OFFICIAL TRANSCRIPT
PROCEEDINGS BEFORE

THE SUPREME COURT
OF THE
UNITED STATES

CAPTION: WASHINGTON, ET AL., Petitioners V. WALTER HARPER

CASE NO: 88-599

PLACE: WASHINGTON, D.C.

DATE: October 11, 1989

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IN THE SUPREME COURT OF THE UNITED STATES

WASHINGTON, ET AL. :

Petitioners, :

v. : No. 88-599

WALTER HARPER :

Washington, D.C.

Wednesday, October 11, 1989

The above-entitled matter came on for oral argument before the Supreme Court of the United States at 12:59 p.m.

APPEARANCES:

WILLIAM L. WILLIAMS, ESQ., Senior Assistant General of Washington, Olympia, Washington; on behalf of Petitioners.

PAUL J. LARKIN, JR., Assistant to the Solicitor General Department of Justice, Washington, D.C.; as amicus curiae, supporting Petitioners.

BRIAN REED PHILLIPS, ESQ., Everett, Washington; on behalf of Respondent.

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P R O C E E D I N G S

12:59 p.m.

CHIEF JUSTICE REHNQUIST: We'll hear argument now in No. 88-599, Washington versus Walter Harper.

Mr. Williams.

ORAL ARGUMENT OF WILLIAM L. WILLIAMS.

ON BEHALF OF PETITIONERS

MR. WILLIAMS: Thank you. Mr. Chief Justice, and may it please the Court:

I am here today representing prison administrators and medical professionals who are charged with the responsibility for the welfare of mentally ill prisoners.

The issue before the Court is what due process requires when my clients' exercise their professional judgment in making a medical treatment decision regarding a mentally ill prisoner who refuses to take prescribed medications.

The outcome of this case will significantly affect not only my clients' ability to carry out their responsibilities, but also will affect the lives of the other inmates for whom my clients are responsible.

At issue here today is the adequacy of a policy at the Special Offender Center, one of 13 prisons administered by the Washington Department of Corrections, which authorizes treatment of certain serious mental illnesses with antipsychotic medications. 'This is the -- often -- or widely

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recognized as the only effective treatment for certain serious mental disorders, including schizophrenia, which was the diagnosis for the respondent, Mr. Harper.

Not only is this treatment widely recognized as the only effective treatment for persons in that situation, it is also generally accepted medical knowledge that failure to provide adequate treatment can result in serious adverse consequences to the mentally ill patient. They can deteriorate further. They can continue in assaultive and disruptive behavior. They can become self-destructive. And they often face only a prospect of lifelong institutionalization.

QUESTION: Mr. Williams, do you mind my asking where Mr. Harper is now?

MR. WILLIAMS: No, your Honor, I do not. It will take me a moment to explain.

Mr. Harper is currently at Western State Hospital, which is a state hospital run by the Department of Social and Health Services.

While Mr. Harper was at the Special Offender Center in January of 1988, he was charged in Snohomish County Superior Court with the crime of assault. In those criminal proceedings, which are still pending in the Snohomish County Superior Court, his defense counsel has raised the question of his competence to stand trial.

QUESTION: Well, there was some suggestion, I think by

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Respondent's counsel, that he had been taken out of the Special Offender Center and taken off the medication, and that that situation had continued for several years and was likely to remain the same.

QUESTION: Well, your Honor, with due respect to counsel, that was an inaccurate representation. Mr. Harper had been, at the time of trial, transferred from the Special Offender Center to the Washington State Penitentiary, which is another prison --

QUESTION: Uh-huh.

QUESTION: -- operated by the Department of Corrections. Subsequent to the trial, in -- I believe it was in April of 1987, he was transferred back to the Special Offender Center, and beginning in September of 1987 --

QUESTION: Was he ever put back on the medication?

MR. WILLIAMS: Yes, ma'am. Yes, your Honor. In September of 1987 he was again subjected to involuntary medication -- pursuant to the SOC policy which had been upheld at the trial level.

QUESTION: Is there some possibility he could be returned there again and --

MR. WILLIAMS: I think there --

QUESTION: -- be subjected --

MR. WILLIAMS: -- is a very good possibility. The trial court order -- the criminal trial court order that he is

currently at Western State Hospital on terminates in October of this year, October 26th.

He'll be returned to Snohomish County Superior Court and either be found competent to trial, go to trial, or be found incompetent to stand trial, and under Washington law the charges would be dismissed without prejudice. In either one of those events, he will come back to the Washington Department of Corrections.

His current sentence that he is serving now and was serving at the time this took place does not expire until 1995, and the earliest he could even be considered for parole currently is in November of 1992. Given that, and given that he continues to be mentally ill, it seems very likely that he would return to the Special Offender Center. And certainly, then, under the test of Vitek v. Jones, this case is not moot.

QUESTION: Mr. Williams, I think Harper says that he's not been involuntarily medicated since 1986. Is that not true?

MR. WILLIAMS: That's what he says, your Honor, but that's not true.

QUESTION: Uh-huh. I gather --

QUESTION: What I have just represented to Justice O'Connor is not in the record because the record closed when the trial took place in 1987.

QUESTION: Well, but I gather the state's position was

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that in any event he had been involuntarily medicated between April '87 and May '88. Is that right?

MR. WILLIAMS: He was at the Special Offender Center during that time period, and beginning in September of '87 to May of '88 he was involuntarily medicated.

QUESTION: Well, now -- and since May of '88?

MR. WILLIAMS: And since May of '88 he's been in one of three different locations. One was the Washington State Penitentiary.

QUESTION: And while -- while there was he involuntarily medicated?

MR. WILLIAMS: No, your Honor, he was not. He was also at times in the Snohomish County Jail where he was being held in connection with the pending criminal charges --

QUESTION: And again not involuntarily medicated there?

MR. WILLIAMS: I do not know. That's run by --

QUESTION: I see.

MR. WILLIAMS: -- by Snohomish County, not the Department of Corrections. But I believe that to be the case, that he would not --

QUESTION: Well, what I'm getting at is whether this issue of involuntary medication is moot.

MR. WILLIAMS: Well, your Honor, it's our position that it is not moot because he will be -- probably within the next month, but certainly within the next few months -- returned to

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the Department of Corrections' custody.

QUESTION: Isn't the -- isn't the State of Washington now under this -- the effect of this judgment?

MR. WILLIAMS: Yes, your Honor, we are.

QUESTION: Well --

MR. WILLIAMS: And that's why we're here today seeking the judgment -- you -- the judgment of the Washington Supreme Court in the case below. Is that the judgment you refer to, your Honor?

QUESTION: Yes.

MR. WILLIAMS: And that's why we're here seeking to have that overturned, because we -- if that decision is not overturned, then of course we would be foreclosed from --

QUESTION: And we don't -- we don't vacate state judgments if they're moot, do they -- do we?

MR. WILLIAMS: Not in any published decision I could find, your Honor. I noticed in the -- I believe it's the Deakins case -- there is a discussion of vacating federal court judgments but not in state court judgments.

In this context the issue is due process. Now, what does due process require? The Court has frequently said that due process requires only procedures which are appropriate under the circumstances. In the Parham case, the Court said that the nature of the process which is required cannot be divorced from the nature of the ultimate decision being made.

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The decision here is a medical treatment decision. Whether recognized, an effective treatment will be administered to mentally ill prisoners.

QUESTION: May I ask you right there, because it's kind of a fundamental question. You -- in your brief you rely in part on Turner against Safley and -- requiring a rational connection between the prison administration and the rule at issue.

And I'm wondering in this case -- I suppose involuntary medication would fairly clearly contribute to the orderly conduct of the prison and -- because these people probably would be less difficult to manage and handle if they are medicated than if they're not. Is that a proper consideration, do you think, to rely on -- do you rely in part on that consideration or do you take the position that it has to entirely be in the best interest of the prisoner?

MR. WILLIAMS: No. To -- we rely on both, your Honor. We believe that since it is a treatment context, it is in the best interest of the prisoner. But also, particularly like Mr. Harper -- was found to be, and the court below found him to be a threat to -- a danger to others. And so we believe that that justifies the medication as well, even where the prisoner feels in his best interests he wants to refuse it because it poses a risk of danger to other inmates and other staff.

QUESTION: What about the --

QUESTION: And if you're right -- could I ask just this one other --

If you're right on that -- because I would think factually you would have a pretty easy case of saying it makes your job a lot easier -- do we really have to face up to the rest of the case? Isn't that a sufficient justification all by itself under your view?

MR. WILLIAMS: Well, we would submit that it is. That that provides at least an alternative basis for the decision that we are seeking from the court.

QUESTION: And is that one of the factors that the panels will rely on in administering this program?

MR. WILLIAMS: Yes, the SOC policy provides that the medication is only administered, one, for the person who is mentally ill -- so, it is a treatment context. Secondly, where the person is either a danger to himself or others or gravely disabled, and those are very detailed -- the definitions of those terms -- are spelled out in great detail.

And we believe that the policy, therefore, by its narrow construction necessarily leads to a situation which was contemplated in Turner v. Safley, that there would be a reasonable relationship between this action and the legitimate penalogical goal.

QUESTION: I suppose you could resort to physical

restraints if the problem was his risk to other people or himself.

MR. WILLIAMS: That is a possibility, your Honor. But, of course, for a mentally ill person there is no showing that that has any treatment benefit. It results in warehousing the mentally ill. It frustrates the legitimate policy of the Special Offender Center which is to provide diagnosis and treatment where it's available so that inmates can be housed in one of the other 12 prisons which the Department of Corrections administers. So --

QUESTION: But, of course, there are certain risks to the administration of the medication, and if someone felt strongly that they didn't want to be medicated and if you had the alternative of isolation or restraint, is that something the state should have to consider in the balance?

MR. WILLIAMS: I think it can be considered but there are risks in administering the medication. But the risk to the inmate of not administering it when it is medically appropriate are equally, if not more, severe.

Further, even with physical restraints someone has to apply the restraints. My clients, or their staffs, have to try to provide food to the patient. Other inmates, when the -- when the individual is released, which has to be sometime during the day, are at risk of assaultive and threatening behavior, such as that as was exhibited by Mr. Harper in this

-- in the case below.

So, we believe that it is -- that is a consideration, but it is ultimately a medical judgment and that the medical model which is utilized by the Special Offender Center is much better geared to meeting the goal of the due process requirement which is ultimately in avoiding or minimizing the risk of an erroneous decision.

There are two potentially erroneous decisions in making these kind of decisions. One is to administer medications to someone who isn't mentally ill or for whatever reason doesn't require them. The Special Offender Center policy, unlike the decision below, not only provides a hearing opportunity for that person but also ongoing medical reviews.

There is a requirement -- after the initial hearing there is another hearing 14 days later, and another hearing 180 days and every two weeks in between there is a report to the Department of Corrections' medical officer. So there is some --

QUESTION: I guess you don't -- you rely entirely on in-house personnel for the review and the hearing and the determination. Is that right?

MR. WILLIAMS: That is correct, your Honor. And --

QUESTION: Would it be burdensome to require some outside consultant, or is that even appropriate to think about? Is there a concern at all that the decision might be weighted

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heavily in favor of just what's convenient for the institution?

MR. WILLIAMS: Well, let me -- let me modify my answer slightly. The psychiatrists are on contract. They are practicing psychiatrists who contract to come to the prison a few days each per week. So, in that sense, they are paid by the Department of Corrections but they're not full-time Civil Service employees of the Department of Corrections.

I suppose there might be at least a theoretical concern. But if you accept our argument that it should be a medical model, any consultant that we review -- we get to review it, is going to be hired and paid for by the Department of Corrections. And so almost inevitably there is going to be that kind of a challenge or concern.

The other point, of course --

QUESTION: Does the -- does the review panel determine the dosage and the type of drugs?

MR. WILLIAMS: Not directly, your Honor. The review panel determines whether the -- what has been prescribed by the treating physician is appropriate. Now, I supposed that one could possibly --

QUESTION: Can that be -- can that be altered after the decision to medicate is approved?

MR. WILLIAMS: Absolutely, your Honor. And I think one of the possible outcomes of the review panel's decision is the

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prescribed medication is maybe not the appropriate one or the dosage is not right, but we recommend a low -- a lower dosage or a different medication, or something of that nature.

QUESTION: But after the review panel makes its initial decision, does any change in the dosage or the -- type of drug used have to go back before that panel?

MR. WILLIAMS: No, your Honor, it does not. Except that the initial hearing must be followed up by -within 14 days by a second hearing. And then there are the ongoing medical reports to the Department of Corrections.

And what I understand from the psychiatric practitioners is that medical judgment is not a snapshot that you take at one time. It's an ongoing thing as the patient changes, progresses or fails to make progress, and that the medications, the type of medications, and the dosages, are changed, again, utilizing the subtle nuances, if you will, of a professional judgment -- medical judgment standard.

QUESTION: Now, these psychotropic drugs alter the emotional state of the individual?

MR. WILLIAMS: As I understand the way they work, they alter the emotional state and try to produce a more normative-type state. They do away with hallucinations and --

QUESTION: Do they alter the cognitive and perceptive faculties of the person?

MR. WILLIAMS: It is my understanding that they -- that

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the can have that effect because they overcome the hallucinatory - and illusionary-type processes that are often at play with such individuals.

QUESTION: Then either in a lay sense or a legal sense I take it we could say that his willingness or his ability to make a voluntary decision to consent or not to consent might also be altered by the drugs themselves.

MR. WILLIAMS: That could be the case. And, in fact, some of the medical studies that we have cited -- and I guess sort of a flip side of that, which is often the initial refusal to take the medication is not so much a manifestation of the individual's true desire as a symptom or a manifestation of the process of the illness from which they are suffering.

QUESTION: In a sense, then, it's qualitatively different from physical restraints, in that with physical restraints the prisoner at least has his voluntary decision, his will respected at all times, I take it, in that he can either consent to the restraints or consent to drug use?

MR. WILLIAMS: If you accept the notion that what he is saying truly manifest -- manifests his will, that would be true. But that places too high a risk upon my clients and the other inmates for whom they are responsible in trying to implement a purely physical restraint regiment when there are mentally ill individuals who could benefit from the treatment

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which my clients wish to provide.

Unless there are further questions, I prefer to reserve the rest of --

QUESTION: I have one question I'd like to ask you, Mr. Williams. In your SOC procedures, in order for the drugs to administer is it required for the -- is it required that the consulting psychiatrist vote to approve them?

MR. WILLIAMS: That is true, your Honor. It's a two-to-one vote unless the psychiatrist member of the panel votes against medication, and then he controls it.

QUESTION: May I ask you one question also?

MR. WILLIAMS: Yes, your Honor.

QUESTION: Assuming a case in which the medical equation is equal -- the medic - medical people conclude it may not do any good and it probably won't do any harm, but it's quite clear that it will make it easier to manage the prisoner if you have this very obstreperous sedated, would it be permissible in your view in such a case to say you must -- you may go ahead and give the drugs?

MR. WILLIAMS: It would not be permissible under the SOC policy because under the SOC policy you can only be administered for a treatment purpose, and under your hypothetical, as I understood it, there would be no treatment purpose.

QUESTION: Thank you, Mr. Williams.

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We'll hear now from you, Mr. Larkin.

ORAL ARGUMENT OF PAUL J. LARKIN, JR. AS AMUCUSCURIAE SUPPORTING PETITIONERS

MR. LARKIN: Thank you, Mr. Chief Justice, and may it please the Court:

In our view, for three reasons, due process allows psychiatrists to make the baseline treatment decisions regarding the appropriate clinical treatment of the severely mentally ill with antipsychotic medication.

The three reasons are as follows. First, for more than 35 years antipsychotic medication has been widely recognized by the psychiatric profession as an acceptable and sometimes the only effective treatment for the seriously mentally ill who are either dangerous, as is Respondent, or who are gravely disabled.

Second, because antipsychotic medication is an appropriate treatment for some mentally ill prisoner, the questions that arise in each case involve quintessentially medical judgments about the appropriateness of a particular medication or a particular dosage for a specific prisoner. And those judgments are more likely to be made far more accurately by a physician than they are by a court.

Third, although we believe a prisoner has a liberty interest in refusing antipsychotic medication, we also submit that the state or federal government has a countervailing

interest in assuring that third-parties who are in an institution are adequately protected from assault and in helping to restore to a person the ability to function.

QUESTION: You began by saying a severely mentally ill person. But by hypothesis, we are dealing here with someone who has the capacity to deny consent from the standpoint of exercising his voluntary choice, do we not?

MR. LARKIN: Not always, your Honor.

QUESTION: Well, doesn't the case come up to us in the context where the man is deemed to be competent, in the lay sense, of deciding whether he wants this medication or not, and to assess the benefits and the disadvantages of not having the medication?

MR. LARKIN: Well, the competency standard that the Respondent has argued we believe is inappropriate for three reasons.

First, as this case illustrates, a person can be competent and yet assaultive. A competency standard, therefore, if it were adopted by this Court, would not adequately protect third parties from assault because it's quite clear that Respondent is seriously mentally ill. He is suffering --

QUESTION: But he is not so seriously mentally ill that if he were a lay person he could be committed. Correct?

MR. LARKIN: I think - no - under a lay standard, because

he would be found to be mentally ill and a danger to others, he could be committed. I think that's the standard this Court adopted in O'Connor v. Donaldson, and it would allow a person who is mentally ill and, therefore - and a danger to others -- not simply mentally ill but mentally ill and a danger to others -- to be committed.

There are people -- the second reason why an incompetency standard I think is inappropriate is that competency can be cyclical. A person can alternate between states in which he is competent and which he is not. And, therefore, he would alternate between instances in which he could be treated and in which he couldn't be treated even if the medication were necessary to render him competent.

What could happen in that circumstance is a person would continually spiral towards a worsening medical condition and continuously treated on an emergency basis as the condition deteriorated.

And third, a legal -- as competency is a legal standard. It is not necessarily coincident, therefore, with the need to treat someone who is gravely disabled.

For example, a person can be very, very severely depressed -- so depressed that in a prison setting he could be seen to be easy prey by other inmates. That person, at the same time, however, may be able to decide whether or not he is willing to accept certain types of treatments. In that

context, it is necessary in some cases to treat that person to avoid him from being assaulted by other people.

That's not the situation here because Respondent himself was responsible for assaulting other people. But that type of situation can arise.

Now, Justice O'Connor asked can restraints be used, perhaps on a person like Respondent. Restraints are only a short-term measure for a variety of reasons.

First, a person who is under restraint can oftentimes injure himself. He can injure nerves or muscles by fighting at the restraints. He can become dehydrated. He could have a heart attack.

Secondly, restraints don't treat the underlying mental illness that is the cause of the problem. Someone like Respondent also suffers from episodic and cyclical episodes of violence. For example, some of the evidence in some of the biweekly reports that were conducted at the SOC indicated that they believed that there was a two to four month pattern of violence that Respondent seemed to indicate, although it was -- there was an overlapping episodic series of violent assaults that could occur.

In that sort of circumstance, it would be impossible to predict when in a particular instance a violent out - outburst might occur and a restraint, therefore, would be an ineffective means of preventing that sort of circumstance.

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So restraints, however, I might add, are the type of consideration that a physician or psychiatrist should be required to consider under the professional judgment standard that this Court adopted in the Youngberg case.

That standard would require a physician to decide amongst the acceptable medical treatments by considering a variety of factors such as the prisoner's past history, his current mental status, his responsiveness to other types of drugs or medication, the risk type and severity of side effects that could occur, and the prospects of gain from using a particular treatment.A court can then intervene in a particular case after the fact just to ensure that a physician exercised his professional judgment. It is not our view that the court should be taken out of this altogether. It's our view that psychiatrists should serve as the baseline decision-makers.

QUESTION: Mr. Larkin, do you think the standard for a prison inmate is any different from the standard for a person who has been committed civilly to a mental hospital?

MR. LARKIN: No. I think in factual cases there will be a variety of different circumstances.

QUESTION: So then your analysis wouldn't rely at all on Turner against Safley and that line of cases?

MR. LARKIN: Correct. The same factual scenarios can arise in both contexts.

QUESTION: Right.

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MR. LARKIN: Now, of course, in a prison context --

QUESTION: I think your position is a little different than the state's position then.

MR. LARKIN: Correct. It is a little different. Our -- our ultimate standard would apply whether a person is in a facility such as the SOC, or is in a mental ward of a hospital, or whether he is in a psychiatric institution in a state or a local government's care. In that respect, we think the same standard would apply across the board.

Now, this --

QUESTION: I'm not sure you -- you say a danger to other is part of the thing that doctors can consider as -- in connection with the medical determination. You've just converted Turner v. Safley into -- into a medical criterion rather than a prison administration criterion.

You acknowledge that that's one of the things that can be considered in prescribing the medical -- the treatment, whether a person would be a danger to other -others.

MR. LARKIN: Correct.

QUESTION: Isn't that right?

MR. LARKIN: Correct. But a person who is a danger to others because, say, for example, he's suffering from a delusion or hallucination that perhaps the guards are the devil -- not a devil, but the devil -- or that people are out to poison him, is in a great deal of distress. And to treat

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him in order to --

QUESTION: No, I understand.

MR. LARKIN: -- prevent him from harming someone else is not simply a means of preventative restraint. It also treats the underlying mental illness. Now, that problem can arise in either a mental hospital or a prison circumstance. It may be more likely to arise in a prison, but our standard would apply across the board.

In either case, you are elevating a person's level of functioning and it, therefore, is a treatment decision. It's not simply a penalogical one.

Now, we think, although this case, as Justice Stevens pointed out, involves only a prisoner who is assaultive and therefore violent, is also one in which for a variety of reasons the Court may want to address the question of whether the professional judgment standard would apply to persons who are gravely disabled.

And we think someone who is gravely disabled and therefore who is in need of medical treatment for his illness is also a person who can be treated, because, as my colleague pointed out, in some cases the only alternative is a lifetime of institutionalization for someone who is severely mentally ill, whether or not he is dangerous.

If he has regressed so far that no other treatment is effective, antipsychotic medication is an appropriate means of

helping to restore that person to a sufficient level of functioning so that he can ultimately leave an institution. Or, even if he cannot, then he can function within that institution at a - at an acceptable level.

The competency standard that Respondent has urged does little, we think, to help serve both of those goals, for the reasons that I explained before. It does nothing to help prevent the risk of violence. It does not overlap at all with the situation in which a person may need this type of treatment in order to receive the care that is necessary in this context. And it is not one that we think is best applied in this circumstance.

If the Court has no further questions, I have nothing further to add.

QUESTION: Thank you, Mr. Larkin.

Mr. Phillips, we'll hear now from you.

ORAL ARGUMENT OF BRIAN REED PHILLIPS.

ON BEHALF OF THE RESPONDENT

MR. PHILLIPS: Mr. Chief Justice, and may it please the Court:

I want to begin by emphasizing the nature of the of the liberty interests at issue here, and in doing so, I want to make a couple of points first.

Mr. Harper has never been determined to be incompetent. Mr. Harper has never been determined by a court to require

treatment. That is, to suffer from a mental disorder and to be gravely disabled or a danger to others. And that is the distinction.Counsel for the Petitioner and for the U.S. government keep talking about treatment. If they are going to treat Mr. Harper, then it seems to me that, one, he is presumed to be a competent person. A competent person has the right to refuse treatment. The doctrine of informed consent implies that a person will be adequately informed and will voluntarily consent to treatment. And that, in fact, is the -- is - we seek to protect that relationship between the doctor and the patient. But part of that relationship is the patient saying I don't want the treatment.

So, it seems to me it's very important in deciding this case to make a very strong distinction to understand what we're talking about between the parens patriae power of the state and the police power of the state, those two interests. They are very different and they have different implications for the resolution of this case.

I disagree with counsel when he indicates that the SOC policy says that it must be -- the treatment -- the involuntary treatment with antipsychotic drugs must be for treatment. I don't think it says that. It says that one can only be medicated if he suffers from a mental disorder and as a result of that is gravely disabled or presents a likelihood of harm to himself or to others.

So, Mr. Harper is not seeking treatment. He is seeking, as a competent adult -- presumed to be and no judicial findings that he is not -- to refuse treatment.

QUESTION: He has that luxury when he's responsible for himself --

MR. PHILLIPS: Uh-huh.

QUESTION: -- to simply refuse treatment.

MR. PHILLIPS: Uh-huh.

QUESTION: But that -- it doesn't necessarily follow that he has that luxury when -- when he's been duly convicted of a crime and has become a ward of the state in an institution to punish him for that crime. Certainly that gives the state some prerogatives that it does not have in the case of a private citizen who may well choose to refuse treatment no matter how much trouble that may give himself and other individuals.

MR. PHILLIPS: Well, the state has the duty and the obligation because Mr. Harper is in custody to offer treatment, certainly, and to provide a minimum level of treatment. But that does not imply, I don't think, that Mr. Harper has a corresponding duty to accept the treatment. The - and I think that's where we get the confusion --

QUESTION: But he does have an obligation not to injure other people.

MR. PHILLIPS: Yes, he does.

QUESTION: And I guess the state has some concern about his behavior.

MR. PHILLIPS: And I think that's -- the two questions posed are where we get to the difficulty in this case, and that is to separate out the parens patriae power from the police power of the state. And I would submit that the parens patriae power of the state does not extend to a competent prisoner the ability of the state to force treatment.

Now, the police power, that's a different issue. And I think when we look at the police power interest in this case, I don't think that the police power interest is sufficient to justify the long-term involuntary treatment with antipsychotic medications that was at issue in this case.

There are, as your Honor has pointed out, other alternatives. Restraints. Isolation is another alternative. Now, counsel for the Petitioner indicated, well, those don't have any treatment benefits. Well, that gets back into the parens patriae part of this equation because once the state decides that it's going to help its prisoner, then you're on the parens patriae side. If they're going to control the prisoner so - to maintain institutional calm and security, of course the state has the right to do that.

QUESTION: But it seems to me the state has a right to do some of each. I suppose they do have a concern about treating people in prison who are ill.

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MR. PHILLIPS: Yes. Yes, they do.

QUESTION: Yeah.

MR. PHILLIPS: But the point is that on the parens patriae side of this equation, they have the right -- they have the obligation, if you will, to provide the minimum level of care. But we're talking about a competent adult, and it seems to me that the fact of conviction doesn't extinguish that liberty interest. That is, the liberty interest to make decisions about what kind of drugs we're going to have or not have.

QUESTION: Let's -- let's see if it helps to put it in a context where it's not mental illness that's being treated.

Suppose a prisoner has contracted leprosy --

MR. PHILLIPS: Uh-huh.

QUESTION: -- and he decides I don't -- I don't want to be treated for leprosy. Would the state have no alternative but to isolate him and not to treat him for leprosy? Or could the state say, I don't care whether you want to be treated for it or not, we're going to treat you?

Now, you know, if you're out privately and you want to - you want to live up on some isolated estate by yourself, I suppose you can turn down treatment. But you're living in a penal institution; we have no choice but to treat you.

Couldn't a state do that?

MR. PHILLIPS: Yes, the state could.

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QUESTION: All right. Now, why is mental illness different?

MR. PHILLIPS: Mental ill -- illness isn't different. What's different is the nature of the intrusion. Now, if, for example, leprosy was being treated with a drug, a new drug -- we have a new drug. It's an experimental drug; we're not sure it's going to work. It may work. Okay? It has very significant side-effects. In 80 -- in 20 percent of all cases where we treat leprosy with this new drug, 20 percent of the people die.

Now, this person says, I don't want to take that risk. I'm a competent adult. That risk is a little too great for me -- and in - 60 percent persons are severely debilitated -- I don't want to take that risk. And it seems to me the government's got to respect that. However, they have the duty to maintain other prisoner's health, if you will. Okay.

So, I think what you look at is a continuum. What is the nature of the intrusion? If the intrusion is minor, you need to take aspirin. If that will calm you down, you need to take aspirin. No problem.

You need to take cold medicine because we don't want you spreading the risk of colds. No problem, because the side-effects aren't so serious. You need to take antipsychotic medications where you run the risk of suffering from -- and Mr. Harper did suffer from -- dystonia and

akathisia. You'll run the further risk of suffering from tardive dyskinesia, which may not appear until after you have discontinued treatment and which is correlated with high dosages and long-term treatment. And Mr. Harper was on these drugs for a very significant period of time. Years.

Now, does the state have the right to say, okay, we're going to treat you against your will with that? Yes, in fact, they do if they go and have a judicial determination because we want to reduce the risk of error. And the risk of error is inherent in this kind of situation, it seems to me, because you're talking about a decision made within the institution, a decision made for reasons of control, I submit, as much as reasons of treatment. But if it's made for --

QUESTION: Well, let me -- let me go back to the leprosy case.

MR. PHILLIPS: Okay.

QUESTION: Suppose the institution has a medical board examine the individual and the medical board says any reasonable person with this condition would accept medical treatment. There is just no reason -- the desire not to have any treatment for this leprosy is just irrational, we think. And both out of concern for the health of the inmate and out of concern for the orderliness and safety of the institution this person should be treated. And that is determined internally by a -- by a medical board within the institution.

That would be no good?

MR. PHILLIPS: Again, I think it depends on the nature of the intrusion.

QUESTION: I've told you what the nature of the intrusion is.

MR. PHILLIPS: Well --

QUESTION: It's sound medical treatment. Any rational person would accept it.

MR. PHILLIPS: Well, on the parens patriae side of this equation, if you will, on the treatment side of this equation, I am a sound competent adult. That does not mean the government can tell me that I need to accept treatment.

QUESTION: I understand that. Outside of prison that's true. But this person is in prison --

MR. PHILLIPS: Right.

QUESTION: -- and the prison makes that judgment.

MR. PHILLIPS: Well, I think --

QUESTION: We don't want to have a special cell for a leper. Any reasonable person would accept medical treatment.

MR. PHILLIPS: Uh-huh.

QUESTION: We're going to give this person medical treatment. Can they do that?

MR. PHILLIPS: It depends -- I think it depends on what -- I don't mean to be disrespectful, but what is the nature of the intrusion? The intrusion here is something that affects

the mind. Now, the leprosy example, if it's a pill, if it's sulfa, and that's going to treat leprosy, then I don't think there is any problem with that.

QUESTION: I don't think it makes any difference what the nature of the intrusion is so long as I've posited that any rational person would accept it. It is a sound -- unquestionably sound medical determination that a reasonable person would accept.

MR. PHILLIPS: Well, but then we're assuming that the inmate is incompetent. That is, he is irrational. And those kinds of --

QUESTION: No, you don't have to be incompetent to be unreasonable about one thing. I'm perfectly competent and I just don't want medical treatment.

MR. PHILLIPS: And I don't see how a criminal conviction does away with the liberty rights or interests to make decisions concerning one's --

QUESTION: The answer is you could not treat the leper in that situation --

MR. PHILLIPS: No, I --

QUESTION: -- in your theory.

MR. PHILLIPS: No, that's not my answer. My answer is --

QUESTION: Well, what is your answer?

MR. PHILLIPS: My answer is it would depend on what the side-effects were of the treatment, number one. Okay? And

you could treat the leper -- if there were very serious side-effects -- okay, no rational person can do it.

QUESTION: That's right. I've said that.

MR. PHILLIPS: Okay.

QUESTION: I've said any rational person would accept the treatment. What more can I say?

MR. PHILLIPS: Then I think you'd need to go to a court and have a proceeding --

QUESTION: So you'd still need to go to court in that situation?

MR. PHILLIPS: In the situation of a rational -- no rational person would refuse this treatment?

QUESTION: Uh-huh.

MR. PHILLIPS: I think a court needs to decide that that is in fact the case.

QUESTION: What makes the court better able to decide that than the medical practitioners, and why isn't the court totally reliant on the advise of the medial practitioners in that situation?

MR. PHILLIPS: Well, I think in - on the parens patriae side of this you're asking -- what you're asking is for a substituted judgment, and courts make those kinds of judgments all the time. Courts decide in competency proceedings to make those kinds of judgments. They decide, based -- informed by psychiatric decisions. But --

QUESTION: Well, in case like Youngberg v. Romeo this Court has held that it can be -- such decisions can be made by medical experts.

MR. PHILLIPS: Well --

QUESTION: That a court isn't always necessary to -- as an intervening power.

MR. PHILLIPS: And there I think it depends on the nature of the liberty interest and the nature of the intrusion.

QUESTION: Well, involuntary commitment is a pretty powerful liberty interest there.

MR. PHILLIPS: Yes, it is. And Mr. -- Mr. - in Youngberg v. Romero, Mr. Romero had been committed by court order. Mr. Harper -- a court order relative to his mental status. Mr. Harper hasn't had that kind of decision - which has resulted in this incarceration and this treatment.

Mr. Youngberg was seeking habilitation, not seeking to refuse treatment. Mr. Youngberg was restrained by soft restraints.

It's not the same kind of liberty interest, the right to be free form the forced administration of antipsychotic drugs.

QUESTION: What if -- what if Washington were to say, all right, we will go to court and get a determination that the prisoner in this case was mentally incompetent, and then we're going to follow our SOC proceedings from then on as to whether drugs should be administered. Would that satisfy you or not?

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MR. PHILLIPS: I think that's a lot closer. Yes. Yes, that would - that would essentially satisfy me. What the particulars are of the procedure --

QUESTION: So, once the determination of mental incompetency has been made, you don't object to the treatment decisions being made administratively?

MR. PHILLIPS: I - I'm not saying that the particular dosage or the particular type of antipsychotic drug would be determined by the court. No, that's not necessary.

QUESTION: Well, would -- would the court need only to determine once that the guy was mentally incompetent?

MR. PHILLIPS: No, I would think that there would have to be some periodic review.

QUESTION: Well, so -- but -- but review of the competence of the individual or review of the -- review of the treatment decisions?

MR. PHILLIPS: I think review of -- the lower court in this situation has indicated that before you can treat you need to in part make a competency determination because they talked about a substituted judgment. But you need to decide that there is a mental disorder and that -- excuse me, you need to decide that there is a compelling state interest and the safety of other prisoners or staffs certainly would be, that that interest would be served by the administration of antipsychotic medications, and that the court is then to look

--

QUESTION: Well, that's quite different, really, than my hypothetical which is a more limited thing. Just a one-shot determination that the person is mentally incompetent. And then if there is a claim that he has regained competence, you go back to court. But no court -- no court hearings on the treatment decisions.

MR. PHILLIPS: Well, I - I'd prefer the lower court's decision. And I think it's more appropriate, given the type of liberty interest at stake and given the type of side-effects that are present or implicated that Mr. Harper suffered and that are implicated by these medications.

QUESTION: Well, if I understand you, the only time this treatment could be imposed involuntarily is if the person is incompetent to make his own decision.

MR. PHILLIPS: No.

QUESTION: You -- you would think that even if a person is competent and refuses, a court could say -- could find him to be a danger to himself and others and then give the --

MR. PHILLIPS: In line with civil commitment acts -- in line with the civil commitment statutes --

QUESTION: Well, what that means is --

MR. PHILLIPS: -- in the State of Washington.

QUESTION: A civil commitment means that you can certainly deprive them of their liberty --

MR. PHILLIPS: Certainly.

QUESTION: -- and restrain them. But it doesn't mean you could necessarily give them psychotic drugs against their will if the man is competent.

MR. PHILLIPS: And I don't --

QUESTION: I thought - I understood that your position was that if he's competent that's the end of the story.

MR. PHILLIPS: Well --

QUESTION: They may not involuntarily --

MR. PHILLIPS: Mr. Harper's position is he's never been seen by a court with respect to his mental status that has led to this incarceration and that has given him drugs, and he wants to be seen by a court.

QUESTION: Well, I know that. But what's the court supposed to find out?

MR. PHILLIPS: I think that the court -- when the court looks --

QUESTION: Suppose they find him competent --

MR. PHILLIPS: Uh-huh.

QUESTION: -- but a danger to himself and others? May the treatment then be imposed?

MR. PHILLIPS: Well, I think that's a question that the court is going to have to deal with.

QUESTION: Well, what's your opinion on that? I think it's --

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MR. PHILLIPS: Well --

QUESTION: I think that's -- I think it depends a lot on how this case comes out. What's a court supposed to be deciding?

MR. PHILLIPS: That the prisoner is in - is incompetent, the prisoner is competent but has been committed. I'm sorry, I didn't --

QUESTION: Well, what -- I would like to know what you are claiming the court must decide.

MR. PHILLIPS: Okay. I think that the court must decide that before one can be involuntarily administered with antipsychotic drugs on a long-term basis there must be a court hearing which resolves the question of -- yes, I think it needs to resolve the question of competency.

QUESTION: Yes. Anything else?

MR. PHILLIPS: It needs to resolve the question of whether or not the person is a danger to himself or others. That is, whether or not there is --

QUESTION: If he's incompetent -- if he's incompetent, they don't need to resolve that? Or --

MR. PHILLIPS: No, I think they need to resolve that as well.

QUESTION: If he's -- even though he's incompetent?

MR. PHILLIPS: Yes.

QUESTION: And if he is competent, they resolve that --

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if they resolve the danger element against him, the drugs may be administered?

MR. PHILLIPS: If he's incompetent?

QUESTION: No. If he's competent.

MR. PHILLIPS: If he's competent.

QUESTION: Uh-huh.

MR. PHILLIPS: Well, I --

QUESTION: Well, the state court answered that very clearly. They said that it has to be in the man's best interest, didn't they?

MR. PHILLIPS: Yes, they did say it had to be in his best interest.

QUESTION: Which they might fail that test even if he's dangerous and even if he's competent or incompetent.

MR. PHILLIPS: And they said they had essentially to make a substituted judgment.

QUESTION: Do you defend the position of the state supreme court?

MR. PHILLIPS: Yes, I do.

QUESTION: So, you can treat him even though he's competent, and even though he doesn't want to be treated? Right? I think that's what you just said.

MR. PHILLIPS: Yeah. I think you could treat him under those circumstances.

QUESTION: And is that true even if the drugs alter his

will?

MR. PHILLIPS: Well, yes, I think it is true even if the drugs alter his will. I think that the question see on --

QUESTION: So that a competent person, over his objection --

MR. PHILLIPS: Uh-huh.

QUESTION: -- can receive psychotropic drugs that alter his will, if there is a court hearing? That's your position?

MR. PHILLIPS: I'm sorry. I think I'm going to retreat from that. I don't think that is my position. I apologize to the Court.

QUESTION: Is your objection in this case to the fact that the drugs alter the will or that they have side-effects because I'd like -- in order to put that proposition to hypothesize that you have a psychotropic drug which has no side-effects but it does alter the will. Could that be administered to a competent person over his objection?

MR. PHILLIPS: No. For reasons of treating him?

QUESTION: Yes.

MR. PHILLIPS: No. That would alter his will? That would alter his ability -- this is --

QUESTION: It would alter his cognitive faculties, his emotional state. It would make him very compliant, and after some treatments with these drugs he would want more because his mind state, where he previously objected to them was now

altered.

MR. PHILLIPS: Well, that would be a very effective drugs -- in some countries that I can think of and -- and would probably be widely used. And I think that's where the --

QUESTION: Is it permissible to administer such a drug to a person against his will if he's competent, in a prison setting?

MR. PHILLIPS: If he's competent?

QUESTION: Yeah.

MR. PHILLIPS: No, I think it would not be permissible.

QUESTION: Well, I guess the court below thought if a person is found to be mentally ill or diseased and a danger to himself or others, then that individual can be involuntarily committed and involuntarily treated if it's in the best interests of that person.

I mean, that clearly was the finding below and the determination below. It didn't require a determination of competence. People can be mentally ill and a danger and committed even though they might be "competent for some purposes." Isn't that true?

MR. PHILLIPS: Well, I think the court below did in effect require a competency decision by referring to a substituted judgment that the person would be too irrational to make a decision and that the court in so doing -- "a court asked to order antipsychotic drug treatment for a

nonconsenting patient must therefore consider the patient's desires before entering an order."

So, in effect, what they're doing is indicate - is making a statement that the individual is incompetent, it seems to me.

QUESTION: That's not what the court said, of course, and that's not the standard for involuntary commitment in Washington State or other states.

MR. PHILLIPS: Well, the court -- the court indicated that the court must set forth findings on, among other things, the desires of the patient or a substituted judgment by the court -- is what the court indicated.

I want to emphasize the importance of this liberty interest. I think that the First Amendment is implicated here. It was -- that claim by the respondent was not addressed by the lower court, but I think it is an important consideration in deciding how important this liberty interest is and how important the private interest is, because if one cannot generate ideas or if one's ability to generate ideas is affected by mind-altering drugs, then the ability to express those ideas is going to be similarly affected.

QUESTION: Well, as an original proposition I think that's -- that's very appealing, and I might agree with it, that maybe the state shouldn't have the right to alter anybody's mind without the person's consent unless the person

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is incompetent in the sense that Justice O'Connor was speaking of.

But in fact do you have any idea whether that has been -- been the tradition in this country in either -- in either penal institutions or mental institutions?

MR. PHILLIPS: The tradition of --

QUESTION: Of simply declining to administer any -- any psychotropic drugs if the individual is competent and refuses them? What has been the practice?

MR. PHILLIPS: Historically in this country?

QUESTION: Historically.

MR. PHILLIPS: I'm really not sure. I can only speak to what has occurred in the State of Washington in the recent past.

QUESTION: But you just think that we ought to adopt a rule that you cannot alter somebody's mind unless -- unless the person is willing or incompetent?

MR. PHILLIPS: I -- I think that the Court needs to bear in mind the implication -- the First Amendment implications of the administration of antipsychotic medications in deciding this case. Yes.

QUESTION: I take it you'd agree that the difficulty of these questions is a strong argument for your position that there should be a court hearing initially?

MR. PHILLIPS: Exactly. And -- what Mathews teaches us

-- I mean, a case about the temporary interruption of disability benefits. But what it teaches us, it seems to me, is that you weight the factors set forth in Mathews. And the compelling nature, I would submit, of this liberty interest weighs very heavily in favor of saying to the state, you must go through these slight -- and I submit it is very slight -- administrative burden of having a judicial hearing rather than the hearing panel.

In response to this decision, the Harper decision, the state legislature engrafted, if you will, the Harper decision onto the civil commitment laws of the State of Washington, and I think that's a recognition that this isn't so burdensome.

In response to Vitek, Congress required judicial hearings for the transfer from a prison to a mental health hospital. That's an indication that it isn't so very burdensome. And if it's not so very burdensome, then what's the problem with providing it where the interest is so significant and where the procedures attendant upon a judicial hearing are going to be more, it seems to me, designed to make a correct decision with less potential for error.

QUESTION: Mr. Phillips, does the record tell us how many prisoners are -- will be affected by this decision in Washington?

MR. PHILLIPS: I believe it indicates in the findings of fact that there were some - something in the 20s who were at

the Special Offender Center who have not been receiving -- who were refusing antipsychotic medications.

There is a Law Review article cited in my memorandum, I think at page 93 -- or, excuse me, footnote 93 -- which was done seven months after -- five months after the decision, which indicated that during that five-month period there had been three hearings.

The hearings are -- this is not in the record -- the hearings are typically held at the institution so there is no problem with security and so forth. And it simply is not that big an administrative burden where the liberty at interest at stake is so important.

I do want to turn to -- to the value of these additional safeguards, and in doing so I want to talk about how the procedure took place in this case at the institution and how in fact it takes place typically at the Special Offender Center and --

QUESTION: Excuse me. Get - we have - There's an important -- for commitment of people to mental institutions, not penal institutions, do you have to be incompetent to be committed or can you be competent but a danger to yourself or others? Is that possible?

MR. PHILLIPS: You do not have to be incompetent.

QUESTION: You don't have to be incompetent?

MR. PHILLIPS: No.

QUESTION: So -- and I assume you would apply the same rule in -- a fortiori, in mental institutions? That somebody who is a danger to himself or others can be committed but cannot against his will be treated?

MR. PHILLIPS: Well, that's the rule I would like to see this Court adopt. Yes. But I don't think that this Court -- I mean, Mr. Harper personally would be, I think, less -- would be satisfied if he had a hearing somewhere before a judge and not a decision made wholly within the institution because when the decision was made in this case -- and is typically made in - within the institution -- what occurs is the staff of the hospital consult outside the presence of Mr. Harper with the hearing committee, review the basis for their decision to recommend treatment, discuss whether or not the guidelines have been met, and then Mr. Harper is brought into the hearing.

I don't think that that even measures up to the kind of thing neutral fact-finder required in -- or, the kind of hearing required in Vitek or in -- or in -- excuse me.

QUESTION: So, this hearing that you're asking would have to occur not just in prisons, but in all -- in all mental institutions in all states for anybody who has been committed not for incompetence but just because the person is a danger to himself or others? Before all of those people can be treated by those institutions where they've been committed for

treatment, there would have to be a judicial hearing with respect to each -- each treatment?

MR. PHILLIPS: That, of course, is not the question before the Court.

QUESTION: Well, no, but I see no reason of distinguishing mental patients from prisoners for that purpose.

MR. PHILLIPS: And that is the decision that has been made by the Washington State Legislature, for example -- to do that.

QUESTION: Well, in Vitek there was a prisoner --involved a prisoner - a transfer to a mental institution.

MR. PHILLIPS: Uh-huh.

QUESTION: He was already in custody. To be transferred to a mental institution he didn't need to be found to be a danger to himself or others?

MR. PHILLIPS: Correct.

QUESTION: And didn't Vitek involve a transfer for treatment?

MR. PHILLIPS: For behavior modification treatment.

QUESTION: Yes. Which is different than this kind of treatment?

MR. PHILLIPS: Yes, it's not as intrusive.

QUESTION: So, it's just a degree of intrusiveness?

MR. PHILLIPS: I think that's a very important factor.

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In Vitek it isn't as intrusive and it doesn't have the kind of side-effects that this medication does.

I want to make another point about --

QUESTION: So we have to -- we have to distinguish between the medications. That was behavioral modification treatment --

MR. PHILLIPS: Right.

QUESTION: -- in Vitek. What is that? What does that do to you?

MR. PHILLIPS: Well, it --

QUESTION: That this doesn't or that -- what does this do to you that that doesn't?

MR. PHILLIPS: It - It's designed to alter your behavior but I would submit that one can refuse to participate.

QUESTION: And altering your will a little bit?

MR. PHILLIPS: One can refuse to participate in the treatment. Once the injection or the drugs are administered in this case, your -- your ability to refuse in the treatment ends, and it doesn't have the kind of side-effects that -- it doesn't result in akathisia or dystonia, or these other side-effects.The other point I think about the procedures here, at SOC the first time that Mr. Harper was medicated, the treating physician was Dr. Pethridge. Two weeks later, Dr. Pethridge is not the treating physician. He is now on the reviewing committee.

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There was, if you will, a rotating door between being a treating physician and being the -- on the reviewing committee. Four psychiatrists went through that door. That's not the kind of of independent, neutral -- independent decision-maker or neutral fact-finder that I think is required. And that's one of the dangers, if you will, of allowing the institutions to adopt their own procedures. We know we will get an independent detached magistrate in a court of law.

The - in addition, there is no announced standard of evidence or standard of proof with respect to the policies. And I want to refer to Addington v. Texas where the Court decided that a clear, cogent and convincing standard was the appropriate standard before civil commitment. And increasing the burden of proof is one way to impress the fact-finder with the importance of the decision and thereby perhaps to reduce the chances that inappropriate commitments will be ordered.

QUESTION: What -- oh, excuse me. I think your time has --

MR. PHILLIPS: Oh, I'm sorry.

QUESTION: Thank you, Mr. Williams -- rather, Mr. Phillips. I'm sorry.

Mr. Williams, you have three minutes remaining.

REBUTTAL ARGUMENT OF WILLIAM L. WILLIAMS.

ON BEHALF OF PETITIONERS

MR. WILLIAMS: Thank you, your Honor. Just a couple of brief points.

First, in response to Justice Steven's question about the number of prisoners. As of the date of trial, there were 25, I believe it was. As of the date of the Washington Supreme Court decision, there were nine, and today there are seven who have been through the hearings required by the decision below.

That's out of the 144 prisoners at the Special Offender Center and 6,000 inmates throughout the Washington Department of Corrections system.

QUESTION: Do you know what the -- what the success rate has been in the hearings? Has the judge usually said, go ahead and give the drugs, or has he --

MR. WILLIAMS: In all seven that have been brought at the prison that has been the result, your Honor.

And the other point in response to the questions Justice White had about Vitek, it's true that the decision there speaks in terms of mandatory behavior modification, but it's our understanding based upon one of the amicus briefs that Respondent submitted, that treatment with antipsychotic medications was contemplated there. And there is an indication in the trial court memorandum decision which is published. There is a footnote, I believe, that speaks to that as well, your Honor.

QUESTION: (Inaudible) just - just behavior modification

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treatment wouldn't necessarily involve the considerations that are in this case?

MR. WILLIAMS: Well, I think they may arguably -- and if it does involve medication, it may arguably involve different kinds of considerations.

But the point remains that the purpose in Vitek was transfer for a treatment, and what we're dealing with here is treatment.

And that brings me to the third point I wanted to make. Counsel suggested that the SOC policy was not geared to treatment. The SOC policy requires that the medications be prescribed by a psychiatrist or in an emergency somebody with prescriptive authority and confirmed by a psychiatrist within 24 hours. And under Washington law, prescribing medications for a non-therapeutic purpose would be illegal.The final point. Since this is a medication decision, a treatment decision, and a due process analysis, the question is what process is most likely to result in the correct decision. And we submit that having a judge make the decision after a full hearing which necessary involves at a minimum delay and in some instances appropriate medical judgment denied, that that does not meet the test of due process. That the medical model implemented in this SOC policy is more appropriate under the due process analysis.

QUESTION: Mr. Williams, what about just having a judge

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make the decision which the judge makes for civil commitment, not that - on the details of medical treatment, but at least a judicial decision that the person is a danger to himself or others? That the person is either incompetent or is a danger to himself or others?

That has been the traditional necessary judicial judgment before you can get civil commitment, right? Now, would you object to that?

MR. WILLIAMS: Well, I guess the response to that is what value does that add to the decision-making process to have a judge make that decision when the result, if he makes a negative decision even though medical professional judgment indicates that the person does constitute because of his medical condition a threat to himself or others -- if one of the outcomes is that the judge is going to in effect overturn that decision, what you have is a judge interfering with the professional medical judgment which this court has said persons in custody are entitled to.

I think that the judge doesn't add anything, and it -- and it increases the risk that an erroneous decision not to provide treatment will be made.

CHIEF JUSTICE REHNQUIST: Thank you, Mr. Williams.

The case is submitted.

(Whereupon, at 1:59 p.m., the case in the above-entitled matter was submitted.)

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Washington, et al., Petitioners V. Walter Harper

NO. 88-599

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BY Judy Freilicher

(REPORTER)