

WHEN COERCION LACKS CARE: COMPETENCY TO MAKE MEDICAL TREATMENT DECISIONS AND *PARENS PATRIAE* CIVIL COMMITMENTS

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The subject of this Article is people who have been civilly committed under a state's parens patriae authority to care for those who are unable to care for themselves. These are people who, because of a mental illness, are a danger to themselves. Even after they have been determined to be so disabled by their mental illness that they cannot care for themselves, many are nonetheless found to be competent to refuse medical treatment. Competency to make medical treatment decisions generally requires only a capacity to understand a proposed treatment, not an actual or rational understanding of that treatment. This Article proposes that in cases of parens patriae civil commitments, an actual or rational understanding should be required. A test of competency that requires actual or rational understanding of a proposed treatment is needed in these cases given the lack of insight commonly experienced by people with psychotic disorders, the potential of psychotic symptoms to interfere with rational decision-making, and the immense harms—both immediate and long-term—that can result from untreated psychotic symptoms.

INTRODUCTION

In every state, someone who is a danger to herself or to other people because of a mental illness is subject to civil commitment.¹ Two different sources of authority justify such commitments: the government's police power—the power to protect public safety—justifies commitments that are necessary to protect other people from harm, while the government's *parens patriae* power—the power to care for people who cannot care for themselves—justifies commitments that are necessary to protect the mentally ill person herself from harm.²

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1. Alexander Scherr, Daubert & Danger: The "Fit" of Expert Predictions in Civil Commitments, 55 HASTINGS L.J. 1, 29 (2003) ("Every state has enacted a form of civil commitment law."); Stephen J. Schulhofer, *Two Systems of Social Protection: Comments on the Civil-Criminal Distinction, with Particular Reference to Sexually Violent Predator Laws*, 7 J. CONTEMP. LEGAL ISSUES 69, 70 (1996) ("All states have statutes permitting the indefinite civil commitment of persons who are mentally ill and dangerous to themselves or others.")

2. See *Addington v. Texas*, 441 U.S. 418, 426 (1979) ("The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of

When someone is committed because she is a danger to others, the government must use the least restrictive means possible to diminish her dangerousness.³ This standard allows the government not only to confine but also to administer involuntary medication, even when a person is competent to make her own decisions regarding whether to accept or refuse medical treatment, so long as involuntary medication is the least restrictive means of diminishing dangerousness.⁴ But when someone is committed because she is a danger to herself, the government may not administer involuntary medication unless involuntary medication is the least restrictive means of diminishing dangerousness and the person is incompetent to make her own medical treatment decisions.⁵

Generally, tests for determining competency to make medical treatment decisions require only that someone possess the capacity to understand the potential advantages and disadvantages of a proposed treatment. These tests aim to minimize medical paternalism and promote individual autonomy by finding that almost all people are competent to make their own treatment decisions.⁶ And these tests do find almost all people competent, even people with severe mental illnesses. Most people with severe mental illnesses, including some people who are experiencing active psychotic episodes, are not so impaired that they are incapable 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.”).

3. See *infra* notes 37–39.

4. See Bruce J. Winick, *Coercion and Mental Health Treatment*, 74 DENV. U. L. REV. 1145, 1148 (1997) (“[W]hen an institutionalized patient or prisoner is dangerous to institutional staff, other patients, or inmates as a result of mental illness, the state may involuntarily administer psychotropic medication as long as it is medically appropriate for the individual and (in non-prison contexts) the least intrusive means of dealing with the problem.”).

5. *Rivers v. Katz*, 495 N.E.2d 337, 343 (N.Y. 1986) (quoting *Rogers v. Okin*, 634 F.2d 650, 657 (1st Cir. 1980)) (“[T]he *sine qua non* for the state’s use of its *parens patriae* power as justification for the forceful administration of mind-affecting drugs is a determination that the individual to whom the drugs are to be administered lacks the capacity to decide for himself whether he should take the drugs.”); see also *Davis v. Hubbard*, 506 F. Supp. 915, 935 (N.D. Ohio 1980) (“[T]he power of the State to drug a patient . . . depends upon whether he is capable of making decisions which affect his fundamental interests.”); *Steele v. Hamilton Cty. Mental Health Bd.*, 736 N.E.2d 10, 19 (Ohio 2000) (“A state’s *parens patriae* power . . . is legitimately invoked in forced-medication cases only when the patient lacks the capacity to make an informed decision regarding his/her treatment.”); cf. *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 278 (1990) (“The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.”).

6. See *Rivers*, 495 N.E.2d at 341 (“[W]here notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with furtherance of his own desires.”).

understanding a proposed medical treatment.⁷ They might refuse treatment for their psychotic symptoms on the basis of unlikely or even obviously false beliefs—most often, the belief that they are not ill⁸—but such beliefs do not necessarily make them incapable of comprehending the proposed treatment. The result is that many people who are subject to civil commitment are competent to refuse medical treatment.

A civil commitment standard that is less rigorous than a competency to refuse treatment standard suggests either (or perhaps both) that too many people are being committed or that not enough people are being found incompetent to refuse treatment. Consider, for example, someone who is unable to care for herself because of active psychotic symptoms—she does not eat because she believes her food has been poisoned, or she wanders outside in freezing weather without adequate clothing because she hears voices telling her to do so. Once she has been determined to be a danger to herself because of these psychotic symptoms and thus subject to civil commitment, neither her psychotic symptoms nor her commitment will be considered in determining whether she is competent to refuse treatment. But it makes little sense, this Article suggests, to say that she is so impaired by her mental illness that she requires commitment but then also to say that the commitment has no bearing on whether she can make her own decisions regarding treatment for her mental illness.⁹ While this

7. See Elyn R. Saks & Dilip V. Jeste, *Capacity to Consent to or Refuse Treatment and/or Research: Theoretical Considerations*, 24 BEHAV. SCI. & L. 411, 426 (2006) (“It is clear . . . that many mentally ill people—indeed, many seriously mentally ill people—are not incompetent on most measures of incompetency.”); see also William T. Carpenter, Jr. et al., *Decisional Capacity for Informed Consent in Schizophrenia Research*, 57 ARCHIVES GEN. PSYCHIATRY 533, 533 (2000) (“Studies of the capacity of schizophrenic patients to make decisions regarding their treatment demonstrate that . . . numerous people with schizophrenia, even when acutely ill, perform no worse than many members of the general population.”); Marsha Garrison, *The Empire of Illness: Competence and Coercion in Health-Care Decision Making*, 49 WM. & MARY L. REV. 781, 814 (2007) (“Patients with severely impaired insight often pass standard competence tests”); Karen McKinnon et al., *Rivers in Practice: Clinicians’ Assessments of Patients’ Decision-Making Capacity*, 40 HOSP. & COMMUNITY PSYCHIATRY 1159, 1159 (1989) (“Clinical evidence suggests that despite alterations in thinking and mood, psychiatric patients are not automatically less capable than others of making health care decisions.”); Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C.L. REV. 945, 998–99 (1991) (“[E]ven patients who deny they are ill, or believe they are bad and deserve to suffer, are competent to refuse treatment.”).

8. Peter F. Buckley et al., *Lack of Insight in Schizophrenia: Impact on Treatment Adherence*, 21 CNS DRUGS 129, 133 (2007) (“Lack of insight is the main cause of treatment nonadherence in patients with schizophrenia.”); *The Treatment of Schizophrenia: Making It Work*, HARV. MENTAL HEALTH LETTER, JUNE 2007, at 4, 4 (“The main reason for neglecting medication is lack of insight into the illness.”).

9. Since the 1980s, the idea that civil commitment says nothing about competency to refuse medication has become something of a mantra. See, e.g., *Rivers*, 495 N.E.2d at 342 (“[N]o relationship necessarily exists between the need for commitment and the capacity to

Article does not propose that civil commitment should serve as a presumption of incapacity to make treatment decisions, it does suggest that the level of impairment that civil commitment evidences ought to be considered in determining whether someone is competent to refuse medication for the illness that is responsible for her civil commitment. To do otherwise does not adequately take account of the reality of the person who is severely ill and confined to a mental institution and who, perhaps, lacks an understanding of the connection between the illness and confinement or the connection between medication and the possibilities for alleviating the illness and being released from confinement.

Someone whose mental illness makes her unable to care for herself and who refuses treatment for that mental illness in effect is deciding to remain unable to care for herself—and is also deciding to forfeit all of the other life decisions that require an ability to care for herself. Given her mental illness, it is at least possible that she does not understand that she is making all of these other decisions by virtue of the one decision to refuse treatment.¹⁰ An assessment of competency that ignores the reality that someone is so disabled by active symptoms of psychosis that she requires confinement to a mental institution when deciding the question whether she is competent to refuse treatment for those symptoms results in an artificially context-free assessment of competency. How can it not matter whether someone understands not just that she is ill, but that she is so ill that the state has assumed responsibility for her care? If she does not understand her present

make treatment decisions”); *Riese v. St. Mary’s Hosp. & Med. Ctr.*, 271 Cal. Rptr. 199 (Ct. App. 1987); see also Grant H. Morris, *Judging Judgment: Assessing the Competence of Mental Patients to Refuse Treatment*, 32 SAN DIEGO L. REV. 343, 402 (1995) (“[E]vidence of the patient’s dangerousness is irrelevant to the assessment of competence.”); Bruce J. Winick, *The Side Effects of Incompetency Labeling and the Implications for Mental Health Law*, 1 PSYCHOL. PUB. POL’Y & L. 6, 35 (1995) (“[C]ourts have begun to recognize that the presumption in favor of competency applies to mentally ill as well as to medically ill people, even to those who have been involuntarily committed under the state’s *parens patriae* power on the basis that they are incompetent to make the hospitalization decision for themselves.”). Many states have incorporated this doctrine into their statutes. *E.g.*, CAL. WELF. & INST. CODE § 5331 (West 2010); 405 ILL. COMP. STAT. 5/2-101 (2010); LA. REV. STAT. ANN. § 28:171(B) (2011); MASS. GEN. LAWS ch. 123, § 24 (2010); N.J. STAT. ANN. § 30:4-24.2(c) (West 2008); N.Y. MENTAL HYG. LAW § 29.03 (McKinney 2011); OHIO REV. CODE ANN. § 5122.301 (LexisNexis 2008); 20 PA. CONS. STAT. ANN. § 5512.1(f) (West 2005 & Supp. 2011).

10. It is also possible that someone might choose to remain unable to care for herself, even knowing that the consequence would be the loss of all of the other choices. See Morris, *supra* note 9, at 387 (describing one person who was found competent to refuse medication in part because he understood that refusing medication would mean that he remained institutionalized). But current competency standards do not require such an understanding; this Article proposes that they should.

circumstances, how can she make medical treatment decisions that further her own interests?

The gap between the standard for civil commitment and the standard for involuntary treatment can be narrowed either by making the standard for involuntary treatment less restrictive or by making the standard for civil commitment more restrictive. Although good arguments can be made for restricting or even eliminating civil commitment,¹¹ this Article accepts that the harms of untreated mental illness do in some cases outweigh the harms of involuntary treatment.¹² Consequently, this Article suggests that in some cases the standard for involuntary treatment should be made less restrictive. In particular, this Article proposes that when someone has been committed because he is a danger to himself, a “rational understanding” standard should be used to determine competency to refuse treatment. This Article focuses on refusing treatment because impaired understanding is more likely to lead someone to refuse treatment than to seek it.¹³ Additionally, this Article focuses on psychosis because active psychotic symptoms are a substantial threat to understanding¹⁴ and because untreated psychosis is exceptionally harmful.¹⁵

“Rational understanding” is the current standard for determining several other kinds of legal competencies, including competency to stand trial and competency to be executed. Because

11. See, e.g., Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CALIF. L. REV. 54 (1982).

12. For an extended defense of this proposition, see generally Dora W. Klein, *Involuntary Treatment of the Mentally Ill: Autonomy Is Asking the Wrong Question*, 27 VT. L. REV. 649 (2003). See also David L. Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process*, 75 COLUM. L. REV. 897, 907 (1975) (“[C]ivil libertarians in their proper concern with limiting state intervention in the lives of disturbed or disturbing individuals may fail to account for the reality of mental disability.”); Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 EMORY L.J. 375, 406 (1982) (“Opponents of all involuntary commitment would do well to ask themselves whether the emphasis on liberty does not sometimes lead to unacceptably great sacrifices of health, safety, and well being.”).

13. See Garrison, *supra* note 7, at 786 (“[I]n recent years evidence has mounted that various common mental conditions often have a coercive effect that may inhibit the choice of a beneficial treatment.”).

14. See Morris, *supra* note 9, at 401 (“Because psychotic individuals are, by definition, grossly impaired in reality testing, their ability to assess rationally the risks and benefits of proposed medication is questionable.”).

15. See *infra* notes 99-106 and accompanying text (discussing psychosis). A few commentators have suggested that when the consequences of a treatment decision are likely to be serious, competency to make that decision should be scrutinized more carefully or established more clearly. Elyn Saks and Dilip Jeste, though ultimately rejecting such a position, acknowledge that “[t]here is certainly some merit to the claim that if a decision has really serious costs, the patient/subject who will bear those costs must have a good understanding of them—essentially, of what she is getting herself into.” Saks & Jeste, *supra* note 7, at 422.

a criminal trial and an execution involve such substantial interests, to be deemed competent a person must have a rational understanding of the process and its consequences: of what is happening (a trial, an execution); why it is happening (an allegation of a crime, a conviction of a crime); and what its consequences will be (a determination of guilt or innocence, a death). Refusing treatment for a psychotic disorder so disabling that it has made someone unable to care for herself implicates similarly substantial interests and thus in these cases competency to refuse treatment ought to require a similar level of understanding.

Part I of this Article reviews the standard for civil commitment, focusing on *parens patriae* commitments. Part II discusses the standard for involuntary treatment—in particular, involuntary treatment with antipsychotic medication—comparing it to the standard for civil commitment. Part III proposes a “rational understanding” standard for competency to refuse treatment when someone is actively psychotic and as a result is a danger to herself. This heightened standard is necessary to increase the likelihood that someone who has already been determined to be substantially disabled by her mental illness fully understands the consequences of refusing treatment. Finally, Part IV discusses several issues regarding individual autonomy and competency to refuse medical treatment. Concern for autonomy underlies the whole doctrine of competency to make medical treatment decisions. The decision of someone who is competent must be respected, otherwise that person’s autonomy is diminished; but the decision of someone who is not competent may be overridden because it is not an autonomous decision. Requiring that people who have been civilly committed because of dangerousness to self have a rational understanding of the consequences of refusing treatment furthers the ultimate goal of promoting autonomous decisions: it helps to ensure that someone who refuses treatment does so because refusing treatment is consistent with her own goals and desires for herself.

I. THE STANDARD FOR CIVIL COMMITMENT

Under the common law, dangerousness was a necessary finding for civil commitment.¹⁶ People were confined if mad and danger-

16. ALBERT DEUTSCH, *THE MENTALLY ILL IN AMERICA* 419 (2d ed. 1949) (“[T]he common law which the colonies inherited from the mother country [England] upheld the right to deprive insane persons of their liberty. Anyone could arrest a ‘furiously insane’ person, or one deemed ‘dangerous to be permitted to be at large,’ and confine him for the duration of his dangerous condition, provided that this were done in a humane manner.”);

ous; those who were mad but not dangerous remained in the community.¹⁷ As states built asylums for the insane, legislatures drafted broad civil commitment standards that did not include explicit dangerousness provisions.¹⁸ In the 1970s, federal district courts began to rule that civil commitment is permitted only when someone is dangerous—and not just generally or potentially dangerous, but “imminently” or “immediately” dangerous. Arguably the most important of these cases was *Lessard v. Schmidt*, in which the District Court for the Eastern District of Wisconsin ruled that imminent dangerousness is constitutionally required.¹⁹ The *Lessard* decision invalidated Wisconsin’s civil commitment scheme and provided the reasoning that many other courts used to invalidate civil commitment schemes.²⁰

Following these judicial decisions, many state legislatures enacted statutes codifying the imminent dangerousness requirement.²¹ Until recently, “imminent dangerousness” was the gold standard for defining the criteria for civil commitment. Most states have now amended their statutes to provide for civil commitment based on dangerousness that is not necessarily imminent, although these statutes still require dangerousness in the near future.²²

MARK E. NEELY, JR. & R. GERALD McMURTRY, *THE INSANITY FILE* 18 (1986) (“In colonial America there were no statutes prescribing the manner in which the mentally ill could be committed. The common law alone governed the problem, allowing anyone to arrest ‘dangerous’ or ‘furiously insane’ persons for commitment until the dangerous condition disappeared.”). This dangerousness requirement was a matter as much of necessity as principle, as there were few places in which to confine someone who was mentally ill.

17. See *In re Oakes*, 8 Law Rep. 122, 124–25 (Mass. 1845) (Shaw, C.J.) (discussing history of civil commitment).

18. Susanna L. Blumenthal, *The Default Legal Person*, 54 U.C.L.A. L. REV. 1135, 1182–83 (2007).

19. *Lessard v. Schmidt*, 349 F. Supp. 1078, 1093 (E.D. Wis. 1972) (finding that the constitution requires the state to prove “that there is an extreme likelihood that if the person is not confined he will do immediate harm to himself or others”). See also *Stamus v. Leonhardt*, 414 F. Supp. 439, 451 (S.D. Iowa 1976) (requiring that subjects pose a threat as evidenced by a recent overt act); *Coll v. Hyland*, 411 F. Supp. 905, 910 (D.N.J. 1976); *Doremus v. Farrell*, 407 F. Supp. 509, 514 (D. Neb. 1975); *Lynch v. Baxley*, 386 F. Supp. 378, 387–88 (M.D. Ala. 1974); *Bell v. Wayne County Gen. Hosp.*, 384 F. Supp. 1085, 1096 (E.D. Mich. 1974).

20. See Rael Jean Isaac & Samuel Jan Brakel, *Subverting Good Intentions: A Brief History of Mental Health Law “Reform”*, 2 CORNELL J.L. & PUB. POL’Y 89, 103 (1992); see also George E. Dix, *Major Current Issues Concerning Civil Commitment Criteria*, 45 LAW & CONTEMP. PROBS. 137, 137 (1982) (“Judicial activism began in 1972 . . . in *Lessard v. Schmidt*.”); John E.B. Myers, *Involuntary Civil Commitment of the Mentally Ill: A System in Need of Change*, 29 VILL. L. REV. 367, 378–79 (1983–84) (*Lessard* was a “landmark case” that set standards that have been “widely followed by courts and legislatures throughout the country”).

21. Reed Groethe, *Overt Dangerous Behavior as a Constitutional Requirement for Involuntary Civil Commitment of the Mentally Ill*, 44 U. CHI. L. REV. 562, 562–63 (1977); John Q. La Fond, *An Examination of the Purposes of Involuntary Civil Commitment*, 30 BUFF. L. REV. 499, 499–500 (1981).

22. John Monahan describes some of these statutory changes:

Despite the rulings of the federal district courts and the enactments of the state legislatures, the United States Supreme Court has never ruled that the Constitution requires dangerousness for civil commitment. However, two Supreme Court decisions do bear on the question of dangerousness and the constitutionality of civil commitment criteria. First, in *O'Connor v. Donaldson*, the Court ruled that mental illness is an insufficient ground for justifying civil commitment.²³ In that case, Donaldson's father successfully petitioned to have him committed. Over many years, Donaldson requested release, arguing that he was neither mentally ill nor dangerous to himself or others. O'Connor, the hospital's superintendent, refused these requests, although he never provided an explanation for his refusals. The Supreme Court ruled that mental illness alone does not justify civil commitment: "A finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement [T]here is . . . no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom."²⁴ The Court left open, though, the question whether mental illness plus a need for treatment could justify civil commitment: "[T]here is no reason now to decide . . . whether the State may compulsorily confine a nondangerous, mentally ill individual for the purpose of treatment."²⁵

In the second case, *Addington v. Texas*, Addington sought to require the state to prove the elements of civil commitment "beyond a reasonable doubt," the standard required in criminal cases.²⁶ The Supreme Court held that imposing a "beyond a reasonable doubt" standard for civil commitment would harm people who meet the civil commitment criteria but about whom the state lacks sufficient evidence.²⁷ On the other hand, the Court ruled that Texas's "preponderance of the evidence" standard was too low, explaining that civil commitment "calls for a showing that the individual suffers

In 2000, South Dakota extended the time frame over which a violent act could be predicted to occur by deleting the word "very" from the previous statutory language that had read "very near future," thereby justifying civil commitments in more instances. Likewise, Minnesota in 2002 and Maryland in 2003 removed the requirement that dangerousness be "imminent" before commitment can be ordered.

John Monahan, *A Jurisprudence of Risk Assessment: Forecasting Harm Among Prisoners, Predators, and Patients*, 92 VA. L. REV. 391, 401 (2006) (footnotes omitted).

23. 422 U.S. 563 (1975).

24. *Id.* at 575.

25. *Id.* at 573.

26. 441 U.S. 418 (1979).

27. *See id.* at 429–30.

from something more serious than is demonstrated by idiosyncratic behavior. 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.²⁸ The intermediate “clear and convincing standard,” the Court decided, appropriately balanced the risk to individuals—that people who do not meet the civil commitment standard will be committed—against the risk to the state—that people who meet the civil commitment standard will not be committed.²⁹

In recent years, states have expanded the kinds of behaviors that will satisfy the dangerousness requirement, first with “gravely disabled” provisions and now, in many states, with “need for treatment” provisions.³⁰ The enactment of these provisions reflects an understanding that people who are mentally ill are a danger to themselves if they are unable to provide for their basic needs or if they are likely to deteriorate without treatment. For example, North Carolina’s civil commitment statute considers a person to be a “danger to himself” if “there is a reasonable probability of his suffering serious physical debilitation within the near future unless adequate treatment is given pursuant to this Chapter.”³¹ Wisconsin has added “needs care or treatment to prevent further disability or deterioration”³² to its list of ways that someone may be dangerous. Similarly, Oregon has added “will continue, to a reasonable medical probability, to physically or mentally deteriorate.”³³ But even with these broader criteria for civil commitment, involuntary medication may be administered to someone who is a danger to himself only if he is not competent to make his own medical treatment decisions. For some mental illnesses, particularly those characterized by psychotic symptoms, medication is the only effective treatment.³⁴ Thus, someone may be subject to civil commitment—to confinement in a mental institution—yet receive no real care for the illness that is responsible for his confinement.

28. *Id.* at 427.

29. *Id.*

30. *E.g.*, ARIZ. REV. STAT. ANN. § 36-540(A) (2009); IDAHO CODE ANN. § 66-339A(2) (2007); S.C. CODE ANN. § 44-17-580 (2002); WASH. REV. CODE ANN. § 71.05.020(17) (West 2008); WIS. STAT. ANN. § 51.20(1)(a)(2) (West 2008).

31. N.C. GEN. STAT. § 122C-3(11)(a) (2009).

32. WIS. STAT. ANN. § 51.20(1)(a)(2)(e) (West 2008).

33. OR. REV. STAT. § 426.005(1)(e)(C)(iv) (2009).

34. *See infra* note 98 and accompanying text.

II. THE LEAST RESTRICTIVE ALTERNATIVE REQUIREMENT: WHY DANGEROUSNESS JUSTIFIES CIVIL COMMITMENT BUT NOT INVOLUNTARY MEDICATION

Due Process requires that a government action that infringes constitutional liberties³⁵ must be tailored to serve the government interest that justifies the infringement.³⁶ In civil commitment cases, this has meant that when the commitment is justified by the government's interest in diminishing dangerousness, the government action that diminishes the dangerousness must be the least restrictive option available.³⁷ In the landmark case of *Lake v. Cameron*, Judge Bazelon wrote for the D.C. Circuit Court of Appeals that “[d]eprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection.”³⁸ In another landmark case, *Lessard v. Schmidt* (the

35. The Due Process Clause of the Fourteenth Amendment of the United States Constitution is one source of a right to refuse medical treatment. See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990). Other sources include state constitutions, state statutes, and the common law.

36. Justin Florence, Note, *Making the No Fly List Fly: A Due Process Model for Terrorist Watchlists*, 115 YALE L.J. 2148, 2165 (2006) (“The Court has repeatedly insisted that the requirements of due process are flexible and must be tailored to particular circumstances.”).

37. There is some uncertainty regarding whether the least restrictive alternative doctrine is constitutionally required in civil commitment cases. In the 1970s, some federal courts ruled that it is. *E.g.*, *Lessard v. Schmidt*, 349 F. Supp. 1078, 1103 (E.D. Wis. 1972); *Lynch v. Baxley*, 386 F. Supp. 378, 392 (M.D. Ala. 1974); *Stamus v. Leonhardt*, 414 F. Supp. 439, 452–53 (S.D. Iowa 1976); *Eubanks v. Clarke*, 434 F. Supp. 1022, 1028 (E.D. Pa. 1977). In 1982, the Supreme Court in *Youngberg v. Romeo* held that due process does not require that people who are institutionalized receive treatment in the least restrictive setting. 457 U.S. 307, 324 (1982) (requiring that people who are institutionalized be subject to “reasonably nonrestrictive confinement conditions”). Yet the issue in *Youngberg* was the right to receive treatment, while the issue in civil commitment and involuntary medication cases is the right to refuse treatment. Additionally, in more recent cases, the Court has ruled that involuntary medication of pretrial detainees who are incompetent to stand trial must be the least restrictive alternative. See *Sell v. United States*, 539 U.S. 166, 177–83 (2003); *Riggins v. Nevada*, 504 U.S. 127, 135 (1992). Statutes in most jurisdictions now require that involuntary treatment be the least restrictive alternative. See, e.g., ALA. CODE § 22-52-10.1(a) (2006); ARIZ. REV. STAT. § 36-540(B) (2003); GA. CODE ANN. § 37-3-161 (1995); ILL. COMP. STAT. ANN. 405 5/3-811 (2004); MINN. STAT. ANN. § 253B.09(1)(a) (2007); WASH. REV. CODE ANN. § 71.05.320(1) (2008); see also *Rennie v. Klein*, 653 F.2d 836, 846–47 (3d Cir. 1981) (“It appears that at least thirty-five jurisdictions explicitly or implicitly acknowledge the least restrictive doctrine in their statutes as applicable to treatment or involuntary commitment.”); Ilissa L. Watnik, Comment, *A Constitutional Analysis of Kendra's Law: New York's Solution for Treatment of the Chronically Mentally Ill*, 149 U. PA. L. REV. 1181, 1203 (2001) (reporting that “most states have incorporated the least restrictive alternative doctrine into their commitment laws”).

38. 364 F.2d 657, 660 (D.C. Cir. 1966). Although *Lake* was decided on statutory grounds, the opinion is often cited as having first applied the least restrictive alternative requirement to civil commitment cases. See, e.g., Dennis E. Cichon, *The Right to “Just Say No”: A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 LA. L. REV. 283, 355 (1992) (“The least restrictive alternative doctrine was first applied in the mental health area in *Lake*

same case that ruled imminent dangerousness is a constitutionally required commitment criterion), the District Court for the Eastern District of Wisconsin concluded that “the Wisconsin civil commitment procedure is constitutionally defective insofar as it . . . fails to require those seeking commitment to consider less restrictive alternatives to commitment.”³⁹

Most courts considering this issue have ruled that involuntary confinement is less restrictive than involuntary medication.⁴⁰ Several courts have ruled that involuntary medication is permitted only after other “less restrictive” treatment options have been considered.⁴¹ In *Rennie v. Klein*, the Third Circuit Court of Appeals explained that “there is a difference of constitutional significance between simple involuntary confinement to a mental institution and commitment combined with enforced administration of antipsychotic drugs.”⁴² The Supreme Court of Massachusetts similarly observed that “[w]e can identify few legitimate medical procedures

v. Cameron.”); Ralph Slovenko, *The Transinstitutionalization of the Mentally Ill*, 29 OHIO N.U. L. REV. 641, 648 (2003) (“The first enunciation of LRA in the law on hospitalization was in the 1966 case of *Lake v. Cameron*.”); Douglas S. Stransky, *Civil Commitment and the Right to Refuse Treatment: Resolving Disputes from a Due Process Perspective*, 50 U. MIAMI L. REV. 413, 437 (1996) (“The first case in the mental health area to apply the least restrictive alternative doctrine was *Lake v. Cameron*.”).

39. 349 F. Supp. at 1103. See also *DeAngelas v. Plaut*, 503 F. Supp. 775, 783 (D. Conn. 1980) (holding state statute unconstitutional “insofar as it fails to require findings . . . that commitment of the accused is the least restrictive alternative”); *Eubanks*, 434 F. Supp. at 1028 (“[D]ue process requires that the state place individuals in the least restrictive setting consistent with legitimate safety, care and treatment objectives.”); *Stamus*, 414 F. Supp. at 453 (finding state law unconstitutional for “failing to require that less restrictive alternatives be considered prior to ordering full-time hospitalization”).

40. *Bee v. Greaves*, 744 F.2d 1387, 1396 (10th Cir. 1984) (“[L]ess restrictive alternatives, such as segregation . . . should be ruled out before resorting to antipsychotic drugs.”); *Rennie*, 653 F.2d at 844 (“[T]here is a difference of constitutional significance between simple involuntary confinement to a mental institution and commitment combined with enforced administration of antipsychotic drugs.”); *Rogers v. Okin*, 634 F.2d 650, 656 (1980) (“[R]easonable alternatives to the administration of antipsychotics must be ruled out.”); *In re Orr*, 531 N.E.2d 64, 73 (Ill. App. Ct. 1988) (“[T]he trial court both exceeded statutory authority and failed to consider important factors and alternatives when it issued the order authorizing the State to forcibly medicate a person found subject to involuntary admission [to a mental health facility].”); *Rogers v. Comm’r of the Dep’t of Mental Health*, 458 N.E.2d 308, 312–15 (Mass. 1983) (distinguishing criteria for involuntary hospitalization from criteria for involuntary medication).

41. E.g., *Bee*, 744 F.2d at 1396; *Rogers*, 634 F.2d at 656 (“[R]easonable alternatives to the administration of antipsychotics must be ruled out.”). Whether involuntary medication really is more restrictive than such other involuntary treatments as seclusion or restraints is a difficult and perhaps unanswerable question. See Robert D. Miller, *The Continuum of Coercion: Constitutional and Clinical Considerations in the Treatment of Mentally Disordered Persons*, 74 DENV. U. L. REV. 1169, 1179 (1997) (“A final legal question concerning the involuntary administration of medication is whether medications are more or less restrictive than seclusion and restraint. There is no judicial or legislative consensus on this question, and legal scholars also disagree.”).

42. 653 F.2d at 844.

which are more intrusive than the forcible injection of antipsychotic medication.”⁴³

Such rulings suggest that if involuntary confinement is sufficient to diminish dangerousness, then involuntary medication is impermissible. In a recent case, the Alaska Supreme Court reasoned that because “API [the Alaska Psychiatric Institute] has not maintained that Myers posed an imminent threat of harm to herself or anyone else after she was committed for treatment at API,” the “state’s power of civil commitment sufficed to meet its police-power interest, so we fail to see how the issue of medication implicates the state’s police power at all.”⁴⁴ Or as the Oklahoma Supreme Court has explained:

If there is no emergency, hospital personnel are in no danger; the only purpose of forcible medication in these circumstances would be to help the patient. But the basic premise of the right to privacy is the freedom to decide whether we prefer to be helped, or to be left alone.⁴⁵

This scheme often does not make sense even in police-power commitments: someone who would be dangerous outside of the hospital still cannot be administered involuntary medications if she is not dangerous inside the hospital. But the scheme makes even less sense in *parens patriae* commitments. If the state interest that justifies commitment is providing care, then the legally required standard should be “most effective,” not “least restrictive.”⁴⁶ Confinement in a hospital might diminish dangerousness by limiting opportunities to act on dangerous thoughts or feelings and providing a calm, structured environment. Hospitalization, to a small extent, can be therapeutic.⁴⁷ But someone who is acutely psychotic will need more than hospitalization if she is to experience substantial relief from her illness and return to anything resembling her pre-illness level of functioning. For that, she most likely needs antipsychotic medication. Other kinds of therapies are also important, especially in the long-term treatment of psychosis. But

43. *In re Guardianship of Roe*, 421 N.E.2d 40, 52 (Mass. 1981).

44. *Myers v. Alaska Psychiatric Inst.*, 138 P.3d 238, 248 (Alaska 2006).

45. *In re K.K.B.*, 609 P.2d 747, 751 (Okla. 1980).

46. *Cf. Jackson v. Indiana*, 406 U.S. 715, 738 (1972) (“At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.”).

47. MARVIN I. HERZ & STEPHEN R. MARDER, *SCHIZOPHRENIA: COMPREHENSIVE TREATMENT AND MANAGEMENT* 42 (Charles W. Mitchell et al. eds., 2002) (“Treatment in the hospital offers the advantage of a safe, secure, structured, and supervised environment while reducing stress on both patients and family members.”).

alone, no psychosocial treatment will be of much assistance to someone who is actively psychotic.⁴⁸ Active psychosis generally requires antipsychotic medication.⁴⁹

The observation that medication is necessary for the effective treatment of an active psychotic episode is not meant to suggest that medication is a panacea. Schizophrenia, the most common of the psychotic disorders, is a terrible illness,⁵⁰ and someone with this disorder will likely face a long and difficult struggle.⁵¹ Antipsychotic medications also have serious flaws—they do not cure schizophrenia, they often fail to alleviate all the symptoms of schizophrenia, and they can cause debilitating side effects.⁵² No doubt, someone with schizophrenia might well decide that living with the symptoms of schizophrenia is preferable to living with the side effects of antipsychotic medication.⁵³ If the decision-maker truly and rationally understands the consequences of refusing medication, then his decision, whatever it might be, should be respected. But current capacity-based standards of competency to make treatment decisions are insufficient to ensure that someone who is experiencing an active psychotic episode—one so disabling that he requires commitment to prevent him from harming himself—truly understands the consequences of a decision to refuse antipsychotic medication.

48. PATRICK W. CORRIGAN ET AL., PRINCIPLES AND PRACTICE OF PSYCHIATRIC REHABILITATION 60 (2008) (“The current view in psychiatry is that psychotropic medications are a critical component of treatment, but that provision of medications in the absence of psychosocial interventions is insufficient.”).

49. See *infra* note 98 and accompanying text.

50. See *infra* notes 99–106 and accompanying text (discussing schizophrenia).

51. According to the American Psychiatric Association, “[e]ducational progress [of people diagnosed with schizophrenia] is frequently disrupted, and the individual may be unable to finish school. Many individuals are unable to hold a job for sustained periods of time and are employed at a lower level than their parents (‘downward drift’). The majority (60%–70%) of individuals with [s]chizophrenia do not marry, and most have relatively limited social contacts.” AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 302 (4th ed. text rev. 2000) [hereinafter DSM-IV-TR]; accord Tania M. Lincoln et al., *Correlates and Long-Term Consequences of Poor Insight in Patients with Schizophrenia: A Systematic Review*, 33 SCHIZOPHRENIA BULL. 1324, 1324 (2007) (“The long-term course of schizophrenia is frequently characterized by reduced social and occupational functioning, loss of independent living, impaired quality of life, substance abuse, and increased risk of suicidal and violent behavior.”).

52. See *infra* notes 91–97 and accompanying text (discussing effects and side effects of antipsychotic medications).

53. See Morris, *supra* note 9, at 405 (“Although competent decisionmaking should also weigh the potential benefits of the proposed medication, a patient’s concern about side effects, particularly if those side effects have been experienced previously, may be a rational basis to support a medication refusal.”).

III. CAPACITY IS NOT ENOUGH: AN ARGUMENT IN FAVOR OF A RATIONAL UNDERSTANDING STANDARD

The Constitution requires “rational understanding” in two particular contexts:⁵⁴ establishing competence to stand trial and establishing competence to be executed.⁵⁵ “Rational understanding,” in contrast to mere “factual understanding,” is necessary because of the magnitude of the interests at stake.

A. Competence to Stand Trial

The Supreme Court has ruled that the Due Process Clause requires that a criminal defendant possess certain competencies, otherwise his trial is unfair.⁵⁶ Generally, a person is competent to stand trial if he has “sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding” and “a rational as well as factual understanding of the proceedings against him.”⁵⁷ As the Court has explained, “[i]t has long been accepted that a person whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his

54. This Article focuses on the two particular contexts in which the requirement of a rational understanding is clear. There are arguably other contexts that could be added to the list, but these are not so clear. For example, competence to waive further death sentence appeals probably requires rational understanding. *See* *Rees v. Peyton*, 384 U.S. 312, 314 (1966). And competence to waive the right to counsel at trial might require more than rational understanding. *See* *Indiana v. Edwards*, 554 U.S. 164 (2008).

55. Additionally, some states require rational understanding for determining other competencies, such as competency to waive Miranda warnings. *See* Saul M. Kassin et al., *Police-Induced Confessions: Risk Factors and Recommendations*, 34 LAW & HUM. BEHAV. 3, 8 (2010).

56. *Pate v. Robinson*, 383 U.S. 375, 385 (1966).

57. *Dusky v. United States*, 362 U.S. 402, 402 (1960) (quoting statement of the solicitor general); *see also* *Drope v. Missouri*, 420 U.S. 162, 171 (1975). Although the *Dusky* decision involved an interpretation of federal statutory law and is therefore not binding on the states, most states have adopted the *Dusky* standard either by judicial decision or statutory enactment. Grant H. Morris & J. Reid Meloy, *Out of Mind? Out of Sight: The Uncivil Commitment of Permanently Incompetent Criminal Defendants*, 27 U.C. DAVIS L. REV. 1, 15 n.67 (1993); Elizabeth S. Scott & Thomas Grisso, *Developmental Incompetence, Due Process, and Juvenile Justice Policy*, 83 N.C. L. REV. 793, 799–800 (2005) (“[T]he federal standard announced by the Supreme Court in *Dusky v. United States* . . . has since been adopted uniformly by American courts.”). Some state statutes describe in more detail the requirements for competency to stand trial. *See, e.g.*, FLA. R. CRIM. P. 3.211(a)(2) (listing as factors to consider in deciding competence to proceed, “the defendant’s capacity to: (i) appreciate the charges or allegations against the defendant; (ii) appreciate the range and nature of possible penalties, if applicable, that may be imposed in the proceedings against the defendant; (iii) understand the adversary nature of the legal process; (iv) disclose to counsel facts pertinent to the proceedings at issue; (v) manifest appropriate courtroom behavior; (vi) testify relevantly”).

defense may not be subjected to a trial.”⁵⁸ If a defendant lacks these competencies, then he is essentially not present at his own trial—he might be physically present, but he is not present in a way that would allow him to participate meaningfully.⁵⁹

People might be incompetent to stand trial because of any number of impairments, including disorders such as mental retardation or schizophrenia. The psychotic symptoms of schizophrenia are especially likely to impair the kind of rational understanding required for competence to stand trial. Various courts and commentators have understood rational understanding to mean something like comprehension, not just of the facts of the situation in an abstract way but of the implications of those facts as applied to the defendant’s particular, personal circumstances.⁶⁰ Someone who is experiencing active psychotic symptoms such as hallucinations—perceptual experiences not based in reality—or delusions—beliefs not based in reality—necessarily is not interacting with the world in an accurate way.⁶¹ When these inaccuracies interfere with a rational understanding of criminal charges or of the trial process, a defendant is not competent to stand trial.⁶²

Like all tests of competency, the standard for competence to stand trial balances a concern for respecting autonomy against a need for protecting those whose mental impairments compromise their autonomy.⁶³ Criminal defendants are presumed competent,⁶⁴

58. *Drope*, 420 U.S. at 171.

59. See Caleb Foote, *A Comment on Pre-Trial Commitment of Criminal Defendants*, 108 U. PA. L. REV. 832, 834 (1960) (arguing that “the mentally incompetent defendant, though physically present in the courtroom, is in reality afforded no opportunity to defend himself”), *quoted in Drope*, 420 U.S. at 171.

60. Scott & Grisso, *supra* note 57, at 818 (“The rational understanding requirement of *Dusky* has been interpreted to mean that defendants must comprehend the implications and significance of what they understand factually regarding the trial process.”).

61. See ANN M. KRING ET AL., *ABNORMAL PSYCHOLOGY* 351–52 (10th ed. 2006) (defining delusions as “beliefs held contrary to reality” and hallucinations as “sensory experiences in the absence of any stimulation from the environment”).

62. *Lafferty v. Cook*, 949 F.2d 1546, 1551 (10th Cir. 1991) (“[A] defendant lacks the requisite rational understanding if his mental condition precludes him from perceiving accurately, interpreting, and/or responding appropriately to the world around him.”); *Strickland v. Francis*, 738 F.2d 1542, 1546, 1551 (11th Cir. 1984) (“Strickland was out of touch with reality and totally incapable of assisting in his defense He suffered from delusional characteristics and had psychotic disorders that made it difficult for him to deal with reality.”); *Bruce v. Estelle*, 536 F.2d 1051, 1063 (5th Cir. 1976) (finding that defendant’s schizophrenia “caused him to misperceive important elements of the proceedings”); Scott & Grisso, *supra* note 57, at 818 (“Deficits in rational understanding typically involve distorted or erroneous beliefs that nullify one’s factual understanding.”).

63. See Paul S. Appelbaum, *Ought We to Require Emotional Capacity as Part of Decisional Competence?*, 8 KENNEDY INST. OF ETHICS J. 377, 378 (1998) (“Contemporary ideas of competence are tied inextricably to the ideal of self-determination in modern Western societies.”).

64. When this presumption is challenged, the defendant in some jurisdictions has the burden of proving incompetence while in other jurisdictions the prosecution has the burden

reflecting the belief that people are likely to possess sufficient understanding to enable them to make autonomous decisions should they be charged with a crime. The decisions of a competent defendant are respected because the defendant is the one who will live with the consequences of the trial's outcome,⁶⁵ and he is presumed to know how best to weigh the many options that a criminal trial presents and to make decisions that further his personal interests.⁶⁶ Finding a defendant incompetent when he really does possess a rational understanding of the charges and the trial process denies him the opportunity to make choices in accordance with his own beliefs and values. But if a defendant does not rationally understand the charges or the proceedings, the presumption that he can weigh options and reach decisions that protect his interest is invalid.⁶⁷ The defendant who lacks rational understanding cannot be brought to trial because he cannot make autonomous decisions, and making autonomous decisions is one of the tasks required of a criminal defendant.⁶⁸

The rational understanding standard requires that a defendant must have more than a mere capacity to participate in the trial process; the defendant must actually exercise that capacity in some meaningful way. Any defendant may choose not to cooperate with her attorney, or may choose not to exercise certain trial rights, but

of proving competence. See Steven R. Marino, *Are you Sufficiently Competent to Prove Your Incompetence? An Analysis of the Paradox in the Federal Courts*, 6 SETON HALL CIR. REV. 165, 180 (2009).

65. *Cooper v. Oklahoma*, 517 U.S. 348, 364 (1996); *Godinez v. Moran*, 509 U.S. 389, 406–07 (1993) (referring to “the variety of decisions that a defendant must make”); *Faretta v. California*, 422 U.S. 806, 834 (1975) (“The defendant, and not his lawyer or the State, will bear the personal consequences of a conviction. It is the defendant, therefore, who must be free personally to decide whether in his particular case counsel is to his advantage.”).

66. Chief among these decisions is whether and how to exercise trial rights, such as the right to a trial by jury, to testify or to remain silent, and to confront witnesses. See *Riggins v. Nevada*, 504 U.S. 127, 139 (1992) (Kennedy, J., concurring in the judgment) (noting that “[c]ompetence to stand trial is rudimentary, for upon it depends the main part of those rights deemed essential to a fair trial”); see also *Cooper*, 517 U.S. at 354; AM. BAR ASS’N, ABA STANDARDS FOR CRIMINAL JUSTICE: PROSECUTION FUNCTION AND DEFENSE FUNCTION § 4-5.2, at 199–200 (3d ed. 1993) (listing decisions criminal defendants must make to include “(i) what pleas to enter; (ii) whether to accept a plea agreement; (iii) whether to waive jury trial; (iv) whether to testify in his or her own behalf; and (v) whether to appeal”).

67. See Erica J. Hashimoto, *Defending the Right of Self-Representation: An Empirical Look at the Pro Se Felony Defendant*, 85 N.C. L. REV. 423, 456 (2007) (“Imbedded within this notion of autonomy and free choice . . . is the idea that the decision . . . is going to be made freely, i.e., without a cloud of mental illness.”).

68. See 4 WILLIAM BLACKSTONE, COMMENTARIES *24 (“[I]f a man in his sound memory commits a capital offense, and before arraignment for it he becomes mad, he ought not to be arraigned for it; because he is not able to plead to it with that advice and caution that he ought.”).

such choices must be based in reality, not in delusion.⁶⁹ A defendant who has a factual understanding of the trial process but who, for example, believes that his special powers will protect him from being found guilty ought not be found competent to stand trial.⁷⁰

The trial of an incompetent defendant harms not only the defendant but also the justice system itself, which relies on the adversarial process to produce the truth.⁷¹ The defendant has an interest in making decisions that accord with his own values and beliefs. The state, meanwhile, has an interest not in prevailing in all criminal trials but in prevailing in those criminal trials in which the defendant is guilty. A defendant who does not act according to a rational understanding of what is at stake in a criminal trial, but instead acts according to his delusional beliefs about the world, is a defendant who risks being convicted even though he is not guilty, and thus jeopardizes his own interests as well as the state's.

B. Competence to Be Executed

In *Ford v. Wainwright*, the Supreme Court ruled that the Eighth Amendment prohibits the government from carrying out a death sentence if the person to be executed does not have “the mental capacity to understand the nature of the death penalty and the reasons why it was imposed on him.”⁷² In the 2007 case *Panetti v.*

69. *Lafferty v. Cook*, 949 F.2d 1546, 1551 (10th Cir. 1991) (ruling that rational understanding requires “a sufficient contact with reality”); *see also* *Coleman v. Saffle*, 912 F.2d 1217, 1227 (10th Cir. 1990); *United States v. Hems*, 901 F.2d 293, 296 (2d Cir. 1990); *Balfour v. Haws*, 892 F.2d 556, 561 (7th Cir. 1989); *Strickland v. Francis*, 738 F.2d 1542, 1551–52 (11th Cir. 1984); *Lokos v. Capps*, 625 F.2d 1258, 1267 (5th Cir. 1980) (“not operating in the world of reality”).

70. Many commentators have suggested that the *Dusky* standard is insufficiently demanding. *See, e.g.*, Ronald L. Kuby & William M. Kunstler, *So Crazy He Thinks He Is Same: The Colin Ferguson Trial and the Competency Standard*, 5 CORNELL J.L. & PUB. POL'Y 19, 24 (1995) (arguing that Ferguson's case is “a good example of just how insane one can be and yet be found competent to stand trial”). But in requiring some degree of actual rational understanding, *Dusky* is more demanding than standards for determining competency to make medical treatment decisions.

71. *See Cooper*, 517 U.S. at 364; *Drope v. Missouri*, 420 U.S. 162, 171–72 (1975) (asserting that the competency requirement “is fundamental to an adversary system of justice”); *Pate v. Robinson*, 383 U.S. 375 (1966).

72. *Ford v. Wainwright*, 477 U.S. 399, 403–04 (1986) (quoting FL. STAT. § 922.07 (1985)) (internal quotation marks omitted). Since *Ford*, many death penalty states have adopted statutory definitions of competency to be executed, identifying the key deficit that determines incompetency with phrases such as “presently unable to know why he or she is being punished and understand the nature of the punishment.” *E.g.*, GA. CODE ANN. § 17-10-60 (2008); *see also* MISS. CODE ANN. § 99-19-57(2)(b) (West 2006 & Supp. 2008) (“[D]oes not have sufficient intelligence to understand the nature of the proceedings against him, what he was tried for, the purpose of his punishment, the impending fate that awaits him, and a sufficient understanding to know any fact that might exist that would make his punishment

Quarterman, the Supreme Court clarified that the understanding required is more than a simple factual understanding. Scott Panetti knew that he had killed two people and he knew that the government's professed reason for planning to execute him was that he had killed two people. But Panetti—who had a long and well-documented history of psychosis⁷³—did not believe that the government's professed reason for planning to execute him was its real reason. Instead, Panetti believed that the government planned to execute him because the government was allied with “the demons and the forces of the darkness” and wanted “to stop him from preaching.”⁷⁴

The Fifth Circuit Court of Appeals ruled that because Panetti was aware of the state's professed reason for executing him, he was competent to be executed.⁷⁵ That Panetti did not believe that reason was the real reason did not make him incompetent.⁷⁶ The Supreme Court disagreed, ruling that mere awareness did not satisfy the requirements of *Ford*. Instead, what Panetti must possess is “a rational understanding of the State's reason for his execution.”⁷⁷

The opinions in *Ford* proposed a variety of grounds for finding that the execution of a person who does not comprehend why he is being executed violates the Eighth Amendment.⁷⁸ Execution of

unjust or unlawful and the intelligence requisite to convey that information to his attorneys or the court.”); MO. ANN. STAT. § 552.060 (West 2002) (“[L]acks capacity to understand the nature and purpose of the punishment about to be imposed upon him or matters in extenuation, arguments for executive clemency or reasons why the sentence should not be carried out.”); UTAH CODE ANN. § 77-19-201 (2007) (“[U]naware of either the punishment he is about to suffer or why he is to suffer it.”).

73. *Panetti v. Quarterman*, 551 U.S. 930, 936 (2007) (discussing history of psychotic symptoms); see also Richard J. Bonnie, *Panetti v. Quarterman: Mental Illness, the Death Penalty, and Human Dignity*, 5 OHIO ST. J. CRIM. L. 257, 259 (2007) (noting that Panetti “had been involuntarily committed to psychiatric hospitals in Texas and Wisconsin more than a dozen times during the decade preceding the crime” and that the “recurrent diagnoses were chronic schizophrenia and schizoaffective disorder, characterized by tangential and circumstantial thinking, hallucinations, delusions, grandiosity and paranoia, with acute psychotic exacerbations complicated by alcohol use”).

74. *Panetti*, 551 U.S. at 954–55.

75. *Id.* at 956 (“The Court of Appeals stated that competency is determined by whether a prisoner is aware ‘that he is going to be executed and why he is going to be executed’” (internal quotation marks omitted)).

76. *Id.* at 958 (“The Court of Appeals’ standard treats a prisoner’s delusional belief system as irrelevant if the prisoner knows that the State has identified his crimes as the reason for his execution.”).

77. *Id.* at 956.

78. *Ford*, 477 U.S. at 407–08. The Court in *Panetti* summarized these grounds:

Explaining the prohibition against executing a prisoner who has lost his sanity, Justice Marshall in the controlling portion of his opinion set forth various rationales, including recognition that “the execution of an insane person simply offends humanity,” that it “provides no example to others,” that “it is uncharitable to dispatch an

someone who does not rationally understand the reasons for the execution has long been considered barbaric.⁷⁹ Both *Ford* and *Panetti* acknowledged the moral impulse that executing someone who does not understand the reasons for his execution “simply offends humanity.”⁸⁰ A person must have an understanding of the connection between his crime and the punishment of death that is rooted in reality; otherwise, “the punishment can serve no proper purpose.”⁸¹

C. Competence to Make Medical Treatment Decisions

Tests to determine competence to make medical treatment decisions assess an individual’s capacity for rational decision making.⁸² As commentators have observed, one problem with such tests is that they are exclusively cognitive; that is, they do not take account of non-cognitive processes, particularly emotional processes, which can interfere with rational decision making.⁸³ An additional

offender into another world, when he is not of a capacity to fit himself for it,” that “madness is its own punishment,” and that executing an insane person serves no retributive purpose.

551 U.S. at 958 (citations omitted).

79. See *Solesbee v. Balkcom*, 339 U.S. 9, 16 (1950) (Frankfurter, J., dissenting) (“This limitation on the power of the State to take life has been part of our law for centuries, recognized during periods of English history when feelings were more barbarous and men recoiled less from brutal action than we like to think is true of our time.”), *abrogated by Ford v. Wainwright*, 477 U.S. 399, 405 (1986); Brief Amici Curiae of Legal Historians in Support of Petitioner at 9–14, *Panetti v. Quarterman*, 551 U.S. 930 (2007) (No. 06-6407); Note, *Insanity of the Condemned*, 88 YALE L.J. 533, 535 (1979) (discussing the common law tradition of banning the execution of the mentally ill); Paul J. Larkin, Note, *The Eighth Amendment and the Execution of the Presently Incompetent*, 32 STAN. L. REV. 765, 778 (1980); DANIEL N. ROBINSON, *WILD BEASTS & IDLE HUMOURS: THE INSANITY DEFENSE FROM ANTIQUITY TO THE PRESENT* 72–73 (1996).

80. *Panetti*, 551 U.S. at 957 (quoting *Ford*, 477 U.S. at 409).

81. *Id.* at 960 (“Gross delusions stemming from a severe mental disorder may put an awareness of a link between a crime and its punishment in a context so far removed from reality that the punishment can serve no proper purpose.”).

82. See Ashley Bassel, Note, *Order at the End of Life: Establishing a Clear and Fair Mechanism for the Resolution of Futility Disputes*, 63 VAND. L. REV. 491, 499 (2010) (noting that “scholarly writing and judicial decisions have established a general standard: a person is competent for purposes of medical decisionmaking when she can (1) understand the consequences of accepting or rejecting a particular treatment, (2) comprehend the benefits and risks of the treatment and alternatives to the proposed treatment, and (3) communicate that decision to another”). The Uniform Health Care Decisions Act, which has been adopted by a handful of states, defines competence as the “ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision.” Uniform Health-Care Decisions Act § 1(3) (1993).

83. See Garrison, *supra* note 7, at 789–90 (“What these varied tests [of competence to make treatment decisions] share is an exclusive focus on cognitive capacity.”).

problem is that capacity for rationality, rather than any degree of actual rationality, is all that is required. In practice, this means that someone is competent so long as “she can accurately describe the treatment choice, its corollary risks, and its potential benefits to her.”⁸⁴ But being able to describe the potential risks and benefits is not the same as actually understanding the potential risks and benefits. When someone has already been determined to be so disabled by symptoms of a mental illness that he is subject to civil commitment, competence to refuse treatment for those symptoms should require an actual, rational understanding.

1. Schizophrenia: What Is at Stake?

Schizophrenia has been called the “most devastating” of all mental disorders.⁸⁵ The symptoms of schizophrenia involve every aspect of psychological functioning, from cognition and emotion to perception, communication, and even physical movement.⁸⁶ Contrary to popular belief, schizophrenia does not mean “split personality.”⁸⁷ The word does mean “split mind;” not a split that creates two neatly separate functioning personas, however, but a split that is more like a shatter, creating fragments of unintegrated mental processes.⁸⁸ The hallmark symptoms of schizophrenia are delusions and

84. *Id.* at 790.

85. See Tandy J. Miller & Thomas H. McGlashan, *The Risks of Not Intervening in Pre-Onset Psychotic Illness*, 12 J. MENTAL HEALTH 345, 347 (2003) (“Schizophrenic psychosis is considered to be the most devastating of the serious mental illnesses.”); accord Steven M. Paul, *Introduction: The New Pharmacotherapy of Schizophrenia*, in CURRENT ISSUES IN THE PHARMACOTHERAPY OF SCHIZOPHRENIA xvii (Alan Breier et al. eds., 2001) (referring to schizophrenia as “arguably the most severe and disabling of the major psychiatric disorders”); see also Kim T. Mueser & Susan R. McGurk, *Schizophrenia*, 363 LANCET 2063, 2063 (2004) (“Schizophrenia is a mental illness that is among the world’s top ten causes of long-term disability.”).

86. According to the American Psychiatric Association, “[t]he characteristic symptoms of [s]chizophrenia involve a range of cognitive and emotional dysfunctions that include perception, inferential thinking, language and communication, behavioral monitoring, affect, fluency and productivity of thought and speech, hedonic capacity, volition and drive, and attention.” DSM-IV-TR, *supra* note 51, at 299. A leading psychiatry text describes schizophrenia as “the paradigmatic illness of psychiatry,” explaining that “[i]t is a clinical syndrome of variable but profoundly disruptive psychopathology, which involves thought, perception, emotion, movement, and behavior. The expression of these symptoms varies across patients and over time, but the cumulative effect of the illness is always severe and usually long lasting.” Robert W. Buchanan & William T. Carpenter, Jr., *Schizophrenia: Introduction and Overview*, in KAPLAN & SADOCK’S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1096, 1096 (Benjamin J. Sadock & Virginia A. Sadock eds., 7th ed. 2000).

87. Cf. NEIL R. CARLSON, FOUNDATIONS OF PHYSIOLOGICAL PSYCHOLOGY 450 (5th ed. 2002) (“Schizophrenia is probably the most misused psychological term in existence.”).

88. Scott O. Lilienfeld & Hal Arkowitz, *Living with Schizophrenia: A Diagnosis of Schizophrenia Is Not Always Grounds for Despair*, SCI. AM., Mar. 2010, at 16 (“People with

hallucinations. These symptoms are often referred to as “psychotic symptoms,” meaning disconnected from reality, or “positive symptoms,” meaning experiences that are in excess of normal experiences.⁸⁹ Schizophrenia is also characterized by other kinds of symptoms, such as “negative symptoms,” which are deficits in normal functioning.⁹⁰ But it is the positive psychotic symptoms that are most likely to interfere with understanding.

Even the voluntary treatment of schizophrenia can be difficult, for several reasons. First, there is no treatment that cures schizophrenia.⁹¹ All available medications are prophylactic only; that is, they might ameliorate the symptoms temporarily but they must be taken on a continuous basis, otherwise the symptoms will likely recur.⁹² In this respect antipsychotic medications resemble insulin, which people with insulin-dependent diabetes must take on a continuous basis, rather than antibiotics, which when effective eliminate the cause of an infection and therefore need not be taken on a continuous basis.⁹³

At best, antipsychotic medications alleviate the symptoms of schizophrenia; sometimes, though, they do not do even that. For some people, antipsychotic medications are “miracle drugs,” restoring functioning to pre-illness levels. For other people, though, antipsychotic medications are only partially effective.⁹⁴

Additionally, all antipsychotic medications have the potential to cause side effects that are serious and distressing.⁹⁵ Different types

schizophrenia possess only one personality, but that personality has been shattered, with severe impairments in thinking, emotion and motivation.”).

89. DSM-IV-TR, *supra* note 51, at 299 (describing positive symptoms as “an excess or distortion of normal functions”).

90. *Id.* (describing negative symptoms as “a diminution or loss of normal functions”).

91. See KRING ET AL., *supra* note 61, at 375 (noting that antipsychotic medications are “not a cure” for schizophrenia); JEFFREY A. LIEBERMAN ET AL., TEXTBOOK OF SCHIZOPHRENIA 303 (2006) (“antipsychotic drugs do not cure schizophrenia”).

92. SUSAN NOLEN-HOEKSEMA, ABNORMAL PSYCHOLOGY 359–60 (2d ed. 2001) (“People with schizophrenia typically must take neuroleptic drugs prophylactically—that is, all the time to prevent new episodes of acute symptoms.”).

93. This is difficult for some people with schizophrenia to accept, and accounts for some disruptions in treatment—people begin taking antipsychotic medications and then stop taking them when the symptoms remit, believing that the medications are no longer necessary.

94. HERZ & MARDER, *supra* note 47, at 76 (“All forms of schizophrenia improve with antipsychotics. However, the extent to which patients improve varies considerably. Whereas many patients improve to the point that they are nearly free of psychotic symptoms, others continue to manifest severe positive symptoms.”); JEFFREY A. LIEBERMAN ET AL., TEXTBOOK OF SCHIZOPHRENIA 327 (Nancy C. Andreasen et al. eds., 2006) (“For the great majority of patients, medications help with symptom control but do not clearly preserve or restore premorbid levels of social and vocational functioning and do not lead to normal functioning.”).

95. According to the American Psychiatric Association:

of antipsychotic medications have different side effect profiles. The most serious side effect concern with older, first-generation antipsychotics is tardive dyskinesia, a potentially permanent, severely disabling movement disorder.⁹⁶ Newer, second-generation antipsychotic medications are less likely to cause movement disorders but are likely to cause metabolic side effects, which can lead to obesity or diabetes.⁹⁷

Despite these flaws, antipsychotic medications are the only effective treatment for active psychotic symptoms.⁹⁸ And the prognosis for someone who refuses antipsychotic medication is grim.⁹⁹ The harms of untreated psychosis are both immediate and long term:

Active psychosis is a dangerous, life-threatening state. Behavior is often unpredictable because of misperceptions, misconceptions, and irrational thinking. The gravest dangers are suicide, homicide, and physical injury. Almost as important are paralyzes of judgment and empathy resulting in

Side effects of medications are a crucial aspect of treatment because they often determine medication choice and are a primary reason for medication discontinuation. Side effects can complicate and undermine antipsychotic treatment in various ways. The side effects themselves may cause or worsen symptoms associated with schizophrenia, including negative, positive, and cognitive symptoms and agitation. In addition, these side effects may contribute to risk for other medical disorders. Finally, these side effects often are subjectively difficult to tolerate and may affect the patient's quality of life and willingness to take the medication.

AM. PSYCH. ASS'N, PRACTICE GUIDELINES FOR THE TREATMENT OF PATIENTS WITH SCHIZOPHRENIA 66–67 (2d ed. 2004) [hereinafter APA PRACTICE GUIDELINES].

96. See ROBERT M. JULIEN, A PRIMER OF DRUG ACTION 331 (9th ed. 2001).

97. Christopher Reist et al., *Second-Generation Antipsychotic Exposure and Metabolic-Related Disorders in Patients with Schizophrenia: An Observational Pharmacoepidemiology Study from 1988 to 2002*, 27 J. CLINICAL PSYCHOPHARMACOLOGY 46, 48–50 (2007).

98. See Brief for the American Psychiatric Ass'n and American Academy of Psychiatry and the Law as Amici Curiae Supporting Respondent at 13–14, *Sell v. United States*, 539 U.S. 166 (2003) (No. 02-5664) (“Antipsychotic medications are not only an accepted but often essential, irreplaceable treatment for psychotic illnesses, as most firmly established for schizophrenia, because the benefits of antipsychotic medications for patients with psychoses, compared to any other available means of treatment, are so palpably great compared with their generally manageable side effects.”); John M. Kane, *Conventional Neuroleptic Treatment: Current Status, Future Role*, in THE NEW PHARMACOTHERAPY OF SCHIZOPHRENIA 89, 90 (Alan Breier ed., 1996) (describing antipsychotic medications as “the primary modality in the treatment of an acute episode or an acute exacerbation of a schizophrenic illness”); Thomas H. McGlashan, *Rationale and Parameters for Medication-Free Research in Psychosis*, 32 SCHIZOPHRENIA BULL. 300, 301 (2006) (noting that antipsychotic medications are “the most rapid, effective, and economical treatment for active psychosis”).

99. See Srinivasan N. Tirupati et al., *Psychopathology in Never-Treated Schizophrenia*, 47 COMPREHENSIVE PSYCHIATRY 1 (2006).

violations of social convention and trust and leading ultimately to social isolation and stigmatization.¹⁰⁰

Some research suggests that untreated psychosis is “neurotoxic,” potentially causing long-term neurological damage and making subsequent treatment less likely to be effective.¹⁰¹ Untreated psychosis undoubtedly causes long-term emotional and social damage.¹⁰² School, work, friends, family—all suffer because of schizophrenia. One research team put the matter succinctly: “untreated psychosis damages lives.”¹⁰³ Another leading schizophrenia researcher has explained:

Acutely active psychosis is a dangerous mental state, if not a medical emergency, because of its aberrant experiences, loss of insight, and distortions of judgment. It requires immediate treatment, including antipsychotic medication, to reduce the danger of such distortions to life and social network. The threat of chronically active psychosis is time rather than mortality and stigma, time immersed in the negative symptoms or cognitive distortions of disorder. If prolonged, it may well create deficits that add to severity beyond the level

100. McGlashan, *supra* note 98, at 300; *see also* HERZ & MARDER, *supra* note 47, at 152 (“Early and definitive intervention with medication is important because patients can do substantial damage to their lives when they are psychotic.”).

101. *See* Tandy J. Miller & Thomas H. McGlashan, *The Risks of Not Intervening in Pre-Onset Psychotic Illness*, 12 J. MENTAL HEALTH 345, 347 (2003) (“[U]nknown and usually irreversible neurobiological processes that create life-long deficits in mental and emotional capacity appear to be most active between 1–3 years prior to and following the onset of the disorder.”); *see also* Tyrone D. Cannon et al., *Antipsychotic Drug Treatment in the Prodromal Phase of Schizophrenia*, 159 AM. J. PSYCHIATRY 1230, 1230 (2002) (“Initiation of drug therapy soon after the onset of psychotic symptoms is associated with better medication response, less likelihood of relapse, and more favorable long-term outcome among patients with schizophrenia.”); Diana O. Perkins et al., *Relationship Between Duration of Untreated Psychosis and Outcome in First-Episode Schizophrenia: A Critical Review and Meta-Analysis*, 162 AM. J. PSYCHIATRY 1785 (2005) (“Shorter duration of untreated psychosis was associated with greater response to antipsychotic treatment, as measured by severity of global psychopathology, positive symptoms, negative symptoms, and functional outcomes.”).

102. *See* Jan O. Johannessen et al., *First-Episode Psychosis Patients Recruited into Treatment via Early Detection Teams Versus Ordinary Pathways: Course, Outcome and Health Service Use During First 2 Years*, 1 EARLY INTERVENTION PSYCHIATRY 40, 40 (2007) (“People in active psychosis are vulnerable to initiating irrational, unpredictable and often permanently damaging behaviours, both to themselves and others.”); Mueser & McGurk, *supra* note 85, at 2063 (“Schizophrenia is a mental illness that is among the world’s top ten causes of long-term disability.”).

103. Jeffrey A. Lieberman & Wayne S. Fenton, *Delayed Detection of Psychosis: Causes, Consequences, and Effect on Public Health*, 157 AM. J. PSYCHIATRY 1727, 1728 (2000).

ultimately determined by the original brain pathophysiology.¹⁰⁴

There is no way to tell, when someone is first diagnosed with schizophrenia, exactly what the course of the illness will be.¹⁰⁵ But the likelihood of every bad outcome measure—recurrent hospitalizations, drug abuse, homelessness, imprisonment—only increases in the absence of treatment with antipsychotic medication.¹⁰⁶

2. A Vicious Circle: Illness as a Cause of Treatment Refusal

Many people with schizophrenia do not believe that they are ill.¹⁰⁷ And for someone who does not believe herself to be ill, medication is unnecessary. For some people, the denial of illness might be at least in part psychologically motivated.¹⁰⁸ For other people, though, lack of insight might itself be a symptom of schizophrenia. As one scientist has explained:

Poor insight in schizophrenia bears remarkable similarities to anosognosia in neurological disorders. Patients with schizophrenia who have poor insight, and neurological disorder patients with anosognosia, exhibit the following characteris-

104. T. H. McGlashan, *Schizophrenia in Translation: Is Active Psychosis Neurotoxic?*, 32 SCHIZOPHRENIA BULL. 609, 613 (2006).

105. HERZ & MARDER, *supra* note 47, at 31 (“The current state of knowledge makes it extremely difficult to predict the course and outcome for a particular patient.”).

106. *See id.* at 275 (noting that homelessness “is associated with noncompliance with treatment and chemical abuse,” and that noncompliance with treatment and chemical abuse are also “associated with involvement in the criminal justice system”); Garrison, *supra* note 7, at 803–04 (“Relatively few untreated schizophrenics can live independently, and many thus wind up on the streets or behind bars; fully half abuse drugs or alcohol, and more than 10 percent succeed in killing themselves.”). A recent meta-analysis of studies concluded, “[s]horter duration of untreated psychosis was associated with greater response to antipsychotic treatment, as measured by severity of global psychopathology, positive symptoms, negative symptoms, and functional outcomes.” Perkins, *supra* note 101, at 1785; *see also* HERZ & MARDER, *supra* note 47, at 31 (“It is likely that with early intervention at the beginning of the first and subsequent episodes and optimal pharmacotherapy and psychosocial treatment throughout the course of the disorder, prognosis can be improved considerably, when compared with outcomes in the past.”).

107. *See* DSM-IV-TR, *supra* note 51, at 304 (“A majority of individuals with schizophrenia have poor insight regarding the fact that they have a psychotic illness.”); KING ET AL., *supra* note 61, at 373 (noting that “some people with schizophrenia lack insight into their impaired condition and refuse any treatment at all”); June R. Husted, *Insight in Severe Mental Illness: Implications for Treatment Decisions*, 27 J. AM. ACAD. PSYCHIATRY & L. 33, 39 (1999) (“Impaired insight is a very common symptom of schizophrenia.”).

108. *See* Ken Kress, *An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa*, 85 IOWA L. REV. 1269, 1274 n. 19 (2000) (discussing psychological theories of lack of insight); Saks, *supra* note 7, at 945.

tics: a very severe lack of awareness of their illness, the belief persisting despite conflicting evidence, confabulations to explain the observations that contradict their belief that they are not ill, and a compulsion to prove their self-concept.¹⁰⁹

Most standards of competence to make medical treatment decisions do not require the decision-maker to actually or rationally appreciate her illness; at best, these standards require the “ability” or “capacity” for appreciation.¹¹⁰ The practical effect of capacity standards is that some people will be found competent when they refuse medication because their illness precludes them—and will continue to preclude them—from knowing that they are ill. Moreover, if someone who is ill makes a decision to refuse medication believing that she is not ill, or not understanding the nature or severity of her illness, it is difficult to see how this decision allows her to advance her own interests—interests that she cannot accurately take into account because she does not understand that she is ill.¹¹¹ Actual, rational understanding seems necessary for the same reason that competent decisions to refuse treatment are respected: to promote autonomy.

109. Xavier F. Amador & Andrew A. Shiva, *Insight into Schizophrenia: Anosognosia, Competency, and Civil Liberties*, 11 GEO. MASON U. C.R. L.J. 25, 27–28 (2000).

110. Elyn R. Saks, *Competency to Refuse Psychotropic Medication: Three Alternatives to the Law’s Cognitive Standard*, 47 U. MIAMI L. REV. 689, 691 (1993); *Conservatorship of Waltz*, 227 Cal. Rptr. 436, 441–42 (Ct. App. 1986) (reversing finding of incompetence to refuse ECT because subject’s refusal was not wholly based in delusion: “[i]n short, Waltz has both a psychotic and a rational fear of ECT”); *Lillian F. v. Superior Court*, 206 Cal. Rptr. 603 (Ct. App. 1984). *But see Rasmussen v. Fleming*, 741 P.2d 674, 683 (Ariz. 1987) (“[T]he patient must have a clear understanding of the risks and benefits of the proposed treatment alternatives or nontreatment, along with a full understanding of the nature of the disease and the prognosis.”); *Miller v. Rhode Island Hosp.*, 625 A.2d 778, 786 (R.I. 1993); *Riese v. St. Mary’s Hosp. & Med. Ctr.*, 271 Cal. Rptr. 199, 211 (Ct. App. 1987). A few states require that someone actually appreciate—as opposed to merely possess the capacity to appreciate—that she is ill in order to be considered competent. For example, Alaska requires that a person “appreciates that [he or she] has a mental disorder or impairment, if the evidence so indicates” but then requires only “the capacity to assimilate relevant facts and to appreciate and understand [his or her] situation with regard to those facts” and “the capacity to participate in treatment decisions by means of a rational thought process.” Alaska Stat. § 47.30.837(d)(1) (2010).

111. Morris, *supra* note 9, at 401 (“Patients who believe that they have no mental disorder are unlikely to value the therapeutic effects of a medication to treat a mental disorder.”). Of course, someone might acknowledge that she is ill yet disagree with her doctor’s particular diagnosis. The argument that someone is not competent to make her own treatment decisions if she does not rationally understand her illness does not mean that she must agree completely with her doctor’s assessment. But, there is a difference in disputing the accuracy of a particular diagnosis and disputing the symptoms that underlie the diagnosis. A patient need not believe that her psychotic symptoms are symptoms of schizophrenia, but she should not be found competent if she believes, for instance, that they will be alleviated by exposure to the sun.

3. Autonomy and Involuntary Treatment

Involuntary treatment compromises the autonomy of people who are competent to make medical treatment decisions for themselves.¹¹² As many commentators have explained, administering medical treatment to someone who has made an autonomous choice to refuse treatment is paternalistic.¹¹³ What is also clear, although stated much less frequently, is that overriding a non-autonomous decision is not paternalistic.¹¹⁴

In the context of medical treatment decisions, autonomy is defined in terms of competence: a decision is autonomous if the decisionmaker is competent to make the decision.¹¹⁵ Thus, the critical question is, what is necessary for a decision to be competent, and thereby autonomous? Current definitions of competence to make medical treatment decisions focus on capacity—what cases like *Dusky* and *Panetti* call “factual understanding.” So long as the patient can recite back what he has been told about the treatment’s risks and benefits, he is competent to decide whether to accept or refuse the treatment.¹¹⁶ But as the *Panetti* Court recognized, if this understanding is disconnected from reality, then there is no meaningful understanding—that is, no understanding that should count as establishing competence.

Requiring rational understanding promotes autonomy because autonomy is a good not only in and of itself, but also as a means of achieving other goods. To some extent, the making of a choice is a good regardless of what is chosen. But what of choices that are contrary to the decision maker’s own goals for himself—what of choices to limit future autonomy, for example? John Stuart Mill, well known for his fierce denunciation of government paternal-

112. As Judge Cardozo famously observed, “Every human being of adult years and sound mind has a right to determine what shall be done with his own body.” *Schloendorff v. Soc’y N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914). This statement, though, is not entirely true in practice. See *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (authorizing involuntary small-pox vaccination); Jonathan Herring, *Entering the Fog: On the Boderlines of Mental Capacity*, 83 IND. L.J. 1619, 1628 n.57 (2008) (“If you wish to remove all your limbs in political protest, the law in many jurisdictions will prevent you from doing so.”).

113. Saks & Jeste, *supra* note 7, at 412; Saks, *supra* note 110, at 730; Fredrick E. Vars, *Illusory Consent: When an Incapacitated Patient Agrees to Treatment*, 87 OR. L. REV. 353, 400 (2008).

114. Saks & Jeste, *supra* note 7, at 412 (“An incompetently made choice is, in an important sense, not an autonomous choice.”); Vars, *supra* note 113, at 400 (2008) (“Respect for individual autonomy sometimes requires overriding what the individual says.”).

115. Herring, *supra* note 112, at 1620 (“For those who possess legal capacity, the cardinal principle is the right of self-determination or autonomy.”); Vars, *supra* note 113, at 394 (“A truly incapacitated patient has no genuine autonomy.”).

116. JESSICA W. BERG ET AL., *INFORMED CONSENT* 353–54 (2d ed. 2001).

ism,¹¹⁷ suggested that the choice to become a slave should not be respected.¹¹⁸ Mill recognized that autonomy is not only the making of choices but more fully is the making of choices that help us become the selves that we want to be.¹¹⁹

That overriding some decisions can promote autonomy does not mean that all decisions causing harm should be overridden. Many decisions to refuse medical treatment, though likely to cause future harm, are autonomous and should be respected. But when someone who is experiencing active psychotic symptoms—and who has been found to be unable to care for herself because of those symptoms—decides to refuse antipsychotic medication, it is worth taking care to find out whether that decision is indeed autonomous, not only in the sense of making a choice but also in the sense of promoting the decision maker's own goals and values. Consider, for example, a college student, diagnosed with schizophrenia, who is besieged by voices telling her that she is worthless and deserves to suffer, so she refuses to eat or drink. She has been committed because her behavior threatens her survival. But she also wants to leave the hospital and return to college. If she does not understand that without medication the voices are likely to remain, while medication offers the best chance of abating these symptoms and enabling her to achieve her own goal of continuing her education, then perhaps she is not competent to decide to refuse antipsychotic medication.¹²⁰

117. John Stuart Mill, *On Liberty*, in MILL: TEXTS COMMENTARIES 41, 48 (Alan Ryan ed., 1997) (“[T]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others.”).

118. *Id.* at 121 (“[A]n engagement by which a person should sell himself, or allow himself to be sold, as a slave, would be null and void . . . The principle of freedom cannot require that he should be free not to be free.”).

119. Ronald Dworkin, *Autonomy and the Demented Self*, 64 MILBANK Q. 4, 8 (1986) (discussing a “view of autonomy [that] focuses not on individual decisions one by one, but the place of each decision in a more general program or picture of life the agent is creating and constructing, a conception of character and achievement that must be allowed its own distinctive integrity”), quoted in Herring, *supra* note 112, at 1628.

120. Most adults would have little difficulty understanding that if hallucinations are interfering with college, then the hallucinations need to be treated or else returning to college is unlikely if not impossible. Someone with schizophrenia, though, might have no trouble at all believing both that the symptoms are interfering with college and that returning to college is likely, regardless of whether the symptoms are treated. The beliefs of some people with schizophrenia are notoriously resistant to logic or reason. DSM-IV-TR, *supra* note 51, at 299 (“The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear contradictory evidence regarding its veracity.”); Judd F. Sneirson, *Black Rage and the Criminal Law: A Principled Approach to a Polarized Debate*, 143 U. PA. L. REV. 2251, 2273 (1995) (“When faced with independent, contradictory, relevant evidence, the paranoid schizophrenic will persist in his delusions—a key factor distinguishing delusory beliefs from merely false beliefs and paranoid schizophrenic actors from merely mistaken actors.”).

IV. CONCERNS AND CAUTIONS

A. Stigmatization of People with Mental Illnesses

Like questions of autonomy and mental illness, questions of stigma and mental illness are confounding: untreated mental illness compromises autonomy and stigmatizes, yet involuntary treatment also compromises autonomy and stigmatizes. Some critics of civil commitment and involuntary medication argue that special rules for people who are mentally ill are stigmatizing. In general, we do not confine or insist upon providing treatment to people who are dangerous and physically ill;¹²¹ therefore, it is degrading to confine or insist upon providing treatment to people who are dangerous and mentally ill.

This argument is highly, although not entirely, persuasive. The problem is that to fail to treat people with mental illnesses differently than people with physical illnesses is to accept other, perhaps more harmful consequences than stigmatization. Involuntary treatment is harmful. But untreated psychosis is harmful too. When people are competent to decide, we leave the choice to them whether psychosis is more harmful than antipsychotic medication. But when people are not competent to decide, the government must provide some way for a choice to be made.¹²² In defining the standard for competency to decide, the government should not regard people with mental illnesses differently than people with physical illnesses unless the benefit of different regard is greater than the harm. Requiring that people whose mental illnesses have made them unable to care for themselves have a rational understanding of the consequences of refusing antipsychotic medication before they are considered competent to refuse this treatment does regard some people with mental illnesses differently than people with physical illnesses, but arguably the benefits of this different regard outweigh the harms.

121. See *State ex rel. Hawks v. Lazaro*, 202 S.E.2d 109, 123 (W.Va. 1974) (“Society abounds with persons who should be hospitalized, either for gallbladder surgery, back operations, corrective orthopedic surgery, or other reasons; yet in these areas society would not contemplate involuntarily hospitalization for treatment.”).

122. Cf. Cass R. Sunstein & Richard H. Thaler, *Libertarian Paternalism Is Not an Oxymoron*, 70 U. CHI. L. REV. 1159, 1165 (2003) (“But governments, no less than cafeterias (which governments frequently run), have to provide starting points of one or another kind; this is not avoidable In this respect, the anti-paternalist position is unhelpful—a literal non-starter.”).

B. Accuracy of Psychiatric Diagnoses

In addition to concerns about autonomy and stigma, a policy that facilitates the administration of involuntary antipsychotic medications must consider concerns about the reliability and validity of psychiatric diagnoses.

In this country, psychiatric diagnoses are governed primarily by The Diagnostic and Statistical Manual, a publication of the American Psychiatric Association. How reliably psychiatric diagnoses can be made is difficult to determine exactly. Psychiatric disorders are difficult to diagnose because the diagnoses are made on the basis of reported and observed symptoms; there are at present no objective measures, such as blood tests or brain scans, that can be used to diagnose psychiatric disorders.¹²³ Schizophrenia, for example, is diagnosed on the basis of a set of symptoms that includes delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms, such as lack of emotion or lack of motivation.¹²⁴

An additional difficulty is that few if any psychiatric symptoms are uniquely diagnostic of particular disorders. Schizophrenia and other “schizophrenia spectrum” disorders necessarily involve psychotic symptoms, but other disorders not included within this spectrum may also involve psychotic symptoms. A severe episode of mania or depression, for example, might well involve psychotic symptoms; psychotic symptoms associated with a mood disorder are usually mood-congruent, so someone in a severe manic episode might experience delusions of grandeur while someone in a severe depressive episode might hear voices telling her that she is worthless.

Because the first symptoms of schizophrenia often appear in late adolescence or early adulthood, these symptoms can be mistaken for signs of extreme, although not pathological, adolescent mood swings or rebellious behaviors. Additionally, psychiatrists might hesitate to diagnose a first episode of psychosis as schizophrenia, given this disorder’s very poor prognosis. But whether a first episode of psychosis turns out to be schizophrenia or some other disorder, antipsychotic medication may be indicated: antipsychotic

123. See U.S. DEP’T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 44 (1999), available at <http://www.surgeongeneral.gov/library/mentalhealth/chapter2/sec2.html#diagnosis> (“The diagnosis of mental disorders is often believed to be more difficult than diagnosis of somatic, or general medical, disorders, since there is no definitive lesion, laboratory test, or abnormality in brain tissue that can identify the illness.”).

124. DSM-IV-TR, *supra* note 51, at 312.

medication is effective in alleviating psychotic symptoms, whether those symptoms are of schizophrenia, or bipolar disorder, or something else. Given that treating the psychosis is critical if the disorder is schizophrenia, and beneficial even if the disorder is not schizophrenia, the uncertainty involved in diagnosing schizophrenia should not prevent the treatment of active psychotic symptoms. Moreover, it is the symptoms of psychosis that interfere with the rational understanding of the consequences of refusing treatment.¹²⁵ Whether those symptoms are best labeled “schizophrenia” or something else is not essential to the question of competency to refuse antipsychotic medications.

C. Accuracy of Competency Determinations

Assessing competency to make medical treatment decisions is an inexact undertaking. It requires that one person evaluate another person’s mental processes. Because determinations of competency are a matter of professional judgment, they are subject to unintended bias and even intentional abuse.¹²⁶ These risks require procedural protections to ensure that people who are found to be incompetent to make their own treatment decisions really are not competent.¹²⁷

One risk is that doctors will deem patients incompetent because the patients disagree with the doctors’ treatment recommendations. Having a doctor other than the treating doctor make the initial competency determinations can minimize this risk. Others,

125. See Christopher Slobogin, “Appreciation” as a Measure of Competency: Some Thoughts About the MacArthur Group’s Approach, 2 PSYCHOL., PUB. POL’Y, & L. 18, 24 (1996) (“[F]ocusing on acknowledgement of symptoms shifts the inquiry from the subjective issue of whether the patient is ‘sick’ to a more objective inquiry into whether the patient is wrong about demonstrable facts.”); Vars, *supra* note 113, at 386 (quoting V. Howe et al., *Competence to Give Informed Consent in Acute Psychosis Is Associated with Symptoms Rather than Diagnosis*, 77 SCHIZOPHRENIA RES. 211, 214 (2005)) (“Symptoms may be more important than diagnosis. . . . [T]he presence of cognitively related symptoms [e.g., delusions, grandiosity, and unusual thought], such as thought disorder rather than diagnosis, may better identify the subgroup of patients who require particular support with consent procedures.”).

126. Susan Stefan, *Silencing the Different Voice: Competence, Feminist Theory and Law*, 47 U. MIAMI L. REV. 763, 790 (1993) (“Competence is . . . relational and contextual and describes communication. It is not a fixed, inherent characteristic of an individual. The relationships and communications that provide the context in which competence is questioned and assessed are powerfully unequal and hierarchical.”).

127. But these risks should not be taken as justifying less stringent tests of competency, because such tests create a risk that people will be found competent when they are not.

including non-doctors, also can review the non-treating doctor's competency determination.¹²⁸

Additionally, it is not the case that everyone who is found to be incompetent to make his or her own treatment decisions will necessarily be administered involuntary treatment. While this Article proposes that competency to decide to refuse treatment for disabling active psychosis should require rational understanding of the decision's consequences, being found incompetent would not automatically result in the administration of involuntary antipsychotic medications. Instead, the result in most states would be the appointment of a surrogate decisionmaker who would assess whether involuntary antipsychotic medication is appropriate,¹²⁹ as well as a judicial determination that any decision the surrogate makes approving involuntary antipsychotic medications is indeed appropriate.¹³⁰

D. Implications for Informed Consent

The argument that in some cases competency to make medical treatment decisions should require a rational understanding of the consequences of refusing treatment implicates the operation of informed consent obligations. The legal obligation to obtain informed consent before providing medical treatment is rooted in tort law.¹³¹ The moral obligation, though, results from the connection between informed consent and autonomy.¹³² Possessing

128. California, for example, mandates that lawyers serve as judges in competency hearings. Morris, *supra* note 9, at 431.

129. In most states, the surrogate decisionmaker will decide by asking whether the incompetent person herself, were she competent, would decide to accept or refuse treatment.

130. In many states, involuntary antipsychotic medication requires a court order even when a surrogate decisionmaker has decided in favor of such treatment. *See Vars, supra* note 113, at 353 n.37 (listing ten states that by statute do not allow a surrogate decisionmaker to consent to psychotropic medication); Diane E. Hoffman & Jack Schwartz, *Proxy Consent to Participation of the Decisionally Impaired in Medical Research-Maryland's Policy Initiative*, 1 J. HEALTH CARE L. & POL'Y 123, 135 (1998) ("[C]ourts and legislatures have generally required safeguards such as judicial approval in cases involving a decision by a surrogate to sterilize or administer psychotropic medications to a mentally incapacitated individual.").

131. *Developments in the Law: Medical Technology and the Law*, 103 HARV. L. REV. 1520, 1662 (1990) ("The common law has considered medical treatment in the absence of the patient's informed consent to be a battery."); Caroline Mala Corbin, *The First Amendment Right Against Compelled Listening*, 89 B.U. L. REV. 939, 1000 (2009) ("Informed consent to medical treatment developed as a means to shield doctors from battery and, later, negligence claims. Doctors who fail to provide all material information, as understood by the medical community or a reasonable patient, risk liability for battery or negligence under tort law.").

132. RUTH R. FADEN ET AL., A HISTORY AND THEORY OF INFORMED CONSENT 9 (1986) ("[T]he obligation to obtain informed consent in research and clinical contexts is generally

adequate information about a proposed medical treatment is critical to making an autonomous choice; that is, a choice that advances the patient's own conception of her well-being.¹³³

Obtaining informed consent for treatment of a mental illness like schizophrenia is a particularly difficult proposition.¹³⁴ If competency to make treatment decisions requires a rational understanding of the consequences of refusing treatment, then treatment providers must make sure that decision-makers are informed of these consequences. For someone who is experiencing an episode of active psychosis so disabling that she cannot care for herself, being informed must mean possessing and actually understanding information not only about the physical consequences of both accepting and refusing antipsychotic medications, but also about the emotional and social consequences.¹³⁵

CONCLUSION

As a society, we could avoid hard questions about overriding medical treatment refusals if we assumed that all conscious adults are competent to make any decisions about their medical care. Such a minimal standard for competency to make treatment deci-

understood to be grounded in a principle of respect for autonomy."); Peter H. Schuck, *Rethinking Informed Consent*, 103 *YALE L.J.* 899, 924 (1994) ("The most fundamental normative argument in favor of requiring health care providers to obtain patients' informed consent to medical treatments proceeds from the principle of autonomy—the notion that each mature individual has a right to make the basic choices that affect her life prospects.").

133. *Downer v. Veilleux*, 322 A.2d 82, 91 (Me. 1974) ("The rationale of this rule lies in the fact that 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."); *Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972) ("The weighing of these [medical] risks against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgment reserved to the patient alone."); BERG, *supra* note 116, at 24 ("In most cases, including most healthcare contexts, respect for an individual's autonomy coincides with promotion of her well-being. So long as an individual decides in the light of adequate information, and chooses freely, she will act to promote her *subjective* well-being, her well-being as she herself defines it."); Schuck, *supra* note 132, at 924.

134. See Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 *L. & HUM. BEHAV.* 149, 149 (1995).

135. Focusing on the psychosocial rather than biological aspects of treatment might benefit all people who are deciding whether to consent to treatment with antipsychotic medication. One treatise on the treatment of schizophrenia suggests that in a conversation about the risks and benefits of antipsychotics, "[i]t can . . . be pointed out that taking the medication will help to prevent any future hospitalizations, which many patients fear, even though they deny the illness. They can be told that it can prevent disruptions in their educational or vocational training programs, jobs, and relationships." HERZ & MARDER, *supra* note 47, at 194.

sions would ensure that all autonomous decisions are respected. The cost, though, would be that some non-autonomous decisions are also respected. This Article has proposed that in cases of *parens patriae* civil commitments, competency to refuse treatment for symptoms of psychosis should require more than capacity or ability to make an informed decision; it should require an actually informed decision. Awareness of the consequences of refusing treatment is not the same as a rational understanding of these consequences.¹³⁶ For someone who is experiencing active psychotic symptoms so disabling that civil commitment is warranted, the question should be whether a decision to refuse antipsychotic medications is based on an actual understanding of the consequences of such a decision. To require less is to sacrifice the decision-maker's present and future health as well as her present and future autonomy.

136. *Cf. Panetti v. Quarterman*, 551 U.S. 930, 933 (2007) ("A prisoner's awareness of the State's rationale for an execution is not the same as a rational understanding of it.").