IN THE

United States Court of Appeals

FOR THE THIRD CIRCUIT

No. 79-2576
No. 79-2577

JOHN RENNIE, *et al.*, *Appellants*,

v.

ANN KLEIN, *et al.*, *Appellees.*

On Appeal From The United States District Court For The District of New Jersey

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BRIEF OF THE AMERICAN PSYCHIATRIC ASSOCIATION AS AMICUS CURIAE

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INTEREST OF AMICUS CURIAE

The American Psychiatric Association, founded in 1844, is the nation's largest organization of qualified doctors of medicine specializing in psychiatry. Almost 26,000 of the nation's approximately 33,000 psychiatrists are members. Psychiatrists have the principal responsibility for providing expert testimony in civil commitment proceedings and

for providing treatment to those who suffer from mental illness. The Association has participated as amicus curiae in numerous cases involving mental health issues, including *O'Connor* v. *Donaldson,* 422 U.S. 563 (1975); *Addington* v. *Texas,* 99 S.Ct. 1804 (1979); and *Parham* v. *J.R.,* 99 S.Ct. 2493 (1979). The instant case, which presents the question of whether civilly committed patients have a constitutional right to refuse psychiatric medication, will have important implications for the treatment of serious mental illness and, consequently, will greatly affect the concerns and the work of the Association and its members.

The parties have consented to the filing of this brief. Copies of their consenting letters have been filed with the Clerk.

STATEMENT OF THE CASE

Plaintiff John Rennie was a civilly committed psychiatric patient at Ancora State Hospital in New Jersey. He brought the instant action for injunctive relief under 42 U.S.C. § 1983 against his treating psychiatrists and other state officials, alleging, *inter alia,* that they had violated his right to refuse psychiatric medication in nonemergency situations.[1]

On December 22, 1977, the day Rennie's complaint was filed, the district court (Brotman, J.) granted plaintiff's motion for a temporary restraining order ("TRO") allowing him to refuse medication above a low-level "maintenance dosage" of prolixin, an antipsychotic medication. Shortly thereafter, the court held lengthy hearings on Rennie's claim for a preliminary injunction against forced medication. *Rennie* v. *Klein,* 462 F.Supp. 1131, 1134 (D.N.J.

[1] Rennie further alleged that defendants had violated his rights to treatment, to access to counsel, and to be free from physical abuse. These aspects of his complaint have been deferred pending resolution of the right to refuse treatment claim.

1978).[2] Although the court acknowledged the general efficacy of psychiatric medications, it found that one group—the antipsychotics [3]—could cause serious side effects, including tardive dyskinesia, a potentially irreversible disorder of the central nervous system characterized by involuntary muscle contractions in the face. In light of this conclusion, the court addressed the "novel and complex" issue, *id.* at 1142, of whether Rennie's constitutional rights were violated by N.J.S.A. 30:4-24.2(d)(1), the statute authorizing involuntary medication of committed patients.

After dismissing claims that involuntary medication violated the First and Eighth Amendments,[4] the district court

[2] During these hearings, Rennie "attempted suicide by swallowing an overdose of pills." *Rennie* v. *Klein,* 462 F.Supp. 1131, 1134 (D.N.J. 1978). Defendants thereupon moved to dissolve the TRO. The court convened the various psychiatrists involved in the case and it was agreed that Rennie would be placed on an antidepressant medication followed by lithium, *see* note 3 *supra,* and that the TRO would be dissolved. Shortly thereafter, Rennie again became assaultive, and, after using restraints for three days, the hospital reinstituted treatment with antipsychotic medication. Based on these facts, the court denied Rennie's renewed motion for a TRO against the use of antipsychotic medication.

[3] In addition to antipsychotic medication—which is used primarily to treat thought disorders—the court's opinion also discusses lithium and antidepressant medication, which are used largely to treat mood disorders. Collectively, these various medications are called "psychotropic medications." The court below, however, erroneously used the term "psychotropic" to refer solely to the antipsychotic medications. Therefore, although on its face the court's final order applies to all psychotropic medications, *e.g., Rennie* v. *Klein,* 476 F.Supp. 1294, 1313 (D.N.J. 1979), it is clear from the court's opinion that the decision applies only to the antipsychotic medications, and not to other psychotropics such as lithium or the antidepressants. *See id.* at 1312. To avoid confusion, amicus will use the term antipsychotic to refer to the class of medication as to which the court found a qualified right to refuse.

[4] The court first found that because the medication "was justifiably administered as treatment, not punishment," 462 F.Supp. at

concluded that involuntary administration of antipsychotic medication in nonemergency situations violated the constitutional right to privacy. The court went on to rule, however, that the patient's right to refuse was not absolute, but, rather, "qualified" by the state's interests in protecting patients and staff from harm, and in making decisions for patients whose capacities are significantly diminished. As an alternative holding, the court ruled that the addition of involuntary medication to involuntary commitment constituted a sufficient change in circumstances that due process required an adversary hearing—with an independent attorney and psychiatrist for the patient—to determine whether a patient's qualified right to refuse could be overridden by the state's interests in a particular instance. This determination was to be made after examination of four factors: "(1) plaintiff's physical threat to patients and staff at the institution, (2) plaintiff's capacity to decide on his particular treatment, (3) whether any less restrictive treatments exist, and (4) the risk of permanent side effects from the proposed treatment." 462 F.Supp. at 1148.[5]

1143, there was no violation of the Eighth Amendment. The court also ruled that there was no First Amendment violation because "the hospital's efforts to alter [Rennie's] thinking disorder" through medication were consistent with his desire "to be cured, not warehoused." *Id.* at 1144.

[5] Balancing these factors in Rennie's case, the court concluded that he should be treated with lithium and an antidepressant, rather than with antipsychotic medication. At the time of its decision, the court noted that Rennie was "not receiving [antipsychotic] drugs, and may soon be released from Ancora." 462 F.Supp. at 1148, n.6. Almost immediately thereafter, however, Rennie's illness "greatly deteriorated," *id.* at 1151, as he became more manic, grandiose and assaultive, and his physical condition worsened significantly. He was put on homicidal precautions, and placed in restraints; in addition, treatment with thorazine, an antipsychotic, was reinstated. Rennie again moved for an injunction against the thorazine, but the court denied his motion.

On March 20, 1979, the court allowed several intervenors to join the case as plaintiffs, and granted Rennie's motion to amend his complaint to include class allegations on behalf of all involuntary and voluntary adult patients at the five state psychiatric facilities in New Jersey. The court held extensive hearings on the class claims, the benefits and side effects of antipsychotic medications, and the conditions and treatment at the five state facilities.

In its opinion issued September 14, 1979, the court reaffirmed its earlier decision that civilly committed patients have a qualified privacy right to refuse antipsychotic medication. 476 F.Supp. 1294, 1307. Relying on the Supreme Court's intervening decisions in *Parham* v. *J.R.*, 99 S.Ct. 2493 (1979), and *Secretary of Public Welfare of Pennsylvania* v. *Institutionalized Juveniles*, 99 S.Ct. 2523 (1979), the court relaxed some of the due process requirements set forth in its initial opinion, however: it held that the required hearing could be informal, with an independent psychiatrist presiding; and that, while the patient could be represented by counsel, a nonattorney "patient advocate" would also be sufficient.

To implement its constitutional holding, the court issued a detailed injunction mandating a complex administrative mechanism applicable, in varying degrees, to both involuntary and voluntary patients. 476 F.Supp. at 1313-15.[6] Under these procedures, before any patient can begin receiving antipsychotic medication, he must sign a written consent form advising him of his right to refuse the medication and listing all of its known long-term and short-term side effects.

[6] Finding that voluntary patients were being forcibly medicated, the court ruled that the Constitution compelled recognition of a right to refuse treatment for them as well. It further held that since voluntary patients had an absolute right to refuse treatment under state law, N.J.S.A. 30:4-24.2(d)(1), the relief with respect to them was bottomed as well on the pendent state claim for enforcement of that statutory right.

If the patient refuses to sign or later orally objects to the medication, the necessary procedures for resolving his rights depend on his status.[7] Involuntary patients who have not been found legally incompetent by a court or "functionally incompetent" by their treating psychiatrists are entitled to an "informal" hearing by an "independent" psychiatrist —*i.e.*, one who does not work at the patient's facility—before medication may be given involuntarily.[8] The independent psychiatrist must issue a written opinion, effective for no more than 60 days, based on the four factors identified by the court, see page 4 *supra*, for deciding whether to accept or to override the patient's qualified right to refuse in each case.[9]

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[7] The court did not require these procedures in an emergency situation, *i.e.*, when there is a "sudden, significant change in the patient's condition which creates danger to the patient himself or to others in the hospital." 476 F.Supp. at 1313. Subject to certain administrative reviews, medication can be administered forcibly for up to six days in emergency situations "if the threat to life or limb continues." *Id.* at 1314.

[8] If the patient is voluntary, his refusal must be honored. If a voluntary patient has been found legally incompetent, and his guardian has not approved the medication, the hospital's medical director can consent to the medication after sending notice to the guardian and giving him an opportunity to object. Involuntary patients who have been found legally incompetent, or whom the treating physician finds incapable of giving consent, may be forcibly medicated, but a patient advocate must be given the opportunity to assess the patient's feelings and condition and to initiate a hearing before an independent psychiatrist if he deems it warranted. *Id.* at 1314.

[9] Although the court held that its independent review mechanism was sufficient for purposes of due process, it made clear that any member of the class retained his right to file a civil rights action in federal district court challenging any forcible medication. The court indicated, however, that "appropriate deference" would be given to the decision of the independent psychiatrist. *Id.* at 1312.

SUMMARY OF ARGUMENT

In fundamental disregard of the New Jersey law governing civil commitment of the mentally ill, the district court has created a constitutional right to refuse effective and necessary psychiatric medication. This new right is purportedly based on the constitutional rights to privacy and procedural due process. In amicus' view, the court's constitutional analysis is unfounded and its result is unwise.

New Jersey law provides that the decision to commit a seriously mentally ill person is a decision to treat that person's illness, even if the person objects. N.J.S.A. 30:4-23, 24.2(d)(1). Civil commitment must, of course, satisfy substantive constitutional norms, *see, e.g., O'Connor* v. *Donaldson*, 422 U.S. 563 (1975), and be attended by the appropriate due process protections, *see, e.g., Addington* v. *Texas*, 99 S.Ct. 1804 (1979). But once those requirements are met, whatever right to reject psychiatric medication that an individual might otherwise possess has been lawfully overcome by the state's legitimate parens patriae interest in treating his serious illness. *See Addington* v. *Texas, supra*, 99 S.Ct. at 1809. By unhinging commitment from treatment, the court below misperceived not only state law, but also the constitutional basis for civil commitment. Without the authority—and indeed the obligation—to treat, the state, in civilly committing someone, engages in nothing more than unlawful preventive confinement. *See Rouse* v. *Cameron*, 373 F.2d 451 (D.C. Cir. 1966); *Gary W.* v. *Louisiana*, 437 F.Supp. 1209, 1216 (E.D. La. 1976).

For like reasons, the district court's due process analysis is unfounded. The court erroneously concluded that "[t]o go from a state of confinement to confinement plus forced medication involves a major change in the conditions of confinement," thereby implicating a "sufficient liberty interest" to require a due process hearing. 462 F.Supp. at 1147. New Jersey law refutes this premise: since commitment is for purposes of treatment, there is no liberty

interest involved when the treatment is forthcoming. *See Meachum* v. *Fano*, 427 U.S. 215 (1976).

The court's remedy—imposition of a system of patient advocates and independent psychiatric reviews—is also inappropriate. While the court made clear that this relief was to help assure that "medication will be used more wisely," 476 F.Supp. at 1306, its order will not achieve this result. Rather, by focusing on the narrow concerns presented by patient refusals of medication, the court may divert resources from more needed reforms and will lock in a rigid constitutional remedy where discretion and flexibility are needed. This intrusion into the interstices of the state's administrative scheme violates well-settled principles of federalism. *See Bell* v. *Wolfish*, 99 S.Ct. 1861 (1979); *Rizzo* v. *Goode*, 423 U.S. 362 (1976).

Finally, plaintiffs have cross-appealed urging that the determination to override a patient's refusal to accept medication must be made at an adversary hearing, with the patient represented by counsel. Plaintiffs' claim must be rejected on the basis of the Supreme Court's recent decision in *Parham* v. *J.R.*, 99 S.Ct. 2493, 2506 (1979), which held that the "neutral and detached trier of fact" for such determinations should appropriately be a physician.

ARGUMENT

The district court found that the right to privacy and the due process clause provide civilly committed patients in New Jersey with a constitutional right to refuse antipsychotic medication. Amicus believes that, in reaching this unsupportable constitutional conclusion, the court confused two distinct issues: (1) a patient's privacy or liberty right to reject medication; and (2) the problems created by the misuse of powerful psychiatric medication. Thus, while invoking the rhetoric of privacy, the court made plain that its primary concern was to assure that "medication will be used more wisely." 476 F.Supp. at 1306.[10]

Amicus shares the court's concern about the misuse of antipsychotic medication resulting from the poor conditions and understaffing at New Jersey's state hospitals. Nevertheless, we believe that the court's approach is misguided. Part I of this brief will show that New Jersey law provides that the decision to civilly commit a mentally ill person authorizes the state to medicate him involuntarily, and that nothing in the Constitution requires a different result. Part II will demonstrate that the relief imposed is likely to frustrate good medication practices, and is constitutionally unwarranted. Finally, Part III will show that in no event does the Constitution require an adversary hearing to decide when to override a patient's decision to refuse medication.

I. CIVILLY COMMITTED PATIENTS DO NOT HAVE A CONSTITUTIONAL RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION IN NONEMERGENCIES.

A. New Jersey Law Specifically Authorizes Involuntary Medication Of Committed Patients.

A person facing civil commitment in New Jersey is assured full due process procedural protections, including a judicial hearing and the right to counsel. *See* N.J.S.A.

[10] The court underscored this fact by applying its holding to antipsychotic medication, not to other kinds of strong medication such as lithium or the antidepressants. *See* n. 3, *supra*. The constitutional analysis that might lead to a right for individuals generally to reject forcible medication by the state, logically should cover all psychiatric medication, not just antipsychotics. But the court limited its ruling to antipsychotic medication, explaining that "it is the only type of drug for which there has been proof of harm to patients and overuse in the hospital." 476 F.Supp. at 1312.

30:4-27 *et seq.*[11] At the commitment hearing, the state must establish by clear and convincing evidence, *Addington* v. *Texas, supra,* that the prospective patient is mentally ill and, as a result, is "dangerous to self or society," *State* v. *Krol,* 344 A.2d 289, 298 (N.J. 1975). "Mental illness," for purposes of commitment, means "mental disease to such an extent that a person so afflicted requires care and treatment for his own welfare, or the welfare of others, or of the community." N.J.S.A. 30:4-23. The state's decision to hospitalize a person involuntarily thus unavoidably requires a prior decision that the person requires care and treatment. In short, treatment—not just confinement—is "inherent in the rationale" for commitment. *State* v. *Carter,* 316 A.2d 449, 456 (N.J. 1974).

The statutory scheme also provides that a committed patient has the right "[n]ot to be subjected to experimental research, shock treatment, psychosurgery or sterilization, without the express and informed consent of the patient after consultation with counsel or interested party of the patient's choice." N.J.S.A. 30:4-24.2(d)(2).[12] In contrast to

[11] Under New Jersey law, a patient may be hospitalized in an emergency on the basis of certificates from two physicians certifying that the patient is in need of immediate confinement in a psychiatric hospital for care and treatment. N.J.S.A. 30:4-29, 30, 37, 38. Where feasible, a temporary order of commitment from a court is required before the patient is hospitalized, *id.* at 30:4-37, but where it is impossible to obtain such a temporary order prior to hospitalization, the hospital's chief executive officer is required to mail the certificates to the county adjuster so that he can file for a temporary order of commitment. *Id.* at 30:4-38. In any event, a full court hearing is required not later than 20 days after the temporary commitment order or 20 days after hospitalization if no such order was issued. *Id.* at 30:4-37, 38. These procedures fully comport with due process. *See Coll* v. *Hyland,* 411 F.Supp. 905 (D.N.J. 1976) (three judges, per curiam).

[12] This section further provides that if a committed patient has also been declared legally incompetent, the designated treatments cannot be administered without a court hearing.

these treatments, however, psychiatric medication is considered a "customary" form of treatment. *Matter of B.,* 383 A.2d 760, 763 (N.J. Super. Ct. 1978). Accordingly, with respect to medication, the patient possesses only the following rights:

> To be free from unnecessary or excessive medication. 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 physician's 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. N.J.S.A. 30:4-24.2(d)(1).[13]

A committed patient thus has no right to refuse psychiatric medication. *See Matter of B., supra.*[14]

[13] In addition, the committed patient has the "right to participate in planning for his own treatment *to the extent that his condition permits.*" N.J.S.A. 30:4-24.1 (emphasis supplied). The New Jersey legislature thus has left the determination of a patient's capacity to participate in planning for his treatment to the expertise of the treating physician.

[14] New Jersey does not revoke a committed patient's other rights, such as to marry or to make a valid will, unless the patient has also been adjudicated incompetent. N.J.S.A. 30:4-24.2(a), (e). This is in no way inconsistent with the state's concomitant decision to limit a committed patient's right to participate in medication decisions. *See id.* at (a) ("no patient shall be deprived of any civil right solely *by reason of his receiving treatment* [as a committed patient]") (emphasis supplied). It is well-recognized that an individual can be competent for some purposes but not for others. *See, e.g.,* Developmental Disabilities Model Legislation Series, 3 Mental Disability L. Rptr. 264-90 (1979); Ford, *The Psychiatrists' Double Bind: The Right to Refuse Medication,* Am. J. Psychiat. 332, 333-34 (1980). By drawing a distinction between civil commitment and an adjudication of incompetence, New Jersey,

B. New Jersey Law Does Not Violate The Constitution.

The district court concluded that New Jersey law was constitutionally deficient in failing to provide committed patients a right to refuse medication in nonemergencies. In reaching this result, the court relied on the "individual's autonomy over his own body," and his "right to protect [his] mental processes from governmental interference." 462 F.Supp. at 1144. Amicus submits that these privacy interests were lawfully overcome by the decision to commit the patient.[15] The fatal flaw in the district court's opinion is its failure to explain why the decision to commit a person against his will is not a sufficient constitutional predicate to justify the provision of that treatment for which the person was committed to receive. Indeed, the thrust of the court's opinion is directly contrary to the recent analysis of three judges of this Court, explaining that in civil commitment, "the very purpose of the governmental intrusion

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like many states, sensibly restricts the legal rights of a committed patient only to the extent necessary for the state to achieve its legitimate interests in civil commitment.

[15] Plaintiffs, in their brief on appeal, claim that the American Psychiatric Association and one of its constituent branches, the Massachusetts Psychiatric Society, have urged that committed patients be given an additional due process hearing before they can be medicated. Plaintiffs Br. at 45-46. Plaintiffs are mistaken. In the report cited by plaintiffs, the APA specifically recognized that involuntary treatment was appropriate "on the basis of valid (legal) commitment certificates." Rachlin, *Civil Commitment, Parens Patriae, and the Right to Refuse Treatment*, 1 Am. J. Forensic Psychiat. 174, 186 (1979). Plaintiffs likewise misperceive the thrust of Dr. Loren Roth's comments, *see* Roth, *Judicial Action Report*, 14 Psychiatric News No. 3 at 18 and No. 9 at 3 (February 2, 1979; May 4, 1979), which, in any event, can hardly be attributed to the APA. Finally, plaintiffs also misrepresent the position of the Massachusetts Psychiatric Society. The position cited by plaintiffs was explicitly proposed as a "fall-back" position. The primary position of the Massachusetts Psychiatric Society was to urge rejection of a right to refuse medication.

is to prevent the individual from exercising his or her freedom in a self-destructive manner." *Halderman* v. *Pennhurst*, —— F.2d ——. (Nos. 78-1490, 78-1564, 78-1602, slip op. at 91) (3d Cir. Dec. 13, 1979) (en banc) (dissenting opinion).

It is well established that the state may commit mentally ill patients for involuntary treatment. The "state has a legitimate interest under its parens patriae powers in providing care to its citizens who are unable because of emotional disorders to care for themselves." *Addington* v. *Texas*, *supra*, 99 S.Ct. at 1809. *See also O'Connor* v. *Donaldson*, *supra*; *French* v. *Blackburn*, 428 F.Supp. 1351, 1354 (M.D.N.C. 1977), *aff'd summarily*, 99 S.Ct. 3091 (1979). It must follow, therefore, that once a patient is properly committed, the state may treat his mental illness even if he objects:

> The question in the case before us is whether the state, consistent with [plaintiff's] right of privacy, can assume the decision of whether [plaintiff], an involuntarily committed mental patient, will undergo psychiatric treatment. We observe that the more fundamental decision, whether he was to undergo hospitalization, was assumed by the state at the commitment proceeding, the validity of which is not contested.
>
> . . . If th[e] interest of the state is sufficiently important to deprive an individual of his physical liberty, it would seem to follow that it would be sufficiently important for the state to assume the treatment decision. We hold that it is. *Price* v. *Sheppard*, 307 Minn. 250, 239 N.W.2d 905, 911 (1976).

See also Rachlin, *Civil Commitment, Parens Patriae, and the Right to Refuse Treatment*, 1 Am. J. Forensic Psychiat. 174 (1979).

The district court in this case attempted to separate the decision to commit from the decision to treat. For persons committed under the state's police power, the court stated that the "fact that the patient is dangerous in free society

may give the state power to confine, but standing alone it does not give the power to treat involuntarily." 462 F.Supp. at 1145.[16] The court mistakenly assumed, however, that in committing persons who are dangerous to others the state is acting with a unitary purpose; this analysis totally ignores the New Jersey statute which makes plain that persons committed as dangerous to others are committed for "care and treatment" as well as for the "welfare of others, or of the community." N.J.S.A. 30:4-23. And for persons committed under the parens patriae power, the court stated that "before the state can use parens patriae as a basis for [forcible] medication, some hearing on the issue of competency must be held." 462 F.Supp. at 1145, 1146. But so far as the decision to reject medication is concerned, that hearing was held at the time of commitment. Indeed, for parens patriae commitments, the *sole* justification is to help the patient; hence the failure to treat renders the purpose of the commitment nugatory. Thus for both police power and parens patriae commitments, the state's lawful purpose, in whole or in part, is to treat the committed patient. *See Rouse* v. *Cameron, supra; Bowring* v. *Godwin,* 551 F.2d 44, 48 (4th Cir. 1977); *Wyatt* v. *Aderholt,* 503 F.2d 1305, 1312-14 (5th Cir. 1974); *Rone* v. *Fireman,* 473 F.Supp. 92, 188 (N.D. Ohio 1979); *Stuebig* v. *Hammel,* 446 F.Supp. 31, 34 (M.D. Pa. 1977).

By separating treatment from commitment, the district court not only misunderstood New Jersey law, but it also undermined the constitutional basis for commitment itself. The Supreme Court has made clear that "[i]n a civil commitment state power is not exercised in a punitive sense." *Addington* v. *Texas, supra,* 99 S.Ct. at 1810 (footnote omitted). Yet, this is precisely what the district court would

[16] The case the court cited in support of this proposition, *Winters* v. *Miller,* 446 F.2d 65 (2d Cir.), *cert. denied,* 404 U.S. 985 (1971), is inapposite. *Winters* involved a refusal of medication by a Christian Scientist founded specifically on the patient's First Amendment right to religious freedom. It did not establish a more general limitation on the state's power to treat.

allow here by its decision to authorize continued commitment of a patient who rejects treatment. The court itself candidly recognized that the "alternative to accepting treatment may be permanent custody [in the hospital]." 462 F.Supp. at 1146. In such circumstances, psychiatric hospitalization impermissibly becomes "equivalent to placement in a penitentiary where one could be held indefinitely for no convicted offense.'" *Gary W.* v. *Louisiana, supra,* 437 F. Supp. at 1216, quoting *Ragsdale* v. *Overholser,* 281 F.2d 943, 950 (D.C. Cir. 1960) (Fahy, J., concurring). *See also Donaldson* v. *O'Connor,* 493 F.2d 507, 52[5] n.22 (5th Cir. 1974), *vacated* and *remanded* 422 U.S. 563 (1975); *Welsch* v. *Likins,* 373 F.Supp. 487, 497 (D. Minn. 1974). In short, treatment is an essential ingredient in commitment, and the decision to commit properly overcomes any right to refuse appropriate medication that a person might otherwise possess.[17]

[17] In apparent elaboration of its privacy analysis, the court below stated that the constitutional doctrine of the least restrictive alternative "should be extended to the choice of medications." 462 F.Supp. at 1146. This unprecedented holding is likewise without constitutional basis and ignores plain clinical realities. Indeed, the application of the doctrine to the choice of custodial settings—let alone medications—has been rejected. *See State* v. *Sanchez,* 457 P.2d 370 (N.M. 1968), *dismissed for want of a substantial federal question,* 396 U.S. 276 (1970). And the only three judges of this Court to consider the issue in a recent case involving housing for mentally retarded citizens rejected this constitutional approach, explaining that the choice of setting was primarily a "medical" one, and that, moreover, the least restrictive setting would change over time; thus adoption of the constitutional rule would mean that "almost every decision concerning the care of a mentally retarded person would be subjected to ongoing judicial review." *Halderman* v. *Pennhurst,* —— F.2d —— (Nos. 78-1490, 78-1564, 78-1602, slip op. at 92) (3d Cir. Dec. 19, 1979) (en banc) (dissenting opinion).

These concerns are even more compelling in considering the application of the doctrine to the choice of psychiatric medications. The assumption that various medications are interchangeable is itself a faulty premise. But even assuming it were true, how does one decide whether a medication with an A percent likelihood of

For the same reasons, the district court's alternative holding that due process requires an additional hearing before a committed patient can be forcibly medicated was also erroneous. Moreover, the court's due process analysis rests on the mistaken assertion that "[t]o go from a state of confinement to confinement plus forced medication involves a major change in the conditions of confinement," thereby implicating a "sufficient liberty interest" to require a due process hearing. 462 F.Supp. at 1147. The Supreme Court has made clear that whether a change in the conditions of confinement implicates a due process liberty interest depends on whether state law creates such an interest. *Meachum* v. *Fano, supra,* 427 U.S. at 226.[18] In this case, New Jersey lawfully deprives an individual of his liberty by the decision to commit and, then, not only does it not create a liberty interest by prohibiting forced medication, it explicitly eschews such an interest by authorizing the practice. State law being clear on this fact, there is no due process issue raised by involuntarily medicating patients. Compare note 20 *infra.*

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reducing psychotic symptoms, a B percent risk of causing serious side effects, a C percent likelihood of requiring hospitalization for D days, and an E percent risk of rehospitalization is more or less restrictive than a medication with a different constellation of probabilities? In more simple terms, is 30 days on an antidepressant less restrictive than 10 days on an antipsychotic, even assuming that these determinations could be made at the outset? *See* Michels, *The Right to Refuse Psychoactive Drugs,* 3 Hasting Ctr. Rpts. 8 (June 1973). In short, the choice of treatment is uniquely a matter for ongoing clinical assessment and review, not for consideration at a due process hearing. *See Parham* v. *J.R.,* 99 S.Ct. 2493, 2507 (1979); *Bowring* v. *Godwin,* 551 F.2d 44, 48 (4th Cir. 1977) ("we disavow any attempt to second-guess the propriety or adequacy of a course of treatment") (footnote omitted).

[18] In *Fano,* the Court ruled that a prisoner could be transferred to a more restrictive setting without a hearing since state law created no liberty interest with respect to the place of confinement.

Nor was the decision below mandated by this Court's decision in *Scott* v. *Plante,* 532 F.2d 939 (3d Cir. 1976).[19] There, an inmate who had been confined in a hospital for the criminally insane for almost twenty years, first on grounds of incompetence to stand trial and then on grounds of acquittal by reason of insanity, brought a § 1983 action alleging, *inter alia,* that he had been involuntarily medicated in violation of various constitutional provisions. This Court reversed the district court's decision granting summary judgment against Scott, stating that forced medication "could amount, *under an appropriate set of facts,* to an interference with Scott's rights under the first amendment," and that "*under certain conditions,* Scott's claim may raise an eighth amendment issue respecting cruel and unusual punishment." 532 F.2d at 946-47 (emphasis supplied).[20]

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[19] It should be noted initially that the only reference to the right to privacy in *Scott* was a footnote where, after laying out in text the possible bases for finding a constitutional violation as a result of involuntary medication, the court noted that "[a] possible fourth constitutional deprivation might include invasion of the inmate's right to bodily privacy which has been adumbrated in various Supreme Court decisions. . . . The scope of such a right, however, remains ill-defined." 532 F.2d at 946 n.9 (citations omitted).

[20] The court also noted a possible due process violation, stating "*on this record* we must assume that Scott, though perhaps properly committable, has never been adjudicated an incompetent who is incapable of giving an informed consent to medical treatment." 532 F.2d at 946 (emphasis supplied). Scott, however, was not hospitalized pursuant to state law governing civil commitment. Rather, he was committed under a different statutory scheme, which concerned insane persons charged with a crime. *See id.* at 944. Under those provisions, state law afforded such patients a right to refuse medication unless a guardian consents on their behalf. *See id.* at 943, 946. Thus, state law created the due process liberty interest. *See Meachum* v. *Fano, supra,* discussed at p. 16. In this case, by contrast, state law, by denying civilly committed patients a right to refuse medication, creates no liberty interest subject to due process scrutiny.

Amicus does not dispute that, in an individual case, forced medication could violate a patient's First or Eighth Amendment rights. When medication is administered not for purposes of treatment but for punitive reasons or in violation of religious rights, a constitutional violation may be found.[21] *See, e.g., Knecht* v. *Gillman,* 488 F.2d 1136 (8th Cir. 1973) (vomit-inducing drug administered to prisoner as punishment); *Mackey* v. *Procunier,* 477 F.2d 877 (9th Cir. 1973) (breath-stopping and paralyzing "fright drug" administered to prisoner); *Nelson* v. *Heyne,* 355 F.Supp. 451 (N.D. Ind. 1972) *aff'd,* 491 F.2d 352 (7th Cir.), *cert. denied,* 417 U.S. 976 (1974) (tranquilizers administered to juveniles in correctional facility without medical evaluation and not as part of treatment program); *Winters* v. *Miller,* 446 F.2d 65 (2d Cir.), *cert. denied,* 404 U.S. 985 (1971) (forced psychiatric medication of Christian Scientists). But where, as in this case, medication is given "as part of an ongoing treatment program authorized and supervised by a physician," *Pena* v. *New York State Division For Youth,* 419 F.Supp. 203, 211 (S.D.N.Y. 1976), no constitutional violation can be established. *See also Welsch* v. *Likins, supra,* 373 F.Supp. at 503.

II. THE RELIEF ORDERED IS CONSTITUTIONALLY INAPPROPRIATE AND WILL NOT REMEDY THE PROBLEM OF MEDICATION MISUSE.

Although the district court found a constitutional right to refuse medication based largely on privacy interests, it is clear that its relief was aimed at assuring that "medication will be used more wisely." 476 F.Supp. at 1306.

[21] In this regard, it should be noted that where, as in *Scott*, an inmate had been committed not for treatment as a regular patient in a civil hospital, but had been diverted from the criminal process into a hospital for the criminally insane, there is greater reason to question whether the medication is part of the ongoing treatment program. This is especially so on a motion for summary judgment. In this case, by contrast, the court specifically found, after a full trial, that there was no First or Eighth Amendment violation. *See* 462 F.Supp. at 1143-44.

Faced with a serious problem of misuse of medication in New Jersey state hospitals, the court fashioned a remedy requiring review of medication practices, as well as patient consent forms and patient advocates. This relief, while well-motivated, is constitutionally inappropriate. If upheld, it will rigidify the treatment system for committed patients at a time when clinical flexibility is needed.

A. Abuses In The Delivery of Psychiatric Care In New Jersey Have Resulted From Inadequate Facilities And Staff.

The court below heard extensive testimony concerning the operation of New Jersey's state hospitals for the mentally ill. Its opinions make clear that it was troubled by what it heard. It found that these hospitals generally have "large, bleak and unpleasant wards," 476 F.Supp. at 1299; that they are so understaffed that psychiatrists have insufficient time for each patient, *ibid, see also* 462 F.Supp. at 1136; and that patients are left with large blocks of unproductive and unstructured time. Likewise, with respect to medication, the court found many practices resulting in inadequate patient care. Decisions about medication are often left to nurses and ward staff rather than physicians; patient records are poorly documented; medication is used sometimes for purposes other than treating the patients' medical problems; and many patients suffer from both transient and permanent side effects that are not properly detected or treated. 476 F.Supp. at 1299-1300.

These results, while disquieting, are not surprising. When hospitals are understaffed and patients are denied proper psychiatric care, the treatment milieu is overcome by the kind of concerns for security that characterize a prison: maintenance of stability and routine become paramount. *See generally* E. Goffman, Asylums (1961). In such circumstances, medication is used not so much to treat the patient, but to restrain him so that idleness and boredom do not result in violence and disruption. *See Nelson* v.

Heyne, supra; Hearings Before the Subcommittee to Investigate Juvenile Delinquency of the Senate Committee on the Judiciary, The Abuse and Misuse of Controlled Drugs in Institutions, 94th Cong., 1st Sess. (1975). This problem feeds on itself because, as the treatment milieu deteriorates, it becomes increasingly difficult to attract competent psychiatrists to work in such settings. *See generally* Note, Psychiatry in the Public Sector, 30 Hosp. & Comm. Psychiat. 733 *et seq.* (1979). Despite social pressures to do so, psychiatrists strongly resist becoming jailers.

These conditions, in turn, lead to the kinds of medication abuse witnessed in this case.[22] Medication dosages are often increased and additional medications are needlessly added as the staff attempts to sedate patients. Thus, while "medicated," patients nonetheless are not being treated. As a result, they remain hospitalized longer than necessary. And, it is when inappropriate dosages of antipsychotics are combined with prolonged hospital stays that the problems with side effects become most dramatic.[23] Finally, in a

[22] For example, in one instance the court below found that a patient had been given heavy dosages of medication because she was frequently "quarrelsome," and that her ill-temper was due in large measure "to the fact that she felt unneeded and idle on the ward and was sometimes subject to physical assault from attendants." 476 F.Supp. at 1301. In another case, a patient's tardive dyskinesia was neglected, apparently because a neurologist's report had been "lost in her records." *Ibid.*

[23] The most serious side effect is tardive dyskinesia, which involves involuntary or semi-involuntary tic-like movements generally of the tongue, facial and neck muscles. *See* R. Baldessarini, Chemotherapy in Psychiatry 46 (1977). Tardive dyskinesia, however, does not occur from short-term use of reasonable dosages of antipsychotics. Rather, it almost always occurs after prolonged usage of high dosages of antipsychotic medication. *See* Jeste, *et al., Tardive Dyskinesia—Reversible and Persistent,* 36 Arch. Gen. Psychiat. 585 (1975). Nevertheless, the problems posed by tardive dyskinesia are indeed serious, and much careful examination should be given to its incidence, effects and reversibility. Amicus has appointed a task force of eminent psychiatrists and neurologists to study the problem, and its report will soon issue. *See also* Dorsey, *et al., Psychopharmacological Screening Criteria Development Project,* 241 J. Amer. Med. Ass'n. 1021 (1979).

Despite these serious concerns, it is important to point out that the extremely tendentious claims concerning tardive dyskinesia, made throughout plaintiffs' brief on appeal, are not medically supportable. Since the symptoms are similar to some of the involuntary movements suffered by many persons with schizophrenia, differentiating between tardive dyskinesia and schizophrenic mannerisms is often quite difficult. Jeste & Wyatt, *Tardive Dyskinesia: The Syndrome,* 10 Psychiat. Annals 16, 19 (1980). Abnormal involuntary movements were reported in chronic patients many years before the antipsychotic medications were used. *Ibid.* Nor is tardive dyskinesia necessarily irreversible. Jeste, *et al. Tardive Dyskinesia —Reversible and Persistent, supra.* In fact, increasingly, new ways to treat or manage tardive dyskinesia are being found. *See* Gelenberg, *et al., Choline and Lecithin in the Treatment of Tardive Dyskinesia: Preliminary Results from a Pilot Study,* 136 Am. J. Psychiat. 772 (1979); Jus, *et al., Long Term Treatment of Tardive Dyskinesia,* 40 J. Clin. Psychiat. 72 (1979); Jeste & Wyatt, *In Search of Treatment for Tardive Dyskinesia: Review of the Literature,* 5 Schizophrenia Bull. 25 (1979).

The other side effects of the antipsychotics, known as extrapyramidal effects, are reversible. They include primarily akinesia (weakness and diminished spontaneity) and akathisia (an inability to be still). Beside subsiding when the medication is discontinued, these side effects can often be alleviated or reduced by changing medications and by treatment with an anti-Parksonian medication. R. Baldessarini, Chemotherapy in Psychiatry, *supra,* at 43-44.

seemingly endless cycle, the same neglect that often causes the serious side effects in the first place assures that they will not be properly dealt with when they occur.

When these problems are vividly portrayed in the drama of a courtroom trial, it is readily understandable that a judge will feel moved to action. The problem is that, as history has repeatedly demonstrated, judicial intervention is not well-suited to remedy these difficult human problems. *See generally* Note, Mental Health Litigation: Implementing Institutional Reform, 2 Mental Dis. L.Rptr. 221 (1977); Lottman, *Enforcement of Judicial Decrees: Now Comes*

The Hard Part, 1 Mental Dis. L.Rptr. 69 (1976). Amicus believes that this is the case here.

B. A Sensible And Effective System Of Psychiatric Care For Committed Patients Requires Medical Discretion And Flexibility.

While it is obviously preferable that psychiatric treatment be made available on a voluntary basis, the simple fact is that many people, precisely *because* they suffer from a serious mental illness, will not or cannot seek such treatment. Thus, in contrast to the delivery of most care for physical illnesses, treatment of mental illness must sometimes be imposed on patients. But this fact notwithstanding, the evidence shows that civil commitment can and does work effectively and in the patient's best interest. For example, one recent study specifically comparing the effects of hospitalization on voluntary and involuntary patients found that, although "committted patients tended to have a much more severe disorder than the voluntary patients," in the year following their release from the hospital, both groups—the involuntary as well as the voluntary patients—experienced "a very discernible improvement in their interpersonal roles" as a result of hospitalization. Gove & Fain, *A Comparison of Voluntary and Committed Psychiatric Patients,* 34 Arch. Gen. Psychiat. 669, 671 (1977).[24]

[24] Similarly, another study of involuntary hospitalization concluded that certification for a brief period of involuntary treatment was sufficiently beneficial to the people involved to warrant its continued use, despite the authors *a priori* belief that only *voluntary* treatment was successful in the long run. Spensley, *et al., Involuntary Hospitalization: What For and How Long?* 131 Am. J. Psychiat. 219, 222 (1974). The researchers found that within a three-day period following the involuntary commitment, all but 19 percent of the initially involuntary patients had either converted themselves to voluntary status or were discharged. Of this small remaining group, over half later accepted voluntary treatment. *Id.* at 221. *See also* Sata & Goldenberg, *A Study of Involuntary Patients in Seattle,* 28 Hosp. & Comm. Psychiat. 834 (1977).

Moreover, by most available accounts, involuntary patients themselves retrospectively view their hospitalization as beneficial. For example, in the Gove and Fain study referred to above, a substantial majority of both the committed patients (75.3 percent) and the voluntary patients (81.4 percent) believed that they had been helped by the hospitalization, whereas a very small number—9.5 percent of the voluntary and only 5.5 percent of the committed patients—believed they were harmed. *Id.* at 675. Likewise, another recent study found that in 30 of 38 different samples, former patients espoused generally favorable attitudes toward their hospitalization. Weinstein, *Patient Attitudes Toward Mental Hospitalization: A Review of Quantitative Research,* 20 J. Health and Soc. Behavior 237 (1979).

Thus, even though civil commitment involves a serious disruption in a person's life, it is legitimate and desirable. "When the choice is between a loss of life or health and a loss of liberty for a brief period of time, the preferable alternative is apparent." *Coll* v. *Hyland,* 411 F.Supp. 905, 910 (D.N.J. 1976) (three judges, per curiam). Equally apparent is the fact that if the benevolent purpose of civil commitment is to be realized, patients will invariably have to be treated for some period of time with the major psychiatric medications at issue in this case.[25] Indeed, before

[25] There are three major categories of medication commonly used in the treatment of committed patients. The antipsychotics, lithium, and the antidepressants. The antipsychotics are used in treating psychoses, particularly schizophrenia. They work by reducing thought disorders, such as hallucinations and delusions. *See generally* R. Baldessarini, Chemotherapy in Psychiatry, Ch. 2 (1977). Lithium operates primarily on mood, rather than thought, disorders. It is generally used to reduce the grandiosity, elation and aggressiveness that characterize the manic phase of manic-depressive psychosis. *See id.* at Ch. 3. The antidepressants are also used to remedy mood disorders, particularly the sense of helplessness and despondency that characterize a psychotic depression. *See id.* at Ch. 4. The Court's order in this case applies only to antipsychotic medication. *See* n. 3, *supra.*

the advent of these medications in the 1950's, seriously mentally ill patients were often subject to long-term custodial warehousing in facilities marked by violence and known best for the repeated use of seclusion and restraints.[26]

The development of the psychiatric medications, particularly the antipsychotics, has had the kind of dramatic effect on the treatment of mental illness that antibiotics have had in the treatment of general illness. *See* R. Baldessarini, Chemotherapy in Psychiatry 36 (1977). Psychiatric hospital populations have declined drastically, from 512,501 in 1950 to 170,619 in 1976, and the decline has continued. *See* Ozarin, *et al., A Quarter Century of Psychiatric Care 1950-1974: A Statistical Review,* 27 Hosp. & Comm. Psychiat. 515, 516 (1976); Witkin, Mental Health Statistical Note #153: Provisional Patient Movement and Selective Administrative Data, State and County Mental Hospitals, Inpatient Services by State (D.HEW Aug. 1979). The use of medications also has enabled patients to be hospitalized for far shorter periods of time—from a median hospital stay of 44 days in 1971 to 26 days in 1975—and has shifted the primary locus of care from the hospital to community

[26] The following description conveys a vivid picture of what hospitalization was like before these medications were available:

> Hallucinating patients paced the floor or rocked in chairs, and talked to their "voices"; paranoid patients scanned the rooms, ever vigilant and ever fearful; catatonic patients remained in fixed positions for days at a time developing swollen limbs and pressure sores; withdrawn patients sat on wooden chairs, year after year, doing nothing, while their physical health deteriorated; manic patients joked, laughed and moved about rapidly for days at a time until they collapsed exhausted; violent or agitated patients attacked other patients or staff members in response to idiosyncratic beliefs. Berger, *Medical Treatment of Mental Illness,* 200 Science 974 (May 20, 1978).

See also Romano, *On the Nature of Schizophrenia: Changes in the Observer as Well as the Observed (1932-77),* 3 Schizophrenia Bull. 532 (1977).

treatment programs. *See* Klerman, *National Trends in Hospitalization,* 30 Hosp. & Comm. Psychiat. 110, 111-12 (1979). *See also* 462 F.Supp. at 1137.

Effective utilization of these medications is most assured when the psychiatrist and patient work together in a therapeutic alliance. Thus, amicus fully supports the notion that the medication and its effects should be discussed with the patient and his cooperation in taking the medication should be enlisted. *See* D. F. Klein & J. Davis, Diagnosis and Drug Treatment of Psychiatric Disorders, 17-23 (1969); Roth, *Clinical and Legal Considerations in the Therapy of Violence-prone Patients,* 18 Current Psychiatric Therapies 55, 61 (Masserman ed. 1978). Similarly, there are occasions when it is clinically sensible to delay medication in the face of a patient objection. *See* Appelbaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients,* 137 Am. J. Psychiat. 340, 345 (1980) ("Permitting both situational and stereotypic refusers in our study to decline medication, not as a 'right' but as a matter of clinical policy, did not seriously impair their overall treatment and yielded some positive advantages"); J. Lion, The Art of Medicating Psychiatric Patients 28 (1978).

Ultimately, however, effective clinical care demands that the physician be allowed to override the committed patient's objection in certain situations. At times, for example, the patient's verbal objection will be patently senseless or accompanied by behavior demonstrating ambivalence about treatment and the loss of his psychotic illness. *See* Hoffman, *The Right to Refuse Psychiatric Treatment: A Clinical Perspective,* 4 Bull. Am. Acad. Psychiat. & Law 269, 271-73 (1976). Appelbaum & Gutheil, *"Rotting With Their Rights On": Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients,* 7 Bull. Am. Acad. Psychiat. & Law 308, 315 (1979).[27] Failure

[27] The authors report a study of 23 patients who accounted for 72 discrete episodes of drug refusal. The stated reasons—sometimes more than one reason was given—for these refusals were as

to impose treatment in such circumstances is irresponsible. Thus, the Massachusetts Supreme Judicial Court specifically criticized a hospital because "[d]rugs were not . . . administered involuntarily where patients refused medication." *Nason* v. *Superintendent of the Bridgewater State Hospital*, 233 N.E.2d 908, 912, n.7 (1968). *See also Whitree* v. *State*, 290 N.Y.S.2d 486, 501 (1968):

> We find [plaintiff] was not treated with any of the modern [psychiatric] drugs or any of their less effective antecedents during his entire stay in the hospital. It was not until 1959 . . . that such drugs were prescribed. We find that the reason for not using such drugs was that Whitree refused them. We consider such reason to be illogical, unprofessional and not consonant with prevailing medical standards.

In sum, it is the physician who must make the day-to-day decisions of how best to manage the patient's care. Even in the best of circumstances, this is admittedly a difficult task, requiring sensitive balancing of various factors.[28]

follows: no reason offered (nine patients); angry or seemingly irrelevant responses (seven patients); side effects (10 patients); overt delusions (nine patients); privacy (eight patients); legal rights (three patients). Appelbaum & Gutheil, *"Rotting With Their Rights On": Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients*, 7 Bull. Am. Acad. Psychiat. & Law 308, 312-313 (1979). In another article, the authors divided these 23 patients into three groups: "(1) situational refusers [13 patients]—a diverse group of patients who on occasion refused medication for a short period of time and for one of a variety of reasons; (2) stereotypic refusers [five patients]—chronically ill patients with paranoid traits who habitually and predictably responded to a variety of stresses with brief medication refusal; and (3) symptomatic refusers [five patients]—young relatively acutely ill patients whose refusal, often based on delusional premises, was sustained over a long period and successfully stymied treatment efforts." Appelbaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 Am. J. Psychiat. 340, 342-44 (1980).

[28] The court below recognized as much by creating a four-factor formula for deciding when to override a patient's right to refuse medication. These factors—(1) likelihood of harm; (2) patient's capacity; (3) availability of alternative treatments; and (4) seriousness of side effects—are all appropriate considerations for the clinician. But having set up this sensitive formula, the court failed to address the hard question: How are these four factors to be weighed and balanced in an individual case? Only trained clinical judgment can answer that inquiry. Such judgments are inevitably subjective, changing rapidly as the patient's condition and treatment change. Thus, at a given point in the treatment process, it may be appropriate to shift to another medication, either because it will be more effective or because the patient is beginning to evidence signs of tardive dyskinesia or because the patient is generally calmer and unlikely to engage in disruptive or harmful behavior. Similarly, the patient's capacity will vary rapidly. Thus, a patient who at one point objects to medication because of its side effects may, soon thereafter, object because he believes the medication will transmit his thoughts to foreign powers. *See* 462 F.Supp. at 1141 ("[plaintiff's] capacity to participate in the refusal of medicine or the choice of medicine is somewhat limited, depending on the day."); Roth, *Involuntary Civil Commitment: The Right to Refuse Treatment* in Psychiatrists and the Legal Process: Diagnosis & Debate 332, 343 (1977) ("patient competency is continually changing, even as a result of treatment"). No legal rule can displace clinical judgment in such circumstances.

And, in such circumstances, physicians will not be infallible; indeed, not only do human failings and poor conditions prevent universal success, but the limits of medical technology do so as well. But the solution is not to replace needed discretion with a legal rule that, while giving the appearance of certainty, offers little more than rigidity. *See Parham* v. *J.R.*, *supra*, 99 S.Ct. at 2506-07.

C. In Violation Of Settled Principles Of Federalism, The District Court's Remedy Forces New Jersey To Implement A Rigid Administrative Scheme.

The essence of the district court's remedy is to require New Jersey to establish a system of patient advocates and "independent" reviewing psychiatrists to hold hearings concerning when to override a patient's objection to medi-

cation. 476 F.Supp. at 1313-15.[29] Amicus does not dispute that these procedures *might* be a sensible part of an administrative solution to a difficult problem. But the problem is that, as a constitutional remedy, they, like the court's approach generally,[30] lock in a single model when greater

[29] The court also ordered that, before patients could be medicated, they had to sign a written consent form detailing all the known long- and short-term side effects of the medication. While amicus generally supports the concept of "informed consent," the court's approach is too simplistic. The focus on the signed form, rather than the quality of the communications between doctor and patient, only impedes truly informed consent. *See* Vaccarino, *Consent, Informed Consent and the Consent Form*, 298 N.E. J. Med. 455 (1978). It is well documented that even nonpsychiatric patients often sign consent forms without understanding their contents. *See, e.g.*, Epstein & Lasagna, *Obtaining Informed Consent*, 123 Arch. Intern. Med. 532 (1969). The problem is even more aggravated with psychiatric patients. *See, e.g.*, Olin & Olin, *Informed Consent in Voluntary Mental Hospital Admissions*, 132 Am. J. Psychiat. 938 (1975); Owens, *When Is a Voluntary Commitment Really Voluntary?*, 47 Amer. J. Orthopsychiat. 104 (1977).

To assure more "informed consent" than the kind evidenced by signing a form requires sensitive, and often protracted, communication between the physician and patient. *See* Stone, *Informed Consent: Special Problems for Psychiatry*, 30 Hosp. & Comm. Psychiat. 321 (1979); Meisel, *et al., Toward a Model of the Legal Doctrine of Informed Consent*, 134 Am. J. Psychiat. 285 (1977). The law itself has had a difficult time adjusting to the various subtleties and nuances presented, including the physician's right to delay disclosure when to do otherwise would be harmful or traumatic to the patient. *See* Meisel, *The "Exceptions" To The Informed Consent Doctrine: Striking A Balance Between Competing Values In Medical Decisionmaking*, 1979 Wisc. L.Rev. 413; Gauvey, *et al., Informed and Substitute Consent to Health Care Procedures: A Proposal for State Legislation*, 15 Harv. J. Legis. 431 (1978). Despite the complications presented, which for centuries have been dealt with by state courts, the court below imposed a uniform constitutional rule as if somehow signing a paper will render consent informed.

[30] Thus, with respect to the serious problem of tardive dyskinesia, *see* n. 23, *supra*, the court sought to devise a simple remedy, suggesting that antipsychotic medication should be ceased in such

flexibility is needed. If it should occur that patient advocates are costly and unnecessary, or that they tend to impede effective treatment,[31] an administrative system, but not a constitutional mandate, can adjust to this problem.

More significantly, the district court's focus was too narrow. Although the record has made clear that there are serious deficiencies in New Jersey's state hospitals for the mentally ill, the court's scrutiny of these problems came in a case invoking a right to refuse medication. Consistent with that constitutional claim, the court fashioned relief that aims largely at reviewing patient refusals. Amicus believes that the constitutional rule announced,[32] as well as

cases. 462 F. Supp. at 1146. Unfortunately, the proposed remedy may well aggravate the problem. Sudden cessation of antipsychotic medication may increase the patient's discomfort since continued administration of the medication may be most effective in suppressing the tardive dyskinesia. *See* Jeste & Wyatt, *In Search of Treatment for Tardive Dyskinesia: Review of the Literature, supra.* Similarly, the effect of the court's ruling, as specifically manifested in the treatment of Rennie, *see* notes 2, 5, *supra*, is to allow antipsychotic medication to be started and stopped. A recent study indicates that this practice may increase the risk of developing tardive dyskinesia. Jeste, *et al., Tardive Dyskinesia—Reversible and Persistent, supra.*

[31] The consequences of the court's mandated system could be very serious if it should occur that the proposed hearings on medication refusals become highly adversarialized. *See* pp. 31-36, *infra*. This risk is heightened because the court's decision allows a patient to be represented by an attorney at such hearings. *See, e.g.*, Ellis, *Volunteering Children*, 62 Calif.L.Rev. 840, 889 (1974); Cyr, *The Role and Functions of the Attorney in the Civil Commitment Process: The District of Columbia's Approach*, 6 J. Psychiat. & Law 107, 120 (1978).

[32] The existence of a right to refuse treatment will increase patient resistance to proper medication. In fact, in Rennie's case, immediately after the court announced its ruling Rennie began to refuse lithium even "though [the court's] opinion approved use of that drug." 462 F.Supp. at 1152, n.1. Moreover, "Mr.

the costs of the relief ordered, will seriously restrict the state's efforts to meet the larger problems of inadequacy of its treatment delivery system for *all* patients in state psychiatric hospitals.[33] It may well be that the funds spent for patient advocates or independent reviewing psychiatrists would be better spent on improving the facilities or hiring more treating physicians. In short, in a world of competing claims and at a time of budgetary restraint, the pressure of a court decree may, by diverting resources in a single direction, frustrate a more comprehensive solution to the overall problem raised.

In recent years the Supreme Court has repeatedly instructed lower courts to proceed cautiously before displacing state administrative schemes with new policies dressed in constitutional rulings. Thus, only this past Term, in words that are remarkably apt in the present case, the Court stated:

> Judges, after all, are human. They, no less than others in our society, have a natural tendency to believe that their individual solutions to often intractable problems are better and more workable than those of the persons who are actually charged with and trained in the running of the particular institution under examination. But under the Constitution, the first question to be answered is not whose plan is best, but

Rennie's discussion of the opinion in a hospital ward for the criminally insane encouraged other patients in that ward to refuse medication." *Id.*

[33] New Jersey has adopted an administrative scheme to address the general problem of medical misuse, Administrative Order 2:13, as well as the specific problem of patient refusals. Administrative Bull. 78-3. *See* 476 F.Supp. at 1315. The district court was concerned that this state scheme was not being properly implemented. But the appropriate solution to that problem is enforcement through state administrative or judicial remedies, not creation of a new administrative approach under the guise of constitutional decisionmaking.

> in what branch of the Government is lodged the authority to initially devise the plan. This does not mean that constitutional rights are not to be scrupulously observed. It does mean, however, that the inquiry of federal courts . . . must be limited to the issue of whether a particular system violates any prohibition of the Constitution. . . . The wide range of "judgment calls" that meet constitutional and statutory requirements are confided to officials outside of the Judicial Branch of Government. *Bell* v. *Wolfish, supra,* 99 S.Ct. at 1886.

Likewise, in this case, the district court impermissibly intruded itself into the "internal affairs" of the State Department of Mental Health; in doing so it violated well-established principles of federalism. *Rizzo* v. *Goode, supra,* 423 U.S. at 380.

III. IN NO EVENT DOES THE CONSTITUTION REQUIRE ADVERSARY HEARINGS FOR COMMITTED PATIENTS WHO REFUSE PSYCHIATRIC MEDICATION.

Relying on the Supreme Court's recent decision in *Parham* v. *J.R., supra,* the district court held that a committed patient's refusal to take medication could be overcome if his treating psychiatrist certifies that he is "functionally incompetent,"[34] or, alternatively, if an independent psychiatrist, using the court's four-factor analysis, decides that treatment should be imposed. At the hearing before the independent psychiatrist the patient may be represented by an attorney, but the state need only provide a patient advocate. *See* 476 F.Supp. at 1314. Plaintiffs challenge these procedures on appeal, asserting that all protesting patients must be provided an adversary hearing, with an attorney, before a nonpsychiatrist. *See* Plaintiffs'

[34] This determination may be reviewed by a patient advocate who can then secure review by an independent psychiatrist. *See* 476 F.Supp. at 1314.

Br. at 45-52.[35] Plaintiffs are mistaken. Even assuming, contrary to the position in this brief, that committed patients have a right to refuse psychiatric medication, due process does not require an adversary hearing before such refusals can be overcome.

This conclusion flows directly from the Supreme Court's recent decision in *Parham* v. *J.R., supra.* In that case, the Court held that an objecting child has a due process liberty interest at stake when his parents attempt to place him in a psychiatric hospital. The Court made clear, however, that "[d]ue process has never been thought to require that the neutral and detached trier of fact be law-trained or a judicial or administrative officer. . . . Surely, this is the case as to medical decisions for 'neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments.' " 99 S.Ct. at 2506-07, quoting *In re Roger S.*, 19 Cal.3d 921, 941, 569 P.2d 1286, 1299 (1977) (Clark, J., dissenting). While recognizing the fallibility of medical and psychiatric decisionmaking, the Court nevertheless explained:

> [W]e do 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. 99 S.Ct. at 2507-08.

Accordingly, the Court concluded, due process is satisfied when the decision to hospitalize the objecting child is made

[35] Plaintiffs do not indicate whether the hearing officer must be a judge.

by "a staff physician . . . so long as he or she is free to evaluate independently the child's mental and emotional condition and need for treatment." *Id.* at 2507.

Likewise, in this case, the due process determination of whether a civilly committed patient should be allowed to exercise his qualified right to refuse medication is precisely the kind of "medical decision that must be left to the judgment of physicians in each case." *Ibid.* There is no fact-finder better able to assess the factors identified by the court—*i.e.*, a patient's propensity toward violence, his day-to-day subjective capacity, the alternative treatments that might be available, and the risks of tardive dyskinesia. *See* note 28 *supra.*

Not only are the benefits of adversary hearings in this context "more illusory than real," *id.* at 2508, the detrimental aspects are substantial. The costs of such hearings —in terms of treatment staff diverted from the hospital, as well as the costs of lawyers and hearing officers—will be significant. "Behavioral experts in courtrooms and hearings are of little help to patients." *Id.* at 2506.[36]

More significantly, these hearings will impede ongoing effective treatment. Under the best of circumstances it will take time—certainly weeks—before notice is provided,

[36] The Supreme Court went on to explain:

> The *amicus* brief of the American Psychiatric Association points out at page 20 that the average staff psychiatrist in a hospital presently is able to devote only 47% of his time to direct patient care. One consequence of increasing the procedures the state must provide prior to a child's voluntary admission will be that mental health professionals will be diverted even more from the treatment of patients in order to travel to and participate in—and wait for—what could be hundreds—or even thousands—of hearings each year. Obviously the cost of these procedures would come from the public monies the legislature intended for mental health care. 99 S.Ct. at 2506.

counsel is appointed, and the hearing completed.[37] During this period, the patient's refusal cannot be overridden except in the limited circumstances of an emergency. This hiatus in treatment, which will often occur at the beginning of a commitment when the patient's illness is likely to be most acute, can have serious consequences, including significant deterioration of an illness that might have been treated quickly and effectively. *See* Gutheil, *et al., Legal Guardianship in Drug Refusal: An Illusory Solution*, 137 Am. J. Psychiat. 347 (1980). As the Supreme Court explained in *Parham*, "[t]he State also has a genuine interest in allocating priority to the diagnosis and treatment of patients as soon as they are admitted to a hospital rather than to time-consuming procedural minuets before the admission." 99 S.Ct. at 2506 (footnote omitted). Plaintiffs, by contrast, propose a procedure whereby the state will have to expend significant resources to warehouse a patient who might have been released before the time for his hearing arrives.

The failure to provide proper medication will work to the detriment of nonobjecting patients as well, because it will increase patient violence thereby leading to the restoration of the prison-like atmosphere that marked state mental hospitals before the 1950's. See pp. 23-24 *supra*. The district court defined an emergency as a "sudden, significant change in the patient's condition which creates danger to the patient himself or to others in the hospital." 476 F. Supp. at 313. In effect, then, absent an actual violent episode a patient cannot be forcibly medicated because psychiatrists cannot otherwise make reliable predictions of when a patient is likely to harm himself or others. *See*

[37] In view of the well-known aversion that psychiatrists have to adversary hearings, *see, e.g.*, Kumasaka, *et al., Criteria for Involuntary Hospitalization*, 26 Arch. Gen. Psychiat. 399 (1972), it is also reasonable to assume that many will reject or delay the decision to move for a hearing hoping that the patient will change his mind and agree to accept medication.

A. Stone, Mental Health and Law: A System in Transition, 27-36 (1975); Amer. Psychiat. Ass'n., Task Force Report No. 8: *Clinical Aspects of the Violent Individual*, 23-24 (1974). Once violence occurs, it is, unfortunately, too late to treat; at that point, seclusion is necessary. If medication is administered, it is essentially used as a "restraint" until the patient is calmed, at which point he can then presumably refuse medication again.

This assessment of the likely effect of requiring adversary hearings is not mere speculation. In Massachusetts, the federal district court required such procedures under a temporary restraining order in an identical case. *See Rogers v. Okin*, 478 F.Supp. 1342 (D. Mass. 1979) (appeal pending Nos. 79-1648, 79-1469). A recent report documents the result:

> "Tension seems to fill the air at the Austin Unit twenty-four hours a day." One wing has been destroyed by fire, set by a patient. One female patient attempted to burn a staff member, to choke a patient, and to strangle herself with a ripped dress. She smashed a window, threatened to kill several staff members, attacked, kicked and spat at them. At another time, she was "screaming, threatening, deluded, beat staff, grabs them, incited another disturbed patient to violence by inviting him to her bed and defying staff to deal with him. This other patient becomes so threatening that the night staff sent Dr. G a letter signed by all informing him that they could not and would not work under these conditions."
>
> Another female Austin Unit patient punched a social worker and several patients, cut herself with flip-tops, and "gouged her face with her fingernails until she bled; this continued almost daily throughout the month of June." A schizophrenic male patient who has refused medication since the grant of the temporary restraining order has had sexual intercourse with at least three different patients who are either retarded or are severely and chronically regressed. He has also broken a window, kicked a patient, and grabbed and threatened two female staff members. The incidence

of assaultive behavior by other Austin patients has also increased as the administration of medication has declined in deference to their wishes.

Patients in the May Unit have experienced similar problems. One woman, while refusing medication, became psychotic and left the hospital in anger, lived on a doorstep without changing her clothes for two weeks, was twice returned to the hospital by police, and twice set herself on fire in her room. In the May, as in Austin Unit, "since the issuance of the temporary restraining order, tensions, threats, agitation and acts of violence have increased." (16, pp. 22, 23; statements in quotation marks are taken from hospital records.) Stone, *Recent Mental Health Litigation: A Critical Perspective,* 134 Am. J. Psychiat. 273, 278 (1977).

These conditions, in turn, will impair the rights of all patients, including, significantly, their constitutional right to treatment. See p. 14 *supra*. Surely the Constitution does not demand such a result.

CONCLUSION

For the foregoing reasons, amicus curiae, the American Psychiatric Association urges this Court to reverse the decision below.

Respectfully submitted,

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