Protecting Our Mentally Ill: A Critique of the Role of Indiana State Courts in Protecting Involuntarily Committed Mental Patients' Right to Refuse Medication

MICHAEL LEONARD GOFF, JR.*

INTRODUCTION

It is a well-settled principle that an involuntarily committed mental patient has a right to refuse unwanted medical treatment and a liberty interest in remaining free from bodily intrusions accompanying such treatment.[1] While the Supreme Court has found such an interest under the Due Process Clause of the U.S. Constitution, it has emphasized that the "substantive and procedural issues [in a case where an involuntarily committed mental patient refuses treatment] are intertwined with state . . . law."[2] As such, the role of state courts in defining the rights of involuntarily committed mental patients to refuse medication is crucial to the protection of a patient's right to refuse unwanted treatment.

In *Youngberg v. Romeo*,[3] the Supreme Court embraced a federal constitutional standard that provides only narrow protection of an involuntarily committed mental patient's right to refuse medication, since it places the decision to medicate solely within the health care provider's professional judgment.[4] In other related contexts, however, the Supreme Court subsequently seemed to recognize a slightly broader right to refuse medication than the professional-judgment standard.[5]

While, at best, the Supreme Court refusal-of-treatment cases provide inconsistent standards of review with a relatively narrow standard for protecting the rights of involuntarily committed mental patients, many state courts have recognized a much broader right to refuse medication under their state constitutions.[6] For example, in *Rivers v. Katz*,[7] the New York Court of Appeals articulated a standard of strict

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* J.D. Candidate, 2001, Indiana University School of Law—Bloomington; B.S., Sociology, 1997, Virginia Commonwealth University. Special thanks to my wife, Vickey, and to my family, Mike, Denise, and Daniel, for their love and encouragement.

1. Youngberg v. Romeo, 457 U.S. 307, 316 (1982); Mills v. Rogers, 457 U.S. 291, 299 (1982); *see also* James A. King, Comment, *An Involuntary Mental Patient's Right to Refuse Treatment with Antipsychotic Drugs: A Reassessment*, 48 OHIO ST. L.J. 1135, 1135-38 (1987).

2. *Mills*, 457 U.S. at 299; Steven Mintz, *The Nightmare of Forcible Medication: The New York Court of Appeals Protects the Rights of the Mentally Ill Under the State Constitution*, 53 BROOK. L. REV. 885, 888-90 (1987) (discussing *Mills*).

3. 457 U.S. 307 (1982).

4. *Id.* at 321-22.

5. *See* William M. Brooks, *Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs*, 31 IND. L. REV. 937, 940 (1998) (discussing the Supreme Court's consideration of cases concerning the right to refuse medication in two other contexts: medicating a prisoner and medicating a criminal defendant to induce competency).

6. *Id.* at 940-41.

7. 495 N.E.2d 337 (N.Y. 1986).

scrutiny that adequately balances the liberty interest of the involuntarily committed mental patient with the state interest in medicating the patient.[8] This standard first requires the state to prove that a patient is incompetent to make their own treatment decisions,[9] an inquiry conducted completely independently of the facts surrounding the patient's initial commitment in the mental facility.[10] After finding that mental illness does not, in and of itself, reduce a person's fundamental right to refuse unwanted intrusion into their body, the court stated that this right can be overridden only by a compelling state interest, such as when the patient poses imminent danger to herself or others.[11] The *Rivers* standard is akin to the strict scrutiny standard applied in substantive due process jurisprudence when an individual's fundamental rights are infringed upon.[12] This strict scrutiny standard adequately protects a patient's right to refuse treatment in nonemergency situations while recognizing a state's overriding compelling interest to medicate in emergencies.

Although the Supreme Court of Indiana has not adopted the professional-judgment standard, the Indiana standard strongly resembles the narrow protection that the professional-judgment standard affords[13] and does not adequately protect the rights of involuntarily committed mental patients. At the time of judicial review, such patients have not been adjudged incompetent to make treatment decisions. Yet, the Indiana standard assumes that the involuntarily committed status of select mental patients equates to incompetency and, therefore, allows the state to assert its parens patriae power without first determining whether the individual is capable of making medical decisions in their own best interest. Indiana courts should recognize that a patient's fundamental rights are not contingent upon their commission status and should be afforded full protection by applying strict judicial scrutiny to unwanted treatment decisions. Because of the inconsistency of the federal judiciary in this area, it is extremely important that the state courts of Indiana formulate a standard of judicial review that adequately protects the fundamental rights of involuntarily committed mental patients in Indiana.

Ironically, in addition to providing insufficient protection for an involuntarily committed mental patient's fundamental rights, the standard of judicial review used in Indiana is unworkable because it fails to make allowances for the state to medicate patients forcibly when a legitimate emergency exists. The Supreme Court of Indiana has expressed misplaced concern for a patient's liberty interest if a standard exempting emergency situations from review were adopted. The compelling interest of the state to medicate a patient in an emergency situation should override a patient's right to refuse medication, so long as a least-restrictive-means analysis is used.

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8. *Id.* at 342-43.

9. *See id.* at 342.

10. Roederick C. White, Sr., *What Right to Privacy? The Risk to the Voluntary Mental Health Patient as a Result of Louisiana's Current Forcible Medication Statute*, 24 S.U. L. REV. 1, 8 (1996).

11. *Rivers*, 495 N.E.2d at 343.

12. *See* White, *supra* note 10, at 11-12.

13. *In re* Mental Commitment of M.P., 510 N.E.2d 645, 647 (Ind. 1987) ("The standard proposed by the State of professional judgment points in the right direction and can lead to a form which will provide an appropriate balance of interests.").

This Note offers the *Rivers* strict scrutiny standard as a model of a more workable standard for the State of Indiana. Part I of this Note considers the extent of the potential infringement upon an individual's fundamental due process rights because of the risks inherent in and the nature of antipsychotic medications. Part II considers the role of courts in cases of refusal of treatment in the State of Indiana and, specifically, the professional-judgment standard as articulated by the Supreme Court of Indiana. It first addresses the problems of using the professional-judgment standard to establish a balance between the liberty interest of the patient and the treatment interests of the state. Part II then moves to a discussion of the problems associated with Indiana's lack of a competency hearing in refusal-of-treatment cases. Finally, the standard adopted by the Supreme Court of Indiana in such cases is criticized as unworkable for its failure to recognize the only interest of the state that should be found overriding without a determination of incompetency: preventing danger to the patient or others. Part III of this Note highlights the advantages of the approach formulated in *Rivers*,[14] among other state court decisions, and suggests that Indiana use a similar approach to protect the rights of its mental patients adequately.

I. THE NATURE AND DANGERS OF ANTIPSYCHOTIC MEDICATION

Antipsychotic drugs[15] are by their very nature designed to affect thought processes of mental patients.[16] The aim of these medications is to reverse symptoms of psychoses.[17] For a patient suffering from psychosis, these drugs may have the dual effect of alleviating delusions and elevating a patient's mood. At the same time these drugs reduce any violent behavior,[18] allowing the mental institution to function more orderly and easing the treatment of patients.[19]

Antipsychotic drugs do have many therapeutic benefits; however, these benefits are undermined by very serious, potentially fatal, side effects.[20] A patient taking antipsychotic medication is at risk of developing numerous side effects,[21] the most

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14. *Rivers*, 495 N.E.2d at 342-44.

15. The term "antipsychotic drugs" usually refers to medications such as Thorazine, Mellaril, Prolixin, and Haldol, which are used in treating psychoses. Mills v. Rogers, 457 U.S. 291, 293 n.1 (1982).

16. *Id.*

17. Psychosis is "a mental disorder characterized by loss of contact with reality." William M. Brooks, *A Comparison of a Mentally Ill Individual's Right to Refuse Medication Under the United States and the New York State Constitutions*, 8 TOURO L. REV. 1, 6 (1991) (citing WEBSTER'S MEDICAL DESK DICTIONARY 588 (1986)).

18. Lisa Litwiller, Note, *Defining Constitutional Parameters: The Forced Drugging of Civilly Committed Mental Patients*, 1 S. CAL. INTERDISCIPLINARY L.J. 57, 60 (1992) (discussing the beneficial aspects of antipsychotic drugs on patients suffering from schizophrenia).

19. *Mills*, 457 U.S. at 293 n.1.

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

21. These side effects, which are for the most part reversible upon termination of medication, include oversedation of the patient, akathesia (which is an irresistible impulse to move), pseudo-Parkinsonism, blurred vision, nausea, dry mouth, and low blood pressure. Riese v. St. Mary's Hosp. & Med. Ctr., 243 Cal. Rptr. 241, 245 (Ct. App. 1987).

devastating of which is the risk of contracting tardive dyskinesia.[22] Tardive dyskinesia is a potentially permanent neurological disorder that has symptoms including involuntary tongue and facial movements, and it may interfere with all motor activity.[23] This disorder may result from cumulative treatment over a long period of time or may occasionally occur after only brief treatment with antipsychotic medications.[24] Evidence suggests that approximately ten to twenty-five percent of patients treated with antipsychotic drugs exhibit symptoms of tardive dyskinesia.[25] Tardive dyskinesia can also be fatal by causing neuroleptic malignant syndrome,[26] a disorder that is fatal twenty-five percent of the time.[27]

Despite the extreme hazards of these drugs, they are still prescribed by clinicians who believe that the beneficial effects outweigh the dangers of the possible side effects.[28] In many, if not most cases, prescribing clinicians would be correct in their assessment that antipsychotic drugs would alleviate a patient's psychoses.[29] These physicians may argue that they are best situated to make such a determination within the institution.

An involuntarily committed mental patient who disagrees with a physician's decision to use these potentially debilitating drugs, however, has little recourse available other than turning to the legal system.[30] The expert medical opinions offered under the Supreme Court's professional-judgment standard[31] may be useful in deciding whether antipsychotic medication for an individual patient may be helpful. The courts, however, should have an important role in defining the substantive rights of the patient to be free from such potentially harmful medication.[32]

Because of the important role of the state courts in protecting a patient's decisions to be free from the previously mentioned serious potential side effects, Indiana

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22. *Id.* at 245-46; Rivers v. Katz, 495 N.E.2d 337, 339 n.1 (N.Y. 1986); Litwiller, *supra* note 18, at 61.

23. *Riese*, 243 Cal. Rptr. at 245-46; *In re* Mental Commitment of M.P., 510 N.E.2d 645, 646-47 (Ind. 1987) (finding that at the heart of an involuntary treatment case was the "virtually undisputed allegation that a person medicated with anti-psychotic drugs has a fifty percent risk of contracting tardive dyskinesia"); Brooks, *supra* note 5, at 948-50 (discussing diagnosis and treatment of tardive dyskinesia).

24. *Riese*, 243 Cal. Rptr. at 246.

25. *Harper*, 494 U.S. at 230.

26. For a discussion of the dangers, symptoms, and prevalence of neuroleptic malignant syndrome, see David E. Sternberg, *Neuroleptic Malignant Syndrome: The Pendulum Swings*, 143 AM. J. PSYCHIATRY 1273 (1986). *See generally* Raymond A. Smego, Jr. & David T. Durack, *The Neuroleptic Malignant Syndrome*, 142 ARCHIVES INTERNAL MED. 1183 (1982).

27. Litwiller, *supra* note 18, at 62.

28. *Id.* (citing Paul S. Appelbaum & Thomas G. Gutheil, *"Rotting with Their Rights On": Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients*, 7 BULL. AM. ACAD. PSYCHIATRY & L. 306, 308 (1979)).

29. *See* Litwiller, *supra* note 18, at 60, 62.

30. *Id.* at 62.

31. Youngberg v. Romeo, 457 U.S. 307, 321-23 & nn.29-31 (1982) (articulating a professional-judgment test for refusal-of-treatment cases).

32. Sheldon Gelman, *The Biological Alteration Cases*, 36 WM. & MARY L. REV. 1203, 1246 (1995).

should adopt a standard of review that will provide broader protection for the patient's right to refuse such treatment in nonemergency situations. The next Part of this Note considers the existing deficiencies of courts' role in refusal-of-treatment cases in Indiana.

II. DEFICIENCIES IN THE STANDARD OF REVIEW USED BY INDIANA COURTS IN REFUSAL-OF-TREATMENT CASES

Indiana statutorily provides for judicial review in situations where treatment has been refused.[33] The Supreme Court of Indiana has adopted an adaptation of the professional-judgment standard when dealing with right-to-refuse cases.[34] The court recognized, however, that the treating psychiatrist may have conflicting interests.[35] The court attempted to protect the involuntarily committed mental patient's liberty interest by requiring a determination of which of the treating psychiatrist's interests is the "honest" foundation for the treatment decision, instead of merely requiring that the judgment be a professionally accepted one.[36] Under this standard, at the statutorily provided judicial hearing the state can override a patient's right to refuse treatment if it is demonstrated by clear and convincing evidence that

> 1) a current and individual medical assessment of the patient's condition has been made; 2) that it resulted in the honest belief of the psychiatrist that the medications will be of substantial benefit in treating the condition suffered, and not just in controlling the behavior of the individual; 3) and that the probable benefits from the proposed treatment outweigh the risk of harm to, and personal concerns of, the patient.[37]

This is the standard articulated by the Supreme Court of Indiana in an attempt to establish "a balance between the patient's liberty interest, the State's *parens patriae* power to act in the patient's best interest, and the State's duty to provide

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33. *See* IND. CODE § 16-14-1.6-7 (repealed 1992) (stating that involuntary patients wishing to refuse treatment are entitled to petition the court for consideration of the treatment). While the Supreme Court of Indiana relied primarily on this statute to find the liberty interest of the patient in 1987, *see In re* Mental Commitment of M.P., 510 N.E.2d 645 (Ind. 1987), in 1992 this statute was repealed, and two new statutes now govern a mental patient's right to refuse medication. Section 12-27-5-1 of the Indiana Code deals with a *voluntary* mental patient's right to refuse, stating that they may refuse medication so long as they are not adjudicated mentally incompetent. IND. CODE § 12-27-5-1 (1998). Section 12-27-5-2 of the Indiana Code follows in the footsteps of the former statute and relies on the Supreme Court of Indiana's decision in *In re Mental Commitment of M.P.,* by allowing the patient wishing to refuse medication to petition the court for consideration. *Id.* § 12-27-5-2. This does not provide the patient with as much of a liberty interest as would the requirement of an adjudication of incompetency.

34. *In re Mental Commitment of M.P.*, 510 N.E.2d. at 647.

35. After recognizing that the professional-judgment standard points in the right direction, the Supreme Court of Indiana found that "[s]tanding alone, however, it is not sufficient, for it does not adequately take into consideration the fact that the psychiatrist has competing interests in providing treatment to the patient, protecting his other patients and the staff of the facility and attempting to secure patient's earliest release from the facility." *Id.*

36. *Id.*

37. *Id.*

treatment."[38] However, this standard, which leans very heavily towards relying solely on the professional judgment of the treating doctors, does not establish this desired balance.

38. *Id.* at 646 (emphasis in original).

A. The Professional-Judgment Standard

While the Indiana standard of judicial review articulated for refusal-of-treatment cases purports not to rely solely on the treating psychiatrist's professional judgment, in reality, it only takes into account the beliefs of the treating psychiatrist.[39] Derived from the professional-judgment standard, Indiana's standard only attempts to determine that there was a current medical assessment resulting in an "honest belief" of the treating psychiatrist that the medication would be of a substantial benefit to the patient and that the probable benefits outweigh the risk of harm.[40] Like the U.S. Supreme Court in *Youngberg*,[41] the Supreme Court of Indiana embraces the idea that judges and juries are not qualified to decide such matters. This type of deference to the treating psychiatrist's opinion, however, loses sight of the fact that a psychiatrist is not an expert on patients' legal rights and minimizes the role of courts in reviewing decisions to medicate patients forcibly.

When the professional-judgment standard is scrutinized, it becomes apparent that it does not afford any protection to individuals wishing to refuse medication.[42] The professional-judgment standard defers the treatment decisions to professionals—who, admittedly, know more about treating psychotic patients on a day-to-day basis.[43] And it is almost a foregone conclusion in the psychiatric profession that when a psychiatrist exercises professional judgment in treating psychosis, the result will be treatment with antipsychotic medication.[44] Adherence to such a narrow standard of professional judgment, therefore, effectively cancels any constitutional protection of a patient's fundamental right to refuse medication.[45] The view that a physician-patient relationship should be governed only by medical interests, while disregarding legal interests, eliminates an individual's constitutional rights and is legally problematic no matter if a patient is voluntary or involuntary.[46]

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39. *See id.* at 647 (articulating a standard for judicial review in refusal-of-treatment cases and requiring the psychiatrist responsible for treatment to be present at the hearing).

40. *Id.* The "honest belief" requirement attempts to limit the effect of conflicting interests of the treating physician in the determination to medicate forcibly, but it still does not give the mental patient's own treatment decisions any weight and does not account for the patient's legal rights. *See id.*

41. Youngberg v. Romeo, 457 U.S. 307, 322-23 (1982) (stating why the standard of review in refusal-of-treatment cases should rely on the "professional judgment" of the treating psychiatrist).

42. Brooks, *supra* note 17, at 18 (criticizing complete reliance by the federal courts on the psychiatrist's judgment).

43. *See* Brooks, *supra* note 17, at 18-19.

44. Jeannette Brian, *The Right to Refuse Antipsychotic Drug Treatment and the Supreme Court:* Washington v. Harper, 40 BUFF. L. REV. 251, 273 (1992) (examining the effects of the Supreme Court's extension of the professional-judgment standard articulated in *Youngberg* to right-to-refuse cases in *Harper*, and stating that extending such deference effectively nullified any right of the patient to refuse treatment).

45. Brooks, *supra* note 17, at 18-19 (finding that a professional-judgment standard in forced-medication cases is "little more than a medical malpractice standard," which does not adequately protect a patient's constitutional rights).

46. *See* Brian, *supra* note 44, at 274 (finding that the deference standard rests on an assumption that the liberty interest in refusal-of-treatment cases is a purely medical one, and

The Supreme Court of Indiana did recognize one of the more grievous problems with the professional-judgment standard: the conflicting interests of the psychiatrist in providing treatment for the patient.[47] The treating psychiatrist may be swayed towards treating the patient with antipsychotic medications by concerns that do not involve the patient's best interest.[48] These conflicting interests may be concerns of maintaining institutional control or budgetary concerns of reducing hospital patients and staff.[49] When taking these conflicts of interest into account, it is of particular concern that patients may suffer when decisions are solely left up to those providing the treatment "since antipsychotic drugs, even if not the best treatment, are the least costly to administer."[50]

The standard of review used in Indiana, while purporting not to rely *solely* on the professional judgment of the treating psychiatrist, is admittedly derived from the professional-judgment standard.[51] The Supreme Court of Indiana seems to recognize that a determination to medicate forcibly, relying solely on the professional judgment of the treating psychiatrist, provides no protection for the patient's constitutional rights. In an attempt to rectify this flaw in the professional-judgment standard, the court attempted to articulate a standard that determines "which of the interests reflected by the psychiatrist is the foundation for his decision to treat the patient with anti-psychotic drugs."[52]

The Indiana Supreme Court apparently intended to eliminate any consideration of conflicting institutional interests of the treating psychiatrist and focus, instead, solely on the psychiatrist's professional judgment in furtherance of the patient's best interest. Requiring an "honest belief of the psychiatrist" that medication is needed to treat the patient's condition and not to control the behavior of the patient[53] seems honorable. In reality, however, the standard does not take account of a patient's legal rights or treatment wishes and is nothing more than a complete acceptance of the psychiatrist's professional judgment with an obligatory, but ultimately uninfluential, nod to the patient's right to refuse treatment.

The U.S. Supreme Court has stated that in cases of forcible treatment of involuntarily committed mental patients "state law may provide greater substantive and procedural rights than federal law."[54] Indiana should follow the lead of other

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that this discounts the individual interests at stake).

47. *See In re* Mental Commitment of M.P., 510 N.E.2d 645, 647 (Ind. 1987).

48. Chris R. Hogle, Note, Woodland v. Angus*: The Right to Refuse Antipsychotic Drugs and Safeguards Appropriate for Its Protection*, 1994 UTAH L. REV. 1169, 1202 (stating "[a]dvocates of the professional judgment standard ignore the imprecise nature of psychiatry and the conflicts that would emerge if hospital staffs were accorded weighty discretion").

49. *Id.* (evaluating the competing interests that a treating psychiatrist will be faced with when considering whether to recognize a patient's constitutional right to refuse treatment).

50. *Id.* at 1203.

51. *See In re Mental Commitment of M.P.*, 510 N.E.2d at 647.

52. *Id.*

53. *Id.* (stating what the state must demonstrate to override a patient's right to refuse medication).

54. Mills v. Rogers, 457 U.S. 291, 299-300 (1982), *cited in* Riese v. St. Mary's Hosp. & Med. Ctr., 243 Cal. Rptr. 241, 252 (Ct. App. 1987).

states and adopt a standard of review in forced-treatment cases that adequately protects the fundamental rights of involuntarily committed mental patients. As it exists, the standard merely restates the professional-judgment standard with a nod to the patient's constitutional rights, while refusing to give those rights any effect in the final treatment determination.

Indiana's current standard of judicial review in forced-medication cases leads to inadequate protection of a patient's fundamental rights, as well as deficient recognition of legitimate overriding interests of the state. Indiana must address both of these flaws and adopt an adequate standard of review.

B. The Need for a Competency Hearing Before Relying on the Professional Judgment of the Physician

There are two legitimate interests that "may override a patient's right to refuse treatment."[55] These interests should be correctly evaluated to form a workable standard of review in refusal-of-treatment cases. One interest, which will be discussed in Part III, is the protection of the patient and others from harm.[56] The second compelling interest is the exercise of the state's parens patriae power[57] to care for its citizens that have been adjudged not to have the ability to care for themselves.[58]

"The law recognizes the right of an individual to make decisions about her life out of respect for the dignity and autonomy of the individual, that interest is no less significant when the individual is mentally . . . ill."[59] The right to be free from bodily intrusions is so fundamental that, when there is a decision about whether to comply with medical treatment, it is the individual who must make that decision in order to protect their right to privacy.[60] It is well settled that it is a constitutional invasion to treat medically a competent person without consent, unless there is an emergency present.[61] Logically, this principle is true of mental patients as well.[62] And, while in

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55. Opinion of the Justices, 465 A.2d 484, 489 (N.H. 1987).

56. *Id.*; *see also* Addington v. Texas, 441 U.S. 418, 426 (1979); Rivers v. Katz, 495 N.E.2d 337, 343 (N.Y. 1986).

57. According to one author:

> The doctrine is used as the basis for state laws that protect the custody, care and education of children; the regulation of child labor; and the prosecution and detention of juvenile delinquents. Each instance involves a situation in which the community has recognized that, but for the state protecting these individuals' interests, their future well-being would be jeopardized. Society also has placed voluntary commitment of individuals and appointment of a guardian under the guise of the *parens patriae* authority.

Mary C. McCarron, Comment, *The Right to Refuse Antipsychotic Drugs: Safeguarding the Mentally Incompetent Patient's Right to Procedural Due Process*, 73 MARQ. L. REV. 477, 490 (1990) (citations omitted) (emphasis in original).

58. *Opinion of the Justices*, 465 A.2d at 489; *see also Mills*, 457 U.S. at 296-97; *Rivers*, 495 N.E.2d at 343.

59. *In re* Mental Health of K.K.B., 609 P.2d 747, 752 (Okla. 1980).

60. *Rivers*, 495 N.E.2d at 341 (citing Erickson v. Dilgard, 44 Misc. 2d 27, 28 (N.Y. Sup. Ct. 1962)).

61. *See* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 278 (1990) ("The

the past the decision of commitment may have been synonymous with a patient's incompetency, it is almost unanimously accepted now by both medical and legal professionals that there is no significant relationship between the need for commitment of a mentally ill patient and the patient's ability to make treatment decisions.[63]

Because involuntary commitment and a patient's mental illness do not make a patient incompetent,[64] the question becomes whether the medical or legal community is best situated to determine a patient's competency.[65] Courts have traditionally been a proper forum for resolving issues of competency in a variety of different contexts, and should therefore be readily equipped to determine the competency of mental patients to make treatment decisions.[66] Another factor decreasing the importance of a professional medical determination of incompetency is the fact that simply because the patient has made an incorrect medical determination does not mean that the patient is incapable of making a treatment decision that is in their best interest.[67] A treating physician would most likely adjudge a patient's competency based solely on whether that patient's decision was right or wrong medically.

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principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."); *see also* White, *supra* note 10, at 10 (discussing the disparity between physical and mental illness in Louisiana's recognition of the right to refuse medical treatment); *supra* note 1 and accompanying text.

62. White, *supra* note 10, at 10.

63. *Rivers*, 495 N.E.2d at 342 (exploring the relationship between involuntary commitment and a finding of incompetency); *see also* Riese v. St. Mary's Hosp. & Med. Ctr., 271 Cal. Rptr. 199, 206 (Ct. App. 1987); *Opinion of the Justices*, 465 A.2d at 490; *In re* Conticchio, 696 N.Y.S.2d 769, 773 (N.Y. Sup. Ct. 1999); *see also* Paul A. Nidich & Jacqueline Collins, *Involuntary Administration of Psychotropic Medication: A Federal Court Update*, HEALTH LAW., May 1999, at 12 (citing Washington v. Harper, 494 U.S. 210, 222-23 (1990) (discussing a Tenth Circuit panel's determination that under the balance formulated by the Court in Washington, a finding of incompetency of the mentally ill patient was needed for forced treatment)).

64. *Rivers*, 495 N.E.2d at 342.

65. One court considered the following factors in determining whether a patient had the capacity to make treatment decisions:

> (1) the person's knowledge that he has a choice to make; (2) the patient's ability to understand the available options, their advantages and disadvantages; (3) the patient's cognitive capacity to consider the relevant factors; (4) the absence of any interfering pathologic perception or belief, such as a delusion concerning the decision; (5) the absence of any interfering emotional state, such as severe manic depression, euphoria or emotional disability; (6) the absence of any interfering pathologic motivational pressure; (7) the absence of any interfering pathologic relationship, such as the conviction of helpless dependency on another person; [and] (8) an awareness of how others view the decision, the general social attitude toward the choices and an understanding of his reason for deviating from that attitude if he does.

Id. at 344 n.7.

66. Mintz, *supra* note 2, at 904-05 (considering the inherent legal questions in resolving a question of competency).

67. *Id.* at 905.

A legal determination of a patient's competency bears upon the state's ability to invoke its parens patriae power to medicate patients forcibly.[68] The parens patriae doctrine conflicts with the patient's liberty interest in refusing treatment by allowing the state to administer treatment without consent.[69] The prerequisite to the use of such power by the state, however, is a judicial determination that a patient lacks the capacity to make treatment decisions.[70] Once the state has obtained a judicial finding of the patient's incompetency, it can provide treatment over the patient's objections by relying on the state's parens patriae power to act its citizens' best interest.[71] There are very few states where the courts have failed to recognize the complete rights of a competent mental patient to refuse treatment.[72]

The Indiana standard, however, does not provide for a judicial hearing on a patient's competency.[73] Although the involuntarily committed mental patient has a statutory right to have a proposed treatment plan judicially reviewed, the standard of review at this hearing does not take into account the possibility that the mental patient may be capable of making an informed treatment decision.[74] Indiana does, however, statutorily require an adjudication of incompetency before medicine can be forcibly administered to a *voluntary* mental patient.[75] The difference in these statutes is suspect because an involuntarily committed mental patient is not necessarily less competent to make treatment decisions than a voluntarily committed mental patient.[76]

Absent a legal finding of incompetency upon the patient's commitment to the institution, an involuntarily committed mental patient should not be presumed to be incompetent and thus suffer deprivation of the right to refuse treatment possessed by voluntarily admitted patients. In other words, unless there is an emergency situation, the involuntarily committed mental patient should not lose the right to make treatment decisions by virtue of their involuntarily committed status.[77]

Nevertheless, without the benefit of an incompetency hearing, the Supreme Court of Indiana attempts to "establish[] . . . a balance between the patient's liberty interest, the State's *parens patriae* power to act in the patient's best interest, and the

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68. *In re Conticchio*, 696 N.Y.S.2d at 773 (determining when the state's parens patriae power can be used as a compelling interest of the state to override the patient's liberty interest).

69. McCarron, *supra* note 57, at 489-91 (discussing the origins and limits of the parens patriae power of the state).

70. *In re Conticchio*, 696 N.Y.S.2d at 773.

71. *See* Brooks, *supra* note 5, at 1000-01 & n.435.

72. *See* Elyn R. Saks, *Competency to Refuse Psychotropic Medication: Three Alternatives to the Law's Cognitive Standard*, 47 U. MIAMI L. REV. 689, 691 n.5 (1993) (noting that the standard articulated by the Supreme Court of Indiana, which fails to recognize a right of competent patients to refuse medication when relying on state statutes, is one adopted by a very small number of states).

73. *In re* Mental Commitment of M.P., 510 N.E.2d 645, 646-48 (Ind. 1987).

74. IND. CODE § 12-27-5-2 (1998).

75. *Id.* § 12-27-5-1.

76. *See* Rivers v. Katz, 495 N.E.2d 337, 342 (N.Y. 1986).

77. *See, e.g.*, Rogers v. Comm'r of Mental Health, 458 N.E.2d 308 (Mass. 1983).

State's duty to provide treatment."[78] Thus, the standard of review in Indiana allows the courts to consider the state's power to act in an involuntarily committed patient's best interest before the patient has been found to be incapable of acting in their own best interest with regard to treatment decisions. But by definition, this power of the state to override a patient's treatment decision should not be considered before that patient is found incompetent.[79] A state cannot legitimately exercise its parens patriae power to act in a patient's best interest until that patient is deemed by the judiciary to be incapable of making autonomous treatment decisions.[80] To hold otherwise is to disregard a competent individual's right to refuse unwanted medical treatment.[81] The requirement of a judicial determination of a patient's incompetency should adequately protect a competent, but involuntarily committed, patient's right to refuse medication, while allowing the state to exercise its parens patriae power when needed to override an incompetent patient's decision.[82]

It is apparent that there should be a judicial determination of incompetency before the state can rely on its parens patriae power to override a patient's treatment decision in a nonemergency situation. It is also clear, however, that the state may have a compelling interest in forcing medication upon a mental patient in an emergency situation. This Note now turns to evaluate the Indiana standard's failure to recognize the state's compelling interest of preventing danger to the patient or others.

C. Providing for Emergency Situations

Although the standard of judicial review in Indiana does not adequately protect a competent, involuntarily committed mental patient's right to refuse medication, the Supreme Court of Indiana was obviously concerned with the rights of mental patients when formulating its quasi professional-judgment standard.[83] This concern led the court to reject the justification of preventing danger as an overriding state interest.[84] But this justification is completely warranted as a compelling state interest. In order to create a workable standard of review that adequately considers the rights of the patient as well as those of the state, the professional-judgement standard must be abandoned in order to protect the patient, and strict scrutiny should be applied to all situations of forcible medication. Strict scrutiny would allow the state to override a patient's fundamental right of refusal in situations where the state has a compelling need (such as reliance on its parens patriae power after a judicial finding of incompetency) and forced medication is the least restrictive means of meeting that

78. *In re Mental Commitment of M.P.*, 510 N.E.2d at 646 (emphasis in original).

79. "*[P]arens patriae* does not allow the state to order treatment for a patient who is able to make treatment decisions for himself or herself, unless that person has been determined legally incompetent, no matter how foolish or irrational the behavior may be." McCarron, *supra* note 57, at 491 (citations omitted) (emphasis in original).

80. *See supra* notes 69-72 and accompanying text.

81. *See supra* note 61 and accompanying text.

82. *See, e.g.*, Brooks, *supra* note 5, at 1007-08.

83. *In re Mental Commitment of M.P.*, 510 N.E.2d at 647.

84. *Id.*

need.[85] The court's concern over a patient's liberty interest in this context is unwarranted if a least-restrictive-means analysis is used.

The only interest that should override a patient's decision to refuse treatment, when there has been no judicial finding of incompetency, is the need to medicate an involuntarily committed mental patient in an emergency situation.[86] If the patient presents a danger to herself or others or engages in destructive behavior in the institution, the state may administer antipsychotic medication over the patient's objections.[87] "In situations where the patient 'poses an imminent threat of harm to himself or others,' and [where] there is no less intrusive alternative [to the forcible medication of the patient], . . . the State may [legitimately] invoke its police . . . power[]" to prevent possible harm.[88]

It is important to note that even if the initial commitment of the patient was based on the exercise of the state's police power in an emergency situation, that commitment decision does not justify forcible medication of the patient.[89] To override a patient's right to refuse medication, the emergency must be a legitimate one that has arisen within the institution.[90] Forced medication has been deemed acceptable in such situations only when the need to eliminate the danger has been found to outweigh the possible harm to the medicated patient and all other reasonable alternatives have been ruled out.[91]

Since "forced drugging abridges a patient's fundamental right to bodily autonomy, due process [should] require[] [that forced medication] be the least restrictive means of satisfying the state interest in question."[92] While an emergency situation may justify the invocation of the state's police power to medicate an involuntarily committed mental patient forcibly, this justification would last only as long as the emergency exists.[93] Without a least-restrictive-means consideration, the patient's fundamental right to refuse medication may be compromised by allowing treatment to be administered or continued when no real emergency exists.[94] In order to protect the patient's right to refuse medication in situations where the state's police power may override the patient's liberty interest, it is important that the interest deemed compelling is immediate and the justification for medication last only as long as the

85. *See* Rivers v. Katz, 495 N.E.2d 337, 342-44 (N.Y. 1986).

86. *See* Hogle, *supra* note 48, at 1179-80 (stating that most courts are more inclined to leave discretion to medical professionals in emergency situations).

87. *Rivers*, 495 N.E.2d at 343 (citing Addington v. Texas, 441 U.S. 418, 426 (1979), Davis v. Hubbard, 506 F. Supp. 915, 934-35 (N.D. Ohio 1980), Colorado v. Medina, 705 P.2d 961, 971 (Colo. 1985), Gundy v. Pauley, 619 S.W.2d 730, 731 (Ky. Ct. App. 1981), and *In re* Mental Health of K.K.B., 609 P.2d 747, 751 (Okla. 1980)).

88. *In re* Guardianship of Linda, 519 N.E.2d 1296, 1299 (Mass. 1988) (citation omitted).

89. *See* Hogle, *supra* note 48, at 1179.

90. *See id.*

91. *See* Rogers v. Okin, 634 F.2d 650, 656 (1st Cir. 1980).

92. Brooks, *supra* note 5, at 1008 (citing Riggins v. Nevada, 504 U.S. 127, 135 (1992) (discussing when a state's overriding interests of controlling hospital emergencies and treating incompetent patients may justify forcing medication)).

93. *See* Rivers v. Katz, 495 N.E.2d 337, 343 (N.Y. 1986).

94. McCarron, *supra* note 57, at 492.

emergency does.[95]

The Supreme Court of Indiana, however, rejected the standard of danger to self or others as a state interest that could override the patient's liberty interest in refusing medication. In *In re Mental Commitment of M.P.*,[96] the court found that "the fact that there is a possibility the patient may harm himself or another person is not a sufficient justification for permitting forced medication with anti-psychotic drugs."[97] Because of risks inherent in antipsychotic medication, the Supreme Court of Indiana found that "the propensity for dangerousness is not sufficient to overcome the patient's liberty interest in being free from unreasonable intrusions into his body and mind."[98] The court feared that if the "danger to self or others" standard was applied when a patient displayed any aggressive tendencies, the treating psychiatrist would feel free to medicate the patient with antipsychotics to control the patient's behavior and have no regard to the inherent risks in these medications.[99]

The Supreme Court of Indiana misinterprets the standard of dangerousness to the patient or others as a continuous, unadulterated license to medicate a patient that displays any dangerous tendencies. In order for this standard to be correctly used as an overriding state interest, it must be coupled with the idea that no less intrusive alternatives are available to the state in controlling the emergency situation.[100] In *In re Mental Commitment of M.P.*, the Supreme Court of Indiana found that the treatment selected should be the one which restricts the patient's liberty interest the least.[101] Thus, the court should have recognized that this least-restrictive-means

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95. Litwiller, *supra* note 18, at 81 (citing Brandenburg v. Ohio, 395 U.S. 444 (1969) (suggesting a test for the emergency medication situation similar to the narrowly tailored direct incitement test in Supreme Court First Amendment jurisprudence)).

> In *Brandenburg v. Ohio*, the Court held that a speaker could be prosecuted for incitement only where his or her speech was (1) directed at producing imminent lawless conduct, and (2) likely to result in such conduct. Similarly, institutions should be permitted to forcibly medicate only where the patient's conduct is (1) visibly antecedent to imminent violent or lawless conduct, and (2) likely to result in such conduct. Further, when an emergency situation is claimed to be the justification for forced administration of antipsychotics, the government should not be permitted to administer an ongoing regimen of psychotropic drugs in order to prevent future lawless or violent conduct. Rather, the courts should recognize this interest as only sufficiently compelling in the context of a present, ongoing emergency situation which justifies immediate action, but only immediate action: that is, medication for the duration of the emergency only.

Id. (footnotes omitted).

96. *In re* Mental Commitment of M.P., 510 N.E.2d 645, 647 (Ind. 1987).

97. *Id.*

98. *Id.*

99. *Id.* (rejecting the standard of dangerous to self or others proposed by the patient's counsel, in favor of leaning towards the more restrictive standard of professional judgment).

100. *See In re* Guardianship of Linda, 519 N.E.2d 1296, 1299 (Mass. 1988); Rivers v. Katz, 495 N.E.2d 337, 343 (N.Y. 1986); Brooks, *supra* note 5, at 1005; Mintz, *supra* note 2, at 915-16; Hogle, *supra* note 48, at 1179-80; McCarron, *supra* note 57, at 492-93.

101. *In re Mental Commitment of M.P.*, 510 N.E.2d at 647-48 ("It must be plain that there exists no less restrictive alternative treatment and that the treatment selected is reasonable and is the one which restricts patient's liberty interest the least degree possible.").

standard would apply in situations where the state had a compelling interest in using its police power to prevent danger within the institution as well.

When the standard of danger to self or others is used in conjunction with the concept that there should be no less restrictive alternative means than forcing medication upon an involuntary mental patient, the reasons offered by the Supreme Court of Indiana against adopting the dangerousness standard[102] disintegrate. Applying the least-restrictive-means concept in emergency situations should prevent any possible abuses by the state. The Supreme Court of Indiana fears that under the standard of danger to self or others, once a patient displays any aggressiveness, the treating psychiatrist will feel free to control the patient's behavior regardless of the risk.[103] This possibility simply does not exist if treatment is only allowed in situations of imminent danger and only so long as the danger persists.[104]

III. AN APPROACH WHICH ADEQUATELY TAKES INTO ACCOUNT INTERESTS OF THE PATIENT AS WELL AS THE STATE

U.S. Supreme Court cases that have considered issues similar to the forced treatment of involuntarily committed mental patients seem to apply inconsistent standards.[105] However, the substantive, as well as the procedural, issues in a forced-treatment case "are intertwined with state law."[106] Therefore, the standard of review adopted by the state courts is crucial in defining both the procedures that must be taken when a mental patient refuses treatment[107] as well as defining the substantive rights that the mental patient has under state law. The standard adopted by the Supreme Court of Indiana thirteen years ago[108] has both procedural and substantive problems. The standard of review for forced-medication cases adopted in New York serves as a model that adequately protects the fundamental rights of mental patients while providing for emergency situations.

In *Rivers v. Katz*,[109] a case decided one year before the Indiana Supreme Court formulated its standard of review for such cases, the highest court in New York adequately resolved both the substantive and procedural issues in forced-medication cases.[110] Substantively, the New York Court of Appeals recognized the liberty

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102. *Id.* at 647.

103. *Id.*

104. *See Rivers*, 495 N.E.2d at 343.

105. *Compare* Youngberg v. Romeo, 457 U.S. 307 (1982) (applying the professional-judgment standard), *with* Washington v. Harper, 494 U.S. 210 (1990) (requiring the state to prove by clear and convincing evidence that the medication was necessary and effective for furthering a compelling state interest), *and* Riggins v. Nevada, 504 U.S. 127 (1992) (finding a broader right to refuse medication under the U.S. Constitution).

106. Mills v. Rogers, 457 U.S. 291, 299 (1982).

107. For a discussion of the importance of state courts as a source of protection in refusal-of-treatment cases, see Ellen Wright Clayton, *From* Rogers *to* Rivers*: The Rights of the Mentally Ill to Refuse Medication*, 13 AM. J.L. & MED. 7 (1987).

108. *See In re* Mental Commitment of M.P., 510 N.E.2d 645, 647 (Ind. 1987).

109. 495 N.E.2d 337 (N.Y. 1986).

110. Mintz, *supra* note 2, at 916. For a review of other state courts that have developed similar standards of review in right-to-refuse cases, see Riese v. St. Mary's Hosp. & Med.

interest of the patient in refusing medication, by requiring that any overriding interests of the state be compelling.[111] Procedurally, the decision focused on providing for a judicial competency hearing and the criteria that should factor into the determination at that hearing.[112] In order to rectify many apparent problems with the judicial standard of review used in Indiana, it must be recognized that the patient's liberty interest is fundamental, and proper procedures should be in place to determine the patient's competency. It must further be recognized that the state can satisfy the strict scrutiny standard if there is a compelling need for immediate medication, such as an emergency situation, and forced medication is the least restrictive solution.[113]

While Indiana statutorily recognizes a right to refuse medication until the proposal has been judicially reviewed,[114] the procedure followed under this rule is constitutionally deficient for lack of guidance.[115] Simply because this statute is in existence does not mean that mental patients' rights will be protected.[116] Without a required judicial finding of incompetency and the demonstration of a compelling state need to force medication, the hearing will simply be a formality to a judicial deference to the treating psychiatrist.[117] The New York Court of Appeals found that the administrative review procedures in place in New York did not sufficiently protect the due process rights of mental patients and found that the New York Constitution required more.[118]

The *Rivers* court standard requires, under the New York Constitution, two separate inquiries before rendering a determination on whether the state can forcibly medicate a patient.[119] The state first bears the burden to show by clear and convincing evidence that the patient is incompetent to make their own treatment decisions.[120] If the state fails to meet this burden of proof, then there is no need for further hearings, and the state may not administer antipsychotic medication to a person capable of making treatment decisions.[121]

If a court concludes that a patient lacks the capacity to make treatment decisions, the court must then determine whether the proposed treatment is "narrowly tailored

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Ctr., 243 Cal. Rptr. 241, 252 (Ct. App. 1987); Gundy v. Pauley, 619 S.W.2d 730, 731 (Ky. Ct. App. 1981); Opinion of the Justices, 465 A.2d 484, 489 (N.H. 1983).

111. *Rivers*, 495 N.E.2d at 343.

112. Mintz, *supra* note 2, at 916.

113. *See Rivers*, 495 N.E.2d at 343.

114. *See supra* note 33.

115. *See In re* Mental Commitment of M.P., 500 N.E.2d 216, 227 (Ind. Ct. App. 1986) (Sullivan, J., dissenting), *superceded by* 510 N.E.2d 645 (Ind. 1987).

116. *See* Clayton, *supra* note 107, at 48 n.189 (stating that despite the presence of a statute in Indiana recognizing a patient's right to refuse medication "the court simply stated that the patient was not rational and then deferred to the doctor's judgment that medication would be better for the patient" (citing *In re Mental Commitment of M.P.*, 500 N.E.2d at 233)).

117. *See id.*

118. *Rivers*, 495 N.E.2d at 344.

119. Mintz, *supra* note 2, at 908.

120. *Id.* (citing *Rivers*, 495 N.E.2d at 344).

121. *Id.*

to give substantive effect to the patient's liberty interest."[122] In order to do this, the court must consider "the patient's best interests, the benefits to be gained by the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments."[123] "The State . . . bear[s] the burden [of] establish[ing] by clear and convincing evidence that the proposed treatment meets these criteria."[124]

Under this standard, the state could properly invoke its parens patriae power, as a compelling interest, to provide care for a mental patient that is unable to care for himself after a proper finding of incompetency.[125] Moreover, in an emergency situation, the state's police power would justify forced medication, but only so long as the emergency persists under the least-restrictive-means consideration.[126] Under the criteria set out in *Rivers*, courts must "balance the patient's liberty interests against the state's asserted compelling need to medicate forcibly."[127] After a finding of incompetency, the state may forcibly medicate a patient "only when the scales tip towards a compelling need to medicate."[128]

The standard set forth in *Rivers*[129] seems to balance adequately all of the factors that the Supreme Court of Indiana was concerned with when it formulated a standard of judicial review for refusal-of-treatment cases.[130] The decision is both substantively and procedurally sound; it adequately recognizes the fundamental liberty interests of the patient and sets forth the proper judicial standard of review and procedures to be taken when that fundamental right is exercised.

Like the highest state court in New York, the Supreme Court of Indiana should recognize that the statute giving mental patients the right to refuse medication does not adequately set out the procedures to protect that right.[131] The lack of political power of the mentally ill is apparent when one considers the lack of action taken by the legislatures for review of treatment for the mentally ill.[132] Thus, the Supreme Court of Indiana must take steps to protect individual rights of involuntarily committed mental patients by formulating a standard that provides adequate due process protection under the Indiana Constitution and adequately provides for emergencies.

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122. *Rivers*, 495 N.E.2d at 344.

123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.* at 343.

127. Mintz, *supra* note 2, at 911 (citing *Rivers*, 495 N.E.2d at 344).

128. *Id.*

129. *Rivers*, 495 N.E.2d at 343-45.

130. *See In re* Mental Commitment of M.P., 510 N.E.2d 645, 646 (Ind. 1987) ("What must be established is a balance between the patient's liberty interest, the State's *parens patriae* power to act in the patient's best interest, and the State's duty to provide treatment." (emphasis in original)).

131. *See* Clayton, *supra* note 107, at 51.

132. For an argument that the legislative provisions for review of mentally ill patient's treatments are inadequate, see *In re* Mental Commitment of M.P., 500 N.E.2d 216, 223-28 (Ind. Ct. App. 1986) (Sullivan, J., dissenting), *superceded by* 510 N.E.2d 645 (Ind. 1987).

CONCLUSION

Although in Indiana the standard for judicial review of forced-treatment cases was formulated thirteen years ago, it is still applied today by Indiana courts considering the issue. When one considers the inherent dangers of antipsychotic drugs it is apparent that this standard should be closely scrutinized. The standard has both substantive and procedural problems that could easily be rectified with both a look to other states that have formed more comprehensive standards and a move away from the application of the professional-judgment standard.

While substantively Indiana recognizes a statutory right for the involuntary mental patient to refuse medication,[133] the judicial standard of review of this statutory right is not the strict scrutiny analysis that should be afforded to a state deprivation of an individual's fundamental rights. In such cases it is important not merely to balance the interests to achieve due process, but for the state to have a *compelling* interest in order to override the patient's fundamental interest.

While the Supreme Court of Indiana was obviously concerned about the liberty interests of mental patients when formulating a standard of judicial review, it failed to protect those interests adequately, by relying on an adaptation of the professional-judgment standard.[134] Moreover, the standard is unworkable for failure to recognize that the state may have a compelling interest in forcing medication in emergency situations.[135]

Using strict scrutiny, Indiana courts should recognize that Indiana would have a compelling interest in preventing danger to the patient or others within the institution. Moreover, the courts of Indiana should not consider the state interest in using its parens patriae power to act in the patient's best interest without a prior finding of incompetency.

Indiana courts should recognize the political powerlessness of the mentally ill and use due process to protect their liberty interest in being free from forced treatment. These important individual rights are adequately protected by application of strict judicial scrutiny in the courts of other states.[136] Involuntarily committed mentally ill patients in Indiana should be afforded no less protection before being deprived of their constitutional rights.

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133. *See supra* note 33 and accompanying text.
134. *See supra* notes 51-54 and accompanying text.
135. *See supra* Part II.C.
136. *See supra* note 110 and accompanying text.