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First Do No Harm: Least Restrictive Alternative Analysis and the Right of Mental Patients to Refuse Treatment

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FIRST DO NO HARM:
LEAST RESTRICTIVE ALTERNATIVE
ANALYSIS AND THE RIGHT OF MENTAL
PATIENTS TO REFUSE TREATMENT

DAVID ZLOTNICK*

I. Introduction .................................. 376

II. The Least Restrictive Alternative Doctrine ..... 384
    A. History of the Doctrine ..................... 385
    B. Different Aspects of the Doctrine's Analysis .. 392
    C. The Doctrine's Role in Mental Health Law .... 400

III. The Right to Refuse Treatment ................. 405
    A. The Competing Interests of the Individual
       and the State .................................. 405
       1. The Liberty Interest of the Individual ...... 406
       2. The State Interest in Compelling
          Treatment ...................................... 412
    B. Judicial Approaches to the Right to Refuse
       Treatment ...................................... 415
       1. The Eighth Amendment Approach ............. 416
       2. The First Amendment Approach ............... 417

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to the Honorable Stanley S. Brotman, United States District Court for the

I would like to make clear that I had no involvement in the decision of any of
the cases discussed in this article. I commenced my tenure with the Honorable
Stanley S. Brotman in the fall of 1980, long after Judge Brotman rendered his
decisions in Rennie v. Klein. I would like to thank Judge Brotman, however, both
for his encouragement of this project and his continual willingness to discuss the
complex issues at the heart of this piece. The opinions expressed in this article
are of course solely my own. In addition, I would like to thank Julian Eule and
Susan Schneider, both of whom were always available for consoling words and
helpful insights during the extended course of this project. Other persons, who
shall remain unnamed, also helped with this project, and I thank them as well.
I. INTRODUCTION

One of the most ancient and fundamental precepts of medicine is *primum non nocere*: First, do no harm. The precept's longevity and its venerable role as one of the primary principles of medical ethics reflect the fact that its few words


Nelson admits the importance of *primum non nocere*, but argues that it should be replaced as the first principle of medical ethics by the maxim *primum utilis esse*: Above all, be useful. Nelson, *supra* note 1, at 655, 666. See also Lasagna, *Discussion of "Do No Harm,"* in *PHILOSOPHICAL MEDICAL ETHICS: ITS NATURE AND SIGNIFICANCE* 43, 46 (1977). Lasagna forcefully argues that "[t]he proper medical and moral stance for today's physician, therefore, is not to avoid harm at all costs, but to optimize treatment." Id. at 43.

Both Nelson and Lasagna seem to view the principle underlying *primum non nocere* in a rather narrow way, which may account for their criticisms of the precept. The precept can be understood to include much more than they find in it,
contain a multiplicity of meanings. Perhaps foremost among those meanings is the recognition that all therapies carry with however. See note 3 infra; see also notes 4-7 and accompanying text infra. Conceived of in an expansive way the precept is much more than a simple injunction not to harm one’s patients. Beyond that, it states a general principle of therapeutic decisionmaking, a principle that counsels caution before one dispenses treatment and thereby upsets the balance that nature has reached. Jonsen, supra note 1, at 40. Nelson would quite probably agree with the primacy of primum non nocere when the doctrine is viewed in this way. He recognizes that therapeutic measures have significant potential for harm, and he stresses the point that treatment should be provided only when it is justified: “Competent physicians should be able to articulate good reasons for holding that their interventions will be of tangible benefit to their patients. This should become an increasingly rigorous requirement as the mortality and morbidity of the intervention increases.” Nelson, supra note 1, at 659; see also, id. at 659-62.

Physicians have always had to walk a tightrope in this respect. They have a responsibility to intervene where they can do good, but an equally important responsibility to abstain where their therapeutic powers are limited or where intervention will likely lead to more harm than good. See Reiser, Refusing Treatment for Mental Illness: Historical and Ethical Dimensions, 137 Am. J. Psych. 329, 329 (1980). The crux of the problem is that many medical decisions are born of substantial uncertainty. As one observer has noted, “[f]or even the best-understood disease there are large gaps in understanding. Causes may be obscure and outcomes vary in probability . . . . For the doctor . . . uncertainty is his constant companion.” Cassell, The Function of Medicine, 7 Hastings Center Report 16, 17 (No. 6, Dec. 1977). In addition see Cassell, Informed Consent in the Therapeutic Relationship, 2 Encyclopedia of Bioethics 767, 768-75 (1978); Boyce & Michael, Nine Assumptions of Western Medicine, 1 Man & Med. 311, 315-16 (1976); Vladeck & Weiss, Commentary, 1 Man & Med. 332, 332-34 (1976).

Physicians have reacted in various ways to the problem of uncertainty in treatment decisionmaking. Some periods have been characterized by restraint; others have been characterized by an interventionist ethic. See Reiser, supra at 329-30. The principle of primum non nocere counsels caution and restraint as opposed to undue activism. At its root, the precept is perhaps best viewed as an “admonition to humility.” Jonsen, supra note 1, at 40. It expresses an understanding of the physician’s limits, and reminds him of the harm that can result from well intentioned interventions beyond those limits. See E. Pellegrino, supra note 1, at 105-06. There is considerable evidence that physicians increasingly appreciate their limits, as well as the negative consequences that may result from ill-considered or overly intrusive therapeutic interventions. See Boyce & Michael, supra at 319-22; Engel, The Need for a New Medical Model: A Challenge for Biomedicine, 196 Science 129, 134 (1977); Reiser, supra at 331.

Jonsen defines four distinct usages of the precept: (1) the idea of medicine as a moral enterprise; (2) the requirement that due care be used in one’s practice; (3) the need to balance the benefits of an action against its risks; and (4) the need to balance the benefits against the detriments of an action. Jonsen, supra note 1, at 28-38. He concludes by noting that the precept may serve “not so much as a morality of lower limits, but as an admonition to humility.” Id. at 40. Thus, the
them both risks and detriments.4 By reminding him of the negative factors that inevitably attend any therapeutic intervention, the precept cautions the physician not to treat as a matter of whim, but only when there are good reasons for doing so. In addition, the precept warns that the particular therapy utilized must be carefully considered and scientifically justified.5 *Primum non nocere* may thus be viewed as stating, in effect, a presumption against treatment. On both the general and particular planes, and thus with respect to both the decision to treat and the choice of a particular therapy, treatment must be justified before it may ethically be administered.6

No comparable principle constrains the actions of those who minister to the ills of the body politic.7 Although the idea that "the government governs best which governs the least"8 has always had its followers, that notion has never dominated American thought,9 and seems out of touch with the realities of

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4 *Id.* at 33-38. See Nelson, *supra* note 1, at 659-62.
6 This is not to say that treatment must be justified in any formal sense, either to the patient or anyone else. The point is simply that the decision to intervene, and the subsequent decision to employ a particular mode of therapy, must be warranted. See sources cited in note 5 *supra*. Of course, a competent patient will normally decide for himself whether his physician's recommendation regarding treatment accords with his own desires and values. Ultimately, the decision is his either to undergo treatment or refuse it. See E. Pellegrino, *supra* note 1, at 100-01; Nelson, *supra* note 1, at 663-66. See generally, Burt, *Informed Consent in Mental Health*, 2 *ENCYCLOPEDIA OF BIOETHICS* 762 (1978).
7 Cf. Liggett Co. v. Baldrige, 278 U.S. 105, 115 (1928) (Holmes, J., dissenting), overruled, North Dakota Bd. of Pharmacy v. Snyder's Drug Stores, Inc., 414 U.S. 156 (1973) ("The Constitution does not make it a condition of preventive legislation that it should work a perfect cure. It is enough if the questioned act has a manifest tendency to cure or at least to make the evil less").
8 People *ex rel.* Rodgers v. Coler, 166 N.Y. 1, 14, 59 N.E. 716, 720 (1901).
9 The Coler court claimed that this idea was dominant at the time of the Constitution's adoption and reasoned that the idea should, therefore, be used when interpreting that document:

> It was once a political maxim that the government governs best which governs the least. It is possible that we have now outgrown it, but it was an idea that was always present to the minds of the men who framed the constitution, and it is proper for courts to bear it in mind when expounding that instrument.

166 N.Y. at 14, 59 N.E. at 720. This claim is rather dubious. Certainly, there were
RIGHT TO REFUSE TREATMENT 379

twentieth century society. More importantly, the idea has never been generally accepted as a constitutional norm. On the contrary, the courts, from the earliest days of the Republic, have presumed the constitutional validity of legislation. This norm, like primum non nocere, operates on both a general and a particular plane. There is a presumption in general that government may legislate, and no specific evil need be addressed by the legislation. In other words, there is no need to justify the fact of governmental action. In its particular sense, the norm people involved in the framing of the Constitution who felt that government should be narrowly restricted. However, this view does not seem to have dominated. See P. Carroll & D. Noble, THE FREE AND THE UNFREE: A NEW HISTORY OF THE UNITED STATES 187-90 (1977); Meyers, Founding and Revolution: A Commentary on Publius-Madison, in THE HOFSTADTER AESIS 3, 4, 25-26 (1974). If strong anti-government feelings had in fact been dominant among the Constitution's framers, it seems likely that the document would contain many more express limitations on the states than it does in fact contain.

A stronger argument can be made that the idea of narrowly restricting government was dominant at the beginning of this century, around the time of Coler; i.e., during the period known as the Lochner era. Decisions of the Lochner era reflect the philosophy of laissez-faire, which was an important, if not dominant, element of the social thought of that period. See Bodenheimer, The Notion of Positive Law, 26 AM. J. COMP. L. 17, 21 (supp. 1978); L. Tribe, American Constitutional Law §§ 8-1 - 8-4 (1978). However, even that period did not witness a general assault on the validity of public welfare legislation. Rather, the Lochner era courts carved out a zone of economic "natural rights" that they protected from governmental regulation. See L. Tribe at § 8-4. Moreover, the very fact that state legislatures passed social welfare legislation, such as that invalidated in Lochner v. New York, 198 U.S. 45 (1905), indicates that even in the economic realm the philosophy of laissez-faire was not without opposition. Indeed, the Lochner court expressly noted, with more than a hint of pique, "[t]his interference on the part of the legislatures of the several states with the ordinary trades and occupations of the people seems to be on the increase." Id. at 63.

10 Even during the Lochner era the courts upheld most public welfare legislation. They did, however, define a zone of economic rights, which they decreed to be beyond the legitimate ambit of governmental regulation. See L. Tribe, supra note 9, at § 8-2.

11 See, e.g., Fletcher v. Peck, 10 U.S. (6 Cranch) 87, 128 (1810); Angel, Substantive Due Process and the Criminal Law, 9 LOY. CHI. L.J. 61, 63 (1977).

12 Justice Black, writing for the Court in Ferguson v. Skrupa, 372 U.S. 726 (1963), expressed this idea in the clearest terms: "Under the system of government created by our Constitution, it is up to legislators, not courts, to decide on the wisdom and utility of legislation. ... 'We are not concerned ... with the wisdom, need or appropriateness of the legislation.'" Id. at 729-30, quoting Olsen v. Nebraska ex rel. Western Reference & Bond Ass'n, 313 U.S. 236, 246 (1941). In addition, see, e.g., Williamson v. Lee Optical, 348 U.S. 483, 486 (1955); Powell v. Pennsylvania, 127 U.S. 678, 686 (1888); Van Loan, Natural Rights and the Ninth Amendment, 48 B.U.L. REV. 1, 17-18 (1968).
teaches that government may act in any rational manner; there is no need to justify the means used to achieve its ends.\(^{13}\) Only arbitrary or irrational governmental action is forbidden.\(^{14}\)

It is inevitable, however, that at times the exercise of governmental authority will intrude on individual rights and interests that are especially important or delicate. In such situations some balance must be achieved; some means must be found to appropriately reconcile the competing interests at stake. The doctrine of the least restrictive alternative represents one ap-

\(^{13}\) See, e.g., Jefferson v. Hackney, 406 U.S. 535, 546-47 (1972); McGowan v. Maryland, 366 U.S. 420, 425-26 (1961); Williamson v. Lee Optical of Okla., 348 U.S. 483, 487-88 (1955). This idea has been firmly established since the early days of the Republic. Writing for the Court, in Martin v. Hunter’s Lessee, 14 U.S. (1 Wheat) 304 (1816), Justice Story noted that the powers granted by the Constitution are expressed in general terms, “leaving [it] to the legislature, from time to time, to adopt its own means to effectuate legitimate objects, and to mould and model the exercise of its powers, as its own wisdom, and the public interests, should require.” Id. at 326-27. Of course, Justice Story was not traversing entirely untraveled ground. See United States v. Fisher, 6 U.S. (2 Cranch) 358, 396 (1805).

Even during the Lochner era, although stringent means-ends analysis was applied to legislation invading the realm of protected economic rights, see L. Tribe, supra note 9, at § 8-3, legislatures were generally allowed to use any rational means to achieve legitimate ends. As one commentator of that period noted, a statute “is not necessarily unconstitutional because the means may seem inexpedient or harsh.” Brown, Due Process of Law, Police Power and the Supreme Court, 40 Harv. L. Rev. 943, 954 (1927). Indeed, even the Lochner Court felt compelled to characterize the statute before it as “unreasonable and entirely arbitrary” when viewed as a health regulation. Lochner v. New York, 198 U.S. 45, 62 (1905). The Court has never required more of police power regulations that do not infringe upon protected rights than that their means rationally relate to a legitimate state end.

There are signs, however, that somewhat more stringent means scrutiny is being employed in an increasing number of equal protection cases. See, e.g., Craig v. Boren, 429 U.S. 190, 197 (1976); see generally L. Tribe, supra note 9, at § 16-30; Gunther, Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection, 86 Harv. L. Rev. 1 (1972). Nonetheless, the norm under both due process and equal protection analysis, unless a fundamental right or suspect classification is implicated, is that government may employ any rational means to achieve a legitimate end. As the Court noted in Whalen v. Roe, 429 U.S. 589 (1977): “The holding in Lochner has been implicitly rejected many times. State legislation which has some effect on individual liberty or privacy may not be held unconstitutional simply because a court finds it unnecessary, in whole or in part.” Id. at 597.

This doctrine requires the government to pursue its ends by means narrowly tailored so as not to encroach unnecessarily on important competing interests. The classic exposition of this doctrine is found in Justice Stewart's opinion for the Court in *Shelton v. Tucker*:

In a series of decisions this Court has held that, even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly pursued. The breadth of legislative abridgement must be viewed in the light of less drastic means for achieving the same basic purpose.

By focusing on means rather than ends, least restrictive alternative analysis can reconcile important conflicting interests without sacrificing either one. Hence, the doctrine is very appealing. In addition, when legislation infringes fundamental liberties, it seems in accord with basic American values to require the government to employ the least restrictive means to achieve its ends. As one commentator has noted, "[t]he notion that government should not constrict the freedom of its citizens to any greater degree than the community needs require may

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15 See Hoffman & Foust, *Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses*, 14 SAN DIEGO L. REV. 1100, 1101-03 (1977). The doctrine frequently passes under other names: It is sometimes called the doctrine of reasonable alternatives, at other times the doctrine of less drastic means or less onerous alternatives. There are still other occasions when the doctrine is used but remains anonymous. The federal bail statute, for example, implicitly establishes a presumption in favor of the use of the least restrictive alternative, but nowhere uses any such language. See 18 U.S.C. § 3146 (1976).

16 364 U.S. 479, 488 (1960) (footnote omitted). In *Shelton*, the Court invalidated on first and fourteenth amendment grounds an Arkansas statute that required all state-employed teachers to file annually an affidavit listing all organizations to which they belonged or contributed. Id. at 480, 490.

seem so elementary in a nation prizing individual freedom as barely to require discussion."18

The least restrictive alternative principle was first articulated by the Supreme Court in the beginning years of the nineteenth century.19 By the final quarter of that century, the doctrine had firm roots in constitutional law, principally in the context of cases concerning state infringements on the federal government's dormant commerce power.20 During the course of this century, the doctrine has been applied in numerous contexts. In recent years, it has been applied primarily when governmental actions have infringed fundamental individual liberties.21 Given the doctrine's capacity to reconcile conflicting interests, it was inevitable that it would be applied to the "massive curtailment of liberty"22 represented by the civil commitment of mentally handicapped persons. Once incorporated into mental health law, it was equally inevitable that least restrictive alternative analysis would be applied to the troublesome issues raised by judicial oversight of the treatment process. The doctrine poses the possibility of reconciling the divergent views of "civil libertarians concerned about unwarranted intrusions upon individual liberties and clinicians concerned more with successful treatment than with temporary restrictions on personal freedom."23 The result is that in little more than a decade this doctrine has become a cornerstone in the developing body of law dealing with the rights of mentally handicapped persons.

Unfortunately, the rapid growth in the use of the least restrictive alternative doctrine, in the context of mental health law, has not been accompanied by a corresponding growth in understanding of the doctrine's contours. The courts have tended

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19 See notes 29-68 infra, and accompanying text for a brief history of the doctrine's role in constitutional adjudication.
20 See, e.g., Schollenberger v. Pennsylvania, 171 U.S. 1, 12-14 (1898); Minnesota v. Barber, 138 U.S. 313, 327-29 (1890); Railroad Co. v. Husen, 95 U.S. 465, 472 (1877); Chy Lung v. Freeman, 92 U.S. 275, 280 (1876).
23 Hoffman & Foust, supra note 15, at 1102-03.
to recite the words "least restrictive alternative" as if incanting a magical formula, often without considering the meaning of the doctrine or the limitations on its use that are appropriate in this context. Thus, many grave and difficult questions remain not merely unanswered but, more seriously, unasked. The most basic of these questions is whether society's interest in providing the most effective treatment possible should be sacrificed in order to maximize the individual's liberty interest. If the answer to this basic question is no, and the state's interests remain paramount, then the least restrictive alternative principle would seem to be virtually meaningless. On the other hand, if the answer is yes, we may have effectively emasculated the state's ability to provide meaningful treatment. Least restrictive alternative analysis, of course, provides no easy answer to this question; it is merely an analytical tool, a way of phrasing and directing one's inquiry. At its best, it offers a means to analyze the question, a means that holds out the hope of a principled reconciliation of the conflicting interests at stake.

To date, neither the case law nor the commentators have thoroughly considered the issue of the appropriate role of least restrictive alternative analysis in the context of right to refuse treatment cases. Therefore, the purpose of this article is to explore the applicability and meaning of the least restrictive alternative doctrine in the context of judicial oversight of the treatment given mentally ill persons. More specifically, its purpose is to address the issue of whether (and to what extent) the doctrine accords persons committed to state institutions a constitutional right to refuse unwanted treatment. Towards this end, Section II of the article, which follows this introduction, examines the history of the least restrictive alternative principle, focusing on its use in constitutional law.24 A few generalizations are advanced regarding different uses of the doctrine, and the doctrine's role in mental health law is discussed in light of those generalizations.25 Section III focuses on the question whether committed mental patients have a constitutional right to refuse intrusive forms of psychiatric treatment. The interests of the individual and the state implicated by this question are explored, and the various approaches the courts have taken to this issue are re-

24 See notes 29-68 infra and accompanying text.
25 See notes 69-118 infra and accompanying text.
viewed. Section IV discusses the applicability of least restrictive alternative analysis to the right to refuse treatment and considers the appropriate nature of a limited right to refuse. Three particular problems in defining that right are then discussed. Finally, the conclusion explores the likely consequences that the ideas discussed in the preceding sections will have on the treatment of the mentally ill, and justifies those ideas on common sense grounds.

II. THE LEAST RESTRICTIVE ALTERNATIVE DOCTRINE

The least restrictive alternative doctrine has played a major role in constitutional adjudication during this century, a role that has assumed leading dimensions in the twenty years since *Shelton v. Tucker* was decided. It is beyond the scope of this article to explore fully the doctrine's numerous appearances, even within the limited field of constitutional law. but some attention to its history is warranted. Through a study of the doc-

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26 See notes 125-195 infra and accompanying text.

27 See notes 196-270 infra and accompanying text. The three basic questions considered are the following: should treatment effectiveness be balanced against the individual's liberty interest and sacrificed in order to maximize the latter interest? To what extent should judges defer to clinical judgments regarding treatment? May the principle of less restrictive alternatives be used to compel the development of new, less restrictive forms of treatment?

28 See notes 271-278 infra and accompanying text.

29 364 U.S. 479 (1960).

30 It should be noted that the least restrictive alternative doctrine also plays a role in a number of disparate statutory contexts. The doctrine has several uses in administrative law; see Gellhorn, *Adverse Publicity By Administrative Agencies*, 86 Harv. L. Rev. 1380, 1426, 1433, 1440 (1973); Levinson, *Enforcement Of Administrative Decisions In The United States And In France*, 23 Emory L.J. 321, 346 (1974); it also figures in various aspects of antitrust adjudication. See Robinson, *Recent Antitrust Developments: 1975*, 76 Colum. L. Rev. 191, 231-33, (1976); Struve, note 21 supra, at 1463 n.1. Furthermore, the doctrine is explicitly incorporated into a number of statutes—for example, in the bill of rights section of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6010 (1976). In addition, the doctrine is implicitly incorporated into other statutes. The federal bail statute, for example, in effect imposes a presumption in favor of the use of the least restrictive form of bail that is feasible. 18 U.S.C. § 3146 (1976). See Bell v. Wolfish, 441 U.S. 520, 523 (1979). Similarly, the principle underlying the doctrine is embodied in the Model Penal Code’s general provision regarding sentencing, § 7.01 (Prop. Official Draft, 1962). See Morris, *The Future Of Imprisonment: Toward A Punitive Philosophy*, 72 Mich. L. Rev. 1161, 1162-63 (1974).
trine's history one can arrive at a fuller appreciation of its strengths and weaknesses, as well as a greater understanding of its usefulness in analyzing the difficult question whether, and to what extent, committed mental patients have a constitutional right to refuse treatment.

A. History of the Doctrine

The least restrictive alternative doctrine appeared in American law at least as early as 1821, in a case concerning Congress' power to punish contempt.\(^{31}\) After determining that Congress had such a power, the Court considered the extent of that power and commented: "Analogy, and the nature of the case, furnish the answer—'the least possible power adequate to the end proposed;' which is the power of imprisonment."\(^{32}\) The least restrictive alternative doctrine is still a vital part of the law governing contempt,\(^{33}\) although its meaning in that context is far from clear.\(^{34}\) The doctrine seems to have two distinct roles in contempt cases: in the context of civil contempt proceedings it limits the sanction that may be imposed to the least drastic one able to accomplish the court's sole legitimate goal of coercion;\(^{35}\) in the context of criminal contempt cases it limits the use of summary proceedings to situations where such summary action is necessary—that is, where the less drastic alternative of notice and a hearing is not adequate to accomplish the state's ends.\(^{36}\)

\(^{31}\) Anderson v. Dunn, 19 U.S. (6 Wheat) 204 (1821).

\(^{32}\) Id. at 230-31. The source of the quotation is not identified, nor is it known to me.


\(^{35}\) Thus, the federal statute governing civil contempt orders for refusal to testify before a grand jury or judicial proceeding specifies that the contemnor's incarceration must end when the proceeding is concluded. 28 U.S.C. § 1826 (1976). The government's sole legitimate objective for incarcerating the person—to coerce his testimony—becomes irrelevant at that point. Hence, further incarceration is not only unnecessary when the proceeding is over; it is totally without a rational relation to any legitimate state end.

\(^{36}\) See United States v. Wilson, 421 U.S. 309, 316-19 (1975); Kuhns, supra note 34, at 71-73.
The budding of least restrictive alternative analysis occurred during the final quarter of the nineteenth century, in the context of cases dealing with state intrusions upon the dormant commerce power of the federal government. In an 1876 decision invalidating a state statute on dormant commerce grounds, the Court noted that although the state's right to regulate under its police power is normally quite broad, that right must be narrowly restricted when it intrudes upon the federal commerce power. A state regulation that affects commerce, the Court commented, "can only arise from a vital necessity for its exercise, and cannot be carried beyond the scope of that necessity." In its next term the Court reiterated this theme, noting that a state "may not interfere with transportation into or through the State, beyond what is absolutely necessary for its self-protection."

Least restrictive alternative analysis continues to play a significant role in dormant commerce power adjudication, but it is by no means invariably applied in those cases. The key factor appears to be whether the state regulation has a discriminatory effect on interstate commerce. If there is such a discriminatory effect, the normal presumption of legislative validity shifts, and the state has the burden of demonstrating both the efficacy of the statute and the absence of less restrict-

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38 Chy Lung v. Freeman, 92 U.S. 275, 280 (1875).
The commerce clause cases demonstrate the usefulness of least restrictive alternative analysis when competing values are at stake. It is crucial that the states be able to enact regulations to protect the health and safety of their citizens. It is, however, also important that the states not be allowed to restrict interstate commerce. The Court therefore demands that the state show the necessity of the legislation—that is, the state must demonstrate that its legitimate interest could not have been adequately served by an alternatives less restrictive of interstate commerce. Least restrictive alternative analysis thus is designed to honor the legitimate purposes of a statute while insisting that it be purged of its illegitimate elements.

Perhaps because there was no comparable distrust of the efficacy of the political process, least restrictive alternative analysis was initially held inapplicable in the context of due process scrutiny of state economic regulations. It was not until the turn of the century that least restrictive alternative analysis became an element in the scrutiny of state economic regulations. As the Court intensified its scrutiny of these regulations during the

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44 The application of least restrictive alternative analysis may reflect judicial distrust of legislative motives in such cases. Cf. Note, Less Drastic Means and the First Amendment, 78 YALE L.J. 464, 469-70, n.27 (1969) (noting that this may be true in the context of first amendment cases). The court may feel that a state legislature is attempting to achieve an illegitimate purpose—e.g., provide domestic businesses with a competitive advantage over out-of-state concerns—under the guise of pursuing a legitimate state end. The fact that a less restrictive alternative was available—i.e., that the legitimate state object could have been achieved without furthering the illegitimate purpose—both evidences the legislature's illicit motives and gives the Court a justification for invalidating the statute.

45 See, e.g., Lochner v. N.Y., 198 U.S. 45, 61 (1905); Lawton v. Steele, 152 U.S. 133 (1894). The Lawton Court demanded that the state's means be "reasonably necessary" for the accomplishment of its purposes. Id. at 137. The concerns of the Lawton opinion, however, center on the procedural due process issues raised by the statute, rather than on its validity as a substantive regulation of economic activity. Id. at 139-41. Despite these concerns, and the adoption of the "reasonably necessary" test, the Court upheld the statute. Id. Note, supra note 37, at 979.
early years of this century, the doctrine became an increasingly important element of such cases. However, in the late 1930's, the Court in effect withdrew from meaningful due process scrutiny of economic regulations. One part of that withdrawal was abandonment of the use of least restrictive alternative analysis in such cases. Since that time, the Court has regularly reiterated that a legislature may use any rational means to reach permissible economic ends, regardless of the availability of less restrictive alternatives. Thus, the least restrictive alternative doctrine today has little role in economic due process analysis.

By contrast, the least restrictive alternative doctrine quickly took root in first amendment cases, and it continues to flourish in that area of the law. Despite the large number of cases employing the doctrine, its role in first amendment adjudication remains unclear. However, a few trends are apparent. The Court tends to employ least restrictive alternative analysis to invalidate a statute when it seems clear that any legitimate state interests served by the statute could be equally well served by an alternative less restrictive of first amendment rights.


49 See Note, supra note 44, at 464.

50 Id. at 469-70 n.27. Probably the best examples of the Court (rightly) suspecting legislative motives are the NAACP cases. See NAACP v. Button, 371
addition, if a statute discriminates against the content of expression or significantly impairs first amendment rights, the court will generally invalidate it; often invoking the doctrine even when there seem to be no equally effective alternatives.\textsuperscript{51} However, in other cases the Court either simply ignores least restrictive alternative analysis,\textsuperscript{52} or uses the doctrine as one element of a legitimate balancing process.\textsuperscript{53} Such cases seem to have three essential prerequisites: the governmental purpose must be both legitimate and important; the regulation must be content neutral; and the intrusion on first amendment rights must be relatively mild.\textsuperscript{54} In these cases the existence of less restrictive alternatives is one of the factors, but not necessarily a determinative factor, in the Court's analysis of the statute's validity. Unfortunately, the Court has not clearly defined the role of least restrictive alternative analysis in the disposition of such cases.

The frequent use of least restrictive alternative analysis in recent first amendment cases is but part of a much broader trend. During the past twenty years, the Court has employed the doctrine in numerous contexts where governmental regulations "broadly stifle fundamental personal liberties."\textsuperscript{55} The fundamental liberties that have received the heightened protection of least restrictive alternative scrutiny include the right of priv-

\textsuperscript{51} See, e.g., Talley v. California, 362 U.S. 60, 71 (1960) (Clark, J., dissenting); L. Tribe, supra note 9, at § 12-30. It is this tendency that led one commentator to observe that "the phrase 'less drastic means' does not so much explain the result as announce it." Note, supra note 44, at 464. \textit{But see} notes 52-54 infra and accompanying text, which disputes this generalization.

\textsuperscript{52} See, e.g., Brown v. Glines, 444 U.S. 348 (1980). Justice Brennan's dissenting opinion pointed to the existence of less restrictive alternatives that could have adequately served the government's legitimate interests. \textit{Id.} at 368. \textit{See also} Bell v. Wolfish, 441 U.S. 520, 559-60 n.40 (1979); \textit{id.} at 574 (Marshall, J., dissenting).


\textsuperscript{54} See L. Tribe, supra note 9, at §§ 12-20, 12-30. \textit{Cf. id.} at § 13-20, regarding applications of the doctrine to ballot access cases.

acy,\textsuperscript{56} the right to travel,\textsuperscript{57} the right to vote and participate in electoral processes,\textsuperscript{58} the right to marry,\textsuperscript{59} and the right to procreate.\textsuperscript{60} Not surprisingly, the commentators have been even more liberal with the doctrine than the Court, proposing that it be used to scrutinize everything from child custody determinations\textsuperscript{61} to the methods used to execute condemned prisoners.\textsuperscript{62}

One ordinarily associates the increased protection of fundamental rights primarily with the strict scrutiny standard of equal protection analysis. This points to the close relationship between the least restrictive alternative doctrine and the equal protection doctrine. By requiring that a classification be necessary to the achievement of a (compelling) state interest, the strict scrutiny test incorporates least restrictive alternative reasoning.\textsuperscript{63} If a less restrictive alternative is available, then, virtually by definition, the classification at issue must not be

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\item See, e.g., Roe v. Wade, 410 U.S. 113, 155 (1973); Griswold v. Connecticut, 381 U.S. 479, 485-86 (1965); id. at 497-99 (Goldberg, J., concurring).
\item See, e.g., Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632, 642-48 (1974).
\item See Chemerinsky, Defining the "Best Interests": Constitutional Protections in Involuntary Adoptions, 18 J. Fam. L. 79, 107-09 (1979).
\item See Gardner, Executions and Indignities—An Eighth Amendment Assessment of Methods of Inflicting Capital Punishment, 39 Ohio St. L.J. 96, 110 (1978).
\item Romeo v. Youngberg, No. 78-1982, slip op. at 23, 29 n.27 (3d Cir. Nov. 28, 1980). See Note, supra note 37, at 997-1004. Of course, equal protection strict scrutiny has a second element; the challenged classification must not only be necessary, it also must be justified by a compelling state interest. See Gunther, supra note 13, at 21: Harzenski & Weckesser, The Case for Strictly Scrutinizing Gender-Based Separate but Equal Classification Schemes, 52 Temp. L.Q. 439, 441 n.3 (1979). Because it does not demand a compelling state interest, least restrictive alternative analysis is therefore not as severe a standard of review as strict scrutiny. See Singer, Sending Men to Prison: Constitutional Aspects of the Burden of Proof and the Doctrine of the Least Drastic Alternative as Applied to Sentencing, 58 Corn. L. Rev. 51, 57-58 (1972); Spece, Justifying Invigorated Scrutiny and the Least Restrictive Alternative as a Superior Form of Intermediate Review: Civil Commitment and the Right to Treatment as a Case Study, 21 Ariz. L. Rev. 1049, 1052-53 (1979).
\end{enumerate}
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necessary for the state to achieve its ends. Similarly, traditional equal protection analysis also incorporates least restrictive alternative concepts. A challenge to a statute on the basis of over-inclusiveness (or, for that matter, under-inclusiveness) is essentially no different than an assertion that less (or, when appropriate, more) restrictive means exist for the state to accomplish its objectives. At its core, the overinclusiveness argument simply contends that the state must more narrowly tailor its means to fit its legitimate ends. The identical argument is at the core of least restrictive alternative analysis.

In a similar sense, the least restrictive alternative doctrine is on an interface with other principles of constitutional law. The doctrine's prevalence in first amendment adjudication reflects its close relationship to overbreadth analysis. Of greater significance in the context of this article, least restrictive alternative analysis is an important element of conclusive presumption analysis. In addition, the doctrine forms an integral part of the "excessiveness" concept enunciated in recent death penalty decisions. Thus, although the least restrictive alternative principle had but a brief existence in the context of economic due process adjudication, the doctrine is unquestionably one of the most important constitutional principles governing the relationship between the individual and the state.

44 See L. Tribe, supra note 9, at § 16-4 n.17; Note, supra note 37, at 1003.
46 See Note, supra note 37, at 464 n.3; Note, supra note 48, at 911-18. Thus, most overbreadth cases can be looked at as least restrictive alternative cases. See, e.g., Shelton v. Tucker, 364 U.S. 479, 488 (1960); Butler v. Michigan, 352 U.S. 380, 382-83 (1957).
47 See, e.g., Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632, 648-49 (1974); Vlandis v. Kline, 412 U.S. 441, 451-52 (1973); Note, supra note 37, at 985-89. The least restrictive alternative doctrine has also been employed in other procedural due process contexts. Id. at 989-93; see, e.g., Kinsella v. Singleton, 361 U.S. 234, 240 (1960); U.S. ex rel. Toth v. Quarles, 350 U.S. 11, 22-23 (1955); Palmigiano v. Baxter, 487 F.2d 1280, 1287-88 (1st Cir. 1973).
48 See, e.g., Godfrey v. Georgia, 446 U.S. 420, 428-29 (1980); Gregg v. Georgia, 428 U.S. 153, 169-73 (1976) (plurality opinion). The significance of this will be discussed in the following part of this section. See notes 78-91 infra and accompanying text.
B. Different Aspects of the Doctrine's Analysis

In *Butler v. Michigan* the Court invalidated a statute that forbade the sale to anyone of books or other matter that could corrupt the morals of minors. Justice Frankfurter's majority opinion contains what is perhaps the most colorful enunciation of the least restrictive alternative doctrine: "The State insists that, by thus quarantining the general reading public against books not too rugged for grown men and women in order to shield juvenile innocence, it is exercising its power to promote the general welfare. Surely, this is to burn the house to roast the pig." Unfortunately, Justice Frankfurter's vivid words can lead to a somewhat mistaken impression of the doctrine, a mistaken impression fostered in the first place by the very words "least restrictive alternative." The doctrine is very rarely employed to invalidate a statute because of its restrictiveness (hereinafter referred to as intrusiveness); rather, least restrictive alternative analysis is almost always used, as it was in *Butler*, to challenge the scope or breadth of governmental action that would have been valid if more narrowly confined.

This important distinction can be clarified by comparing two of the opinions in *Griswold v. Connecticut*. In striking down Connecticut's contraception statute, Justice Douglas's majority opinion was clearly concerned with the intrusiveness of the legislation; it emphasized that by forbidding the *use* of contraceptives, rather than their manufacture or sale, the state pursued its objective in the manner that would have the maximum possible harmful impact upon the basic right of marital privacy. By contrast, Justice Goldberg's concurring opinion focused

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70 Id. at 383. Cf. Partido Nuevo Progresista v. Hernandez Colon, 415 F. Supp. 475 (D.P.R. 1976) (three judge court) (Per curiam). In invalidating a statute that provided for the presence of government inspectors at political fund raising rallies, the court commented: "A cannon has been used to kill a mockingbird." Id. at 483.
72 381 U.S. 479 (1965).
73 Id. at 485. Although they are the exception, there are certainly other least restrictive alternative decisions that focus on a statute's intrusiveness rather
on the impermissible breadth of the statute; it noted that the state's sole objective was to discourage extramarital sexual activity and found the statute to be unacceptably imprecise in that it prohibited the use of contraceptives by married persons as well as by the unmarried. 4

Least restrictive alternative analysis is more common and better established in the overbreadth context than it is in the context of cases challenging statutes as overly intrusive. The typical use of the doctrine in overbreadth cases is important because it indicates that the Court stands on firmer ground when it uses the doctrine in this way than when it uses the doctrine to invalidate legislation on the basis of intrusiveness. It is relatively easy for the Court to observe that a statute sweeps too widely, regulating the behavior of those who do not come within its legitimate ambit as well as the behavior of those who do. In pursuing this function, the Court acts in a time-honored fashion that is consistent with its role in our form of government. 7 On the other hand, when the Court invalidates legislation that directly pursues acceptable state ends, but does so in
too intrusive a manner, it acts in a much more questionable way. The line-drawing involved in such judgments has normally been deemed more appropriate for legislative than for judicial determination. This is not to say that scrutiny of a statute's intrusiveness is never warranted; Griswold appears to be an example of where such scrutiny was appropriate, if unnecessary. However, when a court uses the least restrictive alternative doctrine to analyze a statute challenged as unnecessarily intrusive it should act with especial care and hesitancy.

Only the Court's perception of its limitations in this respect can explain its failure to apply least restrictive alternative analysis to death penalty statutes. On the surface, challenges to these statutes present the most appropriate situations for application of the doctrine: The death penalty is society's most severe intrusion upon the most fundamental individual right. But, despite the urgings of two justices, the Court has never

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76 See Furman v. Georgia, 408 U.S. 238, 418, 430, 451, 456 (1972) (Powell, J., dissenting); Note, supra note 37, at 1032-33. Thus, in many cases where one would have thought least restrictive alternative analysis appropriate the Court has refused to apply it. See, e.g., Bell v. Wolfish, 441 U.S. 520 (1979), which rejected the principle as an inappropriate standard for scrutinizing the conditions of pretrial detainment. Id. at 525. In addition, see United States v. Martinez, 428 U.S. 543, 556-57 n.12 (1976).

77 It is arguable that least restrictive alternative analysis of a statute's intrusiveness is only appropriate when the government seems to have two motives for enacting the statute, one of which is illegitimate. Cf. Bell v. Wolfish, 441 U.S. 520, 532-40 (1979) (refusing to apply least restrictive alternative analysis where government's purposes are legitimate). When legislation furthers legitimate state interests, but also unnecessarily furthers illegitimate ends, the Court can effectively employ least restrictive alternative analysis to scrutinize it. This may, however, be too limited a role for the doctrine. Some argue it should be used whenever a statute seriously intrudes on fundamental individual rights, not merely to purge statutes that clearly further illegitimate interests. Id. at 567-70 (Marshall, J., dissenting). But the Court has been reluctant to invalidate legislation that directly pursues legitimate ends, even if it does so in an unnecessarily harsh fashion or to an unnecessarily harsh degree.

78 See, e.g., Gregg v. Georgia, 428 U.S. 153, 239-41 (1976) (Marshall, J., dissenting); Furman v. Georgia, 408 U.S. 238, 305 (1972) (Brennan, J., concurring). A number of commentators have also argued that least restrictive alternative analysis is appropriate for death penalty issues. See, e.g., Radin, The Jurisprudence of Death: Evolving Standards for the Cruel and Unusual Punishment Clause, 126 PA. L. REV. 989, 1016, 1062 (1978). Indeed, it has been argued that least restrictive alternative analysis is an appropriate form of scrutiny with respect to sentencing issues generally. See id. at 1028; Morris, supra note 30, at
really applied least restrictive alternative analysis to the death penalty.\textsuperscript{79} If it did do so, it seems clear that the Court would be compelled to invalidate all death penalty statutes; no state could bear the burden of proving that the death penalty was necessary for the attainment of its legitimate penological ends.\textsuperscript{80} Although many decry the Court's death penalty decisions, the opinions reveal a legitimate and arguably appropriate unwillingness to challenge legislative determinations regarding the necessity of the sanction's severity.

On the other hand, the Court clearly has not been reluctant to consider death penalty issues; nor, in the last decade, has it been reluctant to invalidate death penalty statutes.\textsuperscript{81} However, in considering these statutes, the Court has focused on issues it feels competent to tackle—primarily, the breadth of applicability of the penalty\textsuperscript{82} and the procedures used in imposing it.\textsuperscript{83} In analyzing these issues, the Court has frequently used the concept of excessiveness, which is quite closely related to the least restrictive alternative doctrine.\textsuperscript{84} The result has not been wholesale invalidation of death penalty statutes, but can be broadly characterized as imposing two kinds of limitations on such statutes. On the substantive level, the Court has required the states to justify imposition of the death penalty—for example, by statutorily defined factors—in an attempt to end the arbitrariness of its use.\textsuperscript{85} On the procedural level, the Court has

\begin{footnotes}
\footnotetext[79]{See Godfrey v. Ga., 446 U.S. 420, 427-28 (1980) (plurality opinion); Gregg v. Ga., 428 U.S. 153, 174-76 (1976); Angel, supra note 11, at 132-33.}
\footnotetext[80]{See Radin, supra note 78, at 1011, 1063-64.}
\footnotetext[82]{Thus, the Court has invalidated mandatory death sentence statutes; Woodson v. North Carolina, 428 U.S. at 305, and it has invalidated statutes where the penalty of death was disproportionate to the offense being punished. See Coker v. Ga., 433 U.S. 584, 598 (1977).}
\footnotetext[83]{Hence, the Court recently invalidated a statute that denied defendants in capital cases the right to an instruction on lesser included offenses, even if the evidence warranted such an instruction. See Beck v. Ala., 100 S. Ct. 2382, 2393 (1980).}
\footnotetext[84]{See, e.g., Coker v. Ga., 433 U.S. 584, 592 (1977) (plurality opinion); Gregg v. Ga., 428 U.S. 153, 173 (1976) (plurality opinion); Radin, supra note 78, at 1048-64.}
\footnotetext[85]{See Furman v. Ga., 408 U.S. 238, 255-57 (1972) (Douglas, J., concurring); id. at 308-10 (Stewart, J., concurring).}
\end{footnotes}
struck down mandatory death statutes and imposed a requirement of individual consideration, in an attempt to further limit use of the penalty to appropriate circumstances.\(^8\) In short, the Court has refused to second-guess legislative decisions to employ this most drastic sanction; but it has continuously attempted to ensure that the sanction is used as responsibly as is possible.

The death penalty cases illustrate the general fact that the Court has been reluctant to rigidly apply the least restrictive alternative doctrine in determining the acceptable degree of intrusiveness of governmental infringements of individual rights. Moreover, on the rare occasions that it has used the doctrine in considering the severity of state intrusions upon basic rights, the Court's focus has invariably been on a statutory scheme. The Court has never required the factfinder in an individualized determination to decide that the sanction being imposed is necessary in that particular case.\(^9\) Such a requirement would seem impossible to meet, given the very nature of the decisionmaking process in the context of individualized adjudications.\(^8\) For example, the Court could very easily decide that the death penalty is unnecessary and, by applying least restrictive alternative analysis, invalidate it. But the Court could not retain the death penalty and, at the same time, require the trial judge to impose it only when it was necessary. It would be meaningless and unrealistic to require the trial judge to justify as necessary the penalty imposed in an individual case. In other words, it would be impossible to justify, in any individual case, the necessity of the significantly greater intrusion represented by the difference between death and the lesser sanction of life imprisonment. The

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\(^9\) See Singer, supra note 63, at 63-64. This should be contrasted with the point made above that in certain situations an individualized determination is necessary. The question then becomes what standard will be used in the individual hearing: Must the state limit itself to the least restrictive alternative in each individual case? The Court seems never to have demanded this.

best a trial judge can do is to exercise his judgment and determine the penalty most appropriate under the circumstances.89

This does not mean that the least restrictive alternative principle has no role to play in sentencing decisions. Certainly, a judge should always consider less restrictive alternatives to any penalty and never impose an unnecessarily harsh sanction.90 The doctrine's role in this context, though, is to express a normative ideal; it does not express a rule of law that is subject to meaningful review. Ultimately, the sanction appropriate in an individual case is simply a matter of judgment. Of course, any appellate court could easily find a sentence of ten years imprisonment to be excessive and unnecessary punishment for the crime of littering. But that would be a judgment that such a severe sentence is invariably unnecessary in light of the social goals served by punishing people for littering. It would not be a decision that the sentence was excessive because of the characteristics of the offender or the circumstances of his offense. When one makes the latter sort of decision, when one chooses between a fine of $10 and one of $100,91 one makes a judgment

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89 See id. Several courts dealing with mental health issues have indicated that the principle requires individualized decisionmaking and a consideration of less restrictive alternatives. But they have not rigidly demanded that the least restrictive alternative always be used rather than other forms of care. See, e.g., Halderman v. Pennhurst State School & Hosp., 612 F.2d 84, 113-16 (3d Cir. 1979) (en banc), cert. granted, 449 U.S. 900 (1980); Gary W. v. State of La., 437 F. Supp. 1209, 1217-18 (E.D. La. 1976). As the court commented in Gary W.: [t]he imperative that least drastic means be considered does not imply a constitutional right on the part of every individual to a personal judicial determination that the means being employed to improve his condition are the best possible or the least restrictive conceivable. What is required is that the state give thoughtful consideration to the needs of the individual, treating him constructively and in accordance with his own situation, rather than automatically placing in institutions, perhaps far away and perhaps forever, all for whom families cannot care and all who are rejected by family or society.

Id. at 1217.

90 As noted earlier, the Model Penal Code adopts this point of view in its general sentencing provision. See note 30 supra.

91 There is, of course, a better argument that least restrictive alternative analysis can be meaningfully applied when sentences are qualitatively different, not just different in degree. See generally Radin, supra note 78. Nonetheless, it is generally accepted that judges have the discretion to impose any sentence authorized by statute. See Williams v. Ill., 399 U.S. 235, 243 (1970).
based upon a complex set of particular factors. It is to be hoped that such judgments are motivated by the spirit of the least restrictive alternative principle, but the doctrine does not have a useful analytical role in the context of these individualized determinations.

The least restrictive alternative doctrine is simply an analytical tool, a way of phrasing and directing one's inquiry. Like all tools, it is very useful for some jobs but only a hindrance for others. The norm expressed by the doctrine is certainly relevant when a court considers the intrusiveness of governmental regulations. But the doctrine has proved to be of little utility in analyzing the constitutional questions that merely involve distinctions in the degree of intrusiveness of regulations. That is especially true in the context of individualized determinations.

There is, therefore, reason to question the usefulness of least restrictive alternative analysis for scrutinizing the constitutionality of compelled psychiatric treatment, at least on the individual level. When considering individual treatment decisions, one must start with the assumption that this kind of state infringement of liberty may be justified: that is, that in certain circumstances it is legitimate for the state to compel mentally ill individuals to undergo psychiatric therapy. The obvious question to be asked is whether these are appropriate circumstances. That inquiry will necessarily include consideration of whether alternative, less intrusive, forms of treatment are available. Given the uncertainties of psychiatric treatment, it is meaningless to impose least restrictive alternative scrutiny on this type of decision. There will always be a less restrictive form of treatment that conceivably could lead to equally good results.

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2 Cf. Bell v. Wolfish, 441 U.S. 520 (1979) (pretrial detention warranted when appropriate). Of course, it is not quite cricket to assume half the answer to the question whether treatment may be compelled. Hence, I have attempted to sketch out some arguments in support of the idea that the state should be able to compel treatment in appropriate circumstances. See notes 149-163 infra and accompanying text. The point here, however, is the difficulty of making the individual determination that treatment is warranted in a given case. Obviously, if it were decided that the state may never compel treatment, one would not reach the issue whether it was warranted to do so in a particular case. Adopting an absolute right to refuse moots this difficult question.

However, the efficacy of such alternative forms of treatment may be quite doubtful. To demand that the least restrictive alternative be used in such situations—that psychotherapy, for example, always be tried before any more intrusive treatments are used—would radically curtail the state’s ability to provide appropriate treatment.

However, least restrictive alternative analysis does have a role in deciding such questions. The norm that it embodies—the idea that government restrictions of liberty should be closely scrutinized and kept to the minimum possible—must be part of the treatment decision. Fortunately, this norm is an element of any legitimate medical decision; it is one of the ideas at the core of the precept *primum non nocere*: All treatments must be justified; their risks and detriments must always be balanced against their advantages.44 Too often, though, the implications of this precept are forgotten, particularly by those practicing in the demanding environment of the public mental institution. However, the command of the least restrictive alternative doctrine is too basic to be ignored; its injunction to closely scrutinize state intrusions upon fundamental liberties must be made meaningful. The doctrine should not be rigidly applied in this context. However, it demands that before the state compels the use of intrusive forms of therapy less intrusive alternatives must be considered; and intrusive treatments should be compelled only when their use is clearly medically warranted. Further, because the doctrine’s basic commands are so frequently ignored, procedural safeguards must be developed to ensure that those commands are adhered to in all decisions to use intrusive forms of psychiatric therapy.45

44 See notes 2-6 supra and accompanying text. As one observer has commented: “in either a private or institutional context, if there is a choice between more or less equally effective therapies, the rational therapist should (and in the case of an involuntarily confined patient, constitutionally must) choose the less intrusive.” Shapiro, *Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 So. Cal. L. Rev. 237, 287 (1974).

C. The Doctrine's Role in Mental Health Law

The least restrictive alternative principle appears to have been initially used in the context of mental health law in *Lake v. Cameron*, a 1966 decision of the District of Columbia circuit. The case was a habeas corpus action brought by Catherine Lake, a somewhat senile but totally harmless elderly woman, challenging her commitment to Saint Elizabeth's Hospital. Chief Judge Bazelon's opinion for the en banc court of appeals noted that Lake's illness did not require the "complete deprivation of liberty that results from commitment..." Based on the District of Columbia commitment statute, the court held that trial courts have a duty to explore alternative courses of treatment, less restrictive than institutionalization. It noted further that "[d]eprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection."

Three years later, in *Covington v. Harris*, Chief Judge Bazelon expanded the scope of the *Lake* decision in two significant ways. First, albeit in dictum, the opinion indicated that the least restrictive alternative principle was constitutionally based:

the principle of the least restrictive alternative consistent with the legitimate purposes of a commitment inheres in the very nature of civil commitment, which entails an extraordinary deprivation of liberty... A statute sanctioning such a drastic curtailment of the rights of citizens must be narrowly, even grudgingly construed in order to avoid deprivations of liberty without due process of law.

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96 364 F.2d 657 (D.C. Cir. 1966) (en banc); See generally Chambers, supra note 18; Hoffman & Faust, supra note 15; Spece, supra note 63.
97 Id. at 658-59.
98 Id. at 660-61.
99 Id. at 659-60.
100 Id. at 660. Judge Wright, concurring, would have gone further. He found Mrs. Lake's inability to care for herself to be an insufficient basis for involuntary commitment: "This evidence makes out a need for custodial care of some sort, but I cannot accept the proposition that this showing automatically entitles the Government to compel Mrs. Lake to accept its help at the price of her freedom." Id. at 662-63. Cf. O'Connor v. Donaldson, 422 U.S. 563, 575 (1975) ("the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution").
101 419 F.2d 617 (D.C. Cir. 1969).
102 Id. at 623.
Secondly, the court held that the principle applied not only to the commitment decision, but also to the subsequent treatment of the committed individual within the hospital:

The principle of the least restrictive alternative is equally applicable to alternate dispositions within a mental hospital. It makes little sense to guard zealously against the possibility of unwarranted deprivations prior to hospitalization, only to abandon the watch once the patient disappears behind hospital doors. The range of possible dispositions of a mentally ill person within a hospital, from maximum security to outpatient status, is almost as wide as that of dispositions without. The commitment statute no more authorizes unnecessary restrictions within the former range than it does within the latter.103

Since Lake and Covington, numerous courts and commentators have applied least restrictive alternative analysis to mental health law issues. The doctrine has been used in four distinct contexts: First, with respect to the issue of commitment, on either the individual or group level.104 Secondly, the doctrine has been used to regulate the conditions of commitment105—e.g.,

103 Id. at 623-24.
whether a maximum security facility is necessary. Thirdly, the doctrine has been used to define the parameters of treatment within the institution. Fourthly, the doctrine has been used to support the concept of a right to treatment. Unfortunately, with few exceptions, the many courts that have used the doctrine have not critically analyzed its meaning, or considered its appropriate role in terms of the issues before them. Rather, they have tended to merely recite the catch words "least restrictive alternative" en route to their decision.

It is beyond the scope of this article to meaningfully analyze the role of least restrictive alternative analysis in each of the above contexts. Nonetheless, a few general thoughts based on


This argument has been advanced by a commentator, but does not seem to have been adopted by any courts. See Spece, Preserving the Right to Treatment: A Critical Assessment and Constructive Development of Constitutional Right To Treatment Theories, 20 ARIZ. L. REV. 1, 33-46 (1978); Spece, supra note 63.

the preceding discussion are appropriate. To the extent a court uses the doctrine to test the intrusiveness of a statute rather than its breadth (and many of these cases will necessarily fall into the former category), it should be reluctant to overturn the legislative determination. Further, in the context of an individualized decision, a court must be particularly wary regarding its use of the doctrine. Perhaps because of an intuitive sense of the doctrine's limitations in such a context, the District of Columbia circuit in Lake stopped short of a strict application. The court did not mandate that all less restrictive alternatives be tried and found wanting before resort to the more drastic alternative of commitment. Rather, it ordered the trial court to explore and consider the feasibility of alternative, less restrictive courses of treatment. This limited remedy, this mandate to consider the alternatives with an eye to minimizing the restrictions on liberty, seems clearly warranted. However, more rigid application of the least restrictive alternative doctrine may well be inappropriate in such a context.

These same concerns were undoubtedly a factor in the Third Circuit's recent en banc decisions in Halderman v. Pennhurst State School and Hospital and Romeo v. Youngberg. Halderman was a class action in which plaintiffs challenged the very existence of Pennsylvania's Pennhurst institution for the mentally retarded; they contended that community living arrange-

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112 612 F.2d 84 (3d Cir. 1979) (en banc), cert. granted, 100 S. Ct. 2984 (1980). For a general discussion of the Pennhurst case's background and import, see Ferleger & Boyd, supra note 109.

113 No. 78-1982 (3d Cir. November 24, 1980).
ments were less restrictive environments than the institution and that the residents of Pennhurst should therefore be cared for in such community centers. The court of appeals held that mentally retarded persons have a right to habilitation in the least restrictive environment, but it reversed the district court's order that Pennhurst must be closed. The court of appeals refused to find that institutions are necessarily less effective than community living arrangements in facilitating the right to habilitation in the least restrictive setting. Rather, the court ordered that the needs of each patient be individually considered and that an appropriate habilitation plan be adopted for each. The court further held that, in devising an individual's habilitation plan, there should be a presumption against institutionalization, but it did not rule that out as a possibility. Thus, the court shied away from a rigid application of the least restrictive alternative doctrine, adopting instead a twofold requirement: It mandated individualized decisionmaking and the concept of a presumption in favor of alternatives less restrictive than institutionalization.

These issues surfaced again in Romeo, a civil rights action in which the plaintiff sought damages for his inappropriate treatment at the hands of Pennhurst officials. The Third Circuit held that least restrictive alternative analysis was appropriate for those claims alleging a direct restraint of plaintiff's liberty. In addition, the court held that where "the issue turns on which of two or more major treatment approaches is to be adopted, a 'least intrusive' analysis may well be appropriate." However,

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114 See generally Ferleger & Boyd, supra note 109.
115 612 F.2d at 107.
116 Id. at 113-15. The district court's opinion is reported at 446 F. Supp. 1295 (E.D. Pa. 1977).
118 612 F.2d at 115-16.
119 That "treatment" included the shackling of Romeo to his bed for extended periods of time. Romeo v. Youngberg, No. 78-1982, slip op. at 5, 13 n.20 (3d Cir. November 24, 1980).
120 Id. at 16.
121 Id. at 28. The court indicated that least restrictive alternative analysis may well be appropriate in the context of challenges to such "fundamental liberty violations" as the involuntary administration of "powerful antipsychotic drugs." Id. at 26.
the court also noted that the "application of a constitutional standard of 'least intrusive alternative' on continuing treatment programs . . . would prove unworkable."122 Further, the court alluded to, but did not resolve, the critical problem that the 'least intrusive' alternative may well be the least effective mode of treatment.123 These issues should be addressed in more detail when the Third Circuit decides Rennie v. Klein,124 the right to refuse treatment case that is currently pending.

III. THE RIGHT TO REFUSE TREATMENT

Least restrictive alternative analysis has been used by a few courts seeking to resolve the difficult question whether mentally ill persons committed to state institutions have a constitutional right to refuse intrusive psychiatric treatment.125 This section considers whether, and to what extent, there should be a right to refuse treatment and discusses the various possible bases for such a right. It is argued that a qualified right to refuse treatment is both a constitutional mandate and a practical necessity, and it is suggested that the appropriate basis for such a right is the Due Process Clause.

A. The Competing Interests of the Individual and the State

Both the individual and the state have extremely significant, and generally conflicting, interests at stake in the decision whether to compel treatment. It is clear that an individual's liberty interests are implicated when the state attempts to force unwanted treatment on him. Given the fact that intrusive psychiatric therapies tread on rights long deemed fundamental, and threaten serious and permanent deprivations of those rights, this liberty interest is significant. However, the state's interests are also significant. The state has a traditional parens patriae interest in aiding the sick individual, and an equally important interest in protecting the health of society. Moreover, with

122 Id. at 28.
123 Id. at 29, 29 n.47. This issue is discussed in the text accompanying notes 252-63 infra.
respects to the individual committed to a public institution, the state has an especially vital interest in providing effective treatment, for only by providing treatment can a state justify the fact of commitment. Thus, the problem is not a simple one, and it admits of no easy, universal answers. On the contrary, the problem demands a subtle balancing of the competing interests at stake, with close attention paid to the unique factors present in each particular case.

1. The Liberty Interest of the Individual

It is incontrovertible that state compelled psychiatric treatment implicates an individual's Fourteenth Amendment liberty interest. As Judge Higginbotham has forcefully observed, it is difficult to believe that one's right to use contraceptives and have an abortion are protected by the Due Process Clause, but

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126 See O'Connor v. Donaldson, 422 U.S. 569, 575-76 (1975); notes 158-60 infra and accompanying text.

127 As the first circuit recently noted:

We begin our analysis with what seems to us to be an intuitively obvious proposition: a person has a constitutionally protected interest in being left free by the state to decide for himself whether to submit to the serious and potentially harmful medical treatment that is represented by the administration of antipsychotic drugs.


See also Vitek v. Jones, 100 S. Ct. 1254, 1263 (1980). The liberty interest has long been recognized as a broad one. As Justice Harlan has observed:

The full scope of the liberty guaranteed by the Due Process Clause cannot be found in or limited by the precise terms of the specific guarantees elsewhere provided in the Constitution. This "liberty" is not a series of isolated points pricked out in terms of the taking of property; the freedom of speech, press and religion; the right to keep and bear arms; the freedom from unreasonable searches and seizures; and so on. It is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints, and which also recognizes, what a reasonable and sensitive judgment must, that certain interests require particularly careful scrutiny of the state needs asserted to justify their abridgement.

128 Oral argument of Romeo v. Youngberg (3d Cir. April 28, 1980) (en banc). Judge Higginbotham's remarks were subsequently confirmed by the third circuit's opinion in Romeo. See No. 78-1982, slip op. at 26-27. Admittedly, psychosurgery is the most blatantly intrusive form of treatment. But the differences between it and other modes of organic treatment are merely a matter of degree. See notes 144-46 & 201-05 infra and accompanying text.

Indeed, in the course of holding that a state may not transfer a prisoner to a mental institution without appropriate procedural safeguards, the Supreme Court has recently recognized that the possibility of compelled treatment implicates protected liberty interests.\footnote{Bell v. Wolfish, 441 U.S. 520, 533-35 (1979); id. at 1895 (Stevens, J., dissenting). Cf. Ingraham v. Wright, 430 U.S. 651, 673-74 (1977) (schoolchildren entitled to due process protections); Wolff v. McDonnell, 418 U.S. 539, 555-56 (1974) (prisoners entitled to due process protections).} Further support for the idea that treatment, like other conditions of confinement, implicates an individual's liberty interest can be found in the Court's recent decision that the conditions in which pretrial detainees are held must comport with due process.\footnote{See, e.g., Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); In re Quackenbush, 156 N.J. Super. 282, 383 A.2d 785 (1978). See generally, Baron, Assuring "Detached but Passionate Investigation and Decision": The Role of Guardians Ad Litem in Saikewicz-Type Cases, 4 Am. J. L. & Med. 111 (1979); Anna, Reconciling Quinlan and Saikewicz: Decision Making for the Terminally Ill Incompetent, 4 Am. J. L. & Med. 367 (1979).} Additionally, a long line of cases has held that individuals have a constitutionally protected interest in refusing various forms of medical treatment.\footnote{Cf. Wolff v. McDonnell, 418 U.S. 539, 555-56 (1974) (must reconcile demands of due process with needs of institutions such as prisons).} There is no legitimate basis for denying the existence of an analogous interest in refusing psychiatric treatment. To be sure, this interest is not an absolute one, and may have to yield to overriding state interests.\footnote{132 Cf. Wolff v. McDonnell, 418 U.S. 539, 555-56 (1974) (must reconcile demands of due process with needs of institutions such as prisons).} But, it is equally certain that the individual has a sig-
significant liberty interest at stake in the treatment decision.

A plausible argument can be made, however, that a decision to commit, especially if the commitment is based on the person's need for treatment, effectively vitiates the committed person's liberty interest in refusing treatment.\textsuperscript{153} Such an argument could find support in the prison conditions cases, which, broadly speaking, indicate that a valid conviction and sentence authorize the state to treat the prisoner in any manner that does not constitute cruel and unusual punishment or contravene an independent constitutional right.\textsuperscript{154} Clearly, any punishment of civilly committed persons would be constitutionally impermissible.\textsuperscript{155} But one could argue that anything short of punishment, any condition reasonably definable as "treatment," is acceptable simply by virtue of the commitment order.\textsuperscript{156} For three reasons, however, this argument is invalid beyond narrowly defined limits.

First, the argument fails because treatment questions simply are not and cannot be decided in the context of a commitment hearing. When an individual is committed, the judge frequently decides to take that action because the individual is in need of treatment. However, the judge never determines what kind of treatment is warranted or, indeed, whether treatment (beyond the fact of commitment) is warranted at all.\textsuperscript{157} The former judg-
ment, that commitment is appropriate, is a matter within the competency of a judge or jury to decide; the latter judgment, whether treatment is appropriate and what form it should assume, is certainly beyond the province of the judicial fact-finder.\textsuperscript{138} Unlike the type of issues that arise in the prison conditions cases,\textsuperscript{139} the decision as to what form of treatment is appropriate is neither reached at the commitment hearing nor is it directly incidental to a decision that is reached. Thus, the commitment order should have no effect whatsoever on the individual's liberty interest regarding treatment decisions. Neither the substantive norms nor the procedural regularity of a commitment hearing can support the legitimacy of a decision never reached in that context.

Secondly, the argument fails because of the very different natures of criminal incarceration and civil commitment, and the markedly different justifications underlying those actions. In punishing a criminal offender, the state acts in furtherance of four generally accepted goals—retribution, deterrence, restraint, and rehabilitation—the combination of which give the state wide latitude in handling the offender.\textsuperscript{140} These goals become appropriate simply by virtue of the conviction—the judgment that the defendant committed a criminal act—and, for the most part, they remain valid throughout the term of the sentence. Hence, the proper sanction, the state's means of achieving these goals, can be determined at the time of conviction.\textsuperscript{141} On

\begin{itemize}
  \item\textsuperscript{138} See Parham v. J.R., 442 U.S. 584 (1979). Choosing a mode of treatment should, however, be distinguished from limited judicial review of that decision. The review of medical decisions to ensure that substantive and procedural norms were complied with is certainly within judicial competency. It is no different than the types of decisions that judges make every day. Of course, even in that context, some deference to the medical professional's judgment is warranted. See notes 255-63 infra and accompanying text.
  \item\textsuperscript{139} See Meachum v. Fano, 427 U.S. 215 (1976).
  \item\textsuperscript{140} See LAFAVE & SCOTT, CRIMINAL LAW § 5 (1972).
  \item\textsuperscript{141} The fact that this initial decision may be revised—for example, by parole—does not negate its legitimacy. Rather, this unfixed quality reflects the fact that rehabilitation and restraint have a forward-looking dimension. To the extent the criminal sanction is solely justified by these goals, sentences should be indeterminate. Because of the disturbing consequences of that point of view, there seems to be renewed appreciation for the punitive purposes of the criminal sanction. See generally Morris, supra note 109.
\end{itemize}
the other hand, the purpose of a parens patriae commitment, and certainly also the purpose of psychiatric treatment, is much more limited: Treatment, like a parens patriae commitment, is solely justified to the extent it helps the person being treated. Moreover, this purpose does not remain fixed as do the justifications for the criminal sanction; rather, by their very nature, treatment decisions must remain subject to change to reflect the person's condition and need for treatment at any given point in time. For this reason, it is inappropriate that the commitment order limit a person's liberty interests in treatment questions.

In addition, there is a third reason why the individual's liberty interest in treatment decisions is not vitiated by a commitment order. The decision to compel treatment is a qualitatively different decision than that to commit, and, in its own right, compelled treatment is a severe intrusion on fundamental individual rights. It seems apparent, for example, that the state may be quite warranted in committing many people, only a small percentage of whom it would be warranted in compelling to undergo psychosurgery. The two matters differ in their essence; the former decision in no way includes the latter. Moreover, compelling an individual to undergo psychosurgery clearly implicates fundamental and basic liberties: one's rights to physical and mental health, to the integrity and autonomy of one's mind, and to one's sense of self in the most direct sense can all be significantly affected. Admittedly, psychosurgery is the most obviously intrusive form of treatment, but the very same interests are implicated by more common forms of treatment—for example, the long-term use of phenothiazines. Compelled medication poses significant risks of permanent and severe injury to

132 See Note, supra note 109, at 1207-22.
143 This distinction is analogous to that between criminal and civil contempt sentences. See notes 34-36 supra, and accompanying text.
See A. Stone, supra note 137, at 47.
an individual's health and mental integrity. Like psychosurgery, this form of treatment affects fundamental individual interests not touched by the fact of commitment. The commitment decision does not in any meaningful sense authorize the compelled use of such intrusive forms of psychiatric therapy.

This does not mean that the commitment decision authorizes nothing beyond the bare fact of institutionalization. Certainly, a valid commitment order removes a person's liberty interest in those conditions that necessarily accompany institutionalization. For example, if a patient is violent, the mere fact of commitment authorizes temporary sedation or restraint. In addition, the decision to commit probably warrants minimally intrusive types of treatment that are generally applicable, such as psychiatric consultations, group therapy, vocational rehabilitation, etc.

Following a valid commitment the individual's liberty interest does not extend to these conditions of hospitalization. But no more is automatically justified by the mere fact of commitment. A commitment simply does not warrant intrusive psychiatric treatment of any kind. The individual's liberty interest in refusing such treatment may not be absolute; but it is an interest that survives the commitment decision and must be reckoned with.

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147 See Romeo v. Youngberg, No. 78-1982, slip op. at 12 (3d Cir. Nov. 24, 1980). Obviously, though, such authority must have limits. Institutional officials should not be able to shackle a nonviolent person to his bed or chair for extended periods of time and then justify that behavior as either a safety precaution or as "treatment."

148 Commitment, without more, warrants only those forms of therapy that are minimally intrusive and generally applicable to committed persons—i.e., what might be called the lowest common denominator of inpatient treatment.

149 See Romeo v. Youngberg, No. 78-1982, slip. op. at 10, 13-14 (3d Cir. Nov. 24, 1980) ("once inside the institution an individual's liberty interest is not summarily extinguished"). Typically, state commitment statutes will also create a liberty interest in treatment questions. Cf. Vitek v. Jones, 100 S. Ct. 1254, 1261-62 (1980) (liberty interest created by statute regulating transfers from prison to mental institutions). New Jersey, for example, provides by statute that commit-
2. The State Interest in Compelling Treatment

No less certain than the individual's liberty interest in refusing unwanted treatment is the state's interest in providing and, when necessary, compelling treatment. This state interest has three somewhat distinct elements: First, the state has a traditional parens patriae interest in aiding the sick individual; secondly, the state has a strong governmental interest in preserving and protecting the public health and welfare; and thirdly, the state has an especial interest in providing treatment to committed mental patients, in order both to justify the fact of commitment and to establish a positive therapeutic environment within the institution. The significance of these interests necessitates the conclusion that, notwithstanding the importance of the individual's liberty interest, there should not be an absolute right to refuse treatment. Rather, any such right must be qualified so as to allow the state to pursue its legitimate, indeed compelling, ends.

Little need be said concerning the state's parens patriae interest in providing mental health care. Although our society has always placed considerable emphasis on both individual liberty and self-reliance, it has long been accepted that government has both the right and the duty to assist those incapable of fending for themselves. This function of government seems particularly critical today, given the shrinking role of family and community in caring for the sick and helpless, and the increasing reliance on societal solutions to these problems. The appropriateness of the state's parens patriae function in providing mental health care has been expressly approved by the Supreme Court in two recent cases. Although in its own right it may not be sufficiently compelling to overcome the individual's liberty interests, the state's parens patriae interest in providing psychiatric treatment is both legitimate and significant.

The state also has a traditional interest in preserving and protecting the public health and welfare. This interest increases in importance to the extent that a disease has significant social costs. Thus, in *Robinson v. California*, while holding that it constituted cruel and unusual punishment to make the status of narcotics addiction a crime, the Court expressly indicated that "a state might establish a program of compulsory treatment for those addicted to narcotics." The Court went on to analogize narcotics addiction to mental illness, noting that "[a] state might determine that the general health and welfare require that the victims of these and other human afflictions be dealt with by compulsory treatment, involving quarantine, confinement or sequestration." It surely requires no elaborate argument to establish that mental illness has serious social costs. Thus, the same rationale that allows the state to compel vaccinations against contagious diseases warrants compelled treatment of serious mental illness. The social costs of each are simply too great.

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154 Id. at 665. Although the quoted passage is clearly dictum, the forcefulness of its expression coupled with the idea's repetition later in the opinion, see id. at 666, indicates that the *Robinson* court had little doubt about the validity of the civil commitment of addicts.
155 See also id. at 668-69 (Douglas, J., concurring).
157 See Gomes v. Gaughan, 471 F.2d 794, 800 (1st Cir. 1973). This rationale for civil commitment and treatment is not widely used, but perhaps should be. For the truth is that while we most commonly justify mental health care with *parens patriae* notions, that is not the reason we commit people or compel treatment. We take these drastic steps most often because of the social costs and problems that accompany serious mental illness; ordinary families and communities simply cannot cope with these problems and, at their breaking point, they come to society for help. It is important to develop a rationale for society's role in mental health matters that accords with this reality. For only by squarely facing this reality, and abandoning the myth of *parens patriae*, can we meaningfully distinguish legitimate government action from the kind of illegitimate and blatant abuses of authority exemplified by *O'Connor v. Donaldson*, 422 U.S. 563 (1975). Mere public intolerance or animosity is not an acceptable basis for commitment. *Id.* at 575. But when people's lives are endangered or seriously interfered with and society has no other mechanisms to resolve the problem, commitment may be necessary. The *parens patriae* rationale merely diverts attention from the realistic issues that should be examined when we must decide whether to commit. In addition, the
Probably the most significant state interest in compelling treatment is the third one: Commitment warrants a state intrusion that would not otherwise be acceptable. It simply makes no sense for society to commit an individual, thus restricting his liberty in the broadest, most fundamental ways, and then not utilize the beneficent powers at its disposal to treat that individual and hopefully end the necessity of commitment. Treatment is what justifies commitment; if we must commit, then we have an obligation to treat.

To allow our institutions to become mere warehouses for the confinement of the mentally ill is not the sign of a rational society. Finally, commitment warrants compelled treatment for another reason: It is essential for the state to maintain a positive, therapeutic environment within the

*parens patriae* theory goes too far; it has no intrinsic limits. We should be wary of a government that justifies the imposition of its will by saying that it is acting for our own good, rather than admitting that it acts to meet social needs and pressures. As Justice Brandeis has written:

> Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficial. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning, but without understanding.

Olmstead v. United States, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting).


See Price v. Sheppard, 239 N.W.2d 905, 911 (Minn. 1976); Note, supra note 109, at 1344. Cf. United States v. Alexander, 471 F.2d 923, 964 n.120 (D.C. Cir. 1973) (Bazelon, C.J., dissenting) ("If we can tolerate the use of only these techniques that are unlikely to 'work,' in the sense of altering behavior or physical condition, how can we continue to justify involuntary hospitalization on the grounds that it permits us to use those very techniques in the 'treatment' of mental illness?"). Admittedly, the argument advanced in the text can be criticized as being circular. We commit someone because he is in need of treatment and then we justify compelled treatment by the fact of commitment: How can one justify depriving a person of a protected liberty interest on the basis that he has already been deprived of a more significant liberty interest? These criticisms have some validity. But though they are logical, these arguments lose sight of the reality of the situation. Ultimately, perhaps the best answer is to point out that many things in the world are in fact somewhat circular. See generally Milton, Lycidas.

institution.\textsuperscript{161} The committed person is not merely removed from society; he is placed in a new society. That new society has its own legitimate demands and needs which are peculiar to its unique role.\textsuperscript{162} Thus, the state has an interest in compelling treatment both to justify the fact of commitment and to maintain a therapeutic environment within the institution. The significance of these state interests requires that there be no absolute right to refuse treatment;\textsuperscript{163} any right to refuse must be conceived in a manner that will minimally interfere with these critical state interests.

B. Judicial Approaches to the Right to Refuse Treatment

In their attempts to resolve the constitutional issues raised by compelled psychiatric treatment, and appropriately reconcile the competing interests at stake, the courts have taken four distinct tacks.\textsuperscript{164} A number of courts have grounded the right to

\textsuperscript{161} Dr. Stone has documented the institutional problems that can follow the adoption of an absolute right to refuse treatment. See Stone, \textit{Recent Mental Health Litigation: A Critical Perspective}, 134 Am J. Psych. 273, 278 (1977).


Other courts have based a right to refuse treatment on statutory grounds. See, e.g., Naughton v. Bevilacqua, 458 F. Supp. 610, 614 (D.R.I. 1978); Goedecke v. State Dept. of Institutions, 603 P.2d 123, 125 (Colo. 1979); Plotkin, \textit{supra} note 146, at 497-502. Other courts have looked to common law principles as the basis of such a right. See \textit{id.} at 490 n.174. Neither of these approaches is dealt with in this article.
refuse treatment on the eighth amendment prohibition of cruel and unusual punishment. Other courts have looked to the first amendment as the basis of a constitutional right to refuse. In recent years, though, the focus has been on the right of privacy and the due process clause as the sources of a committed patient's right to refuse psychiatric treatment. The following section briefly examines each of these four approaches.\(^{165}\)

1. The Eighth Amendment Approach

It is clear that the state has a legitimate interest in treating the mentally ill, but does not have a legitimate interest in punishing people on account of their illness.\(^{166}\) Frequently, however, the line between treatment and punishment is a rather tenuous one. This has led a number of courts to ground a right to refuse treatment on the eighth amendment prohibition against cruel and unusual punishment. In a pair of 1973 decisions, \textit{Mackey v. Procunier} \(^{167}\) and \textit{Knecht v. Gillman},\(^{168}\) two courts of appeals held that the use of harsh forms of aversive therapy could constitute cruel and unusual punishment. \textit{Mackey} involved allegations of non-consensual administration of the drug succinycholine, which can induce the sensations of paralysis and inability to breathe, leading to feelings of extreme fright.\(^{169}\) \textit{Knecht} involved allegations of forced administration of


\(^{167}\) 477 F.2d 877 (9th Cir. 1973).


\(^{169}\) 477 F.2d at 877-78.
The drug apomorphine, following minor disciplinary infractions. The drug induces a prolonged period of vomiting as well as temporary cardiovascular changes. These cases illustrate situations in which eighth amendment analysis of compelled treatment seems appropriate, but they also illustrate the limitations of this approach. Presumably, most right to refuse treatment cases will not involve such harsh and clearly punitive actions. When the state's objectives are legitimately therapeutic rather than punitive, eighth amendment analysis is simply inappropriate.

Thus, although the eighth amendment approach may be useful in the most egregious circumstances, it is of little help in resolving the majority of cases, which present the more difficult question whether committed mental patients have a right to refuse legitimate therapeutic measures.

2. The First Amendment Approach

It seems undeniable that the first amendment prohibits not only state restrictions on the communication of ideas but also "impermissible tinkering with mental processes." This has led several courts to conclude that mental patients have, at least in certain circumstances, a first amendment right to refuse treatment. Barring exceptional circumstances, however, basing
the right to refuse treatment on the first amendment seems as inappropriate as basing it on the eighth amendment. Ultimately, the conclusion that first amendment analysis is misplaced is founded on the belief that legitimate psychiatric therapy of any sort will enhance one's ability to think and communicate freely. Treatment should not deprive John Rennie (the plaintiff in *Rennie v. Klein*) of the capacity to believe or express the idea that he is the "'alpha omega'... or Christ;"76 rather, it should give him the capacity that he now lacks to reject that idea as unrealistic. In short, appropriate psychiatric treatment liberates the mind, as well as one's potential for meaningful expression and association; legitimate therapy is no more an abridgement of these basic rights than it is a form of punishment.177

There is a second, less abstract, reason to eschew first amendment analysis of compelled treatment issues. Even if one assumes that a mental patient has a first amendment interest in declining treatment, it is still necessary to confront the fact that the state has strong reasons for requiring appropriate treatment.178 These competing interests, though, seem incapable of any accommodation or even meaningful analysis. How does one begin to measure the individual's loss of first amendment rights against the state's interests in compelling treatment? It is like

basis of the court's ruling in *Winters v. Miller*, 446 F.2d 65 (2d Cir. 1971), *cert. denied*, 404 U.S. 985 (1971). In addition, any evidence that psychiatric treatment was being abused, as it has been for example in the Soviet Union, in order to suppress political dissent or disfavored ideas would call first amendment analysis into play.


177 See Appelbaum & Gutheil, *The Boston State Hospital Case: "Involuntary Mind Control," the Constitution, and the "Right to Rot,"* 137 AM. J. PSYCH. 720, 721 (1980) ("Psychiatrists do not administer neuroleptics in an attempt to 'control' minds but to restore them to the patient's control"). Many forms of treatment do result in transitory side effects on thinking and one's ability to communicate. These side effects, however, do not rise to the level of significant first amendment abridgements, see *Rennie v. Klein*, 462 F. Supp. at 1144, particularly when one considers them in conjunction with the compelling state interests in providing treatment. See notes 150-63 *supra* and accompanying text. Cf. *Brown v. Gilnes*, 444 U.S. 346, 359-60 (1980) (needs of the military warrant some incidental first amendment restrictions).

178 See notes 150-63 *supra* and accompanying text.
trying to balance asparagus against French pastry: True, one eats both, but beyond that fact one searches in vain for a meaningful basis for comparison. The result of such a test can only be ad hoc, outcome oriented decisionmaking. Thus, the first amendment approach, even if it is valid, is not likely to lead to meaningful analysis.

3. The Right of Privacy Approach

In the last several years, the courts have tended to base the right to refuse treatment on the emerging constitutional right of privacy. The courts have found in the right of privacy broad protection for individual autonomy that includes freedom from state authorized bodily intrusions. When it is used in this sense, it is clear that the constitutional right of privacy is no different than substantive due process. Whether one calls it "liberty" or "bodily autonomy," it is equally clear that the individual has very significant interests implicated when the state attempts to use intrusive forms of psychiatric therapy on him. The significance of these interests has led at least two courts to conclude that competent mental patients have an absolute right to refuse intrusive psychiatric treatment. Other courts, more at-
tuned to the significant state interests in compelling treatment, have found that patients have a qualified right to refuse.\textsuperscript{183}

It makes little difference whether one uses the jargon of privacy or that of substantive due process.\textsuperscript{184} However, it makes a tremendous difference whether one adopts an absolute or a qualified right to refuse treatment. Given the compelling state interests in providing psychiatric treatment to committed patients,\textsuperscript{185} an absolute right to refuse treatment is inappropriate. It thus becomes necessary to define the proper scope of a qualified right to refuse treatment. Because of the nature of the decision, the substantive standard that measures the state’s right to compel treatment must be medical in nature. The state should be able to compel treatment whenever it can demonstrate that the treatment proposed is clearly medically justified. Obviously, any such judgment will have to take into account a large number of factors: the seriousness of the person’s condition, the likelihood of deterioration (or improvement) without the treatment, the efficacy of the treatment with respect to the person’s condition, the detriments associated with the treatment, the likelihood and severity of possible side effects, and, not least important, the availability of less restrictive alternatives.\textsuperscript{186} All of


\textsuperscript{184} Substantive due process analysis is preferable for two reasons. First, due process has an established history. That history provides courts with a body of law to guide them in new situations. It also provides developed modes of analysis—e.g., least restrictive alternative scrutiny. In addition, that history provides useful parameters for judicial scrutiny: it reminds judges that they have, at times, outstepped the proper bounds of judicial review. For the same reason, then, that many avoid due process analysis—the \textit{Lochner} heritage—it may well be the preferable approach. Secondly, due process scrutiny focuses the courts’ attention on the issue at the heart of these cases—whether the state’s interests in compelling treatment warrant the deprivation of individual liberty that results. Admittedly, the question is not an easy one, but it will not disappear, try as we might to ignore it. Unless the courts adopt either an absolute right to refuse treatment or an unfettered right to compel treatment, this question must be asked in every case. Due process analysis brings the competing interests to the fore and, hence, tends to lead to decisionmaking that is firmly rooted in reality. \textit{See Comment}, \textit{Madness and Medicine}, supra note 173, at 506-07 n.46.

\textsuperscript{185} See notes 150-63 supra and accompanying text.

these factors are, of course, relevant whenever a physician decides upon a proper course of therapy, whatever the con-
text. However, because this particular context—that of state compelled treatment—implicates significant fourteenth amend-
ment liberty interests, the equation requires one additional fac-
tor. There should be a presumption against the compelled use of 
any intrusive form of therapy. In other words, before it may 
compel the use of intrusive psychiatric treatment in non-
emergency situations, the state should be required to 
demonstrate that the treatment proposed is clearly medically 
warranted. Demanding any more would hopelessly constrict the 
state's ability to provide needed psychiatric care, given the un-
certainties inherent in psychiatric diagnosis and treatment. 
Demanding any less of a showing would short change the critical 
individual interests at stake. Those very same uncertainties 
counsel caution when we invoke the authority of the state to 
compel the use of intrusive forms of treatment.

4. The Due Process Approach

Those courts that have adopted a qualified right to refuse 
treatment have recognized the need for procedural protections 
to make that right meaningful. Such protections are clearly


The presumption against compelled treatment is also suggested by the fact that psychiatric therapy is more likely to be successful when the patient voluntarily accepts it and involves himself in a therapeutic alliance with his physi-
cians. See O'Connor v. Donaldson, 422 U.S. 563, 579 (1975) (Burger, C.J., concurr-
ing).


See Davis v. Hubbard, No. 73-265 (N. Dist. Ohio Sept. 16, 1980); Rennie v. Klein, 462 F. Supp. 1131, 1147-48 (D.N.J. 1978); 476 F. Supp. 1294, 1307-11 (1979), appeal docketed, No. 79-2557 (3d Cir. Jan. 5, 1981); Price v. Sheppard, 239 N.W.2d 905, 911 (Minn. 1976). A number of other cases have also recognized the need for procedural due process protections to safeguard the integrity of treatment deci-
warranted in the light of the critical individual interests at stake and the significant risk of error inherent in all treatment decisions: The decision is simply too important and too prone to error to be left unreviewed.\textsuperscript{191} Admittedly, the courts can not hope to ensure the correctness of all treatment decisions; but they can, indeed, they must ensure the legitimacy of any decision to compel the use of intrusive forms of treatment.

The appropriate nature of due process review is discussed at some length in the following section.\textsuperscript{192} At this point, it is fitting, however, to note the advantages of an approach that emphasizes procedural protections. Foremost among these advantages is the fact that procedural norms minimally encroach upon the prerogatives of other branches of government. They do not restrict the substantive choices available to the legislature and executive, but merely safeguard the manner in which those choices are implemented.\textsuperscript{193} Of course, to impose procedural safeguards involves costs in terms of both time and money. Hence, it is important to devise procedures that minimize those costs insofar as is possible. However, when the state encroaches upon fundamental individual interests it must be prepared to accept those costs that cannot be avoided.

\textsuperscript{191} The significant likelihood of erroneous treatment decisions is the result of a number of factors: One factor is simply the considerable degree of uncertainty that pervades psychiatric decisions in general; that uncertainty is exacerbated by the awful conditions—understaffing, overcrowding, and lack of facilities—that are the norm in our public mental institutions. Further, for several reasons, it is likely that treatment decisions will err in the direction of excessive and unwarranted treatment, rather than in the direction of withholding necessary treatment. See notes 209-10 infra and accompanying text. This significant risk of erroneous treatment decisions is an important factor of the procedural due process calculus and necessitates some form of procedural protections. See Morrissey v. Brewer, 408 U.S. 471, 485 (1972). Procedural due process analysis must reflect the reality of the setting under review. See In re Gault, 387 U.S. 1, 21 (1967). The incontrovertible reality of our public mental institutions is that they are a mess. See American Psychiatric Association—Position Statement, A Call to Action for the Nation's Chronic Mental Patient, 136 Am. J. Psych. 748, 749 (1979). Unjustified treatment is an everyday fact of life at these institutions, requiring the imposition of meaningful procedural due process safeguards. See Rennie v. Klein, 462 F Supp. 1131, 1147-48 (D.N.J. 1978), appeal docketed, No. 79-2557 (3d Cir. Jan. 5, 1981).

\textsuperscript{192} See Notes 224-39 infra and accompanying text.

\textsuperscript{193} Procedural due process scrutiny shares this advantage with other forms of means-oriented review, including least restrictive alternative analysis.
The procedural due process approach has other important advantages. It stands on firmer constitutional ground than either substantive due process or privacy, and, more importantly, it is an approach better suited to the capabilities of courts. It is certainly inappropriate for courts to determine either the substantive standards for psychiatric treatment or the form of treatment that is suitable in any individual case. However, it is within the capacity of the courts to determine that a decision was reached in a legitimate manner, or to examine a set of facts and decide whether an inference drawn from them was warranted. These are time honored functions of the courts, and ones that courts are uniquely qualified to handle. Such procedural protections serve limited but important purposes. They can correct gross abuses of authority; they can illuminate the decisionmaking process and render it more accountable; and they can help to define and clarify the applicable substantive standards. To the extent the courts can achieve these goals with respect to decisions to compel psychiatric treatment, they will have done much to protect the rights of committed mental patients without sacrificing the important state interests implicated in such decisions.

IV. THE ROLE OF LEAST RESTRICTIVE ALTERNATIVE ANALYSIS IN RIGHT TO REFUSE TREATMENT CASES

In the preceding section it was argued that recognizing an absolute right of committed mentally ill persons to refuse treatment would be inappropriate in light of the significant state interests in compelling treatment. However, given the equally critical individual interests implicated by treatment decisions, a qualified right to refuse is essential. It was further argued that the proper foundation for such a right is the due process clause, barring unusual facts that implicate other provisions of the Constitution. Due process analysis has two major advantages over other approaches: It aids the court in squarely confronting the competing interests before it, and it enables the court to recon-

194 See generally J. ELY, DEMOCRACY AND DISTRUST (1980).
circle those interests in a manner that minimally sacrifices each. The latter advantage is especially true to the extent that the court uses a means oriented form of due process scrutiny, or to the extent a court relies on procedural due process protections rather than imposing substantive limitations on state action.

This section further explores the dimensions of the right to refuse treatment and considers the import of least restrictive alternative analysis in defining the right. It begins with a justification for the use of least restrictive alternative analysis in deciding right to refuse treatment issues. It then proposes parameters for a qualified right to refuse, focusing first on the appropriate substantive standard and then on the procedural protections that are warranted. Finally, it examines three problems raised by least restrictive alternative analysis of treatment issues: Should treatment effectiveness be sacrificed in order to maximise the individual's liberty interest? To what extent should the courts defer to medical opinions regarding the appropriate form of treatment? And may least restrictive alternative analysis be used to compel the creation of new less restrictive alternatives?

A. *The Justification for Using Least Restrictive Alternative Analysis in Deciding Right to Refuse Treatment Issues.*

In a straightforward, uncomplicated sense it seems appropriate to apply least restrictive alternative analysis to right to refuse treatment issues. Traditionally, this mode of analysis has been used whenever governmental actions threaten to "stifle fundamental personal liberties." It cannot be disputed that the compelled use of intrusive forms of therapy upon mentally ill persons threatens protected fourteenth amendment liberty interests. However, liberty is an amorphous concept, and it seems clear that not all deprivations of liberty merit the intensified level of scrutiny represented by least restrictive alternative analysis. Moreover, the earlier discussion indicated that

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198 See notes 127-49 supra and accompanying text.
the applicability of this mode of analysis is questionable when
the intrusiveness of governmental action, rather than its
breadth, is in issue.200 Nonetheless, because of the nature and ex-
tent of the deprivation of liberty caused by the compelled use of
intrusive forms of therapy, least restrictive alternative analysis
is appropriate for handling right to refuse treatment issues.

Intrusive forms of psychiatric treatment—including
psychosurgery, electroconvulsive therapy, aversive therapy,
and the use of psychotropic drugs201—tread on the most basic
liberty interests of the individual. Moreover, the intrusion on
these fundamental interests is radical in its degree.202 By their
very nature, these techniques seek to effect significant changes
in the minds and emotions of the people subjected to them, and
they have serious side effects upon the physical and mental
health, as well as the ability to socially function, of the people on
whom they are used. By their very nature, such treatments pose
the risk of serious injury and even death.203 Given the nature of
the individual interests at stake, and the extent to which those
interests are implicated, it seems self-evident that the use of in-
trusive forms of psychiatric therapy must be subjected to exact-

200 See notes 69-91 supra and accompanying text. It would probably be more
accurate to say not that the doctrine is inapplicable in such a context, but that it
must be understood and employed in a more flexible manner than is usual. There
is little theoretical basis for arguing that the doctrine is inapplicable when the
issue is the intrusiveness of governmental regulation rather than its breadth. But
there are cogent practical arguments in support of the position that the doctrine
must be understood differently when the issue is that of intrusiveness—par-
ticularly in the context of an individualized determination. Id.

201 These seem to be generally accepted as the more intrusive forms of
psychiatric treatment.

202 Both in due process and equal protection analysis, the Court appears to be
more consciously attuned to differences of degree in recent years. See, e.g.,
Zablocki v. Redhail, 434 U.S. 374, 387 n.12 (1978); id. at 391 (Burger, C.J., concur-
ring).

203 The scholarly literature on the risks and side effects of intrusive forms of
therapy is quite extensive. See, e.g., Friedman, Legal Regulation of Applied
Behavior Analysis in Mental Institutions and Prisons, 17 Ariz. L. Rev. 39 (1975);
Gobert, supra note 93; Plotkin, supra note 146; Plotkin & Gill, supra note 129;
Shapiro, supra note 94; Comment, Advances in Mental Health: A Case for the
Right to Refuse Treatment, 48 Temp. L.Q. 354 (1975); Note, Conditioning and
Other Technologies Used to "Treat?"—"Rehabilitate?" "Demolish?" Prisoners
and Mental Patients, 45 S. Cal. L. Rev. 616 (1972). See also the sources cited in
note 164 supra.
ing judicial scrutiny. Least restrictive alternative analysis is an integral part of such intensified scrutiny. Indeed, because of its capacity to reconcile competing interests, the least restrictive alternative doctrine is ideally suited to resolving the difficult problems raised by right to refuse treatment cases.

Other factors also counsel intensified judicial scrutiny of right to refuse treatment questions. For one matter, treatment decisions are typically made by physicians and institutional staff. This is, of course, appropriate, but it is arguable that decisions made by administrators of this sort are entitled to less deference than decisions made by a popularly elected legislature, for example. A second factor is that compelled treat-

204 See Romeo v. Youngberg, No. 78-1982, slip op. at 26-27 (3d Cir. Nov. 24, 1980). Little effort has been devoted to supporting this point because it seems so indisputable. In addition, previous commentators have extensively discussed the risks and detriments associated with intrusive forms of therapy. See the sources cited in note 203 supra. A more down-to-earth appreciation of the pervasive effects of the most common mode of therapy—medication—can be gleaned from a few pages of the opinion in Rennie v. Klein, 476 F. Supp. 1294 (D.N.J. 1979), appeal docketed, No. 79-2557 (3d Cir. Jan. 5, 1981). In an unemotional but moving fashion, the opinion describes the effects of medication on a few typical residents of Ancora State Hospital. Id. at 1300-03. More convincingly than scores of pages of scientific studies or legal theory, this brief discussion demonstrates that compelled treatment can profoundly affect many of the most fundamental human rights.

205 See Halderman v. Pennhurst State School & Hosp., 612 F.2d 84, 115 (3d Cir. 1979) (en banc), cert. granted, 100 S. Ct. 2984 (1980). The decision to invoke intensified due process scrutiny inevitably brings into play least restrictive alternative analysis. See Note, supra note 37, at 1036-39. The doctrine is an element of that higher level of judicial review. Professor Spece argues, though, that the least restrictive alternative doctrine represents an independent, intermediate standard of judicial review. See Spece, supra note 63, at 1059-86. Certainly, it is true that the least restrictive alternative principle is different than the compelling state interest test: The former looks at the state's means, the latter at its ends. See Singer, supra note 63, at 57-58. However, the two tests are generally used in tandem and are together referred to as strict scrutiny. In addition, the compelling interest test is rarely used without the least restrictive alternative test. Thus, while it may well be that the principle can stand on its own as an independent level of review, least restrictive alternative analysis is an integral part of all forms of intensified judicial review.

206 For a discussion of the factors justifying intensified judicial review, see P. Brest, PROCESSES OF CONSTITUTIONAL DECISIONMAKING 982-83 (1975); Spece, supra note 63, at 1059-86.

207 See Del. River Basin Comm. v. Bucks County Water and Sewer Auth., No. 80-1662, slip op. at 10 n.11 (3d Cir. Feb. 18, 1981). See also Spece, supra note
ment presents a paradigmatic example of an individual's claim against governmental intrusion. Such claims have typically received greater protection than claims for governmental benefits. Our constitutional history reveals a consistent judicial preference for placing limits on government over mandates of affirmative government action. A third factor suggesting the need for intensified scrutiny is simply the awful conditions typical of our public mental institutions. The misuse and overly excessive use of intrusive forms of treatment is a fact of life in these institutions. The overuse of treatment, in particular of medication, is not so much a reflection of shoddy medical standards as it is an inherent product of institutional life; it is an inevitable response to the endemic problems of overcrowding and understaffing. Although this factor—the significant risk of improper use of intrusive therapies—is perhaps more relevant to procedural due process concerns, it is not irrelevant with respect to the appropriate substantive standard. When coupled

63, at 1078. For a discussion of the question of the appropriate degree of deference to medical judgments, see notes 254-63 infra and accompanying text.

204 This preference is well illustrated by the Supreme Court's decision in O'Connor v. Donaldson, 422 U.S. 563 (1975). The Fifth Circuit Court of Appeals had predicated its decision on the existence of a constitutional right to treatment. 493 F.2d 507, 520 (1974). The Supreme Court affirmed the holding that Donaldson had been deprived of his constitutional rights, but inverted the approach. Rather than basing the decision on a right to treatment, the Court based it on the right to liberty, which one cannot be deprived of except for good cause. 422 U.S. at 572-76. The Court found that mere custodial care, such as that provided to Donaldson, was insufficient to constitutionally justify the massive deprivation of liberty represented by commitment.


206 See notes 230-32 infra and accompanying text.

211 See Romeo v. Youngberg, No. 78-1982, slip op. at 15 n.26 (3d Cir. Nov. 24, 1980). The proposals suggested in this article are essentially procedural in nature. Even the substantive standard recommended, that of a presumption against the use of intrusive forms of therapy, is quasi procedural in nature.
with the fundamental interests at stake, and the significant extent to which those interests are implicated by treatment decisions, the fact that errors are common demands that the standards for compelled treatment be subject to stringent judicial review. Least restrictive alternative analysis is a vital element of this review. But the doctrine should not be blindly applied to the difficult questions raised by treatment decisions—for example, to prohibit entirely the use of the more intrusive therapies. Rather, we should seek to utilize the doctrine in a manner that will maximize its potential to reconcile the competing interests at stake without sacrificing either one.

B. The Substantive Standard for Compelled Treatment

Least restrictive alternative scrutiny mandates both substantive and procedural constraints when the state seeks to compel the use of intrusive forms of psychiatric therapy. Substantively, the principle demands that there be a presumption against the use of all intrusive forms of therapy; and to the extent that there is a choice between different types of therapy, there should be a presumption in favor of the less intrusive. In other words, any intrusive treatment should be clearly warranted by contemporary medical standards before its use is compelled. On a procedural plane, the least restrictive alternative principle requires that all treatment decisions be individualized; moreover, the principle demands suitable procedural mechanisms to safeguard the integrity of the decisionmaking process. At a minimum those safeguards must include the review by a panel of independent psychiatrists of all decisions to compel treatment. In addition, appellate review by the courts should be available, but should be limited to the standard of the substantial evidence test.

212 See Rogers v. Okin, Nos. 79-1648/1649, slip op. at 10 (1st Cir. Nov. 25, 1980). See also notes 252-63 infra and accompanying text, which considers whether the efficacy of treatment should be sacrificed in order to minimize its intrusiveness.


214 This is the standard of review normally used by the courts in overseeing administrative agency adjudications. The decisions of such agencies will be
All treatment decisions require balancing the expected benefits of the treatment against its costs and risks. On some occasions the balance tilts dramatically to one side or the other; on other occasions, either because of the serious consequences of the therapy, its limited chance for success, or the relative efficacy of alternative modes of treatment, the therapeutic decision is a difficult one. Of course, normally, the decision is the upheld unless they are not supported by substantial evidence. This is a highly deferential standard of review, giving the benefit of all reasonable inferences to the agency decision. See United States v. Carlo Bianchi & Co., 373 U.S. 709, 715-16 (1963); K. Davis, Administrative Law Text §§ 29.01-29.03 (3d ed. 1972).

For example, an individual with Stage One Hodgkins disease will generally be treated with radiation therapy. The decision to undergo the therapy is usually a clear one despite the fact that it involves significant costs and risks. Almost everyone treated with the intensive amounts of radiation necessary to cure Hodgkins will suffer numerous unpleasant side effects including nausea, fatigue, loss of hair and soreness of the skin. Moreover, the therapy significantly increases the patient's chance of suffering other serious illnesses. Nonetheless, the decision is usually clear because if left untreated Hodgkins will normally be fatal within a fairly short time; if treated appropriately, chances of complete cure are quite good. Thus, it clearly makes sense to accept the risks and detriments of the therapy, serious as they are.

Therapeutic decisions may be difficult for various reasons. Perhaps, the most common concern is the risk of the therapy. For example, surgery almost invariably entails significant risks. Thus, although it is often the most effective form of therapy available, it may also be the most dangerous. This dilemma is illustrated by the situation of a patient who had colon cancer resected a few years previously and who now shows indications that the colon has metastasized to the liver. At least two modes of therapy are reasonable choices—chemotherapy or surgical removal of a significant portion of the liver. The surgery yields significantly better chances for prolonged survival; however, there is approximately a 15% mortality rate from such an operation. Thus, the risk factor makes the choice of therapy difficult.

That choice can also be difficult because of the detriments associated with the therapy. For example, assume a person with chronic ulcerative colitis, which flares up periodically requiring hospitalization and causing serious disruption of the person's life. The most effective treatment for this condition is an ileostomy—i.e., a removal of the colon. The treatment cures the disease and involves relatively little risk, but it causes permanent inconvenience to the patient. Thus, this decision can also be a difficult one.

It is crucial to recognize two characteristics of the above decisions. First, they are necessarily individualized decisions; the age, physical condition, etc. of an individual patient may well be determinative of these difficult choices. Second, it is important to recognize that these decisions are not purely medical judgments. When all of the medical facts are known, there is still a difficult value judgment that must be made. Normally, of course, this value judgment should be left to the patient. See Comment, Madness and Medicine, supra note 164, at 521
patient's,217 guided by the advice and information provided by his physician. In providing that advice—that is, in arriving at his own decision as to the appropriate mode of therapy—the physician is held to a standard of reasonable care. He is responsible for exercising reasonable medical judgment.

However, when the physician vests himself with the mantle of state authority and seeks to compel treatment on unwilling patients, the situation is very different. In at least certain of these situations, the normal prerogative of the patient to make the treatment decision must yield to the overriding state interest of providing appropriate treatment to committed mental patients.218 However, more than a reasonable medical judgment must support taking this drastic step. For treatment to be compelled it should be clearly warranted in light of all relevant factors. The patient's significant fourteenth amendment liberty interest requires such a presumption against the compelled use of intrusive forms of treatment.219 The presumption should only be overcome by a convincing showing that the proposed treatment is justified.

The decision whether treatment is warranted is essentially medical in nature. Hence, the factors relevant to that decision are those that govern all therapeutic decisionmaking. They include the seriousness of the illness, the likelihood of improvement or deterioration without the treatment, the benefits of the treatment, the costs of the treatment, and the risks associated with the treatment.220 Not least important is the existence or

("The weighing of these risks against the patient's own subjective hopes and fears is not an expert skill. It is a nonmedical judgment allocated to the patient alone").

217 See generally Burt, Informed Consent in Mental Health, 2 ENCY. BIOETHICS 762; Cassell & Katz, Informed Consent in the Therapeutic Relationship, 2 ENCY. BIOETHICS 767.

218 The state's interests are discussed at notes 150-63 supra and accompanying text.


absence of alternative, less intrusive modes of treatment. Any rational therapist will always steer a course that aims at both the most efficacious form of treatment and the least costly. This is not to say, however, that the least intrusive mode of treatment imaginable will always or even generally prevail. Intrusiveness is but one factor in a complex equation. It is an important factor, though, and the rational therapist will naturally lean towards those forms of therapy that have minimal negative effects.\textsuperscript{21}

Properly understood, the doctrine of least restrictive alternatives demands precisely this presumption against intrusive forms of therapy. In the context of an individualized decision, the doctrine cannot be applied strictly.\textsuperscript{22} It does not entitle one to that particular form of treatment that is least restrictive of his liberty. Nor does it entitle one to have less restrictive alternatives tried and found wanting before resort to more restrictive approaches. It does, however, entitle committed mental patients to have less restrictive alternatives fully considered before they are compelled to undergo intrusive forms of psychiatric treatment. Further, it entitles them to a presumption against the compelled use of any intrusive form of therapy.\textsuperscript{23}
The use of such therapies should be compelled only when clearly warranted.

C. The Requisite Procedural Safeguards

The foregoing substantive standard—that of a presumption against the compelled use of intrusive forms of therapy—is meaningless unless accompanied by procedural mechanisms that can adequately ensure the integrity of treatment decisions. In recent years the Court has extended due process protections to various aspects of the commitment decision. However, despite the fact that procedural due process holdings represent minimal intrusions upon the states’ prerogatives, the Court has not intervened into intra-institutional decisions. A reluctance to intervene into such decisions is understandable: They seem peculiarly within the province and judgment of the mental health professionals who administer such institutions and peculiarly outside the province of judicial scrutiny. Nonetheless, procedural due process safeguards are vitally necessary to ensure the legitimacy of treatment decisions. The need for such safeguards is supported both by traditional procedural due process analysis and least restrictive alternative analysis of right to refuse treatment issues.

Whether procedural due process safeguards are required in a given situation, and the kind of procedures deemed necessary,
 depend on three factors—the significance of the individual interests at stake, the risk of an erroneous deprivation of those interests, and the costs to the state of providing the safeguards. The significance of the interests implicated by compelled treatment decisions has already been discussed. Because intrusive forms of therapy directly affect one's physical and mental well-being to a very significant degree, compelled treatment implicates interests of the first rank. Equally importantly, there is a considerable risk of error inherent in all such decisions. One reason for that large risk of error is simply the substantial uncertainty that attends all forms of psychiatric diagnosis and treatment. While those uncertainties require deference to legitimate psychiatric judgments, and reveal the inappropriateness of imposing too exacting a standard of proof, they also counsel care in the decisionmaking process. Further, the significant risk of error inevitably associated with psychiatric judgments is exacerbated in the context of public mental institutions by the overcrowding and understaffing that is a fact of life at those institutions. For the simple reason that there is inadequate time to devote to each patient, these institutional conditions inevitably lead to erroneous treatment decisions. Moreover, it is critical to realize that the risk of error is heavily skewed towards providing inappropriate or excessive treatment, rather than towards withholding appropriate treatment. One reason for this bias in favor of treatment is the pressure on the psychiatrist to keep his patients under control and not allow them to disrupt institutional life. A second reason is the psychiatrist's natural desire to help his patients. This laudable desire unfortunately leads the physician to provide therapy in situations where it is not warranted: It is his job to heal and it is difficult to admit that because of the limitations of his science or the scarce resources at his disposal he can do nothing. It is much easier to make some attempt to help, even if that therapeutic intervention is not warranted. Thus, not only do treatment deci-

229 See notes 206-14 supra and accompanying text.
231 Id.
233 See id.; Lerner, The Excessive Need to Treat: A Countertherapeutic Force in Psychiatric Hospital Treatment, 43 BULL. MENNINGER CLINIC 463, 465
sions inevitably involve a significant risk of error, but it is likely that most of those errors will result in excessive or inappropriate treatment, not the withholding of appropriate therapy. When one bears in mind the critical individual interests affected by treatment decisions, it is clear that some form of review of those decisions is warranted.232

The procedural mechanisms adopted should be those that will provide meaningful review at the smallest possible cost to the state. Additionally, it is important to devise procedures that will minimize delays and interferences with the treatment process.233 Thus, although some form of adversary hearing is necessary, that hearing should be informal in nature. In addition, it seems appropriate that the decisionmaker be a psychiatrist or, preferably, a panel of psychiatrists. The most important requirement is that whoever makes the decision be truly independent of the institutional mental health system.234 The patient must have adequate representation, preferably by an attorney, although other competent persons could fill that need.235


234 See Davis v. Hubbard, No. 73-205 (N. D. Ohio Sept. 16, 1980); Rennie v. Klein, 476 F. Supp. 1294, 1308 (D.N.J. 1979), appeal docketed, No. 79-2557 (3d Cir. Jan. 5, 1981). But cf. Vitek v. Jones, 100 S. Ct. 1254, 1264-65 (1980) (independent decisionmaker "need not come from outside the prison or hospital administration"). In Vitek, which involved the decision to transfer a prisoner to an institution, the independent decisionmaker would not be in the position of reviewing a decision to which he was a party. Nor was the decision being reviewed an everyday type of decision that the reviewer himself had a vested interest in. By contrast, treatment decisions must be made daily by all hospital physicians, and they inevitably have an interest in the review of such decisions. Thus, it would be inappropriate to allow a physician associated with the hospital to review treatment decisions. He simply could not be truly independent.

235 Compare Vitek v. Jones, 100 S. Ct. 1254, 1265 (1980) (Opinion of White, J.,) (attorney is necessary) with id. at 1286-67 (Powell, J., concurring) (attorney not necessary).
decision should be in writing, supported by a brief statement of the underlying reasons. The decision should reveal that less restrictive alternatives were considered and the reason that such alternatives were rejected. Finally, an appeal to the courts should be available, but should be discretionary with the court and limited by the standard of the substantial evidence test. Obviously, such a system will have costs in terms of both time and money, but when the state seeks to compel the use of intrusive forms of psychiatric therapy, regular review of the decision to do so is necessary to ensure that the treatment is appropriate and warranted.

Least restrictive alternative analysis supports the establishment of procedural safeguards for the decision to compel treatment. Its mandate that less restrictive modes of treatment always be considered and be utilized whenever appropriate can only be realized by establishing a structure to review the initial treatment decision. Procedural protections of this sort serve limited but important functions: They can correct gross errors; they illuminate the decisionmaking process and render it accountable; they ensure procedural regularity; and they define standards for the primary decisionmaker to use. The availability of judicial oversight is necessary in order to prevent gross abuses of authority and aid in defining appropriate treatment standards. Such review, however, should be limited in order to prevent essentially medical judgments from being second-guessed by the judiciary. The limited review normally accorded administrative agency rulings, see note 214 supra, seems appropriate in this context.

How often such review is appropriate is a difficult question, and one that probably will have to be answered on an individual basis. Obviously, challenges to treatment decisions cannot be allowed on every occasion that a person is medicated; equally obviously, approval of any course of treatment cannot be meaningful after a certain point. Where that point lies will necessarily vary both with the patient and with the type of treatment. Hence, it will have to be determined on an ad hoc basis. It is to be hoped that one result of according a limited right to refuse treatment is that more attention and thought will be given to treatment plans. The knowledge that such plans are subject to review should have this effect.

See Bazelon, supra note 176, at 909. Cf. Halderman v. Pennhurst State School & Hosp., 612 F.2d 84, 113-16 (3d Cir. 1979) (en banc), cert. granted, 100 S. Ct. 2984 (1980) (least restrictive alternative analysis compels individualized determination of whether institutionalization of retarded persons is necessary). In other contexts least restrictive alternative reasoning has also been found to mandate procedural protections. See notes 67-68 & 81-86 supra and accompanying text.

review of treatment decisions will ensure that the presumption against the compelled use of intrusive therapies is taken seriously in each individual case. The least restrictive alternative principle demands this; and surely our mentally ill citizens deserve no less.

D. Three Problem Areas

Many troubling questions arise when one attempts to apply least restrictive alternative analysis to mental health treatment issues. Three of the most basic questions are discussed in this section: First, whether in the search for less restrictive alternatives, treatment effectiveness should be balanced against the patient’s liberty, and sacrificed to an extent in order to maximize the latter interest; secondly, to what extent should judges defer to medical judgments regarding the proper mode of treatment? Thirdly, whether the least restrictive alternative doctrine may appropriately be used to compel the creation of new, less restrictive alternatives.

1. Should Treatment Effectiveness Be Part of the Balance?

The most fundamental question is this initial one: If two treatment alternatives are available, one of which is both substantially more restrictive and substantially more effective than the other, which one should be used? Expressed in more general terms, the issue is whether treatment efficacy should be thrown into the balance and sacrificed when doing so will significantly increase competing interests. If the more effective alternative is invariably favored, there would seem to be little meaningful protection for the individual’s interests. However, to the extent that more effective forms of treatment are sacrificed, the state’s ability to provide treatment will be seriously eroded, posing the

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240 See notes 243-53 infra and accompanying text.

241 See notes 256-65 infra and accompanying text.

242 See notes 266-71 infra and accompanying text.

243 See Romeo v. Youngberg, No. 78-1982, slip op. at 23, 29 n.47 (3d Cir. Nov. 24, 1980). Compare Hoffman & Foust, supra note 15, at 1107-08, 1142-44, 1153, which although somewhat unclear on this issue, seems to favor throwing effectiveness into the balance, with Chambers, supra note 18, at 1184-88, which indicates that the state’s interests, if they are significant, should not be sacrificed. See also Perr, supra note 160.
danger that state institutions will be transformed into little more than warehouses for mentally handicapped persons.\textsuperscript{244} Although the question is a troubling one, the appropriate legal standard should not sacrifice treatment effectiveness to increase competing liberty interests.\textsuperscript{245} This result is supported both by the history of the least restrictive alternative doctrine and by consideration of the way in which the doctrine is being used in this context. Most importantly, this result makes sense because an interest in maximizing the patient's liberty is an important element of any medical (and especially psychiatric) treatment decision. Because the balancing of effectiveness and restrictiveness is performed as an integral part of the primary medical decision, it need not be an element of the governing legal standard. Those reviewing the initial medical decision need simply ascertain that the individual's liberty interest was in fact accorded due weight in the decisionmaking process. Thus, effectiveness will in fact be balanced against intrusiveness, but only with respect to whether treatment is medically appropriate. The legal standard should incorporate that test, but should not require additional sacrifices of therapeutic effectiveness.

The history of the least restrictive alternative doctrine, as well as the philosophy underlying the doctrine, support the idea that effectiveness ought not be sacrificed—that is, that only equally effective less restrictive alternatives need be used. As noted earlier, one of the chief virtues historically advanced for the principle is that it scrutinizes the state's means rather than its ends.\textsuperscript{246} It thus makes little sense to use the doctrine in a manner that requires the government to sacrifice its legitimate ends. Traditionally, therefore, the doctrine did not require a state to adopt alternatives that would be less effective in achieving its ends. Legislation was only invalidated when the state had an equally effective but less restrictive means to reach its goal. The

\textsuperscript{244} Perr, supra note 243, at iv-vi.

\textsuperscript{245} Of course, a \textit{de minimus} loss in treatment effectiveness should be tolerated if to do so will allow the use of less intrusive forms of therapy. Moreover, responsible medical decisionmaking may well require even substantial losses in effectiveness if the risks or detriments of the more effective therapy are too great. See notes 253-54 \textit{infra} and accompanying text. See also notes 1-6 supra and accompanying text.

\textsuperscript{246} See note 17 supra and accompanying text. See also text following note 28 supra.
balancing of competing interests was eschewed. However, this rule was not always adhered to. In certain contexts, most notably in first amendment adjudication, "the Court has required the use of a statute narrowly drawn to the dimensions of the particular legislative goal, whether or not this is as satisfactory as a broader law." Thus, one could argue that, because fundamental personal liberties are directly affected by treatment decisions, the relevant interests should be balanced.

That argument can be faulted, however, for ignoring the unique context of treatment decisions and blindly using ideas applicable only in other circumstances. Earlier it was noted that restrictiveness exists in two different dimensions—with respect to the breadth of a statute and with respect to its intrusiveness. Effectiveness, similarly, may relate both to the inclusiveness of governmental regulation and to its ability to accomplish its ends with respect to those properly caught within its ambit. Good arguments can be made that some sacrifices in terms of inclusiveness should be accepted, particularly when the price for not accepting them is overly broad limitations on basic rights. There is much less justification, though, for sacrificing the efficacy of regulations in achieving legitimate governmental ends with respect to those properly within the ambit of the regulations. Because treatment questions fall into this latter category, it seems inappropriate to sacrifice effectiveness, even though important liberty interests are at stake.

The most important reason, though, is that the medical judgment as to the appropriate form of treatment necessarily takes cognizance of the individual's liberty interest, albeit in medical terms, and balances the intrusiveness of a therapy against its effectiveness. That is particularly true with respect to mental

247 See Struve, supra note 21, at 1463, 1468; Wormuth & Mirkin, supra note 31, at 287.
248 Id. See generally, Note, supra note 44; Note, supra note 109, at 1249-50. Arguably, even in contexts other than that of first amendment adjudication least restrictive alternative analysis has been used to balance competing interests, with a resulting decrease in effectiveness of state regulation. Note, supra note 31, at 1029-30, 1039-40.
249 See Hoffman & Foust, supra note 15, at 1142-44.
250 See notes 69-74 supra and accompanying text.
251 See generally, Note, supra note 48; Note, supra note 44.
252 See notes 75-95 supra and accompanying text.
health treatment decisions. An appropriate therapeutic decision, whether aimed at the normalization of a mentally ill person or the habilitation of a retarded person, necessarily places strong emphasis on maximizing the patient's liberty. Striking the balance between treatment effectiveness and restrictiveness is a quintessential medical decision. That does not mean that the decision is unreviewable, but simply that the decision can and should be made by doctors in accord with established medical standards. To superimpose a legal standard that once again balances treatment effectiveness and restrictiveness would be unnecessary and inappropriate. Judicial reviews of treatment decisions should be limited to ensuring that the patient's liberty interest was accorded suitable weight in the initial decision—that is, that there was a presumption in favor of less restrictive forms of therapy. If, however, a more intrusive form of therapy is likely to be significantly more effective, the presumption may be overcome and the treatment should be allowed. Only by refusing to sacrifice treatment effectiveness can the judiciary avoid sacrificing the needs of patients on the altar of individual rights.

2. The Appropriate Degree of Deference to Medical Judgments

It is surely indisputable that judges are not the proper persons to make psychiatric treatment decisions. Nonetheless, it would be equally inappropriate to totally exclude the judiciary from the decision whether the state can compel the use of intrusive forms of psychiatric therapy. Judicial oversight of that decision is necessary, but it must be tempered by considerable deference to legitimate medical judgments. The appropriate standard for judicial review of treatment decisions is the substantial evidence test, widely used in administrative law. Judi-

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254 See Romeo v. Youngberg, No. 78-1982, slip op. at 28 n.45 (3d Cir. Nov. 24, 1980).

cial scrutiny under this standard will serve limited but impor-
tant functions in helping to ensure the legitimacy and propriety
of compelled treatment.

Chief Justice Burger has recently pointed out the useless-
ness of excessive judicial involvement in psychiatric decision-
making:

Although we acknowledge the fallability of medical and psychi-
atriac diagnosis, we do not accept the notion that the shortcom-
ings of specialists can always be avoided by shifting the deci-
sion from a trained specialist using the traditional tools of
medical science to an untrained judge or administrative hearing
officer after a judicial-type hearing. Even after a hearing, the
nonspecialist decisionmaker must make a medical-psychiatric
decision. Common human experience and scholarly opinions
suggest that the supposed protections of an adversary proceed-
ing to determine the appropriateness of medical decisions for
the commitment and treatment of mental and emotional illness
may well be more illusory than real.256

It is essential that the judiciary not intrude into areas of
decisionmaking that are in fact purely medical, and it seems in-
appropriate for judges to second-guess psychiatrists with
respect to the proper treatment for a given patient. None-
theless, the judiciary does have a legitimate role in overseeing
the decision to compel treatment.

Several factors support a limited role for the judiciary in
mental health treatment decisionmaking. The underlying ra-
tionale for this role is that, although the physician's decision to
recommend treatment is a medical judgment, the patient's deci-
sion to undergo treatment is not a medical judgment. Rather, it
is a moral judgment, a value decision.257 Normally, of course, this
decision is left to the patient, who is, in most cases, no more ex-
pert in medicine than the typical judge. Because of the critical
state interests in providing psychiatric treatment to committed
mental patients, this decision may, in appropriate situations, be
made by someone else—that is, treatment may be compelled.258

257 See Reiser, supra note 2, at 330-31. See also Burt, supra note 217; Cassell
& Katz, supra note 217; Cassell, The Function of Medicine, 7 HASTING CENTER
REP. 16, 16-17 (No. 6 Dec. 1977).
258 The state's interests in compelling appropriate treatment are discussed in
the text accompanying notes 159-72 infra.
However, there is no reason to entrust this value judgment entirely to a physician. On the contrary, when the state seeks to compel the use of intrusive forms of therapy, it directly intrudes on fourteenth amendment liberty interests of the individual, and it is emphatically the province of the judiciary to safeguard individual liberty against unwarranted encroachment by the state. This value judgment can, indeed must, be made by the judiciary.

As one court recently observed, "whenever unalterable interferences with bodily integrity place deprivations of liberty in issue, the law and not medicine is the ultimate decision-maker."

Some form of judicial scrutiny of psychiatric treatment decisions is thus necessitated by the courts' duty to protect individual liberties. It is also necessitated by the fact that psychiatrists are no more immune from errors and institutional biases than other mortals. Their errors can take the form of gross abuses of authority, occasionally amounting to cruel and unusual punishment that poses as "treatment." More commonly, however, their errors are neither so extreme nor so visible. Unfortunately, though, they are quite common: Perhaps the best argument for judicial scrutiny of therapeutic decisions is simply the awful conditions and standard of treatment that are typical of our public mental institutions. Moreover, both institutional pressures to control patients and well-intentioned desires to help inevitably

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229 See notes 127-49 supra and accompanying text.
230 As Justice Stewart observed in his opinion for the Court in O'Connor v. Donaldson, 422 U.S. 563 (1975);
O'Connor argues that, despite the jury's verdict, the Court must assume that Donaldson was receiving treatment sufficient to justify his confinement, because the adequacy of treatment is a "nonjusticiable" question that must be left to the discretion of the psychiatric profession. That argument is unpersuasive. Where "treatment" is the sole asserted ground for depriving a person of his liberty, it is plainly unacceptable to suggest that courts are powerless to determine whether the asserted ground is present.
Id. at 574, n.10. See Covington v. Harris, 419 F.2d 617, 629 (Fahy, J., concurring), Spece, supra note 108, at 40-41, n.137.
231 Romeo v. Youngberg, No. 78-1982, slip op. at 27 (3d Cir. November 24, 1980) (en banc).
233 See, e.g., Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973); Mackey v. Procurier, 477 F.2d 877 (9th Cir. 1973).
lead to a tendency to overtreatment. Thus, although deference to legitimate medical judgments is appropriate, total withdrawal from judicial scrutiny of treatment decisions is not warranted.

While necessary, judicial review of treatment decisions should be of limited scope and should accord broad discretion to physicians and hospital officials on matters of legitimate medical judgment and hospital policy. The review of treatment decisions should be handled like the judicial review of administrative agency determinations. Though limited, this standard of review can serve very important functions: It can correct gross abuses; it can illuminate the decisionmaking process and render it more accountable; it can ensure procedural regularity; and it can help to define standards for use in future situations. No more can be done without encroaching on the breadth of choice that must be available to those whose job it is to provide psychiatric treatment; no less can be done without abdicating the responsibility to safeguard basic constitutional rights.

3. Whether Least Restrictive Alternative Analysis May Be Used to Require the Creation of New, Less Restrictive Alternatives

Perhaps the most intractable question is this one—whether least restrictive alternative analysis can be used to demand the development and use of new, less restrictive modes of treatment. Whatever theory one uses, the issue of new modes of treatment is necessarily a question of what is practical and to what degree. Least restrictive alternative analysis is no excep-

24 See notes 230-31 supra and accompanying text.
25 See Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969). In Covington Chief Judge Bazelon analogized the courts' role with respect to treatment issues to their role in reviewing administrative agency determinations. He noted the purposes of limited judicial review:

The principle purpose of limited judicial review of administrative action is to insure that the decision-makers have (1) reached a reasoned and not unreasonable decision, (2) by employing the proper criteria, and (3) without overlooking anything of substantial relevance. More than this the courts do not pretend to do, and probably are not competent to do. To do less would abandon the interests affected to the absolute power of administrative officials.

Id. at 621. The standard for reviewing the findings of administrative agencies is the deferential substantial evidence test. See note 214 supra.
tion. Surely, a state would not be able to compel a person to undergo psychosurgery when treatment with an accepted drug would be equally effective, even if the drug was unavailable in some sense. However, it seems equally obvious that a state could not be required to provide years of intensive psychotherapy when it had at its disposal a drug generally used for the patient's malady. In general though, least restrictive alternative analysis is ill-suited as a basis for imposing affirmative obligations on government to create new forms of treatment.

There is some support on both sides of this issue. Several commentators have suggested that the doctrine can be used to require new treatment alternatives. Indeed, one has gone so far as to argue that least restrictive alternative analysis is the proper foundation for the right to treatment. No court has gone that far, but several lean in that direction. Other courts, however, have indicated that least restrictive alternative analysis neither requires the creation of new treatment alternatives nor the expenditure of additional funds.

The idea of creating new, less restrictive modes of mental health care is certainly appealing, but the courts should be hesitant to find such a mandate in the least restrictive alternative principle. It is simply not suited to act as the catalyst for this kind of social change. Historically, the doctrine has been used to check the state's ability to encroach unnecessarily on the fundamental liberties of its citizens. The doctrine says to the state: "Intrude on liberty if you must, but do so in the least harmful manner." Its beauty lies in the fact that it minimally interferes with the functions and prerogatives of the executive and legislative branches of government. That beauty is lost when the doctrine is bent to serve as a vehicle for judicially mandated af-

263 See, e.g., Chambers, supra note 18, at 1189-98; Note, supra note 109, at 1250-53.
264 See Spece, supra note 108.
firmative reforms. It is, thus, the appropriate theory with which to enforce a qualified right to refuse treatment. It is not, however, an appropriate basis for imposing a right to treatment. And to the extent that the courts possess the authority to require the allocation of societal resources to new modes of mental health care, that authority would seem to derive more logically from the right to treatment than from the doctrine of the least restrictive alternative.

V. CONCLUSION

The least restrictive alternative doctrine is useful in analyzing the difficult questions of whether and to what extent committed mental patients have a constitutional right to refuse treatment. However, the doctrine should not be viewed as a hard and fast rule of law directly derived from well-established principles of substantive due process. Rather it should be viewed as the expression of a basic societal norm loosely rooted in our notions of the proper relationship between government and the individual. That norm teaches that the treatment and care of mentally handicapped persons should be done in the manner least restrictive of the freedom of those persons. A corollary of this basic norm is the principle that treatments that effect a significant deprivation of individual liberty should not be undertaken without good justification. When viewed in this light, it is a principle that all understand and that no one disputes.

Moreover, it is clear that when a form of treatment significantly affects an individual's liberty interests, this principle attains constitutional significance. It does not, however, demand any discreet mode of treatment, but instead cajoles the decision-maker to use that treatment which is least restrictive and most appropriate under the circumstances.

When understood as the expression of a normative judgment rather than a decisionmaking imperative, the least re-

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270 In this regard it is fitting to recall how the Supreme Court used the doctrine in O'Connor v. Donaldson, 422 U.S. 563 (1975). See note 208 supra.
271 But cf. Spece, supra note 63, which argues that the right to treatment should be based on the least restrictive alternative principle.
strictive alternative principle is closely related to one of the most fundamental precepts of medicine: *primum non nocere*. That precept embodies the principle, integral to sound medical practice, that no treatment be undertaken without a purpose or without a legitimate, scientifically-based expectation that its purpose can be achieved.\(^2\) The norm expressed by *primum non nocere* is especially relevant to the treatment of mentally ill persons. Contemporary understanding regards normalization as the goal of treatment for such persons. That goal can only be pursued by reducing, whenever possible, the constraints imposed by treatment, and allowing the individual to develop his capacity to function independently.\(^2\) Normalization does not mean that intrusive forms of therapy are never appropriate. It does, however, state a presumption in favor of the least restrictive and most normalizing form of treatment. It counsels that to the extent possible those providing treatment should not unnecessarily infringe on the liberty of their patients.

Unfortunately, the treatment decisions made in our public mental institutions are not characteristically governed by the principle of normalization or the precept *primum non nocere*. It is because the reality of those institutions is so far removed from the norms that should govern their operation that legal safeguards are warranted.\(^2\) Given the failure and the inability of those institutions to adhere to proper standards of medical decisionmaking, it is necessary that legal standards be adopted.

\(^2\) In other words, it states a presumption against the use of intrusive forms of therapy. See notes 3-6 supra and accompanying text.

\(^2\) See 42 U.S.C. § 6010 (1976); APA Position Statement, supra note 191, at 749-52; Task Panel, supra note 232, at 104-11; Roos, supra note 253, at 621-22. As Senator Stafford has commented: "We are concerned that children with handicapping conditions be educated in the most normal possible and least restrictive setting, for how else will they adapt to the world beyond the educational environment, and how else will the nonhandicapped adapt to them? 120 CONG. REC. 15, 272 (1974). His words have considerable relevance beyond their narrowly defined focus.

to check the abuse of intrusive forms of psychiatric treatment. Those standards must resurrect the presumption against the use of intrusive therapies that has not survived in the harsh institutional environment. Most importantly, procedural protections are necessary to make those standards meaningful.

Legal review of treatment decisions is necessary, but only because of the failure of institutional officials to follow medical norms. Hence, legal review of such decisions should be limited to ensuring that they are in accord with the standards that should govern them and that the decisions are legitimately arrived at. In other words, when treatment is clearly medically appropriate the state should be able to compel its use. Ultimately, this argument is grounded more upon a bias than upon legal theory. That bias is that when society commits persons to mental institutions it should use any truly beneficent powers at its disposal to treat those persons. Only a society unmoored from its values can justify locking up sick people, but then not use the ability it has to heal and cure those people. Of course, there is a snag in this scheme: It is simply the fact that many forms of psychiatric treatment are of questionable benefit; they often have limited potential to cure or even significantly relieve illness, but considerable potential for harm. Thus, the key is to determine when treatment is appropriate. When it is, society must be able to compel its use. Many people may feel somewhat uneasy with the disquieting images of a "brave new world" raised by the above suggestion. Norval Morris has recently written:

Not only lack of knowledge forces us to hesitate to impose dramatic or Draconian "cures" on criminals; basic views of the minimum freedoms and dignities rightfully accorded human beings stay our punitive hands. . . . If criminals, the mentally ill, or the retarded are subjected to coercive control beyond that justified by the past injuries they have inflicted, then why not you, and certainly me? We find ourselves in the business of remaking man, and that is beyond our competence; it is an empyrean rather than an earthly task.\(^{277}\)

What is noteworthy about this passage is not Professor Morris's rhetorical skill—not his blunt description of cures as


\(^{277}\) Morris, supra note 30, at 1179-80.
"Draconian" nor his more subtle attribution to physicians of "punitive hands." The noteworthy fact is that its conclusion inevitably retracts its opening line. Despite his protestations to the contrary, Professor Morris ultimately focuses on the core issue—competency. His conclusions on that issue are simply too absolute. Though there is much to the remaking of man that is beyond our competence, there is now much that is within our competence. Just as it is the job of mechanics to retool our cars and the job of the legal profession to rework society, it is the job of the medical profession to remake man.

Obviously, that job has its limits. To some extent those limits are a function of competency. Much in the realm of psychiatric therapy is still uncertain and unknown. Where uncertainty reigns supreme, it will generally be inappropriate for the state to sanction the compelled use of intrusive therapies. In such situations a more difficult path must be followed: We must accept our limitations and live with them. The second limit on the proper remaking of man is a matter of scope rather than of competency. Mental illness often borders closely on mere differences in values, beliefs, and ideas. It is important, particularly when the coercive powers of the state are involved, to keep psychiatric treatment in its proper place—dealing with illness, not with social or political dissent. In this sense we must ensure that the remaking of man does not infringe on basic human freedoms and dignities. But there is neither dignity nor freedom in mental illness: The acute anxiety, chronic depression, and uncontrollable hallucinations that may characterize serious mental illness do not deserve our protection. Society, for its own sake and that of its wards, must be allowed to use the beneficent powers at its disposal to control and eradicate those flaws in human nature.

Thus, an absolute right to refuse treatment is not warranted. However, the power to compel treatment must be confined to prevent it outstepping its proper limits. The least restrictive alternative doctrine is the appropriate means to accommodate these competing interests. The doctrine simply stands for the principle that when the state infringes fundamental individual liberties it should do so in the least harmful manner possible. Precisely how the doctrine should be realized must, of course, vary with the context in which it is used. Properly applied in this context, the doctrine demands that before the state compels the use of intrusive forms of psychiatric therapy it must
show that such treatment is clearly medically warranted. If invested with procedural safeguards that will make this standard realistically effective, the doctrine can protect mentally ill persons from unwarranted intrusions justified in the name of treatment. The advantage of least restrictive alternative analysis is that it imposes minimal constraints upon the treatment choices available to the state, while at the same time it effectively safeguards the liberties of mentally ill persons. Properly confined by the requirements of this context, the least restrictive alternative doctrine can help lead the way to an appropriate balance.

* Ed. note. Subsequent to the editing of this article, the Supreme Court rendered its opinion in Pennhurst State School & Hosp. v. Halderman, 49 U.S.L.W. 4363 (April 21, 1981). The Court held that the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §§ 6000-6081 (1976), did not create any substantive right of mentally retarded persons to receive treatment in the "least restrictive environment." 49 U.S.L.W. at 4368-69. The Court remanded the matter to the Third Circuit to consider whether a right to treatment in the least restrictive environment is provided by other statutes or by the Constitution. Because of its disposition of the case, the Court never reached the question of the appropriate contours of a right to least restrictive treatment.

Interestingly, on the same day, the Court granted certiorari in Rodgers v. Okin, 49 U.S.L.W. 3779. Thus, the Court will soon consider the question whether "committed mental patients have [a] constitutional right to refuse treatment with antipsychotic medication." Id.