The Scope of the Involuntarily Committed Mental Patient's Right to Refuse Treatment with Psychotropic Drugs: An Analysis of the Least Restrictive Alternative Doctrine

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THE SCOPE OF THE INVOLUNTARILY COMMITTED MENTAL PATIENT'S RIGHT TO REFUSE TREATMENT WITH PSYCHOTROPIC DRUGS: AN ANALYSIS OF THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE

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(101)
I. INTRODUCTION

The use of psychotropic drugs by mental institutions across the United States to medicate mental patients is a widespread phenomenon that is relatively unknown by the American public. These drugs, which include Thorazine, Prolixin, Haldol, and Lithium, are effective in altering mental patients' moods, behavior, and thought processes, and, therefore, are used by psychiatrists and hospital staff to control mental patients who suffer from various psychoses. The primary motivations of the medical profession in the application of psychotropic drugs to mental patients has shifted from concern to convenience.

1. See notes 6 & 24 and accompanying text infra.


3. See note 24 and accompanying text infra.

4. See Rennie v. Klein, 476 F. Supp. 1294, 1299 (D.N.J. 1979), cert. denied, 101 S. Ct. 3059 (1981), modified and remanded, 653 F.2d 836 (3d Cir. 1981). The district court in Rennie v. Klein cited a study by Dr. George Crane, a psychiatrist, which concluded that psychotropic drugs are prescribed by hospital staff doctors to solve all types of management problems in addition to medical problems. Id. at 1299 (quoting G. Crane, Clinical Psychopharmacology in Its 20th Year, 181 SCIENCE 124 (1973)). The study concluded that "[m]any physicians, nurses, guardians and family members who resent the patient's behavior and are threatened by potential acts of violence fail to distinguish between manifestations of illness and responses to frustrations" in their application of the drugs. Id. The medical staff at the institution gains a feeling of accomplishment from the patient's adherence to a regimented treatment program, while the nursing personnel and relatives, who are in more direct contact with the patient, derive a spurious feeling of security when the doctor's orders are implemented. Id. These practices by hospital staff members must be viewed with respect to the hospital conditions in which they occur. As one commentator notes, "the evidence is legion that . . . mental hospitals are overcrowded, understaffed and underfinanced. There is such a shortage of physicians [that many of the doctors] are not fully licensed to practice in the state in which they are working." Plotkin, Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment, 72 NW. U.L. REV. 461, 463-64 (1978) (footnotes omitted). See M. A. Piezke, INVOLUNTARY TREATMENT FOR THE MENTALLY ILL: THE PROBLEM OF AUTONOMY 66-68, 74 (1975); Rennie v. Klein, 476 F. Supp. 1294, 1299 (D.N.J. 1979) (mental hospitals in issue are understaffed and patients have trouble seeing a psychiatrist); Rennie v. Klein, 462 F. Supp. 1131, 1136 (D.N.J. 1978) (doctors at mental hospital do not have sufficient time for each patient). As a consequence of the deficiencies of the mental hospitals and their staffs, rather than the severity of the patient's behavior or disorder, resort to psychotropic drugs for treatment follows. Plotkin & Gill, Invisible Manacles: Drugging Mentally Retarded People, 31 STAN. L. REV. 637, 650 (1979); Halderman v. Pennhurst State School & Hosp., 446 F. Supp. 1295, 1303, 1307-08 (E.D. Pa. 1977), aff'd, 612 F.2d 84 (3d Cir. 1979).
Studies show that psychotropic drugs are overused by mental institutions in the name of orderly hospital administration rather than patient rehabilitation, and that this overuse results in patients' dependence on such drugs. This extensive use of the psychotropic drugs by mental patients causes them to experience transient and permanent physical and mental side effects, including tardive dyskinesia (characterized by involuntary muscle movements) and drug-induced parkinsonism.

These side effects have caused involuntarily committed mental patients to refuse treatment with psychotropic drugs and to seek to establish their rights to refuse treatment in the courts. Recently, two federal appellate courts have recognized qualified constitutional rights to refuse psychotropic drugs.

In \textit{Rennie v. Klein}, the Third Circuit held that mental patients have a qualified constitutional right to refuse drugs. In so holding, the Third Circuit concluded that medication with antipsychotic drugs


5. See note 4 supra.


9. 653 F.2d at 838. \textit{Rennie} was decided in the context of one type of psychotropic drug, the antipsychotics. \textit{Id.} For a discussion of the antipsychotics, see notes 21-56 and accompanying text infra. The \textit{Rennie} court applied its constitutional analysis to only involuntarily committed mental patients because a New Jersey statute afforded voluntarily committed mental patients the right to refuse treatment. 653 F.2d at 848 (citing N.J. STAT. ANN. § 30:4-24.2(d)(1) (West. 1981)).
cannot be given, even where sedation of the patient is justified, until the hospital medical staff determines that there exists no less restrictive alternative treatment.\textsuperscript{10} The medical staff is required to explore the various means available to control the patients, and to select the treatment which restricts the patient's liberty in the least degree possible.\textsuperscript{11} The Rennie court also highlighted other issues implicated by the recognition of the right to refuse drugs, including the procedures that due process requires for implementation and protection of this right,\textsuperscript{12} and what circumstances constitute an "emergency situation" which relieves the hospital medical staff from affording mental patients these procedural due process protections.\textsuperscript{13}

In Rogers \textit{v. Okin},\textsuperscript{14} the First Circuit also recognized a constitutional right to refuse drugs and similarly adopted the "least restrictive alternative" as a factor in defining the scope of that right.\textsuperscript{15} The Supreme Court in \textit{Mills v. Rogers}\textsuperscript{16} vacated the First Circuit's decision; however, it did not reach the constitutional issues.\textsuperscript{17}

This comment will focus on the least restrictive alternative treatment doctrine adopted by these two federal appellate courts in the context of the mental patient's right to refuse drugs. A critical issue in defining the scope of the right to refuse treatment is whether the presence of a less restrictive alternative means of treatment should be a constitutional factor. Proponents of the application of the doctrine in this context argue that it is both an appropriate and necessary factor in the balancing of the interests of the state and the patient.\textsuperscript{18} Critics of the doctrine argue that its application brings the judiciary into conflict with medical professionals and places the judge in a position of reviewing and second-guessing medical decisions.\textsuperscript{19} The purpose of this comment is to present a proposed resolution of this conflict.

This comment will first discuss the psychotropic drugs, specifically the antipsychotics, and their effects on the individual.\textsuperscript{20} Next, it will examine the decisions in Rennie \textit{v. Klein} and Rogers \textit{v. Okin}, outlining their respective analyses of the right to refuse and the least re-
strictive alternative treatment doctrine. It will also present the arguments against the application of the doctrine as expressed by the concurring opinions in Rennie. Finally, this comment will analyze whether the least restrictive alternative doctrine should be recognized as a constitutional factor in cases involving the rights of involuntarily committed mental patients. It ultimately concludes that, in light of its application by the federal courts in other contexts and in light of a review of the benefits and detriments to those affected by its application, including the patient, psychiatrist, judiciary, and state, the doctrine should be a required factor in defining the scope of the right to refuse treatment.

II. THE PROBLEM:
THE USE OF PSYCHOTROPIC DRUGS

Psychotropic drugs are commonly used in mental hospitals for the treatment of committed patients afflicted with any of the various psychoses such as the schizophrenic disorders or any of the major affective disorders. The psychotropics' main utility lies in their ability to alter the moods, behavior, and thought processes of the patient. These drugs have been used for the treatment of psychiatric disorders since the early fifties. See Plotkin, supra note 5, at 474. In the last 20 years, psychotropic drugs have been regularly used to treat the most serious forms of mental illness. Crane, supra note 5, at 124. One study of drug therapy has revealed that in four state hospitals, slightly over 95% of the patients were receiving psychotropic drugs. Mason, Newiano & De Burger, Patterns of Antipsychotic Drug Use in Four Southeastern State Hospitals, 38 DISEASES OF THE NERVOUS SYSTEM 541 (1977). Another study of long-term patients at a state hospital indicated that 85% of such patients were taking psychotropic drugs. Crane, supra note 5, at 128 n.13. For an excellent discussion of psychotropic drugs in general, see Plotkin, supra note 5, at 474-79.


22. See notes 110-31 and accompanying text infra.

23. See notes 170-284 and accompanying text infra.

24. Crane, supra note 5, at 124. These drugs have been used for the treatment of psychiatric disorders since the early fifties. See Plotkin, supra note 5, at 474. In the last 20 years, psychotropic drugs have been regularly used to treat the most serious forms of mental illness. Crane, supra note 5, at 124. One study of drug therapy has revealed that in four state hospitals, slightly over 95% of the patients were receiving psychotropic drugs. Mason, Newiano & De Burger, Patterns of Antipsychotic Drug Use in Four Southeastern State Hospitals, 38 DISEASES OF THE NERVOUS SYSTEM 541 (1977). Another study of long-term patients at a state hospital indicated that 85% of such patients were taking psychotropic drugs. Crane, supra note 5, at 128 n.13. For an excellent discussion of psychotropic drugs in general, see Plotkin, supra note 5, at 474-79.

25. Among the major affective disorders are depression, characterized by extreme feelings of sadness, hopelessness and guilt, and by slowing of the thought processes and speech, and manic-depressive illness, in which periods of depression alternate with periods of mania, with the patient exhibiting elation, excitement, grandiosity and rapid flight of ideas. BECK & GREENBURG, DEPRESSION: CLINICAL ASPECTS, BIOLOGICAL BASES OF PSYCHIATRIC DISORDERS 201 (1977); A. CHAPMAN, TEXTBOOK OF CLINICAL PSYCHIATRY (2d ed. 1976).
Up to the present time the controversy in the right to refuse treatment cases has focused primarily, although not exclusively, on the common and forcible use of one class of psychotropic drug—the antipsychotics. The antipsychotics, also referred to as neuroleptics, are commonly used in treating patients with diagnoses of schizophrenia, or schizophrenia-like illness. The drugs elicit an initial sedation, followed by an antipsychotic effect which modifies such symptoms of schizophrenia as thought disorders, autism, hallucinations, delusions, and paranoid ideation. Their use is thought to be valuable in the treatment of these illnesses, relieving the symptoms on a short-term and parallel benefits of shortening patients’ hospital stays and allowing them to function in the community. See Winick, Psychotropic Medication and Competence to Stand Trial, Am. B. Found. Research J. 769, 773-74 (1977); Zander, Prolixin Decanoate: A Review of the Research, 2 Mental Disability L. Rep. 37 (1977).

The two other major categories of psychotropic medication commonly used in the treatment of committed patients are lithium and the antidepressants. See generally R. Balestas, Chemotherapy in Psychiatry 57-125 (1977). Lithium operates primarily on mood, rather than thought, disorders. See id. at 75-74. It is generally used to reduce the grandiosity, elation, and aggression that characterize the manic phase of manic-depressive psychosis. The antidepressants are also used to remedy mood disorders, particularly the sense of helplessness and despondency that characterizes psychotic depression. See id. at 75-125.

The classes of antipsychotics are the phenothiazines such as Thorazine (chlorpromazine) and Prolixin (theophenazine); the thioxanthenes such as Navane (thiothexene); and the butyrophenones such as Haldol (halopendol). See Cole, Pharmacotherapy of Psychosis, in Psychopharmacology in the Practice of Medicine 205, 206-07 (M. Jawik ed. 1977). The effects of the various classes of antipsychotics are similar. Id. at 205; Byck, supra note 25, at 156-58. For a discussion of these effects, see notes 44-56 & 268-72 infra.

For a discussion of these drugs, see note 24 supra. Persons may be diagnosed as being “schizoid” or “borderline schizophrenic,” the latter class of patients not having as great a degree of schizophrenic symptoms as the former. See Fuller & Thompson, Behavior Genetics in Schizophrenia, in Psychopathology Today 370, 373 (W. Sahakian ed. 1970).

Byck, supra note 27, at 158. As noted by one authority, if a single dose of 100 milligrams of chlorpromazine is given to a normal subject, the subject will experience a fall in blood pressure, tachycardia (increased heart rate), a slight decrease in respiratory rate, decreased salivary secretion, miosis (constriction of the pupils), and decreased motor activity. Id. The subject will sit in silence and show an indifference to those stimuli that would arouse him under normal circumstances. Id.

Frazer & Winokur, Therapeutic and Pharmacological Aspects of Psychotropic Drugs, Biological Bases of Psychiatric Disorders 155 (1977). According to many medical authorities, the antipsychotic effect of the drugs may take several weeks to develop fully. Id. at 156.
occasionally long-term basis.\textsuperscript{34} Antipsychotics often make it possible to shorten the period of confinement and make the patients more manageable and less of a threat to themselves and others.\textsuperscript{35}

Antipsychotics are, however, not generally considered cures for schizophrenia;\textsuperscript{36} patients frequently relapse when taken off the medication,\textsuperscript{37} and, while some patients may experience relief from certain symptoms of the disease, they may continue to experience decreased initiative, vague thinking, and residual paranoia.\textsuperscript{38}

The task of deciding which drugs to prescribe for specific conditions has proven to be difficult for researchers.\textsuperscript{39} The results of various attempts to pair particular phenothiazines,\textsuperscript{40} for example, with individual symptoms, have been inconclusive.\textsuperscript{41} Furthermore, problems also remain in determining the specific dosage that should be given to the patient.\textsuperscript{42} In practice, “[d]rugs are chosen by custom and rumored repute, and dosage is commonly adjusted upward until the patient either responds or develops toxic symptoms.”\textsuperscript{43}

The potential side effects that accompany treatment with antipsychotic drugs are many. The patient may experience an increased heart rate, nasal congestion, blurred vision, constipation, drowsiness, fluctuation of temperature, or altered skin pigmentation.\textsuperscript{44} Orthostatic or postural hypotension, resulting in dizziness, weakness, or fainting when the patient stands up, may also be caused by the use of antipsychotics.\textsuperscript{45} Furthermore, the drugs may affect appetite, libido, and

\textsuperscript{34} See Rennie v. Klein, 653 F.2d at 845.
\textsuperscript{35} Id.
\textsuperscript{36} Id. at 378.
\textsuperscript{37} Cole, supra note 29, at 211.
\textsuperscript{38} Id. at 210. For a discussion of the dispute surrounding the effectiveness of antipsychotic drugs on various forms of schizophrenia, see Rhoden, supra note 28, at 378 n.77.
\textsuperscript{39} Plotkin, supra note 5, at 475.
\textsuperscript{40} For a discussion of phenothiazines, see note 29 supra. Phenothiazines are the most commonly prescribed class of antipsychotics. Hollister, Drug Therapy: Mental Disorders—Antipsychotic and Antimaniac Drugs, 286 New Eng. J. Med. 984, 984 (1972).
\textsuperscript{41} See Plotkin, supra note 5, at 475. Compare Hollister, Clinical Use of Psychotherapeutic Drugs: Current Status, 10 Clinical Pharmacology & Therapeutics 171-72 (1969) (the sedative phenothiazines were effective on agitated patients; less sedative drugs worked best with symptoms of withdrawal and retardation) with National Institute of Mental Health Psychopharmacology Research Branch Collaborative Study Group, Differences in Clinical Effects of Three Phenothiazines in “Acute” Schizophrenia, 28 Diseases Nervous Sys. 369, 381 (1967) (chlorpromazine is more effective for core symptoms such as apathy and retardation).
\textsuperscript{42} See Plotkin, supra note 5, at 474-75.
\textsuperscript{43} May, Van Putten, Yale, Potepan, Jenden, Fairchild, Goldstein & Dixon, Predicting Individual Responses to Drug Treatment in Schizophrenia: A Test Dose Model, 162 J. Nervous & Mental Disease 177, 177-78 (1976).
\textsuperscript{44} Byck, supra note 27, at 164-65.
\textsuperscript{45} Rhoden, supra note 28, at 380.
the secretion of certain hormones. Blood dyscrasias (which increase susceptibility to infection), allergic reactions, and jaundice are complications which occur less frequently, but nevertheless are potentially serious. Other infrequent, but serious, nonmuscular side effects, such as skin rash and skin discoloration, ocular changes, cardiovascular changes, and occasionally, sudden death, have also been documented.

Antipsychotic drugs may also cause abnormalities in the patient's motor activity, known as extrapyramidal side effects. The most common of these side effects, which are temporary and disappear when the drug is terminated, are dystonic reactions, akathisia, and parkinsonism. Dystonic reactions are manifested by muscle spasms, especially in the eyes, neck, face, and arms, or in irregular flexing, writhing or grimacing movements, or protrusion of the tongue. Akathisia refers to an inability to stay still, restlessness, and agitation, and parkinsonism is manifested by a mask-like face, drooling, muscle stiffness and rigidity, a shuffling gait, and tremors.

A more serious side effect, which is potentially permanent, is tardive diskinesia, which is characterized by rhythmic, repetitive, and involun-

46. Byck, supra note 27, at 164.
47. Id.
52. Byck, supra note 27, at 168.
54. See authorities cited in note 53 supra.
55. Id.
tary movements of the tongue, face, mouth, and jaw, and sometimes accompanied by other bizarre muscular activity. 56

While treatment with psychotropic drugs may be effective in controlling and treating certain mental patients on a short-term basis, the cost associated with the use of these drugs may be high because they involve the risk to the patient of serious side effects, both temporary and permanent. State interests in controlling and treating mental patients may on occasion be achieved by courses of treatment which are less detrimental to the patient. For example, different drugs, smaller dosages, or different therapies may be effective in treating the patient while not resulting in these serious side effects. 57 Alternatives to drug treatment may encompass counseling techniques such as psychotherapy, milieu therapy, or behavior modification, or may simply take the form of physical restraint or seclusion in times of danger. 58

The fact that mental patients have asserted a right to refuse treatment with psychotropic drugs illustrates that there are problems in their use. While the decision as to a particular course of treatment is a medical question, recent cases have recognized that under certain circumstances the mental patient may have a right to refuse treatment. 59 These cases have defined the scope of that right with reference to a number of factors, including the physical danger posed by the patient, the patient's mental competency, the risk of side effects, and the availability of less restrictive treatments. 60

The existence of a less detrimental alternative course of treatment necessarily puts the judiciary in the role of reviewing medical decisions of the psychiatrist. The appropriateness of such a review is the central issue in the debate over whether the least restrictive alternative doctrine should be used to define the scope of the right to refuse treatment. 61


57. Rennie v. Klein, 653 F.2d at 847; See also Davis v. Hubbard, 506 F. Supp. 915 (N.D. Ohio 1980).


60. See notes 84-99 & 142-55 and accompanying text infra.

61. See notes 170-284 and accompanying text infra.
III. THE RIGHT TO REFUSE TREATMENT: DEFINING ITS SCOPE

A. Recognition of a Right to Refuse Treatment: Rennie v. Klein

In Rennie v. Klein,62 the Third Circuit, sitting en banc, was directly confronted with the issue of the mental patient's right to refuse treatment with antipsychotic drugs and the task of defining the scope of that right. On December 22, 1977, John Rennie, an involuntarily committed mental patient at the Ancora Psychiatric Hospital, a state institution in New Jersey, brought an action in the United States District Court for the District of New Jersey against the hospital and the New Jersey State Department of Human Services.63 Rennie sought a preliminary injunction to enjoin the psychiatrists and officials at the hospital from forcibly administering psychotropic drugs to him in the absence of an emergency situation.64 Rennie claimed that the forced administration of drugs constituted an invasion of his constitutional right to refuse medication in non-emergency circumstances.65


The New Jersey statute provided in pertinent part:

No medication shall be administered unless at the written order of a physician. Notation of each patient's medication shall be kept in his treatment records. At least weekly, the attending physician shall review the drug regimen of each patient under his care. All physicians' orders or prescriptions shall be written with a termination date, which shall not exceed 30 days. Medication shall not be used as punishment, for the convenience of staff, as a substitute for a treatment program, or in quantities that interfere with the patient's treatment program. Voluntarily committed patients shall have the right to refuse medication.


64. Rennie v. Klein, 462 F. Supp. at 1134. Rennie had been variously diagnosed during his frequent admissions to the hospital as a schizophrenic and manic-depressive. Id. at 1135-36. For discussion of these illnesses, see notes 25 & 26 supra. Rennie was treated during these various admissions to Ancora Psychiatric Hospital, starting in 1973, with several psychotropic drugs including Thorazine, Lithium, Prolixin Decanoate, Etrafon, Haldol, and Elavil. 462 F. Supp. at 1135-36. Psychotropic drugs are used by mental hospitals to alter and control patients' behavior, moods, and thought processes, in the hope of making them more manageable. For a complete discussion of the use of psychotropic drugs, see notes 24-56 supra. Rennie suffered from a number of common side effects of the psychotropic drugs, and had at various times objected to their use. 462 F. Supp. at 1140-41. For a discussion of the side effects associated with psychotropic drugs, see notes 44-56 supra & notes 268-72 and accompanying text infra.

65. 462 F. Supp. at 1134. Rennie charged the defendants with violations of four rights: 1) the right to refuse medication in non-emergency circum-
The district court held that involuntarily confined mental patients have a qualified constitutional right to refuse psychotropic medication. The court initially outlined three factors to be considered in determining whether institutional personnel have deprived a patient of his qualified right to refuse treatment: 1) the patient's physical threat to other patients and staff at the institution; 2) the patient's competence to make treatment decisions himself; and 3) the existence of less restrictive alternative treatments. In a subsequent hearing, the right to refuse medication was the only issue considered by the parties on Rennie's motion for preliminary injunction.

66. Id. at 1145-48. The court based this conclusion on the constitutional right to privacy which it determined was "broad enough to include the right to protect one's own mental processes from governmental interference." Id. at 1144. The court rejected the argument by the plaintiff that the forcible treatment of psychotropic drugs constituted cruel and unusual punishment in violation of the eighth amendment, finding that the drugs are an established medical treatment for schizophrenia and were justifiably administered as treatment for Rennie. Id. at 1143. For an analysis of the eighth amendment implications of the coercive administration of psychotropic drugs, see Symonds, Mental Patients: Right to Refuse Drugs; Involuntary Medication as Cruel and Unusual Punishment, 7 Hastings Const. L.Q. 701 (1980). The court also rejected the plaintiff's argument that the forcible administration of mind-altering drugs violated his first amendment right to freedom of thought. 462 F. Supp. at 1143-44. But cf. Kaimowitz v. Department of Mental Health, Civ. No. 73-19454-AW (Cir. Ct. Wayne County, Mich. July 10, 1973), reprinted in A. Brooks, Law, Psychiatry and the Mental Health System 902 (1974) (involuntarily confined mental patient could not give legally adequate consent to experimental procedure of psychosurgery because of first amendment protection of the freedom to generate ideas). The Rennie district court distinguished the Kaimowitz holding, reasoning that Rennie's ability to perform on intelligence tests had not been impaired by the use of the drugs, that he desired to be cured of his mental illness, and that the use of anti-psychotic drugs does not cause irreversible personality change, as does psychosurgery, and thus does not permanently constrict the patients' freedom of thought. 462 F. Supp. at 1144. For a discussion of the freedom of thought as a basis for the right to refuse psychotropic drugs, see Rhoden, supra note 28, at 388-96.

67. 462 F. Supp. at 1145-47. Within the element of the least restrictive alternative, the court included the risk of side effects. Id. at 1146-47. For example, if a patient were likely to contract tardive dyskenisia through administration of psychotropic drugs, involuntary medication would not be permitted. Id. at 1146. However, in a subsequent phase of the Rennie litigation, the district court treated these issues as separate factors. See Rennie v. Klein, 476 F. Supp. 1294, 1297 (D.N.J. 1979) cert. denied, 101 S.Ct. 3059 (1981), modified and remanded, 653 F.2d 836 (3d Cir. 1981) (en banc).

68. The first Rennie district court opinion covered multiple hearings. The court's decision that involuntarily confined mental patients have a qualified right to refuse psychotropic medication was made on November 9, 1978, 462 F. Supp. at 1131. Subsequent hearings and findings by the court on a motion for preliminary injunction, after the court's decision on November 9, 1978, are reported in the same opinion, which was issued on December 12, 1978. Id. Because of the court's decision on November 9, 1978, Rennie was no longer being forcibly medicated. Id. at 1148 n.6. Therefore, the court did not grant the subsequent motion for an injunction. Id. at 1148.
the district court applied a four-factor analysis adding the element of the risk of permanent side effects from the proposed treatment. The district court, however, denied the plaintiff's motion for a preliminary injunction against the forcible administration of psychotropic drugs on the grounds that the plaintiff was "floridly psychotic" and assaultive, that his capacity to make treatment decisions was limited, and that no treatment less intrusive than antipsychotic medication would stabilize his condition.

The action was subsequently expanded into a class action on behalf of all persons committed in New Jersey mental health facilities and upon a third hearing of the case, the district court prescribed specific due process procedures to be followed in order to protect the committed patient's qualified right to refuse medication. The court issued a preliminary injunction which required the following procedures. First, the hospital was required to inform the patients of their right to refuse psychotropic medication, and of the side effects which may accompany the use of the drug. Furthermore, whenever possible, written consent must be obtained prior to treatment. If the patient refused to give written consent, and if the involuntary patient was declared legally incompetent or certified "functionally incompetent" (unable to provide knowledgeable consent) by a treating physician, the decision to forcibly medicate the patient must be referred to a patient advocate who may, at his discretion, request a hearing before an independent psychiatrist. For involuntary patients ever, shortly after the first decision on November 9, 1978, the plaintiff's condition worsened and the hospital reinstated forcible medication. The plaintiff subsequently renewed his motion for a preliminary injunction.
not declared legally or functionally incompetent and who refused to consent, a hearing and a written opinion by the independent psychiatrist was required to precede any forcible medication. However, in “emergency situations,” a voluntarily or involuntarily committed patient could be forcibly medicated without any due process hearing. Emergency situations are defined as those in which there is a “sudden, significant change in the patient’s condition which creates danger to the patient himself or to others in the hospital.”

On appeal, the United States Court of Appeals for the Third Circuit, sitting en banc, modified and remanded, holding that 1) mental patients who are involuntarily committed to state institutions nevertheless retain a constitutional right to refuse antipsychotic drugs; 2) the state may not override that right without affording the patient a due process hearing except in emergency situations; and 3) the basis for any decision to override the patient’s privacy right.

See text accompanying note 52 supra.

76. 476 F. Supp. at 1314.

77. Id. at 1313. In an emergency, medication can be forcibly administered for up to 72 hours. Id. If the “threat to life or limb continues,” certification by the medical director of the hospital may extend this period an additional 72 hours. Id. at 1313-14.

78. Id. at 1315.

79. Id. at 1294.

80. 653 F.2d at 836. Both parties cross-appealed from the district court order of September 4, 1979 reported at 476 F. Supp. 1294 (D.N.J. 1979). Id. at 840. The defendants first contended that the district court erred in recognizing a constitutional right to refuse treatment and, in the alternative, that the procedures embodied in the New Jersey administrative bulletin which addressed the administration of psychotropic drugs were sufficient to protect any such right. Id. The plaintiffs asserted that the relief ordered by the district court was inadequate, and that “independent psychiatrists retained by and responsible to the Commissioner of the Department of Human Services cannot be the neutral decision makers required by the due process clause.” Id. They further questioned the due process effectiveness of the system of patient advocates who, like the independent psychiatrists, would be retained by and responsible to the defendant Commissioner. Id. Finally, the “plaintiffs challenge[d] the portion of the district court’s order that permitted a doctor to medicate the patient by declaring him to be ‘functionally incompetent,’ a procedure they claimed would allow the circumvention of the mandatory review of all refusals of medication.” Id.

The case was initially argued on April 22, 1980 before Judges Aldisert, Weis and Garth. Id. at 838. It was subsequently reargued en banc on May 12, 1981 before Chief Judge Seitz and Judges Aldisert, Adams, Gibbons, Hunter, Weis, Garth, Higginbotham, and Sloviter. Judge Weis wrote the majority opinion. Id. Judges Adams, Higginbotham, and Sloviter concurred. Id. Chief Judge Seitz and Judges Aldisert, Hunter, and Garth concurred in part. Id. at 838, 855. Judge Gibbons concurred in part and dissented in part from the judgment. Id. at 888, 865.

81. Id. Only the antipsychotics, one subclass of the psychotropic drugs, were the subject of the court’s opinion. Id. at 839 n.2. For a discussion of the various classes of psychotropic drugs, see note 21 supra.

82. 653 F.2d at 838. The court defined emergency situations as those in which the “patient is a danger to himself or others.” Id.
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formal administrative procedure already established by New Jersey Department of Human Services met the constitutional standards of due process. 88

1. Substantive Due Process Right to Refuse Treatment

The Third Circuit originally determined that there are two sources from which a substantive liberty interest 84 can be derived: state law and the federal Constitution. 85 The court concluded that New Jersey law did not create such a liberty interest in involuntarily committed mental patients. 86 The court reached this conclusion by noting that New Jersey, which had by statute affirmatively recognized the right of voluntarily committed patients to refuse medication, 87 had failed to recognize an equivalent right in those who are involuntarily committed. 88

Having found no substantive right to refuse in state law, the court turned to a federal constitutional analysis in determining whether the Constitution creates a liberty interest in involuntarily committed mental patients to refuse antipsychotic drugs. The Third Circuit initially addressed the defendant's argument that an involuntary commitment extinguishes the freedom to refuse medication normally possessed by an individual. 89 The court rejected this argument, holding that the patient has a substantive constitutional right to refuse medication based on the right to be free from unjustified intrusions of personal

83. Id. at 838.

84. 653 F.2d at 841 n.6. Unlike the district court, which characterized the right as a privacy interest, the Third Circuit, noting that nothing of significance turned on the choice of characterization, concluded that the right to refuse treatment was better viewed as a liberty interest. For a discussion of the district court's characterization of the interest, see notes 66-67 and accompanying text supra.

85. 653 F.2d at 841-42. The court rejected the defendant's argument that because no liberty interest exists in state law, plaintiffs have no liberty interest. Id. at 842. In rejecting this argument, the court reasoned that to conclude otherwise would place a state's statutory law above the Constitution. Id.

86. Id. at 842. For the text of the relevant statute and a discussion of its implication that involuntarily committed patients have no right to refuse medication, see note 63 supra.

87. Id. (quoting N.J. Stat. Ann. § 30:4-24.2(d)(1) (West 1981) ("voluntarily committed patients shall have the right to refuse medication."). For the relevant text of this statute, see note 63 supra.

88. 653 F.2d at 842 (citing In re B, 156 N.J. Super. 231, 383 A.2d 760 (N.J. Super. Ct. Law Div. 1977)). The court noted that a New Jersey trial court had held that the implication of the statute was that involuntarily committed patients do not have the right to refuse medication. Id.

89. 653 F.2d at 843. The defendants argued that involuntary commitment takes away all aspects of a person's liberty interest. Id.
security under the due process clause of the fourteenth amendment. In support of its holding, the court, drawing an analogy to a prison setting, emphasized that compulsory medication of a nonconsenting patient, with its serious risks, must be deemed a “major change in the conditions of confinement” and, therefore, a liberty deprivation of the patient.

2. Defining the Scope of the Right to Refuse: The Least Intrusive Means Standard

Having concluded that there exists a constitutional right “to be free from treatment that poses substantial risks to [one’s] well being”, the Third Circuit proceeded to consider the scope of that right. The court recognized that such a right is not absolute, but must be limited by legitimate governmental concerns and obligations such as protecting the public, property, and the person himself. Five members of the court concluded that the deprivation of liberty imposed by the state as the result of the medication of patients with antipsychotic drugs “must not exceed that required by needed care or legitimate administrative concerns” and must be the “least intrusive infringement” available. The court defined the least intrusive means standard as

90. Id. at 843-44 (citing Ingraham v. Wright, 430 U.S. 651 (1977)). The court noted that “the patient’s liberty is diminished only to the extent necessary to allow for confinement by the state so as to prevent him from being a danger to himself or to others”. Id. at 843. All nine members of the en banc panel concurred in this holding. Id. at 838.

91. 653 F.2d at 843. The Third Circuit drew an analogy to Wolff v. McDonnell, 418 U.S. 539 (1974). In Wolff, the Supreme Court had held that in the prison setting, the imposition of solitary confinement “represents a major change in the conditions of confinement” which implicated the necessity of procedural due process safeguards to protect against an arbitrary imposition of such a sanction. Id. at 571-72 n.19. In support of this determination, the court relied upon evidence in the record which showed that numerous disorders of the central nervous system may be created by the use of antipsychotic drugs. 653 F.2d at 843-44. For a discussion of the effects of antipsychotic drugs, see notes 44-53 and accompanying text supra and notes 268-72 and accompanying text infra.

92. 653 F.2d at 844-45.

93. Id. at 845. The court relied upon evidence in the record which demonstrated the value of antipsychotic drugs in the treatment of certain mental illnesses and in relieving symptoms accompanying those illnesses. The court noted that the use of the drugs serves legitimate state concerns and obligations by often making it possible to drastically shorten the period of confinement and by making patients more manageable, and, therefore, less of a threat to others. Id.

94. Id. The court further explained that “[t]he means chosen to promote the state’s substantial concerns must be carefully tailored to effectuate those objectives with minimal infringement of protected interests.” Id. at 846 (citing Griswold v. Connecticut, 381 U.S. 479, 485 (1965)). The court found support for its least restrictive analysis in a decision by another federal court of appeals as well as in Congressional and state legislation. Id. at 846-47 n.13 (citing Rogers v. Okin, 634 F.2d 650 (1st Cir. 1980); 42 U.S.C. §§ 9401-
not prohibiting all intrusions into a patient's personal liberty, but, rather, as requiring avoidance of those intrusions "which are unnecessary or whose cost benefit ratios, weighed from the patient's standpoint, are unacceptable." The court noted that hourly or daily judicial oversight is obviously unworkable and is not required. Rather, it defined the issue of judicial review as "whether the choice of treatment strikes a proper balance between efficacy and intrusiveness." In this balancing process, the court would require that the psychiatrist determine whether a different drug, a smaller dosage, or a different therapy would serve the interests of both the patient and the state. Finally, the court noted that the psychiatrist may be granted more discretion in emergency situations requiring the medication of patients.


The Third Circuit next examined the appropriateness of the procedures imposed by the district court for the protection of the right to refuse. The court found that existing procedures established by the New Jersey Department of Human Services complied with due process requirements, and thus held that the additional requirements imposed by the district court were unnecessary. The court initially noted that the legal standard applicable in determining whether the existing procedural safeguards afforded the patient would pass constitutional muster is that formulated by the United States Supreme Court in Matthews v. Eldridge. In Matthews, the Court listed three

95. 653 F.2d at 847.
96. Id. The court required a careful balancing of the interests furthered by administering the drug against the interests of the patient. Id.
97. Id. In search of the proper balance, the court noted that it would depend on medical and psychiatric opinion. Id. This dependence on professional opinion, reasoned the court, would notify the "psychiatric community" that a "conscious weighing of the constitutional liberty interest in any determination of proper treatment alternatives is necessary." Id.
98. Id.
99. Id. In explanation of this point, the court noted that treatment with antipsychotic drugs for a limited period of time is not as likely to have as intrusive an effect upon the patient as the administration of the drugs for an extended time, and, therefore, the least intrusive standard is generally applicable to a "regimen or treatment program," rather than to individual dosages. Id. at 847-48. The court also emphasized that the emergency treatment provisions were not at issue in Rennie. Id. at 848.
100. Id.
factors to be considered in determining whether state agency proceedings comply with due process: 1) the private liberty interest; 2) the risk of an erroneous deprivation of the liberty interest through the procedures used, as well as the value of any additional or substituted procedural safeguards; and 3) the governmental interest, including the activity involved and the fiscal and administrative burdens that additional procedural requirements would impose.\(^\text{102}\) Applying the three factors enunciated in *Matthews*, the Third Circuit analyzed the procedures established by New Jersey\(^\text{103}\) in order to determine their constitutionality.\(^\text{104}\)

In discussing the first *Matthews* factor, the *Rennie* court indicated that it had found a significant private liberty interest of the patient implicated in the right of refusal.\(^\text{105}\) Under the second *Matthews* factor, the court held that the New Jersey procedures, whereby the hospital medical staff makes the decision to compel medication only after consultation with the patient and supervisory personnel,\(^\text{106}\) posed only a minor risk of erroneous deprivation of personal liberty because of the staff's close connection with the patient and his treatment program, and their knowledge of his medical history.\(^\text{107}\) The court additionally found that the risk of an erroneous deprivation would not be significantly reduced by further imposing the requirement of an adversary hearing wherein an independent psychiatrist would determine whether the patient's refusal of medication should be honored,\(^\text{108}\) as

\(^{102}\) 424 U.S. at 335. The *Rennie* court noted that any due process procedures promulgated must provide an opportunity for the exercise of professional medical judgment with respect to various matters, including the likelihood of violence on the part of the patient, his previous reaction to acute psychotropic drugs, the duration of previous drug therapy, and other factors as well. 653 F.2d at 848. Furthermore, the court recognized that the existence of these factors and their varied application to different patients required that the decision to administer drugs be made on an individualized basis. *Id.*

\(^{103}\) See 653 F.2d at 840. See also N.J. STAT. ANN. § 30:4-24.1 (West 1981) (legislation regulating treatment of mentally ill). See also Administrative Bulletin 78-3. The Bulletin sets up a procedural mechanism through which a decision to administer drugs against a patient's wishes is made and reviewed. 653 F.2d at 848-49. For a discussion of this procedural mechanism, see notes 106-12 and accompanying text infra.

\(^{104}\) 653 F.2d at 848-51.

\(^{105}\) *Id.* at 850. For a discussion of this liberty interest, see notes 85-91 and accompanying text supra.

\(^{106}\) See 653 F.2d at 840. The attending psychiatrist's decision to compel medication is reviewed by the medical director. *Id.*

\(^{107}\) *Id.* at 850. The court concluded that the weeks or months spent by a patient in the institution should provide a more accurate and reliable basis for the staff's judgment as to the patients' condition and needs than would an ad hoc decision by an independent psychiatrist whose experience with the patient would be limited. *Id.*

\(^{108}\) The *Rennie* court concluded the "adversary contest implicit in the district court's order" was ill-suited to the medical determination that must
mandated by the district court. In discussing the third *Matthews* factor, the court observed that great expenditures of staff time at the hospitals and substantial financial burdens on the state would be imposed by implementation of the procedures mandated by the district court. The court found that this element, more than the others, counseled its approval of the New Jersey procedures and its rejection of the procedural safeguards mandated by the district court.

The court based this conclusion on the Supreme Court's rationale in *Parham v. J.R.*, 442 U.S. 584 (1979). The court in *Parham* stated that it did not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing. Even after a hearing, the nonspecialist decisionmaker must make a medical-psychiatric decision. Common human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real.

Id. at 609.

109. For a discussion of the due process procedures ordered by the district court, see notes 71-78 and accompanying text supra. The Rennie court also addressed the district court's concern about the independence of the doctors and officials responsible for representing the patient's interests when the need for a decision to medicate arises. 653 F.2d at 850. The Third Circuit, relying on Supreme Court decisions in "analogous contexts," found that there was "no due process violation in the use of such decisionmakers employed by and responsible to the state bureaucracies." Id. (citing *Vitek v. Jones*, 445 U.S. 480, 496 (1980); *Parham v. J.R.*, 442 U.S. 584, 607 (1979); *Wolff v. McDonald*, 418 U.S. 539, 570-71 (1974)). The Rennie court supported its conclusion by noting that 1) to rule otherwise would be to "void almost all intra-administrative appeals where institutional pressures abound;" and 2) "the New Jersey provision for retaining an outside psychiatrist in certain circumstances tends to blunt the district court's concern that institutional pressure will prevent an independent decision." The provision states that if the medical director desires to avoid institutional influences, he is empowered to call upon a disinterested authority for the final decision. 653 F.2d at 850-51.

110. 653 F.2d at 851. The court concluded that the district court's order would impose "substantial additional financial burdens" on the state. Id.

111. Id. The court stated that these financial burdens would result in the diversion of funds from the finite resources available for the care of the mentally ill to the financing of non-essential administrative procedures which would not provide help for the patient's most critical needs. Id. The court further reasoned that these adversary proceedings would be counterproductive, creating stress which would interfere with the successful, long-range treatment of the mentally ill. Id. (citing *Parham v. J.R.*, 442 U.S. 584, 616 (1979)).

112. In rejecting the adoption of adversary proceedings, the court, noting the marginal utility of these proceedings to patients, necessarily discarded the district court's holding requiring behavioral experts, such as psychiatrists, in such proceedings. 653 F.2d at 851 (citing *Parham v. J.R.*, 442 U.S. 584, 606 (1979)). For a discussion of the procedures mandated by the district court, see notes 71-78 and accompanying text supra.
B. The Case Against the Least Restrictive Alternative: The Rennie Concurrences

Four members of the Rennie court were vehemently opposed to the majority's adoption of the least restrictive alternative doctrine. Although agreeing that the mental patient has a substantive constitutional right to refuse treatment with antipsychotic drugs, they argued that the least restrictive alternative doctrine was an inappropriate factor to define the scope of that right.

Chief Judge Seitz, while concurring in part, dissented from the majority's application of the least restrictive alternative standard to both the procedural and the substantive due process issues presented. Chief Judge Seitz concluded that "the least restrictive alternative standard is irrelevant to a determination of the sufficiency" of the New Jersey procedures "because such a standard does not assist in the determination of what procedures are required to protect a patient's right to refuse medication." Further, Chief Judge Seitz determined that the least restrictive alternative standard, as applied by the majority to the substantive due process rights of involuntarily committed mental patients, was inappropriately and improperly used, since the Constitution does not require such an impingement on the professional judgment of the psychiatrist in the treatment of patients. Chief Judge Seitz concluded that the applicable constitutional standard governing a patient's right to refuse and the state's ability to override that right should be whether the psychiatrist's treatment "substantially depart[ed] from accepted professional judgment."
Judge Garth, joined by two other judges, also concurred with the majority's finding of a right to refuse treatment, but concluded that neither the least restrictive alternative treatment factor nor the risk of side effects factor should be applied in a constitutional analysis of the patient's right to refuse treatment. Judge Garth asserted that the state may administer antipsychotic drugs in the face of the patient's refusal only when the state demonstrates either that 1) the medication is necessary to prevent the patient from posing a danger to himself or to others, or 2) the patient does not have the mental capacity to make a rational decision with respect to medication, irrespective of whether the treatment program adopted is the least restrictive or whether risks of permanent side effects are present.

In addition, Judge Garth specifically dissented from the majority's holding that any medical treatment program, as opposed to an individual dosage, to be constitutionally adequate, must be the least restrictive. Judge Garth argued that the least restrictive alternative fits into the constitutional analysis, and concluded that, although side effects alone were of no independent constitutional significance, they should be considered along with other relevant factors in determining whether accepted professional judgment was exercised.

121. 653 F.2d at 855 (Garth, J., concurring in part and dissenting in part). Judges Aldisert and Hunter joined in the opinion.

122. Id. Judge Garth concluded that the majority accepted the four constitutional factors applied by the district court in its determination of the patient's right to refuse treatment: "1) does the patient constitute a physical threat to other patients and to staff at the institution; 2) does the patient have the capacity to decide on his own particular treatment; 3) do any less restrictive treatments exist; and 4) are there risks of permanent side effects from the proposed treatment." Id. Judge Garth noted that the majority emphasized the third factor in its constitutional analysis of patients' right to refuse medication. Id. at 855-56 (Garth, J., concurring in part and dissenting in part).

123. Id. at 858 (Garth, J., concurring in part and dissenting in part).

124. Id. at 860 (Garth, J., concurring in part and dissenting in part). Judge Garth first noted that the record of the district court, by which the majority was bound, presented "no evidence of a choice between major courses of treatment, nor . . . of any major course of treatment that was considered as an alternative to the psychotropic drug treatment by which Rennie was medicated." Id. Judge Garth stated that he did not feel free to hypothesize differing circumstances which might "trigger the formulation of a constitutional standard." Id. (citing Rennie v. Klein, 462 F. Supp. at 1140). Moreover, he stated that the district court held that Rennie received drug treatment that was both indicated and required. Id. He also noted the district court's thorough analysis of the plaintiff's condition, psychotropic drugs and their effects, and the appropriate medication for the plaintiff given his condition.

125. Id. Given this analysis, Judge Garth concluded that the district court formulated its least restrictive standard in a setting involving individual dosages, but that the majority interpreted this in terms of courses of treatment. Id. at 861 (Garth, J., concurring in part and dissenting in part). Regardless of the differing characterizations, Judge Garth thought that any attempt to construct a least restrictive alternative test in an area requiring medical judgment was unsound. He further pointed out that, on this reasoning, the Romeo court (on which the majority relied in adopting the least restrictive
approach would involve the district courts in the review of highly individualized treatment programs on a continuing basis and that this review would drastically interfere with the administration of needed medication and therapy. Moreover, he stated "the imposition of such a standard would as a practical matter require each district court judge to exchange his robe for a medical gown" and impose upon each judge the duties of a "super-diagnosticiant" and "super-physician" for each institutionalized patient. He ultimately concluded that the determination as to the proper course of treatment is a decision best left to the medical profession and in which the judiciary should not interfere.

alternative standard) expressly labeled the application of such a standard to continuing treatment programs as "unsuitable." Id. at n.14 (Garth, J., concurring in part and dissenting in part) (quoting Romeo v. Youngberg, 644 F.2d 147, 166-67 (3d Cir. 1980), vacated and remanded, 102 S. Ct. 2452 (1982)). Judge Garth also accused the majority of formulating its least restrictive alternative treatment standard from cases "far removed from the context of treatment involving the mentally ill." Id. at 861 (Garth, J., concurring in part and dissenting in part). Judge Garth noted that the case of Shelton v. Tucker, 364 U.S. 479 (1960) relied on by the majority, involved a first amendment attack on an Arkansas statute requiring public school teachers to annually list all of their organizational affiliations for the preceding five years. Id. (Garth, J., concurring in part and dissenting in part). Judge Garth also noted that the cases giving rise to the least restrictive alternative doctrine relied upon by the majority involved only a single legislative enactment or a discrete state action as contrasted with the continued judicial supervision required in the context of Rennie. 653 F.2d at 862 (Garth, J., concurring in part, dissenting in part). For a discussion of the Supreme Court's application of the least restrictive alternative doctrine, see notes 170-212 and accompanying text infra.

125. 653 F.2d at 859 (Garth, J., concurring in part and dissenting in part). Judge Garth argued that courts under the majority opinion are faced with reviewing "day-to-day and even hour-to-hour decisions" by hospital staff concerning the medical treatment of patients, and that such treatment is "highly individualized" and varies markedly from patient to patient. Id. (Garth J., concurring in part and dissenting in part). Judge Garth factually supported this observation by noting that in Rennie, the district court was "repeatedly called upon to hold hearings and rule in a medical context on various aspects of the plaintiff's day to day treatment." Id.

126. Id.

127. Id. at 861 (Garth, J., concurring in part and dissenting in part). Judge Garth stated that

any attempt to construct a "least restrictive" constitutional standard in an area where medical judgment should control is unsound, unworkable and unwarranted. The many subjective determinations that form the matrix of a medical judgment are best left to the members of the medical profession. Such determinations ought not to involve the judiciary in an assessment, even if one can be made, as to whether a particular mode of treatment or . . . discrete treatment, is more or less intrusive than another.

Id.

Judge Garth also fervently disagreed with the majority's reliance on the case of Romeo v. Youngberg, 644 F.2d 147 (3d Cir. 1980), in adopting the least restrictive alternative standard in the context of the constitutional rights of the involuntarily committed mental patient. Id. at 859-60 (Garth, J., con-
Finally, Judge Garth indicated that the continued vitality of the least restrictive alternative standard was questionable in light of the recent Supreme Court decision in Pennhurst State School and Hospital v. Halderman, in which the standard was questioned in the context of the statutory rights of the mentally retarded, and in light of the subsequent grants of certiorari in cases involving the least restrictive alternative standard in the context of the constitutional rights of both the mentally ill and the mentally retarded.

Judge Garth also concluded that the risk of permanent side effects factor employed by the majority had no place in the constitutional analysis of a patient's right to refuse medication. In his view, the

128. 612 F.2d 84 (3d Cir. 1979) (en banc), rev'd and remanded, 101 S. Ct. 1531 (1981). In Halderman, the Third Circuit held that the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6000, required rehabilitation of the mentally retarded in the least restrictive environment.

129. 101 S. Ct. at 1539 n.12. Justice Rehnquist indicated that it was questionable whether the least restrictive concept was appropriate in the setting of rehabilitation of the mentally retarded. Id.

130. 653 F.2d at 863 (Garth, J., concurring in part and dissenting in part) (citing Rogers v. Okin, 654 F.2d 650 (1st Cir. 1980), vacated and remanded, Mills v. Rogers, 102 S. Ct. 2442 (1982) (least restrictive alternative standard in context of rights of mentally ill) and Romeo v. Youngberg, 644 F.2d 147 (3d Cir. 1980), vacated and remanded, 102 S. Ct. 2452 (1982) (least restrictive alternative standard in context of rights of mentally retarded)). Judge Garth concluded that the Romeo record involved the problems and characteristics of the mentally retarded patient, which, he stated, are “critically” different from those of the mentally ill. Id. Further, Judge Garth held that Romeo did not mandate the least restrictive alternative standard, but instead suggested its possible application. Id.

In Mills v. Rogers, the United States Supreme Court never reached the least restrictive alternative issue. 102 S. Ct. at 2442. For a discussion of Mills, see notes 132-69 and accompanying text infra.

In Romeo v. Youngberg, the Supreme Court expressly noted that the issue of the least restrictive alternative standard was not present in the case. 102 S. Ct. at 2457 n.15. However, it is suggested that the Court held sub silentio that the least restrictive alternative standard is no longer constitutionally required in determining whether a breach of a mentally retarded patient’s liberty interest has occurred. Id. at 2463 (patient entitled to “reasonably nonrestrictive confinement conditions”). For a discussion of Romeo, see notes 200-07 and accompanying text infra.

131. See notes 122-23 and accompanying text supra.
state's power to administer medication which poses a risk of serious permanent side effects is limited not by the patient's right to refuse treatment, but, rather, by the standard of care with which the state is charged and by the accompanying tort action available to the patient for abuse of that standard.132

C. Mills v. Rogers: A Missed Opportunity?

In Rogers v. Okin,133 the First Circuit was confronted with an issue identical to that of Rennie—the right to refuse treatment with antipsychotic drugs. The First Circuit recognized a right to refuse antipsychotic drug treatment, requiring an analysis of the likelihood...
of violence by the patient, the risk of side effects, and an appraisal of less restrictive alternative treatments in defining the scope of the right. However, it regrettably chose not to resolve the significant constitutional questions as to the existence and scope of the right to refuse treatment.

Rogers involved a group of involuntary and voluntary mental patients represented in a class action to enjoin the medical staff at the Boston State Hospital from forcibly medicating and secluding patients in non-emergency situations. The patients claimed that these hospital policies infringed upon their constitutional rights to refuse treatment. Judge Tauro of the United States District Court for the District of Massachusetts issued a temporary restraining order requiring the hospital to discontinue the medication and seclusion practices without the informed consent of either the patient or his guardian if the patient had been declared incompetent. Subsequent to a lengthy trial, the court made the order permanent. Judge Tauro based his

134. 634 F.2d at 655-56. See notes 142-55 and accompanying text infra.
135. 102 S. Ct. 2442 (1982). For a discussion of Rogers, see notes 156-69 and accompanying text infra.
136. Rogers v. Okin, 478 F. Supp. 1342, 1360 (D. Mass. 1979) modified, vacated and remanded, 634 F.2d 650 (1st Cir. 1980), vacated and remanded sub nom. Mills v. Rogers, 102 S. Ct. at 2442. The district court certified a class consisting of “all persons, who are presently, or will be, patients at the May and Austin Units of Boston State Hospital and who have been or will be secluded without their consent or medicated without their consent.” Id. at 1352 n.1. The medications contested were one class of psychotropic drugs—the antipsychotics. Id. at 1359-60. For a discussion of these drugs, see notes 24-56 and accompanying text supra.
138. Id. at 1353. Upon admission to Boston State Hospital, voluntary patients sign a form which states, “I understand that during my hospitalization and any after care, I will be given care and treatment which may include the injection of medicines.” Id. at 1367. The defendants, the Commissioner of the Massachusetts Department of Mental Health and officials of the hospital, argued that voluntarily admitted patients had waived any constitutional right to refuse treatment by signing the form. Id. The court rejected this argument, finding that waiver of the right to refuse medication requires that the patient must first understand that such a right exists and then that he knowingly and explicitly waive it. Id. at 1368. The defendants also argued that once admitted to a mental institution, a patient is deemed incompetent to decide whether to accept treatment or what treatment to accept in either emergency or non-emergency situations, and, therefore, cannot assert any constitutional right to refuse treatment. Id. at 1361. The district court rejected the incompetency argument noting that most patients “are able to appreciate the benefits, risks, and discomfort that may reasonably be expected from receiving psychotropic medication.” Id. In reaching this conclusion, the court also relied upon Massachusetts law, which provides unequivocally that, although committed, a mental patient is nonetheless presumed to be competent to manage his affairs, dispose of property, carry on a licensed profession, and even to vote. Id. (Citing Mass. Gen. Laws Ann. ch. 123, § 25 (West Supp. 1970) and D.M.H. Reg. § 221.02.)
139. 478 F. Supp. at 1371.
adoption of a right to refuse antipsychotic drugs upon two constitutional rights: the penumbral right of privacy and the First Amendment right of protection of thought. The court held that only in emergency situations that create “a substantial likelihood of physical harm” to the patient or others could medication be forcibly administered.

On appeal, the United States Court of Appeals for the First Circuit modified and remanded, holding that an involuntarily committed patient has a constitutional right to decide for himself whether to accept or refuse antipsychotic drug treatment. Chief Judge Coffin, writing for the court, found this right rooted in the penumbral rights of privacy, bodily integrity, and personal security guaranteed by the due process clause of the fourteenth amendment. The court held, however, that a patient may be forcibly medicated with antipsychotic drugs in an “emergency situation.” In identifying such a situation, the court went beyond the district court’s formulation, and incorporated additional factors that must be considered by the hospital medical staff member who is considering treating a patient with antipsychotic drugs. In accordance with these additional factors, the medical staff member must make an “individualized” analysis of the patient, including an estimation of the possibility and type of violence that might occur without antipsychotic drug treatment, the likely effects

140. Id. at 1365-67. The court first noted that a patient’s right of privacy, interpreted as protecting, among other things, an individual’s bodily integrity, allows him to refuse the antipsychotic medication as well as its concomitant dangerous side effects. Id. at 1365-66. Secondly, Judge Tauro held that the involuntary administration of drugs violates a patient’s first amendment right to freedom of thought. Id. at 1366-67. Judge Tauro reasoned that such a right was necessarily implicated in an individual’s first amendment right to freedom of communication of ideas. Id. The court stated that “[t]he First Amendment protects the communication of ideas. That protected right of communication presupposes a capacity to produce ideas. As a practical matter, therefore, the power to produce ideas is fundamental to our cherished right to communicate and is entitled to comparable constitutional protection.” Id. at 1367. Judge Tauro observed that these first amendment rights were infringed by the drug’s mind-altering effects on the patient’s mood, attitude, and thought processes. Id. at 1366-67.

141. Id. at 1364-65. The court did not create a special procedural due process mechanism for reviewing a patient’s refusal, but rather left undisturbed the patient’s absolute right in non-emergency situations to refuse antipsychotic drug treatment. Id. at 1368-71.

142. The case was argued before Chief Judge Coffin, and Judges Campbell and Davis. Chief Judge Coffin wrote the opinion.

143. 634 F.2d at 653.

144. Id. The court found it “unnecessary” to reach the district court’s implication of first amendment rights. Id. at 654 n.2.

145. Id. at 655-56 & 659-60.

146. See note 141 supra.

147. 634 F.2d at 655-56 & 659-60.
of particular drugs on the particular patient, and an appraisal of alternative, less restrictive courses of action available.\textsuperscript{148}

In summarily discussing the least restrictive alternative treatment it adopted, the court observed that the prior side effects of antipsychotics on the patient should be an important factor in determining how extensive an exploration of less restrictive alternative treatments must be made by a psychiatrist.\textsuperscript{149} In addressing the constitutional prerequisites to the forcible administration of antipsychotic drugs in \textit{non-emergency situations}, the court held that "the \textit{sine qua non} for the state's use of its \textit{parens patriae} power as justification for the forceful administration of mind-affecting drugs is a determination that the individual to whom the drugs are to be administered lacks the capacity to decide for himself whether he should take the drugs."\textsuperscript{150} Chief Judge Coffin affirmed, by implication, the district court holding that in both emergency and non-emergency situations some determination of incompetency must be made before the patient may be treated.\textsuperscript{161}

\begin{itemize}
  \item[\textsuperscript{148}] In making this determination, the court identified two competing interests at stake: 1) the institutional interest in a) protecting the public and the medical staff by preventing violence in a setting containing a large concentration of individuals with a demonstrated proclivity for committing acts of violence and b) preventing harm to the patients themselves from such violence; and 2) the patient's interest in remaining free from the forcible administration of antipsychotic drugs that may occasion temporary distress and possible harmful after effects. \textit{Id.} at 655. The court also noted that, in order to satisfy the minimum procedural due process guarantees of the fourteenth amendment, a determination that the medication is necessary must be made by a qualified physician as to each individual patient who is to be medicated. \textit{Id.} at 656-57. Chief Justice Coffin left the district court free on remand to determine what additional procedures might be warranted to effectuate these guarantees. \textit{Id.} at 656.
  \item[\textsuperscript{149}] \textit{Id.} The court posited the following:
    [If the violence feared [of a patient] is potentially life-threatening, and the patient's prior experience with antipsychotics favorable, it would be patently unreasonable to require that defendants determine that the probability of the feared violence occurring is greater than fifty percent before they can act. By contrast, if the patient has experienced severe adverse side-effects from antipsychotics, it would be only reasonable to expect defendants to explore less harmful alternatives much more vigorously than in the former case.
  \item[\textsuperscript{150}] \textit{Id.} at 657. The court noted that to rule otherwise would be to ignore the very justification for the state's purported exercise of its \textit{parens patriae} power—a citizen's inability to care for himself. \textit{Id.} Noting that the Massachusetts judicial commitment statute contained no inference of a determination of incompetency of those committed, the court rejected the defendants' argument that the Massachusetts judicial commitment proceedings themselves result in a determination of mental illness and incapacity, which overrides a patient's decision to reject voluntary hospitalization and its treatment. \textit{Id.} at 657-59.
  \item[\textsuperscript{151}] \textit{Id.} at 659. The court did not specify what kind of determination of incompetency was necessary. \textit{Id.} Chief Judge Coffin stated:
\end{itemize}
However, contrary to the district court, he held that an emergency situation may also be one in which any delay in treating the patient could result in a significant deterioration of the patient's mental health, and that, in such situations, means other than adjudicatory proceedings must be employed. Finally, the court rejected the district court's requirement that, once a determination of incompetency is made, an individual guardian must make all treatment decisions involving the use of antipsychotic drugs and instead held that following a determination of incompetency, state actions based on parens patriae interests must be taken with the aim of making treatment decisions as the individual himself would were he competent to do so.

On writ of certiorari to the United States Supreme Court, the case was vacated and remanded without reaching the constitutional issues. Justice Powell, writing for a unanimous Court, held that such a disposition of the case was appropriate because of the combination of two factors: 1) the unclear record in the case with respect to the point of our analysis is instead to demonstrate that the commitment decision itself is an inadequate predicate to the forcible administration of drugs to an individual where the purported justification for that action is the state's parens patriae power. In so ruling, we recognize that there is a need for some procedure whereby the state can provide needed treatment to an objecting individual who lacks the capacity to make meaningful treatment decisions on his own.

Id.

152. See note 121 and accompanying text supra.

153. Id. at 659-60. The court accordingly vacated the district court's definition of the emergency circumstances in which adjudications are not required and remanded the case "for consideration of alternative means for making incompetency determinations in situations where any delay could result in significant deterioration of the patient's mental health." Id. at 660.

154. Id.

155. Id. at 661. In so holding, the court cited as its main concern the prevention of situations in which the best interests of a patient would dictate the use of medication, but delay in receiving the necessary approval of the guardian would delay such use, or deter such use by doctors. Id. at 661-62 n.9.

See also Davis v. Hubbard, 506 F. Supp. 915 (N.D. Ohio 1980). In Davis, the United States District Court for the Northern District of Ohio held that the fourteenth amendment's substantive due process guarantee of liberty affords a competent mental patient the constitutional right to refuse psychotropic drugs. Id. at 929-33. The court found, however, that the state may forcibly administer these drugs when it has "as a constitutional minimum" at least probable cause to believe that the patient is presently violent or self-destructive, and in such a condition is a present danger to himself, other patients, or the medical staff. Id. at 935. The court noted that it is not enough that the patient has at previous times exhibited violent tendencies. Id. The court also determined that the state may impose psychotropic drugs on the patient through its parens patriae power, but only upon a determination that the patient is not capable of rationally deciding for himself. Id. at 935.

156. 102 S. Ct. at 2442.
to whether the plaintiffs rested their claimed substantive and procedural liberty protections on state or federal law,\textsuperscript{157} and 2) the recent decision by the Massachusetts Supreme Judicial Court in \textit{In re Guardianship of Roe},\textsuperscript{158} which, according to the Court, could influence the disposition of the case because of its express reliance on Massachusetts state law as the basis of the individual's right to refuse treatment with antipsychotic drugs.\textsuperscript{159}

The Court initially noted that the issue of whether an involuntarily committed mental patient has a constitutional right to refuse treatment with antipsychotic drugs involves both substantive and procedural aspects.\textsuperscript{160} The substantive aspect was identified by the Court as involving the definition of the protected constitutional right, if any, and a determination of the competing state interests which might outweigh it.\textsuperscript{161} The Court identified the procedural aspect as "the minimum procedures required by the Constitution for determining that the individual's liberty interest actually is outweighed in a particular instance."\textsuperscript{162} The Court then noted that the substantive and procedural issues were intertwined with unavoidable questions of state law, which might afford state citizens broader substantive and procedural rights than those afforded by the Constitution.\textsuperscript{163} As a result, the Court concluded, "the minimal requirements of the Federal Constitution would not be controlling, and would not need to be identified in order to determine the legal rights and duties of persons within that State."\textsuperscript{164}

The Court observed that after certiorari was granted in \textit{Rogers}, the Supreme Judicial Court of Massachusetts announced its decision in \textit{Roe}.\textsuperscript{165} Based on the holding in \textit{Roe},\textsuperscript{166} the Court concluded that

\textsuperscript{157} Id.
\textsuperscript{158} Id. at 2449 (citing \textit{In re Guardianship of Roe}, - Mass. - , 421 N.E.2d 40 (1981)). For a discussion of \textit{Roe}, see notes 208-16 and accompanying text infra.
\textsuperscript{159} 102 S. Ct. at 2450-51.
\textsuperscript{160} Id. at 2448.
\textsuperscript{161} Id.
\textsuperscript{162} Id.
\textsuperscript{163} Id. at 2448-49. The Court noted the basic constitutional principle that "[w]ithin our federal system the substantive [and procedural] rights provided by the Federal Constitution define only a minimum. State law may recognize liberty interests [and procedural protections thereof] more extensive than those independently protected by the Federal Constitution." Id. at 2449.
\textsuperscript{164} Id.
\textsuperscript{165} Id. (citing \textit{In re Guardianship of Roe}, - Mass. - , 421 N.E.2d 40 (1981)).
\textsuperscript{166} The \textit{Roe} court held that a noninstitutionalized mentally incompetent person has a protected liberty interest in deciding whether to accept treatment with antipsychotic drugs. For a discussion of \textit{Roe}, see notes 208-16 and accompanying text infra.
Massachusetts common law might provide incompetents with substantive and procedural liberty rights broader than those of the Federal Constitution. The Court found, therefore, that it would be "inappropriate . . . to attempt to weigh or even to identify relevant liberty interests that might be derived directly from the Constitution, independently of state law." Accordingly, the Court held that the First Circuit on remand was to determine whether its holding should be revised in light of *Roe*, whether *Roe* may require the certification of "potentially dispositive state law questions to the Supreme Judicial Court of Massachusetts," or whether abstention might be appropriate. Thus, the continued vitality of the least restrictive alternative treatment doctrine adopted by the First Circuit in *Rogers* is uncertain.

IV. THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE:
AN ANALYSIS

The least restrictive alternative doctrine provides that governmental action must not intrude upon constitutionally protected interests to a degree greater than necessary to achieve a legitimate governmental purpose. In the context of the rights of involuntarily committed mental patients to refuse antipsychotic drugs, the application of this doctrine means that the existence of a less restrictive alternative treatment must be considered in determining whether a mental
patient's right to refuse such drugs overrides the state's powers and interests.\(^\text{172}\)

Members of the federal judiciary disagree as to whether the least restrictive alternative treatment doctrine is appropriate as a constitutional factor in defining the scope of the right to refuse treatment. The view advanced by the circuit court majority opinions in both Rogers v. Okin\(^\text{173}\) and Rennie v. Klein\(^\text{174}\) is that the least restrictive alternative treatment doctrine is such a constitutional factor. The First Circuit in Rogers concluded that both the state police power and the availability of a less restrictive alternative treatment are factors to be given equal weight in the individualized evaluation of the appropriate treatment to be administered to each patient in all circumstances.\(^\text{175}\) Similarly, the court in Rennie v. Klein was motivated by the importance of balancing the state's police power and parens patriae interests with the due process liberty interests retained by involuntarily committed mental patients.\(^\text{176}\)

The contrary view, expressed by Judge Garth in his separate opinion in Rennie v. Klein,\(^\text{177}\) is that the least restrictive alternative treatment standard should not be considered in the constitutional determination of whether the state may forcibly administer anti-drug, a smaller dosage of the intended drug, a different therapy, or physical restraints (seclusion, straightjacket, cuffs, padded leather belt, and wristlets). 653 F.2d at 847; Davis v. Hubbard, 506 F. Supp. 915, 940 (N.D. Ohio 1980). For a discussion of the various therapies available to psychiatrists for the treatment of mental patients, see Note, supra note 58, at 619-39. These therapies include the non-intrusive counseling or behavior modes (milieu therapy, psychotherapy and behavior modification) and the intrusive modes which may or may not be coupled with counseling techniques (drug therapy electroconvulsive therapy, electronic stimulation of the brain, lobotomy, and stereotactic psychosurgery). \textit{Id. See also} notes 57-58 and accompanying text supra.

172. The enforcement of the state's interests in the involuntary commitment of the mentally ill is rooted in the state's police and parens patriae powers. \textit{See}, e.g., Rennie v. Klein, 653 F.2d at 856 (Garth, J., concurring in part and dissenting in part). The state's police power is the power to protect the health and safety of the community, and the parens patriae power is the power to act on behalf of an individual who does not have the mental capacity to act in his own best interest. \textit{Id.}

173. 634 F.2d at 650. For a discussion of Rogers v. Okin, see notes 182-55 and accompanying text supra.

174. 653 F.2d at 836. For a discussion of Rennie, see notes 62-131 and accompanying text supra.

175. 634 F.2d at 655-56. \textit{See} notes 148-49 and accompanying text supra. The court in Rogers v. Okin required a case-by-case evaluation of the possibility and type of violence, the likely effects of a particular drug on the individual, and an appraisal of less restrictive alternative treatments. \textit{Id.} at 656.

176. 658 F.2d at 845-48. For a discussion of the least restrictive alternative treatment standard in Rennie, see notes 93-99 and accompanying text supra.

177. For a discussion of Judge Garth's opinion, see notes 121-31 and accompanying text supra.
psychotic drugs over a patient's refusal, primarily because it would be an unwarranted and unworkable intrusion of the judiciary into an area which should be left to medical judgment and expertise. According to Judge Garth, the state may administer antipsychotic drugs unconditionally if it demonstrates that an emergency situation exists, or that the patient does not have the mental capacity to make a rational decision with respect to medication.

It is submitted that from both a legal and operational standpoint, the least restrictive alternative treatment doctrine is an appropriate constitutional factor to be employed by courts confronted with the right to refuse treatment. The doctrine has gained wide recognition by the courts in a variety of factual contexts and is essential to the adequate protection of individual rights. The following analysis will outline the various factual contexts in which the least restrictive alternative doctrine has been accepted and applied as a legally permissible constitutional factor, including cases in which the doctrine has been applied to the rights of involuntarily committed patients. It will then examine the impact of applying the doctrine upon the various interests implicated by a mental patient's right to refuse antipsychotic drug treatment.

A. Application of the Least Restrictive Alternative Doctrine in Defining Constitutional Rights

The least restrictive alternative doctrine has been applied regularly in various factual contexts by the United States Supreme Court. In each instance, its application has been motivated by a recognition of a duty to afford individuals the full protection of their constitutional rights, even where the state has convinced the Court that some infringement on those rights is justified.

In Shelton v. Tucker, the Court held that the least restrictive alternative doctrine must be applied in protecting an individual's first amendment rights. The Court struck down an Arkansas personal history statute, which required disclosure of organizational member-

178. 653 F.2d at 859, 861 (Garth, J., concurring in part and dissenting in part). See notes 121-31 and accompanying text supra.
179. 653 F.2d at 857, 858 (Garth, J., concurring in part and dissenting in part). According to Judge Garth, an emergency situation would exist where it is necessary to prevent the patient from endangering himself or others. Id.
180. See notes 122-23 supra.
181. See notes 183-231 and accompanying text infra.
182. See notes 183-284 and accompanying text infra.
183. 364 U.S. 479 (1960).
184. Id. at 488.
185. Id. at 480-83. The statute compelled every teacher, as a condition of employment in state-supported schools or colleges, to file annually an
ship, as overbroad and used the least restrictive alternative doctrine as a "constitutional principle." It stated that

even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose. 187

Similarly, in Griswold v. Connecticut, 188 the least restrictive alternative doctrine was used by the Court, under the due process clause of the fourteenth amendment, to protect an individual's right to privacy which is embodied, as stated by the Court, in "several fundamental constitutional guarantees." 189 In Griswold, suit was brought challenging the constitutionality of a Connecticut anti-contraception statute. 190 In finding the law unconstitutional, 191 the Court relied upon the "fundamental principle" that "a governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms." 192

affidavit listing every organization to which he or she had belonged or regularly attended within the preceding five years. Id.

186. Id. at 489. The Court made this characterization after a lengthy review of first amendment cases it had decided since the early 1900's in which the least restrictive alternative doctrine was consistently highlighted and applied. Id. at 488-89 (citing Kunz v. New York, 340 U.S. 290 (1951); Sala v. New York, 334 U.S. 558 (1948); Martin v. Struthers, 319 U.S. 141 (1943); Cantwell v. Connecticut, 310 U.S. 296 (1940); Schneider v. State, 308 U.S. 147 (1939); Lovell v. Griffin, 303 U.S. 444 (1938)).

187. 364 U.S. at 488 (footnotes omitted).

188. 381 U.S. 479 (1965).

189. Id. at 485. The Court found the right of privacy rooted in various constitutional provisions including the first amendment's rights of freedom of the press, speech, and assembly, the third amendment's prohibition of the quartering of soldiers "in any house" in time of peace without the consent of the owner, the fourth amendment's right against unreasonable search and seizures, the fifth amendment's protection against self-incrimination, and the ninth amendment's preservation of all constitutional rights without prejudice. Id. at 482-85.

190. The statute made it a crime for any person to use "any drug, medicinal article or instrument for the purpose of preventing conception." Id. at 480 (quoting CONN. GEN. STAT. § 53-32 (1958)).

191. 381 U.S. at 485.

192. Id. (quoting NAACP v. Alabama, 377 U.S. 288, 307 (1964)). The Court has applied the doctrine under the due process clause in various other instances. See, e.g., Ingraham v. Wright, 430 U.S. 651, 673 (1977) (rights of students to be free from corporal punishment without due process); Wolff v. McDonnell, 418 U.S. 539, 555-56 (1974) (rights of prisoners to disciplinary proceedings must be accompanied by due process protections); Kent v. Dulles, 357 U.S. 116, 125 (1958) (right to travel with due process implications).
The Court has also applied the least restrictive alternative doctrine in cases under the commerce clause of the Constitution. For example, in *Dean Milk Company v. City of Madison*, suit was brought by a milk distributor challenging the constitutionality of a city ordinance which made it unlawful to sell any milk as pasteurized unless it had been processed and bottled at an approved pasteurization plant within a five-mile radius of the city's central square. In striking down the ordinance as an unconstitutional burden on interstate commerce, the Court recognized limits to justifiable state regulation, stating that "even in the exercise of . . . [a state's] unquestioned power to protect the health and safety of its people, if reasonable nondiscriminatory alternatives, adequate to conserve legitimate local interests, are available," they must be used.

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194. Id. at 350 (citing General Ordinance of the City of Madison § 7.21 (1949)).
195. Id.
196. Id. at 354. The Court has also applied the least restrictive alternative doctrine under an equal protection analysis of state regulations. See, e.g., Dunn v. Blumstein, 405 U.S. 330, 343 (1972). In *Blumstein*, the Court held that the right to vote merited the application of the least restrictive means doctrine. The Court stated:

> The State cannot choose means that unnecessarily burden or restrict constitutionally protected activity. Statutes affecting constitutional rights must be drawn with "precision" . . . and must be "tailored" to serve their legitimate objectives. And if there are other, reasonable ways to achieve those goals with a lesser burden on constitutionally protected activity, a State may not choose the way of greater interference. If it acts at all, it must choose "less drastic means."

Id.


Various federal appellate and district courts have also recognized and applied the least restrictive alternative doctrine in various factual contexts as has the Supreme Court. There is general agreement among at least four federal circuits that under the due process clause of the fourteenth amendment the states may constitutionally deprive pre-trial detainees of liberty only to the extent necessary to ensure their presence at trial. See, e.g., Duran v. Elrod, 542 F.2d 998, 999 (7th Cir. 1976); United States ex rel. Tyrrell v. Speaker, 535 F.2d 823, 827 (3d Cir. 1976); Rhem v. Malcolm, 507 F.2d 333, 336-39 (2d Cir. 1974); Anderson v. Nosser, 456 F.2d 835, 837-38 (5th Cir. 1972) (en banc), modifying, 438 F.2d 183 (5th Cir. 1971), cert. denied, 409 U.S. 848 (1972). But see Feeley v. Sampson, 570 F.2d 364, 370-71 (1st Cir. 1978) (rejection of least restrictive alternative standard in equal protection strict scrutiny analysis of detainee's rights concerning prison conditions).

The federal district court for the Northern District of California has held that under the eighth amendment of the Constitution accused criminals must be confined at the most limited level of restrictiveness necessary to ensure their appearance at trial and prevent danger to prison security. *Brenneman*
Although the above-mentioned cases recognize and accept the least restrictive alternative doctrine in factual contexts that differ from that of the involuntarily committed mental patient's right to refuse treatment, they support an application of the doctrine in that context. The doctrine as applied in the above cases protects the same fundamental personal rights which serve as the basis of the involuntarily committed mental patient's right to refuse treatment.197 These rights include the first amendment right of freedom of speech198 and the fourteenth amendment guarantee of liberty.199 It is the importance and sanctity of these constitutional rights which link all of these cases.

B. The Least Restrictive Alternative Doctrine as Applied in the Area of Mental Health Litigation

Within the last two decades, mental health litigation has also evidenced a concern for the personal liberties of mentally ill and mentally retarded patients with the application of the least restrictive alternative doctrine in varying factual contexts involving these patients. In *Romeo v. Youngberg*,200 the doctrine was implemented by the Third Circuit in the context of the rights of institutionalized mentally retarded patients to receive adequate treatment.201 In *Romeo*, the
plaintiff brought an action against officials of the Pennhurst State School and Hospital in Pennsylvania, alleging that the defendants improperly shackled him, failed to provide adequate protection for him from other residents, and afforded him inadequate treatment. In vacating the district court's verdict for the defendants and remanding the case for a new trial, the Third Circuit discussed the least restrictive alternative doctrine and indicated that "[w]here the issue turns on which of two or more major treatment approaches is to be


203. 644 F.2d at 154-56. The plaintiff was a 30-year-old mentally retarded person, suffering from a chemical imbalance of the brain that rendered his mental capacity approximately that of an 18-month-old child. Id. at 154-55. The plaintiff received various injuries resulting from attacks by other patients. These included a broken arm, fractured finger, and injuries to the sexual organs. Id. at 155. Also, after initiation of the suit, the defendants kept the plaintiff shackled to a bed or chair in the hospital for long periods each day and allegedly gave him inadequate medical attention. Id.

204. Id. at 172. The Third Circuit rejected the district court's application of an eighth amendment cruel and unusual punishment standard as inappropriate in the context of civil (as distinguished from criminal) confinement, and turned instead to a fourteenth amendment analysis to determine if the plaintiff's liberty interests were adequately protected. Id. at 156.

On writ of certiorari, the Supreme Court of the United States vacated and remanded the Third Circuit's decision, holding that the plaintiff had constitutionally protected liberty interests under the due process clause of the fourteenth amendment which entitled him to reasonably safe conditions of confinement, freedom from unreasonable bodily restraints, and such minimally adequate training as reasonably may be required by these interests. 102 S. Ct. at 2458-60. The Court also held that the plaintiff's constitutional rights must be balanced against the relevant interests of the state in protecting the patients and others in the institutions. Id. at 2460-61. The proper standard for determining whether the State has adequately protected such rights, the Court held, is whether professional judgment was in fact exercised by medical personnel at the institutions. Id. at 2461. The Court also held that in determining what is "reasonable," courts must show deference to the judgment exercised by a qualified professional, whose decision is presumptively valid. Id. at 2461-62. According to the Court, liability may be imposed on the professional "only when the decision...is such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment." Id. at 2462.

It is arguable that this language by the Court, granting extreme deference to the professional judgment of the medical personnel at the institutions, means that, if the professional applies a treatment within the range of "accepted professional judgment," it does not have to be the least restrictive treatment available. The Supreme Court, however, expressly stated that applicability of the least restrictive alternative was not present in the case. Id. at 2457 n.14.
adopted, a 'least intrusive' analysis may be appropriate." 205 The court recognized, however, that under the least restrictive alternative doctrine, the possibility of the effectiveness of a course of treatment and the danger of side effects must be considered. Where both exist, the court stated, the State should err in favor of the patient's safety. 206 This observation by the court shows its concern that a patient's constitutional interests be infringed only in the least restrictive manner available, even where the treatment would be potentially effective. 207

In the most recent case of In re Guardianship of Roe, 208 the parents of Richard Roe, III, a temporarily committed mentally ill patient, successfully petitioned the Massachusetts Probate Court to appoint the father as temporary and then permanent guardian of their son. 209 As guardian, the father was by implication authorized to make treatment decisions for his son. 210 Upon motion of Roe's guardian ad litem, however, the court prohibited the forcible administration of antipsychotic medication to Roe. 211 On appeal to the Supreme Judicial Court of Massachusetts, the issue was whether the guardian of a mentally ill person has the authority to consent to the forcible administration of antipsychotic drugs to his non-institutionalized ward in the absence of an emergency. 212 The court held that such

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205. 644 F.2d at 166.
206. Id. at 166 & n.45.
207. The court did note that any judicial scrutiny under the least restrictive alternative doctrine must be made of treatment programs, and not day-to-day or hour-to-hour medical decisions. Id. at 166-67, 168-69. In the appendix to the opinion, the court certified the following proposed jury instruction:

If you find that a selection of a mode of treatment subjected the plaintiff to significant deprivations of liberty, then you must go on and determine whether that decision provided for the least intrusive treatment available under the circumstances. If the defendants considered other alternatives and ascertained that the program adopted was the least intrusive available, then you should find the defendants not liable.

Id. at 173 (Appendix III C).

209. Id. at —, 421 N.E.2d at 44. Richard Roe, III, was temporarily committed to a state mental hospital for observation as a result of being charged with attempted unarmed robbery and assault and battery. Id. It was recommended that he be treated with antipsychotics, but Roe refused. Id.

210. Id.
211. Id. The initial prohibition was for a 10-day period. Id. A single justice of the Massachusetts Supreme Judicial Court, however, extended the stay until the time at which the court could hear the case on its merits. Id.
212. Id. at —, 421 N.E.2d at 42. The court also addressed the issues of whether the appointment of the guardians was proper in the circumstances presented in the case, and what the proper standard of proof in guardianship proceedings should be. Id. at —, 421 N.E.2d at 45. It must be noted that even though the ward in this case, Richard Roe, III, was institutionalized
a guardian has no authority to consent to the administration of antipsychotics in these circumstances. The court determined instead that a judicial determination was required to arrive at a "substituted judgment." The court also held that in making such "substituted judgments," the courts must respect the least restrictive alternative treatment doctrine where the state's interests in protecting the public safety justify forcible treatment of an individual. The court noted that "[t]he right to the least intrusive means is derived from the right to privacy, which stands as a constitutional expression of the 'sanctity of individual free choice and self-determination as fundamental constituents of life.'"

In Lake v. Cameron, the plaintiff, Catherine Lake, a sixty-year-old woman, was in commitment proceedings determined to be unable to care for herself and was consequently institutionalized in a mental institution at various times, the case was decided in the factual context of a non-institutionalized mentally ill person. Id. at —, 421 N.E.2d at 62.

Id. at —, 421 N.E.2d at 50.

Id. The court elaborated:

No medical expertise is required in such a . . . [determination], although medical advice and opinion is to be used for the same purposes and sought to the same extent that the incompetent individual would, if he were competent. We emphasize that the determination is not medically what is in the ward's best interest—a determination better left to those with extensive medical training and experience. The determination of what the incompetent individual would do if competent will probe . . . [his] values and preferences, and such an inquiry, in a case involving antipsychotic drugs, is best made in courts of competent jurisdiction.

Id. at —, 421 N.E.2d at 52. The court noted that the judicial determination of substituted judgment is a subjective rather than an objective determination. Id. at —, 421 N.E.2d at 56. Among the factors to be considered by the court in such a determination are 1) the ward's expressed preferences regarding treatment, 2) his religious beliefs, and 3) the probability of adverse side effects. Id. at —, 421 N.E.2d at 57-59.

The court also noted that circumstances exist in which the individual's right to refuse is subordinate to state interests. Id. at —, 421 N.E.2d at 59. The court identified these state interests as, inter alia, 1) the preservation of life, 2) the protection of the interests of innocent third parties, 3) the prevention of suicide, and 4) maintaining the ethical integrity of the medical profession. Id. (quoting Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 741, 370 N.E.2d 417, 426 (1977)).

Id., Mass. at —, 421 N.E.2d at 61. The court determined that the choices available to the non-institutionalized patient were involuntary commitment or involuntary medication. Id. According to the court, in applying the least restrictive alternative doctrine, courts are to choose those "means of restraint which would be chosen by the ward if he were competent to choose." Id. at n.24.

Id. at 61 (quoting Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 742, 370 N.E.2d 417, 426 (1977)). Interestingly, the Roe court, in an earlier portion of its opinion, cited the First Circuit's opinion in Rogers for this proposition. Id. at 50 n.9.

364 F.2d 657 (D.C. Cir. 1966).
hospital. The plaintiff appealed the denial of her petition for a writ of habeas corpus on the grounds that more appropriate treatment was available to her in a setting less restrictive than the "total confinement" of the hospital. Writing for the court, Chief Judge Bazelon held that "[d]eprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection." Instructions were given to the district court on remand to consider alternative courses of treatment, such as requiring Mrs. Lake to carry an identification card to ensure her speedy return home if she should wander, or requiring treatment in a public nursing home or community mental health center.

In Covington v. Harris, decided three years after Lake by the same court, the plaintiff was civilly committed to the maximum security pavilion of a mental hospital. Covington's habeas corpus petition seeking transfer from the maximum security pavilion to a less restrictive setting originated with a habeas corpus petition seeking release from a mental hospital where the petitioner had been sent after being detained for wandering the streets of Washington, D.C. Mrs. Lake was adjudged "of unsound mind" and committed to the same mental hospital.

Mrs. Lake did not contest the legality of the decision itself to commit and impose treatment. Id. at 660 (footnote omitted). Chief Judge Bazelon reasoned that "though [the plaintiff] cannot be given such care . . . [as a wealthy person because of her indigency] an earnest effort should be made to review and exhaust available resources of the community in order to provide care reasonably suited to her needs." Id. (emphasis added).

After Lake, several jurisdictions applied the least restrictive alternative standard in civil commitment decisions. See, e.g., In re Walls, 442 F.2d 749, 751 (D.C. Cir. 1971); Stamus v. Leonhardt, 414 F. Supp. 439, 452-53 (S.D. Iowa 1976); Dixon v. Attorney Gen. of Pa., 325 F. Supp. 966, 974 (M.D. Pa. 1971). Following the decision in Lake, the application of the doctrine was also suggested for the civil commitment of individuals under sexual psychopath statutes. See Fuller v. United States, 390 F.2d 468, 471 (D.C. Cir. 1967) (Bazelon, J., concurring). In a recent case, the United States District Court for the District of Connecticut held that a criminal defendant who is found incompetent to stand trial should be involuntarily committed only after a consideration of the least restrictive alternatives consistent with his restoration to capacity. DeAngelis v. Plaut, 503 F. Supp. 775, 780-81 (D.C. Conn. 1980). However, the Wisconsin Supreme Court recently rejected the doctrine's application to commitment hearings under that state's juvenile code. See J.K. v. State, 68 Wis. 2d 426, 228 N.W.2d 713 (1975).
restrictive ward was dismissed by the district court. On appeal, Chief Judge Bazelon ruled that the least restrictive alternative doctrine fashioned in Lake was also applicable to treatment decisions during involuntary hospitalization.

Since Covington, other jurisdictions have applied the doctrine of least restrictive treatment to post-commitment treatment decisions involving a hospitalized patient’s transfer to a more restrictive ward, and, generally, the right of all patients to receive treatment. Moreover, several jurisdictions have suggested that the doctrine applies to conditional discharge and outright release decisions.

The above cases in the mental health area indicate that the least restrictive alternative doctrine is a vital and active legal doctrine capable of application to prevent unjustifiable intrusions into a mental patient’s constitutional rights.

C. Application of the Least Restrictive Alternative Doctrine in Defining the Scope of the Right to Refuse Treatment: An Operational Analysis

In ultimately deciding whether the least restrictive alternative doctrine is a legitimate factor to be used in the context of an involuntarily committed mental patient’s right to refuse antipsychotic drugs, an operational analysis of the effects of this application will next be undertaken. It is submitted that a balancing of the quantity and quality of benefits and detriments to each party affected by this application—psychiatrist, judiciary, patient, and state—is necessary to determine the constitutional validity of requiring the application of the

225. Id. at 619-20.
226. For a discussion of the Lake holding, see text accompanying note supra.
227. 419 F.2d at 623-24. Judge Bazelon stated:
It makes little sense to guard zealously against the possibility of unwarranted deprivations prior to hospitalization, only to abandon the watch once the patient disappears behind hospital doors. The range of possible dispositions of a mentally ill person within a hospital, from maximum security to outpatient status, is almost as wide as that of dispositions without.

Id.
232. See notes 233-84 and accompanying text infra.
least restrictive alternative doctrine in the area of mental patients' refusals of antipsychotic drugs.

1. Interests of Psychiatrists and Medical Staff

Application of the least restrictive alternative treatment doctrine directly bears on the interests of the psychiatrist because judicial review of the medical treatment decisions made for various patients will necessarily accompany the doctrine. The psychiatrist will be required to participate in judicial hearings to explain various aspects of a patient's treatment program by producing medical records and medical treatment data on various patients, by appearing personally to testify, or both. The practical results would, therefore, seemingly include an additional burden on the psychiatrist's time, and a possible interference with his administrative duties, medical judgment, and treatment philosophies. From the psychiatrist's point of view, these practical consequences might seem to be an alarming intrusion into his practice. It is suggested, however, that there are four factors which not only allow but compel this intrusion. First, under the least restrictive alternative treatment doctrine as adopted by the circuit courts of appeals in Rennie and Rogers, interference with a

233. Use of the word "psychiatrist" in this comment is intended to encompass the entire medical staff of mental hospitals.

234. This judicial review would possibly consist of a formal or informal hearing, in which the facts surrounding the particular patient's treatment program would be determined through the presentation of evidence and testimony (the extent of which may be flexible), in which medical testimony as to the least restrictive treatment available would be offered by qualified psychiatric personnel, and in which a decision would be rendered by the judge as to whether the treatment program at issue is, in fact, the least restrictive. The judge, with the assistance of qualified psychiatric testimony, would retain the power to reform an unacceptable, non-restrictive treatment program, and enforce sanctions against the treating psychiatrist for failure to administer the reformed program.

235. Situations may be posited in which a hospital may not have a collection of medical treatment data or medical records of patients as extensive as a court may require in order to effectively monitor a patient's treatment program. In these cases, application of the doctrine would allow the judge to dictate what information must be compiled over the course of the treatment program.

236. This burden and interference could result from a least restrictive alternative treatment order by the judiciary or subsequent remedial penalties for failure to tailor the treatment program as judicially ordered.

237. This potential intrusion was cited by Judge Garth in Rennie v. Klein as a primary reason for his rejection of the least restrictive alternative doctrine in the context of the mental patient's right to refuse treatment. See note 123 and accompanying text supra.

238. For a discussion of Rennie v. Klein, see notes 62-131 and accompanying text supra.

239. For a discussion of the First Circuit's opinion in Mills v. Rogers, see notes 142-55 and accompanying text supra.
psychiatrist's time and administrative duties will actually be negligible in relation to the daily time and effort he devotes to his practice because the court will only review treatment programs and not daily decisions. Secondly, recent studies have demonstrated that psychiatrists often do not approach the treatment of mental patients with adequate concern for their rehabilitation and care. Thirdly, the intrusion may force the state and the psychiatric profession to re-examine and develop a conscious awareness of the importance of the patient's interests, thereby inducing further research and the creation of programs for the benefit of these patients. Although the psychiatric profession may feel resentful or burdened as a result of this judicial oversight, it is consistent with the professional and ethical duties owed by the psychiatric profession to its patients. Finally, the interests of the state and of the mental patient should weigh more heavily in this balancing of interests analysis than do the interests of the psychiatrists.

240. The circuit courts in *Rennie* and *Mills* held that the doctrine applies to an entire treatment program rather than to the daily or hourly administration of medical treatment. See notes 99 & 148 and accompanying text *supra*. Therefore, judicial review under the doctrine and the burden it would place on the psychiatrist's time would thus be triggered only on an infrequent basis, after a treatment program has been formulated, applied, and evaluated—a period which may encompass weeks or months. The actual period over which the treatment program will progress until it is reviewed, if ever, will depend on a number of factors, including whether the patient does in fact assert his right to a least restrictive treatment; the amenability of the particular psychiatrist to suggestions for changes in the treatment program by the patient or his counsel; and, if the program becomes subject to judicial review, the particular judge's degree of adherence to the standards set forth by the circuit courts in *Rennie* and *Rogers* with respect to review of a treatment program rather than of the daily or hourly administration of medication. For a discussion of the review of treatment programs as set out in *Rennie* and *Rogers*, see notes 99 & 148 and accompanying text *supra*.

241. For a discussion of these studies, see note 5 and accompanying text *supra*.

242. Enforcement of the least restrictive alternative treatment doctrine may serve to awaken the psychiatric profession as a whole to the specific, and largely neglected, needs of the mentally ill patient, and to new methods or medications for treating these needs and rehabilitating mental patients.

243. Perhaps mental patients and society can take solace in statements made by Dr. Michael Alfred Piezke made in response to criticism directed against the psychiatric profession:

> The challenge of . . . criticism, however, is that it continually forces the profession to look to itself for greater skill and precision in its language and in the treatment modalities that it delivers. If there is one thing that psychiatry, as part of medicine, can take pride in, it is its humility and willingness to incorporate into its practices lessons learned from experience.


244. For a discussion of the state's interest, see notes 253-64 and accompanying text *infra*. The patients' interests are dealt with at notes 257-72 and accompanying text *infra*.
2. Interests of the Judiciary

Application of the least restrictive alternative treatment doctrine requires the judiciary to review medical treatment decisions and to monitor the consequences. These tasks necessarily result in an increased burden and stress on the judges' time and expertise. Judges will be periodically faced with the duties of arranging, preparing for, and conducting hearings. Furthermore, the judge, in his limited capacity as a decisionmaker without medical training, will nevertheless be called upon to ultimately determine the least restrictive alternative treatment in each situation. It is submitted, however, that this reliance on the judge's limited expertise will be eased by documentary evidence and testimony, including that of medical experts, produced at the hearing.

Critics of the least restrictive alternative treatment doctrine have cited the effect on judicial time and the lack of expertise as the primary reasons for rejection of the doctrine in this context. The flaw in this criticism, with respect to the burden on judicial time, lies in its focus on the immediate effects of the application of the doctrine. The focus might be more properly placed on the long-term effects of the doctrine. It is suggested that in the long-run the application of the doctrine will reduce judicial involvement in treatment decisions by increasing the state and medical professionals' concern and accountability for the rehabilitation and care of patients through treatment. The result would thus be a lower incidence of patient-contested treatment decisions. It is further submitted that a blanket adoption of the least restrictive alternative treatment doctrine by the judiciary would effectively destroy the possibility of irresponsible and convenience-oriented treatment of mental patients by the mental establishment.

245. For a discussion of the possible nature of these judicial review proceedings, see note 234 supra.

246. Id.

247. For a discussion of the probable nature of the judicial hearings, see note 234 supra. In fact, given the possibility that the treatment approach at issue involves an evaluation of complicated mental illnesses and various treatment methods, medications, and consequences, it is arguable that the psychiatric expert at the hearing may be relied on by the court to such a great degree that "judicial expertise" may not actually be exercised at all.

248. See Rennie v. Klein, 653 F.2d at 859, 861, and note 123 and accompanying text supra.

249. For a discussion of the immediate effects on the judiciary of the doctrine's application, see text accompanying notes 245-47 supra.

250. A necessary premise to this conclusion is that the state and professional psychiatric authorities will implement responsible and constructive treatment programs subsequent to a court's imposition of the least restrictive alternative doctrine in this context. For a discussion of this premise, see notes 242-43 and accompanying text supra.

251. For a discussion of this convenience-oriented treatment, see notes 5 & 241 and accompanying text supra.
spontaneous responses to the plight of the mental patient by state and professional medical authorities, the burden on the courts associated with the adoption and application of the least restrictive alternative treatment doctrine is a necessary short-term evil.

Criticism of the least restrictive alternative treatment doctrine as an improper usurpation of medical decisions by an unqualified judiciary may be rebutted in two ways. First, as discussed above, the use of medical documentary evidence and expert testimony in the hearings will provide a sound resource on which the judiciary may rely in the judgment process. Secondly, and most important, it cannot be forgotten that courts are frequently called upon to make specialized and difficult decisions in many areas as part of their duty to decide cases and controversies.

3. Interests of the Patient

Among the interests of a patient that are affected by the forced use of the antipsychotic drugs is his interest in remaining free from unwarranted intrusions into his physical person and his mind.

252. *Id.*

253. The duration of this short-term burden necessarily depends upon the response time of the state and professional psychiatric authorities to the judicial imposition of least restrictive treatment orders, and/or penalties for failure to follow those orders. It would be too speculative to estimate when this will occur.

254. For a discussion of this criticism of the doctrine, see note 123 and accompanying text.

255. For a discussion of these hearings, see note 234 and accompanying text.

256. See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973) (Court called upon to decide issue of whether, and to what degree, a woman's right to have an abortion exists and the medical questions that necessarily surrounded such an issue).

257. Accordingly, the court in *Rennie* found a constitutional basis for this interest in the guarantee of liberty found in the fourteenth amendment. See 653 F.2d at 841-44. See also notes 85-91 and accompanying text. The circuit court in *Mills v. Rogers* found this interest rooted in the constitutional right to privacy. See 634 F.2d at 650. See also notes 143-44 and accompanying text. Also, a number of cases have rooted this interest in the eighth amendment. See *Knecht v. Gillman*, 488 F.2d 1156, 1158 (8th Cir. 1973) (administration of vomit-inducing drug in treatment of mental institution inmate without his written consent constitutes cruel and unusual punishment in violation of the eighth amendment); *Mackey v. Procunier*, 477 F.2d 877 (9th Cir. 1973) (allegation of administration of "fright drug" to patient at state medical facility without his consent sufficiently asserted a cause of action in cruel and unusual punishment in violation of the eighth amendment); *Pena v. New York State Div. for Youth*, 419 F. Supp. 203, 205 (S.D.N.Y. 1976) (administration of antipsychotics to youths at juvenile detention center without supervision by a physician under an ongoing treatment program is cruel and unusual punishment in violation of the eighth amendment).

258. Various courts have found the first amendment's right to mentation or thought as the constitutional root of this interest. See *Scott v. Plante*, 437 U.S. 268 (1978).
In the history of the common law, there is perhaps no right which is more respected than a person’s right to be free from unwarranted personal contact. As early as the middle of the thirteenth century, English law provided a method for monetary recovery for unauthorized contacts with the person. In fact, at a very early time, the cause of action required only a slight force, and did not depend upon whether the touching was done intentionally, negligently, or even accidentally. It is this very interest in physical security of the person and integrity of the body upon which the modern tort of battery is premised, and which is also protected by other tort actions including assault and intentional infliction of emotional distress. The interest of the person in the physical security of his body was also recognized in the 39th Article of the Magna Carta and was referred to by Blackstone as one of the three elements of liberty guaranteed to all Englishmen. Furthermore, our own constitutional history is filled with references to the importance of the “inviolability of the person.”
In fact, the prevailing constitutional tests which are applied by the courts to determine whether state action is constitutional differentiate between the fundamental interests, which include the interest in personal security, and the economic interests of the individual, with the former afforded more protection. And, as Professor Tribe states, "[t]he Constitution was consecrated to the blessings of liberty for ourselves and posterity. . . . [T]hose aspects of self . . . must be preserved and allowed to flourish if we are to promote the fullest development of human faculties and ensure the greatest breadth to personal liberty . . . ."  

The invasive use of antipsychotic drugs is likely to cause dysfunctions of the patient's mental nervous system as well as other symptoms. The patient may experience dizziness, weakness, or fainting. His appetite, heart rate, vision, and skin may be affected by the drugs. Muscle spasms and uncontrollable movements of the face, neck, tongue, and arms may occur along with other bizarre muscular activity. And unfortunately, some of these symptoms may be permanent.

265. For a discussion of this interest in the context of the patient affected by the use of antipsychotics, see notes 257-58 and accompanying text supra.

266. In order to pass constitutional muster, state action that infringes upon the "personal" or "fundamental" rights of an individual is strictly scrutinized. See, e.g., Roe v. Wade, 410 U.S. 113, 155 (1973) (limitations on the right of privacy bearing on the right to have an abortion must further a compelling state interest). On the other hand, state action that regulates the economic interests of the individual must only have some rational relation to a legitimate governmental purpose. See, e.g., Williamson v. Lee Optical Co., 348 U.S. 483 (1955) (economic regulation upheld if it is rationally related to a legitimate governmental end). The distinctions in the level of scrutiny applied by the Court to the various interests of the individual is rooted in the relative weight and importance afforded such interests.

267. L. Tribe, American Constitutional Law 893 (1978). Professor Tribe, addressing the issue of dangers to the rights of privacy and personhood presented by society, has stated further:

It is to resist such dangers that rights of personhood are elaborated, serving both as reminders of values to be preserved and as hints of values not yet realized. . . . Any fundamental rights of personhood and privacy too precisely or inflexibly defined defy the seasons and are likely to be bypassed by the spring floods. The best we can hope for is to encourage wise reflection—through strict scrutiny of any government action or deliberate omission that appears to transgress what it means to be human at a given time and place. Nothing less will yield a language and structure for creating a future continuous with and contiguous to the most humane designs of the past. 

Id. at 892-93.

268. For a full discussion of the side effects of antipsychotic drugs, see text and accompany notes 44-56.

269. See text accompanying notes 44-45.

270. See text accompanying notes 46-51.

271. See text accompanying notes 43-55.

272. See text accompanying note 56.
These effects represent the most extreme intrusion into the physical person and into the physical and mental security of an individual, since he is unable to combat or even control them in the slightest way. The drugs take up an authoritative residence in the mental patient's body. In these circumstances, the patient retains as much liberty to control his basic bodily functions as does a puppet—none. His constitutional right of liberty, as it relates to the most basic functions of a person—the control of one's body movements—becomes substantially impaired.

4. Interests of the State:

The interests of society would also be affected by an adoption of the least restrictive alternative treatment doctrine in a constitutional analysis of the involuntarily committed mental patient's right to refuse antipsychotic drugs. First, the state has an interest in protecting the public from individuals who may be dangerous to both the public and themselves.273 It is firmly established that the state is justified under a proper exercise of its police power in restricting the liberty of individuals in emergency situations.274 This restriction is accomplished initially by involuntary commitment of the individual to protect the general public.275 Subsequently, the individual may be subject to further restriction within the mental hospital to protect others in the hospital, including the patients, the medical staff, and visitors.276 Second, the state has an interest in caring for members of society who are unable to care for themselves, with the ultimate objective of making them constructive members of society. This interest falls under the state's parens patriae power.277 Again, involuntary commitment of an individual is the first step in accomplishing this restriction by placing the individual in an environment where he can be treated.278 Thereafter, various types of treatment may be given to the individual in

273. For a discussion of the state's interests triggered by the institutionalization of mentally ill individuals, see notes 90, 148 & 155 and accompanying text supra.

274. Id.

275. For a discussion of involuntary commitment procedures, see A. Brooks, supra note 48, at 605-06 (1974).

276. Such restriction may take the form of medication, including psychotropic drugs, mechanical restraints or physical restraints. See notes 57-58 & 172 and accompanying text supra.

277. For a discussion of the state's parens patriae power, see notes 90 & 152-55 and accompanying text supra; Siegel, The Justification for Medical Commitment—Real or Illusory?, 6 WAKE FOREST L. REV. 21, 29-33 (1969). See also an array of articles compiled by Professor Brooks on involuntary civil commitment. A. Brooks, supra note 48, at 601-05.

278. For a discussion of involuntary commitment procedures, see A. Brooks, supra note 66, at 675-78.
an attempt to improve his condition and develop him into a functional member of society. 279

Application of the least restrictive alternative treatment doctrine affects these state interests by restricting the state in its choice of treatments for the mental patient in certain situations. Under the doctrine, the state would be unable to pick and choose among various treatments. 280 Rather, it would be required to adopt the treatment that least infringes upon the patient's interests in bodily integrity. 281 It is submitted that application of the doctrine does not interfere with the state's interests per se, but only restricts the means by which the state may protect and advance these interests. 282 The purposes underlying the state's interests—protection of the public and medical staff from the patient, and the patient from himself—would not be frustrated.

The final interest of the state that would be affected by application of the least restrictive alternative doctrine is the control of the costs of mental health. The state has an interest in providing proper medical care to the mentally ill at the least expense to the taxpaying public. It is suggested that an application of the least restrictive alternative treatment doctrine could actually work to reduce the expense of medical care for the mentally ill by reducing the dependency of mental hospitals on antipsychotic drugs. 283 Further, savings may be garnered because the tools associated with alternative treatments, such as physical restraints in the form of ties or straight-jackets, may be reusable. Therefore, the primary, non-recurring cost would be the initial fixed purchase cost of such tools. 284 Given the present alleged

279. For a discussion of the various treatments available, see note 172 and accompanying text supra.

280. For a discussion of the definition of the least restrictive alternative doctrine, see notes 170-72 and accompanying text supra.

281. Id.

282. After the doctrine is applied, the states are still able to protect their interests, but can do so only in a more limited manner. For example, in a particular emergency circumstance, the state may be just as able to protect the attending psychiatrists and medical personnel, as well as the patient, by using a straight-jacket or wristlets rather than psychotropic medication, and, in particular, antipsychotics. For a discussion of the least restrictive alternative doctrine, see note 172 and accompanying text supra.

283. The initial fact to be noted is that the use of antipsychotic drugs by psychiatrists in medical hospitals in the treatment of mentally ill patients is a nationwide phenomenon. It is the rule rather than the exception. In addition, these drugs obviously cannot be reused. Like any other medication, they are expended when used and must be replaced if needed again. See notes 2-3 and accompanying text supra.

284. Of course, there would be costs associated with such tools, including maintenance and replacement. However, these costs can be reasonably expected to be proportionately low over their useful lives. Further, if psychoanalytical therapy is used as an alternative treatment, it can be seen that there will be no additional costs associated with such treatment beyond the recurring annual salary paid to the state psychiatrist.
overuse of antipsychotic drugs in mental hospitals, it is submitted that application of the doctrine will most certainly result in a reduction of the use of antipsychotic drugs and the costs associated with them.

V. CONCLUSION

It is submitted that an analysis of the relevant interests affected by application of the least restrictive alternative treatment doctrine and of the acceptance of the doctrine in other factual contexts supports a conclusion that the doctrine must be adopted in a constitutional analysis of the right of the involuntarily committed mental patient to refuse antipsychotic drugs. The initial premise underlying this conclusion is that the interests of the patient are the most important of those affected, as demonstrated by the doctrine's precedential acceptance in varying factual contexts, and, therefore, any medical and judicial decisions affecting them must be more closely scrutinized. The least restrictive alternative treatment doctrine protects the personal or fundamental interests of the patient by requiring medical personnel to apply that treatment which will result in the least intrusion into such interests while affording the patient a rehabilitative effect.

The benefits of the doctrine are not, however, restricted to the patient. It is submitted that adoption of the doctrine would also result in long-term economic benefits to society by reducing the amounts of money expended for medical care. It is further submitted that the interests of the judiciary will be promoted by a gradual transfer of its initial involvement in treatment decisions back to the psychiatric profession, where it primarily belongs, once the application of the doctrine gains widespread acceptance. Finally, it is suggested that adoption of the doctrine will improve the present levels of responsibility and accountability of the psychiatric profession to the best interests of the medical patient.

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