The Constitutionality of Assisted Outpatient Treatment

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Abstract

States are increasingly turning to assisted outpatient treatment (more accurately called preventive outpatient civil commitment) to ameliorate the mental health and homelessness crises. These laws authorize court-ordered community treatment for individuals with mental illnesses and a history of treatment noncompliance and aim to prevent psychiatric deterioration before causing dangerousness to self or others. Affected individuals pose no immediate danger, typically can make rational treatment decisions, and may reside in the community. These laws dramatically extend states' means of social control and cannot be easily justified by traditional understandings of states' police power or *parens patriae* commitment authority. Courts have subjected only one state's preventive outpatient commitment law to constitutional scrutiny. Those decisions applied differing legal standards, reached conflicting conclusions about affected liberties, employed flawed reasoning, and turned upon statutory features absent from most states' laws. Rigorous scholarly scrutiny of these laws has been minimal.

This Article examines the constitutionality of existing preventive outpatient commitment laws. It identifies the individual and state interests implicated by preventive outpatient commitment and assesses available enforcement measures, revealing that most attempts to remove courts' inherent contempt power likely violate state law. It then analyzes involuntary treatment and civil commitment case law to construct a proper constitutional framework for scrutinizing preventive outpatient commitment laws. This framework is applied to all twenty-three current preventive outpatient commitment statutes to conclude that only five states' statutes include most or all of the substantive components necessary for involuntary outpatient commitment under states' police power or *parens patriae* authority. Effects on the balance of interests from removing courts' enforcement power are also examined. In isolating substantive components most and least likely to survive constitutional scrutiny, this examination should guide courts' review of these statutes, inform current debates about expanding or adopting preventive outpatient commitment, and invite reevaluation of questionably constitutional statutes.

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Introduction

Assisted outpatient treatment, or preventive outpatient civil commitment ("POC"),[1] is rapidly spreading across the country as a key strategy to address homelessness and mental health crises. POC involves court-ordered community treatment for individuals with mental illnesses and a history of treatment noncompliance and aims to prevent psychiatric deterioration before it leads to dangerousness to self or others.[2] Mayors, legislators, and scholars promote this compelled community treatment as a remedy for unmet mental health needs, homelessness, and the escalating

[1] Assisted outpatient treatment is the colloquial term for preventive outpatient civil commitment. This article will use the latter term since the former has multiple, contested meanings. E. Lea Johnston & Autumn Klein, *Assisted Outpatient Treatment: A State-by-State Comparative Review*, 73 CLEVELAND ST. L.R. __ (forthcoming 2025).

[2] *See* Steven J. Schwartz & Cathy E. Costanzo, *Compelling Treatment in the Community: Distorted Doctrines and Violated Values* 20 LOY. L.A. L. REV. 1329, 1332-33, 1346 (1987); *In re Dennis H.*, 647 N.W.2d 851, 863 (Wis. 2002). Importantly, the criteria of these statutes are broader than those necessary for involuntary hospitalization. *See infra* note 8 and associated text.

costs of "revolving door" patients who cycle through hospitals, jails, and communities.[3] While courts may mandate a variety of services, the central aim of POC is usually medication compliance.[4] Currently, twenty-three states have POC statutes,[5] with fifteen of these laws having been enacted or expanded since 2019.[6] At least three states are currently considering approving or broadening POC statutes.[7]

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[3] *See, e.g.*, Jeffrey W. Swanson & Marvin S. Swartz, *Why the Evidence for Outpatient Commitment Is Good Enough*, 65 PSYCHIATRIC SVCS. 808 (2014); Jan Ransom et al., *Adams Says City is Seeing Results in its Effort to Get Help to the Mentally Ill*, N.Y. TIMES, Nov. 30, 2023, at A24; Alisa Chang, *The Politics of Involuntary Commitment*, NAT'L PUB. RADIO (March 29, 2023, 5:00 PM), https://www.npr.org/2023/03/29/1166782560/the-politics-of-involuntary-commitment (reporting that Portland Mayor Ted Wheeler called for expanding outpatient commitment to address homelessness and quoting New York City Mayor Eric Adams's announcement: "If severe mental illness is causing someone to be unsheltered and a danger to themselves, we have a moral obligation to help them get the treatment and care they need."); Brian Day, *Three Unsheltered Families Housed During Victorville Homeless Outreach*, Victorville Daily press (May 25, 2024) (quoting San Bernardino County First District Supervisor Paul Cook as observing that "[h]omelessness is, in large part, a mental health problem" and characterizing POC as "recogniz[ing] that reality and giv[ing] law enforcement and the courts new tools and resources to ensure that our chronically homeless get the mental health services they need"); Assisted Outpatient Treatment Demonstration Project Act of 2002, 2002 Cal. Legis. Serv. ch. 1017 (A.B. 1421) (West) (codified at CAL. WELF. & INST. CODE §§ 5345–5349.5 (West 2024)) (ordering counties to report "the effectiveness of the strategies employed… in reducing homelessness and hospitalization of persons in the program and in reducing involvement with local law enforcement by persons in the program").

[4] *See* AM. PSYCHIATRIC ASS'N, POSITION STATEMENT ON INVOLUNTARY OUTPATIENT COMMITMENT AND RELATED PROGRAMS OF ASSISTED OUTPATIENT TREATMENT 3 (2020), *available at* https://www.psychiatry.org/getattachment/d50db97b-59aa-4dd4-a0ec-d09b4e19112e/Position-Involuntary-Outpatient-Commitment.pdf ("Psychotropic medication is an essential part of treatment for most patients under involuntary outpatient commitment."); *infra* notes 63, 406 (Texas).

[5] *See* ALA. CODE § 22-52-10.2(a) (2023) (expiring Dec. 31, 2024, effective Jan. 1, 2025); CAL. WELF. & INST. CODE § 5346(a) (West 2023); DEL. CODE ANN. tit. 16, § 5013(a) (2023); FLA. STAT. ANN. §394.467 (West 2024); GA. CODE ANN. § 37-3-1(12) (2023); GA. CODE ANN. § 37-3-1(12.1) (2023); HAW. REV. STAT. ANN. § 334-121 (LexisNexis 2023); 405 ILL. COMP. STAT. ANN. 5/119.1 (LexisNexis 2023); KY. REV. STAT. ANN. § 202A.081(5) (LexisNexis 2023); LA. STAT. ANN. § 28:66(A) (2023); ME. REV. STAT. ANN. tit. 34B, § 3873-A (2023); 2024 Md. Legis. Serv. ch. 704 (S.B. 453) (West) (to be codified at MD. CODE ANN, HEALTH-GEN. § 10-6A-05 (West 2024)); MONT. CODE ANN. § 53-21-127(7) (2023) (expiring June 30, 2025, effective July 1, 2025); MONT. CODE ANN. § 53-21-126(1)(d) (2023); NEV. REV. STAT. ANN. § 433A.335(3) (LexisNexis 2023); N.M. STAT. ANN. § 43-1B-3 (LexisNexis 2023); N.Y. MENTAL HYG. LAW § 9.60(c) (LexisNexis 2023) ("Kendra's Law") (expiring June 30, 2027); N.C. GEN. STAT. § 122C-271(a)(1) (2023); OHIO REV. CODE ANN. § 5122.01(B)(5)(a) (West 2023); OKLA. STAT. tit. 43A, § 1-103(20) (West 2023) (expiring Oct. 31, 2024, effective Nov. 1, 2024); OR. REV. STAT. ANN. § 426.133(2)-(3) (West 2023); 50 PA. STAT. AND CONS. STAT. § 7301(c) (West 2023); TEX. HEALTH & SAFETY CODE § 574.0345(a) (West 2023); UTAH CODE ANN. § 26B-5-351(14) (LexisNexis 2023); WASH. REV. CODE ANN. § 71.05.148(1) (LexisNexis 2023). In March 2024, Kansas passed a new law that may qualify as a POC statute. *See* KAN. STAT. ANN. § 59-2967 (West 2024). Because the statute authorizes a court to order outpatient treatment "in lieu of any type of order that would have required inpatient care and treatment," outpatient treatment may only substitute for an inpatient commitment order. *See id.* However, this interpretation renders superfluous the new statutory standard added in section 59-2967(a)(2), which seems to permit outpatient commitment before the person meets the inpatient standard. *See id.* Given the effective date of the statute (July 2024), it is too early to tell which interpretation is correct. This Article reflects statutes as of November 2024.

[6] *See* Johnston & Klein, *supra* note 1.

[7] *See, e.g.*, S. 980, 193rd Gen. Assemb. (Mass. 2023) (filed in January 2023, sent to a study order by the Joint Committee on the Judiciary on July 1, 2024); H.B. 508, 113th Gen. Assemb. (Tenn. 2023) (pending consideration in the House Health Subcommittee). New Mexico is slated to address an expansion to the state's Assisted Outpatient Treatment Act during a sixty-day session in January 2025. *See* Daniel J. Chacón, *Governor Withdraws Highly*

Among varieties of outpatient commitment, POC presents a particularly grave normative threat. By expanding the scope of states' power to compel treatment, POC enlarges states' nets of social control. This largely differentiates POC from two other common, less controversial forms of outpatient commitment.[8] One form offers compelled community treatment as a less restrictive alternative to involuntary hospitalization.[9] Another uses it as a means of conditional release from hospitalization,[10] where release requires individuals' compliance with community treatment.[11] Importantly, the criteria of less-restrictive and conditional-release outpatient commitment statutes often (although not always) [12] mirror states' inpatient commitment criteria. Thus, both forms of commitment can serve to *reduce* deprivations of liberty by allowing individuals who might otherwise be involuntarily hospitalized to receive treatment in a less restrictive community setting. In contrast, POC allows state intervention *before* individuals qualify for involuntary hospitalization and therefore *expands* states' power to compel treatment by asserting social control over those living in the community who may require future inpatient care.

Only two major cases, both reviewing New York's Kendra's Law, directly address the constitutionality of POC.[13] The first, *In re K.L.*, by New York's highest court, includes problematic reasoning,[14] has been strongly criticized,[15] and depends on statutory features absent from most POC statutes.[16] The second, *Coleman v. State Supreme Court*, a federal district court decision,

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Contentious Bill from Special Session Agenda, SANTA FE NEW MEXICAN (last updated June 27, 2024), https://www.santafenewmexican.com/news/local_news/governor-withdraws-highly-contentious-bill-from-special-session-agenda/article_da056f72-33d8-11ef-ae55-0b8030ae15d1.html.

[8] *See* Bruce J. Winick et al., *Outpatient Commitment: A Therapeutic Jurisprudence Analysis*, 9 PSYCH. PUB. POL'Y & L. 107, 111–13 (2003).

[9] *See id.* at 111.

[10] *See , e.g.*, ALASKA STAT. § 47.30.795; ARIZ. REV. STAT. ANN. § 36-540.01(A).

[11] *See* Christopher Slobogin, *Involuntary Community Treatment of People Who Are Violent and Mentally Ill: A Legal Analysis*, 45 HOSP. & CMTY. PSYCHIATRY 685, 686 (1994).

[12] *See* Richard C. Boldt, *Conditional Release and Consent to Treatment*, 48 LAW & PSYCH. REV. 39, 42 (2023) ("In some jurisdictions, the step-down conditional release arrangement is based on an assessment that the patient no longer meets the state law requirements for inpatient commitment, particularly that she is no longer dangerous to herself or to others.").

[13] *See In re K.L.*, 806 N.E.2d 480, 484-86 (N.Y. 2004); Coleman v. State S. Ct., 697 F. Supp. 2d 493, 508-09 (S.D.N.Y. 2010). An earlier decision by a New York county court preceded *In re K.L. See In re Urcuyo*, 185 Misc. 2d 836, 842-44 (N.Y. Sup. Ct. 2000). Because *In re K.L.* largely repeats the lower court's reasoning, this article will not analyze *In re Urcuyo* separately. For discussion of *In re K.L.* and *Coleman*, see infra notes 111, 116, 287, 409-411, 469-477.

[14] *See supra* notes 111 & 469-475 and accompanying text.

[15] *See* Candice T. Player, *Involuntary Outpatient Commitment: The Limits of Prevention*, 26 STAN. L. & POL'Y REV. 159, 187-91 (2015); Michael L. Perlin, *Therapeutic Jurisprudence and Outpatient Commitment Law: Kendra's Law as Case Study*, 9 PSYCHOL. PUB. POL'Y & L. 183, 195–96 (2003); Jennifer Gutterman, Note, *Waging a War on Drugs: Administering a Lethal Dose to Kendra's Law*, 68 FORDHAM L. REV. 2401, 2441 (2000) (arguing that the contemporaneous version of New York's outpatient treatment law was overbroad for allowing coerced treatment of those neither dangerous nor incompetent to make treatment decisions); Erin O'Connor, Note, *Is Kendra's Law a Keeper? How Kendra's Law Erodes Fundamentally the Rights of the Mentally Ill*, 11 J.L. & POL'Y 313 (2002); Emily S. Huggins, Note, *Assisted Outpatient Treatment: An Unconstitutional Invasion of Protected Rights or a Necessary Government Safeguard?*, 30 J. LEGIS. 305 (arguing that New York's statutory standards, while not patently unconstitutional, should be strengthened by requiring a finding of incompetence). *But see* Illisa Watnick, Comment, *A Constitutional Analysis of Kendra's Law: New York's Solution for the Treatment of the Chronically Mentally Ill*, 149 U. PA. L. REV. 1181 (2001) (arguing that Kendra's Law does not violate substantive due process).

[16] *See infra* note 119.

implicitly rejects the key reasoning of *In re K.L.* but unfortunately focuses solely on one of several liberty deprivations and provides a deficient analysis of the state's commitment rationale.[17] Thus, these cases offer weak precedent for subsequent courts.

Some POC statutes are of dubious constitutionality yet evade careful review.[18] Scholarly reviews are often outdated, focus narrowly on one jurisdiction, consider only outpatient treatment generally, or do not thoroughly examine constitutional requirements for involuntary treatment and commitment.[19] Thorough analysis of relevant legal interests and a thoughtful forecast of constitutional requirements are therefore urgently needed to inform policy debates and guide judicial review.

The appropriate level of scrutiny for judicial review of these statutes is unclear. The cases reviewing POC statutes employ intermediate scrutiny[20] or ad hoc balancing tests weighing the state's police power and *parens patriae* interests against individuals' liberty interest in refusing involuntary treatment.[21] However, courts have characterized the right to refuse certain treatments as "fundamental"[22]—suggesting the necessity of applying strict scrutiny[23]—and the U.S. Supreme

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[17] *See infra* notes 409-413, 476-477. Both *In re K.L.* and *Coleman* focused only on the right to refuse treatment. They did not assess additional liberties infringed by POC, such as freedom from constructive confinement, freedom from stigmatization, and freedom of the mind. *See In re K.L.*, 806 N.E.2d at 474 (noting respondent's "regimen of psychiatric outpatient care, case management, blood testing, individual therapy and medication").

[18] *See* Robert F. Schopp, *Civil Commitment and Sexual Predators: Competence and Condemnation*, 4 PSYCHOL. PUB. POL'Y & L. 323, 331-32 (1998) ("Cases and commentators tend to appeal to traditional *parens patriae* and police powers of the state in order to provide the substantive justification of commitment, but these powers and the parameters of the justification they can provide rarely receive careful analysis.").

[19] *See* Gutterman, *supra* note 15; Connor, *supra* note 15; Watnick, *supra* note 15; Huggins, *supra* note 15; Jeffrey Geller & Jonathan A. Stanley, *Settling the Doubts About the Constitutionality of Outpatient Commitment*, 31 NEW ENG. J. CRIM. & CIV. CONFINEMENT 127 (2005); John Parry, *Involuntary Civil Commitment in the 90s: A Constitutional Perspective,* 18 MENTAL & PHYSICAL DISABILITY L. REP. 320, 323 (1994); Bruce J. Winick, *Coercion and Mental Health Treatment*, 74 DENV. U. L. REV. 1145, 1154-55 (1997); Robert D. Miller, *The Continuum of Coercion: Constitutional and Clinical Considerations in the Treatment of Mentally Disordered Persons*, 74 DENV. U. L. REV. 1169, 1180 (1997); Player, *supra* note 15, at 187-91; Susan Stefan , *Preventive Outpatient Commitment: The Concept and its Pitfalls*, 11 MENTAL & PHYS. DISABILITY L. REP. 288 (1987); Perlin, *supra* note 15; Karen B. Tavolaro, *Preventive Outpatient Civil Commitment and the Right to Refuse Treatment: Can Pragmatic Realities and Constitutional Requirements Be Reconciled*, 11 MED. & L. 249 (1992); Erika F. King, *Outpatient Civil Commitment in North Carolina: Constitutional and Policy Concerns,* 58 L. & CONTEMP. PROBS. 251, 262 (1995); Robert F. Schopp, *Outpatient Civil Commitment: A Dangerous Charade or a Component of a Comprehensive Institution of Civil Commitment?*, 9 PSYCHOLOGY, PUBLIC POLICY, & L. 33 (2003); Schwartz & Costanzo, *supra* note 2; Slobogin, *supra* note 8, at 686.

[20] *See Coleman*, 697 F. Supp. 2d at 509 (holding that required participation in POC conformed to due process because the POC statute "furthers important government interests, requires medication only where medically appropriate, and is less intrusive than alternative methods of ensuring the safety of the community and mentally ill patients").

[21] *See In re Urcuyo*, 185 Misc. 2d at 842-47 (finding the state's response to noncompliance with court-ordered treatment to be "reasonable" when "balanced against the compelling State interests which are involved"); *In re K.L.*, 806 N.E.2d at 485 (finding the "right to refuse treatment is outweighed by the state's compelling interests in both its police and *parens patriae* powers").

[22] *See* Riggins v. Nevada, 504 U.S. 127, 135 (1992) (referencing "alleged infringements of fundamental constitutional rights"); *In re Brown*, 478 So. 2d 1033, 1039-40 (Miss. 1985); State ex rel. Iowa Dept. of Health v. Van Wyk, 320 N.W.2d 599, 606 (Iowa 1982). *Cf.* Cruzan by Cruzan v. Dir., Missouri Dept. of Health, 497 U.S. 261, 278 (1990) (referring to the right to refuse treatment as "a significant liberty interest").

[23] *See* San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 16 (1973).

Court has held that the involuntary administration of antipsychotic medication is impermissible unless medically appropriate and the *least intrusive means* "necessary to accomplish an *essential* state policy."[24] Moreover, POC impinges additional liberty interests, including freedoms from constructive confinement and stigmatization.[25] Thus, any proper balancing test requires that state interests outweigh all significant liberty deprivations involved. Cases evaluating the constitutionality of involuntary *inpatient* commitment—which effects a "massive curtailment of liberty,"[26] including individuals' fundamental right to freedom from confinement[27] and significant liberty interest in freedom from stigmatization[28]—crystallize findings necessary for legitimate exercises of commitment authority and indicate how great state interests must be to outweigh significant liberty deprivations. While some courts hold that liberty deprivations inherent in inpatient commitment warrant strict scrutiny,[29] courts frequently "engage in an ad hoc balancing" of states' and individuals' liberty interests.[30] This process often includes language and analysis resembling strict scrutiny without applying it exactly.[31] Accordingly, multiple lines of authority suggest that constitutional POC (at least that authorizing medication orders)[32] must be medically appropriate and the least intrusive means to achieve compelling state interests that outweigh prospective committees' liberty interests.[33]

This Article evaluates the constitutionality of POC. It analyzes case law regarding the right to refuse treatment, outpatient commitment, and inpatient commitment to derive a constitutional

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[24] *Riggins*, 504 U.S. at 135, 138 (emphasis added).

[25] *See infra* note 37, Part I.A.2.

[26] Humphrey v. Cady, 405 U.S. 504, 509 (1972).

[27] *See* Foucha v. Louisiana, 504 U.S. 71, 80 (1992).

[28] Addington v. Texas, 441 U.S. 418, 425-26 (1979) (recognizing the "indisputable" reality that involuntary commitment "can engender adverse social consequences . . . [and] can have a very significant impact on the individual"); Stamus v. Leonhardt, 414 F. Supp. 439, 449 (S.D. Iowa 1976) (recognizing the stigma of mental illness imposed through civil commitment is a "most profound consequence" that "can be as debilitating as that of a criminal conviction").

[29] *See, e.g.*, *In re Linehan*, 594 N.W.2d 867, 872 (Minn. 1999); State v. McCuistion, 275 P.3d 1092, 1101 (Wash. 2012) (en banc); Matter of Minor, 148 N.E.3d 1182, 1195 (Mass. 2020).

[30] Richard H. Fallon, Jr., *Some Confusions about Due Process, Judicial Review, and Constitutional Remedies* 93 COLUMBIA L. REV. 309, 317 (1993); *see, e.g.*, *In re Labelle*, 728 P.2d 138, 145 (Wash. 1986) (determining whether "involuntary commitment" is "supported by a sufficiently justifying compelling state interest to justify such a significant deprivation of liberty" without first articulating a standard of review); Colyar v. Third Jud. Dist. Ct. for Salt Lake Cnty., 469 F. Supp. 424, 430 (D. Utah 1979) ("[I]n order to determine the validity of involuntary commitment…, the court must analyze the state interest involved and balance it against the substantial individual interest which is impaired by the state action."); *In re Detention of Anderson*, 895 N.W.2d 131, 141 (Iowa 2017) ("[T]he appropriate test is to weigh the individual's liberty interest against the State's reason for restraining the individual's liberty."). Some courts seem to apply rational basis review. *See In re Dennis H.*, 647 N.W.2d at 856 ("Every presumption must be indulged to sustain the law if at all possible and, wherever doubt exists as to a legislative enactment's constitutionality, it must be resolved in favor of constitutionality.").

[31] *See In re Torski C.*, 918 N.E.2d 1218, 1230 (Ill. App. 4th Dist. 2009) ("[W]hen the State's police-power action infringes fundamental liberties, the public interests advanced must be 'compelling' and the action taken must be the least-restrictive alternative to serve those interests."); *In re Labelle*, 728 P.2d at 146 (determining whether "involuntary commitment" is "supported by a sufficiently justifying compelling state interest to justify such a significant deprivation of liberty").

[32] *See infra* notes 50-57, 406, & 518.

[33] *Cf.* BRUCE J. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT 222 (1997) (arguing that certain invasive techniques attending civil commitment "should receive at least intermediate and in most cases strict judicial scrutiny" while noting that commitment's lesser infringements should receive "deferential minimal judicial scrutiny").

framework for weighing individual interests against state interests in the POC context. This analysis is in some ways narrower than that of past scholarship, focusing on extricating and developing substantive constitutional standards for POC specifically. In other ways this analysis is broader, taking a nationwide approach to POC as a whole.

Part I of this Article identifies liberty interests impinged by POC and the degree of their deprivation, along with state interests potentially justifying this infringement. Liberty interests include the rights to refuse treatment and make significant treatment decisions, the First Amendment right to freedom of mentation, and freedom from constructive confinement and stigmatization. Most POC statutes are enforceable through courts' contempt authority, and many that prohibit use of this authority appear to violate state law. Countervailing state interests arise from states' *parens patriae* power (the authority to care for those unable to care for themselves) and police power (the authority to ensure public safety).

Part II examines requirements for constitutional exercises of these state powers. POC implicates two bodies of law: that governing involuntary treatment, and that of involuntary civil commitment. Part II plumbs both domains to glean lessons for the quantum of compelling state interests necessary to justify POC's significant liberty deprivations. Although the standards governing involuntary treatment and commitment differ, both suggest the central requirement for POC's constitutionality is a finding of dangerousness. Another requirement, essential only for valid exercises of *parens patriae*, is a finding of treatment decision-making incapacity. Finally, preventive *inpatient* commitment cases suggest the due process balancing test requires that preventive *outpatient* commitment statutes include either a strong dangerousness element *or* a treatment decision-making incapacity element paired with a more relaxed dangerousness definition. Anything less is at best questionably constitutional.

Part III applies these constitutional requirements to existing statutory schemes. It determines five POC statutes are constitutional or nearly constitutional, and three are clearly unconstitutional. The implications of eliminating courts' contempt power on the balance between state and individual interests are also examined. Part IV concludes by proposing California's Laura's Law as a possible model for expanding treatment access without involuntary medication. This law empowers individuals to self-manage their illnesses[34] and provides a partial blueprint for states seeking to expand community mental health treatment in a constitutionally sound manner.

I. The Interests Defined

Involuntary outpatient commitment "requires due process protection."[35] POC impinges a range of significant interests: the rights to refuse treatment and make significant treatment decisions,[36] First Amendment rights over mentation, and freedom from effective confinement and

[34] Calif. Welf. & Inst. Code § 5348(a)(4)(F) (directing that personal services plans should "enable recipients to . . . self-manage their illnesses and exert as much control as possible over both the day-to-day and long-term decisions that affect their lives").

[35] *Addington*, 441 U.S. at 425 (inpatient); *see Coleman*, 697 F. Supp. 2d at 505-06 (outpatient).

[36] These rights may be separately violated in the context of a POC order that overrides advance directives made when the person was competent. *See* Johnston & Klein, *supra* note 1, at X.

stigmatization.[37] These interests are not absolute and may be qualified by compelling state interests. States seek to effectuate two core goals through involuntary commitment: protecting citizens from harm (through their police power) and caring for individuals who cannot care for themselves (under their *parens patriae* authority). Balancing threatened liberties and asserted state interests is only possible when each is fully weighed and understood.

A. Individual Interests

1. Right to refuse treatment

The right to refuse medical treatment originates from common law and the U.S. Constitution. In *Cruzan v. Missouri Department of Health*,[38] the Supreme Court applied common law when "assum[ing]" competent persons have a liberty interest in refusing unwanted medical treatment.[39] Quoting its 1891 decision, *Union Pacific R. Co. v. Botsford*, the *Cruzan* Court declared, "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."[40] This right's two components—bodily integrity and self-determination—are embodied in the common law tort doctrine of informed consent and protected by the Fourteenth Amendment Due Process Clause.[41]

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[37] *See* Elyn R. Saks, *Involuntary Outpatient Commitment*, 9 PSYCH. PUB. POL'Y, & L. 94, 102 (2003) (observing that court-ordered medication has a stigmatizing effect even without hospitalization); Elyn R. Saks & Stephen H. Behnke, *Competency to Decide on Treatment and Research: MacArthur and Beyond*, 10 J. CONTEMP. LEGAL ISSUES 103, 120 (1999) (finding a self-stigmatization and "narcissistic injury" involved in acknowledging mental illness and that "[a] person denying [they are] mentally ill might draw on resources [they] would be too discouraged to use if the person admitted the illness"). Surveys consistently affirm that patients often view compelled community treatment as stigmatizing and disempowering. *See, e.g.*, Lisa Brophy & David Ring, *The Efficacy of Involuntary Treatment in the Community: Consumer and Service Provider Perspectives*, 2 SOC. WORK APPROACHES HEALTH & MENTAL HEALTH 157, 158, 171 (2004) (finding a "common area of agreement" between individuals ordered to treatment and mental health professionals that orders "had the propensity to be stigmatizing and disempowering"); Karen Schwartz et al., *Community Treatment Orders: The Service User Speaks. Exploring the Lived Experience of Community Treatment Orders*, 15 INT'L J. PSYCHOSOCIAL REHAB. 39, *8 (2010) (reporting that participants described the experience of stigmatization as feeling feared by, isolated from, and judged by community members); Magnus Mfoafo-M'Carthy, *Community Treatment Orders and The Experiences of Ethnic Minority Individuals Diagnosed with Serious Mental Illness in the Canadian Mental Health System*, INT'L J. EQUITY HEALTH *6 (2014) (reporting that compelled treatment orders made some participants "feel like second-class citizens").

[38] 497 U.S. 261 (1990).

[39] *Id.* at 279.

[40] *Id.* at 269 (quoting Union Pacific R. Co. v. Botsford, 141 U.S. 250, 251 (1891)).

[41] *Id.* at 269-70. The informed consent doctrine demands that, if a patient is mentally and physically able to be consulted, their informed and knowledgeable consent is prerequisite to treatment. *See* Moure v. Raeuchle, 604 A.2d 1003, 1008 (Pa. 1992). The doctrine typically applies to both invasive and noninvasive treatments. *See* Matthies v. Mastromonaco, 733 A.2d 456, 460-61 (N.J. 1999. *Cruzan* said "a right to refuse treatment . . . is more properly analyzed in terms of a Fourteenth Amendment liberty interest," not as a privacy right derived from the Constitution. 497 U.S. at 279 n.7. Therefore, *Cruzan* may be less vulnerable to reversal after *Dobbs* than cases relying solely on a broad, penumbral right to privacy. *See* Dobbs v. Jackson Women's Health Organization, 597 U.S. 215, 231 (2022).

Lower courts also derive a right to make treatment decisions from the Constitution's "penumbral" privacy rights.[42] Recognizing "a sphere within which the individual may assert the supremacy of his own will, and rightfully dispute the authority of any human government . . . to interfere with the exercise of that will,"[43] the Supreme Court has ruled the Constitution protects autonomous decision-making in areas traditionally recognized as personal and of major importance to the individual.[44] As one state supreme court recognized,

> [t]he constitutional right to privacy . . . is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.[45]

Compelled treatment also encroaches upon First Amendment rights.[46] The First Amendment protects the right "to think and to communicate freely."[47] Accordingly, this amendment provides additional authority supporting an individual's right to refuse, at minimum, intrusive, mind-altering therapies.[48] Moreover, the First Amendment protects unpopular, countercultural, and dissident speech, safeguarding an 'atypical' mind containing culturally aberrant ideas.[49]

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[42] *See, e.g.*, Price v. Sheppard, 239 N.W.2d 905, 910 (Minn. 1976); Matter of Quinlan, 355 A.2d 647, 663 (N.J. 1976); Davis v. Hubbard, 506 F. Supp. 915, 930-33 (N.D. Ohio 1980); Rennie v. Klein, 462 F. Supp. 1131, 1144 (D.N.J. 1978).

[43] Jacobson v. Massachusetts, 197 U.S. 11, 29 (1905).

[44] WINICK, *supra* note 33, at 216-217; *see, e.g.*, Meyer v. Nebraska, 262 U.S. 390 (1923) (right to teach children foreign languages); Griswold v. Connecticut, 381 U.S. 479 (1965) (right of married persons to obtain contraceptives); Loving v. Virginia, 388 U.S. 1 (1967) (interracial marriage); Moore v. City of E. Cleveland, 431 U.S. 494 (1977) (right to reside with relatives).

[45] Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 426 (Mass. 1977).

[46] *See e.g.*, *Davis*, 506 F. Supp. at 933 (drawing a right to refuse treatment from precedent establishing a liberty interest in free thought); Lojuk v. Quandt, 706 F.2d 1456, 1465 (7th Cir. 1983); Scott v. Plante, 532 F.2d 939, 946 (3d Cir. 1976); Mackey v. Procunier, 477 F.2d 877, 878 (9th Cir. 1973) ("impermissible tinkering with the mental processes"). The First Amendment Free Exercise Clause provides an additional source of constitutional protection. *See In re Boyd*, 403 A.2d 744, 750 (D.C. 1979).

[47] *Davis*, 506 F. Supp. at 933; *Lojuk*, 706 F.2d at 1465; *see* Palko v. Connecticut, 302 U.S. 319, 326-27 (1937) (recognizing "freedom of thought and speech" as "the matrix, the indispensable condition, of nearly every other form of freedom); *Griswold*, 381 U.S. at 482 (recognizing "freedom of inquiry, freedom of thought"); Stanley v. Georgia, 394 U.S. 557, 565-66 (1969) ("Our whole constitutional heritage rebels at the thought of giving government the power to control men's minds. . . [T]he State's assertion of a right] to control the moral content of a person's thoughts . . . is wholly inconsistent with the philosophy of the First Amendment.").

[48] *See Davis*, 506 F. Supp. at 933; WINICK, *supra* note 33, at 135; United States v. Charters, 829 F.2d 479, 489 (4th Cir. 1987), on reh'g, 863 F.2d 302 (4th Cir. 1988) (identifying "the protection of the thought processes that define individuality" as "an interest at the core of liberty," and remarking: "[F]orcible medication with mind-altering drugs will affect the well functioning aspects of personality as well as the disturbed aspects. The drugs may affect mood and emotion, dull the senses and make reading and concentration difficult.").

[49] WINICK, *supra* note 33, at 156-158.

Often employing multiple authorities,[50] courts find significant liberty interests in refusing various medical treatments.[51] The Supreme Court has repeatedly recognized a right to refuse antipsychotic medications[52] and finds a general liberty interest in refusing mandatory behavior modification treatment.[53] Lower courts recognize rights to refuse electroconvulsive therapy and psychosurgery.[54]

The strength of state interests necessary to outweigh the right to refuse a given treatment often depends upon the treatment's impact and intrusiveness.[55] Right-to-refuse decisions consider numerous treatment characteristics, including the probability, severity, and longevity of adverse side effects; bodily intrusiveness; associated pain; the extent and duration of behavioral and mental activity affected by the treatment; and the treatment's acceptance by the state medical community.[56] As the Minnesota Supreme Court explained,

> [a]s the impact [of a particular treatment] increases, so must the importance of the state's interest. Some decisions . . . will be of little consequence to the individual and a showing of a legitimate state interest will justify its intrusion; other decisions . . . will be of such major consequence that only the most compelling state interest will justify the intrusion."[57]

Individuals with mental illnesses "are not to be treated as persons of lesser status or dignity because of their illness" and thus have as robust a right to make healthcare decisions as those without illness.[58] So long as individuals are capable of making an informed choice to reject treatment, their choice must be protected.[59] Empirical studies establish that most individuals with severe mental disabilities retain the ability to make rational treatment decisions.[60]

Competent individuals—even those with a history of psychiatric treatment—have a right to refuse outpatient treatment. The Supreme Court has established that individuals have a

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[50] *See, e.g.*, *Davis*, 506 F. Supp. at 930–34; *In re K. K. B.*, 609 P.2d 747, 749 (Okla. 1980); *Lojuk*, 706 F.2d at 1465.

[51] *See In re K.K.B.*, 609 P.2d at 749 (limiting its decision to "'organic therapy' which can change a patient's behavior without his cooperation such as electroshock, psychosurgery and . . . the use of anti-psychotic drugs"); *Price*, 239 N.W.2d at 911-13 (differentiating the more intrusive techniques of drugs, aversion, electroconvulsive therapy, and psychosurgery from the "least intrusive forms such as "milieu therapy (behavior changes produced by manipulation of the patient's environment) and psychoanalysis").

[52] *See* Washington v. Harper, 494 U.S. 210, 221-222 (1990); *Riggins*, 504 U.S. at 134; *Sell*, 539 U.S. at 179; Mills v. Rogers, 457 U.S. 291, 294 n. 4, 299 n.16 (1982).

[53] Vitek v. Jones, 445 U.S. 480, 494, 495 (1980).

[54] *See supra* note 51.

[55] *See id.*

[56] Myers v. Alaska Psychiatric Inst., 138 P.3d 238, 252 (Alaska 2006); Jarvis v. Levine, 418 N.W.2d 139, 145–46 (Minn. 1988) (stating that an appraisal of probable effects of a treatment on a patient's body should form the starting point of any analysis of "intrusiveness"); *see supra* note 51.

[57] *Price*, 239 N.W.2d at 910.

[58] Rivers v. Katz, 495 N.E.2d 337 (N.Y. 1986); *see In re K. K. B*., 609 P.2d at 751.

[59] *Colyar*, 469 F. Supp. at 432. Indeed, even an incompetent, committed person retains the right to refuse certain treatment modalities, including antipsychotic medications. *See Price*, 239 N.W.2d at 911-13.

[60] *See infra* notes 175-176 (discussing a meta-review regarding the treatment decision-making ability of individuals with mental disorders).

significant (if not fundamental)[61] interest in refusing antipsychotic medications that can only be overridden by findings that medication is medically appropriate and the least restrictive means "to accomplish an essential state policy."[62] Scholars have identified "the core of outpatient treatment" as "forced medication,"[63] and at least two courts have equated a POC order for the administration of medication with its forcible administration—even when a commitment court lacks enforcement ability.[64] Relatedly, an individual may have an interest in rejecting blood draws to assess medication compliance.[65]

Although not intrusive in the traditional sense, an individual may also have a right to refuse psychotherapy.[66] Some courts construe the right to refuse treatment broadly, recognizing a person's right to refuse *any* treatment,[67] including psychotherapy.[68] Indeed this must be the case. If "every competent adult has the right to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks, however unwise his sense of values may be to others,"[69] then the significance of treatment must be judged by the individual—according to their values and preferences—not by a court or treatment provider. A central goal of psychotherapy for mentally disordered, treatment-noncompliant individuals is, unsurprisingly, acceptance of their diagnoses and compliance with medication regimens.[70] Whether to accept a diagnosis and how to treat it are decisions of fundamental importance to many individuals with serious mental illnesses. Mental illness has been described as a "master status—that status which above all others defines the

[61] *See supra* note 22.

[62] *Riggins*, 504 U.S. at 135, 138; *Sell*, 539 U.S. at 179.

[63] Stefan, *supra* note 19, at 294; *see* Winick, *supra* note 8, at 108–09, 115 ("[p]reventive outpatient commitment seeks to invoke the *parens patriae* power to justify forced treatment").

[64] *See* Protec. and Advoc. System v. City of Albuquerque, 195 P.3d 1, 20-21 (N.M. App. 2008) (equating a court order to "self-administer psychotropic drugs or accept the administration of such drugs by an authorized professional" with the forcible administration of medication "regardless of whether there are sanctions . . . for failure to comply with court-ordered treatment, [given] the coercive nature of a court order"); *Coleman*, 697 F. Supp. 2d at 506-09 (framing the federal substantive due process claim presented by the POC statute as whether authorizing the forcible administration of antipsychotic drugs was justified by an "essential" government interest, even though the statute did not allow patients to be forcibly injected with medications against their will or the court to respond to noncompliance with incarceration or a fine).

[65] *See* People v. Floyd, 655 N.E.2d 10, 15 (Il. 5th Dist. 1995) (holding blood draws to monitor medication levels included within the state's authority to forcibly administer antipsychotic drugs under certain circumstances); Cohen v. State, 843 N.Y.S.2d 810, 814 (N.Y. Ct. Cl. 2007) (citing *Rivers*, 495 N.E.2d 337, and recognizing that blood draws are "an invasive procedure, with respect to which the patient had the right to be involved in the decision-making process").

[66] *See supra* notes 51, 55-57; *Price*, 239 N.W.2d at 910 ("As the impact [of a particular treatment] increases, so must the importance of the state's interest. Some decisions . . . will be of little consequence to the individual and a showing of a legitimate state interest will justify its intrusion; other decisions . . . will be of such major consequence that only the most compelling state interest will justify the intrusion.").

[67] *See* Tune v. Walter Reed Army Medical Hospital, 602 F. Supp. 1452, 1455 (D.D.C. 1985) (ruling that the right to refuse treatment "has never been qualified in its application by either the nature or purpose of the treatment, or the gravity of the consequences of acceding to or foregoing it"); *In re Guardianship of Browning*, 568 So. 2d 4, 8 (Fla. 1990) ("Recognizing that one has the inherent right to make choices about medical treatment, we necessarily conclude that this right encompasses all medical choices.").

[68] *See* Commitment of T.S. v. Logansport State Hosp., 959 N.E.2d 855, 858-59 (Ind. App. 2011) (holding the principles constraining forcible medication apply to forcible treatment, including counseling and non-drug-related therapy).

[69] Downer v. Veilleux, 322 A.2d 82, 91 (Me.1974).

[70] *See* AM. PSYCHIATRIC ASS'N, *supra* note 4, at 1.

individual's position within . . . society in general."[71] Certain diagnoses affect one's worldview, image, and evaluation of future opportunities.[72] In addition to their all-encompassing nature, mental disorders are generally incurable, subjective, and often contested.[73] Psychotherapy involves probing the patient's mind,[74] including past traumas and guilt, which may be mentally taxing and unpleasant and even worsen the patient's mental state, at least in the short term.[75] While a person could refuse to participate in compulsory therapy sessions, such obdurate behavior likely establishes lack of insight, a common ground for commitment order renewal.[76]

2. Freedom from constructive confinement

Outpatient commitment imposes numerous conditions that restrict freedom of movement and can amount to constructive confinement.[77] Indeed, many statutes identify the supervision and structure of POC as what enables individuals to survive safely in the community.[78] Orders can include individual or group therapy, full-day or partial-day programming activities, vocational activities, educational activities, substance use disorder treatment and counseling, periodic blood or urine testing for the presence of alcohol or narcotics, and supervised living arrangements.[79] Two states permit a court to order an individual's placement in the custody of a relative or other willing

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[71] *See* William H. Fisher et al., *Beyond Criminalization: Toward a Criminologically Informed Framework for Mental Health Policy and Services Research*, 33 ADMIN. & POL'Y MENTAL HEALTH & MENTAL HEALTH SERVS. RSCH. 544, 549 (2006).

[72] *See* Manvir Singh, *Read the Label: How Psychiatric Diagnoses Create Identities*, NEW YORKER 20 (May 13, 2024); Schwartz et al., *supra* note 37, at *9 (reporting some individuals under community treatment orders report "losing their identity to the illness"); Henriette Riley et al., *'When Coercion Moves Into Your Home' – A Qualitative Study of Patient Experiences with Outpatient Commitment in Norway*, 22 HEALTH & SOCIAL CARE CMTY. 506, 510 (2014) (reporting a community treatment order can maintain a person's "identity as a patient"); *supra* note 37 (stigma).

[73] *See* Stephen J. Morse, *Excusing and the New Excuse Defenses: A Legal and Conceptual Review*, 23 CRIME & JUST. 329, 369-70 (1998); Jeremy Matuszak & Melissa Piasecki, *Inter-rater Reliability in Psychiatric Diagnosis*, 29 PSYCHIATRIC TIMES 10 (2012); Munira Kapadia et al., *Fractures in the Framework: Limitations of Classification Systems in Psychiatry*, 22 DIALOGES CLIN. NEUROSCI. 17 (2020) (outlining concerns about the reliability, validity, comorbidity, and heterogeneity within diagnostic categories of contemporary classification systems); S. Berendsen et al., *Psychometric Properties of the DSM-5 Clinician-Rated Dimensions of Psychosis Symptom Severity*, 216 SCHIZOPHRENIA RES. 416 (2020) (finding low inter-rater reliability in the Clinician-Rated Dimensions of Psychosis Symptom Severity—presented in the DSM-5 as a new instrument to assess the dimensional aspects of symptoms of psychosis—among raters in clinical practice).

[74] *See Taylor v. United States*, 222 F.2d 398, 401 (D.C. Cir. 1955).

[75] *See* Michael Linden & Marie-Luise Schermuly-Haupt, *Definition, Assessment and Rate of Psychotherapy Side Effects,* 13 WORLD PSYCHIATRY 306 (2014) ("[T]here is an emerging consensus that unwanted events should be expected in about 5 to 20% of psychotherapy patients . . . includ[ing] treatment failure and deterioration of symptoms, emergence of new symptoms, suicidality, occupational problems or stigmatization, changes in the social network or strains in relationships, therapy dependence, or undermining of self-efficacy."); Noam Shpancer, *When Talking Doesn't Cure: Negative Outcomes in Therapy*, Psychology Today, https://www.psychologytoday.com/us/blog/insight-therapy/202003/when-talking-doesnt-cure-negative-outcomes-in-therapy (reviewing estimates of negative psychotherapy outcomes, which range from 3 to 14%).

[76] *See infra* note 102.

[77] Seventeen states' statutes authorize specific services for inclusion in POC plans. *See* Johnston & Klein, *supra* note 1.

[78] *See, e.g.*, CAL. WELF. & INST. CODE § 5346(a)(3)(A).

[79] *See* Johnston & Klein, *supra* note 1.

person.[80] These conditions mandate a person be at a place and time not of their choosing for an activity coerced through state authority.

Surveys of individuals subjected to compelled community treatment document its onerous and restrictive nature.[81] Many patients report that treatment orders restrict their abilities to travel, participate in social activities, and seek employment.[82] Patients report needing to adapt everyday activities around treatment and monitoring requirements.[83] Some patients experience restrictions as privacy invasions,[84] means of surveillance, or forms of social control.[85] One study explains, "One's living room . . . becomes an institution outside the [hospital], and the home an arena for the structure and implementation" of outpatient commitment.[86] Some patients liken community treatment orders to probation[87] or incarceration.[88] One study of participants from ethnic minority backgrounds reported, "Their lived experience was based on fear that they might inadvertently violate the conditions of their treatment and be apprehended."[89]

Abiding by numerous community conditions—especially treatment conditions—may be as burdensome as institutional confinement.[90] Studies in the criminal context suggest individuals often consider programs of intensive community supervision to be as onerous as, or more onerous than, short-term incarceration.[91] Studies comparing community conditions indicate individuals

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[80] *See* Mont. Code Ann. § 53-21-149(2); 405 Ill. Comp. Stat. Ann.§ 5/3-812(a)(i).

[81] *See, e.g.*, Krysia Canvin et al., *A 'Bittersweet Pill to Swallow': Learning from Mental Health Service Users' Responses to Compulsory Community Care in England*, 10 HEALTH & SOC. CARE CMTY. 361 (2002); Kate Francombe Pridham, *Exploring Experiences with Compulsory Psychiatric Community Treatment: A Qualitative Multi-Perspective Pilot Study in an Urban Canadian Context*, 57 INT'L J. L. & PSYCHIATRY 122, 126 (2018).

[82] *See* Anita Gibbs et al*., Community Treatment Orders for People with Serious Mental Illness: A New Zealand Study*, 36 BRITISH J. SOC. WORK 1085, 1093 (2006) (reporting that "many" individuals subject to community treatment orders "were clear that the order limited their freedom with regard to choice of treatment, travel, residence and decision-making capacity"); Pridham, *supra* note 81, at 126 (reporting that some clients "saw their psychiatric appointments as incompatible with their other priorities, like employment and involvement in social activities").

[83] *See* Riley et al., *supra* note 72, at 510 ("Due to the administration of medication, keeping medical appointments, care and supervision in the home, the patients' privacy and everyday activities needed to be planned and adapted to the structures of the healthcare services.").

[84] *See* Canvin et al., *supra* note 81, at 364.

[85] *See id.*; Schwartz et al., *supra* note 37, at *10 ("The stigma experienced by service users from the community was articulated as a feeling of being under surveillance."); Gibbs et al*., supra* note 82, at 1093 (reporting that typical phrases used by individuals subject to community treatment orders were: "'I have to do what they say', 'under control, supervision and surveillance', 'restricted, ordered, pressured'").

[86] Riley et al., *supra* note 72, at 512.

[87] Mfoafo-M'Carthy, *Community Treatment Orders*, *supra* note 37, at *7.

[88] Pridham, *supra* note 81, at 126.

[89] Mfoafo-M'Carthy, *supra* note 37, at *8.

[90] *See* NORVAL MORRIS & MICHAEL TONRY, BETWEEN PRISON AND PROBATION: INTERMEDIATE PUNISHMENTS IN A RATIONAL SENTENCING SYSTEM 4 (1991) ("[M]any community-based sentences impose and enforce considerable restrictions on the offender's freedom of movement, approximating to the custodial, and coercively limit other aspects of his autonomy.").

[91] *Compare* Joan Petersilia, *When Probation Becomes More Dreaded than Prison*, 54 FED. PROB. 23, 24 (1990) (reporting that about a third of those eligible for an experimental intensive community supervision program refused to participate when given the choice after being sentenced to prison), *with* Peter B. Wood & Harold G. Grasmick, *Toward the Development of Punishment Equivalencies: Male and Female Inmates Rate the Severity of Alternative*

experience *treatment* conditions as particularly onerous.[92] Study authors hypothesize this finding may reflect "offenders' understanding of the effort required to successfully complete treatment-oriented sanctions."[93] Whereas jail "does not require the offender to put forth any particular effort,"[94] treatment conditions require "a great deal of active participation."[95] A 2020 study reached similar conclusions.[96]

POC is made even more onerous by its length. Multiple states permit one-year, renewable terms of compelled community treatment.[97] Washington permits orders effective for eighteen months.[98] Hawaii authorizes orders for up to two years.[99] Oklahoma does not set a durational limit, only requiring annual review to reconsider an individual's treatment needs.[100] Additionally, courts and service providers often expect that prospective committees need multiple terms of court-ordered care, with the American Psychiatric Association asserting that long duration is crucial for treatment effectiveness.[101] Over time, this can create a "lobster pot" effect, "in that [community treatment orders] can be easy to apply whilst also difficult to justify removing."[102]

Sanctions Compared to Prison, 16 JUST. Q. 19, 34-35 (1999) (among 415 convicted offenders with experience serving a given in-community punishment, twelve months of intensive supervision probation were perceived as more punitive than twelve months imprisonment); *id.* at 28 (finding that 26.3% of surveyed, incarcerated offenders would refuse to serve any amount of intensive community supervision to avoid a four-month prison sentence). The requirements of intensive community supervision overlap to a considerable degree with authorized elements of POC. *See* MORRIS & TONRY, *supra* note 90, at 7 (reporting that "prominent features of orders for intensive supervision" include conditions of residence and treatment programs for drugs, alcohol, and mental illness).

[92] *See* Eric J. Wodahl et al., *Offender Perceptions of Graduated Sanctions*, 59 CRIME & DELINQUENCY 1185, 1196, 1201 (2009) (finding that offenders facing a two-day jail sentence considered one additional hour of outpatient treatment to be equivalent to one extra day in jail); *infra* note 96.

[93] Wodahl et al., *supra* note 92, at 1201.

[94] *Id.*

[95] *Id.*

[96] *See* Eric J. Wodahl et al., *Are Jail Sanctions More Punitive Than Community-Based Punishments? An Examination into the Perceived Severity of Alternative Sanctions in Community Supervision*, 31 CRIM. JUST. POL'Y REV. 696, 710 (2020) (in a survey of 185 active probationers, finding the median exchange rate of hours of additional outpatient treatment per day of jail avoided at the two-day jail sanction mark to be 1.5:1 and the ratio to be 0.72:1 at the fourteen-day mark).

[97] *See* LA. STAT. ANN. § 28:71(B); LA. STAT. ANN. § 28:72(A); N.Y. MENTAL HYG. LAW § 9.60(j)(2), (k)(2); OKLA. STAT. ANN. tit. 43A, § 5-416(M), (B)(1)(b); UTAH CODE ANN. § 26B-5-351(17)(a), (b).

[98] WASH. REV. CODE ANN. § 71.05.148(3).

[99] HAW. REV. STAT. ANN. § 334-127(b).

[100] *See* OKLA. STAT. ANN. tit. 43A, § 5-416(B)(1).

[101] *See* AM. PSYCHIATRIC ASS'N, *supra* note 70, at 3.

[102] Hannah Jobling, *The Legal Oversight of Community Treatment Orders: A Qualitative Analysis of Tribunal Decision-Making*, 62 INT'L J. L. & PSYCHIATRY 95, 96 (2019); *see id.* at 100 (finding that tribunals in England often renewed community treatment orders on grounds of "maintaining the status quo" if they were working effectively, yet also on grounds of lack of insight, risk, or lack of social support if the tribunal saw, or feared, difficulty in treatment compliance).

B. Degree of liberty deprivation & effect of enforcement mechanisms

The degree of a liberty interest's infringement is a crucial aspect of the balancing test that weighs liberty deprivations against state interests.[103] Extrapolating from statutes' expressly authorized and prohibited responses to noncompliance, courts and commentators have characterized POC statutes' enforcement mechanisms as weak.[104] However, a thorough examination of POC statutes and the legality of their provisions suggests a different conclusion.

This section details the availability of three types of enforcement measures available in POC states. First, nearly all states expressly authorize the involuntary seizure, transport, and examination of noncompliant individuals to determine their suitability for inpatient civil commitment. Second, contrary to courts' and commentators' conclusions, most states' courts retain the power to incarcerate and fine noncompliant individuals, either because statutes preserve courts' inherent contempt power or because removing courts' enforcement power is likely unconstitutional. Third, a substantial minority of POC statutes appear to authorize the forcible, involuntary medication of POC patients.

1. Involuntary seizure, transport, hold, and examination

Clearly, individuals ordered to treatment and associated services "may face consequences if they do not comply."[105] Nearly all POC statutes expressly permit noncompliance to serve as grounds for an involuntary multi-day hold and examination, or immediate hearing, to determine the appropriateness of inpatient commitment.[106] Individuals' refusal to take medications can factor into this calculus,[107] although a substantial minority of POC states (6/23) clarify that treatment refusal alone cannot provide the basis for involuntary hospitalization.[108] One state, Kentucky, provides that a "substantial failure" to comply with a treatment order may constitute "presumptive grounds" for emergency hospitalization.[109] States typically apply the same inpatient commitment standard to noncomplying individuals under POC as to those outside this context, but at least one

[103] *See* Large v. Super. Ct., in and for Maricopa Cnty., 714 P.2d 399, 405–06 (Ariz. 1986) (asking, "in deciding whether a person has been deprived of a protected liberty or property interest without due process of law . . . (1) does the state's action implicate a protected liberty interest; [and] (2) if so, does the state's interest justify the degree of infringement on the liberty interest").

[104] *See* Johnston & Klein, *supra* note 1, at X (discussing commentators' disquiet about the widespread, "mistaken" view of POC that courts can compel compliance through sanctions or forcible medication, criticism of commitment statutes' reliance on this belief, and call for patient education to dispel widespread ignorance).

[105] *Coleman*, 697 F.Supp.2d at 509; *see* Johnston & Klein, *supra* note 1, at 16-25 (reviewing states' enforcement measures and noting that, while Delaware provides no express guidance on responding to noncompliance, it does not remove POC courts' contempt power). Maryland supplies no guidance for responding to noncompliance but provides that noncompliance cannot be grounds for contempt findings or involuntary admission. *See* 2024 Md. Legis. Serv. ch. 704, § 10-6A-10(D).

[106] *See* Johnston & Klein, *supra* note 1, at 23.

[107] *See* LA. STAT. ANN. § 28:75(D); N.Y. MENTAL HYG. LAW § 9.60(n).

[108] *See* HAW. REV. STAT. ANN. § 334-129(d); LA. STAT. ANN. § 28:71(F); N.M. STAT. ANN. § 43-1B-13(B); N.Y. MENTAL HYG. LAW § 9.60(n); OKLA. STAT. ANN. tit. 43A, § 5-416(Q); 2024 Md. Legis. Serv. ch. 704.

[109] KY. REV. STAT. ANN. § 202A.0823.

state, Utah, authorizes the hospitalization of noncompliant outpatient committees upon a *lesser showing*.[110]

In *In re K.L.*, the court framed the liberty deprivation imposed through threatened evaluation for inpatient commitment as "minimal;"[111] yet a law enforcement seizure, a multi-day hold, and scrutinization for involuntary hospitalization is a serious consequence with substantial coercive power.[112] Commentators stress that "being forcibly brought to an emergency room and held in the hospital for seventy-two hours without the option of leaving" generates a "narrative truth reflecting a considerable sense of coercion and loss of personal dignity."[113] One qualitative study of individuals' experiences of compulsory community treatment found that "most" participants experienced the "explicit threat of law-enforcement . . . apprehension for hospital assessment, and involuntary hospitalization if assessment warrants so" as a "severe consequence."[114] Indeed, "the threat of detention and transportation may operate as a significant limitation on the practical ability of patients to resist medication-based psychiatric treatment in the outpatient setting."[115] As *Coleman* recognized, these consequences burden individuals' "fundamental right to reject treatment."[116]

2. Availability of courts' contempt power

In many POC states (11/23), courts retain the ability to enforce treatment orders through incarceration and fines.[117] Holding individuals in contempt of court is one of the most serious forms of coercion available to the state.[118] Ten POC statutes prohibit courts from holding

[110] *See* UTAH CODE ANN. § 26B-5-333(2) (permitting an individual ordered to outpatient treatment to be involuntarily committed if the court finds the person "is still mentally ill," no less restrictive alternative to inpatient commitment exists," and "based upon the patient's conduct and statements during the preceding six months, or the patient's failure to comply with treatment recommendations during the preceding six months, the court finds that absent an order of involuntary commitment, the patient is likely to pose a substantial danger to self or others"); *id.* § 26B-5-332(16)(a) (authorizing the inpatient commitment of an adult if the court finds by clear and convincing evidence that the patient has a mental illness, because of that mental illness poses a substantial danger to self or others, and "lacks the ability to engage in a rational decision-making process regarding the acceptance of mental treatment as demonstrated by evidence of inability to weigh the possible risks of accepting or rejecting treatment").

[111] *See In re K.L.*, 806 N.E.2d at 485.

[112] *See* Courtney A. Bergan, *The Right to Choose and Refuse Mental Health Care: A Human Rights Based Approach to Ending Compulsory Psychiatric Intervention*, 27 J. HEALTH CARE L. & POLICY 49, 74 (2024) ("Involuntary outpatient treatment programs subject marginalized individuals to increased law enforcement involvement and ongoing threats of involuntary institutionalization for noncompliance, putting people with psychosocial disabilities at an increased risk of abuse and even death.").

[113] Henry A. Dlugacz, *Involuntary Outpatient Commitment: Some Thoughts on Promoting a Meaningful Dialogue Between Mental Health Advocates and Lawmakers*, 53 N.Y.L. SCH. L. REV. 79, 88–89 (2009).

[114] Pridham, *supra* note 81, at 124.

[115] Boldt, *supra* note 12, at 54.

[116] *Coleman*, 697 F.Supp.2d at 504.

[117] *See* Johnston & Klein, *supra* note 1; *Protec. & Advoc. Sys.*, 195 P.3d at 20–21 (indicating that noncompliance with outpatient treatment orders can be punished as contempt of court absent an express statutory prohibition).

[118] *See, e.g.,* Murphy v. Waterfront Comm'n of N.Y. Harbor, 378 U.S. 52, 55 (1964) (explaining that the rationale of the Fifth Amendment's privilege against self-incrimination is to free criminal defendants of the "cruel trilemma of self-accusation, perjury or contempt").

noncompliant individuals in contempt.[119] Two additional states forbid courts from using incarceration as a sanction for treatment noncompliance.[120] Removing courts' contempt power appears to be an effort to safeguard the constitutionality of POC laws.[121]

However, contempt removal provisions may be unconstitutional. At least seven of the twelve contempt-removal or incarceration-removal provisions—those in California,[122] New Mexico,[123] Ohio,[124] Pennsylvania,[125] Texas,[126] Maryland,[127] and Kentucky[128]—appear to violate separation of powers principles under state case law.[129]

For example, Pennsylvania courts view the contempt power as "essential to the preservation of the court's authority and prevent[ing] the administration of justice from falling into disrepute."[130] The contempt power is inherent to the courts, and the legislature may only regulate

[119] *See* CAL. WELF. & INST. CODE § 5346(f); KY. REV. STAT. § 202A.0823; LA. STAT. § 28:71(F); N.M. STAT. § 43-1B-13(B); N.Y. MENTAL HYG. LAW § 9.60(n); OKLA. STAT. tit. 43A, § 5-416(Q); 50 PA. STAT. AND CONS. STAT. § 7304(f)(6); TEX. HEALTH & SAFETY CODE § 574.037(c-4); UTAH CODE. § 26B-5-351(19); 2024 MD. LEGIS. SERV. ch. 704, § 10-6A-10(D).

[120] OHIO REV. CODE § 5122.15(N); FLA. STAT. ANN. § 394.467(10)(b).

[121] *See* Sarah K. Capps, *Are They Dangerous Yet?: The Foreseeability of Dangerousness in Oklahoma's Involuntary Outpatient Commitment Law and Its Implications for Patient Due Process Rights*, 71 OKLA. L. REV. 1189, 1204–05 (2019).

[122] *See* In re McKinney, 447 P.2d 972 (Cal. 1968) (recognizing that the court "has held a legislative limitation on the contempt power unconstitutional . . . where the Legislature had completely stripped the courts of power to treat or punish as contempt a class of offenses"); People v. Lawson, 267 Cal. Rptr. 3d 183, 192 (Cal. App. 1st Dist. 2020) (upholding a statute that prohibits courts from jailing for contempt sexual assault victims who refuse to testify against their attackers because it "does not deprive the court of all power to punish a class of contempts" but still permits judges to impose fines and adjudge recalcitrant individuals to be in contempt); *infra* note 135.

[123] *See* State ex rel. Bliss v. Greenwood, 315 P.2d 223, 227 (N.M. 1957) ("[W]hile the legislature may provide rules of procedure which are reasonable regulations of the contempt power it may not, either by enacting procedural rules or by limiting the penalty unduly, substantially impair or destroy the implied power of the court to punish for contempt."); State v. Julia S., 719 P.2d 449, 455 (N.M. App. 1986) (finding a statute to be a reasonable regulation of courts' contempt power because it allowed courts to jail contemnors for repeated violations, permitted courts to perform their judicial functions, and did not limit punishments for indirect contempts that are not probation violations).

[124] *See* Hale v. State, 45 N.E. 199, 200 (Ohio 1896) (holding the legislature incompetent to abridge the power of a constitutional court to punish wrongful acts); Turner v. Albin, 161 N.E. 792, 794 (Ohio 1928) ("If the court has the inherent power to summarily punish contempts, it must by the same token have the power to determine the kind and character of conduct which will constitute contempt."); *infra* note 137.

[125] *See infra* notes 130-133.

[126] *See Ex parte Barnett*, 600 S.W.2d 252, 254 (Tex. 1980) ("The power to punish a party who fails or refuses to obey a prior order or decree of the court for contempt . . . is an essential element of judicial independence and authority.").

[127] *See* Usiak v. State, 993 A.2d 39, 45 (Md. 2010) ("the power to hold a person in contempt is inherent in all courts as a principal tool to protect the orderly administration of justice and the dignity of that branch of government that adjudicates the rights and interests of the people"); *infra* note 135.

[128] *See* Arnett v. Meade, 462 S.W.2d 940, 946 (Ky. 1971) ("the legislature may put reasonable restrictions upon constitutional functions of the courts, provided that such restrictions do not defeat or materially impair the exercise of those functions"); *infra* note 135.

[129] *See also* Rosser v. Rosser, 502 P.3d 294, 301 (Utah 2021) ("A court's inherent contempt authority is 'independent of statutory authority.' These inherent contempt powers 'are necessary to the proper discharge of [the court's] duties.'").

[130] Garr v. Peters, 773 A.2d 183, 189 (Pa. Super. 2001).

the manner of its exercise.[131] The separation of powers doctrine, "essential to our triparte governmental framework and . . . the cornerstone of judicial independence,"[132] "provid[es] a bulwark to defend the judiciary against unintentional, or intentional, encroachments on its power by [its] sister branches."[133] Accordingly, the Pennsylvania Supreme Court found unconstitutional a statute that restricted the court's power to punish indirect criminal contempt by imposing a maximum fine and sentence length.[134] Similarly, California and Kentucky courts have declared unconstitutional statutes that materially limit courts' contempt power.[135] Maryland also prohibits the legislature from abridging or limiting judicial power through statutory enactments.[136] In Ohio, trial courts view statutory limits on courts' contempt penalties as mere permissive "guideline[s]" because the legislature, as a coequal branch of government, lacks the power to abridge courts' contempt power.[137]

Finally, even if states permit legislative abridgment of courts' inherent contempt power, this prohibition may not meaningfully decrease POC laws' coercive force. Precedent suggests that, *even in states with specific statutory prohibitions*, a person may be held in contempt for POC-related conduct.[138] Moreover, removing courts' contempt power does not preclude the possibility of forcible medication. POC statutes in Florida, Kentucky, Louisiana, Maryland, New York, Ohio, Oklahoma, and Pennsylvania prohibit using noncompliance with ordered treatment as grounds for contempt penalties but do not clearly address the availability of forcible medication.[139] As the next

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[131] *See* Wagner v. Wagner, 564 A.2d 162, 164 (Pa. Super. 1989); Renner v. Ct. of Com. Pleas of Lehigh Cnty., 234 A.3d 411, 419 (Pa. 2020) ("to 'avert the danger inherent in the concentration of power in any single branch or body,' no branch may exercise the functions delegated to another branch").

[132] *Renner*, 234 A.3d at 419.

[133] *Id.*

[134] *See* Com. v. McMullen, 961 A.2d 842, 850 (Pa. 2008).

[135] *See In re San Francisco Chron.*, 36 P.2d 369 (Cal. 1934) (voiding a statute limiting the court's power to punish constructive contempts and declaring that legislatures may "provide for the procedure by which such contempt shall be tried and punished" but cannot "affect the power of the courts to punish for contempt"); *Arnett*, 462 S.W.2d at 946-48 (holding that limits of fines and imprisonment length were unconstitutional restrictions of the court's contempt power); Woods v. Com., 712 S.W.2d 363, 365 (Ky. Ct. App. 1986) (holding that a statute limiting incarceration for uncooperative witnesses unconstitutionally interfered with the court's contempt power).

[136] *In re Lee*, 183 A. 560, 561-62 (Md. 1936) ("The power and authority to punish contempts is one of common-law origin and has existed in courts of law and equity since ancient times. . . . The power and authority possessed by courts may not be destroyed or abridged by legislative enactment."). However, statutes can set procedural requirements for contempt proceedings. *See* Usiak v. State, 993 A.2d 39, 45 (Md. 2010).

[137] *State ex rel. Yost v. Crossridge, Inc.*, 188 N.E.3d 629, 639 (Ohio App. 7th Dist. 2022); *see* McDaniel v. McDaniel, 599 N.E.2d 758, 759 (Ohio App. 8th Dist. 1991) (observing that "a court may, pursuant to its inherent powers, punish a contemptuous refusal to comply with its orders, without regard to the statutory penalties" set forth); *Scarnecchia v. Rebhan*, 2006-Ohio-7053, ¶ 44 ("If the legislature were able to limit the sanctions a court could impose for contempt, then the legislature would effectively control the court's contempt powers and potentially prevent the court from being able to fashion a punishment that will induce the contemnor to remedy the contempt involved.").

[138] *See In re T.S.*, 32 So. 3d 1026, 1028-29 (La. Ct. App. 2d Cir. 2010) (indicating that a person could be found guilty of constructive contempt for a failure to comply with treatment orders and to appear in response to noncompliance); Johnston & Klein, *supra* note 1, at 18 (discussing this case).

[139] *Cf.* 50 Pa. Cons. Stat. § 7304(e)(8)(3) (permitting a *recommended* treatment plan to specify "whether such medication should be . . . administered by a specified provider" but disallowing any *recommendation* to use "physical force or restraints to administer medication to the person"). Florida has a later, more broadly applicable statutory provision governing informed consent. *See* FLA. STAT. ANN. § 394.459(3)(a)(1).

section documents, statutory language often suggests that noncompliance with medication directives may be met with physical force.

3. Availability of forcible medication

While most POC statutes do not explicitly authorize forcible medication,[140] many imply such authority.[141] Most POC statutes expressly permit courts to order medication,[142] but fewer than half (5/17) make clear they are not creating new forcible medication authority.[143] Furthermore, statutory language often suggests forcible administration is permissible. Several states authorize courts to "order the patient to self-administer psychotropic drugs or accept the administration of such drugs by authorized personnel as part of [a POC] program."[144] Nearly half of these statutes do not explicitly prohibit forcible medication.[145] Notably, New York and Louisiana authorize periodic blood tests or urinalysis to confirm medication compliance, reinforcing the impression that medication may be compelled.[146]

Accordingly, at least one court has equated the compulsive force of a court order to "self-administer psychotropic drugs or accept the administration of such drugs by an authorized professional" with a forcible medication order.[147] A New Mexico appellate court rejected an argument differentiating the two, stressing that "the [POC] [o]rdinance allows a court to order a subject with capacity to comply with a treatment plan, which can include taking medication, to which [they do] not consent," while, conversely, "the [civil] [c]ode prohibits the administration of medication absent consent except where the individual lacks capacity."[148] Therefore, the ordinance and code are "in conflict and cannot be harmonized."[149] Crucially, the court recognized the coercive nature of the court order itself compels the nonconsensual uptake of medication, regardless of the availability of sanctions for noncompliance.[150]

C. State Interests

State action infringing on individuals' substantive due process interests requires a sufficiently compelling justification. In both the involuntary commitment and forcible treatment contexts, these interests include providing necessary care under states' *parens patriae* authority

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[140] *But see* MONT. CODE ANN. § 53-21-127(6) (permitting a court to authorize a physician "to administer appropriate medication involuntarily if the court finds that involuntary medication is necessary . . . to facilitate effective treatment"); Johnston & Klein, *supra* note 1, at X (discussing the operation of this statute).

[141] *See* Johnston & Klein, *supra* note 1.

[142] *See id.* at 19-20 (listing seventeen states).

[143] *See id.* at 19 (listing five states).

[144] 43A OKLA. STAT. ANN. § 5-416(K); *see* NEV. REV. STAT. ANN. § 433A.343(4); N.M. STAT. ANN. § 43-1B-7(C); LA. STAT. ANN. § 28:71(D); *id.* § 28:70(A); N.Y. MENTAL HYG. LAW § 9.60(j)(4); N.C. GEN. STAT. ANN. § 122C-273(a); PA. STAT. ANN. tit. 50, § 7304(e)(8)(iii).

[145] *See* 43A OKLA. STAT. ANN. § 5-416(K); LA. STAT. ANN. § 28:71(D); *id.* § 28:70(A); N.Y. MENTAL HYG. LAW § 9.60(i), (j)(4).

[146] *See* LA. STAT. ANN. § 28:70(C)(2)(c); N.Y. MENTAL HYG. LAW § 9.60(a)(1).

[147] *Protec. & Advoc. Sys.*, 195 P.3d at 18 (quoting N.M. STAT. ANN. § 43-1-15(A)).

[148] *Id.* at 20.

[149] *Id.*

[150] *Id.* at 21.

and protecting the community from danger under their police power.[151] POC squarely serves the *parens patriae* interest of providing necessary care and treatment, while often including diluted dangerousness requirements implicating police power interests.[152] The *parens patriae* doctrine appears to be the superior justification, given its emphasis on preventing deterioration before individuals become dangerous.[153]

1. Police power

The state employs its police power to protect society against potentially dangerous acts.[154] States' police power to involuntarily commit or treat an individual depends on the danger the individual poses and the extent of the exacted deprivations.[155] "[T]he necessity which creates the law, creates the limitation of the law;"[156] thus, while public safety may require restraining liberty, chosen means must be reasonably necessary and not unduly oppressive.[157] Although the police power interest alone may not justify curtailing the liberties of those who only endanger themselves,[158] the Supreme Court has acknowledged states' interest in preventing self-harm as part of their mission to ensure public safety.[159] The state's police power may only justify POC when the magnitude of the individual's threat—a product of the nature and severity of anticipated harm and the probability of its occurrence—exceeds the liberty deprivations effected by state interference.[160]

2. Parens patriae

Under its *parens patriae* authority, the state serves as guardian for disabled citizens who cannot act in their best interests.[161] Since the late thirteenth century, the English Crown claimed

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[151] *See Addington*, 441 U.S. at 426 ("The state has a legitimate interest under its parens patriae powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill.").

[152] *See In re Dennis H.*, 647 N.W.2d at 862-63; *State v. Brungard*, 789 P.2d 683, 687 (Or. Ct. App. 1990); Schopp, *supra* note 19, at 37-38, 41; Schopp, *supra* note 18, at 349-51 (exploring the dangers inherent in statutes with blended justification).

[153] *See* AM. PSYCHIATRIC ASSN. TASK FORCE ON INVOLUNTARY OUTPATIENT COMMITMENT, INVOLUNTARY COMMITMENT TO OUTPATIENT TREATMENT 6 (1987).

[154] *Lessard*, 349 F. Supp. at 1084.

[155] *In re Torski C.*, 918 N.E.2d at 1229-30.

[156] *In re Oakes*, 8 Law Rep. 123, 125 (Mass. 1845).

[157] Goldblatt v. Town of Hempstead, N. Y., 369 U.S. 590, 595 (1962) (outlining limits on exercising police power).

[158] *Lessard*, 349 F. Supp. at 1085 (noting that dangerousness to self became a possible basis for commitment only through the *parens patriae* powers).

[159] *See Humphrey*, 405 U.S. at 509 (stating in the context of civil commitment for sexually violent offenders that the same societal interest that allows commitment based on harm to others is found in commitment based on harm to self).

[160] *See supra* note 155; *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1236-45 (1974) (discussing these requirements and their complications).

[161] *See* Hawaii v. Standard Oil Company of California, 405 U.S. 251, 257 (1972); State ex rel. Hawks v. Lazaro, 202 S.E.2d 109, 117-20 (W. Va. 1974).

guardianship over those who could not care for themselves due to severe mental illness or intellectual disability.[162] Pursuant to this duty, the monarch or their representative acted to promote wards' best interests.[163] Following American independence, this power vested in state legislatures, which often entrusted *parens patriae* responsibilities to state courts.[164] Since at least 1885, courts and legislatures have used their *parens patriae* power to involuntarily commit individuals with mental illnesses.[165] States draw upon their *parens patriae* authority when involuntarily treating or committing individuals with mental illnesses who are unable to make rational treatment decisions or "survive safely" in the community without supervised treatment.[166]

Critically, logic and doctrine require individuals be incapable of advancing their best interests before the state exercises *parens patriae* authority to act on their behalf.[167] Under the *parens patriae* doctrine, the state substitutes its judgment for the patient's, ostensibly for the patient's betterment. Absent treatment decision-making incapacity "the very justification for the state's purported exercise of its *parens patriae* power—its citizen's inability to care for himself—. . . would be missing."[168] Furthermore, the state's *parens patriae* goal of maintaining the wellbeing of its citizens is best realized by respecting a competent patient's treatment choice, for it is the informed individual—not the state—who is best positioned to weigh a treatment's risks and benefits within the context of the individual's lived experience and decide where their best interests lie.[169]

Historically, legislatures and courts have treated serious mental illness as synonymous with mental incapacity, including in the context of mental health care.[170] The presumed incompetence of individuals with serious mental illnesses remains widespread,[171] even among treating

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[162] *Developments, supra* note 160, at 1207-08; Lawrence B. Custer, *The Origins of the Doctrine of Parens Patriae*, 27 EMORY L.J. 195, 195 (1978).

[163] *Developments, supra* note 160, at 1208.

[164] *Id.* at 1208. *See, e.g., In re Barker*, 2 Johns. Ch. 232, 233 (N.Y. Ch. 1816) ("The Court of Chancery is the constitutional and appropriate tribunal to take care of those who are incompetent to take care of themselves. There would be a deplorable failure of justice, without such a power.").

[165] *See In re Oakes*, 8 Law Rep. 122; *The "Crime of Mental Illness: Extension of "Criminal" Procedural Safeguards to Involuntary Civil Commitments*, 66 J. CRIM. L. & CRIMINOLOGY 255, 255 n.2 (1975).

[166] John Q. La Fond, *An Examination of the Purposes of Involuntary Civil Commitment*, 30 BUFF. L. REV. 499, 504 (1981); *infra* notes 167-168.

[167] *See Developments*, *supra* note 160, at 1208-09, 1212; *Colyar*, 469 F. Supp. at 434 (holding that a statute authorizing involuntary commitment under the *parens patriae* power requires, as a precondition, a finding that the proposed patient lacks treatment decision-making capacity).

[168] Rogers v. Okin, 634 F.2d 650, 657 (1st Cir. 1980); *see In re Torski C.*, 918 N.E.2d at 1228; Stephen J. Morse, *A Preference for Liberty: The Case against Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54, 64 (1982).

[169] *Charters*, 829 F.2d at 494–95.

[170] *See* John Kip Cornwell, *Understanding the Role of the Police and Parens Patriae Powers in Involuntary Civil Commitment Before and After Hendricks*, 4 PSYCH. PUB. POL'Y & L. 377, 382 (1998) (criticizing civil commitment statutes that "relied entirely on standards that conflates mental illness, either explicitly or implicitly, with the predicate need-for-treatment requirement" and noting others' objection of "vagueness and circularity, charges that may be fairly leveled as well against modern statutes whose definitions likewise suffer from inherent ambiguity"); *infra* note 171.

[171] *See* George Szmukler & Brendan D. Kelly, *We Should Replace Conventional Mental Health Law with Capacity-Based Law*, 209 BRITISH J. PSYCHIATRY 449, 449 (2016) (Szmukler: "There is an underlying assumption in mental health legislation that 'mental disorder' necessarily entails mental incapacity, and that the wishes and preferences of a person with a 'disordered mind' are not a reliable guide to where their best interests lie.").

physicians.[172] The common equation of serious mental illness with incapacity reflects a frequent hallmark of serious mental illness: anosognosia. Anosognosia is the lack of insight into one's illness, the pathological source of one's symptoms, or one's need for treatment.[173] Researchers estimate that 40% of individuals with bipolar disorder and 57–98% of individuals with schizophrenia have partial or no insight into those matters.[174]

However, accumulated empirical evidence demonstrates that presuming treatment decision-making incapacity from the common feature of anosognosia is unfounded. A 2020 meta-review evaluating treatment decision-making ability in individuals with mental disorders found consensus: most individuals with severe mental disabilities retain the capacity to make rational, informed treatment decisions.[175] Severe mental illness does not necessarily—or even usually—negate one's ability to make intricate risk-reward or treatment decisions.[176] Likewise, treatment abstinence need not be—nor is likely—uninformed or irrational.[177]

Rather, treatment refusal often stems from sound reasons, including a preference to avoid the well-known, serious side effects associated with certain medications.[178] Antipsychotic medications in particular are associated with substantial, long-lasting side effects including sexual side effects, diabetes mellitus, and movement disorders.[179] Even newer antipsychotic medications commonly cause weight gain, lethargy, lack of coordination, and muscle problems such as tenderness, twitches, and tremors.[180] Antipsychotic medications are ineffective for about one

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[172] *See* Dilip V. Jeste et al., *Magnitude of Impairment in Decisional Capacity in People with Schizophrenia Compared to Normal Subjects: An Overview*, 32 SCHIZOPHRENIA BULL. 121, 122 (2006) ("Based on the National Bioethics Advisory Commission report and surveys of clinicians, there appears to be an existing bias that assumes almost everyone with schizophrenia has impaired decisional capacity, whereas nonpsychiatric comparison subjects are not impaired.").

[173] *See* Anthony S. David, *Insight and Psychosis*, 156 BRITISH J. PSYCHIATRY 798, 805 (1990) (proposing three distinct, overlapping dimensions of insight).

[174] *See* Douglas S. Lehrer & Jennifer Lorenz, *Anosognosia in Schizophrenia: Hidden in Plain Sight*, 11 INNOVATIONS CLINICAL NEUROSCIENCE 10, 11 (2014); Shmuel Fennig et al., *Insight in First-Admission Psychotic Patients*, 22 SCHIZOPHRENIA RSCH. 257, 259–60 (1996); *Agnosia*, CLEVELAND CLINIC, https://my.clevelandclinic.org/health/diseases/22832-anosognosia (last updated Apr. 21, 2022) [https://perma.cc/8K36-4GJ9].

[175] A. Calcedo-Barba et al., *A Meta-Review of Literature Reviews Assessing the Capacity of Patients with Severe Mental Disorders to Make Decisions about their Healthcare*, 20 BMC PSYCHIATRY 1, 12 (2020) ("Authors across studies are coincident in emphasizing that most patients with a severe mental disorder are able to make rational decisions about their medical care and to participate in decision-making regarding treatments despite temporal impairments.").

[176] *Id.*

[177] Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945, 990–91 (1990).

[178] *See* BARBARA A. WEINER & ROBERT M. WETTSTEIN, LEGAL ISSUES IN MENTAL HEALTH CARE 131 (1993) (identifying categories of reasons for refusal of psychotropic medication).

[179] *See, e.g.*, Alp Ucok & Wolfgang Gaebel, *Side Effects of Atypical Antipsychotics: A Brief Overview*, 7 WORLD PSYCHIATRY 58, 58-62 (2008); John R. Hayes, Sell v. United States: *Is Competency Enough to Forcibly Medicate A Criminal Defendant?*, 94 J. CRIM. L. & CRIMINOLOGY 657, 658-59 (2004). Numerous cases have recognized the severe side effects of antipsychotic medications. *See, e.g.*, *Harper*, 494 U.S. at 239-41 & n.4 (Stevens, J., concurring in part); *Riggins*, 504 U.S. at 134.

[180] *See* Elisa Cascade et al., *Real-world Data on Atypical Antipsychotic Medication Side Effects*, 7 PSYCHIATRY 9, 9-12 (2010) (reporting that 54% of 353 respondents taking at least one atypical antipsychotic medication experienced a side effect).

quarter of patients with schizophrenia,[181] and "on average the acute efficacy of antipsychotics is modest."[182] Thus, the risk/benefit calculus for a particular patient is often difficult and uncertain. Outpatient treatment may also be incompatible with an individual's life commitments.[183]

Given the scientific consensus that most individuals with serious mental disorders retain treatment decision-making capacity, compulsory treatment under the state's *parens patriae* power requires finding that the individual lacks that particular capacity in a given case.[184] Courts differ on necessary standards for incapacity or incompetence,[185] but statutory criteria designed to ensure treatment decision-making incapacity should focus on individuals' decision-making processes—not the decisions reached—since individuals' values and priorities may differ from those of evaluators or courts.[186] As one state supreme court ruled, statutes "must leave room for the individual who would rather remain free of therapeutic intervention even though that freedom is obtained at the price of diminished functional capacity."[187]

In addition to treatment decision-making incapacity, a valid exercise of *parens patriae* authority requires a demonstrable threat of harm to the individual absent treatment.[188] The scope of harm for substantive due process purposes—specifically, whether a finding of mental illness

[181] Boldt, *supra* note 12, at 82.

[182] Peter M. Haddad & Christoph U. Correll, *The Acute Efficacy of Antipsychotics in Schizophrenia: A Review of Recent Meta-analyses*, 8 THERAPEUTIC ADVANCES IN PSYCHOPHARMACOLOGY 303, 316 (2018).

[183] Player, *supra* note 15, at 210.

[184] *See In re Torski C.*, 918 N.E.2d at 1228 ("To satisfy due process, it is understood that the State's powers cannot be extended to those individuals capable of making their own treatment decisions. The State has no interest or authority to assert is *parens patriae* power over those who can protect themselves."); *Colyar*, 469 F. Supp. at 434; Winters v. Miller, 446 F.2d 65, 71 (2d Cir.); *Developments*, *supra* note 160, at 1213.

[185] *See* Boldt, *supra* note 12, 71-76 (outlining states' varying incapacity requirements for involuntary medication); Jessica Wilen Berg, J.D. et. al., *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 RUTGERS L. REV. 345, 351-62 (1996) (surveying state standards and discussing how courts understand the four principle components of competence standards: (i) ability to communicate a choice, (ii) ability to understand relevant information, (iii) ability to appreciate the nature of the situation and its likely consequences, and (iv) ability to manipulate information rationally). Scholars and other commentators have debated which components should be necessary for legal competence to refuse treatment. *See, e.g.*, Saks, *supra* note 177; CHRISTOPHER SLOBOGIN, MINDING JUSTICE: LAWS THAT DEPRIVE PEOPLE WITH MENTAL DISABILITY OF LIFE AND LIBERTY 233-35 (2006) (proposing a "basic rationality and self-regard" standard); Dora W. Klein, *When Coercion Lacks Care: Competency to Make Medical Treatment Decisions and Parens Patriae Civil Commitments*, 45 U. MICH. J.L. REFORM 561, 585 (2012).

[186] *See Colyar*, 469 F. Supp. at 434; *Rivers*, 495 N.E.2d at 342.

[187] *Colyar*, 469 F. Supp. at 434.

[188] *See* Lynch v. Baxley, 386 F. Supp. 378, 390 (M.D. Ala. 1974); *Lessard*, 349 F. Supp. at 1093; *B.A.A.*, 421 N.W.2d at 123-24 (recognizing that "commit[ting] an individual solely because treatment is in the person's best interest under the *parens patriae* doctrine" violates due process; "[t]here must also be a likelihood that the individual constitutes a danger to himself or others, a reflection of the police power doctrine"); Doremus v. Farrell, 407 F. Supp. 509, 514 (D. Neb. 1975) ("Considering the fundamental rights involved in civil commitment, the *parens patriae* power must require a compelling interest of the state to justify the deprivation of liberty . . . [T]he need for treatment without some degree of imminent harm to the person or dangerousness to society is not a compelling justification."); *infra* notes 268-285 (involuntary treatment), 303 (*Humphrey*).

paired with a "need for treatment" satisfies this requirement—has long been contentious.[189] This controversy likely influences decisions regarding the constitutionality of POC statutes.

II. Gleaning Constitutional Standards for Preventive Outpatient Commitment

POC statutes have existed since at least 1983,[190] yet only New York's Kendra's Law has undergone significant constitutional scrutiny. Cases examining this law focused on the right to refuse treatment.[191] The federal court applied the Supreme Court's test for justifying forcible treatment developed in *Washington v. Harper* and its progeny.[192] In contrast, the state court acknowledged the right to refuse treatment was implicated but—emphasizing that *forcible* treatment was neither authorized nor a consequence of noncompliance—drew upon the involuntary inpatient commitment case law in simply balancing the "minimal" restriction of the individual's freedom effected by a court order against the state's police power and *parens patriae* interests.[193]

Both *Coleman*'s and *In re K.L.*'s analyses are deficient,[194] yet they highlight that POC stands between two bodies of case law: that governing forcible treatment and that of inpatient civil commitment. POC's constitutionality depends on a framework drawing from both. Although POC does not usually authorize physically forcible treatment, medication orders often may be enforced though the threat of incarceration for noncompliance. And, while POC does not authorize inpatient confinement, the aggregate of ordered conditions may amount to constructive confinement and be similarly onerous. Meanwhile, states' interests remain consistent: protecting the community from harm and providing necessary treatment. Together, case law establishing the constitutional parameters of involuntary treatment and inpatient commitment to prevent deterioration suggests a framework for determining the weight of states' interests needed to justify POC. The Parts below analyze parallel doctrines from each body of case law separately before synthesizing them into a constitutional framework for POC in Part III.

A. The Right to Refuse Treatment

One way to assess the constitutionality of POC laws is through the lens of involuntary medication.[195] POC typically requires an individual to adhere to a treatment plan that includes medication.[196] In most states, courts can hold noncompliant individuals in contempt.[197] Submitting to court-ordered medication under threat of incarceration certainly qualifies as involuntary

[189] *See Lessard*, 349 F. Supp. at 1084-90, 1093-94 (exploring the history of civil commitment and the dangers in allowing commitment absent dangerousness).

[190] Stefan, *supra* note 19, at 288.

[191] *See In re K.L.*, 806 N.E.2d at 484-86; *Coleman*, 697 F. Supp. 2d at 508-09.

[192] *Coleman*, 697 F. Supp. 2d at 506-09.

[193] *See In re K.L.*, 806 N.E.2d at 485-86 (quoting *Addington*, 441 U.S. at 426).

[194] *See infra* notes 469-477.

[195] *See* State v. Kotis, 984 P.2d 78, 90 n.14 (Haw. 1999) (construing a POC statute's language of "medication specifically authorized by court order" as equivalent to authorizing "involuntary medication of a patient on an outpatient basis").

[196] *See supra* notes 4 & 63.

[197] *See supra* Part I.B.2.

treatment, even if few states explicitly authorize forcible administration.[198] When reviewing antipsychotic medication as a condition of supervised release, federal courts have recognized that, while "[u]se of physical force to administer unwanted drugs is more intrusive, certainly, than coercing ingestion through the threat of incarceration," both constitute involuntary treatment.[199] The Supreme Court has affirmed that "a court order [to take medication] . . . backed by the contempt power" qualifies as involuntary medication, although it is a "less intrusive means" than using physical force.[200]

Given *Cruzan*'s imprimatur of settled case law precepts,[201] "a competent adult has a virtually absolute right to make decisions concerning [their] care, even at serious risk to that person's life or health."[202] Courts have identified four potentially countervailing state interests that may limit a patient's choice to decline treatment: "the preservation of life, the protection of the interests of innocent third parties, the prevention of suicide, and the maintenance of the ethical integrity of the medical profession."[203] Courts recognize that medical ethics rarely require overruling patient autonomy.[204] One state supreme court has cautioned, "[I]f the patient's right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the values of the medical profession as a whole."[205] Courts have also stressed that, while states have substantial interest in protecting public safety, states' "interest is relatively low when the acts of one individual do not injure others or impact the public at large."[206] "This is consistent with the primary function of the state to preserve and promote liberty and the personal autonomy of the individual."[207] Therefore, "[o]n balance, the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death."[208]

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[198] *See supra* note 140 (Montana). U.S. Supreme Court case law appears to treat "forced," "compelled" and "unwanted" medication as involuntary. *See Riggins*, 504 U.S. at 133 (using allegations of "unwanted," "over objection," "compelled," and "forced" treatment as evidence of "involuntary" treatment).

[199] United States v. Williams, 356 F.3d 1045, 1053 n.10 & 1055 (9th Cir. 2004); *see id.* at 1055 ("Replacing Williams' incarceration with a court-backed threat of renewed incarceration should he violate an order to take prescribed psychotropic medication does not eliminate the coercive nature of the medication requirement or otherwise lessen the impairment of the recognized liberty interest in being free of unwanted antipsychotic medication."); Felce v. Fiedler, 974 F.2d 1484, 1494-95 (7th Cir. 1992) (finding that a parolee has a liberty interest in being free from the involuntary use of antipsychotic drugs and this interest "is essentially the same as that recognized for those incarcerated in an institutional setting").

[200] *Williams*, 356 F.3d at 1053 n.10 (quoting *Sell*, 123 S.Ct. at 2185).

[201] *See supra* notes 38-41 (*Cruzan*).

[202] CLAIRE C. OBADE, COMPETENT ADULT, PATIENT CARE DECISION-MAKING: A LEGAL GUIDE FOR PROVIDERS § 8:11 (Apr. 20210) (West) (collecting sources); *see* Boldt, *supra* note 12, at 61 ("[T]he law generally assumes that adult patients who have not been adjudicated incompetent retain the capacity to grant or withhold consent to treatment, even if their 'clinical competence' has been compromised by significant mental illness or other mental disability, and even if they have been involuntarily hospitalized following a civil commitment hearing."); *infra* note 267 (legal incompetence and clinical incapacity).

[203] *Cruzan*, 497 U.S. at 271.

[204] *Saikewicz*, 370 N.E.2d at 426–27.

[205] *In re Conroy*, 486 A.2d 1209, 1225 (N.J. 1985).

[206] *In re Duran*, 769 A.2d 497, 504 (Pa. Super. 2001).

[207] See Fosmire v. Nicoleau, 551 N.E.2d 77, 82 (N.Y. 1990).

[208] *In re Conroy*, 486 A.2d at 1225.

On multiple occasions, the Supreme Court has recognized that individuals with serious mental illnesses have a qualified liberty interest in refusing antipsychotic medications.[209] In *Harper*, the Court held that, "given the requirements of the prison environment, the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest."[210] The language "is dangerous" signals the requirement of *current* dangerousness.[211] Crucially, the policy upheld in *Harper* authorized involuntary treatment if the prisoner "suffers from a 'mental disorder'" and "poses a 'likelihood of serious harm' to himself, others, or their property."[212] In the policy, "likelihood of serious harm" required a *substantial risk* of physical harm, supported by certain, specified evidence.[213] The feared harm need not be imminent.[214]

The *Harper* Court repeatedly emphasized its holding was specific to the unique environment of prisons,[215] where state officials must ensure the safety of prison staff, other prisoners, and the inmate.[216] Reasoning that state hospitals operate under similar conditions and have analogous interests, lower courts have applied the *Harper* standard to the forcible treatment of involuntarily hospitalized patients.[217] The Supreme Court has "assumed" that involuntarily hospitalized patients retain the right to refuse treatment.[218]

Cases involving forcibly treating individuals *living in the community* are distinguishable from those involving institutional settings.[219] While the interests of the individual and the state in

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[209] *See Harper*, 494 U.S. at 227; *Riggins*, 504 U.S. 127; *Sell*, 539 U.S. 166.

[210] *Harper*, 494 U.S. at 227.

[211] *See, e.g.*, *Kotis*, 984 P.2d at 93 (requiring the individual "actually poses a danger of physical harm to himself or herself or others" and "the treatment is essential to forestall the danger"); Dept. of Health and Mental Hygiene v. Kelly, 918 A.2d 470, 489–90 (Md. 2007) ("Obviously, the danger alluded to in the Washington policy [in *Harper*] was that which is current, or manifest in the institution."); United States v. Berry, 911 F.3d 354, 365 (6th Cir. 2018) (finding that "the uncontested evidence that in his current setting he poses no appreciable risk to himself or others undercuts the governmental interest necessary to medicate him" under *Harper*).

[212] *Harper*, 494 U.S. at 215.

[213] *See id.* at 215 n.3 (defining key terms).

[214] *See id.*

[215] *See id.* at 222 ("The extent of a prisoner's right . . . to avoid the unwanted administration of antipsychotic drugs must be defined in the context of the inmate's confinement."); *id.* at 225 ("[t]here are few cases in which the State's interest in combating the danger posed by a person to both himself and others is greater than in a prison environment").

[216] *Id.* at 225-26.

[217] *See, e.g.,* Morgan v. Rabun, 128 F.3d 694, 697 (8th Cir. 1997); Disability Rights New Jersey, Inc. v. Velez, 974 F. Supp. 2d 705, 724 (D.N.J. 2013); Williams v Wilzack, 573 A.2d 809, 820 (Md. 1990).

[218] *Mills*, 457 U.S. at 303.

[219] Institutional contexts heighten states' interests in preserving security and maintaining order, and the balancing of individual against state interests reflects these institutional concerns. *See supra* notes 210-217. On the other hand, institutionalized individuals typically do not present a danger to the general public. *See In re K. K. B.*, 609 P.2d at 751. Thus these cases almost exclusively discuss necessary dangerousness in terms of an emergency exception. It may be that—because the person is already confined—seclusion, increased monitoring, placement on a more secure floor, or other options relating to housing and supervision are typically available to mitigate less acute threats. In the community, these options are not available. However, in the arguably analogous context of prison version probation, courts have found that "the basic responsibility of the state to the inmate and those around him remains constant despite the change in the degree of physical custody"—i.e., the state's responsibility does not *increase* upon the prisoner's release into the community. *Felce*, 974 F.2d at 1495. Moreover, the state could always initiate inpatient

POC often parallel those in institutional settings, the state's interests in security, order, and treatment are significantly stronger in institutional contexts compared to the community.[220] Meanwhile, individuals living freely in the community have, at a minimum, equally significant interests in bodily integrity, autonomy over deeply personal decisions, freedom of mentation, and protection from stigmatization and de facto confinement as those already deprived of their liberty. Indeed, at least one court has found that an individual's "interest in avoiding . . . an invasion of his bodily integrity can only be *greater* when a court of law has already declared him fit to return to life in the community."[221] Therefore, the threshold for state intervention should be higher outside institutions.[222] On the other hand, involuntary treatment enforced through threat of incarceration is less intrusive than forcible medication. Because both enforcement measures are extremely coercive, however, it is unclear how this distinction should affect the balance of interests.

Outside the institutional context, the Supreme Court holds that imposing unwanted medication requires a "compelling," "overriding," or "essential" state interest.[223] The Court established in *Riggins v. Nevada* that "forcing antipsychotic drugs" on an individual "*at least*" is impermissible "absent a finding of overriding justification and a determination of medical appropriateness."[224] In contrast, due process "certainly" permits involuntary medication if "treatment with antipsychotic medication [is] medically appropriate and, considering less intrusive alternatives, essential for the sake of [the individual's] own safety or the safety of others."[225] In *Sell v. United States*, the Court affirmed that "an individual has a constitutionally protected liberty 'interest in avoiding involuntary administration of antipsychotic drugs'—an interest that only an 'essential' or 'overriding' state interest might overcome."[226]

As *Coleman* recognized,[227] the constitutionality of POC depends on whether involuntary treatment is medically appropriate and, "considering less intrusive alternatives, essential for the sake of [the individual's] own safety or the safety of others."[228] This balancing of interests should

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commitment proceedings if warranted to protect the community from danger. *See* Disability Rights New Jersey, Inc. v. Commr., New Jersey Dept. of Human Services, 796 F.3d 293, 310 (3d Cir. 2015) (ruling that, "[i]f a patient actually remains so dangerous as to require long-term, nonemergent forcible medication, the appropriate course for the State is to recommit the patient through normal judicial channels").

[220] *See supra* note 219.

[221] *Disability Rights New Jersey*, 796 F.3d at 309.

[222] *See* Winick, *supra* note 8, at 114 ("Evolving legal principles would seem to require that involuntary psychotropic medication [authorized by POC] be permitted only in the presence of compelling necessity, with the exception of medication administered within a prison, for which a somewhat lesser standard would need to be satisfied.").

[223] *Riggins*, 504 U.S. at 135-36; *Sell*, 539 U.S. at 178-79.

[224] *Riggins*, 504 U.S. at 135 (emphasis added).

[225] *Id.*

[226] *Sell*, 539 U.S. at 178-79. In imposing these substantive due process standards, *Riggins* and *Sell* appeared to relegate the "professional judgment" standard of *Youngberg v. Romeo* to the realm of procedural due process, at least for statutes motivated by police power interests and applicable to competent individuals. *See* Youngberg v. Romeo, 457 U.S. 307, 320-24 (1982); *see infra* notes 228, 235. Some courts have held that *Harper*'s substantive due process requirements also eclipsed the *Youngberg* standard in the context of persons incompetent to refuse medication. *See* Enis v. Dept. of Health and Soc. Resources of the State of Wis., 962 F. Supp. 1192, 1201 (W.D. Wis. 1996).

[227] *See infra* notes 409-411, 476-477 (*Coleman*).

[228] *Riggins*, 504 U.S. at 135. Alternatively, to judge the constitutionality of a *parens patriae* statute, courts could look to the pre-*Harper* case of *Youngberg*, which involved a civilly committed, developmentally disabled man with

reflect the general background rule—under settled common law and now the Constitution—that competent adults may refuse even life-saving treatment.[229]

Several POC statutes clearly violate *Riggins* by failing to ensure that compelled treatment is "medically appropriate" and the "least restrictive alternative" for achieving the state's goals. In particular, Alabama's POC statute does not guarantee that medication is either medically appropriate or the least intrusive means to achieve state ends.[230] Similarly, Nevada's statute falls short in ensuring medication is medically appropriate.[231] Although Oregon's statute likely meets the least intrusive means requirement by targeting only those at high risk of involuntary hospitalization,[232] it does not ensure the treatment's medical appropriateness.[233]

A more complex analysis is whether a POC statute satisfies *Riggins*'s requirement that involuntary treatment serve an "essential" or "compelling" state interest.[234] The specific statutory elements necessary to ensure the crucial nature of the state's interest depend on whether the state aims to prevent future harm or improve individuals' health.

1. Police power

Involuntary medication cases—mostly occurring in institutional settings with heightened interests in security, order, and treatment—strongly suggest that POC statutes designed to prevent harm must include stringent standards of dangerousness to satisfy substantive due process.[235] *Riggins* allows involuntary medication if "essential for the sake of [the individual's] safety or the safety of others,"[236] while *Sell* further stresses that "only an 'essential' or 'overriding' state interest" justifies such treatment.[237] These cases establish that compelled treatment must be *crucial* to addressing an *essential* safety concern, with the "overriding" or "essential" nature of the interest

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the mental capacity of an 18-month-old child. *See Youngberg*, 457 U.S. at 309. After recognizing Romeo's liberty interests in personal safety and freedom from bodily restraint, the Court held that Romeo was entitled only to assurance that "professional judgment in fact was exercised" in deciding the care and protective conditions he would receive. *Id.* at 321-22. If a court were to apply *Youngberg*'s highly deferential, substantive due process test to a POC statute, the statute may pass constitutional muster if, in the exercise of professional judgment, involuntary treatment were limited to individuals lacking treatment decision-making capacity for whom treatment is in their best interests. However, a clearer, cleaner approach would be to subject all POC statutes—regardless of the state's underlying, animating aims—to the substantive due process requirements of *Riggins*, whose broad contours seem to encompass forcible medication for police power or *parens patriae* interests, or both.

[229] *See supra* notes 202, 208.

[230] *See* ALA. CODE §§ 22-52-10.2, 22-52-10.3(c).

[231] *See* NEV. REV. STAT. § 433A.335(4).

[232] *See* OR. REV. STAT. § 426.133(2).

[233] *See id.* § 426.133(4).

[234] *Riggins*, 504 U.S. at 135.

[235] A line of cases—nearly all federal cases prior to *Harper*—followed *Youngberg*, holding that although the forcible administration of antipsychotic medication to an involuntarily committed psychiatric patient implicates a constitutionally protected liberty interest, "due process considerations may be satisfied if professional medical judgment is exercised in making the determination to override the patient's refusal." *Wilzack*, 573 A.2d at 813 (listing representative cases); *see supra* note 226 (discussing the current status of *Youngberg*).

[236] *Riggins*, 504 U.S. at 135.

[237] *Sell*, 539 U.S. at 178-79.

indicating the high level of danger required. A minimal, speculative, or distant threat of minor harm cannot meet this standard.

Accordingly, courts typically interpret federal law to allow involuntary medication of competent *inpatient* psychiatric patients only when they present an immediate risk of substantial physical harm.[238] The California Supreme Court has warned that "a regime of forced medication based on a vague and generalized suspicion of dangerousness would likely violate the state, if not the federal, Constitution," while the forcible medication of a person who "*is a demonstrated danger* and . . . *was recently dangerous*" would be constitutionally justified.[239] In *Davis v. Hubbard*, a federal court advised that, due to the significant deprivation of liberty entailed by forcible medication, "the risk of danger which the State has a legitimate interest in protecting against must be sufficiently *grave and imminent* to permit their coerced use."[240] It therefore held the state must have "probable cause to believe that the patient is *presently violent or self-destructive* . . . and presents a *present danger* to himself, other patients or the institution's staff" to justify forced medication.[241] Similarly, other courts authorize forcible medication under federal law when a patient "poses an *immediate threat of physical harm*"[242] or when "a failure to [medicate] would result in a *substantial likelihood of physical harm* to that patient, other patients, or to staff members of the institution."[243] The Oklahoma Supreme Court and the Tenth Circuit restrict involuntary medication under the state's police power to "*emergencies*."[244] Courts have interpreted POC states' constitutional and common law requirements in like manner.[245]

Relevant to POC, courts have construed a pattern of serious, violent behavior clearly caused by mental disorder as satisfying *Harper*'s dangerousness standard. For example, in *United States v. Hardy*, the Second Circuit approved the forcible medication of a detainee whose "past conduct indicates that he poses a danger to others,"[246] where the detainee's "attempts to harm prison personnel resulted principally from his delusions that he is custody without reason."[247] The lower court emphasized that "Hardy's outbursts [were] not isolated incidents, but a pattern of

[238] *See* Boldt, *supra* note 12, at 84 ("most states restrict the involuntary administration of antipsychotic medications to patients who either pose an imminent threat of harm to self or others or who lack decision-making capacity").

[239] *In re Qawi*, 81 P.3d 224, 234-35 (Cal. 2004) (emphasis added).

[240] 506 F.Supp. 915, 935 (N.D.Oh.1980).

[241] *Id.* (emphasis added).

[242] *Matter of Orr*, 531 N.E.2d 64, 70–71 (Ill. App. 4th Dist. 1988) (emphasis added).

[243] Rogers v. Okin, 478 F. Supp. 1342, 1361 (D. Mass. 1979), aff'd in part, rev'd in part, 634 F.2d 650 (1st Cir. 1980), vacated sub nom. *Mills*, 457 U.S. 291 (emphasis added).

[244] *In re K. K. B.*, 609 P.2d at 751; Bee v. Greaves, 744 F.2d 1387, 1395 (10th Cir. 1984).

[245] *See* Steele v. Hamilton Cnty. Cmty. Mental Health Bd., 736 N.E.2d 10, 20-21 (Ohio 2000) (applying federal and Ohio constitutions in ruling that "[t]he state's right to invoke its police power . . . turns upon the determination that an emergency exists in which a failure to medicate a mentally ill person with antipsychotic drugs would result in a substantial likelihood of physical harm to that person or others" and stressing "[t]he requirement . . . [of] imminent danger of harm cannot be overemphasized"); *Rivers*, 495 N.E.2d at 343 (applying common law and state constitution in ruling that "[w]here the patient presents a danger to himself or other members of society . . . the State may be warranted, in the exercise of its police power, in administering antipsychotic medication over the patient's objections" especially in "an emergency situation, such as when there is imminent danger to a patient or others in the immediate vicinity."). State definitions of "emergency" vary. *See* Catherine E. Blackburn, *The "Therapeutic Orgy"' and the "Right to Rot"' Collide: The Right to Refuse Antipsychotic Drugs Under State Law*, 27 HOUS. L. REV. 447, 457 n.52 (1990).

[246] United States v. Hardy, 724 F.3d 280, 296 (2d Cir. 2013).

[247] *Id.* at 297.

violent behavior,"[248] which included lunging repeatedly at guards with shanks, attempting to bite an officer, and throwing irritating liquids in officers' eyes.[249] These events were all relatively recent, with one incident occurring six months before the court's decision and all occurring within the previous two years.[250] The lower court concluded that this history established Hardy's continuing danger to others because his psychosis, which continued to plague him and would not abate without pharmaceutical treatment,[251] drove his violent behavior.[252]

Several cases have considered when preventing deterioration may justify the forcible medication of confined individuals under federal and state constitutional law.[253] Some courts construe preventing deterioration primarily as a *parens patriae* concern,[254] limiting involuntary treatment of competent individuals to emergency situations where treatment is necessary to prevent immediate, substantial, irreparable harm.[255] Others interpret *Harper* and *Riggins* as authorizing involuntary medication to address "gravely disabled" individuals whose existing deterioration or mental state poses a significant risk of substantial harm.[256] These latter rulings note that *Harper*

[248] *Id.* at 293.

[249] *See id.* at 292.

[250] *See id*.

[251] *See id.* at 291-92. Hardy's psychosis contributed to his incompetency to stand trial. *See id.* at 285-86.

[252] *See id.* at 292.

[253] Although not a POC state, the Colorado Supreme Court has addressed how likely, significant, and concrete the risk of deterioration must be to justify the involuntary administration—or increased dosage—of antipsychotic medication to an incompetent person. See People v. Marquardt, 364 P.3d 499, 504 (Colo. 2016); People v. Medina, 705 P.2d 961, 974 (Colo. 1985) (interpreting Colorado common law to hold that a patient's refusal of antipsychotic medication may be overridden in emergency situations "to prevent the immediate and irreversible deterioration of the patient due to a psychotic episode"); *id.* at 963-64 (holding that, in nonemergency situations, involuntary treatment could be justified by the state's *parens patriae* interests only if "the patient is incompetent to effectively participate in the treatment decision; . . . treatment by antipsychotic medication is necessary to prevent a significant and likely long-term deterioration in the patient's mental condition . . . ; . . . a less intrusive treatment alternative is not available; and . . . the patient's need for treatment by antipsychotic medication is sufficiently compelling to override any bona fide and legitimate interest of the patient in refusing treatment"). The court rejected the argument that an abstract "possibility of future deterioration is sufficient to support a medication order." *Marquardt*, 364 P.3d at 504.

[254] *See infra* Part II.A.2.

[255] *See Rivers*, 495 N.E.2d at 343 (holding that, for a state to invoke an interest in involuntarily administering medication to "'improve' [a person's] condition [to] facilitate [their] return to the community," or to avoid deterioration "if such medication were discontinued provided in a different manner," "the individual himself must be incapable of making a competent decision concerning treatment on his own."); *Rogers*, 634 F.2d at 659-60 (finding a federal due process right to refuse treatment and recognizing that the state could only impose forced medication to prevent further significant deterioration of the patient's mental health after determining the individual lacks the capacity to decide for themselves whether to take the drugs); *cf. supra* note 253 (Colorado).

[256] See United States v. McAllister, 969 F. Supp. 1200, 1207–08 (D. Minn. 1997) ("If the 'gravely disabled' language in the federal regulations were not read to require a showing of dangerousness within the institution, the regulation would be unconstitutional under the Due Process Clause."); Hightower by Dahler v. Olmstead, 959 F. Supp. 1549, 1563–64 (N.D. Ga. 1996), aff'd sub nom. Hightower v. Olmstead, 166 F.3d 351 (11th Cir. 1998) (upholding Georgia's policy of permitting the involuntary medication of patients at a state mental hospital if patients are "unsafe," meaning they are demonstrating "[a] mental state and/or pattern of behavior which assigns a significant risk for actions injurious to self or others," construed in that case as "exhibit[ing] potentially dangerous thoughts or behaviors which indicate, or have been indicators of in the patient's past history, a significant risk of injurious or life-endangering conduct"); Jurasek v. Utah State Hosp., 158 F.3d 506, 510–11 (10th Cir. 1998) (upholding the forcible medication of civilly committed patient determined to be currently dangerous and "gravely disabled," defined as having a mental disorder such that they "manifest[], or will manifest, severe deterioration in routine function evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential

involved a prison policy that authorized forcible medication for prisoners posing a "likelihood of serious harm" and those who are "gravely disabled," defined as "manifesting severe deterioration in routine functioning, evidenced by repeated and escalating loss of cognitive or volitional control" and "not receiving such care as is essential for his or her health or safety."[257] Although *Harper* did not rule on the "grave disability" aspect of Washington's prison policy,[258] *Sell* seemed to find this portion of the policy significant in emphasizing that "forced medication [may be] warranted for . . . the purposes set out in *Harper* related to the individual's dangerousness, or purposes related to the individual's own interests where refusal to take drugs puts his health gravely at risk."[259] Also, lower courts have read *Riggins* as expanding *Harper*'s conception of current dangerousness beyond the specifically reviewed policy criteria to include gravely disabled individuals not receiving care essential for their health or safety.[260]

Cases authorizing forcible treatment without finding treatment decision-making incapacity indicate that POC laws must meet stringent standards of dangerousness to be constitutionally valid expressions of states' police powers. Crucially, these cases suggest that involuntary medication is typically justified only by a current, substantial threat of significant physical harm. A recent pattern of violent conduct, clearly driven by mental disorder, can establish current dangerousness. Involuntary medication may also be permissible in response to grave disability when individuals' severe health conditions pose a significant risk of substantial harm, and treatment is essential for health or safety. To justify involuntary treatment beyond this context of current dangerousness, states must appeal to their *parens patriae* interests.

2. Parens patriae

Beyond current danger, jurisdictions typically—but not always[261]—limit forcible treatment to individuals found incompetent to make treatment decisions.[262] Indeed, the Supreme Court has urged "medical and legal focus" upon this question: "Why is it medically appropriate forcibly to

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for his or her health or safety"); Green v. Dormire, 691 F.3d 917, 922–23 & n.4 (8th Cir. 2012) (upholding Missouri's policy of forcibly medicating "gravely disabled" inmates, where the inmate's mental disorder "interferes with their functioning" and renders the inmate, although not immediately dangerous, unable "to function in prison or in the population upon release" without treatment).

[257] *Harper*, 494 U.S. at 215 & n.3; *see Hightower*, 959 F. Suppp. at 1564; *Green*, 691 F.3d at 923; *Jurasek*, 158 F.3d at 510-12; *McAllister*, 969 F. Supp. at 1205, 1207 n.4.

[258] *Jurasek*, 158 F.3d at 511-12.

[259] *Sell*, 539 U.S. at 182.

[260] *See Jurasek*, 158 F.3d at 512 & n.2.

[261] *See* Boldt, *supra* note 12, at 73-78 (discussing the variance in state statutory provisions regarding the rights of psychiatric patients to refuse treatment absent an emergency). Importantly, some POC states do *not* limit nonemergency forcible treatment to incompetent patients. *See* MONT. CODE ANN. § 53-21-127(6) ("The court may authorize . . . a physician . . . to administer appropriate medication involuntarily if the court finds that involuntary medication is necessary to protect the respondent or the public or to facilitate effective treatment."); La. Stat. Ann. § 28:55(I)(1)(A) ("A patient confined to a treatment facility by judicial commitment may receive medication and treatment without his consent…."); *id.* § 28:55(I)(1)(B); Ky. Rev. Stat. Ann. §§ 202A.191(1)(h), 202A.196 (approving forcible medication if "appropriate" and part of patient's "individual treatment plan;" incapacity of giving informed consent is one of several factors for consideration). While the Kentucky forcible treatment statute does not require incapacity, Kentucky case law suggests its necessity. *See Gundy*, 619 S.W.2d at 731−32.

[262] *See Sell*, 539 U.S. at 182; Boldt, *supra* note 12, at 79 ("the governing doctrine in a majority of states protects patients who have not been adjudicated incompetent to make treatment decisions by requiring that they voluntarily agree to the administration of antipsychotic drugs").

administer antipsychotic drugs to an individual who (1) is not dangerous and (2) is competent to make up his own mind about treatment?"[263] Accordingly, some lower courts, applying federal law, have recognized that finding incompetence is prerequisite to nonconsensually treating involuntarily hospitalized individuals under a state's *parens patriae* authority.[264] Other courts reaching this conclusion apply state law.[265] As Richard Boldt reports, "[o]n balance, . . . the majority of state appellate courts that have considered the question have held that involuntary psychiatric medication is permissible only in an emergency or following a determination that the patient is not capable of making a competent treatment decision."[266]

In addition to finding treatment decision-making incapacity,[267] POC statutes under a state's *parens patraie* power should require treatment to avert likely harm or at least confer a substantial net benefit.[268] Otherwise, the state lacks a legitimate basis for overruling the patient's objection to treatment, ignoring any previously expressed wishes regarding antipsychotic medication made when competent, and forcing the individual to experience unwanted, invasive treatment that carries potentially serious and long-lasting side effects.[269] The minimum degree of danger or anticipated benefit required by substantive due process, if any, is unclear.

Some courts interpret *Harper*, *Riggins*, and *Sell* to require findings of current dangerousness to forcibly administer antipsychotic medication to any individual,[270] including those lacking treatment decision-making capacity. One district court ruled "[o]nly present dangerousness and present need for medication justify the significant intrusion represented by the forced administration of psychotropic medication" to competent or incompetent individuals.[271] The court noted *Harper*'s "strong concern" about administering medication without clearly showing its necessity given the risk of harm presented by the inmate and the medical need to reduce this danger.[272]

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[263] *Sell*, 539 U.S. at 182; *see In re Qawi*, 81 P.3d at 234 (characterizing *Sell* as indicating it is "questionable whether government can justify involuntary antipsychotic medication of person neither incompetent nor dangerous").

[264] *See, e.g.*, *Charters*, 829 F.2d at 494; *In re K. K. B.*, 609 P.2d at 750; *In re Torski C.*, 918 N.E.2d at 1228; Swanigan v. Avenues Healthcare Inc., 524 P.3d 173, 176 n. 3 (Utah Ct. App. 2023).

[265] *See, e.g.*, *Rivers*, 495 N.E.2d at 343; *Steele*, 736 N.E.2d at 19.

[266] Boldt, *supra* note 115, at 72.

[267] States vary in their definitions of legal competence to consent to treatment and whether they require incompetence or incapacity for forcible treatment in nonemergency situations. *See* Boldt, *supra* note 12, at 71-72, 74-77, 85-86; *supra* note 185. For more on the distinction between legal and clinical competence to consent to treatment, and strategies mental health professionals employ when dealing with patients apparently clinically incompetent (yet still legally competent) to consent to psychiatric treatment, see WEINER & WETTSTEIN, *supra* note 178, at 116-17.

[268] *See Matter of Commitment of C.S.*, 940 N.W.2d 875, 888 (Wis. 2020) ("Without more, mental illness and incompetence to refuse medication alone are not reasonably related to a legitimate penological interest. The State may not force a particular medication on a mentally ill inmate merely because the inmate is incompetent to refuse it."); Graves v. MidHudson, No. CV-04-3957 (FB) LB, 2006 WL 3103293, at *4 (E.D.N.Y. Nov. 2, 2006) (holding "that the State may only administer psychotropic drugs over the objection of an involuntarily committed patient if (1) the patient is incompetent to make medical decisions, (2) the patient is dangerous to himself or others, and (3) the treatment is in the patient's medical interest").

[269] *See supra* notes 179-182 (side effects of antipsychotic medications).

[270] *See, e.g.*, Dept. of Health and Mental Hygiene v. Kelly, 918 A.2d 470, 480 (Md. 2007).

[271] *Enis*, 962 F. Supp. at 1199-1200.

[272] *Id.* at 1201.

Similar reasoning motivated the 2020 decision of the Wisconsin Supreme Court in *Matter of Commitment of C.S.*, which held that any statute authorizing forcible medication of incompetent, involuntarily hospitalized patients must include findings of current dangerousness and medication being in the patient's medical interest to outweigh individuals' significant liberty interests.[273] Although the court did not specify the level of danger required, it deemed treatment "for the general welfare of the prisoner" insufficient, warning that would render the state's *parens patriae* power "limitless."[274] Other Wisconsin decisions hold that demonstrating "'a substantial likelihood, based on the . . . individual's treatment record, that [they] would be a proper subject for commitment if treatment were withdrawn'" establishes a sufficient level of danger,[275] as would the possibility of the patient's causing physical harm to self or others, "harm to the prospects for successful treatment of the patient's mental condition if medication was not administered," and possible "significant deterioration to [the patient's] health or safety . . ., considering the effect of the patient's mental condition on [their] ability or willingness to receive [essential] care."[276]

Additionally, the Tenth Circuit has held "the Due Process Clause allows a state hospital to forcibly medicate a mentally ill patient who has been found incompetent to make medical decisions if the patient is dangerous to himself or others and the treatment is in the patient's medical interests."[277] The court found that a need for "care 'essential for [the patient's] health or safety'" provides a sufficient justification for forcible treatment under *Riggins*.[278] Thus, at least in the context of incompetent individuals, individuals may be considered "currently" dangerous under *Harper* if treatment abstention poses dangerous future consequences.

States diverge on the dangerousness or net benefit required to justify involuntary medication for individuals with treatment decision-making incapacity under state constitutional and common law.[279] Some states require particular quotients of harm, permitting involuntary treatment only when necessary to prevent substantial and likely irreversible or long-term deterioration.[280] Others require "necessary" treatment that meets additional qualifications. For example, New York permits treatment "necessary" for the care of an incompetent patient,[281] considering their "best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments."[282] Minnesota mandates that treatment be both necessary and reasonable.[283] In contrast, some states only require that treatment align with the incompetent individual's best interests[284] or aim to "improve [their] condition and hasten [their] return to society."[285] Notably, few POC states have clearly prescribed

[273] *Matter of Commitment of C.S.*, 940 N.W.2d at 888.
[274] *Id.* at 891.
[275] *See Matter of Commitment of K.E.K.*, 954 N.W.2d 366, 375 (Wis. 2021) (civil commitment); *Matter of Commitment of E.A.B.*, 966 N.W.2d 283 (Wis. App. 2021) (unpublished decision); *Matter of Commitment of E.W.*, 2 N.W.3d 417 (Wis. App. 2023) (unpublished decision).
[276] State v. Wood, 780 N.W.2d 63, 78-80 (Wis. 2010).
[277] *Jurasek*, 158 F.3d at 511.
[278] *Id.* at 512.
[279] *See supra* note 262 (concerning variance among state standards).
[280] *See* Rogers v. Commr. of Dept. of Mental Health, 458 N.E.2d 308, 310–11 (Mass. 1983).
[281] *Rivers*, 495 N.E.2d at 345.
[282] *Id.* at 344.
[283] *Jarvis*, 418 N.W.2d at 148 (quoting *Price*, 239 N.W.2d at 913).
[284] *See Myers*, 138 P.3d at 254; *Steele*, 736 N.E.2d at 20-21.
[285] Op. of the Justs., 465 A.2d 484, 489-90 (N.H. 1983).

the level of danger (or net benefit) needed to justify involuntary treatment in cases of treatment decision-making incapacity.[286]

B. Involuntary Inpatient Commitment

Involuntary treatment cases offer one method to assess POC laws' constitutionality. Another approach is to evaluate POC's constitutionality as a form of involuntary civil commitment. *In re K.L.* signals the appropriateness of this approach.[287]

Deriving a constitutional framework from inpatient commitment case law offers many benefits. First, POC, like inpatient commitment, entails significant liberty infringements. These deprivations extend beyond its core of involuntary treatment. In authorizing courts to order sometimes over a dozen therapeutic programs, services, and forms of supervision,[288] POC may function as de facto confinement. Indeed, courts have identified the "structure and supervision" of POC as its main contribution.[289] Patient surveys attest that POC interferes with life commitments,[290] is deeply stigmatizing, and can lead to social isolation.[291] The *Harper* test and its progeny do not account for these additional infringements of liberty. However, the ad hoc balancing test utilized in involuntary commitment cases is capacious and can accommodate multiple individual and state interests simultaneously.[292]

Second, a deep well of constitutional case law has generated a sophisticated understanding of the essential criterion of an individual's dangerousness to involuntary commitment, how its necessary aspects (such as likelihood) interact with the nature of anticipated harm (such as passive neglect), and the role that danger must play in involuntary commitment for *parens patriae* purposes. This nuanced body of law is useful in determining when a POC statute's dangerousness element is stringent enough to survive constitutional scrutiny.

Third, a small but well-reasoned body of case law examines the constitutionality of using involuntary commitment to prevent deterioration predicted to result in future dangerousness. These preventive *inpatient* commitment cases address the same issue posed by POC: when are the state's interests sufficiently compelling to justify the immense deprivation of liberty involved in involuntary commitment? So long as POC entails a similarly substantial deprivation of liberty, evaluations of the constitutionality of preventive *inpatient* commitment laws provide useful guidance for determining when a state's *parens patriae* and police power interests collectively justify the liberty deprivations and stigmatization associated with POC.

As explained below, the key feature of constitutional involuntary commitment—under the police power, the *parens patriae* power, or both—is the dangerousness requirement.[293] Although slowly developed, the dangerousness standard is now a fully entrenched requirement for inpatient

[286] *See supra* notes 281 (New York) & 284 (Ohio).
[287] *In re K.L.*, 806 N.E.2d at 485 (quoting *Addington*, 441 U.S. at 426).
[288] *See, e.g.*, Calif. Welf. & Inst. Code § 5348.
[289] *See In re K.L.*, 806 N.E.2d at 484.
[290] *See supra* notes 81-89.
[291] *See supra* notes 28 & 37 (stigmatizing effect of involuntary commitment).
[292] *See supra* note 30 (balancing test).
[293] *See supra* note 188.

commitment to justify its "massive" liberty deprivation.[294] That requirement has been adopted, with some modifications, in the preventive context.[295] Where dangerousness is insufficient to justify involuntary commitment under the state's police power, a statute must require a finding of treatment decision-making incapacity.

1. The necessity of dangerousness

Dangerousness is a necessary criterion for involuntary inpatient commitment.[296] In *O'Connor v. Donaldson*, the Court found commitment in the absence of danger and treatment unconstitutional.[297] The Court held, "[A] State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[298] In *Addington*, the Court affirmed that "the State has no interest in confining individuals involuntarily if they are not mentally ill or if they do not pose some danger to themselves or others."[299] The constitutional necessity of dangerousness for all involuntary inpatient commitments was confirmed in *Jones v. United States*[300] and *Foucha v. Louisiana*.[301] Accordingly, lower courts consistently demand that inpatient commitment statutes require findings of both mental illness and dangerousness.[302] These constitutional precepts apply to commitment statutes issued under a state's police power or *parens patriae* authority.[303] As involuntary outpatient commitment entails significant liberty deprivations—and no case law exists to the contrary—these holdings likely apply to POC.

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[294] *See B.A.A.*, 421 N.W.2d at 122-24; *Humphrey*, 405 U.S. at 509.

[295] *See infra* Part II.B.3.

[296] *See O'Connor*, 422 U.S. at 575-76; *Addington*, 441 U.S. at 426; Jones v. United States, 463 U.S. 354, 362 (1983); *Foucha*, 504 U.S. at 78.

[297] *O'Connor*, 422 U.S. at 575.

[298] *Id.* at 576; *see id*. at 575 ("there is . . . no constitutional basis for confining [mentally ill] persons involuntarily if they are dangerous to no one and can live safely in freedom"). The questions avoided by the Court—including whether the State can commit "a non-dangerous, mentally ill individual for the purpose of treatment"—left unclear whether a committed individual must, or merely may, be dangerous for involuntary commitment to satisfy due process. *Id.* at 573. The Supreme Court has never expressly clarified whether nondangerous individuals can be confined to provide medically appropriate treatment. However, subsequent cases suggest that answer is "no." *See infra* notes 299-303.

[299] 441 U.S. at 426. Texas law at that time included a dangerousness requirement, however, so the Court's requirement of dangerousness could plausibly be read as interpreting the substantive criteria of Texas law rather than articulating a constitutional principle. *See id.* at 428 n.4; State v. Turner, 556 S.W.2d 563, 564 (Tex. 1977) (articulating the standard for involuntary civil commitment in Texas).

[300] 463 U.S. 354, 362 (1983) ("the Due Process Clause requires committing courts to demonstrate . . . that the individual is mentally ill and dangerous").

[301] 504 U.S. 71 (1992) ("[T]o commit an individual to a mental institution in a civil proceeding, the State is required by the Due Process Clause to prove . . . the two statutory preconditions to commitment: that the person sought to be committed is mentally ill and that he requires hospitalization for his own welfare and protection of others."); *id.* at 77 (characterizing the confinement of "a harmless, mentally ill person" as unconstitutional).

[302] *See, e.g.*, *B.A.A.*, 421 N.W.2d at 123; *In re Dennis H.*, 647 N.W.2d at 862; *In re Torski C.*, 918 N.E.2d at 1227; Mays v. State, 68 P.3d 1114, 1118 (Wash. 2003).

[303] The necessity of including a dangerousness element in a *parens patriae* statute was signaled through the Court's dicta in *Humphrey v. Cady*. *See infra* notes 333-336.

2. Defining dangerousness: Imminence, likelihood, and magnitude of harm

Importantly, necessary characteristics of danger may vary depending on the nature of anticipated harm. Dangerousness is a vague and amorphous concept.[304] The Supreme Court did not define standards for dangerousness sufficient to justify involuntary commitment.[305] This task was left to the states, with courts showing deference to legislative decisions in this "complex, delicate, and policy-sensitive area."[306]

In the 1970s, partly in response to revelations of antitherapeutic conditions in mental health hospitals that undermined the *parens patriae* commitment rationale,[307] a number of courts interpreted substantive due process to require an imminent threat of substantial harm to justify inpatient commitment.[308] This trend continued as other courts required "serious and highly probable threats of [physical] harm" in the near term to meet the criteria for dangerousness.[309] These standards ensure that only the most dangerous lose liberty and face stigmas associated with involuntary hospitalization.[310]

Some jurisdictions recognize that dangerousness consists of three aspects: magnitude, immediacy, and likelihood of harm.[311] These aspects may be applied in various proportions to ensure that an individual's dangerousness justifies involuntary commitment.[312] Thus, where potential harm is likely *and* great, it may not need to be very imminent to satisfy due process.[313] Where likelihood is difficult to accurately predict, its necessary degree may depend on the expected harm's severity.[314] Courts recognizing this balance of factors consistently treat the gravity of anticipated harm as paramount.[315] Courts concur that involuntary commitment must aim to prevent serious harm.[316] Although courts in most jurisdictions have not determined the necessary

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[304] *See* State v. Krol, 344 A.2d 289, 301–03 (N.J. 1975); William M. Brooks, *The Tail Still Wags the Dog: The Pervasive and Inappropriate Influence by the Psychiatric Profession on the Civil Commitment Process*, 86 N.D.L. REV. 259, 292 (2010).

[305] *See Mays*, 68 P.3d at 1119; *In re Dennis H.*, 647 N.W.2d at 856.

[306] *In re Dennis H.*, 647 N.W.2d at 856.

[307] *See* Cornwell, *supra* note 170, at 385.

[308] *See*, *e.g.*, *Doremus*, 407 F. Supp. at 514-15; Dixon v. Attorney General, 325 F. Supp. 966, 974 (M.D.Pa.1971); *Lessard*, 349 F. Supp. at 1093; *Lynch*, 386 F. Supp. at 391; Suzuki v. Yuen, 617 F.2d 173, 178 (9th Cir. 1980); *Colyar*, 469 F. Supp. at 432.

[309] *In re S. R. J.*, 386 P.3d 99, 104 (Or. App. 2016).

[310] *See* Donald Stone, *Dangerous Minds: Myths and Realities Behind the Violent Behavior of the Mentally Ill, Public Perceptions, and the Judicial Response Through Involuntary Civil Commitment*, 42 L. & PSYCHOL. REV. 59, 65 (2018).

[311] *See infra* notes 313-314.

[312] *See infra* notes 313-314.

[313] *See In re Labelle*, 728 P.2d at 144.

[314] Cross v. Harris, 418 F.2d 1095, 1100 (D.C. Cir. 1969) (identifying "the seriousness of the expected harm" as a "particularly relevant consideration" as to "the degree of likelihood necessary to support commitment").

[315] *See In re Torski C.*, 918 N.E.2d at 1230; *infra* note 316.

[316] *See, e.g.*, *Doremus*, 407 F. Supp. at 515 ("substantial harm to himself or to others"); *Lynch*, 386 F. Supp. at 390-91 ("substantial harm to himself or to others"); *Dixon*, 325 F. Supp. at 974 ("serious physical harm to other persons or to himself"); *supra* note 303 (*Humphrey*). Whether the nature of this serious harm must be physical is

components of dangerousness,[317] relevant opinions suggest that involuntary commitment is only appropriate in response to remote dangers if offset by particularly grave and highly likely harms.[318]

Courts consistently deem "grave disability," a form of passive harm often resulting from an inability to provide for basic needs, to be a sufficiently severe danger to justify involuntary commitment.[319] When courts find grave disability standards too broad, encompassing conduct that would not necessarily lead to serious harm, they often construe statutes to require additional elements that elevate the gravity, the likelihood, and sometimes the imminence of the harm. For example, Alaska's supreme court found "grave disability"— a condition in which a person will suffer severe distress associated with significant impairment of judgment or behavior causing a substantial deterioration of independent functioning—to be insufficiently serious.[320] To avoid constitutional problems, the court elevated the gravity of the harm, holding that "distress" must "refer[] to a level of incapacity that prevents the person in question from being able to live safely outside of a controlled environment."[321]

Similarly, Washington's supreme court construed its grave disability statute to require additional probability and timing elements. Washington's commitment statute defined grave disability as "a condition in which a person, as a result of a mental disorder, is in danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety."[322] The court held this standard requires "a showing of a *substantial risk* of danger of serious physical harm" in order to justify commitment's immense liberty deprivations.[323] Establishing this likelihood requires "recent, tangible evidence of failure or inability [due to mental illness] to provide for such essential human needs as food, clothing, shelter, and medical treatment

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uncertain. *Compare In re Torski C.*, 918 N.E.2d at 1230 (construing substantive due process to require likely injury to self or others), *with In re Maricopa Cnty*. Cause No. MH-90-00566, 840 P.2d 1042, 1048 (Ariz. App. 1st Div. 1992) (recognizing emotional harm).

[317] Brooks, *supra* note 304, at 293.

[318] *See* Commonwealth v. Nassar, 380 Mass. 908, 406 N.E.2d 1286, 1291 (1980) (accepting that "in the degree that the anticipated physical harm is serious approaches death some lessening of a requirement of 'imminence' seems justified"); People v. Taylor, 618 P.2d 1127, 1137 (Colo. 1980) (acknowledging that "[p]assive injury to oneself, because of an inability to take care of one's most basic personal needs, may be as dangerous or damaging to the individual as the active threat posed by suicide" and opining "that an allegation that a person is mentally ill and, as a result of that illness, gravely disabled because of an inability to take care of basic personal needs is sufficient and need not further allege imminent and substantial danger in order to pass constitutional scrutiny"); *Krol*, 344 A.2d at 302 ("Commitment requires that there be a substantial risk of dangerous conduct within the reasonably foreseeable future. Evaluation of the magnitude of the risk involves consideration both of the likelihood of dangerous conduct and the seriousness of the harm which may ensue if such conduct takes place."); *In re Harris*, 654 P.2d 109, 112-13 (Wash. 1982) (ruling a "substantial" risk of "serious" harm satisfies the Supreme Court's requirement that potential for harm be "great enough to justify such a massive curtailment of liberty"). Other courts have also held that a "substantial risk" of danger must exist when harm is not imminent. *See, e.g., Lynch*, 386 F. Supp. at 391; Hatcher v. Wachtel, 269 S.E.2d 849, 852 (W.Va.1980); *cf. Doremus*, 407 F. Supp. at 515 ("poses a serious threat of substantial harm to himself or to others"). At least one court in this context has interpreted "substantial risk" to require evidence of a "high probability" of serious harm. *In re Labelle*, 728 P.2d at 144.

[319] *See Gallinot*, 486 F. Supp. at 991; *Taylor*, 618 P.2d at 1137.

[320] Wetherhorn v. Alaska Psychiatric Inst., 156 P.3d 371, 376 (Alaska 2007), overruled in part by *In re Naomi B*., 435 P.3d 918 (Alaska 2019).

[321] *Id.* at 377.

[322] *In re Labelle*, 728 P.2d at 143 (quoting WASH. REV. CODE §71.05.020(1)(a)).

[323] *Id.* at 144.

which presents a *high probability* of serious physical harm *within the near future* unless adequate treatment is afforded."[324] Both the Alaska and Washington supreme courts defended their statutory interpretations as necessary to guard against imposing "majoritarian values on a person's chosen lifestyle which, although not sufficiently harmful to justify commitment, may be perceived by most of society as eccentric, substandard, or otherwise offensive."[325]

Courts have reached two areas of consensus on what does *not* constitute serious harm justifying involuntary inpatient commitment. First, courts recognize that "some types of behavior, even if certain to occur, may present too minimal a threat to society to justify confinement."[326] Dangerous conduct excludes behavior that is merely irritating or frightening, makes others uncomfortable, or falls "outside the normative expectations of society."[327] As the New Jersey Supreme Court explained, "[p]ersonal liberty and autonomy are of too great value to be sacrificed to protect society against the possibility of future behavior which some may find odd, disagreeable, or offensive, or even against the possibility of future non-dangerous acts which would be ground for criminal prosecution if actually committed."[328]

Second, multiple courts hold that a mentally ill individual's "need for treatment" is an insufficiently weighty justification for involuntary commitment and imparts excessive discretion to the state.[329] For example, a federal district court in Nebraska asserted, "To permit involuntary commitment upon a finding of 'mental illness' and the need for treatment alone would be tantamount to condoning the State's commitment of persons deemed socially undesirable for the purpose of indoctrination or conforming the individual's beliefs to the beliefs of the State."[330] Other state supreme and federal courts have struck down need-for-treatment statutes on grounds of vagueness or overbreadth.[331] One Pennsylvania court chastised, "'In need of care' is so broad as to be virtually meaningless. Furthermore, once a finding of mental illness is made, it would be impossible not to find that the individual is in need of care."[332]

Cases prohibiting involuntary commitment merely to provide necessary treatment concur with dicta from the U.S. Supreme Court in *Humphrey v. v. Cady*.[333] There, the Court construed a Wisconsin statute authorizing the commitment of a person with a mental illness who is a "proper

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[324] *Id.*

[325] *Id.*; *see Wetherhorn*, 156 P.3d at 377.

[326] *In re Torski C.*, 918 N.E.2d at 1230.

[327] *Id.*; *see Krol*, 344 A.2d at 302 ("Dangerous conduct involves not merely violation of social norms enforced by criminal sanctions.").

[328] *Krol*, 344 A.2d at 302.

[329] *See, e.g., Stamus*, 414 F. Supp. at 449-51 (finding an Iowa statute permitting the commitment of those "believed to be mentally ill, and a fit subject for custody and treatment" to violate substantive due process); *In re Labelle*, 728 P.2d at 146 ("It is not enough to show that care and treatment of an individual's mental illness would be preferred or beneficial or even in his best interests. To justify commitment, such care must be shown to be essential to an individual's health or safety and the evidence should indicate the harmful consequences likely to follow if involuntary treatment is not ordered."); *In re Stephen O*., 314 P.3d 1185, 1196 (Alaska 2013) (same); *see infra* notes 330-332.

[330] *Doremus*, 407 F. Supp. at 514-15.

[331] *See Hawks*, 202 S.E.2d at 123; *Stamus*, 414 F. Supp. at 452; *In Johnson v. Solomon*, 484 F.Supp. 278, 284 (D.Md.1979); Bell v. Wayne Cnty. Gen. Hosp. at Eloise, 384 F. Supp. 1085, 1096 (E.D. Mich. 1974).

[332] Commonwealth ex rel. Finken v. Roop, 339 A.2d 764, 778 (Pa. Super. 1975).

[333] 405 U.S. 504 (1972).

subject for custody and treatment"[334] to require dangerousness to self or others.[335] The Court explained that "[the individual's] potential for doing harm, to himself or to others, [must be] great enough to justify such a massive curtailment of liberty."[336] Again, only when acting to prevent substantial harm may the state deprive a person with mental illness of their liberty through involuntary commitment.

The above inpatient commitment cases—some reviewing statutes aimed to prevent non-imminent or passive harm—suggest lessons for the constitutionality of POC. First, the state may use involuntary commitment to prevent future (non-imminent) harm in certain circumstances. Second, without an imminence requirement, courts require anticipated harm to be quite grave and highly probable to justify state intervention.[337] Finally, involuntary commitment, involving substantial liberty deprivations even in its outpatient form,[338] cannot be justified by asserted needs to provide treatment to those with mental illnesses or to prevent behavior that merely frightens, repulses, annoys, or causes minor physical injury.

3. Standards established in preventive inpatient commitment cases

By definition, preventive commitment statutes seek to interrupt or prevent a person's deterioration before they become dangerous to themselves or others.[339] Thus, anticipated harm will not be imminent and may not be likely. The few courts reviewing preventive inpatient commitment statutes deal with this diluted dangerousness criterion in various ways, with most accepting a state's interest in preventing deterioration while stressing the crucial importance of treatment decision-making incapacity and probability of serious harm.[340] So long as courts recognize that outpatient commitment effects substantial liberty deprivations, these decisions suggest that treatment decision-making incapacity and dangerousness should be necessary features of POC statutes to satisfy due process requirements.

a) Require treatment decision-making incapacity and serious harm

In *In re Labelle*, the Washington Supreme Court construed an inpatient commitment statute designed to interrupt deterioration and provide essential treatment to require a finding of likelihood of serious harm and treatment decision-making incapacity.[341] Washington's statute allowed the involuntary hospitalization of one who, "as a result of a mental disorder,… [m]anifests severe deterioration in routine functioning evidenced by a repeated or escalating loss of cognition and volitional control over [their] actions and is not receiving care as essential for [their] health or

[334] *Id.* at 509 & n.4. Wisconsin defined mental illness as "mental disease to such extent that a person so afflicted requires care and treatment for his own welfare, or the welfare of others, or of the community." *Id.* at 509 n.4.

[335] *Id.* at 509. Subsequent cases have construed *Humphrey* as requiring a dangerousness element. *See, e.g., Lynch*, 386 F. Supp. at 390; *Bell*, 384 F. Supp. at 1096; *Suzuki*, 617 F.2d at 176.

[336] 405 U.S. at 509.

[337] *See supra* notes 313-325.

[338] *See supra* Part I.A.

[339] *See In re Labelle*, 728 P.2d at 145.

[340] *See supra* Parts II.B.1-3; *see also* State v. Brungard, 789 P.2d 683, 687 (Or. Ct. App. 1990) (upholding the constitutionality of an inpatient preventive commitment statute under the state's police power by reading a timeliness factor into the definition of mental illness focused on future harm).

[341] *In re LaBelle*, 728 P.2d at 146.

safety."[342] The court noted "serious constitutional concerns" with this standard.[343] In particular, "[t]here is a danger that persons will be involuntarily committed under this standard solely because they are suffering from mental illness and may benefit from treatment," which would not provide a sufficiently compelling state interest to justify involuntary commitment.[344] In addition, because of the inquiry's inherent medical nature, there exists "a danger that excessive judicial deference will be given to the opinions of mental health professionals, thereby effectively insulating their commitment recommendations from judicial review."[345]

To justify confinement, a "causal nexus" must exist between an individual's mental illness and failure to receive essential care.[346] The *LaBelle* court found the commitment standard constitutional but construed it to require treatment decision-making incapacity due to mental illness.[347] The court observed, "[T]he mere fact that an individual is mentally ill does not also mean that the person so affected is incapable of making a rational choice with respect to [their] need for treatment."[348] Therefore, it is "not enough" to show, from an objective vantagepoint, that "care and treatment of an individual's mental illness would be preferred or beneficial or even in his best interests."[349] Thus, to establish that a person, *because of their mental disorder*, is not receiving treatment necessary to avert serious harm, the state must show the refusal of or failure to seek treatment results from treatment decision-making incapacity. If the person, despite their mental illness, retains this capacity—as individuals with severe mental illnesses overwhelmingly do[350]—then they retain their right to decline even "essential" treatment.[351]

b) Require treatment incapacity, high probability of serious harm, and current deterioration

In *In re Torski C.*, an Illinois appellate court held that Illinois's preventive inpatient commitment statute[352] must require proof of treatment decision-making incapacity along with a high probability of injury to self or others to comport with due process.[353] The *Torski* court recognized the state's "well-established, legitimate interest under its *parens patriae* authority in providing care to persons unable to care for themselves."[354] Because the preventive commitment statute sought to provide necessary treatment, the statute advanced the state's *parens patriae*

[342] *Id.*; WASH. REV. CODE §70.05.020(25) (2023).

[343] *In re Labelle*, 728 P.2d at 146.

[344] *Id.*

[345] *Id.*

[346] *Id.*

[347] *Id.* (construing as "implicit" in the statute "a requirement that the individual is unable, because of severe deterioration of mental functioning, to make a rational decision with respect to his need for treatment).

[348] *Id.*

[349] *Id.*

[350] *See supra* notes 175-176.

[351] *See In re Labelle*, 728 P.2d at 146.

[352] The standard at issue permitted involuntary commitment of "[a] person with mental illness who, because of the nature of [their] illness, is unable to understand [their] need for treatment and who, if not treated, is reasonably expected to suffer or continue to suffer mental deterioration or emotional deterioration, or both, to the point that the person is reasonably expected to engage in dangerous conduct." *In re Torski C.*, 918 N.E.2d at 1219 (quoting 405 ILCS 5/1-119).

[353] *Id.* at 1228–30.

[354] *Id.* at 1226.

concerns.[355] However, the court acknowledged, "The State has no interest or authority to assert its *parens patriae* power over those who can protect themselves."[356] Therefore, the court found that due process dictates a statutory requirement that the individual lacks treatment decision-making capacity due to mental illness.[357] Because the statue included this element, it passed constitutional muster.[358]

The court then turned to the statute's dangerousness element.[359] The court characterized the statutory provision concerning deterioration and forecasted harm as "nothing more than part of the court's analysis of whether a mentally ill individual poses a sufficient danger in order to be constitutionally confined."[360] The court explained, "This factor aids the trial court in making a prediction regarding the anticipated risk of harm:"[361]

> The analysis of whether the individual is deteriorating, either mentally or emotionally, should take into account the severity of [their] symptoms, past patterns of behavior, and whether known risk factors exist. As it is part of the analysis of predicting a respondent's future dangerousness, it is not, in and of itself, a standard subject to constitutional scrutiny.[362]

Notably, in discussing how the deterioration provision contributed to the court's dangerousness assessment, the court emphasized the individual's current deterioration and symptomology—neither of which was required by the statutory language.[363]

Ultimately, the court ruled a committing court must determine whether "the magnitude of the harm [the individual] is predicted to cause and the probability that [they] will cause it" justify confinement.[364] The court recognized the state may have valid police power interests in confining persons in anticipation of future behavior.[365] But whether the state's interest is sufficiently compelling to justify confinement depends upon the nature and degree of individuals' dangerousness.[366] Given the extreme liberty deprivation from inpatient commitment, "a valid exercise of the State's police power shall be taken only in the interest of preventing behavior likely to result in injury to one's self or others."[367]

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[355] *Id.* at 1225.

[356] *Id.* at 1228.

[357] *Id*.

[358] *Id.*; *see supra* note 352 (including statutory criteria).

[359] *In re Torski C.*, 918 N.E.2d at 1229 ("Once a mentally ill individual meets the threshold requirement of diminished decisional capacity, the State's police-power authority to commit him depends on whether the magnitude of the threat he poses to its citizens exceeds the deprivations imposed by involuntary commitment.").

[360] *Id.*

[361] *Id.*

[362] *Id.*

[363] *See supra* note 352.

[364] *In re Torski C.*, 918 N.E.2d at 1230.

[365] *Id*.

[366] *Id.*

[367] *Id.*

c) Expand "dangerousness" for those without treatment decision-making capacity

In *In re Dennis H.*, the Wisconsin Supreme Court accepted a broader conception of dangerousness—one designed to interrupt deterioration predicted to lead to future (non-imminent) harm—for individuals without treatment decision-making capacity.[368] In doing so, the court recognized that treatment decision-making incompetency increases the likelihood of deterioration[369] and the harm ultimately resulting from that deterioration.[370] Thus, the opinion suggests treatment decision-making incapacity may be essential to establish the quantum of dangerousness necessary to justify commitment in this context.

The court stressed that those without treatment decision-making competency are particularly vulnerable.[371] It explained that individuals qualifying for commitment under the deterioration standard "are clearly dangerous to themselves *because* their incapacity to make informed medication or treatment decisions makes them *more vulnerable* to severely harmful deterioration than those who are competent to make such decisions."[372] It is an individual's treatment decision-making incapacity that "makes it substantially probable that, without treatment, disability or deterioration will result, bringing on a loss of ability to provide self-care or control thoughts or actions."[373] The court stressed that—while a person with mental illness "who retains the capacity to make an informed decision about medication or treatment" can choose, if they wish, to accept treatment and improve their condition—a person who lacks this capacity "is helpless, by virtue of an inability to choose medication or treatment, to avoid the harm associated with the deteriorating condition."[374] Thus, it is the individual's treatment decision-making incapacity that makes deterioration *likely* to cause the harm sought to be prevented, and "[t]he state has a strong interest in providing care and treatment before that incapacity results in a loss of ability to function."[375]

The court also found the individual's decision-making incapacity to contribute to the ultimate harm. The court recognized that, under *O'Connor*, a person may be dangerous to self if "'he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends.'"[376] The *Dennis H.* court found the relevant statute designed to prevent danger caused by the self-neglect of a person lacking treatment decision-making capacity, "permit[ting] commitment only when a mentally ill person needs care or treatment to prevent

[368] 647 N.W.2d 851.

[369] *See infra* notes 372-375 and accompanying text.

[370] *See In re Dennis H.*, 647 N.W.2d at 860 (finding that this form of dangerousness to self is of "a particularly insidious nature because it is chronic and cyclical . . . , and brought on by mental illness that produces an incapacity to make medication or treatment decisions as well as a substantial probability of an incapacity to care for oneself"); *infra* notes 376-379 and accompanying text.

[371] This portion of the court's opinion responded to the petitioner's equal protection argument. *See In re Dennis H.*, 647 N.W.2d at 860-62.

[372] *Id.* at 862 (emphasis added).

[373] *Id.* at 861.

[374] *Id.* at 861–62.

[375] *Id.* at 862.

[376] *Id.* at 863 (quoting *O'Connor*, 422 U.S. at 574 n.9).

deterioration but is unable to make an informed choice to accept it."[377] Thus, the court concluded, this standard "fits easily within the *O'Connor* formulation."[378] If an individual lacks treatment decision-making competency and will likely suffer serious harm without treatment, they will be "helpless to avoid the hazards" of community life.[379] However, an individual with this competency will not be so "helpless."

The Wisconsin Supreme Court upheld the preventive commitment statute because the combination of elements requires a highly probable future harm.[380] This harm will be the product of mental illness, a need for care, a lack of willingness to receive care, and, critically, an incapacity to understand the need for care.[381] Because the probability of deterioration toward future harm is high and the harm contemplated by the deterioration is substantial, the definition satisfies constitutional standards, even absent an imminence requirement.[382]

Courts have retained the dangerousness requirement in preventive inpatient commitment, emphasizing the necessity of treatment decision-making incapacity and, absent imminence, a high probability of serious harm. In the realm of *outpatient* commitment, where the prophylactic focus is greater, state action should also be restricted to those lacking treatment decision-making capacity unless the dangerousness requirement includes constraints to ensure that serious harm is likely and reasonably imminent.

4. Conclusion

Because *O'Connor*'s progeny establish that treatment need alone cannot justify civil commitment's substantial liberty deprivations,[383] preventing harm to self or others must be a necessary goal of POC.[384] Doctrinally, commitment statutes motivated by police power interests must be limited to situations posing a risk of harm.[385] Evidence of danger must include a balance of likelihood, imminence, and severity of harm,[386] although some of these factors may be relaxed in the POC context.[387] As states expand into more preventive measures with attenuated danger, statutes' dangerousness components may extend beyond what is constitutionally permissible under police powers alone. These broader conceptions of danger must be supported by an additional or alternative *parens patriae* interest.[388] But relying on *parens patriae* authority to justify state action

[377] *Id.*

[378] *Id.*

[379] *Id.*

[380] *Id.*

[381] *Id.* at 859.

[382] *Id.* at 862–63.

[383] *See supra* notes 329-336 (cases holding or, in the case of *Humphrey* indicating, that mental illness and need for treatment are inadequate to satisfy due process).

[384] *See In re Dennis H.*, 647 N.W.2d at 863; *In re Torski C.*, 918 N.E.2d at 1228-30; *B.A.A.*, 421 N.W.2d at 123.

[385] *Developments*, *supra* note 160, at 1216; *In re Torski C.*, 918 N.E.2d at 1229.

[386] *See supra* notes 312-325.

[387] *See, e.g.*, *In re Labelle*, 728 P.2d at 146; *In re Torski C.*, 918 N.E.2d at 1228; Schopp, note 19, at 37-38.

[388] *See In re Dennis H.*, 647 N.W.2d at 862-63; *In re Labelle*, 728 P.2d at 145; *In re Harris*, 654 P.2d at 113; *supra* note 153 (suggesting the *parens patriae* doctrine is the more appropriate justification).

requires limiting that action to individuals lacking treatment decision-making capacity.[389] Therefore, POC statutes with diluted dangerousness requirements must include this incapacity element.[390]

While dangerousness is essential for constitutional civil commitment, it need not be as stringent in a *parens patriae* statute as that required to justify an exercise of the state's police power. In striking the balance of seeking to prevent harm, some POC states utilize the language of "unlikely to survive safely in the community" without supervision or treatment.[391] This element is insufficient to support a police power justification: it is individually focused, its meaning is unclear (what does "unsafe" survival mean?), it omits elements of severity and imminence, and it does not clearly denote the severe inability to care for oneself captured in grave disability statutes.[392] However, the language of "unlikely to survive safely in the community" speaks to harm relevant to the *parens patriae* rationale.[393] Thus, when paired with treatment decision-making incapacity, this language may suffice to establish states' *parens patriae* interests.[394] For this reason, and because of the frequency with which this language appears in POC statutes, this Article refers to this language as 'the *parens patriae* dangerousness element.'

III. Lessons for POC Statutes

Assessing POC's constitutionality requires clear parameters. POC expands states' authority to override individuals' autonomy over treatment and lifestyle decisions. If not carefully cabined, states could use POC to regulate individuals with mental disorders and a history of brief hospitalizations (even voluntary hospitalizations)[395] who reject the well-meaning efforts of others, are "socially eccentric," or exhibit atypical, offensive behavior.[396] POC could also be used to clear sidewalks of individuals with housing insecurity whose primary hindrance is poverty, not mental illness.[397] If individuals are able to function reasonably well in society—such that they pose no serious, near-term risk of harm to themselves or others—they should retain their right to accommodate their illness as they choose.[398]

Identifying the precise legal framework with which to evaluate the constitutionality of POC laws is difficult, as these laws occupy a liminal legal space between forcible care and traditional involuntary commitment. The different approaches taken by *In re K.L.* and *Coleman* reveal confusion over whether to view POC as "forcible" treatment that necessitates analysis under

[389] *See supra* notes 167-187.

[390] *See In re Torski C.*, 918 N.E.2d at 1228; *Developments*, *supra* note 160, at 1216; *In re Dennis H.*, 647 N.W.2d 851.

[391] *See, e.g.*, CAL. WELF. & INST. CODE § 5346(a)(3); DEL. CODE tit. 16, § 5013(a)(3); FLA. STAT. §394.4655(2)(c).

[392] *See In re Labelle*, 728 P.2d at 145-46; *In re Dennis H.*, 647 N.W.2d at 863.

[393] *See In re Oakes*, 8 Law. Rep. at 125; *In re Dennis H.*, 647 N.W.2d at 862-63.

[394] *See In re Labelle*, 728 P.2d at 146; *In re Dennis H.*, 647 N.W.2d at 861-62; *Developments*, *supra* note 160, at 1213-16.

[395] *See* Dinah Miller, MD, *Outpatient Civil Commitment: A Look at Maryland's New Legislation*, 41 PSYCHIATRIC TIMES 16 (2024).

[396] *See Wetherhorn*, 156 P.3d at 377.

[397] *See supra* note 3.

[398] *See In re Levias*, 517 P.2d 588, 591 (Wash. 1973), overruled in part by *In re McLaughlin*, 676 P.2d 444 (Wash. 1984).

Harper and its progeny, or as some other deprivation that warrants a more flexible ad hoc analysis under traditional involuntary commitment law. This confusion is most acute in states like New York that prohibit courts' use of contempt powers to enforce compliance.[399]

This Part seeks to draw lessons from the forcible treatment and inpatient commitment cases potentially useful in evaluating POC statutes' constitutionality. First, it proposes a framework for evaluating the constitutionality of POC statutes. Since POC principally involves the imposition of unwanted treatment, *Riggins* dictates that POC requires a "compelling," "overriding," or "essential" state interest.[400] *Harper* and its progeny in the civil commitment context provide the best standard for judging the sufficiency of states' police power interests in ordering POC. When judging the sufficiency of POC statutes motivated by *parens patriae* interests, however, this Article recommends drawing from the forcible treatment and preventive inpatient commitment cases in tandem. More precisely, to determine when a state's interest in involuntary medication is "essential" under *Riggins*, courts should use the standards developed in the preventive inpatient commitment cases. These cases provide the clearest indication of when the state's interest in preventing deterioration to future dangerousness justifies the substantial liberty deprivations inherent in involuntary commitment. This Part identifies the few POC statutes that are constitutional, or nearly constitution, under this dual framework.

This Part also explores possible implications of removing courts' contempt power on the balance of interests. Legislatures' power to remove courts' inherent authority to enforce their orders is suspect. Were contempt removal provisions to be upheld, these provisions could lessen the state interests needed to sustain POC statutes. However, given the substantial deprivation of liberty nevertheless effected by outpatient commitment orders, these statutes must still be justified by significant state interests. This Part draws from the inpatient commitment cases to suggest tentative standards by which to measure the sufficiency of states' police power and *parens patriae* interests. It applies these proposed standards to the few POC statutes with contempt removal provisions likely to be upheld under state law. Given the tentative nature of this analysis, this Part also discusses the implications of courts' acceptance of the standards approved in *In re K.L.* and *Coleman*.

A. A Proposed Constitutional Framework

Court-ordered outpatient treatment is "involuntary."[401] The fundamental right of individuals to make significant medical decisions, a right deeply rooted in both common law and the Constitution, extends beyond merely being free from government intrusion; it encompasses a right to receive treatment only after informed consent, enforceable through tort law.[402] The profound significance of this right—to refuse invasive treatment, regardless of its potential life-saving nature—yields a demanding test for any governmental override: involuntary treatment must be justified by an "essential" or "compelling" state interest.[403] This rigorous standard undoubtedly applies to any POC statute enforceable via courts' contempt power.[404] The test should also apply

[399] *See supra* note 119 (states removing courts' contempt power).
[400] *Riggins*, 504 U.S. at 135-36; *Sell*, 539 U.S. at 178-79.
[401] *See supra* notes 195, 198-200 (language in *Riggins* and supervised release cases).
[402] *See supra* note 41 (informed consent).
[403] *Riggins*, 504 U.S. at 135-36; *Sell*, 539 U.S. at 178-79.
[404] *See supra* note 199.

when judicial contempt powers are absent and POC orders are enforced by weaker mechanisms, such as heightened scrutiny for inpatient commitment, law enforcement seizures, and 72-hour holds.[405] These are all coercive measures involving multi-day losses of liberty.

Therefore, *Harper* and *Riggins* should apply to POC statutes authorizing courts to order involuntary medication. This includes all POC states except California, which expressly disallows "involuntary medication."[406] Remaining POC states must have a compelling, overriding, essential interest to order unwanted treatment.[407] When this interest concerns safety, treatment must be "medically appropriate and, considering less intrusive alternatives, essential for the sake of [the individual's] own safety or the safety of others."[408] The *Harper* standard most clearly applies to statutes motivated by states' police power interests.

To this degree, *Coleman*'s reasoning was sound. Quoting *Riggins*, the district court ruled involuntary medication justifiable only "if it was medically appropriate and, 'considering less intrusive alternatives, essential for the sake of [the plaintiff's] own safety or the safety of others.'"[409] Through its silence, the court recognized (correctly) that Kendra's Law was not justified by the *parens patriae* interest, since the law extends to individuals with treatment decision-making capacity.[410] But then the court erred: it construed *Riggins*'s term "essential" in the abstract and found it satisfied by a mishmash of anticipated *future* danger (including *future* deterioration), historical noncompliance, and a current unwillingness to participate in treatment.[411] *Harper*, *Riggins*, and their progeny are consistent: involuntary treatment of potentially competent individuals is only warranted when individuals, because of their mental disorders, present a *current danger*.[412] Dangerousness can include passive harm, but only when individuals' *current* deterioration or mental state—viewed through the lens of their past experiences—poses a *significant risk of substantial harm*.[413]

1. Police power grounds

POC statutes' harm criterion is typically too speculative for involuntary treatment to be *essential* to address an *essential* safety concern without a finding of incompetence to consent to

[405] *See Coleman*, 697 F.Supp.2d at 505-09 (applying *Harper* to New York's POC statute).

[406] *See infra* Part IV. Texas provides that courts can order patients to participate in treatment programs "but may not compel performance." Tex. Health & Safety Code § 574.037(c-3). However, unlike California, Texas clearly authorizes courts to order the administration of medication, *id.* § 574.037(b)(2), and apparently most treatment plans include medication orders. TEXAS AOT PRACTITIONER'S GUIDE 27 (2022), https://www.texasjcmh.gov/media/svlj51l4/texas-aot-practitioners-guide.pdf. Practitioners have interpreted the "no compulsion" provision as confirmation that physical force will not be used to secure compliance. *Id.* at 29.

[407] *Riggins*, 504 U.S. at 135-36; *Sell*, 539 U.S. at 178-79.

[408] *Riggins*, 504 at 135.

[409] *See Coleman*, 697 F. Supp. 2d at 506 (discussing *Riggins*); *id.* at 508 (recognizing "only an 'essential' interest" of the state could override Coleman's liberty interest).

[410] *In re K.L.* identifies participants' capacity to participate in their treatment plans as a central component of the law. *See In re K.L.*, 806 N.E.2d at 484.

[411] *See Coleman*, 697 F. Supp. 2d at 508.

[412] *See supra* note 210-213 (*Harper*'s current danger standard).

[413] *See supra* note 256 (applying *Harper* in context of grave disability and deterioration statutes).

treatment.[414] Under *Harper*, involuntary medication may be justified by a state's police power only by a current, substantial threat of significant physical harm,[415] or when individuals' severe health conditions pose a significant risk of substantial harm and treatment is essential for health or safety.[416] Additionally, the treatment must be "medically appropriate" and the "least restrictive alternative" for achieving the state's goals.[417] Current deterioration is required for current dangerousness. Only three POC statutes require *current deterioration*;[418] the remainder seek to prevent *anticipated*, not necessarily likely, *future* deterioration.[419]

Of the three statutes requiring current deterioration, Nevada's comes closest to meeting *Harper*'s dangerousness threshold for involuntary treatment under a state's police power. **Nevada** authorizes POC if it "is the least restrictive appropriate means to prevent *further disability or deterioration* that would result in the person becoming a person in a mental health crisis."[420] A person in a mental health crisis is one

> [w]hose capacity to exercise self-control, judgment and discretion in the conduct of the person's affairs and social relations or to care for his or her personal needs is diminished, as a result of the mental illness, to the extent that the person presents a *substantial likelihood* of *serious harm*[421] to himself or herself or others.[422]

This dangerousness standard meets the threshold accepted in forcible treatment[423] (and inpatient commitment)[424] cases involving grave disability and deterioration. However, the statute violates *Riggins* in failing to ensure that treatment is medically appropriate.[425]

2. *Parens patriae* and lesser police power grounds

When evaluating the sufficiency of POC statutes motivated by *parens patriae* interests and (typically)[426] lesser police power grounds, courts should draw from both forcible treatment and

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[414] *See supra* notes 236-237 (discussing implications of *Riggins* and *Sell*); Johnston & Klein, *supra* note 1, at Part IV (examining the harm components of 23 POC statutes).

[415] *See supra* notes 210-213, 238-252.

[416] *See supra* notes 253-260.

[417] *Riggins*, 504 U.S. at 135. Winick proposed a more rigorous dangerousness standard informed by case law before 2003. *See* Winick, *supra* note 8, at 114 ("the government should be required to demonstrate that the individual is presently dangerous, that the predicted violence is imminent, that the medication sought to be administered is medically appropriate, and that no less intrusive means would suffice").

[418] Only the POC statutes of Georgia, North Carolina, and Nevada require evidence of current deterioration or disability. *See* Johnston & Klein, *supra* note 1, at X (cite to tables with full statutory provisions, not summary tables).

[419] *See id.* at Part IV.

[420] Nev. Rev. Stat. Ann. § 433A.335(3).

[421] *Id.* § 433A.0195 (defining substantial likelihood of serious harm).

[422] *Id.* § 433A.0175(1).

[423] *See supra* note 256 (suggesting forcible treatment's permissibility in response to *existing deterioration* or mental states *currently posing* a *significant risk* of *substantial harm*).

[424] *See supra* notes 313-325 (suggesting that inpatient commitment is only appropriate in response to remote dangers if offset by particularly grave and highly likely harms).

[425] *See supra* notes 224-225 (*Riggins*); NEV. REV. STAT. ANN. § 433A.335(4) (requiring a sworn statement from a medical or mental health professional stating they evaluated the person, recommend the person be ordered to receive POC, and are willing to provide POC).

[426] *See infra* note 431

preventive inpatient commitment jurisprudence. Lower courts suggest that states may have compelling *parens patriae* interests in involuntarily treating incompetent individuals to prevent significant future harm,[427] but case law lacks clear standards for justifying this authority. Given the profound liberties implicated by POC, courts should apply the constitutional framework developed in preventive inpatient commitment cases.[428] Combining these cases' lessons with those of *Riggins*, court-ordered community treatment justified by a state's *parens patriae* interest requires demonstrating an individual's treatment decision-making incapacity;[429] that treatment is necessary to avert significant harm, medically appropriate, and in the individual's best interests; and that no less restrictive alternative means of achieving the state's interest is reasonably available.

Under this framework, the POC statutes of **Georgia** and **North Carolina** are both constitutional. Both require treatment decision-making incapacity plus current disability or deterioration that "would predictably result in dangerousness" to self or others.[430] These statutes focus on present deterioration likely to cause severe harm, whether that harm involves active danger or passive neglect and debilitation.[431] Both also require that treatment be medically appropriate[432] and the least intrusive means to achieve the state's interest.[433]

Hawaii's statute is also likely constitutional. Although not requiring current deterioration, the statute includes a *parens patriae* dangerousness element[434] and requires the incapacitated individual presently need treatment "to prevent a relapse or deterioration that would predictably result in the person becoming imminently dangerous to self or others.[435]"[436] This likely surpasses the dangerousness threshold necessary for POC under the *parens patriae* rationale. Hawaii requires finding that POC, "[c]onsidering less intrusive alternatives, . . . is essential to prevent the danger posed by the person, is medically appropriate, and is in the person's medical interests."[437]

Oregon's POC statute could possibly be constitutional under *Harper*'s progeny and the preventive inpatient commitment cases if it included a provision ensuring medically appropriate treatment. Oregon requires treatment decision-making incapacity, includes a *parens patriae*

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[427] *See supra* notes 271-278.

[428] *See supra* notes 341-382.

[429] Given the importance of treatment decision-making incapacity for a valid exercise of *parens patriae* power, which impairments—and at what level of severity—are necessary or sufficient to establish this "incapacity" becomes a crucial question. *See supra* note 185.

[430] *See* GA. CODE ANN. § 37-3-1(12.1)(B); N.C. GEN. STAT. § 122C-271(a)(1).

[431] *See* N.C. GEN. STAT. § 122C-3(11) (defining "dangerous to self or others"). Indeed, these statutes' dangerousness components are so robust that these statutes are likely justified on police power grounds alone. *See supra* Part III.A.1.

[432] *See* GA. CODE ANN.. §§ 37-3-94(a), 37-1-120(2)(C), (F); N.C. GEN. STAT. § 122C-273(a).

[433] *See* GA. CODE ANN. §§ 37-3-1(12.2), 37-3-1(12.1)(B)-(C); N.C. GEN. STAT. §§ 122C-263(d)(1), 122C-273(a)(4)-(5).

[434] *See supra* note 391 and associated text; HAW. REV. STAT. ANN. § 334-121(2) ("is unlikely to live safely in the community without available supervision").

[435] HAW. REV. STAT. ANN. § 334-1 (defining "imminently dangerous to self or others" to mean "that, without intervention, the person will likely become dangerous to self or dangerous to others within the next forty-five days").

[436] *Id.* § 334-121(2).

[437] *Id.* § 334-121(4).

dangerousness element,[438] and aims to prevent deterioration.[439] This deterioration need only "predictably" result in the person meeting inpatient treatment conditions, allowing for a low likelihood.[440] Additionally, one identified harm in the inpatient commitment provision is itself deterioration.[441] That future deterioration must be ongoing and requires a "reasonable medical probability" of causing either "danger to self or others" or inability to care for one's "basic personal needs that are necessary to avoid serious physical harm in the near future."[442] While insufficient under *O'Connor*'s dangerousness progeny, these components satisfy the substantive requirements of *parens patriae* under preventive inpatient commitment case law and may suffice under *Harper*. However, as previously discussed, the statute's failure to ensure treatment's medical appropriateness violates *Riggins* and renders the statute constitutionally problematic.[443]

3. Likely unconstitutional POC statutes

Otherwise, POC statutes' harm is too speculative for involuntary treatment to be *essential* to address an *essential* safety concern.[444] None of the remaining seventeen statutes include dangerousness elements robust enough to satisfy *Harper*'s requirements for involuntarily treating competent individuals.[445] Six POC statutes authorize court-ordered treatment to prevent the future deterioration of competent individuals to a condition permitting involuntary hospitalization.[446] Four additional states seek to prevent the future deterioration of competent individuals likely to cause serious harm, but the degree of this harm would be *insufficient* for inpatient commitment.[447] Even more constitutionally dubious, four other POC statutes permit the outpatient commitment of competent individuals merely upon (a) a finding of the *parens patriae* dangerousness element,[448] or (b) anticipated deterioration to an intolerably speculative future harm.[449] Fewer than half of

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[438] *See* OR. REV. STAT. § 426.133(2)(b)(A); *supra* note 391 and associated text.

[439] OR. REV. STAT. § 426.133(2)(b).

[440] *Id.*

[441] *Id.* § 426.005(f)(C)(iv).

[442] *Id.* § 426.005(f).

[443] *See supra* notes 232-233.

[444] *See supra* notes 236-237 (discussing implications of *Riggins* and *Sell*).

[445] The constitutionality of Florida, Louisiana, New York, Oklahoma, and Utah's POC statutes is discussed in Part III.B.

[446] *See* S.B. 453, § 10-6A-05(A)(4), 446th Gen. Assemb., Reg. Sess. (Md. 2024) (aiming to prevent "deterioration that would create a substantial risk of serious harm to the individual or others"); N.M. STAT. § 43-1B-3(E) (2023) (aiming to prevent deterioration "likely to result in serious harm to self or . . . others"); OHIO REV. CODE § 5122.01(B)(5)(a)(iv) (2023) (aiming to prevent deterioration likely to lead to "substantial risk of serious harm to the person or others"); TEX. HEALTH & SAFETY CODE § 574.0345(a)(2)(B), (C) (seeking to prevent deterioration to an inability "to live safely in the community without court-ordered outpatient mental health services" and relapse likely "to result in serious harm" to self or others). This analysis also extends to the POC statutes of Louisiana and New York. *See infra* Part III.B.4.

[447] *Compare* MONT. CODE §§ 53-21-127(7), 53-21-126(1)(d), *with id.* § 53-21-126(1)(a)-(c); *compare* 50 PA. CONS. STAT. § 7301(c)(i), (iv), *with id.* § 7301(a). This analysis also extends to Oklahoma and Florida. *See infra* Part III.B.4.

[448] *See* DEL. CODE tit. 16, § 5013(a)(3); WASH. REV. CODE § 71.05.148(1)(b)(i).

[449] *See* ME. REV. STAT. tit. 34-B, § 3801(4-A)(D) (requiring "a *reasonable likelihood* that the person's mental health will deteriorate and that the person will *in the foreseeable future* pose a likelihood of serious harm" satisfying the inpatient requirements); 405 ILL. COMP. STAT. 5/1-119.1(2) (requiring, for POC, that symptomology is "reasonably

these statutes require evidence of treatment nonadherence resulting in hospitalizations or acts or threats of violence within the preceding 48 months.[450]

The POC statutes of **Alabama** and **Kentucky** (and **Utah**, discussed in Part III.B.4) are most clearly unconstitutional. Alabama allows outpatient commitment if a competent individual "will suffer mental distress and experience deterioration of the ability to function independently."[451] The degree of deterioration from one's current condition is unstated. Alabama courts need not find significant decision-making impairment so long as they can identify instances of inconsistent treatment maintenance over the preceding two years, a standard possibly indicative of a mere unwillingness, or inability for reasons unrelated to mental illness, to follow a particular treatment regimen.[452]

Kentucky's POC statute requires finding treatment decision-making impairment but not dangerousness, necessitating only that the person have a history of treatment nonadherence, be "in need of . . . treatment," have a history of repeated nonadherence within the preceding four years, and be suffering from "a serious mental illness."[453] A need-for-treatment standard has repeatedly been rejected in the inpatient commitment context.[454]

B. Effect of removing courts' contempt power

The impact of removing courts' contempt power on this analysis is uncertain. Individuals' right to control significant treatment decisions constitutes such an important liberty interest that it necessitates protection unless the state can demonstrate a compelling or essential reason to override it, irrespective of the strength of the state's enforcement mechanisms. Reducing the severity of the state's response to noncompliance undoubtedly mitigates liberty deprivations and affects the balance of interests.[455] However, practically all POC statutes include express, nontrivial responses to noncompliance, thereby still materially diminishing individual liberty.[456]

More fundamentally, the apparent underlying aim of contempt removal measures—to shield POC statutes from substantive due process challenge—should not be sanctioned by the judiciary. These provisions implicitly acknowledge that enforcing POC treatment orders *as written*

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expected" to worsen such that individuals would then meet the inpatient commitment standards.); *Id.* 5/1-119 (permitting inpatient commitment of individuals "unable to understand [their] need for treatment" *and* with a reasonable expectation of "suffer[ing] mental or emotional deterioration" which will then result in a reasonable expectation of meeting the normal inpatient commitment dangerousness requirements). Because the Illinois outpatient standards allow the commitment of someone who is "reasonably expected" to deteriorate with the possible result of merely further deterioration, the dangerousness standard is unmet. The harm is simply too speculative.

[450] Seven of eighteen states do. *See* MD. HEALTH-GEN. CODE ANN. § 10-6A-05(a)(3); N.M. STAT. ANN. § 43-1B-3(C); N.Y. MENTAL HYG. LAW § 9.60(c)(4); OHIO REV. CODE ANN. § 5122.01(B)(5)(a)(ii); OKL. STAT. tit. 43A, § 1-103(20)(d); 50 PA. CONS. STAT. § 7301(c)(ii); WASH. REV. CODE ANN. § 71.05.148(1)(c).

[451] ALA. CODE § 22-52-10.2(a)(2).

[452] *Id.* § 22-52-10.2(a)(3); *see* Johnston & Klein, *supra* note 1, at X (differentiating between situational and contumacious noncompliance).

[453] KY. REV. STAT. § 202A.0815.

[454] *See supra* notes 329-336.

[455] *See supra* note 103.

[456] *See supra* Part I.B.1.

likely contravenes substantive due process.[457] A court should not be permitted to use its mantle of legitimacy to mandate compliance with directives that, if enforced, would violate individuals' substantive due process rights.[458] Doing so hollows the legitimacy of the judicial system, invites defiance of court orders, and absolves the legislative branch of its duty to adhere to constitutional constraints.[459] Society would be unlikely to tolerate this action if it applied to the general population; we should be no less vigilant and faithful to the Constitution when motivated by paternalism toward a vulnerable, marginalized population unlikely to fully comprehend—or be confident enough to assert—their constitutional rights.[460]

Thus, the *Harper* and *Riggins* tests should apply to POC laws in the few states where contempt removal provisions are likely to withstand state constitutional scrutiny:[461] Florida,[462] Louisiana,[463] New York,[464] Oklahoma,[465] and Utah.[466] Individuals' rights to refuse treatment should be protected unless outweighed by a compelling or essential state interest. However, the reduced deprivation resulting from the absence of harsh enforcement mechanisms such as steep fines or incarceration should be considered in the analysis.[467] Identifying precedent to guide this balancing of interests is difficult.

To date, courts have only scrutinized the constitutionality of Kendra's Law, which forbids courts' use of contempt power to enforce treatment orders.[468] *Coleman* and *In re K.L.* permitted a *less pressing danger* to establish the state's interest than would traditionally satisfy the rigorous test established by *Harper* and *Riggins* for potentially competent individuals. *In re K.L.* framed this lower standard as a permissible consequence of determining that committees suffered only a "minimal" deprivation of liberty, which would, given its trivial nature, be outweighed by non-

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[457] *See supra* note 121.

[458] The "black robe effect"—or the effect of "the symbolic power of the court as an authority figure" in ordering treatment (separate from the enforceability of that order)—is widely credited with individuals' compliance with treatment orders. *See* Brian D. Shannon, *Model Legal Processes for Court-Ordered Mental Health Treatment-A Modern Approach*, 18 FIU L. Rev. 113, 147 & n.143 (2023). However, "there is no existing research that empirically examines this phenomenon." Elizabeth Sincliar Hancq et al., *Critical Gaps in Assisted Outpatient Treatment Research in the United States*, SPRINGER MEDIZIN *2 (Apr. 30, 2024).

[459] *Cf.* Escobedo v. Illinois, 378 U.S. 478, 490 (1964) ("If the exercise of constitutional rights will thwart the effectiveness of a system of law enforcement, then there is something very wrong with that system.").

[460] *See* Olmstead v. United States, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting) ("Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent.").

[461] *See supra* notes 119-40 (contempt removal provisions), 122-128 (case law suggesting the unconstitutionality of those provisions).

[462] *See* A.A. v. Rolle, 604 So. 2d 813, 815 (Fla. 1992) ("the sanctions to be used by the courts in punishing contempt may properly be limited by statute"); Walker v. Bentley, 660 So. 2d 313, 319 (Fla. 2d Dist. App. 1995).

[463] *See* LA. CONST. ANN. ART. V, § 2 ("The power to punish for contempt of court shall be limited by law."); Art. 227. Punishment for contempt., 1 LA. PRAC. CIV. PROC. ART. 227 (2024 ED.).

[464] *See* Douglas v. Adel, 199 N.E. 35, 36 (N.Y. 1935) (recognizing that Judiciary Law Art. 19 "enumerates the acts which constitute criminal contempt . . . and extent of the punishment"); N.Y. JUDICIARY LAW § 753 (defining courts' power to punish for civil contempts); Dollard v. Koronsky, 121 N.Y.S. 987, 990 (N.Y. App. Term. 1910) (stating "the private or civil contempt might go beyond the statutory enumeration and include also what was usual or permissible at common law" and discussing common-law power).

[465] *See* OKLA. CONST. ART. II, § 25 ("The legislature shall pass laws defining contempts and regulating the proceedings and punishment in matters of contempt.").

[466] The constitutionality of Utah's contempt removal provision is unclear. *See supra* note 129.

[467] *See supra* note 103.

[468] *See* N.Y. MENTAL HYG. LAW § 9.60(n).

trivial state interests.[469] The entirety of the court's police powers analysis consisted of quoting the deterioration provision of Kendra's Law then concluding that "the state's police power justifies the minimal restriction on the right to refuse treatment."[470] The court's *parens patriae* analysis was even more deficient. Listing a host of POC criteria,[471] the court (again summarily) concluded "the state's *parens patriae* interest in providing care to its citizens who are unable to care for themselves because of mental illness is properly invoked"[472]—despite the court's express recognition that "a large number of [POC] patients" retain treatment decision-making competency.[473] This contradicts longstanding law in the involuntary commitment context.[474] The state may only involuntarily commit individuals who *retain* the competency to make treatment decisions when their dangerousness justifies associated liberty deprivations.[475] Merging a constitutionally insufficient police powers interest with a constitutionally insufficient *parens patriae* interest does not produce *en toto* a sufficiently compelling state interest to justify involuntary commitment.

On the other hand, *Coleman* purported to apply the standard developed in *Harper* and its progeny but likewise supplied a superficial police powers analysis. After noting that "only an 'essential' interest on the part of the state can override th[e] liberty interest [of avoiding the forced administration of antipsychotics]," the court listed findings required by the POC statute then promptly concluded the statute "essentially requires a finding of dangerousness—either to the patient or others."[476] The court failed to evaluate the magnitude of the "dangerousness" presented or to recognize the statute does not require current or even likely deterioration. Like *In re K.L.*, the federal court's analysis neglected to assess how unlikely, non-imminent deterioration may affect the "danger" the individual presents when treatment is compelled. The extent to which the state's removal of courts' contempt power affected *Coleman*'s analysis is unclear. *After* having established the state's "essential" interest, the court noted that "the limitations on a patient's liberty interests effected by [a POC] order are considerably less invasive than those considered in *Harper*, *Riggins*, and *Sell*," which permitted forcible injection.[477] This observation seemed to strengthen the court's conclusion of the law's constitutionality, but whether it played any role in decreasing the dangerousness threshold necessary to establish the state's "essential" safety interest was not indicated.

These cases provide insufficient guidance for determining how lesser enforcement should affect the balance of interests. To generate a lesser threshold for the state's police power interests, courts could draw inspiration from inpatient commitment cases involving grave disability and

[469] *See In re K.L.*, 806 N.E.2d at 485.

[470] *See id.*

[471] *Id.* at 486 (noting the POC law "requires findings that the patient is unlikely to survive safely in the community without supervision; the patient has a history of lack of compliance with treatment that has either necessitated hospitalization or resulted in acts of serious violent behavior or threats of, or attempts at, serious physical harm; the patient is unlikely to voluntarily participate in the recommended treatment plan; the patient is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others; and it is likely that the patient will benefit from assisted outpatient treatment").

[472] *Id.*

[473] *Id.* at 484.

[474] *See supra* notes 329-336 (pertaining to the unconstitutionality of involuntary commitment merely to provide needed treatment for a mental illness).

[475] *See supra* Part II.A-B.

[476] *Coleman*, 697 F. Supp. 2d at 508-09.

[477] *Id.* at 509.

deterioration, which evaluate the various facets of dangerousness. These precedents recognize that dangerousness may justify involuntary hospitalization if anticipated harm, though not imminent, is both highly probable and very grave.[478] In manipulating differing gradations of imminence, likelihood, and severity of harm, these cases (although in a different context) suggest that a milder form of danger—with lesser degrees of likelihood and severity of harm—may justify court-ordered involuntary treatment when defiance of court orders will be met with nonpunitive enforcement.

1. Police power grounds

As discussed previously, the *Harper* line of cases suggests that, when noncompliance with medication orders will be met with severe enforcement measures, involuntary medication may be justified via police power only by a current, substantial threat of significant physical harm,[479] or when individuals' severe health conditions pose a significant risk of substantial harm and treatment is essential for health or safety.[480] Given these standards, when individuals who defy medication orders *cannot* be incarcerated or fined, POC might be justified by a *significant* threat of serious harm, or, stated differently, by harm that is *significantly likely* and serious.[481] Given the critical liberties at stake—the freedom to make important treatment decisions, bodily integrity, and freedom of mentation—the anticipated harm must be serious, and its likelihood must be at least significant for POC to be justified.

Crucially, POC involves harm that is typically two steps removed: it involves a future deterioration of a particular likelihood, which in turn entails a particular likelihood of a particularly severe harm. Therefore, a potential standard for POC enforced through less stringent mechanisms could be a requirement of a *substantial likelihood* of deterioration that is *substantially likely* to lead to *serious harm*.[482] Statutes requiring the individual to have had an involuntary civil commitment or forensic care within the prior year or two—currently not a requirement of any existing statute[483]—could possibly assist in meeting this standard.[484] Although "substantial" seems materially greater than "significant," a substantial likelihood of deterioration leading to a substantial likelihood of harm can equate to a significant overall likelihood. For instance, assuming

[478] *See supra* notes 313-325; 341-367.

[479] *See supra* notes 210-213, 238-252.

[480] *See supra* notes 253-260.

[481] *Cf.* E. Lea Johnston, *Imperfect Insanity and Diminished Responsibility*, 76 FLA. L. REV. 553 575-76 (2024) (arguing that partial responsibility standards should recognize a lesser degree of impairment than that required for nonresponsibility and drawing from examples in the United States and internationally).

[482] *Cf. supra* notes 313-325 (discussing cases requiring that, in an absence of imminence, inpatient commitment statutes require anticipated harm to be quite grave and highly probable to justify state intervention); *In re Torski C.*, 918 N.E.2d at 1230 (holding, in the context of a preventive inpatient commitment statute *requiring treatment decision-making incapacity*, that "a valid exercise of the State's police power shall be taken only in the interest of preventing behavior likely to result in injury to one's self or others"); *In re Dennis H.*, 647 N.W.2d at 860-62 (finding a preventive inpatient commitment statute *requiring treatment decision-making incapacity* to be constitutional because the probability of deterioration toward future harm is high and the harm contemplated by the deterioration is substantial).

[483] Ten of 23 POC statutes require specific evidence of past treatment failures, with most of these considering incidents within the preceding 48 months. *See* Johnston & Klein, *supra* note 1.

[484] *See* Heller v. Doe, 509 U.S. 312, 323 (1993) ("Previous instances of violent behavior are an important indicator of future violent tendencies.").

"substantial" translates to roughly a 60% probability, a substantial likelihood of deterioration carrying a substantial likelihood of harm results in a 36% likelihood of harm (0.60 x 0.60).

2. *Parens patriae* and lesser police power grounds

Regarding states' *parens patriae* interests, the case law on involuntary treatment and preventive inpatient commitment coalesce around the importance of limiting these measures to individuals who lack treatment decision-making competency.[485] Otherwise, the state has no legitimate interest in substituting its judgment for that of the patient.[486] Additionally, POC statutes rooted in *parens patriae* power should require that treatment confer a substantial net benefit or avert likely harm. Without this, the state lacks a legitimate basis for overruling a patient's objection to unwanted, invasive treatment with potentially serious and long-lasting side effects. Existing case law does not provide a clear standard for the minimum degree of danger or anticipated benefit required by substantive due process in this context.

3. Application to POC statutes prohibiting contempt sanctions

None of the five POC statutes whose contempt prohibitions are most likely to survive states' separation of power principles—those of **Florida**, **Louisiana**, **New York**, **Oklahoma,** and **Utah**—would meet either of the standards proposed above. None of these statutes requires treatment decision-making incapacity, so none is justified via a state's *parens patriae* authority.[487] Additionally, while most contemplate serious harm,[488] none requires *likely* deterioration, or deterioration *substantially likely* to result in harm.[489]

4. Application of *Coleman* and *In re K.L.* to POC statutes prohibiting contempt sanctions

Given the uncertainty around the impact of removing courts' contempt power on the evaluation of POC's constitutionality, it may be valuable to assess the potential influence of *In re K.L.* and *Coleman* on the POC laws in Florida, Louisiana, Oklahoma, and Utah, should courts find

[485] *See supra* notes 167-169, 184-187, 262-266, 341-382.
[486] *See supra* notes 167-187.
[487] *See supra* note 485.
[488] *But see infra* notes 499-500 (Florida).
[489] *See* La. Rev. Stat. Ann. § 28:66(A)(3), (6) ("is unlikely to survive safely in the community without supervision[; and . . . in] view of the treatment history and current behavior . . . is in need of [POC] to prevent a relapse or deterioration which would be likely to result in the respondent's becoming dangerous to self or others or gravely disabled"); Okla. Stat. Ann. tit. 43A, § 1-103(20)(c), (f) ("[i]s incapable of surviving safely in the community without treatment; and [r]equires treatment to prevent a deterioration in the person's condition that will predictably result in the person becoming a person with mental illness"); *id.* § 426.130(1)(a) (defining "person with mental illness); N.Y. Mental Hyg. Law § 9.60(c)(3), (6) ("is unlikely to survive safely in the community without supervision, based on a clinical determination; . . . [and] in view of his or her treatment history and current behavior, is in need of [POC] to prevent a relapse or deterioration which would be likely to result in serious harm to the person or others"); *infra* notes 511-513 (Utah).

these cases persuasive. Louisiana's POC law, in terms of its dangerousness criterion[490] and explicit consequences for noncompliance, [491] closely mirrors that of New York and would likely be upheld.

This result is less certain in Oklahoma for two reasons. First, Oklahoma's dangerousness requirement is less demanding than New York's. Kendra's Law seeks to prevent deterioration likely to result in serious harm to self or others,[492] defined as a substantial risk of physical harm manifested by threats of violent behavior.[493] Oklahoma's POC statute includes the *parens patriae* dangerousness formulation[494] and seeks to prevent deterioration "likely to result in serious harm,"[495] which, unlike the harm component of its inpatient commitment standard,[496] is undefined. Second, Oklahoma provides for stronger means of enforcement than New York. In addition to evaluation for inpatient commitment,[497] Oklahoma courts may respond to noncompliance by "order[ing] the person to show cause why the court should not . . . enter an order of admission . . . to inpatient treatment."[498] Placing the burden on the noncompliant individual to demonstrate why inpatient commitment is not appropriate makes inpatient placement considerably more likely, thus increasing the coercive nature of POC.

The constitutionality of Florida's POC law is also unclear. Like Oklahoma, Florida's POC statute includes a lower dangerousness threshold and permits harsher enforcement mechanisms than Kendra's Law. Florida's POC statute includes the *parens patriae* dangerousness formulation and seeks to prevent deterioration "likely to result in serious bodily harm . . . or a *substantial harm to [the individual's] well-being*,"[499] construed to require "some risk to personal safety."[500] "Some risk to personal safety" is a far cry from New York's requirement of "a substantial risk of physical harm" manifested by particular conduct.[501] Moreover, even if the anticipated harm in Florida's POC statute were to manifest, it would not necessarily meet Florida's involuntary hospitalization standard, as the inpatient statute requires a greater degree of gravity and much higher likelihood and imminence requirements.[502] While Kendra's Law requires a particularized history of treatment nonadherence within the preceding four years, Florida merely requires a nonspecific "history" of nonadherence.[503] Finally, while Florida's POC law removes incarceration as a sanction for noncompliance,[504] it leaves intact courts' other contempt sanctions, including fines, revocation of a driver's license, and garnishment of wages.[505]

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[490] *See supra* note 489.
[491] La. Rev. Stat. Ann. § 28:75(c).
[492] N.Y. MENTAL HYGIENE LAW § 9.60(c)(6).
[493] *Id.* at § 9.01.
[494] OKLA. STAT. tit. 43A, § 1-103(20)(c).
[495] *Id.* § 1-103(20)(f).
[496] *Id.* § 1-103(13)(a).
[497] *Id.* § 5-416 (P).
[498] *Id.* § 5-416(B)(2)(b).
[499] Fla. Stat. Ann. § 394.467(2)(a)(2), (4).
[500] Hedrick v. Fla. Hosp. Medical Ctr., 633 So. 2d 1153, 1154 (Fla. Dist. Ct. App. 1994).
[501] N.Y. MENTAL HYGIENE LAW §§ 9.60(c)(6), 9.01.
[502] *See* Fla. Stat. Ann. § 394.467(2)(b).
[503] *See* Fla. Stat. Ann. § 394.467(2)(a)(3).
[504] *See id.* § 394.467(10)(b).
[505] Parisi v. Broward Cnty., 769 So. 2d 359, 365 (Fla. 2000).

Utah's POC statute is likely unconstitutional under any plausible standard. Even if its contempt provision were upheld,[506] its authorized response to noncompliance is so coercive that it likely operates as an effective substitute for a court's threat to incarcerate. Upon noncompliance, "[a] local mental health authority . . . is authorized to issue an order for the immediate placement of a current patient into a more restrictive environment."[507] This restrictive placement may continue *until the original order of commitment expires* so long as the patient "is in the least restrictive environment that is appropriate for the patient's needs," give their demonstrated noncompliance.[508] Thus, while the court lacks the power to incarcerate for noncompliance, a mental health authority can confine noncompliant individuals for a year *without meeting inpatient criteria*.[509] This is arguably an equally coercive enforcement mechanism and ultimate deprivation of liberty.[510]

Additionally, Utah's POC statute is unlikely to satisfy the *Harper* standard. Utah offers two grounds for POC: an individual may *either* "lack[] the ability to engage in a rational decision-making process regarding the acceptance of mental health treatment" *or* need treatment "to prevent relapse or deterioration that is likely to result in the proposed patient posing a substantial danger to self or others."[511] As discussed, commitment based solely on need for treatment is unconstitutional.[512] Commitment under the dangerousness criterion should also be unconstitutional. Current deterioration is not required, and a substantial danger may be established by finding the person's mental illness poses a "serious risk" of "caus[ing] a substantial deterioration of the individual's previous ability to function independently."[513] Loss of independence does not encompass severe harm. This dangerousness element cannot satisfy the police powers doctrine and would require a finding of incapacity (here, a different option) to satisfy the *parens patriae* doctrine.

IV. Conclusion

POC is a runaway train that legislatures are actively accelerating. While certainly motivated by benevolent intentions,[514] these laws allow states to override the treatment and lifestyle decisions of nondangerous, competent individuals with mental disorders and dramatically expand states' control over a vulnerable, historically stigmatized class of people.

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[506] *See* UTAH CODE § 26B-5-351(20); *supra* note 129.

[507] UTAH CODE § 26B-5-337(3)(a) (so long as the patient had agreed to that plan in writing).

[508] *Id.* § 26B-5-337(3)(d). If an objecting patient requests a hearing, *id.* § 26B-5-337(3)(c), the court must find the patient did indeed fail to comply, procedural requirements were met, and the patient "is in the least restrictive environment that is appropriate for the patient's needs." *Id.* § 26B-5-337(3)(d).

[509] *Id.* § 26B-5-351(18)(a).

[510] *See also supra* note 110 (regarding a lower threshold for the inpatient commitment of individuals under POC orders).

[511] UTAH CODE § 26B-5-351(14)(a).

[512] *See supra* notes 329-336 (inpatient commitment).

[513] UTAH CODE § 26B-5-301(24).

[514] *See, e.g.*, TREATMENT ADVOC. CTR., A PROMISING START 3 (2019), https://www.tac.org/wp-content/uploads/2023/11/A-Promising-Start.pdf ("The intent of the practice explicitly authorized by [a POC law], is to provide access to treatment otherwise unavailable to people with severe mental illness who, as a manifestation of the illness, either will not volunteer for services or have demonstrated poor engagement with voluntary services."); *supra* notes 2-3.

These laws typically do not reflect strong police power or *parens patriae* interests and thus are of questionable constitutionality. To date, only Kendra's Law has received sustained constitutional scrutiny. These cases are of limited utility given their superficial analyses of police power and *parens patriae* interests. Additionally, New York belongs to the minority of states that prohibit courts from enforcing treatment orders through their contempt power. This distinguishing characteristic renders those decisions inapplicable to the majority of POC states that permit courts to incarcerate or fine noncomplying individuals or whose contempt-removal provisions are likely unconstitutional under state law.

POC involves court-ordered medication as well as community treatment programs, services, and supervision measures. Its dual nature implicates two critical bodies of constitutional law: those governing forcible medication and inpatient civil commitment. Consequently, the constitutionality of POC statutes should be assessed through a synergistic framework derived from both legal contexts. This Article examines relevant case law to distill plausible constitutional standards for evaluating POC statutes. It proposes that *Harper*'s dangerousness standard should govern POC statutes dominated by police power interests, while an amalgam of principles from the forcible treatment and preventive inpatient commitment cases should set constitutional thresholds for POC statutes motivated by *parens patriae* and lesser police power interests.

Applying these standards, the Article identifies five states whose POC laws are likely constitutional, or nearly so.[515] Three POC statutes are clearly unconstitutional.[516] Fourteen POC statutes are of dubious constitutionality. Three of these statutes' legality will depend on how states' removal of courts' contempt power affects the quantum of state interests necessary to justify the lesser infringement of liberty.[517] The author hopes this constitutional analysis will guide courts' review of POC statutes and prompt legislative reflection on the constitutionality of pending bills and existing POC schemes.

States seeking to better engage individuals with serious mental illnesses in intensive case management and services, while adhering to constitutional standards, might look to California's POC statute, Laura's Law, for inspiration. Unique among POC laws, Laura's Law prohibits "*involuntary* medication."[518] Treatment under Laura's Law typically occurs voluntarily, without court involvement.[519] Recent reports from the California Department of Health Care Services show that 72% to 81% of eligible individuals participate in services voluntarily, without the need for a court petition.[520] Counties attribute the high degree of voluntary participation to sustained

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[515] *See supra* Part III.A.1-2 (Nevada, Georgia, North Carolina, Hawaii, Oregon).

[516] *See supra* Part III.A.3, B.4 (Alabama, Kentucky, Utah).

[517] *See supra* Part III.B.

[518] CAL. WELF. & INST. CODE § 5348(c). *Cf. supra* note 406 (Texas).

[519] TREATMENT ADVOC. CTR., *supra* note 514, at 13.

[520] *See* CA. DEP'T OF HEALTH CARE SERVS., LAURA'S LAW: ASSISTED OUTPATIENT TREATMENT DEMONSTRATION PROJECT ACT OF 2002 8 (2020), https://www.dhcs.ca.gov/Documents/CSD_KS/Laura's%20Law/Laura's-Law-Legislative-Report-2018-19.pdf (reporting that 75% of individuals (686/914) accepted voluntary services); CA. DEP'T OF HEALTH CARE SERVS., LAURA'S LAW: ASSISTED OUTPATIENT TREATMENT DEMONSTRATION PROJECT ACT OF 2002 5 (2021), https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Lauras-LawLegRpt-July2018-June2019.pdf ("The AOT program showed high voluntary participation – 75 percent of total individuals referred for an assessment who were located for services participated voluntarily."); CA. DEP'T OF HEALTH CARE SERVS., LAURA'S LAW: ASSISTED OUTPATIENT TREATMENT DEMONSTRATION PROJECT ACT OF 2002 5 (2022),

community outreach and targeted engagement with individuals discharged from hospitals or released from jail.[521] Counties report an average of 22 contact attempts over 61 days before escalating to court petition.[522]

Of the 20 to 30% of individuals who receive services through court engagement, only about half are under court order.[523] Unlike other states, California mandates that authorities invite individuals to voluntarily accept services before processing a court petition for compulsory treatment.[524] When individuals voluntarily accept services, it is known as a voluntary settlement agreement, which, in California, does not involve judicial oversight.[525]

Court-ordered plans under Laura's Law primarily consist of services rather than medication. Evidence suggests that many—although not all[526]—counties have interpreted Laura's Law's to prohibit court-ordered medication.[527] Some counties provide medication support services only when individuals sign consent forms.[528] The consent rate is unclear but may be high due to the coercive threat of possible involuntary hospitalization for treatment refusal.[529] Without court-ordered medication, California's service plans may include psychiatric and psychological services, substance abuse services, housing assistance, vocational rehabilitation, and veterans' services.[530] While mandatory attendance at these programs can be burdensome, they are generally not

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https://www.dhcs.ca.gov/formsandpubs/Documents/Lauras-Law-AOT-Report-2021.pdf (72%); CA. DEP'T OF HEALTH CARE SERVS., LAURA'S LAW: ASSISTED OUTPATIENT TREATMENT DEMONSTRATION PROJECT ACT OF 2002 15 (2023), https://www.dhcs.ca.gov/Documents/2022-Lauras-Law-Assisted-Outpatient-Treatment-Demonstration-Project-Act-of-2002.pdf (81%).

[521] *See* CA. DEP'T OF HEALTH CARE SERVS. (2023), *supra* note 520, at 15; TREATMENT ADVOC. CTR., *supra* note 514, at 10.

[522] CA. DEP'T OF HEALTH CARE SERVS. (2023), *supra* note 520, at 16.

[523] *See id.* at 12 (showing that of those who received services through involvement of courts, 46% reached voluntary settlements, while 54% received court orders).

[524] CAL. WELF. & INST. CODE § 5348(b).

[525] TREATMENT ADVOC. CTR., *supra* note 514, at 16.

[526] *See* NEVADA CNTY., THE NEVADA COUNTY EXPERIENCE ASSISTED OUTPATIENT TREATMENT (W&I CODE 5345) (AB 1421) "LAURA'S LAW" 19 (2014), https://www.nevadacountyca.gov/DocumentCenter/View/10779/Assisted-Outpatient-Treatment-The-Nevada-County-Experience-Revised-June-2014-PDF.

[527] *See* TREATMENT ADVOC. CTR., *supra* note 514, at 16.

[528] *See* California Assoc. Local Behav. Health Bds. & Commissions, Laura's Law (last accessed Sept. 28, 2024), https://www.calbhbc.org/lauras-law.html (explaining that, "while medication is not forced, medication outreach is ordered when a client agrees to medication as part of treatment (the medication is to be self-administered)"); L.A. Co. Dept. of Mental Health, Assisted Outpatient Treatment for Los Angeles, Frequently Asked Questions, https://file.lacounty.gov/SDSInter/dmh/242332_AOT-LAFAQsrevised03212016.pdf ("DMH and/or contract providers may provide medication support services provided a consent for medication form is signed by a client.").

[529] *See* CA. PSYCHIATRIC ASS'N, THE ASSISTED OUTPATIENT TREATMENT DEMONSTRATION PROJECT ACT OF 2002 LAURA'S LAW: THE FACTS 2–3 (2011), https://dhs.saccounty.gov/BHS/Documents/Advisory-Boards-Committees/Mental-Health-Board/MHB-General-Meeting-Minutes-2011/2011-09-07_MHB_Gen_Minutes--AttF_Laura%27s_Law-Hagar.pdf (discussing the consequences of noncompliance); Jorgio Castro, *Laura's Law: Concerns, Effectiveness, and Implementation*, 10 CA. LEGAL HIST. 175, 184 (2015) (referring to a Section 5150 hold as "the 'stick' in the court-ordered process meant to persuade compliance with the court order."); Cal. Welf. & Inst. Code § 5150 (criteria for involuntary hold for inpatient commitment evaluation); Boldt, *supra* note 12, at 88-89 (exploring the problematic nature of "consent" given under coercive circumstances).

[530] CAL. WELF. & INST. CODE § 5348(a)(2)(B).

considered invasive[531] and thus require lower justifications of police power and *parens patriae* interests.[532]

The longevity and apparent success of California's POC program demonstrate the feasibility of expanding mental health treatment through sustained outreach and the use of intensive voluntary treatment modalities like ACT.[533] The separation of medication directives from court-ordered services appears workable. A 2019 review by the Treatment Advocacy Center found that all counties with Laura's Law programs "experienced decreases in psychiatric hospitalizations, crisis contacts, incarcerations and/or homelessness among . . . enrollees."[534] The most recent state report, reflecting data collected between July 2020 and June 2021, concluded that Laura's Law reduced homelessness by 26%, hospitalizations by 51%, law enforcement contacts by 70%, victimization by 67%, violent behavior by 80%, and substance abuse by 29%.[535]

Given the consensus that voluntary treatment is preferable to involuntary treatment,[536] states should follow California's example by rejecting involuntary medication and investing in expanded outreach and voluntary intensive services. This approach may achieve the goals of POC while placing these laws on more solid constitutional footing.

[531] *See supra* notes 55-57. *But see supra* notes 66-76 (arguing that individuals should have a right to refuse psychotherapy treatment).

[532] Laura's Law may, therefore, be constitutional. *See* CAL. WELF. & INST. CODE § 5346(a)(3) (authorizing POC if POC if: (A) The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating[; or] (B) The person is in need of [POC] in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or to others."). A more granular analysis of the constitutionality of Laura's Law is beyond the scope of this article.

[533] *See* TREATMENT ADVOC. CTR., *supra* note 514, at 2; California Assoc. Local Behav. Health Bds. & Commissions, *supra* note 528 (including links to legislative reports on results of Laura's Law, passed in 2002).

[534] TREATMENT ADVOC. CTR., *supra* note 514, at 3.

[535] CA. DEP'T OF HEALTH CARE SERVS. (2023), *supra* note 520, at 5.

[536] *See* Bruce J. Winick, *The Right to Refuse Mental Health Treatment: A Therapeutic Jurisprudence Analysis*, 17 INT'L J. L. PSYCHIATRY 99, 100-16 (1994) (surveying psychological literature on the value of choice).