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Forcible Medication of Civilly Committed Patients: Balancing Treatment Needs and Constitutional Protections

Tristan Potter-Strait

A. Introduction

Mental health issues are garnering more attention by the media and society in recent years. Society stigmatizes those with mental health problems, viewing them as being sick, incompetent, or crazy, undermining both the person's abilities and freedom of choice[1]. This stigma is pervasive. It is found in every aspect of our culture, from the media to the justice system. Congress recognized and attempted to combat this stigma when they enacted the Americans with Disabilities Act[2] (ADA), giving rights back to a group of people that have often felt powerless and frustrated with the lack of compassion and understanding they experience in their everyday lives. While this legislation has been beneficial, it has not eradicated the stigma for those that battle mental health issues.

This paper will explore the result of that stigma by addressing the Third Circuit's decision to allow forcible medication of civilly committed mental health patients in non-emergency situations, the relevant case law on the subject, and demonstrate how this decision is a violation of Title II of the ADA[3] and the US Constitution[4]. Specifically, three cases are relevant to the topic. First, *Washington v. Harper*[5] was a landmark case heard by the Supreme Court, which held that inmates do not have a right to refuse medication as long as there is a process in place that allows the inmate to voice his or her concerns. Next, *Hargrave v. Vermont*[6] was decided by the Second Circuit Court, which held that a civilly committed patient who wished to refuse medication could execute a Durable Power of Attorney (DPOA) and assign the power to make decisions regarding medication to a principal, and those decisions can only be

[1] *See generally* 42 USCS § 12101(a)(2)
[2] 42 USCS § 12101
[3] 28 CFR 35.130
[4] U.S. Const.
[5] *Washington v. Harper*, 494 U.S. 210 (1990).
[6] *Hargrave v. Vermont*, 340 F.3d 27 (2d Cir. 2003).

overruled in a court of law. Finally, the Third Circuit decided *Disability Rights v. NJ*[7], holding that patients who have been discharged and are awaiting a new placement can refuse treatment, but those still in custody of a state psychiatric hospital do not have the same right. The rules handed down from these cases create a situation that makes it difficult for people with mental disabilities to refuse medication when they are committed to a state hospital. However, two different sources of law could bring relief for these patients. First, Title II of the ADA[8] prohibits states and local governments from discriminating against those with disabilities. This regulation allows those with mental disabilities to file a lawsuit against state-owned psychiatric hospitals if they believe they have suffered from discrimination, such as forcible medication[9]. Second, the Fourteenth Amendment of the US Constitution protects citizens from a variety of harms[10]. Both of these arguments are explored in more detail below. Finally, this paper will discuss remedies and demonstrate how they are reasonable modifications of the existing programs.

B. History of Disparate Treatment

This section will explore the cases that are relevant to this topic to give background information on the history of this issue in the courts. In particular, this section will discuss a case decided by the Supreme Court and cases decided in the Second and Third Circuits. These cases showcase differing opinions regarding the treatment of mental health patients in state run psychiatric hospitals.

[7] *Disability Rights N.J., Inc. v. Comm'r, N.J. Dep't of Human Servs*., 796 F.3d at 296 (3d Cir. 2015).
[8] 28 CFR 35.130
[9] 42 USCS § 12101
[10] U.S. Const. amend. XIV

1. *Washington v. Harper*[11]

The Supreme Court has never addressed the issue of forced medication for civilly committed patients[12]. However, they have decided a case that involved forced medication of criminally committed patients. There, the Court decided this was permissible under the Due Process Clause of the Constitution[13].

In *Washington v. Harper*[14], Harper was convicted of robbery and served time in the prison's mental health unit after being diagnosed with a mental disorder[15]. For a time, he consented to treatment by antipsychotic drugs, but when he first refused treatment, his physician sought to forcibly medicate him[16]. In order to do this, the physician had to follow the rules set out in SOC Policy 600.30, which states that a physician who wishes to forcibly medicate a patient must present his reasons before a special committee; if the committee approves the treatment, then the inmate must submit[17]. The inmate has certain rights, such as the right to attend the meeting, present evidence, receive notice of the diagnosis, to receive assistance during the hearing, and to appeal the decision. Finally, forced medication can only occur for a specific period of time, and after that time has lapsed, the process must start over if the inmate continues to refuse treatment[18]. In Harper's case, the special committee found that forcible medication was appropriate, as he was considered a danger to himself or others as a consequence of his mental disorder. As a result of this decision, Harper was forcibly medicated for one year[19]. Harper filed a lawsuit, arguing that the hearing before the special committee did not satisfy the Due Process

[11] *Washington*, 494 U.S. 210.
[12] *Disability Rights N.J., Inc.*, 796 F.3d at 5.
[13] *Washington*, 494 U.S. at 236.
[14] *Id*.
[15] *Id*. at 213.
[16] *Id*. at 214.
[17] *Id*. at 215-216.
[18] *Id*. at 216.
[19] *Id*. at 217.

Clause, and sought both damages and injunctive relief[20]. The Court recognized that Harper had a great interest in whether or not he received treatment via antipsychotic medication, but decided that the hearing before the special committee satisfies the Due Process Clause, since an inmate is only forcibly medicated if he or she is a danger to himself, herself, or others. The Supreme Court held that it is in the inmate's best interest to be forcibly medicated in this type of situation, and the process outlined in SOC Policy 600.30 comports with the Due Process Clause under these circumstances[21].

While the majority agreed with this decision, there was a compelling dissent authored by Justices Stevens, Brennan, and Marshall[22]. The dissenters stated that forcible medication is degrading and a gross violation of the inmate's liberty[23]. They elaborated that the right to choose whether or not to be treated by antipsychotic medication is a fundamental right that deserves the highest level of protection, and that test was not met in this case, concluding that SOC Policy 600.30 violates the Due Process Clause and is unconstitutional[24].

While this case is not concerned with a mental health patient that is civilly committed, it does shed some light on various perceptions of people who have mental illnesses. Here, the majority decided that if the person is a danger to himself or others, that person's right to choose how to be treated is disregarded. On the other hand, the dissent argued that a person's right to choose should almost never be taken from them[25]. This case also centers around a person who was deemed to be a danger to himself or others, which is a different situation than the cases heard by the Second or Third Circuits, and could be the reason why the Supreme Court believed

[20] *Id*.
[21] *Id*. at 221-223.
[22] *Id*. at 237.
[23] *Id*. at 238.
[24] *Id*. at 241, 243.
[25] *Id*. at 221-223, 241, 243.

they were justified in upholding SOC Policy 600.30. However, the question as to whether this same type of policy should be upheld for those who are civilly committed and not deemed to be dangerous remains undecided by the Supreme Court.

2. *Hargrave v. Vermont*[26]

In 2003, the Second Circuit addressed the question posed above. Vermont enacted a statute that allows civilly committed mental health patients to execute a durable power of attorney (DPOA) and authorize a person, also known as a principal, to make decisions for them, including whether or not forcible medication is appropriate[27]. If the principal refuses pharmacological treatment on behalf of the patient, the statute allows mental health professionals to petition a probate court to override their decision. The court then allows the principal's decision to stand for 45 days, after which the patient's condition will be reviewed. If the patient's condition has not improved, the court may decide that forcible medication is appropriate and disregard the principal's request, even in non-emergency situations[28].

Nancy Hargrave suffers from paranoid schizophrenia and was civilly committed multiple times, where she was forcibly medicated but did not exercise her right to execute a DPOA[29]. After being forcibly medicated in a non-emergency situation, she executed a DPOA and filed a lawsuit against the state of Vermont, alleging that the statute violated Title II of the ADA and Section 504 of the Rehabilitation Act[30]. She argued that the statute was discriminatory based on her disability, while the state argued that Hargrave fell into the "direct threat" exception outlined

[26] *Hargrave*, 340 F.3d 27.
[27] *Id*. at 31.
[28] *Id*.
[29] *Id*. at 32.
[30] *Id*.

in the ADA, meaning that those who pose a direct threat to themselves or others are not provided protection under the ADA[31].

The court did not agree that all mental health patients that are civilly committed pose a direct threat, as the state did not prove that all patients pose a threat to others, per the definition of "direct threat" under the ADA. Also, the court held that the state did not determine whether the patient posed a direct threat to others at the time they overrode the principal's request, which can be a significant period of time after commitment, and the patient's behavior and circumstances may have changed significantly since then[32]. This determination is a crucial requirement when overriding the principal's request; otherwise, execution of a DPOA has little merit and offers little protection to the patient.

The court then analyzed whether the Vermont statute discriminated on the basis of disability. The court reasoned that the statute enacted a process where only mentally ill patients who are subject to forcible medication and execute DPOAs must appeal to a family court if their preferences are overridden, where other individuals who are physically disabled may appeal their principal's overridden requests in probate court. The difference between the two circumstances means the statute treats mentally ill patients differently than it treats other types of patients, and that is discriminatory per the ADA[33].

Vermont then argued that changing the process by which abrogation of the principal occurs would fundamentally alter the program, and the ADA protects programs by prohibiting changes that would be a fundamental alteration[34]. However, the court reasoned that the program is not what would be altered, but rather the way in which the principal's requests are overridden,

[31] *Id*. at 32, 35.
[32] *Id*.at 35-36.
[33] *Id*. at 37.
[34] *Id*.

which would only be a minor change and is allowable by the ADA. Therefore, the defendants lost the case and the court found for the plaintiff[35].

This case focused on the topic of this paper—forcible medication of civilly committed mental health patients in non-emergency situations. The outcome is telling, because the plaintiff won on the argument that her rights were violated per the ADA and the Rehabilitation Act, unlike the plaintiff in *Washington v. Harper*, who argued and lost on the argument that his constitutional rights of procedural due process were violated[36]. It appears, based on these two cases, that claiming a person suffered discrimination prohibited by the ADA is more persuasive than arguing that a person is not adequately protected by procedures. That conclusion is reinforced by a case heard by the Third Circuit this past year.

3. *Disability Rights N.J. Inc. v. Comm'r N.J. Dep't of Human Servs*[37]

This case is the main focus of this paper. The plaintiff's argument appears to be clumsy, and the Third Circuit responds accordingly. Here, the facts are somewhat similar to *Hargrave v. Vermont*[38], but the court narrowly distinguishes the two cases instead of creating a circuit split[39]. The facts and analysis are discussed below.

The state of New Jersey operates four psychiatric hospitals for civilly committed patients[40]. There are two different types of patients at the hospitals—those that are civilly committed and CEPP patients, or Condition Extension Pending Placement. These patients no longer need the hospital's services and are waiting on an appropriate alternative placement, but

[35] *Id.*at 38.
[36] *Id.* at 32; *Washington*, 494 U.S. 210.
[37] *Disability Rights N.J., Inc.,* 796 F.3d 293.
[38] 340 F.3d 27.
[39] *Disability Rights N.J., Inc.,* 796 F.3d at 306.
[40] *Id.* at 295.

may not be moved immediately because of a lack of availability, so they can carry their CEPP status for some time. Both types of patients are subject to two different policies for forcible medication—AB 5:04A, which addresses forcible medication in emergencies, and AB 5:04B, which addresses forcible medication in non-emergency situations[41]. As this paper focuses on forcible medications in non-emergency situations, AB 5:04B is the only policy that will be discussed.

AB 5:04B states that a mental health patient can be forcibly medicated if he or she has been involuntarily committed, has been diagnosed with a mental illness, and poses a risk of harm to self, others, or property if the medication is not administered[42]. The risk of harm is defined as suicidal threats or attempts, severe self-neglect, behavior that places others in reasonable belief that they will be harmed, or behavior that has resulted in substantial damage to property. If a patient meets this test, then they may be forcibly medicated once the review process has been completed[43].

The review process is similar to judicial review[44]. First, the treating physician must file an involuntary medication administration report, which gives the reasons why the patient should be forcibly medicated. Next, a panel is assembled of hospital employees who may treat patients but are not involved in that particular patient's treatment, and that panel then conducts a hearing to decide if the doctor's recommendation of forcible medication should be honored[45]. The patient can attend the hearing and present evidence on his or her behalf, and can request a mental health professional, legal counsel, or a client services advocate to attend, all who would assist the

[41] *Id.* at 298.
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] *Id.* at 299.

patient through this hearing. If the chair of the panel and one other member vote that the substantive standard is satisfied, meaning that they believe that the patient is mentally ill and poses a risk of harm to self, others, or property, the patient can be forcibly medicated. This decision is valid for 14 days, after which a panel may then authorize forcible medication for 90 days. If the patient still does not consent to medication at the end of this time period, the hospital must start the process over again if they wish to continue forcible medication[46]. This policy applies to all patients, including those labeled as CEPP[47], an issue the Third Circuit deals with in this case.

Disability Rights, the plaintiff, made two arguments, the first being that AB 5:04B was a violation of the patient's due process rights. Specifically, they argued that the process outlined above does not satisfy their due process rights because it is not a judicial process[48]. They brought this claim under Title II of the ADA, which posits that state entities may not discriminate against disabled persons by excluding them from a "service[], program[], or activit[y]"[49]. The plaintiffs argued that the judicial process is the service they are being excluded from, instead of the right to refuse medication[50]. The court appeared confused by this argument, believing Disability Rights to be mistaken and even asked the plaintiffs to clarify what exactly they were arguing. The Third Circuit noted that Disability Rights had at one time argued that the "service[], program[], or activit[y]" being denied was the right to refuse forcible medication; however, the plaintiffs reiterated that their argument was confined to the judicial process, or procedural aspect, instead of a right to refuse medication as a violation of the ADA[51]. Therefore,

[46] *Id.*
[47] *Id.*
[48] *Id.* at 301.
[49] 42 USCS § 12134
[50] *Disability Rights N.J., Inc.,* 796 F.3d at 301.
[51] *Id.* at 302-303.

the court confined its analysis to a procedural argument and thus a procedural remedy, and did not consider whether the right to refuse medication could be considered a "service[], program[], or activit[y]" protected by the ADA[52].

The Third Circuit reasoned that the plaintiffs must lose, because the right to a judicial process is not guaranteed to nondisabled people, and interpreted Title II of the ADA as only extending the rights traditionally given to nondisabled people to those who are disabled[53]. Specifically, all New Jersey citizens are entitled to a judicial process when they are being committed; however, after that point, there is no such protected right. The only protected rights that civilly committed patients have in New Jersey are those contained in AB 5:04. The Third Circuit reasoned that the ADA does not guarantee that disabled people receive the same procedural treatment when being cared for or treated as those who are not disabled[54]. However, New Jersey law does protect the rights of other patients, such as hospital patients, to refuse medication and treatment. This differs from the argument the plaintiffs made, which is specifically focused on the lack of judicial processes, and not the right of refusal[55].

The Third Circuit then addressed *Hargrave v. Vermont*[56], which the plaintiffs relied upon when presenting their argument[57]. The Third Circuit distinguished the case before them from *Hargrave*, stating that the plaintiffs in *Hargrave* successfully identified a service, program, or activity that was being excluded from those that were civilly committed and refusing treatment—the right to execute a DPOA only to have the principal's decisions overridden in family court. Disability Rights failed to identify a similar program, activity, or service, and as such the court

[52] *Id.* at 304.
[53] *Id.*
[54] *Id.*
[55] *Id.* at 305.
[56] *Hargrave*, 340 F.3d 27.
[57] *Disability Rights N.J., Inc.,* 796 F.3d at 305.

reasoned that there was not a circuit split. The court reiterated that *Hargrave* further proves their point—Title II only protects a disabled person from being denied a benefit from a public entity that has been given to nondisabled people[58]. Therefore, the Third Circuit held that both CEPP and non-CEPP patients lost the Title II claim[59].

Disability Rights also argued that the process outlined in AB 5:04B violated the Due Process Clause of the 14th Amendment of the United States Constitution[60]. The Third Circuit addressed this claim differently for CEPP and non-CEPP patients[61]. The court used *Harper*[62] to determine that non-CEPP patients' constitutional rights had not been violated, as the Supreme Court upheld a policy almost identical to that laid out in AB 5:04B[63].

The Third Circuit then turned their analysis to CEPP patients, who are different from non-CEPP patients, as they have already been deemed to no longer need or qualify for involuntary confinement and are remaining in custody until they are transferred to a different facility[64]. The court stated that *Harper*[65] did not address this situation, so it cannot control the analysis[66], and instead, turned to another case, *Matthews v. Eldridge*[67], which used a balancing test that is more appropriate to this situation. After applying that test, the court held that AB 5:04B cannot apply to CEPP patients[68]. If a patient is truly in need of psychotropic drugs and is refusing, New Jersey should recommit the patient, removing them from CEPP status, before

[58] *Id.* at 306.
[59] *Id.* at 307.
[60] *Id.* at 297.
[61] *Id.* at 307.
[62] *Washington*, 494 U.S. 210.
[63] *Disability Rights N.J., Inc.*, 796 F.3d at 308, 307.
[64] *Id.* at 309.
[65] *Washington*, 494 U.S. 210.
[66] *Disability Rights N.J., Inc.*, 796 F.3d at 309.
[67] *See Harper*, 494 U.S. at 229 (citing *Matthews v. Eldridge*, 424 U.S. 319 (1976)).
[68] *Disability Rights N.J., Inc.*, 796 F.3d at 310.

doing so. Otherwise, the person's constitutional rights are violated. Therefore, CEPP patients are entitled to a judicial process before being forcibly medicated, per their constitutional rights[69].

In summary, the Third Circuit did not address the issue of the right to refuse forcible medication as a right protected under Title II of the ADA or the Constitution[70]. Instead, the issue addressed is whether civilly committed patients who refuse forcible medication are entitled to a judicial process. The court held that the process outlined in AB 5:04B does not violate Title II of the ADA, but does violate the Constitution for CEPP patients[71].

C. Analysis of *Disability Rights N.J. Inc. v. Comm'r N.J. Dep't of Human Servs*

There is some indication in the Third Circuit's opinion that if the plaintiffs had claimed that the right of refusal, instead of the judicial process, was the service, program, or activity being excluded from civilly committed patients, the court would have used a different analysis and the case may have had a different outcome. The court made it very clear that this was not what was being argued before them, and asked Disability Rights to clarify their argument before undergoing any type of analysis[72]. It can be implied, then, that their holding can only be applied to the specific argument presented by Disability Rights, and the question of whether the right of refusal is a viable argument is still open.

The court first asked the plaintiffs to clarify their argument because they referred to both the right of refusal and the judicial process as being the activity, program, or service that was being withheld from civilly committed patients[73]. After asking for clarification, the plaintiffs

[69] *Id.*
[70] *Id.* at 304.
[71] *Id.* at 307, 310.
[72] *Disability Rights N.J., Inc.,* 796 F.3d at 302-303.
[73] *Id.* at 307, 310.

stated that their argument was limited to the lack of judicial process, and the court discussed at great length how they were bound by this answer when analyzing the argument[74]. Given the court's great care in ensuring that they did not include the right of refusal in their analysis, and the great care they took in ensuring that the parties knew that this was not included in their decision, it begs the question whether the Third Circuit believes that the right of refusal was the better argument. In other words, it leaves one to wonder what the outcome of the case would have been if the plaintiffs had answered differently, and stated that the right of refusal was the activity, service, or program being withheld.

There are a few other indications within the opinion that bolsters this theory. The Third Circuit alludes to the fact that a right of refusal could be considered an activity, program, or service under Title II of the ADA. Specifically, they state that the "phrase 'service, program, or activity is extremely broad in scope and includes 'anything a public entity does'"[75]. The court then quotes Title II of the ADA, pointing out that the "regulations provide that '[a] public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, . . . limit a qualified individual with a disability in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving the aid, benefit, or service'"[76]. Finally, the court almost says it outright: "[A]lthough we assume that the right to refuse medical treatment (or another such right, whether it be common-law or statutory) could be a service, program, or activity within the meaning of Title II, this is not the service, program, or activity posited by Disability Rights"[77]. This can be interpreted as an admission that the right to

[74] *Id.* at 302-304.
[75] *Id.* at 301, quoting *Yeskey v. Pa. Dep't of Corrs.*, 118 F.3d 168 (3d Cir. 1997).
[76] *Id.* at 301-302, quoting 28 CFR 35.130.
[77] *Id.* at 302.

refuse is still a valid claim and should have been argued by the plaintiffs. Unfortunately, the plaintiffs utilized a different approach, and the court was bound by that argument[78].

The Third Circuit appeared open to the argument outlined above, which would have led to a different outcome and given patients greater protections while under the state's care. It is argued in this paper that this is exactly the case, and unless AB 5:04B is revised in some way, perhaps to be similar to Vermont's statute that allows the execution of DPOAs, then the mental health patients that are civilly committed in New Jersey and being forcibly medicated are suffering from unlawful discrimination. Alternatively, the plaintiffs could have also sought relief under the Fourteenth Amendment of the U.S. Constitution if they had reframed the issue during their argument. A different outcome would have occurred if the plaintiffs had utilized either argument.

D. Title II of the ADA

1. History

At this point, it is appropriate to focus on the American with Disabilities Act. The Act is broad, so Title II will be the main focus, since it is the focus of the dispute in the above case. In order to fully understand the issue of this paper, the scope and intent of the statute should be discussed and some examples of the statute protecting individuals with disabilities should be examined.

Congress enacted the ADA in 1990 to combat discrimination against people with disabilities[79]. It had large support in both houses after a task force presented evidence of

[78] *Id.* at 304.
[79] 42 USCS § 12101

discrimination against people with disabilities[80]. In particular, Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem"[81]. Congress also reached the conclusion that "physical or mental disabilities in no way diminish a person's right to fully participate in all aspects of society"[82]. In response, Congress enacted the ADA and gave it the power necessary to remedy the wrongs they discovered. Specifically, the ADA "invoke[s] the sweep of congressional authority, including the power to enforce the fourteenth amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities"[83].

The ADA has three distinct parts, all regulating different aspects of life in order to accommodate people with disabilities. Title II is concerned with public services and regulates both state and local governments[84]. It specifically states that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity"[85]. Also, the types of mental health issues that would warrant civil commitment are included in the ADA's definition of disability[86]. As a result, the ADA could provide a remedy for the issue present in *Disability Rights N.J., Inc*[87].

[80] *Id.*
[81] 42 USCS § 12101(a)(2)
[82] 42 USCS § 12101(a)(1)
[83] 42 USCS § 12101(b)(4)
[84] 42 USCS § 12131
[85] 42 USCS § 12132
[86] 42 USCS § 12102
[87] *Disability Rights N.J., Inc.,* 796 F.3d 293.

There is an exception for state governments included in Title II. The regulation states that the government only needs to make a reasonable modification, and that if the modification would fundamentally alter the program, service or activity, the state does not have to make the modification[88]. Therefore, it is up to the government to prove that any alteration would make a fundamental difference; if they cannot support this claim, the modification must be made.

2. Title II of the ADA in Court

Several cases have been argued seeking remedies provided by Title II of the ADA, but none have argued that forcible medication of civilly committed patients in a non-emergency situation is prohibited[89]. A variety of other claims have been settled under Title II, though, demonstrating the ADA's strength and legislative breadth. In *Tennessee v. Lane*, the plaintiff sued the state for a lack of accommodations necessary to access the courthouse[90]. The case reached the Supreme Court, which held that the claim was appropriately brought under Title II of the ADA and that creating an accommodation would not fundamentally alter the courthouse[91]. In *Olmstead v. L. C. by Zimring*, the plaintiffs were mental health patients seeking placement in a different facility, and they argued that the defendant's refusal to transfer them was discrimination under Title II of the ADA[92]. The defendants raised the reasonable modifications defense, and the Supreme Court stated that while the defense is valid, the defendants must prove that placing the plaintiffs in a different treatment program would truly be more than a reasonable modification[93]. Finally, in *Cal. Council of the Blind v. County of Alameda*, the plaintiffs were blind and brought

[88] 28 CFR 35.130
[89] *Disability Rights N.J., Inc. v. Velez*, 974 F. Supp. 2d 736 (D.N.J. 2013).
[90] *Tennessee v. Lane*, 541 U.S. 509 (2004).
[91] *Id.*
[92] 527 U.S. 581 (1999).
[93] *Id.*

an action under Title II of the ADA for a lack of accommodation when voting in elections[94]. The court in that case found for the plaintiffs[95]. Although there are many other cases brought under Title II of the ADA, these three demonstrate the variety of issues that are covered by the act. This is consistent with the purpose and scope of the act, as Congress intended for the ADA to remedy a variety of wrongs suffered by those with disabilities[96].

Title II of the ADA gives citizens a private right of action, allowing people who have physical or mental disabilities to file a lawsuit for discrimination[97]. Title II specifically prohibits state and local governments from discriminating against qualified individuals with disabilities[98], unless a modification would present an undue burden or fundamental alteration of the program, service or activity that is in dispute[99]. While this relieves some pressure off the state or local government, the government still carries the burden of proof when arguing that the modification would fit the exception. A variety of different claims can be brought under the act, and although unattempted, arguing that the right to refuse forcible medication in non-emergency situations for civilly committed mental health patients is a violation of the act.

E. Forcible Medication of Civilly Committed Patients in Non-Emergency Situations is a Violation of Title II of the ADA

As the Third Circuit indicated, forcible medication of civilly committed patients in non-emergency situations is prohibited by Title II of the ADA[100]. In order for this claim to proceed,

[94] 985 F. Supp. 2d 1229 (N.D. Cal. 2013).
[95] *Id.*
[96] 42 USCS § 12101
[97] *Id.*
[98] 42 USCS § 12131
[99] 28 CFR 35.130
[100] *Disability Rights N.J., Inc.,* 796 F.3d 293.

the requirements set out by the ADA must be met[101], and a reasonable modification must be possible[102]. The argument that the plaintiffs in *Disability Rights N.J., Inc.*[103] should have brought is laid out below.

First, Title II is addressed to state and local governments, so the discrimination must be a result of the state or local government's action[104]. That requirement is satisfied in the case, because the psychiatric hospitals are operated and funded by the state of New Jersey[105]. As a result, this criterion is not an issue. Second, only "qualified individuals" may bring suit[106]. This means that only individuals who would need the services provided by the psychiatric hospitals can file a lawsuit, which also is not an issue in this case. Finally, the remedy must be reasonable, and any modifications made cannot fundamentally alter the program, service, or activity[107]. That will be addressed below, but does not pose a problem in this situation.

Similar to the above cases, Disability Rights could have shown that AB 5:04B is discriminatory on its face, because it does not allow mentally ill patients the right to refuse medication in non-emergency situations[108]. Generally, this is a right conferred upon others that are not mentally ill. For example, if someone goes to the doctor for a cold and the doctor prescribes a medicine, the patient is under no obligation to fill the prescription or to take the medicine. AB 5:04B treats those who are mentally ill differently than those who are not mentally ill, which is the very definition of discrimination. This type of treatment is born out of the stigma associated with mental health. It appears that the state of New Jersey believes its

[101] 42 USCS § 12131
[102] 28 CFR 35.130
[103] 796 F.3d 293.
[104] 42 USCS § 12131
[105] *Disability Rights N.J., Inc.,* 796 F.3d 293.
[106] 42 USCS § 12131
[107] 28 CFR 35.130
[108] *Disability Rights N.J., Inc.,* 796 F.3d 293.

judgment concerning medication is better than those with mental health issues. However, the Supreme Court has recognized that mental health patients have a significant interest in whether or not they are medicated[109]. The dissent in *Washington v. Harper* states that "[e]very violation of a person's bodily integrity is an invasion of his or her liberty. . . . And when the purpose or effect of forced drugging is to alter the will and the mind of the subject, it constitutes a deprivation of liberty in the most literal and fundamental sense"[110]. The dissenting justices go on to say that the ability to refuse forced medication is a basic value of our society, and that those who are not mentally ill have been granted the right to refuse medication because their fundamental rights are protected[111]. This differential treatment is discrimination—protecting the rights of those that are mentally competent, but overriding the rights of those that are mentally ill through a procedural process in a psychiatric hospital.

Of course, a right is not the same thing as a "program[], service[] or activit[y]"[112]. This might be the source of the difficulty the Third Circuit faced while deciding *Disability Rights*[113]. However, some of the cases brought under Title II of the ADA dealt with rights that had been denied those with a disability because of a lack of an appropriate program, service or activity. For example, as discussed above, the plaintiff in *Tennessee v. Lane* had been denied the right to vote because he was unable to get to the voting booth as a result of his disability[114]. Voting is considered a fundamental right in this country[115]. In *Tennessee*, the need for a program, service, or activity was directly tied to a fundamental right—if the plaintiff was unable to access the

[109] *Washington*, 494 U.S. 210.
[110] *Id.* at 237-238.
[111] *Id.* at 238, 241.
[112] 42 USCS § 12132
[113] *Disability Rights N.J., Inc.*, 796 F.3d 293.
[114] *Tennessee*, 541 U.S. 509.
[115] See generally *Harper v. Va. State Bd. of Elections*, 383 U.S. 663 (1966); *Kramer v. Union Free Sch. Dist.*, 395 U.S. 621 (1969).

voting booth, he was essentially being denied a fundamental right[116]. A similar situation arose in *Cal. Council of the Blind v. County of Alameda* when the plaintiffs were also unable to vote as a result of their disability[117]. The plaintiffs sued for a different machine that would allow them to vote, which is considered a program, service, or activity. Again, the accommodation was directly tied to a fundamental right, and without the accommodation, the fundamental right was denied. In *Disability Rights*, the plaintiffs are denied the right to refuse medication in non-emergency situations. The program, service, or activity that could be instituted is not necessarily an automatic accommodation of that right. In other words, the remedy is not necessarily giving civilly committed patients the absolute right to refuse medication. The remedy would be implementing a program, service, or activity that would protect their right to refuse medication through a hearing process. The procedural hearing process in place right now is inadequate to protect the fundamental rights of civilly committed patients. This remedy is discussed in more detail below.

The ADA was designed to prevent such situations from even occurring[118], and the facts presented in this case are a violation of the prohibitions contained in the statute. People suffering from mental health problems still have a liberty interest in what happens to their body[119], and if they are not deemed dangerous, then they should be considered competent to make their own decisions. As such, if the plaintiffs in *Disability Rights* had argued the case in another way, the results would have been different.

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116 *Tennessee*, 541 U.S. 509.
117 *Cal Council of the Blind*, 985 F. Supp. 2d 1229 (N.D. Cal. 2013).
118 42 USCS § 12101
119 *Washington*, 494 U.S. 210.

F. Forcible Medication of Civilly Committed Patients in Non-Emergency Situations is a Violation of the Due Process Clause of the 14th Amendment

1. Substantive Due Process

Another argument the plaintiffs made in *Disability Rights* is that the plaintiffs' due process rights were violated[120]. The court only analyzed a procedural due process claim, and held that non-CEPP patients' due process rights were not violated by the process allowing forcible medication, but that CEPP patients' rights were violated, and their due process rights required a judicial process[121]. While the procedural due process claim may not have merit for non-CEPP patients, a substantive due process claim should.

The Supreme Court has long acknowledged that the Due Process Clause of the 14th Amendment has both procedural and substantive components. The procedural component encompasses the right to a procedural due process, and the Supreme Court has protected that right on a number of occasions[122]. The Court has also recognized that the Due Process Clause contains a substantive component[123]. The substantive component protects a person's liberty, as stated in the clause, and the Court has used these words on a number of occasions to curtail government action[124]. The plaintiffs in *Disability Rights* should have argued that the way AB 5:04B reads is a violation of substantive due process.

The patients in New Jersey's psychiatric hospitals have a fundamental right to refuse forcible medication. As discussed above, the dissenting justices in *Washington v. Harper* recognized this right, and disagreed with the majority in the outcome of the case, believing that

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[120] *Disability Rights N.J., Inc.*, 796 F.3d at 307.
[121] *Id*. at 310.
[122] See generally *Perry v. Sindermann*, 408 U.S. 593 (1972); *Goss v. Lopez*, 419 U.S. 565 (1975); *Vitek v. Jones*, 445 U.S. 480 (1980); *Wilkinson v. Austin*, 545 U.S. 209 (2005).
[123] *McDonald v. City of Chi*., 561 U.S. 742 (2010).
[124] See generally *Skinner v. Oklahoma*, 316 U.S. 535 (1942); *Harper v. Va. State Bd. of Elections*, 383 U.S. 663 (1966); *Shapiro v. Thompson*, 394 U.S. 618 (1969).

the right to say what happens to one's body is a fundamental liberty interest[125]. This right is ground in a number of Supreme Court cases, starting with *Griswold v. Connecticut*, where the Court established a right to privacy and bodily autonomy[126]. The Supreme Court has repeatedly recognized implied fundamental rights, such as the right to bodily autonomy and integrity, which are not expressly stated in the Constitution[127]. With this judicial recognition as a foundation, and with the Court's willingness to find implied fundamental rights in a variety of cases, it can be easily inferred that the right to refuse forcible medication is another such right.

Once it has been established that the right to refuse medication is a fundamental right, the court should use strict scrutiny to determine whether AB 5:04B violates that right, meaning that the court will examine the policy extremely closely to determine whether or not it should be upheld. This is a tier of review that the Supreme Court has previously utilized whenever a fundamental right has allegedly been violated[128]. Legislation that inhibits fundamental rights is allowed as long as there is a compelling state or government interest and the legislation is narrowly tailored to address the problem[129]. Here, AB 5:04B fails both prongs of the test—the government interest is not compelling and the policy is not narrowly tailored. First, the government interest is not compelling because AB 5:04B only applies in non-emergency situations, implying that the government simply wishes to medicate the patient because the state believes that is the best mode of treatment. The patient has not been deemed to be a danger to him or herself, others, or property. Therefore, the government would need to produce another reason as to why they are forcibly medicating in these situations. Next, AB 5:04B is not

[125] *Washington*, 494 U.S. at 237-238.
[126] *Griswold v. Connecticut,* 381 U.S. 479 (1965).
[127] See generally *Griswold v. Connecticut,* 381 U.S. 479 (1965); *Roe v. Wade*, 410 U.S. 113 (1973); *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).
[128] See generally *Loving v. Virginia*, 388 U.S. 1 (1967); *Grutter v. Bollinger*, 539 U.S. 306 (2003); *Parents Involved in Cmty. Sch. v. Seattle Sch. Dist. No. 1*, 551 U.S. 701 (2007); *Sugarman v. Dougall*, 413 U.S. 634 (1973).
[129] See generally *Korematsu v. United States*, 323 U.S. 214 (1944); *Gonzales v. Carhart*, 550 U.S. 124 (2007).

narrowly tailored, because it allows forcible medication anytime the hearing committee decides this is the best course of action. The patient has a chance to be heard during the hearing process, but if his or her wishes are overridden, then the hearing panel has the final decision. There is no other alternative built in for the patient to protect his or her choice of treatment. The government has other available alternatives to ensure that the patient's treatment wishes are respected while also effectively treating the patient, such as engaging in other modes of therapy, assigning the patient a DPOA as in *Hargrave*[130], or allowing the patient to go off of his or her medication and then allowing the patient to decide what he or she wants in terms of treatment. Policy AB 5:04B only provides for the hearing process as a remedy for a patient who refuses medication, and the Supreme Court generally does not allow that sort of broad or all-encompassing solution when a fundamental right is at stake.

The plaintiffs in *Disability Rights* argued that their procedural due process rights were violated by AB 5:04B, and the Third Circuit rejected this argument for non-CEPP patients[131]. Procedural due process rights generally only guarantee that a process is in place that allows a person to voice his or her concerns; therefore, a judicial process is not guaranteed by the Due Process Clause of the 14th Amendment[132]. Unfortunately, the plaintiffs did not argue that their substantive due process rights were violated, which very well may have been a winning argument. The patients have a liberty interest in resisting medication, which is a fundamental right protected by the Constitution. As a result, the Third Circuit would need to engage in a heightened level of review—strict scrutiny—when analyzing whether or not AB 5:04B should be

[130] *Hargrave,* 340 F.3d 27.
[131] *Disability Rights N.J., Inc.,* 796 F.3d at 304.
[132] See generally *Mathews v. Eldridge*, 424 U.S. 319 (1976); *Turner v. Rogers*, 131 S.Ct. 2507 (2011).

upheld. Since the government interest is not compelling and the policy is not narrowly tailored, it should be struck down.

1. Procedural Due Process

Disability Rights attempted to make a procedural due process argument and failed in regards to non-CEPP patients[133]. However, if they reframed their procedural due process argument, then the case would have had a different outcome. As discussed earlier, the Third Circuit hinted at such a situation when discussing whether or not the plaintiff's argument was a right to refuse medication or the need for a judicial process[134]. If the plaintiffs had argued that their procedural due process rights were violated because they were not afforded adequate protection when refusing medication, the court would have found in favor of the plaintiffs for both CEPP and non-CEPP patients.

The Supreme Court has repeatedly addressed issues arising out of the procedural component of the Due Process Clause, giving citizens rights to express their concerns when they have been deprived of life, liberty, or property[135]. As both *Harper*[136] and *Disability Rights*[137] have demonstrated, that hearing does not always mean that a judicial process is warranted. However, the more serious the alleged harm, the more likely the court will be to hold that a procedural issue exists. The plaintiffs in *Disability Rights* are deprived of a right that is central to our societal values—liberty. The plaintiffs have a liberty interest in having their right to refuse medication in non-emergency situations by a more robust procedural process. The Third Circuit engaged in the *Mathews* balancing test when analyzing whether or not CEPP patients'

[133] *Disability Rights N.J., Inc.,* 796 F.3d at 304.
[134] *Disability Rights N.J., Inc.,* 796 F.3d at 302.
[135] See generally *Perry v. Sindermann*, 408 U.S. 593 (1972); *Goss v. Lopez*, 419 U.S. 565 (1975); *Vitek v. Jones*, 445 U.S. 480 (1980); *Wilkinson v. Austin*, 545 U.S. 209 (2005).
[136] *Washington,* 494 U.S. 210.
[137] *Disability Rights N.J., Inc.,* 796 F.3d 293.

procedural due process rights had been violated, but not for non-CEPP patients[138]. This is a direct result of how the argument was framed. The plaintiffs argued that a judicial process was required instead of arguing that a procedural process that better protects the right to refuse medication is necessary. Since that was the argument, the Third Circuit relied on *Harper* when analyzing the claim for non-CEPP patients, because it is binding authority[139]. *Harper* did not apply to CEPP patients, so the Third Circuit relied on the *Mathews* balancing test[140]. If the plaintiffs had argued that the right to refuse was the program, service, or activity that was denied, the Third Circuit would have found the procedural process outlined in Policy 5:04B inadequate for both CEPP and non-CEPP patients.

If analyzing the claim that the right to refuse medication is what is being denied patients at psychiatric hospitals in New Jersey, the Third Circuit would not be able to rely on *Harper*[141], but instead would have to utilize the *Mathews* balancing test[142]. *Harper* applies when the argument is that a judicial process is required to protect procedural due process rights; here, it is argued that a more robust procedure is required, and not necessarily one that is judicial in nature. The Third Circuit would need to balance the following factors: (1) "the private interest that will be affected by the official action" (2) "the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards"; and (3) "the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail."[143] After balancing these factors with the facts present in *Disability Rights*[144], the Third

[138] *Id*. at 309, 307.
[139] *Id*. at 307.
[140] *Id*. at 309.
[141] *Washington,* 494 U.S. 210.
[142] *Mathews v. Eldridge*, 424 U.S. 319 (1976).
[143] *Id*. at 335.
[144] *Disability Rights N.J., Inc.,* 796 F.3d 293.

Circuit would hold that a more robust procedural process must be in place to protect a citizen's right to refuse forcible medication in non-emergency situations.

First, the "private interest that will be affected by the official action"[145] is substantial. The dissent in *Harper* vehemently stated that people have a strong liberty interest in resisting forcible medication, stating that such a violation of a person's liberty deserves the highest protection[146]. Bodily autonomy and integrity is what is affected by the official action, and it deserves more protection than what AB 5:04B current gives. Next, "the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards"[147] also tips in the plaintiffs' favor. The risk of error is great—citizens are forced to endure a treatment that they do not choose, even in non-emergency situations. They must endure the side effects of psychotropic medication, which can be great[148]. They also must endure the humiliation of submitting to another person when it comes to treating their mental illness or disorder. This is amplified when considering the second prong of this requirement—the probable value of additional procedural safeguards. If the procedural process that allowed patients to voice their concerns were more robust, then it is likely that fewer patients would have to be forcibly medicated. Third, "the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail" also sides with the plaintiff[149]. The government has an interest in treating patients that are admitted to their psychiatric hospitals. They also have an interest in keeping these patients safe and helping them function at their

[145] *Mathews*, 424 U.S. 319 at 335.
[146] *Washington*, 494 U.S. at 238.
[147] *Mathews*, 424 U.S. 319 at 335.
[148] *Washington*, 494 U.S. 210.
[149] *Mathews*, 424 U.S. 319 at 335.

highest level possible. The government's interest can be protected with a more robust procedural process, and the additional expense would be minimal. The process is already in place, as described in *Disability Rights*[150], so the changes would incur minimal expense. The changes would ensure that the patients' concerns were heard and protected, while also taking into account the government's wishes in regards to treatment.

The plaintiff's in *Disability Rights* attempted to make a procedural due process argument, but failed in regards to non-CEPP patients[151]. The claim should have centered around a patient's right to refuse medication, and not the lack of a judicial process. If the plaintiff's had claimed that their right to refuse medication was unprotected by the existing procedure found in AB 5:04B, the Third Circuit would have found in favor of the plaintiffs after engaging in the balancing test found in *Mathews v. Eldridge*[152].

E. Remedies and Reasonable Modifications to AB 5:04B

1. Allowing a patient to assign a DPOA

If the plaintiffs had reframed their argument and relied on one of the two authorities outlined above, then the case would have been decided differently. At that point, the state would need to decide how to modify the existing program in order to accommodate those who wish to refuse medication. There are a few alternatives that are available to the government that will not fundamentally alter the existing process and can ensure that each patient receives the appropriate treatment[153]. The fact that there are such alternatives available helps to prove the point made earlier—that the policy as it stands violates the Due Process Clause of the 14th Amendment. If

[150] *Disability Rights N.J., Inc.*, 796 F.3d 293.
[151] *Id.* at 304.
[152] 424 U.S. 319.
[153] 28 CFR 35.130

no alternatives were available, the court could rule that the existing policy is narrowly tailored to fit the problem. However, AB 5:04B is not narrowly tailored and alternatives are available. The best modification is the system available in Vermont—allowing patients to assign a person power of attorney and to allow that person to make decisions for them.

The Second Circuit has already decided that allowing a patient to execute a DPOA is appropriate from both a medical and a legal standpoint[154]. Adding this provision to AB 5:04B allows the state to accomplish their goal of respecting the patient's autonomy while also ensuring that they receive the best treatment. By allowing the patient's voice to be heard when making decisions regarding treatment, giving them the autonomy and integrity they deserve, and allowing a person who is of sound mind and body to be the person making decisions and working with the physicians and psychiatrists when making decisions about treatment, a DPOA protects the patient and enables the state to continue operating their psychiatric hospitals as unusual. It is suspected that the state overrides a patient's wishes because there is little respect given for the decisions made by those who suffer from mental illness[155]. Perhaps the state views the patient to be incompetent, thus believing that the soundness of the patients' decision to be compromised. The Third Circuit correctly recognized that they can no longer make decisions of this nature for CEPP patients, but the judicial system should also respect non-CEPP patients' refusal to be medicated. Allowing the patient to assign a principal will give the patient that freedom and allow the state to discuss treatment options with someone who does not suffer from mental illness.

Additionally, allowing a patient to execute a DPOA is not a fundamental alteration of the program. The only change would be the assignment of a principal to a patient who refuses to be

[154] *Hargrave*, 340 F.3d 27.
[155] *Washington*, 494 U.S. 210 (1990) (dissenting opinion by Justices Stevens, Brennan, and Marshall).

medicated and requests such an accommodation. Then, the state would need to treat the principal's decisions in the same way they would treat someone possessing power of attorney for someone who is not mentally ill. In other words, if the state still wishes to override the principal's decision, then that could be done, but only through a process that is not discriminatory towards those with mental illnesses. The process would need to be the same process enacted when overriding the power of attorney for someone who is not mentally ill. The process would also need to satisfy the procedural and substantive components of the Due Process Clause of the 14th Amendment.

The current solution—allowing a court to override a patient's medical treatment preferences—allows a person who is unconnected with the patient to make decisions for them. Judges have to find a solution that objectively balances their notion of justice with the law's theories of individual autonomy and liberty. This is different from a doctor or therapist, who tends to make treatment decisions based on what he or she subjectively believes is best for the patient. It is believed that a principal will be more in line with the doctor or the therapist when making treatment decisions for the patient, creating an acceptable solution for a difficult situation. It is in the patient's best interest to have someone who is intimately acquainted with his or her medical diagnosis and treatment making decisions for him or her, instead of a third party who must weigh other considerations outside of the patient's treatment.

Per Title II of the ADA, the state is required to provide "auxiliary services or aids" to accommodate those with disabilities[156]. This has been mandated by the judicial system again and again, as demonstrated in the discussion regarding the cases successfully brought under Title

[156] 42 USCS § 12131

II of the ADA[157]. The option to assign somebody with power of attorney could be another such "auxiliary service[] or aid[]" to accommodate someone with a mental health disability.

2. Mandating that the patient's counselor be involved

Changing AB 5:04B to mandate that the patient's counselor be present at all hearings and be part of the decision making process is another accommodation that could protect the patient. The counselor can advocate for the patient and give him or her a voice when the patient would not otherwise have a way to speak up for him or herself.

As AB 5:04B currently stands, the counselor that works with the mental health patient can be present at all hearings, but is not required to be, and is not allowed to be on the panel or committee that makes the decision to forcibly medicate the patient. This is disturbing for a few reasons. Mental health professionals create a certain type of relationship with their patients. They see their patients weekly, sometimes daily, and understand their needs in a way that an impartial panel or committee does not. Also, the way that AB 5:04B is written does not ensure that the hearing committee is entirely impartial. It is comprised of professionals that are not involved in that particular patient's case, but all of the professionals work together at the same hospital or facility[158]. The panel members know each other, and some members may be in positions of authority over others, potentially leading to a conflict of interest during a hearing. Given this set of facts, it only makes sense that the patient's counselor be involved in this process. The counselor can educate the panel or committee on the patient's mental health history and why he or she is refusing medication. In other words, the "auxiliary aid or service" provided

[157] *Supra* D.2
[158] *Disability Rights N.J., Inc.,* 796 F.3d at 298-299.

would be requiring that the counselor be present at such hearings in order to advocate for the patient.

In addition to those explained above, there are also several alternatives the state could utilize to change AB 5:04B to be less discriminatory towards mental health patients who refuse medication. The remedies discussed are just a few that are available, but would help to satisfy the substantive component of the Due Process Clause of the 14th Amendment and Title II of the ADA. Allowing a patient to assign a DPOA has already been approved by the Second Circuit[159], indicating that it is a reasonable remedy that would not fundamentally alter the nature of the existing program in New Jersey. Mandating that a counselor be present at the hearings has not been proposed, yet, but it is another component that could be added to AB 5:04B that would allow the patients to have an advocate that truly understands their needs.

F. Conclusion

People with disabilities have long faced discrimination by both private individuals and the government[160]. Those suffering from mental disabilities are no exception, and many are subjected to a lifetime of treatment and misunderstanding. Forcibly medicating a patient in a non-emergency situation is not something that has been widely analyzed by courts in this country; however, some courts have tackled the issue with mixed results[161]. The courts have to balance the autonomy of the patient and the interests of the state, which may be tainted by beliefs that people suffering from mental disorders cannot make sound decisions for themselves. This can be a difficult balance to strike, but it is possible. The plaintiffs in *Disability Rights* have

[159] *Hargrave*, 340 F.3d 27.
[160] 42 USCS § 12101(a)(2)
[161] See generally *Hargrave*, 340 F.3d 27; *Disability Rights N.J., Inc.*, 796 F.3d 293.

valid arguments, but they were not presented or addressed in the recent decision handed down by the Third Circuit[162]. As it stands, AB 5:04B violates both Title II of the ADA and the Due Process Clause of the 14th Amendment. If New Jersey allowed civilly committed mental health patients to execute a DPOA, then both of those violations would be satisfied and the existing program would not be fundamentally altered.

[162] *Disability Rights N.J., Inc.,* 796 F.3d at 293.