rennie II*] (re-examining ruling in *Rennie I* on forced medication policy); *Rennie I*, 653 F.2d 836, 848 (3d Cir. 1981) (addressing constitutional challenges to New Jersey policy on forced medication of mentally ill).

17. See Fahad Ali & Kenneth J. Weiss, *The State Cannot Force Medications on Committed Patients Who Are No Longer Considered Dangerous*, 44 LEGAL DIG. 259, 261 (2016) (expressing general agreement with Third Circuit's ruling in *Disability Rights*). Of course, the underlying principle of the court's reasoning—that they prefer to trust the opinions of medical professionals over those of lawmakers—weighs heavily in favor of the state and parties that will be in like positions in cases in the future. See *Disability Rights*, 796 F.3d at 310 ("[W]hile judges have an important role to play in the civil commitment process, matters of medical treatment are more appropriately handled by medical professionals.").

18. See *Disability Rights*, 796 F.3d at 310 (finding patients with CEPP status cannot be forcibly medicated unless reevaluated via judicial proceeding and found to be dangerous). Conditional extension pending placement (CEPP) status, which will be discussed further in this Casebrief, essentially means that the patient has

ity Rights also established that the Third Circuit will generally defer to the opinions of medical professionals rather than those of judges and other lawmakers.¹⁹

This Casebrief offers advice to both civil rights and health law attorneys in the Third Circuit on how to address forced medication and similar medical claims from the perspective of both medical practitioners and patients.²⁰ Part II discusses the history of medication of the mentally ill and the development of policy for the forcible medication of civilly committed mental patients.²¹ Part III discusses both the background and the court's analysis in *Disability Rights*.²² Part IV addresses the court's rationale in *Disability Rights*.²³ Additionally, Part IV also provides advice to practitioners on both sides of the docket about how to effectively represent their clients.²⁴ Part V concludes this Casebrief by stressing the key takeaways of *Disability Rights* and how its holding can help both medical practitioners and mental patients alike.²⁵

II. ALAN'S PSYCHEDELIC BREAKFAST: THE DEVELOPMENT OF MENTAL HEALTH TREATMENT AND POLICY

Civilization has debated the proper methods to treat mentally ill patients for centuries.²⁶ The methods employed have ranged from locking the mentally ill away to administering lobotomies.²⁷ In the modern era, medication has been the preferred means to treat the mentally ill either

been deemed not dangerous as a matter of law and only remains in the hospital on a temporary basis as the patient awaits relocation for different treatment. *See id.* at 294–95. Since patients on CEPP status are by definition not dangerous, they cannot be forcibly medicated so long as they maintain that status. *See id.* at 310.

19. *See id.* at 310 (“[W]hile judges have an important role to play in the civil commitment process, matters of medical treatment are more appropriately handled by medical professionals. We conclude that the State’s approach comports with the demands of the Constitution and the Americans with Disabilities Act . . .”).

20. *See infra* notes 115–33 and accompanying text.

21. *See infra* notes 26–68 and accompanying text.

22. *See infra* notes 69–108 and accompanying text.

23. *See infra* notes 109–33 and accompanying text.

24. *See infra* notes 109–33 and accompanying text.

25. *See infra* notes 134–37 and accompanying text.

26. *See* Foerschner, *supra* note 3, at 1 (“Attempts to treat mental illness date back as early as 5000 BCE.”).

27. *See id.* at 1–4 (discussing many treatments historically used to treat mental illness). The methods varied among geographic regions, time periods, and cultures. *See id.* at 1–6 (discussing treatment methods used). During classical antiquity in Mesopotamia, people with mental illness were treated with religious and magic ceremonies that were believed to perform some sort of exorcism on the demons that supposedly resided in the individual. *See id.* at 1. In a seemingly forward-looking effort, the ancient Egyptians engaged their mentally ill in activities such as painting and dancing to return them to a sense of normalcy. *See id.*

with or without their consent.²⁸ The administration of antipsychotic medication became mainstream when it was introduced during the 1950s because it created a simpler, more humane mode of treating the mentally ill.²⁹ Even though antipsychotic medication helps to alleviate the major disruptive symptoms of mental illness, it can have equally disruptive and harsh side effects for the person taking it.³⁰ More philosophically, every person in the United States is entitled to autonomy and the right to choose what does or does not go into their own body.³¹ As a result, a number of issues have arisen over the years concerning the administration of antipsychotic medications in both the criminal and civil context.³² Specifically, the issue is whether forced or involuntary administration conflicts with concepts of due process, the right to privacy, the right to refuse treatment, informed consent, and medical ethics.³³

Policies of the last few decades that led to the discharge of a large portion of the civilian psychiatric population have, in turn, increased the population of mentally ill persons in prisons.³⁴ As a result, there has been

28. See Mary C. McCarron, Comment, *The Right to Refuse Antipsychotic Drugs: Safeguarding the Mentally Incompetent Patient's Right to Procedural Due Process*, 73 MARQ. L. REV. 477, 480–85 (1990) (discussing history of medication for treatment of mentally ill).

29. See *id.* at 480 (discussing introduction of medication to treat mental illness).

30. See *id.* at 477 (discussing nature of antipsychotic medication). Ultimately, side effects are numerous and could be either temporary or permanent. See *id.* at 482. Examples of temporary side effects include akathisia (restlessness or agitation), dystonia (muscle contractions), and Parkinsonian syndrome (has a number of “the same symptoms of Parkinson’s disease” but is different because it is temporary), all of which stop when the medication is discontinued. See *id.* at 482, 482 nn.30–32 (discussing side effects of antipsychotic medication). Examples of common, permanent side effects are tardive dyskinesia, a permanent “disorder characterized by involuntary” spasms in the face and mouth muscles that is untreatable, and neuroleptic malignant syndrome, which is fatal in 30% of cases. See *Washington v. Harper*, 494 U.S. 210, 239–40 (1994) (Stevens, J., concurring) (discussing neuroleptic malignant syndrome); McCarron, *supra* note 28, at 482 n.35 (discussing tardive dyskinesia). McCarron also writes that “[i]t is apparent that antipsychotic drugs produce effects that are independent of the volition of the patient and in this respect can be labeled intrusive.” See McCarron, *supra* note 28, at 482–83.

31. See *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972) (stating informed consent doctrine rooted in “concept, fundamental in American jurisprudence, that ‘[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body’” (quoting *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914))).

32. See Chuck Weller, *Forced Administration of Antipsychotic Drugs to Civilly Committed Mental Patients in Nevada: A Remedy Without a Clear Statutory Authorization*, 11 NEV. L.J. 759, 759–60 (2011) (discussing legal and medical hurdles to involuntary medication).

33. See *id.* at 763–64 (discussing hurdles that policies of forced medication face).

34. See 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, 157–58 (2000) (discussing implications of large mentally-ill population in United States).

an increase in litigation about medicating the mentally ill within the United States prison system.³⁵ The benchmark case on this topic is *Washington v. Harper*.³⁶ In that case, Harper argued that if he was going to be forced to take the medication, he was at least entitled to a judicial hearing prior to its administration.³⁷ The Supreme Court, however, held

that the regulation before us is permissible under the Constitution. It is an accommodation between an inmate's liberty interest in avoiding the forced administration of antipsychotic drugs and the State's interests in providing appropriate medical treatment to reduce the danger that an inmate suffering from a serious mental disorder represents to himself or others.³⁸

The Court also reasoned that the administrative hearing process that was used to determine whether Harper should be forcibly medicated was constitutional.³⁹ Though *Harper* was set in the criminal rather than the civil context, it is frequently cited by courts that are adjudicating forced medication cases in the civil context.⁴⁰

prison system). In his article, Stavis writes that the large volume of discharges over the past thirty years can be generally attributed to the discovery of psychotropic medications as well as "economic and bureaucratic influences." *See id.* at 158 (discussing implementation of psychotropic medications' impact on society). He goes on to assert that this "dehospitalization was either premature or poorly executed because formerly hospitalized patients are increasingly and often needlessly becoming prisoners." *See id.*

35. *See, e.g., Sell v. United States*, 539 U.S. 166, 186 (2003) (holding defendant could be involuntarily medicated in order to obtain competence to stand trial); *Washington v. Harper*, 494 U.S. 210, 236 (1990) (holding prisoners could be forcibly medicated if mentally ill and posed danger to self or others); *United States v. Cruz*, 757 F.3d 372, 384 (3d Cir. 2014) (holding state had interest in forcibly medicating defendant to ensure his competence for trial); *United States v. Baldovinos*, 434 F.3d 233, 243 (4th Cir. 2006) (holding defendant could be involuntarily medicated in order to stand trial); *Dancy v. Simms*, 116 F. Supp. 2d 652, 656–58 (D. Md. 2000) (holding involuntary medication of defendant did not violate due process).

36. 494 U.S. 210 (1990); *see Disability Rights N.J., Inc. v. Comm'r N.J. Dept. of Human Servs.*, 796 F.3d 293, 296 (3d Cir. 2015) (referring to *Harper* as "the most relevant of these cases for our purposes"). In *Harper*, a mentally ill man who had been in and out of prison for fourteen years for a robbery conviction challenged a Washington state policy that forced him to take antipsychotic medication. *See Harper*, 494 U.S. at 210. The policy in question stated that an inmate could be involuntarily medicated if the inmate had a "mental disorder" and the inmate posed a "likelihood of serious harm" to himself and others. *See id.*

37. *See id.* (discussing facts of case). Eventually, the plaintiff in *Disability Rights* would argue the same: if the patients were going to be forcibly medicated, they were entitled to a judicial hearing on the matter. *See Disability Rights*, 796 F.3d at 297 (discussing *Disability Rights* New Jersey's argument and remedy sought).

38. *Harper*, 494 U.S. at 236.

39. *See id.* (finding Washington policy did not violate Constitution's Due Process Clause).

40. *See, e.g., Disability Rights*, 796 F.3d at 296 ("*Harper* [is] the most relevant of these cases for our purposes . . ."); *Jurasek v. Utah State Hosp.*, 158 F.3d 506, 510–11 (10th Cir. 1998) (explaining that *Harper* adopted balancing test between prison inmate's liberty interest and state's interest in public health and safety).

Turning to the civil side, psychiatric facilities in the United States involuntarily hold and treat more than 1,000,000 patients annually.⁴¹ Around 2010, the year Disability Rights New Jersey brought its initial suit against New Jersey, state and private psychiatric hospitals in the state housed roughly 2,800 patients in five facilities.⁴² Relying in part on cases such as *Harper*, courts have historically held that civilly committed mental health patients can be forcibly medicated for a certain amount of time provided certain procedural requirements are met.⁴³ Still, irrespective of those certain procedural requirements, forced medication depends on the medical status of the civilian patient.⁴⁴ In New Jersey, this status could be either conditional extension pending placement (CEPP) or non-CEPP.⁴⁵ CEPP status means that the patient is deemed “not dangerous” (either by the hospital or by judicial review) and that the individual only remains in the state hospital for the amount of time necessary to be relocated to “appropriate placement.”⁴⁶ These patients may not be forcibly medicated except under the emergency provisions of various state policies, such as New Jersey’s.⁴⁷ Non-CEPP status means that the patient is not given a “not dan-

41. See William M. Brooks, *The Tail Still Wags the Dog: The Pervasive and Inappropriate Influence by the Psychiatric Profession on the Civil Commitment Process*, 86 N.D. L. REV. 259, 261 (2010) (discussing impact of civil commitment process on mentally ill population). See generally John A. Menninger, *Involuntary Treatment: Hospitalization and Medications*, BROWN UNIV.: DEP’T OF PSYCHIATRY, https://www.brown.edu/Courses/BI_278/Other/Clerkship/Didactics/Readings/INVOLUNTARY%20TREATMENT.pdf [<https://perma.cc/43ST-2B3T>] (last visited, August 2, 2017) (identifying medical and legal basis for institutionalization).

42. See Richard Perez-Pena, *New Jersey Is Sued over the Forced Medication of Patients at Psychiatric Hospitals*, N.Y. TIMES (Aug. 3, 2010), <http://www.nytimes.com/2010/08/04/health/policy/04psych.html> (“There are about 1,800 patients at any given time in New Jersey’s five state psychiatric hospitals, and 1,000 in private ones.”).

43. See, e.g., *Disability Rights*, 796 F.3d at 308 (holding portion of New Jersey policy that forcibly medicates non-CEPP patients is constitutional). The Third Circuit likely upheld that portion of New Jersey’s policy because it was a comprehensive, multi-step process that has a number of safeguards, including (1) mandatory reports describing the diagnosis, treatment plan, and reason as to why “patient satisfies the substantive standard”; (2) meeting by an objective panel of doctors who are not involved in the patient’s care; and (3) the right of the patient “to appeal the panel’s decision.” See *id.* at 298–99 (discussing steps of New Jersey policy); see also *infra* notes 57–68 and accompanying text for description of the *Rennie* Process.

44. See *Disability Rights*, 796 F.3d at 307–10 (discussing why non-CEPP patients can be forcibly medicated while CEPP patients cannot).

45. See *id.* at 295, 307–10 (discussing differences between CEPP and non-CEPP status, and finding CEPP patients could not be forcibly medicated so long as they maintained that status).

46. See *id.* at 295 (“Patients on CEPP status remain in the hospital only because an appropriate alternative placement is unavailable; their status is reviewed within 60 days of the CEPP order’s issuance and then periodically at intervals no longer than six months.”); Ali & Weiss, *supra* note 17, at 259 (discussing definition of CEPP status).

47. See *Disability Rights*, 796 F.3d at 300 (agreeing with lower court’s finding that “[CEPP] patients have already been found by a court of law not to be danger-

gerous” status and that the individual remains in the hospital for further treatment.⁴⁸ Non-CEPP patients can be forcibly medicated in any situation (emergency or non-emergency) provided certain medical procedures are met.⁴⁹

The Supreme Court has yet to rule on the standards for policies mandating the medication of patients who bring a civil suit.⁵⁰ Nevertheless, in addition to *Harper*, the Supreme Court heard another case that is vital to analysis in forced medication cases: *Mathews v. Eldridge*.⁵¹ In *Mathews*, the plaintiff’s disability benefits from the Social Security Administration were terminated.⁵² The plaintiff argued that before the Administration could cancel his benefits, some form of judicial hearing had to be held to determine whether he could receive a continuation on the benefits.⁵³ The Court held that the plaintiff was not entitled to such a hearing based on the balancing of three factors: (1) “private interests [affected by] the official action,” (2) “the risk of . . . deprivation” of interest “through the procedures used,” and (3) the “government’s interest.”⁵⁴ This test was used to determine the issues in *Harper* and was significantly relied on by the Third Circuit in *Disability Rights*.⁵⁵

ous, and any ‘volatility’ or relapse into dangerousness could be addressed using the emergency provisions of AB 5:04A or the recommitment process”).

48. *See id.* (stating non-CEPP “treatment is not based on disability, but based on a finding of dangerousness” (quoting *Disability Rights N.J., Inc. v. Velez*, 974 F. Supp. 2d 705, 711 (D.N.J. 2013))). By definition, non-CEPP is the opposite of CEPP. *See id.*

49. *See id.* at 310 (holding New Jersey’s “approach [to non-CEPP patients] comports with the demands of the Constitution and the Americans with Disabilities Act, except as to CEPP patients”).

50. *See id.* at 296 (“The Supreme Court has never decided whether civilly committed individuals have a constitutional right to refuse psychotropic drugs.”). Again, though the Court has addressed forced medication in prisons, as a general matter, it has never explicitly addressed its application to the civil context. *See id.* (noting that court never addressed forced medication in civil context).

51. 424 U.S. 319 (1976); *see also* *Washington v. Harper*, 494 U.S. 210, 229–31 (1990) (using *Mathews*’s balancing test to determine decision to medicate Harper was best left to medical professionals); *Disability Rights*, 796 F.3d at 309 (using *Mathews* to analyze procedural due process rights in forced medication claim).

52. *See Mathews*, 424 U.S. at 324 (discussing facts of case).

53. *See id.* at 324–25 (discussing plaintiff’s argument).

54. *See id.* at 335 (promulgating three step balancing test for procedural due process claims). The exact test was that the court addressing the claim should consider:

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government’s interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

Id. at 335.

55. *See Harper* 494 U.S. 229–31 (using *Mathews*’s balancing test to determine decision to medicate Harper was best left to medical professionals); *Disability*

Five years after *Mathews*, the Third Circuit directly addressed the question of forced medication in the civil context in *Rennie v. Klein (Rennie I)*⁵⁶ and *Rennie v. Klein (Rennie II)*.⁵⁷ In *Rennie I*, the Third Circuit found that a civilly committed patient did have the “qualified constitutional right to refuse antipsychotic medication,” but that a patient’s decision to refuse the medication could be overridden by a process that became known as the “*Rennie Process*.”⁵⁸ Though the Supreme Court ordered a rehearing of the case, the same result was ultimately reached again in *Rennie II*.⁵⁹ The *Rennie Process* was utilized by New Jersey until it was sued by Disability Rights New Jersey in 2012.⁶⁰

In New Jersey, the *Rennie Process* was codified by New Jersey Department of Human Services Division of Mental Health and Addiction Services

Rights, 796 F.3d at 309 (using *Mathews* to analyze procedural due process rights in forced medication claim).

56. 653 F.2d 836 (3d Cir. 1981). Note that there are two *Rennie* cases because the Supreme Court remanded the first case back to the Third Circuit for rehearing. See *Disability Rights*, 796 F.3d at 297 (discussing *Rennie I* and *Rennie II*). The Third Circuit does not consider that remanding of *Rennie* an instance in which the Supreme Court directly addressed involuntary medication in the civil context because the Court simply vacated the decision and did not reverse it. See *id.* at 296–97.

57. 720 F.2d 266 (3d Cir. 1983) [hereinafter *Rennie III*]; see also *Disability Rights*, 796 F.3d at 297 (discussing *Rennie I* and *Rennie II*).

58. See *Rennie I*, 653 F.2d at 854 (Seitz, J., concurring) (explaining that patients have qualified right to refuse medication). The *Rennie Process* was the three-step administrative process by which a patient could be forced to take antipsychotic medication. See *Disability Rights*, 796 F.3d at 296–97. *Disability Rights* provides an overview of the *Rennie Process*:

(1) At the first level, when a patient refuses to accept medication, the treating physician must explain to the patient the nature of his condition, the rationale for using the particular drug, and the risks or benefits of it as well as those of alternative treatments. (2) If the patient still declines, the matter is discussed at a meeting of the patient’s treatment team, which is composed of the treating physician and other hospital personnel, such as psychologists, social workers, and nurses who have regular contact with the patient. The patient is to be present at this meeting if his condition permits. (3) If, after the team meeting, the impasse remains, the medical director of the hospital or his designee must personally examine the patient and review the record. In the event the director agrees with the physician’s assessment of the need for involuntary treatment, medication may then be administered. The medical director is also authorized, but not required, to retain an independent psychiatrist to evaluate the patient’s need for medication. Finally, the director is required to make a weekly review of the treatment program of each patient who is being drugged against his will to determine whether the compulsory treatment is still necessary.

Id. (quoting *Rennie I*, 653 F.2d at 848–49).

59. See *Rennie II*, 720 F.2d at 269 (holding patients can refuse forced medication unless they pose danger to themselves or others).

60. See *Disability Rights*, 796 F.3d at 296, 298 (“New Jersey adopted Administrative Bulletin 78-3, which became known as the ‘*Rennie process*. . . .”).

Administrative Bulletin 78-3 (AB 78-3).⁶¹ AB 78-3 implemented a three-step process that required the following before a patient could be forcibly medicated: (1) psych-education for the civil patient's treating psychiatrist or physician, (2) a treatment team meeting that discussed the possibility of forced medication, and (3) an evaluation of the patient by the facility's medical director or designee.⁶² AB 78-3 was replaced in 2012 with the more comprehensive policies described in Administrative Bulletin 5:04A (AB 5:04A) and Administrative Bulletin 5:04B (AB 5:04B).⁶³

Under the emergency provisions of AB 5:04A, a patient can be forcibly medicated for up to three days while imminently dangerous but must be reassessed every twenty-four hours.⁶⁴ Under the non-emergency provisions of AB 5:04B, an involuntarily committed patient can be forcibly medicated only when the untreated mental illness poses a serious risk of harm

61. *See id.* at 296 (discussing adoption of AB 78-3). AB 78-3 was only adopted in response to the plaintiff's suit in *Rennie*. *See id.* at 296 (describing adoption of AB 78-3). That codification and the change that came again in 2012 go to show that to make a real change, all that often need to happen is to file suit and the change will come even before the judgment is handed down. *See generally id.* at 296–98 (describing *Rennie* process and subsequent legislation).

62. *See id.* at 296–97 (discussing the procedure required under AB 78-3).

63. *See id.* at 298 (“In June 2012, while Disability Rights’ lawsuit remained pending, the State replaced the *Rennie* process with two separate policies for forcible treatment in emergencies (AB 5:04A) and nonemergent situations (AB 5:04B).”). The “Policy” section of AB 5:04A states, “[a]ll patients must be given the opportunity to consent to the administration of psychotropic medications and necessary tests and co-medications. In an emergency, as defined herein, any patient regardless of legal status . . . may be given such treatment by following the procedure herein.” DIVISION MENTAL HEALTH & ADDICTION SERVS., N.J. DEP’T OF HUMAN SERVS., ADMINISTRATIVE BULLETIN A.B. 5:04A: THE EMERGENCY EXCEPTION TO THE NECESSITY TO OBTAIN CONSENT TO TREATMENT WITH PSYCHOTROPIC MEDICATIONS (June 4, 2012) [hereinafter A.B. 5:04A]. AB 5:04A then goes on to detail the procedure that must be met. *See id.* (describing treatment procedure). The “Procedure” section of AB 5:04B states,

In a non-emergency situation, when an involuntary patient . . . does not provide or cannot provide consent to the proposed administration of psychotropic medication after being given the opportunity to consent pursuant to the informed consent policy, and the patient’s prescriber documents that the patient has been diagnosed with a mental illness, and, as a result of mental illness, poses a likelihood of serious harm to self, others, or property without the medication, the treating prescriber shall initiate the Involuntary Medication Procedure as follows, if he or she has determined, after considering less restrictive interventions, that medication is appropriate[.]

DIVISION MENTAL HEALTH & ADDICTION SERVS., N.J. DEP’T OF HUMAN SERVS., ADMINISTRATIVE BULLETIN A.B. 5:04B: THE EMERGENCY EXCEPTION TO THE NECESSITY TO OBTAIN CONSENT TO TREATMENT WITH PSYCHOTROPIC MEDICATIONS (June 4, 2012) [hereinafter A.B. 5:04B].

64. *See* A.B. 5:04A(V)(C) (discussing procedure for emergency forced medication policy). This section of the policy states: “[a]t least every 24 hours during the 72 hours, the nursing staff assigned to the patient shall document any effects of the medication, both positive and negative” *See id.*

to self, others, or property.⁶⁵ AB 5:04B is more controversial than AB 5:04A because it addresses the forcible medication of patients in non-emergency situations, i.e., situations where the patient did not pose an imminent threat to safety.⁶⁶ AB 5:04B also details a number of steps for an administrative hearing process before the medication can be involuntarily administered.⁶⁷ These steps include: (1) submission of a medical report

65. See A.B. 5:04B(I)(A)(1) (stating 5:04B applies where mental health patient “poses a likelihood of serious harm to self, others, or property if psychotropic medication is not administered”).

66. See *Disability Rights*, 796 F.3d at 298–99 (discussing details of New Jersey administrative bulletins 5:04A and 5:04B). The fact that Disability Rights New Jersey was only challenging AB 5:04B shows that it was the more controversial administrative bulletin. See *id.* (describing stringent requirements of 5:04B).

67. See *id.* at 298–99 (discussing AB 5:04B). Because the exact policy is lengthy, the court in *Disability Rights* provided a succinct summary of it:

First, the patient’s treating physician must complete an involuntary medication administration report, which documents the patient’s diagnosis, the medication and dosage contemplated, the rationale for concluding that the patient satisfies the substantive standard outlined above, the less restrictive alternatives considered and rejected, the efforts made to explain to the patient the need for medication, and any objections expressed by the patient. Next, the hospital’s medical director appoints a three-person panel chaired by a psychiatrist who may be a hospital employee but who may not be currently involved in the patient’s treatment. The other members of the panel must be a hospital administrator and a clinician, neither of whom may be currently involved in the patient’s treatment.

At a medication review hearing held on the patient’s ward within five days of the involuntary medication administration report being submitted to the medical director, the panel hears evidence to determine whether to approve involuntary medication. The patient has the right to be notified of the hearing, attend the hearing, testify, present evidence and witnesses, cross-examine witnesses, and have a mental health professional or legal counsel present (at the patient’s expense). The patient is also afforded the assistance of the hospital’s client services advocate, a psychiatric nurse who consults with the patient and assists him in presenting evidence and making objections at the hearing. After the hearing, involuntary medication will be authorized only if the chair and at least one other member of the panel agree that the substantive standard is satisfied. The patient has 24 hours to appeal the panel’s decision to the medical director, and administration of the medication can begin immediately if the panel’s decision is affirmed. Any further appeal must be made to the Appellate Division of the New Jersey Superior Court.

The initial approval of forcible medication is valid for 14 days. Within 12 days of that approval, the treating psychiatrist must report on the patient’s positive and negative responses to the medication, what less restrictive interventions have been attempted or ruled out, and whether the patient is continuing to withhold consent. A panel—which need not comprise the same people as before—may then authorize forcible medication lasting up to 90 days. Throughout that period, the treating prescriber must submit biweekly reports to the medical director detailing the patient’s progress. If, at the end of 90 days, the patient still does not consent to medication, the hospital must start the entire process over again in order to continue the forcible medication.

by the patient's psychiatrist, (2) a review of the report by a medical panel, (3) the right of the patient to testify and call witnesses at a hearing held by the panel, and (4) the patient's right to appeal the panel's decision to forcibly medicate to a New Jersey state court.⁶⁸

III. CAREFUL WITH THAT NEEDLE, NEW JERSEY: THE THIRD CIRCUIT ADDRESSES *DISABILITY RIGHTS*

When New Jersey's forced medication policy changed after nearly thirty years in 2012, Disability Rights New Jersey still was not satisfied.⁶⁹ Under the revised policy, even the sanest and least dangerous of New Jersey's psychiatric patients could still be forcibly medicated.⁷⁰ Contrary to Nurse Ratched's advice, Disability Rights New Jersey would not go on with its daily routine.⁷¹

A. *Mother, Should I Trust the Government? Facts and Procedure of Disability Rights*

Disability Rights New Jersey is a nonprofit, government-funded organization that was formed in 1994 to advocate for citizens with disabilities.⁷² In August 2010, Disability Rights New Jersey filed suit against the New Jersey Department of Human Services in the United States District Court of the District of New Jersey claiming the *Rennie* Process violated provisions of the United States Constitution, Americans with Disabilities Act (ADA), and the Rehabilitation Act of 1973.⁷³ Disability Rights New Jersey asked for declaratory and injunctive relief that would invalidate the *Rennie* Process as a whole and requested that any new procedure require the state

Id. (citation and internal quotations omitted).

68. *See id.* (discussing AB 5:04A and AB 5:04B). *See generally* Roy F. Harmon & A.G. Harmon, *Weight Medical Judgments: Explaining Evidentiary Preferences for Treating Physician Opinions in ERISA Cases After Black & Decker Disability Plan v. Nord*, 13 MICH. ST. U. J. MED. & L. 157, 157–58 (2009) (discussing correct evidentiary weight that should be afforded to medical opinions).

69. *See Disability Rights*, 796 F.3d at 299 (“New Jersey’s replacement of the *Rennie* process with the Policy did not resolve the litigation because the Policy did not go as far as Disability Rights requested in its complaint.”).

70. *See generally* A.B. 5:04A(I)–(VII) (allowing New Jersey psychiatric facilities to forcibly medicate CEPP patients).

71. *See ONE FLEW OVER THE CUCKOO’S NEST* (Fantasy Films 1975). Nurse Ratched, the film’s famous villain, at one point attempts to calm a crowd of angry patients who gathered to protest her involvement in another patient’s suicide. *See id.* (depicting scene in film). In attempt to calm the crowd, Nurse Ratched says, “[n]ow calm down. The best thing we can do is go on with our daily routine.” *Id.*

72. *See About DRNJ*, DISABILITY RIGHTS N.J., <http://www.drnj.org/aboutdrnj.htm> [<https://perma.cc/4G5E-9RDP>] (last visited Feb. 13, 2017) (explaining DRNJ’s mission). More specifically, DRNJ has nine federally funded programs, including the program “Protection and Advocacy for Individuals with Mental Illness.” *See id.* DRNJ is funded principally by the United States Department of Health and Human Services, the Department of Education, and the Social Security Administration. *See id.*

73. *See Disability Rights*, 796 F.3d at 297 (discussing procedural posture).

to provide judicial hearings before patients could be medicated in non-emergency situations.⁷⁴ New Jersey immediately moved to dismiss Disability Rights New Jersey's assertions by arguing that the *Rennie* cases strictly precluded such claims.⁷⁵ But the district court refused the state's request based on *Rennie I* and the Court's decision in *Harper*.⁷⁶ In March 2012, New Jersey moved to vacate, which the court granted.⁷⁷

As previously mentioned, just a few months after its motion to vacate was granted, New Jersey revised its forcible medication policy by replacing the *Rennie* Process with AB 5:04A and AB 5:04B.⁷⁸ Still, the replacement did not go as far as Disability Rights wanted because the new policy did not "require premedication judicial process, a 'clear and convincing' showing of incompetence, a right to counsel in medication review proceedings, or a right to appointed experts."⁷⁹ Specifically, Disability Rights New Jersey challenged AB 5:04B's medication of patients in non-emergency situations, claiming that it allowed the state to discriminate based on mental health status and to forcibly medicate certain citizens without the process

74. *See id.* (discussing relief requested by plaintiffs). The DRNJ complaint actually asked for more than just a judicial hearing in such non-emergency situations. *See id.* It also requested

a requirement that nonemergent forcible medication take place only after a finding that the patient is incompetent to make medical decisions; a right to counsel at the hearing; establishment of a system of "experienced and knowledgeable" counsel to advocate for patients' interests; a right to have independent expert witnesses appointed; imposition of a "clear and convincing evidence" burden of proof in forcible medication proceedings; assurance that hospital staff would be properly trained in the administration of psychotropic drugs; and a requirement that the State report monthly to Disability Rights on its use of psychotropic medication in psychiatric hospitals.

Id. These were essentially all the due process requests that New Jersey adopted when it replaced the *Rennie* Process with 5:04A and 5:04B in 2012. *See id.* at 298–300.

75. *See id.* at 298 (discussing New Jersey's argument that cited the Third Circuit's *Rennie* decision).

76. *See id.* (addressing district court's treatment of New Jersey's argument). With regards to *Rennie I*, the court stated that case "specifically held that the involuntarily committed patients were to be accorded no fewer constitutional protections than prisoners." *See id.* (quoting *Disability Rights N.J., Inc. v. Valez*, Civ. No. 10-3950(DRD), 2011 WL 2976849, at *9 (D.N.J. July 20, 2011)). When it came to denying the motion based on *Harper*, the court stated that case stood for the proposition that "mentally ill prisoners facing forcible medication were entitled to procedural protections that 'dwarf[ed]' what the *Rennie* process provided." *See id.* at 298 (quoting *Disability Rights*, 2011 WL 29676849, at *10).

77. *See id.* (discussing district court's grant of motion to vacate).

78. *See id.* (discussing New Jersey's adoption of new forced medication policy).

79. *See id.* at 299 (discussing Disability Rights' issues with revised New Jersey policy).

they were entitled to.⁸⁰ Both parties then filed for summary judgment.⁸¹ The district court held that the revised New Jersey policies withstood all of Disability Rights New Jersey's claims, except when it came to the forcible medication of patients with CEPP status.⁸² The district court upheld the policy as it pertained to non-CEPP patients because the policy was a "legitimate safety requirement" and because the discrimination in the policy was not based on disability but on "a finding of dangerousness."⁸³ When it came to CEPP patients, however, the policy did not pass muster because those patients were "found by a court of law not to be dangerous" and that any "relapse into dangerousness" could easily be handled by AB 5:04A's emergency provision.⁸⁴ Unsatisfied with the judgment, Disability Rights New Jersey appealed the decision to uphold the process with respect to non-CEPP patients to the Third Circuit.⁸⁵

B. *Hey! Doctor! Leave Them CEPP Patients Alone! The Third Circuit's Analysis in Disability Rights*

On appeal, the Third Circuit upheld the district court's judgment.⁸⁶ In doing so, the court first addressed one of the most important questions: whether the New Jersey policy was discriminatory within the framework of the ADA.⁸⁷ The court answered that question negatively and held that the "fatal defect" in Disability Rights' ADA claim was that the right to judicial process before medication is forcibly administered "does not exist in New Jersey for nondisabled people."⁸⁸ To the court, this showed that a denial

80. *See id.* (discussing Disability Rights New Jersey's argument with respect to AB 5:04B). Disability Rights did not challenge the AB 5:04A policy that "a patient who 'presents a risk of imminent or reasonably impending harm or danger to self or others' can be forcibly medicated for up to 72 hours unless a less restrictive alternative method is available." *See id.* at 298. Perhaps that was in part due to the necessary safety measures it imposes, or perhaps it was because patients subject to forced medication under AB 5:04A must be reassessed every twenty-four hours after that initial seventy-two-hour period "to determine whether the emergency persists." *See id.*

81. *See id.* at 299 (stating "the parties filed cross-motions for summary judgment").

82. *See id.* at 300 (discussing district court's holding and reasoning).

83. *See id.* (quoting Disability Rights N.J., Inc. v. Velez, 974 F. Supp. 2d 705, 739 (D.N.J. 2013)).

84. *See id.* (discussing district court's holding that deferred to AB 5:04A).

85. *See id.* at 299–300 (discussing Disability Rights New Jersey's appeal that claimed New Jersey's new policy still did not provide sufficient due process).

86. *See id.* at 310 ("We therefore affirm the District Court's summary judgment for Disability Rights on the due process claim with respect to CEPP patients.").

87. *See id.* at 301–02 (explaining that ADA claim requires that "public entity" that provides benefits may not exclude disabled individual from receiving same benefits).

88. *See id.* at 304 (explaining that Disability Rights New Jersey argued that right to refuse medication is "benefit" being denied to plaintiffs).

of such a right for mentally disabled patients is not discriminatory.⁸⁹ Though it was true that people are entitled to judicial process before being committed, there is no premedication judicial process for anyone in New Jersey.⁹⁰ Disability Rights New Jersey's ADA claim did not allege that disabled people were "denied some [service, program, activity, or] benefit that a public entity [had] extended to nondisabled people."⁹¹ Therefore, the policy withstood the ADA claim.⁹²

The court then turned to Disability Rights New Jersey's due process claims with a particular focus on its procedural due process claims.⁹³ Because the New Jersey policy addressed both non-CEPP and CEPP patients,

89. *See id.* (discussing merits of ADA claim). Title II of the ADA states, "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132 (2012). However, states do not have to comply with all ADA provisions if a disabled person "pose[s] a 'direct threat' to others, as long as the States make these determinations using comprehensive 'individualized assessment[s].'" *See Disability Rights*, 796 F.3d at 301 (quoting 28 C.F.R. § 35.139(b) (2017)).

90. *See id.* at 304 (noting that Disability Rights New Jersey conceded as much in its brief).

91. *See id.* at 306 (discussing Disability Rights New Jersey's inability to establish prima facie case for ADA claim). To establish a prima facie case under the ADA, a plaintiff "must show that he is a 'qualified individual with a disability'; that he was excluded from a service, program, or activity of a public entity; and that he was excluded because of his disability." *See id.* at 301.

92. *See id.* at 307 ("[W]e hold that Disability Rights has failed to allege a prima facie violation of Title II of the ADA . . ."). The court talked at length about Disability Rights New Jersey's inability to identify the exact "service, program, or activity" mental health patients were not being offered by the State. *See id.* at 301–07. At oral argument, Disability Rights New Jersey argued that the service or program not offered to psychiatric patients was "the right to judicial process before being administered medication in nonemergent situations." *See id.* at 302. However, in its brief to the court, it also referred to the service or program as "the right to refuse medical treatment." *See id.* The court did not take this betrayal of "considerable confusion over the nature of the service, program, or activity in question" lightly. *See id.* at 302. After discussing the numerous contradictory statements Disability Rights New Jersey made on the subject, the court concluded that the service, program, or activity in question was the right to judicial process before being forcibly medicated. *See id.* at 303. In doing so, the court stated:

Here, there is no debate that the remedy demanded by Disability Rights is an order requiring New Jersey to provide judicial hearings (and associated procedural protections) prior to nonemergent forcible medication. Where, as here, a party clearly articulates the remedy sought but offers shifting or perhaps ambiguous indications as to the corresponding service, program, or activity, we can (and should) infer from that remedy the true identity of the service, program, or activity. The undisputed fact that Disability Rights seeks only a procedural remedy is thus compelling evidence that the service, program, or activity is procedural too.

Id. at 304 (citation omitted).

93. *See id.* at 307 ("Having rejected Disability Rights' statutory claims, we turn now to its constitutional claims. The District Court split its analysis of the due process claim into substantive and procedural components, but we focus on procedural due process.").

the court broke up its due process analysis into two parts, discussing the implications for the non-CEPP patients first.⁹⁴ To the judges on the panel, the policy at issue in *Harper* was virtually identical to the New Jersey policy at hand.⁹⁵ As such, the panel relied on the precedent *Harper* established and the test the Supreme Court relied on in that case: the *Mathews* balancing test.⁹⁶ Recall the *Mathews* test requires that a court considering procedural due process claims on forcible medication balance the patient's interest in avoiding unwanted medication with the state's interest in safety in security.⁹⁷ In *Harper*, the plaintiff's claim was rejected under *Mathews* because his interests did not outweigh state's interests.⁹⁸ Moreover, the *Harper* Court emphasized that "[t]he risks associated with antipsychotic drugs are for the most part medical ones, best assessed by medical professionals."⁹⁹ With regards to Disability Rights New Jersey's claim concerning AB 5:04A and non-CEPP patients, the Third Circuit applied the same test and line of reasoning concerning medical opinions and rejected the due process claims concerning those patients.¹⁰⁰

Next, the court analyzed the issue of forcibly medicating CEPP patients.¹⁰¹ The court found that, because CEPP patients have already been adjudged not dangerous by a court of law, *Harper* did not apply.¹⁰² Because *Harper* did not apply, the court leaned heavily on the *Mathews* balancing test and considered: (1) the affected private interest, (2) "the risk

94. *See id.* ("Because the due process analysis is different for non-CEPP and CEPP patients, we evaluate them separately.").

95. *See id.* ("As Disability Rights admits, New Jersey's Policy is essentially identical to the Washington policy at issue in *Harper*, which required approval of forcible medication by a three-person committee accompanied by various other procedural protections." (citation omitted)).

96. *See id.* (relying on *Harper* precedent to identify proper due process analysis to apply); *see also* *Washington v. Harper*, 494 U.S. 210, 228 (1990) (utilizing *Mathews* balancing test).

97. *See Disability Rights*, 796 F.3d at 307–08 (discussing *Mathews* balancing test in context of *Harper* decision).

98. *See Harper*, 494 U.S. at 236 ("[W]e hold that the [Washington state policy] is permissible under the Constitution. It is an accommodation between an inmate's liberty interest in avoiding the forced administration of antipsychotic drugs and the State's interests in providing appropriate medical treatment to reduce the danger that an inmate suffering from a serious mental disorder represents to himself or others.").

99. *See id.* at 231, 233 ("[W]e conclude that an inmate's interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge.").

100. *See Disability Rights*, 796 F.3d at 307–09 (discussing *Harper* and agreeing with its application of *Mathews* and opinion regarding expertise of medical professionals in adjudging whether to forcibly medicate mentally ill patients).

101. *See id.* at 309–10 (discussing constitutional claims pertaining to forced medication of CEPP patients).

102. *See id.* at 309 ("Disability Rights is correct that *Harper* . . . does not control with respect to CEPP patients."). The court's rationale in this respect was that prisoners, as the plaintiff was in *Harper*, are not adjudged by a court of law as "not dangerous," as civil CEPP patients are. *See id.*

of an erroneous deprivation of such interest” if the policy was carried out as proscribed, and (3) the government’s interest.¹⁰³ First, the Third Circuit agreed with the district court that the civil patient’s interest in avoiding the unwanted administration of antipsychotic drugs is significant, especially “when a court of law has already declared [the patient] fit to return to life in the community.”¹⁰⁴ Next, the court found the risk of erroneous results was high because allowing hospitals to decide to forcibly medicate CEPP patients would allow doctors to easily overrule any judicial determination that the patients were no longer dangerous.¹⁰⁵ Last, the government’s interest in forcibly medicating CEPP patients was “slight” because the AB 5:04A emergency policy already accounted for the scenario when CEPP patients relapsed into dangerousness.¹⁰⁶ In addition to its conclusions on those factors, the court also found that any “‘fiscal or administrative burden’ imposed on New Jersey by a judicial hearing requirement for CEPP patients would be light.”¹⁰⁷ For these reasons, the court held the New Jersey policy of forcibly medicating non-dangerous, CEPP patients was unconstitutional.¹⁰⁸

103. *See id.* (applying *Mathews* balancing test (quoting *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976))).

104. *See id.* (applying first prong of *Mathews* and agreeing with district court). Analyzing the first prong of *Mathews*, the court stated: “Psychotropic medication alters and regulates the patient’s cognitive processes and can trigger serious side effects. A patient’s interest in avoiding such an invasion of his bodily integrity can only be greater when a court of law has already declared him fit to return to life in the community.” *See id.* (citation omitted).

105. *See id.* (applying second prong of *Mathews* balancing test). The court stated:

When New Jersey applies the Policy to a CEPP patient, it effectively vacates a court’s prior determination that the patient is not dangerous. Such a decision may be appropriate in some circumstances—CEPP patients are only entitled to judicial review hearings every six months after their first 60 days on CEPP status, so they have plenty of time in State custody in which to relapse into dangerousness. But allowing the Policy to be applied to CEPP patients would permit the State to forcibly medicate a patient just a few days after a judge has deemed the patient no longer dangerous.

Id. (citation omitted).

106. *See id.* at 309 (characterizing New Jersey’s interest in AB 5:04B as “slight”).

107. *See id.* at 309–10 (discussing and applying third prong of *Mathews* balancing test (quoting *Mathews*, 424 U.S. at 335)). During trial, the State of New Jersey admitted that it “‘very rarely’ sought to forcibly medicate CEPP patients pursuant to [its policy].” *See id.* at 309. It further admitted that “providing judicial process for *all* psychiatric patients would result in just a five-percent increase in hearings,” which the court interpreted as evidence of a miniscule financial burden on the State if it provided such hearings for CEPP patients alone. *See id.* at 309–10.

108. *See id.* at 310 (finding New Jersey policy unconstitutional on issue of forcibly medicating CEPP patients).

IV. THE DIVISION BELL: ADDRESSING FORCIBLE MEDICATION CLAIMS IN
THE THIRD CIRCUIT POST-*DISABILITY RIGHTS*

The Third Circuit's holding in *Disability Rights* indicates one overarching principle: deference to the opinions of medical experts on medical issues.¹⁰⁹ Though this deference was not an original pillar of the Third Circuit's reasoning, the Third Circuit chose to adopt it for the same reasons the Supreme Court did in *Harper*.¹¹⁰ In *Harper*, the Supreme Court rejected "the notion that forcible medication decisions had to be made by judges rather than medical professionals."¹¹¹ This was because "[t]he risks associated with antipsychotic drugs are for the most part medical

109. *See id.* at 310 (looking to *Harper* for justification that "it is less than crystal clear why lawyers must be available to identify possible errors in medical judgment" (quoting *Washington v. Harper*, 494 U.S. 210, 236 (1990))). In the court's opinion, there were experts on nearly every subject, and there is no one better than mental health professionals when it comes to medicating the mentally ill. *See id.* The court was reluctant to insert a judge's opinion in a matter where the opinion was best left to the professional of that field. *See id.* ("New Jersey determined that, while judges have an important role to play in the civil commitment process, matters of medical treatment are more appropriately handled by medical professionals."). This was especially true because, as the court pointed out, judges are already involved in the civil commitment process when deciding to commit patients and, potentially, if the patients appeal their forcible medication order to a state court. *See id.* at 299.

110. *See Harper*, 494 U.S. at 231, 236 (discussing need to defer to medical judgment); *see also Disability Rights*, 796 F.3d at 310 (discussing deference to medical opinions over judicial opinions). Both the Supreme Court in *Harper* and the Third Circuit in *Disability Rights* emphasized the patient's interest in having decisions to forcibly medicate be made by medical professionals rather than judges. *See Harper*, 494 U.S. at 231 (discussing importance of decisions by medical professionals); *see also Disability Rights*, 796 F.3d at 310 (refusing to substitute judicial opinions for medical diagnoses). In *Disability Rights*, the Third Circuit put it this way:

We note that Disability Rights would have us unravel a policy that may well be equal or superior to the judicial model it demands. The State asserts that the Policy was developed at least in part with bona fide concerns for patient welfare in mind. Disability Rights has not produced any evidence that judicial hearings would more effectively prevent unnecessary medication than the Policy—for example, it has not shown that psychiatric patients are medicated with appreciably less frequency in States that do provide judicial process. While it urges us to extend the coverage of Title II beyond what the statute will bear, Disability Rights also fails to show that invalidating the Policy would actually serve the interests of psychiatric patients in New Jersey.

Disability Rights, 796 F.3d at 306–07 (footnotes omitted) (citation omitted).

111. *See id.* at 308 (discussing *Harper* Court's rejection of injecting judicial decision making into all medical decisions). One area of the *Harper* opinion in which the Court assented to the opinions of medical professionals came when the Court stated, "[n]otwithstanding the risks that are involved, we conclude that an inmate's interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge." *Harper*, 494 U.S. at 231.

ones, best assessed by medical professionals.”¹¹² Similarly, the Third Circuit conformed to New Jersey’s rationale for its forcible medication policy, which maintained that while judges are important to the civil commitment process, decisions to medicate and other aspects of medical treatment are decisions that are best left to medical professionals.¹¹³ Ultimately, the adoption of this rationale in the Third Circuit proves to be a positive for medical practitioners and their attorneys, while it will likely make claims similar to those advanced by Disability Rights New Jersey tougher for advocates for those with mental or intellectual disabilities to assert.¹¹⁴

A. *Waiting for Someone or Something to Show You the Way: Advice for Medical Practitioners and Their Attorneys*

The response from mental health practitioners to *Disability Rights* has been favorable.¹¹⁵ There were two key concepts—one legal and the other practical—that arose from *Disability Rights* that attorneys for medical practitioners should assert if they find themselves arguing a due process case in the medical sphere.¹¹⁶ Legally, *Disability Rights* allows doctors to implement health procedures that are necessary to keep the patient and others

112. See *Disability Rights*, 796 F.3d at 308 (discussing how deference to medical opinions rather than judicial ones is in best interest of mentally-ill prisoner (quoting *Harper*, 494 U.S. at 233)). “A State may conclude with good reason that a judicial hearing will not be as effective, as continuous, or as probing as administrative review using medical decisionmakers.” *Id.*

113. See *Disability Rights*, 796 F.3d at 310 (“New Jersey determined that, while judges have an important role to play in the civil commitment process, matters of medical treatment are more appropriately handled by medical professionals.”).

114. See *id.* at 306–10 (adopting general deference to medical opinions in due process claims pertaining to involuntary medication of mentally ill).

115. See *Ali & Weiss*, *supra* note 17, at 261 (“We agree that the court’s nuanced reasoning will advance these adjudications.”). More generally, many mental health professionals agree that involuntary commitment and sometimes involuntary medication are necessary because “patients may recognize their symptoms as part of an illness, but disagree with and refuse recommended treatment[,]” which could cause them to harm themselves or others. See *Menninger*, *supra* note 41 (explaining why involuntary hospitalization is necessary in some instances). *Menninger* goes on to write:

“Untreated depression, mania, and psychosis can have devastating effects on both the affected individual and those around him or her: suicide, assaults on others, inadvertent tragedies stemming from delusional thinking, financial and social ruin, and inability to adequately care for one’s own needs. Because insight often is lacking, civil commitment may be initiated by others who witness or are the brunt of concerning behavior, whether they be family members, police, or mental health providers.

Id. Though *Menninger*’s words were written long before *Disability Rights*, they offer support from the medical community that the Third Circuit’s deference to medical opinions on issues of mental health is warranted. See *id.* (discussing medical and legal basis for involuntary treatment).

116. See *generally Disability Rights*, 796 F.3d at 300 (discussing need for state policy to serve “legitimate safety requirement” and need to defer to medical opinions on medical matters (quoting *Disability Rights N.J., Inc. v. Velez*, 974 F. Supp. 2d 705, 739 (D.N.J. 2013))).

safe.¹¹⁷ This is demonstrated by the court's affirmation of the New Jersey policy as it pertained to legally-dangerous, non-CEPP patients.¹¹⁸ This, however, is not novel; the Supreme Court has long held that safety of the general public necessitates what would otherwise be considered an infringement on citizens' constitutional rights.¹¹⁹

Nevertheless, *Disability Rights* does more than simply provide a Third Circuit case that embodies that legal principal.¹²⁰ As a practical matter, *Disability Rights* provides attorneys representing medical practitioners with concrete support for the assertion that judges should not substitute their own judgment for that of medical professionals when it comes to medical issues.¹²¹ This is an assertion that the medical community has highlighted and looked upon favorably since this case was decided in 2015 because it provides medical organizations with comprehensive authority to promulgate rules and regulations so long as they are related to public health and safety.¹²² Accordingly, attorneys for medical practitioners should assert *Disability Rights* and its findings on a broad basis when they are arguing judges should defer to their client's judgment.¹²³

B. *What Have We Found? The Same Old Fears: Advice for Patients' Attorneys*

Historically, courts have given general deference to the opinions of medical professionals.¹²⁴ *Disability Rights* embodies specific precedent for medical practitioners in the Third Circuit to assert that notion.¹²⁵ Still, an

117. *See id.* at 308 (“[F]orced administration of psychotropic drugs can be used only for safety and treatment reasons . . .”).

118. *See id.* (“affirm[ing] the District Court’s summary judgment in favor of New Jersey on the due process claim with respect to non-CEPP patients”).

119. *See* *Washington v. Harper*, 494 U.S. 210, 223 (1990) (finding plaintiff’s interests could be outweighed by Washington’s interest in safety and security).

120. *See generally* *Disability Rights*, 796 F.3d at 306–10 (discussing New Jersey’s rationale for adopting forcible medication policy and reinforcing deference to medical opinions).

121. *See id.* at 310 (“New Jersey determined that, while judges have an important role to play in the civil commitment process, matters of medical treatment are more appropriately handled by medical professionals.”).

122. *See, e.g.*, *Ali & Weiss*, *supra* note 17, at 259–61 (agreeing with findings of *Disability Rights*); *see also* *Disability Rights*, 796 F.3d at 308 (discussing state’s interests in safety regarding forcible medication policies).

123. *See generally* *Ali & Weiss*, *supra* note 17, at 260–61 (agreeing with Third Circuit’s emphasis in *Disability Rights* on deference to medical opinions).

124. *See* *Harmon & Harmon*, *supra* note 68, at 157–58 (2009) (discussing judicial deference to opinions of medical professionals). As Roy and A.G. Harmon point out, “[o]ne of the more significant examples is the rule favoring the testimony of treating physicians in Social Security disability cases. By regulation, the Social Security Administration regards treating physicians’ opinions as providing a ‘detailed, longitudinal picture’ of impairment inaccessible from other sources, such as objective medical findings standing alone.” *See id.* at 158 (footnotes omitted).

125. *See* *Disability Rights*, 796 F.3d at 306–10 (granting general deference to opinions of medical professionals on medical issues).

attorney defending a patient's due process claim can use *Disability Rights* advantageously by arguing that it narrowly applies to forcible medication cases involving policies the same as or largely similar to New Jersey's.¹²⁶ First, AB 5:04A and AB 5:04B were very comprehensive in that there were a number of steps and safeguards in place to reduce the likelihood of physicians' mistakes throughout the process of determining whether or not a patient needed to be forcibly medicated.¹²⁷ A patient's attorney can argue that *Disability Rights* does not apply because the policy that his or her client is challenging is not as broad as New Jersey's.¹²⁸ Second, in its conclusion, the court simply stated, "the State's approach comports with the demands of the Constitution and the [ADA], except as to CEPP patients."¹²⁹ The court specified that *New Jersey's* approach was partially adequate, but the court did not say that *any* or *all* policies that aim to forcibly medicate non-CEPP patients would be constitutional.¹³⁰ The court's language is evidence that *Disability Rights* should only apply to New Jersey's policy or policies the same or largely similar to it.¹³¹ In another context, *Disability Rights* held that only patients whom were found to be dangerous could be forcibly medicated.¹³² If attorneys can certify that their client is not legally dangerous, then any state measure that infringes on the client's due process rights will not stand up to *Disability Rights'* scrutiny even if the state argues that its policy is justified for safety reasons.¹³³

V. CONCLUSION: HIGH HOPES FOR THE FUTURE OF MENTAL HEALTH LAW

For medical practitioners and their attorneys, *Disability Rights* is a favorable case because it emphasizes deference to medical opinions on medical matters.¹³⁴ Meanwhile, for patients and their attorneys, *Disability Rights* does not provide much substantive law to utilize in their favor.¹³⁵ Still, this case demonstrates that, while mental health professionals provide valued insight and opinions for the formation of mental health law, they do not have unlimited authority to promulgate forcible medication

126. For support of this assertion, see *supra* notes 62–68 and accompanying text, and see *infra* notes 127–33 and accompanying text.

127. For discussion on AB 5:04A and AB 5:04B, see *supra* notes 62–68 and accompanying text.

128. For discussion on AB 5:04A and AB 5:04B, see *supra* notes 62–68 and accompanying text.

129. See *Disability Rights*, 796 F.3d at 310 (finding New Jersey's plan comported with Constitution, "except as to CEPP patients").

130. See *id.* (finding New Jersey's policy partially complied with Constitution).

131. For further discussion, see *supra* notes 127–28 and accompanying text.

132. See *Disability Rights*, 796 F.3d at 307–08, 310 (finding non-CEPP patients can be forcibly medicated under AB 5:04A).

133. See *id.* at 309–10 (determining patients found not dangerous as matter of law cannot be forcibly medicated without judicial process).

134. For further discussion on the Third Circuit's deference to medical opinions, see *supra* notes 109–14 and accompanying text.

135. For a discussion on *Disability Rights'* impact on patients and their attorneys, see *supra* notes 124–33 and accompanying text.

policies.¹³⁶ For that reason, *Disability Rights* is a positive step for mental health law reform in the United States, no matter if viewed from the perspective of a medical practitioner or from that of a mental health patient.¹³⁷

136. See *Disability Rights*, 796 F.3d at 307–10 (finding New Jersey’s forcible medication law is only partially constitutional).

137. For further discussion and support, see *supra* notes 109–33 and accompanying text.