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A Right To Remain Psychotic? A New Standard For Involuntary Treatment In Light Of Current Science

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A RIGHT TO REMAIN PSYCHOTIC? A NEW STANDARD FOR INVOLUNTARY TREATMENT IN LIGHT OF CURRENT SCIENCE

*Elizabeth Bennion**

Mass shootings, such as the killing of school children and staff in Newtown, Connecticut, have provided brutal reminders of inadequacies in our nation's mental health system. In the wake of these shootings, President Obama asserted that "[w]e are going to need to work on making access to mental health care as easy as access to a gun." But what should society do when the person needing mental health treatment refuses care—when the problem is not rooted in access but in free will? When is involuntary treatment justified? In deciding whether to forcibly medicate, multiple interests come into play, including patient autonomy, public safety, and the patient's medical welfare. As a society, we have overemphasized patient autonomy and underemphasized patient welfare to the detriment not only of the patient's well-being but also of public safety—and even to the detriment of patient autonomy itself. This Article briefly examines the history of the involuntary treatment debate and how society arrived at the present imbalance. It then considers the implications of current scientific research on the brain and the nature of severe mental illness, using schizophrenia as an illustrative example. The Article explains how current involuntary treatment standards could be revised to reflect this scientific understanding and continue protecting a patient's civil rights without making undue sacrifices of the patient's long-term health and well-being. It also defends the proposed new standard against potential constitutional challenges.

The new standard would allow involuntary treatment for a limited number of years after onset of severe psychotic symptoms under specified conditions. It would also provide for more access to medical information by patients' immediate family members and primary

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caretakers. The standard reflects (1) research showing the vital importance of early treatment for long-term prognosis and prevention of irreversible injury to the brain; (2) statistics suggesting the particular vulnerability of a maturing brain; (3) a respect for autonomy and the patient's ultimate agency to reject treatment if no satisfactory treatment option can be found; (4) consideration of factors that uniquely affect autonomy concerns when patients are severely psychotic; and (5) research demonstrating that family involvement can greatly benefit treatment outcomes. Because brain science is currently an area of explosive growth and discovery, this Article recognizes that any involuntary treatment standard will need to be continually re-examined and revised in light of scientific progress.

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I. INTRODUCTION

It must be remembered that for the person with severe mental illness who has no treatment the most dreaded of confinements can be the imprisonment inflicted by his own mind, which shuts reality out and subjects him to the torment of voices and images beyond our powers to describe.¹

Mental health issues have been brought to the forefront of national debate by a series of tragic episodes. Deadly violence erupted at a political gathering in an Arizona parking lot, at a Batman showing in a Colorado movie theater, and at an elementary school in Connecticut.² Such events can distort the public perception of the severely mentally ill, most of whom are not a danger to society.³ But the accompanying perception that this nation's mental health system is in desperate need of reform is a fact.

In the wake of these events, President Obama declared the necessity of "making access to mental health care as easy as access to a gun."⁴ While knowledge of and access to appropriate services are certainly vital issues, they do not address the full problem—for what if a patient refuses the treatment offered? What if the problem is rooted not in access but in free will?

Even when concerned family or friends of a severely mentally ill individual know where to turn for help and have the resources to do

1. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 609–10 (1999) (Kennedy, J., concurring).

2. See, e.g., Ethan Bronner, *Tough Legal Issues Converge in Colorado Shooting Case*, N.Y. TIMES, Aug. 1, 2012, http://www.nytimes.com/2012/08/02/us/james-holmes-case-raises-complex-legal-issues.html?_r=1 (discussing both the Arizona and Colorado cases); David Brooks & Gail Collins, *The Newtown Aftermath*, N.Y. TIMES, (Dec. 19, 2012, 1:24 PM), <http://opinionator.blogs.nytimes.com/2012/12/19/the-newtown-aftermath/?hp> (discussing mental health and gun control issues stemming from the Connecticut incident).

3. Sally Satel, *Enforce the Laws, Don't Add to Them*, N.Y. TIMES, Jan. 17, 2013, <http://www.nytimes.com/roomfordebate/2013/01/17/can-mental-health-care-reduce-gun-violence/enforce-mental-health-laws-dont-add-to-them> (Approximately "3 to 5 percent of violent crimes in the general population" can be attributed to mentally ill persons "whose symptoms are unmedicated and/or who abuse stimulants or alcohol."); Thomas Insel, *Understanding Severe Mental Illness*, NAT'L INST. MENTAL HEALTH (Jan. 11, 2011), <http://www.nimh.nih.gov/about/director/2011/understanding-severe-mental-illness.shtml> ("[M]ental illness contributes very little to the overall rate of violence in the community.")

4. Valerie Strauss, *Obama's Proposals on School Safety*, WASH. POST, Jan. 16, 2013, <http://www.washingtonpost.com/blogs/answer-sheet/wp/2013/01/16/obamas-proposals-on-school-safety/>.

so, there are legal hurdles to forcing an unwilling patient to receive treatment. There have been reports that the mother of Adam Lanza, the man who killed twenty children and six adults at an elementary school, may have been seeking to have her son committed to a hospital before she, too, was killed.⁵ If she was seeking involuntary treatment for Adam, she was doing so in Connecticut, which has been criticized as “among the worst states to seek such treatment” with “among the weakest involuntary treatment laws.”⁶

Such laws were created to protect the civil liberties of individuals who resist medical treatment. The movement to create these laws stemmed from serious abuses of many mentally ill patients who had been constrained under horrible conditions. This Article does not take issue with the importance of such civil liberties and autonomy interests. Instead, it argues that in reacting to abuses in history, the pendulum has swung too far. The modern legal debate regarding involuntary treatment has failed to sufficiently weigh the welfare of the patient in its analysis, especially given emerging scientific research about the nature of severe mental illness and its treatments. Autonomy concerns do not fall by the wayside, but this Article explains why they should be given less emphasis under the current scientific regime.

Knowledge of the human brain is expanding exponentially due to new technologies that allow scientists to study living brains in unprecedented ways,⁷ and our laws have failed to keep sufficient pace with that changing scientific understanding in the mental health sphere. *Nature*, one of the world’s premiere science journals, has labeled this as a “decade for psychiatric disorders” because of the “many ways in which the understanding and treatment of conditions such as schizophrenia are ripe for a revolution.”⁸ Although there have been tremendous scientific advances, scientists and scholars

5. *Adam Lanza’s Motive: Did Fear of Being Committed Lead to Sandy Hook Elementary Shooting?*, HUFFINGTON POST (Dec. 19, 2012, 9:02 AM), http://www.huffingtonpost.com/2012/12/19/adam-lanza-motive_n_2329508.html.

6. E. Fuller Torrey & Doris A. Fuller, *The Potential Killers We Let Loose: The U.S. Would Have Fewer Mass Killings if Individuals with Severe Mental Illness Received Proper Treatment*, WALL ST. J., Dec. 18, 2012, <http://online.wsj.com/article/SB10001424127887324407504578185361458883822.html>.

7. See Henry T. Greely, *Neuroscience and Criminal Justice: Not Responsibility but Treatment*, 56 U. KAN. L. REV. 1103, 1103, 1137 (2008).

8. See Editorial, *A Decade for Psychiatric Disorders*, 463 NATURE 9 (2010), available at <http://www.nature.com/nature/journal/v463/n7277/full/463009a.html>.

recognize that given the extreme complexity of the brain, neuroscience is still in its infancy⁹—and thus as the science continues to progress, further revisions of legal standards will likely be necessary.

This Article proposes a new standard for involuntary treatment that incorporates relevant insights from current science. The standard offers an additional set of circumstances under which forcible treatment could be justified beyond those outlined in existing law. The standard is discussed more fully in Part IV, but its essence is that (1) if earnest efforts have been made to try to convince a patient to take needed medications voluntarily (including exploration of the reasons for refusal and possible alternatives to address such concerns); (2) and if involuntary treatment would be in the best medical interest of the patient; (3) then involuntary treatment would be allowed for as long as necessary to stabilize a case of severe and active psychosis. However, this standard could only be used for two years after the onset of such severe symptoms or age 27, whichever is later. These time limits respond to research showing the vital importance of early treatment for long-term prognosis and prevention of irreversible injury to the brain, as well as the particular vulnerability of a young, maturing brain. The time limits also reflect a respect for autonomy and the individual's ultimate agency to reject treatment if no satisfactory treatment option can be found—tempered by factors that reduce certain autonomy concerns when a patient is severely psychotic. The new standard would also allow more access to medical information by the immediate family members and primary caretakers whose support, research shows, can be vital to successful treatment efforts.¹⁰

This proposed standard would make it easier to forcibly medicate an individual at earlier stages of disease. For that minority of severely mentally ill patients prone to become violent—the standard could help to prevent allowing them to deteriorate so far as to become a significant public threat. In this way, it would increase

9. See, e.g., Kathleen Kocks, *Illuminating the Mind*, GEO. WASH. RES. (Fall 2011), available at http://www.gwu.edu/~magazine/archive/2011_research_fall/feature6.html (quoting Dr. Anthony-Samuel LaMantia, founding director of the George Washington University Institute for Neuroscience).

10. See, e.g., Esther Pousa Tomas, *Effectiveness of Family Work Interventions on Schizophrenia: Evidence from a Multicenter Study in Catalonia*, 58 INT'L J. SOC. PSYCHIATRY 587, 588 (2011), available at <http://isp.sagepub.com/content/58/6/587.full.pdf+html>.

public safety, but the focus of the standard is on what is in the best medical interest of the patient, while still preserving important autonomy interests. Thus, the focus is on a state's *parens patriae* interest rather than its police powers.¹¹ Every state retains its police power to confine anyone who is an imminent danger, but the hope is that society could help patients get necessary treatment long before such dire circumstances develop.

Part II of this Article discusses the involuntary treatment debate. It includes a brief summary of the medical and legal history of the issue—and how the laws have responded to scientific developments in the past. It clarifies the opposing arguments and the current status of the law, which is rapidly changing due to political rallying after the Newtown shootings. Part III examines the evolving scientific understanding of the causes, effects, and treatments of severe mental illness, using schizophrenia as an illustrative example, and how that understanding is relevant to the debate over when the severely mentally ill should be treated against their expressed desires. Part IV proposes reform and explains why the new standard introduced in this Article would rationally reflect current scientific data and adequately balance autonomy and patient welfare interests. Part V addresses constitutional concerns and why the new standard should survive them. The Conclusion recognizes that in light of the rapid scientific advances in understanding the human brain and mental illness, this Article's proposal is one that should also be subject to future revision.

II. INVOLUNTARY TREATMENT

A. Brief Background: Medical and Social History of This Nation's Severely Mentally Ill

To understand the involuntary treatment debate, one must begin with some understanding of the history of this nation's evolving attitudes toward and treatment of its severely mentally ill.

For centuries, psychotic individuals were believed to be possessed by demons.¹² In colonial times, many such people were

11. See 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, 288 (1992).

12. Thomas H. McGlashan, *Treatment Timing vs Treatment Type in First-Episode Psychosis: A Paradigm Shift in Strategy and Effectiveness*, 38 SCHIZOPHRENIA BULL. 902,

either locked in jail or watched over by their own families.¹³ A turning point for the United States occurred in 1843, when Dorothea Dix was visiting a Boston jail to teach Bible classes. As she passed through the building, she noted that a portion of the jail was not heated. When she objected, she was informed there was no need to heat that area because it housed the insane.¹⁴ Over the next several decades, Ms. Dix actively campaigned for better treatment of the severely mentally ill. She argued they required medical treatment rather than penal punishment. She convinced approximately thirty states to open asylums so that the mentally ill could be removed from jails. By 1900, every state had a mental institution.¹⁵

What began as a crusade with the best of intentions, however, degenerated into a serious problem of its own over the next half century. Many state mental hospitals became scenes of terrible abuse and neglect.¹⁶ Indeed, one book on the subject found that they provided comparable conditions to the Nazi concentration camps of World War II.¹⁷ News reports reflecting this kind of information and the release of an extremely disturbing and popular fictional movie on the subject (*One Flew Over the Cuckoo's Nest*) created public outrage and political pressure for change.¹⁸

Meanwhile, on the medical front, significant changes had occurred. Before the discovery of today's antipsychotic drugs, patients suffering from severe psychotic disorders were often treated with sedatives such as barbiturates.¹⁹ They were "housed in institutions for indefinite periods of time, and treatment was often unsuccessful."²⁰

A major breakthrough in psychiatric treatment came in 1952 when a French surgeon was investigating ways to reduce surgical

902 (2012), available at <http://schizophreniabulletin.oxfordjournals.org/content/38/5/902.full.pdf+html>.

13. PETE EARLEY, CRAZY: A FATHER'S SEARCH THROUGH AMERICA'S MENTAL HEALTH MADNESS 64 (2006).

14. *Id.* at 65.

15. *Id.*

16. *Id.* at 65–67.

17. *Id.* at 67 (citing ALBERT DEUTSCH, THE SHAME OF THE STATES (MENTAL ILLNESS AND SOCIAL POLICY: THE AMERICAN EXPERIENCE) (1948)).

18. *Id.* at 66–70.

19. Alicia B. Minns & Richard Clark, *Toxicology and Overdose of Atypical Antipsychotics*, 43 J. OF EMERGENCY MED. 906 (2012), available at <http://www.sciencedirect.com/science/article/pii/S0736467912003587>.

20. *Id.* at 906.

shock. He “noticed that an antihistamine he was using, chlorpromazine, had a powerful calming effect on mentation.”²¹ Hearing about these results, a psychiatrist, Pierre Denker, tried the drug on some of his most difficult patients. “The results were remarkable, and chlorpromazine was approved by the U.S. Food and Drug Administration (FDA) in 1954.”²² Thus, the drug was not developed with any understanding of the underlying diseases or the drug’s interactions with the brain—it was entirely a serendipitous discovery based on the drug’s effects on behavior. A decade later, approximately fifty million people had been treated with this medication worldwide, and several other similar medications had entered the market.²³ These drugs have come to be known as first-generation or typical antipsychotics.²⁴

Initially perceived by many as a miracle drug and cure-all for mental illness,²⁵ it would later become clear that such drugs were not successful with all patients, did not treat all aspects of diseases such as schizophrenia, and had severe potential side effects, including tremors, rigidity, persistent muscle spasms, or restlessness²⁶ and, in rare cases, death. Still, the drugs were remarkable in that they did make it possible to stabilize most severely mentally ill patients so that they could live safely within communities as long as they had access to treatment in community healthcare facilities.²⁷

A second wave of antipsychotics would become available around 1989.²⁸ Known as second-generation or atypical antipsychotics, these drugs were also effective in treating psychosis but had fewer of the extrapyramidal side effects. However, these drugs carry dangerous and undesirable potential side effects of their

21. *Id.*

22. *Id.*

23. *Id.*

24. Jennifer C. Seida et al., FIRST- AND SECOND-GENERATION ANTIPSYCHOTICS FOR CHILDREN AND ADULTS 1–2 (2012) available at <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0040940/pdf/TOC.pdf>

25. EARLEY, *supra* note 13, at 69.

26. See *id.* at 71; NAT’L INST. MENTAL HEALTH, SCHIZOPHRENIA 10 [hereinafter NIMH, SCHIZOPHRENIA] available at <http://www.nimh.nih.gov/health/publications/schizophrenia/schizophrenia-booklet-2009.pdf> (last revised 2009).

27. E. FULLER TORREY ET AL., TREATMENT ADVOCACY CTR., NO ROOM AT THE INN: TRENDS AND CONSEQUENCES OF CLOSING PUBLIC PSYCHIATRIC HOSPITALS, 7 (2012), available at http://www.treatmentadvocacycenter.org/storage/documents/no_room_at_the_inn-2012.pdf.

28. Minns & Clark, *supra* note 19.

own, including issues such as increased blood sugar, elevated lipids and cholesterol, weight gain, and diabetes.²⁹

President John F. Kennedy responded to some of these medical and social events in 1963 by signing a national mental health law that authorized expenditure of up to three billion dollars to construct community-based mental health centers across the nation.³⁰ The idea was that state hospitals could shut down and patients could successfully survive in the community, so long as they were supported by the new drugs and these yet-to-be-created institutions.³¹ Thus the new law was, in large part, a direct response to the scientific development of antipsychotic drugs.

State legislatures, responding to financial pressures, civil lawsuits, public outrage, and the promise of federal funding for these community institutions, began a massive closing of state hospitals.³² While in 1955 there were 558,922 state hospital beds for the severely mentally ill, currently “95% of [those] public psychiatric hospital beds [have] disappeared, but community psychiatric care exists for fewer than half the patients who need it.”³³ By 2010 there were approximately the same number of state psychiatric beds per capita as there had been in 1850 at the beginning of the movement to provide more humane treatment for the seriously mentally ill—approximately fourteen beds per 100,000 people.³⁴ And, even with the hugely diminished number of beds, the trend in downsizing continues. A study showed that thirteen states had closed 25 percent or more of their total state hospital beds between 2005 and 2010—some states closing upwards of 50 percent.³⁵

Why was the three billion dollars not spent to create thousands of community health centers? Scholars cite multiple causes: the prolonged Vietnam War, the distraction of Watergate, the Reagan administration’s focus on federal downsizing, etc.³⁶

29. GARY B. MELTON ET AL., *PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS* 382 (3rd ed. 2007).

30. EARLEY, *supra* note 13, at 69.

31. *Id.*

32. *See id.* at 70–71.

33. TORREY ET AL., *supra* note 27, at 7.

34. *Id.* at 5.

35. *Id.*

36. *See* EARLEY, *supra* note 13, at 71; Steven S. Sharfstein, *Whatever Happened to Community Mental Health?*, 51 *PSYCHIATRIC SERVICES* 616, 618 (2000), available at <http://psychiatryonline.org/data/Journals/PSS/3542/616.pdf>; Mark Moran, *Vision Revisited*: 50

Some argue that the underlying problem was not that the money was unspent and the centers were never created in anything close to the numbers promised, but that those community mental health centers that *were* created never focused on caring for the most severely mentally ill patients released from the hospitals. Instead, the centers focused on those with much less severe mental health issues—"the worried well."³⁷ "Federal studies reported individuals discharged from state hospitals initially made up between 4% and 7% of the [community mental health centers'] patient load, and the longer the [center] was in existence the lower this percentage became."³⁸

With state hospitals largely closed down and insufficient community resources to provide the support needed for successful integration into the community (for those that could be stabilized with proper medication and therapeutic support), prisons, jails, and the streets began filling with the displaced mentally ill.³⁹ Mental health publications in the 1990s began to reference "transinstitutionalization," meaning the transfer of the mentally ill from the state hospitals to jails.⁴⁰ A mentally ill person is three times more likely to be incarcerated than hospitalized, and there are thirty-five thousand suicides by the mentally ill annually.⁴¹ It is estimated that there are currently 360,000 severely mentally ill people in our jails and prisons, half a million on probation, and more than a million that are processed through the criminal justice system every year.⁴² Today, the largest public mental health facility in the nation is a wing of the Los Angeles county jail.⁴³ Thus, we seem to

Years of the Community Mental Health Act, PSYCHIATRIC NEWS (Nov. 7, 2013), <http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1769257>; Michelle R. Smith, *Kennedy's Vision for Mental Health Never Realized*, ASSOCIATED PRESS, Oct. 20, 2013, <http://bigstory.ap.org/article/kennedys-vision-mental-health-never-realized>.

37. E. Fuller Torrey, *Fifty Years of Failing America's Mentally Ill*, WALL ST. J., Feb. 5, 2013, <http://online.wsj.com/article/SB10001424127887323539804578260023200841756.html>.

38. *Id.*

39. See EARLEY, *supra* note 13, at 71; Shijie Feng, *Madness and Mayhem: Reforming the Mental Health Care System in Arizona*, 54 ARIZ. L. REV. 541, 546-47 (2012).

40. See EARLEY, *supra* note 13, at 71.

41. Dr. J. Jaffe, Op-Ed., *Require Therapists to Warn of Danger*, N.Y. TIMES, Jan. 17, 2013, <http://www.nytimes.com/roomfordebate/2013/01/17/can-mental-health-care-reduce-gun-violence/require-therapists-to-warn-authorities-of-danger>.

42. Pete Earley, Saks Institute Distinguished Lecture (Nov. 15, 2012), *available at* <http://lawmedia.usc.edu/mediasite/play/80b008e1e8284e35ab12db25fb2a45b7>.

43. Renee Montagne, *Inside the Nation's Largest Mental Institution*, NAT'L PUB. RADIO (Apr. 13, 2008), <http://www.npr.org/templates/story/story.php?storyId=93581736>.

have come full circle—once again punishing, rather than treating, our severely mentally ill.⁴⁴

The shootings at Newtown that killed twenty children and six staff members at Sandy Hook Elementary School,⁴⁵ as well as the shooter's mother, refocused the nation on mental health issues. Indeed, never before had the political body reacted with such speed and determination to address a host of mental health issues, including issues related to treatment. In the beginning of 2013, the Health, Education, Labor and Pensions Committee of the United States Senate held a hearing on mental health. The chairman of that committee said it “was the first time in six years that the panel had really returned to a focus on mental illness.”⁴⁶

B. History and Explanation of the Involuntary Treatment Debate

Although it seems clear that the state legislatures' closures of state hospitals were mainly a response to financial incentives, another impetus for change was the concurrent wave of civil suits aiming to protect the civil liberties of the severely mentally ill.⁴⁷ These suits changed the legal landscape in regard to involuntary treatment options. They also served as a focal point for the articulation of different visions of the needs, rights, and welfare of the severely mentally ill.

1. Different Perspectives: Medical Model v. Civil Rights Model

The suits aimed at protecting the civil rights of severely mentally ill patients stemmed from a fundamental disagreement between those concerned with treating a patient's illness and those concerned with protecting a patient's autonomy and human rights. These two perspectives have been termed the medical and the civil

44. It is estimated that less than 50 percent of people with mental illness receive treatment. Erlanger A. Turner, Op-Ed., *Improve Access, Erase the Stigma*, N.Y. TIMES, Jan. 17, 2013, <http://www.nytimes.com/roomfordebate/2013/01/17/can-mental-health-care-reduce-gun-violence/improve-access-to-health-care-and-erase-its-stigma>.

45. See generally Marc Santora, *A Bleak Procession of Funerals for Shooting Victims Ends in Newtown*, N.Y. TIMES, Dec. 22, 2012, <http://www.nytimes.com/2012/12/23/nyregion/newtown-mourns-last-of-its-children-killed-in-massacre.html> (explaining the Newtown shooting and burial of the victims).

46. Paige Winfield Cunningham, *Newtown Renews Panel's Focus on Mental Health*, POLITICO (Jan. 25, 2013, 5:01 AM), <http://www.politico.com/story/2013/01/newtown-renews-panels-focus-on-mental-health-86697.html?hp=r2> (citing Tom Harkin (D-Iowa)).

47. See EARLEY, *supra* note 13, at 70–71.

rights models, respectively—or, at times, over-generalized as a struggle between doctors and lawyers.⁴⁸

Those espousing the medical model tend to view health as the predominant social value.⁴⁹ Refusal of hospitalization or treatment tends to be perceived as merely a symptom of the mental illness.⁵⁰ Because the purpose of hospitalization is treatment, the medical model views allowing one without the other as illogical.⁵¹ Because treatment will restore people to their “right minds” (thus increasing long-term capacities and freedoms), involuntary treatment is seen as promoting rather than impeding autonomy in a broad sense.⁵²

By contrast, the civil rights model prioritizes the values of immediate freedom and noninterference with a patient’s present choices⁵³—thus interpreting autonomy in a more narrow sense than the medical model. Whereas the medical model values well-being in terms of physical health, the civil rights model values well-being in terms of human dignity and respect.⁵⁴ The civil rights model views treatment resistance as an act of free will rather than a symptom of illness. Advocates of this view would highlight examples such as the fact that we allow people to choose to smoke or refuse chemotherapy as evidence that people may rationally choose options that are not in

48. See ELYN SAKS, REFUSING CARE: FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL 5–19 (2002); Jennifer Fischer, *A Comparative Look at the Right to Refuse Treatment for Involuntarily Hospitalized Persons with a Mental Illness*, 29 HASTINGS INT’L & COMP. L. REV. 153, 154–57 (Winter 2006); see also Wendy F. Hensel, *Interacting With Others: A Major Life Activity Under the Americans with Disabilities Act?*, 2002 WIS. L. REV. 1139, 1145 (2002) (comparing the social model to the civil rights model); Cheryl L. Anderson, “*Deserving Disabilities*”: *Why the Definition of Disability Under the Americans with Disabilities Act Should Be Revised to Eliminate the Substantial Limitation Requirement*, 65 MO. L. REV. 83, 100 (2000) (demonstrating the legislative success of advocates of the civil rights model); Mary Crossley, *The Disability Kaleidoscope*, 74 NOTRE DAME L. REV. 621, 649–59 (1999) (addressing the differences between the “social model” and the “medical model”); Lars Noah, *Pigeonholing Illness: Medical Diagnosis as a Legal Construct*, 50 HASTINGS L.J. 241, 291 (1999) (identifying a period of time when disability programs subscribed to a rehabilitative rather than civil rights model). There is also “[a] whole new school of mental health law called therapeutic jurisprudence [that] takes as its task the evaluation of legal rules in terms of their therapeutic benefits or detriments.” SAKS, *supra*, at 17. Therapeutic jurisprudence endeavors to find a middle road between the medical and civil rights models that focuses on the “law’s healing potential.” Bruce Winick, *Therapeutic Jurisprudence and the Role of Counsel in Litigation*, 37 CAL. W. L. REV. 105, 108 (2000).

49. Fischer, *supra* note 48, at 155.

50. *Id.*

51. *Id.*

52. *Id.* at 155–56; see SAKS, *supra* note 48, at 5–19.

53. SAKS, *supra* note 47, at 12.

54. *Id.* at 17.

their best medical interest—yet as a society we do not force them to change related behavior.⁵⁵ Likewise, the civil rights model demands equality of treatment for the severely mentally ill who refuse medical care.⁵⁶

Among those who defend a patient's right to refuse under most circumstances is Professor Elyn R. Saks. She has long been a renowned scholar of mental health law, but it was only in 2007 that she revealed to the world her severe struggles with schizophrenia.⁵⁷ Her best-selling book published that year, *The Center Cannot Hold: My Journey Through Madness*, earned her a \$500,000 MacArthur Foundation “genius” award with which she has established the Saks Institute for Mental Health Law, Policy, and Ethics at the University of Southern California Gould School of Law “to study issues at the intersection of law, mental health, and ethics as well as influence policy reform and advocacy actions for improved treatment of people with mental illness.”⁵⁸ *The Center Cannot Hold* describes, among other things, her severe psychotic break during which she was forcibly medicated when she was studying law at Yale.⁵⁹

On the issue of involuntary treatment she explains:

As someone who benefits from medication, I know that the question of when one should be allowed to refuse is a complicated one. But I also believe that individual autonomy is vitally important, even precious—after all, it's central to who we are as humans on the planet, with free will and self-ownership.⁶⁰

Before publishing the book on her personal experiences, Professor Saks had published another book entirely devoted to the issue of refusing medical care.⁶¹ As will be discussed later in this Article, she does support at least one measure that would be a

55. Fischer, *supra* note 47, at 156 (citing SAKS, *supra* note 47, at 46).

56. *See id.* at 156–57; SAKS, *supra* note 48, at 5–19.

57. *See* ELYN R. SAKS, *THE CENTER CANNOT HOLD: MY JOURNEY THROUGH MADNESS* (2007).

58. SAKS INST. FOR MENTAL HEALTH, LAW, POLICY AND ETHICS, <http://weblaw.usc.edu/centers/saks/> (last visited February 5, 2014); *see also* Benedict Carey, *Memoir About Schizophrenia Spurs Others to Come Forward*, N.Y. TIMES, Oct. 22, 2011, http://www.nytimes.com/2011/10/23/health/23livesside.html?_r=0 (noting that Dr. Saks won a \$500,000 MacArthur Foundation “genius” award).

59. *See* SAKS, *supra* note 57, at 2–4.

60. *Id.* at 262.

61. SAKS, *supra* note 48.

significant loosening of the restrictions on involuntary treatment but, on the whole, would respect the choices of the mentally ill so long as they are competent—even if psychotic and significantly impaired.⁶² This, despite her admission that she wishes she had not tried to get off medication at some points in her life.⁶³

One scholar, mirroring the medical model values, criticizes Professor Saks's position, in that if her autonomy had been respected in terms of allowing her to refuse medication, she might have lacked autonomy to make a host of other choices—beginning with returning to school.⁶⁴ “Strategies for protecting the autonomy of patients who refuse medication must consider the serious erosion of autonomy that psychosis produces.”⁶⁵

The medical model's response to civil rights arguments was rather dramatically illustrated in a *Los Angeles Times* article by Jim Randall, a former president of the National Alliance on Mental Illness.

Civil libertarians say no—that it is our right to commit crimes that land us in prison, that it is our choice to be so ill that we prefer to forage through garbage and live on the streets, that it is our prerogative to let voices in our heads torment us into sleepless nights. But something tells me that the people locked up in San Quentin with a mental illness, and the people roving the back alleys of skid row, are not singing “God Bless America.” These are our sons and daughters, our brothers and sisters, and they need our help.⁶⁶

Thus, both the civil rights model and the medical model have strong advocates who are passionately concerned about the welfare

62. See, e.g., *id.* at 89, 93–94.

63. See Carla K. Johnson & Patrick Condon, *Shootings Expose Cracks in U.S. Mental Health System*, POST-TRIBUNE (Oct. 5, 2012, 4:14 PM), <http://posttrib.suntimes.com/photos/galleries/15536969-417/shootings-expose-cracks-in-us-mental-health-system.html> (quoting Ms. Saks, “Each time I tried to get off medication, I did it with great gusto and failed miserably. . . . Frankly, I’m sorry I wasn’t smarter sooner.”).

64. See Dora W. Klein, *Autonomy and Acute Psychosis: When Choices Collide*, 15 VA. J. SOC. POL’Y & L. 355, 394–95 (2008).

65. *Id.* at 388 (quoting Harold I. Schwartz et al., *Autonomy and the Right to Refuse Treatment: Patients’ Attitudes After Involuntary Medication*, 39 HOSP. & COMMUNITY PSYCHIATRY 1049, 1054 (1988)).

66. Jim Randall, *Helping Those Who Don’t Know They Want It*, L.A. TIMES, Mar. 12, 2006, <http://articles.latimes.com/2006/mar/12/opinion/oe-randall12>.

of the mentally ill. The two models prioritize and define their values differently—yet both are concerned with some definition or vision of patient welfare and autonomy.

While not necessarily adhering consistently to either of these models for analysis, the legal scholarship on involuntary treatment for the severely mentally ill generally leans toward the civil rights model: if a position is taken on the proper standard, it tends to be an argument for either the strong status quo or even more stringent protections of the right to refuse.⁶⁷ However, there are exceptions.⁶⁸

2. Legal Battles Over Involuntary Treatment

“In the 1960s, at the height of the civil rights era, a small group of young lawyers focused on the fact that the civil rights of hospitalized psychiatric patients were being violated, which in many instances was true.”⁶⁹ Thomas Szasz’s book, *The Myth of Mental*

67. See, e.g., Debra A. Breneman, *Forcible Antipsychotic Medication and the Unfortunate Side Effects of Sell v. United States*, 27 HARV. J. L. & PUB. POL’Y 965, 966 (2004); Jennifer Colangelo, *The Right to Refuse Treatment for Mental Illness*, 5 RUTGERS J.L. & PUB. POL’Y 492, 493 (2008); Kristina M. Campbell, *Blurring the Lines of the Danger Zone*, 16 NOTRE DAME J.L. ETHICS & PUB. POL’Y 173, 175 (2002); Lyn Suzanne Entzeroth, *The Illusion of Sanity: The Constitutional and Moral Danger of Medicating Condemned Prisoners in Order to Execute Them*, 76 TENN. L. REV. 641, 642, 658 (2009); John R. Hayes, *Sell v. United States: Is Competency Enough to Forcibly Medicate a Criminal Defendant?*, 94 J. CRIM. L. & CRIMINOLOGY 657, 657 (2004); Dora W. Klein, *Trial Rights and Psychotropic Drugs: The Case Against Administering Involuntary Medications to A Defendant During Trial*, 55 VAND. L. REV. 165, 170 (2002); Dora W. Klein, *Unreasonable: Involuntary Medications, Incompetent Criminal Defendants, and the Fourth Amendment*, 46 SAN DIEGO L. REV. 161, 162 (2009); Amanda E. Lee, *Protecting the Inmate’s Right to Refuse Antipsychotic Drugs*, 64 WASH. L. REV. 459, 460 (1989); Megan Quinlan, *Forcible Medication and Personal Autonomy: The Case of Charles Thomas Sell*, 84 B.U. L. REV. 275, 299 (2004); David M. Siegel et al., *Old Law Meets New Medicine: Revisiting Involuntary Psychotropic Medication of the Criminal Defendant*, 2001 WIS. L. REV. 307, 313, 378 (2001).

68. Dora W. Klein, *Involuntary Treatment of the Mentally Ill: Autonomy Is Asking the Wrong Question*, 27 VT. L. REV. 649, 653 (2003) (arguing for a standard “allow[ing] involuntary treatment when, for someone who is mentally ill, the benefits achieved by involuntary treatment—the relief of the most serious symptoms of the most serious mental illnesses—would be sufficient to outweigh the harms caused . . .”); see, e.g., Klein, *supra* note 64, at 394–95 (arguing that autonomy should not be the sole concern in analyzing involuntary treatment); see also Lisa Kim Anh Nguyen, *In Defense of Sell: Involuntary Medication and the Permanently Incompetent Criminal Defendant*, 2005 U. CHI. LEGAL F. 597, 623 (2005) (arguing not for a more lenient standard but defending *Sell* partly on the basis that forced medication may prevent indefinite detention); Bruce J. Winick, *New Directions in the Right to Refuse Mental Health Treatment: The Implications of Riggins v. Nevada*, 2 WM. & MARY BILL RTS. J. 205, 238 (1993) (arguing not for a more lenient standard but explicitly employing a therapeutic model of analysis).

69. E. FULLER TORREY, *THE INSANITY OFFENSE: HOW AMERICA’S FAILURE TO TREAT THE SERIOUSLY MENTALLY ILL ENDANGERS ITS CITIZENS* 3–4 (2012).

Illness, was influential with some of these civil rights attorneys.⁷⁰ It denied the existence of mental illness, arguing that so-called mental illnesses were simply arbitrarily defined categories of behavior.⁷¹ This view is no longer accepted in the mainstream today, but it had an impact on some of the arguments made for patients' civil rights.

One of the leaders among these civil rights attorneys, Bruce Ennis—a recent law graduate having no previous experience with the mentally ill, concluded that psychiatric hospitals were “places where sick people get sicker and sane people go mad.”⁷² His goal was therefore “nothing less than the abolition of involuntary hospitalization” and the permanent closure of psychiatric hospitals.⁷³ In testimony before a U.S. Senate subcommittee in 1969, he stated that “[c]ommitment because of alleged danger to self or others should require proof beyond a reasonable doubt, based on a recent overt act or threat, that the person would, if at liberty, inflict substantial physical injury upon himself or others within the immediate future.”⁷⁴ His articulation of this “dangerousness” standard would have great influence on the emerging law for both involuntary commitment and involuntary treatment standards.

Much of the civil litigation on the issue of involuntary commitment and treatment occurred between the 1960s and the 1980s—at the same time that deinstitutionalization was emptying psychiatric beds and closing psychiatric hospitals.⁷⁵ Before the rise of this litigation, it was common for courts to generally leave the custody, care, and treatment of involuntarily committed mental patients within the discretion of institutional authorities.⁷⁶

Extremely influential cases from this period included *Lessard v. Schmidt*,⁷⁷ a case originating from a Wisconsin U.S. District Court that provided procedural protections for involuntary commitment, incorporated a least restrictive alternative requirement, and found that the Constitution required the state to prove “that there is an extreme likelihood that if the person is not confined he will do

70. *See id.* at 77–79.

71. *See* THOMAS SZASZ, *THE MYTH OF MENTAL ILLNESS*, at x, 2 (1961).

72. TORREY, *supra* note 69.

73. *Id.*

74. *Id.* at 78.

75. *Id.* at 4–5.

76. Cichon, *supra* note 11, at 286.

77. *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972).

immediate harm to himself or others.”⁷⁸ Cases recognizing a constitutional right to refuse treatment from this period included *Rennie v. Klein*,⁷⁹ *Rogers v. Okin*,⁸⁰ *Davis v. Hubbard*,⁸¹ and *Bee v. Greaves*.⁸² In analyzing the influence of these cases, one scholar explained that they were

cited again and again not only during their progress to finality but in the years after the final outcomes were handed down. And, they are cited as much for the verbiage and the rhetoric they employ as for their outcomes, if not more so. In fact, the way the cases are used by advocates and academic commentators alike suggests a heavy-on-the-process, need-to-police-the-psychiatrists solidarity that fails to reflect the substantial differences in the diagnoses of the issue and the consequent remedies proposed or imposed by the various courts.⁸³

The U.S. Supreme Court has rarely directly considered the right to refuse antipsychotic medications in any detail, although there are a host of constitutional principles that advocates and commentators have argued may come into play—including a liberty interest under the Due Process Clause, freedom of speech and thought under the

78. *Id.* at 1093.

79. 462 F. Supp. 1131, 1131 (D.N.J. 1978) (holding that a patient’s right to refuse medication in the absence of an emergency stems from a constitutional right to privacy and requiring some due process procedures in that context).

80. 478 F. Supp. 1342, 1361, 1364–66 (D. Mass 1979) (reasoning that “although committed mental patients do suffer at least some impairment of their relationship to reality, most are able to appreciate the benefits, risks, and discomfort that may reasonably be expected from receiving psychotropic medication.” The opinion refuses to define an emergency situation in broad psychiatric terms. It also recognizes a constitutional right to refuse based both on privacy and the First Amendment.) *aff’d in part, rev’d in part*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom.*, *Mills v. Rogers*, 457 U.S. 291 (1982), *Rogers v. Comm’r*, 458 N.E.2d 308 (Mass. 1983).

81. 506 F. Supp. 915, 929 (N.D. Ohio 1980) (“[U]nlike some of the courts which have derived the right to refuse treatment from the First Amendment, the Eighth Amendment, as well as the ‘penumbras’ and ‘shadows’ of these and the Third, Fourth, and Fifth Amendments, this Court believes the source of the right can best be understood as substantive due process, or phrased differently, as an aspect of ‘liberty’ guaranteed by the due process clause of the Fourteenth Amendment.”).

82. 744 F.2d 1387, 1394 (10th Cir. 1984) (holding that “[g]iven the undisputed nature of antipsychotic drugs, . . . a pretrial detainee retains a liberty interest derived from the Constitution in avoiding unwanted medication with such drugs,” but that interest “must be balanced against competing state interests to determine whether it is outweighed by the demands of an organized society” (internal quotation marks omitted)).

83. Samuel Jan Brakel & John M. Davis, *Overriding Mental Health Treatment Refusals: How Much Process Is “Due”?*, 52 ST. LOUIS U. L.J. 501, 531 (2008).

First Amendment, the right to avoid cruel and unusual punishment, the Equal Protection Clause (because non-mentally ill patients may generally refuse medical treatment), and the penumbral right to privacy.⁸⁴

The Supreme Court has never directly addressed the issue of the right to refuse psychotropic medications when a state has no criminal justice interest involved. But it has addressed such involuntary treatment issues for a convicted prisoner,⁸⁵ a detainee during trial,⁸⁶ and a detainee for whom such medication may be required to establish competency for a future trial “for serious, but nonviolent crimes.”⁸⁷

These cases all focused on involuntary treatment issues in the criminal context but are not entirely relevant to the issue at hand, because this Article addresses an appropriate involuntary treatment standard regardless of whether the situation involves a criminal justice issue. However, these cases have included relevant reasoning that has influenced laws and legal argument regarding involuntary treatment both within and outside a criminal justice context.

For example, *Washington v. Harper* recognized “a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment.”⁸⁸ In recognizing that liberty interest, the Court put substantial emphasis on dangerous potential side effects of the drugs.⁸⁹ *Harper* required a finding of dangerousness and that it was in an inmate’s medical interest to forcibly medicate,⁹⁰ but it was initially unclear how broadly this standard might apply outside a prison context.

Riggins v. Nevada held that “[t]he Fourteenth Amendment affords at least as much protection to persons the State detains for trial” as it does for convicted prisoners as addressed in *Harper*.⁹¹ *Riggins* therefore required not only medical appropriateness and an “overriding justification” (thus characterizing *Harper*’s

84. MELTON et al., *supra* note 29, at 382–83.

85. *Washington v. Harper*, 494 U.S. 210 (1990).

86. *Riggins v. Nevada*, 504 U.S. 127, 129 (1992).

87. *Sell v. U.S.*, 539 U.S. 166, 169 (2003).

88. *Harper*, 494 U.S. at 221–22.

89. *Id.* at 229–30.

90. *Id.* at 227.

91. *Riggins*, 504 U.S. at 135.

“dangerousness” standard as a subset of such justifications rather than the standard in itself), but also a consideration of “less intrusive alternatives.”⁹² While *Riggins* did not consider whether First Amendment rights were involved, the court was clearly concerned with antipsychotic medication’s potential effects on communication.⁹³

Most recently, in *Sell v. United States*, the Supreme Court held that antipsychotic medications can be involuntarily administered to render competency for trial if:

[1] a mentally ill defendant [2] [is] facing serious criminal charges . . . [and] [3] the treatment is medically appropriate [and] [4] is substantially unlikely to have side effects that may undermine the fairness of the trial, and, [5] taking account of less intrusive alternatives, [6] is necessary [to] significantly . . . further important governmental trial-related interests.⁹⁴

The Court elaborated on the proper meaning and analysis of these points in significant length and detail and then promptly proceeded to discourage this test’s use.⁹⁵ The Court explained that the test would not be necessary if a reviewing court could base the order for forced medication on a different purpose than simply competency for trial.⁹⁶ As alternative purposes, the Court provided the example of *Harper* with “purposes . . . related to the individual’s dangerousness, or purposes related to the individual’s own interests where refusal to take drugs puts his health gravely at risk.”⁹⁷ The Court explicitly stated that such alternative purposes (and thus alternative tests) should be used “*before* turning to the trial competence question”⁹⁸ and that authorizing medication on alternative grounds would make any need to consider competency grounds “likely disappear.”⁹⁹

Thus, relevant themes of recurring concern for the various courts in these cases include liberty and privacy interests, medical appropriateness, side effects of the medications (both in terms of

92. *Id.*

93. *See id.* at 137.

94. *Sell v. United States*, 539 U.S. 166, 179 (2003).

95. *Id.* at 181–82.

96. *Id.*

97. *Id.* at 182.

98. *Id.*

99. *Id.* at 183.

danger/discomfort to the patient and interference with communication), grave disability, less restrictive alternatives, safety of the community, and various other potential state interests.

3. Current State of Involuntary Treatment (and Related) Laws

State laws have developed both in response to cases, such as those described above, and as a reaction to various events and political pressures. For example,

[b]efore the *Lessard* decision, only nine states used ‘dangerousness’ as the sole criterion for involuntary psychiatric hospitalization. By 1980, every state had changed its statute to restrict hospitalization to persons who were dangerous to themselves or others . . . or had interpreted its preexisting statute in a way so as to save it from being found unconstitutional.¹⁰⁰

These laws “made it difficult—and illegal in some states—to force a person into treatment unless he or she was homicidal or suicidal.”¹⁰¹

Responding to such standards, one physician, Dr. Darold Treffert, collected stories of those that could not qualify for involuntary treatment and later killed themselves—he coined the phrase “dying with their rights on.”¹⁰²

Today, “[t]he pendulum is slowly returning to a reasonable balance,” Dr. Treffert observed in a 2012 *Associated Press* news article.¹⁰³ Currently, the vast majority of states allow intervention on broader grounds than “dangerousness to self and others,” though a small minority continues to require “dangerousness” as the sole basis for intervention and ordering treatment.¹⁰⁴

Standards vary among the states, but often another ground is “grave disability,” which usually focuses on the person’s ability to

100. TORREY, *supra* note 69, at 123 (citing DG Langsley & JT Barter, *Community Mental Health in California*, 122 W. J. MED. 271 (1975); SP Segal et al., *Civil Commitment in the Psychiatric Emergency Room*, 45 ARCHIVES GEN. PSYCHIATRY 753 (1988); PAUL S. APPLEBAUM, *ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE* 28 (1994)).

101. Johnson & Condon, *supra* note 63.

102. *Id.*

103. *Id.*

104. See *Improved Treatment Standards*, TREATMENT ADVOCACY CTR., <http://www.treatmentadvocacycenter.org/solution/improved-treatment-standards> (last visited Sept. 21, 2013).

meet basic survival needs.¹⁰⁵ A significant number of states have also added “need-for-treatment” provisions. Definitions of such provisions again vary among the states, but might, for example, allow intervention if it was necessary to prevent further psychiatric deterioration.¹⁰⁶ Arizona, which is among the more lenient states in this area, allows any concerned party to petition the court for an order of treatment. An evaluation and subsequent care may be mandated if the person is found to be “persistently and acutely disabled” by severe mental illness and “likely to benefit from treatment.”¹⁰⁷ Jared Loughner might have been prevented from shooting former Representative Gabrielle Giffords, and killing and wounding a host of others, had someone filed such a petition—especially given his “worrisome track record—the number of times the campus police were called to intervene; the pressing concerns of his teacher and of other students; and the . . . fact that the college would not readmit him after his suspension without psychiatric clearance.”¹⁰⁸

Civil commitment of a psychotic individual does not guarantee the ability to get treatment. “Another court order [may be] necessary for doctors to treat hospitalized patients against their will.”¹⁰⁹ As explained above, a court may consider whatever relevant grounds the statutes of a state provide for determining whether medication may be forcibly administered. Doctors (and a court) will also consider a patient’s competency to make the medication decision, but as one scholar explained, the test for such competency is usually remarkably low.

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. And these tests do find*

105. *Id.*

106. *Id.*

107. Satel, *supra* note 3.

108. *Id.*

109. Lloyd I. Sederer, *The Tragedy of Mental-Health Law*, WALL ST. J., Jan. 11, 2013, <http://online.wsj.com/article/SB10001424127887324081704578234002322233718.html>.

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 understanding a proposed medical treatment. *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 ill—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.¹¹⁰

Privacy laws also frequently frustrate parents and family members of severely mentally ill patients. “The 1996 federal law known as HIPAA (the Health Insurance Portability and Accountability Act) is meant to protect the medical information of individuals, but it has also come to limit what a doctor can say to a patient’s family (with the exception of unemancipated minors).”¹¹¹ This can inhibit educated family support, which research has shown can greatly affect treatment outcomes.¹¹²

As of January 2013, forty-five states had Assisted Outpatient Treatment laws (AOT).¹¹³ Such laws vary by state, but under certain conditions (such as a history of frequent hospitalizations and/or violence) they provide court-ordered treatment for severely mentally ill patients who have a history of treatment noncompliance as a condition of remaining in the community.¹¹⁴ In other words, if they

110. Dora W. Klein, *When Coercion Lacks Care: Competency to Make Medical Treatment Decisions and Parens Patriae Civil Commitments*, 45 U. MICH. J.L. REFORM 561, 562–63 (2012) (emphasis added). See generally Elyn R. Saks, *Competency to Refuse Psychotropic Medication: Three Alternatives to the Law’s Cognitive Standard*, 47 U. MIAMI L. REV. 689, 691–92 (1993) (providing an in-depth discussion of competency).

111. Sederer, *supra* note 108.

112. See Tomas, *supra* note 10.

113. *Assisted Outpatient Treatment Laws*, TREATMENT ADVOCACY CTR., <http://www.treatmentadvocacycenter.org/solution/assisted-outpatient-treatment-laws> (last visited Sept. 21, 2013) (“The five states that do not have AOT are Connecticut, Maryland, Massachusetts, New Mexico, and Tennessee.”). See Lori R. Holyfield, *One Fell Through the Cracks: Why Tennessee Needs an Initial Outpatient Commitment Statute*, 42 U. MEM. L. REV. 221, 232 (2011); Bruce J. Winick et al., *Involuntary Outpatient Commitment*, 9 PSYCHOL. PUB. POL’Y & L. 94 (2003).

114. See Steven K. Erickson, Michael J. Vitacco & Gregory J. Van Rybroek, *Beyond Overt Violence: Wisconsin’s Progressive Civil Commitment Statute As A Marker of A New Era in*

choose not to take their medications, these severely mentally ill patients may be civilly committed for a specified period of time.¹¹⁵ One of the most famous examples that spawned increased national interest is Kendra's Law of New York—named for a young woman who died in 1999 after being pushed in front of a subway train by a schizophrenic man with a history of violence who failed to take his medication.¹¹⁶ New York was relatively late in adopting such a statute,¹¹⁷ but many states had not (and some still do not) make significant use of the AOT provisions they have adopted.¹¹⁸ Some (but not all) studies have linked AOT programs with increased participation in case management and reduced arrests, hospitalizations, assaults, threats of violence, incarceration, and homelessness.¹¹⁹

In the wake of the Newtown shootings, many lawmakers are reconsidering mental health laws. Gun control laws in New York that were passed in the aftermath of Newtown included a measure to strengthen Kendra's Law but, according to critics, "left big gaps in the safety net that scream for closure."¹²⁰ In January 2013, the *New York Times* reported that

Mental Health Law, 89 MARQ. L. REV. 359, 384 (2005) (explaining some states also use "predicted deterioration" statutes—these "states allow involuntary commitment to rest on a prediction of future deterioration or relapse of mental illness, with only a portion of [those states] requiring a further link to dangerousness."). Paul P. Christopher & Debra A. Pinals *Civil Commitment Based on Predicted Deterioration*, 37 J. AM. ACAD. PSYCHIATRY LAW 399, 401 (2009), available at <http://www.jaapl.org/content/37/3/399.full>.

115. See *Assisted Outpatient Treatment Laws*, *supra* note 112.

116. John Monahan, *A Jurisprudence of Risk Assessment: Forecasting Harm Among Prisoners, Predators, and Patients*, 92 VA. L. REV. 391, 402 (2006); Ilissa L. Watnik, *A Constitutional Analysis of Kendra's Law: New York's Solution for Treatment of the Chronically Mentally Ill*, 149 U. PA. L. REV. 1181 (2001).

117. See Kathryn A. Worthington, *Kendra's Law and the Rights of the Mentally Ill: An Empirical Peek Behind the Courts' Legal Analysis and A Suggested Template for the New York State Legislature's Reconsideration for Renewal in 2010*, 19 CORNELL J.L. & PUB. POL'Y 213, 224 (2009).

118. See Monahan, *supra* note 116 at 401–02; TREATMENT ADVOCACY CTR., MENTAL HEALTH POLICY REFORMS TO REDUCE MASS SHOOTINGS (2013), available at <http://www.treatmentadvocacycenter.org/storage/documents/proposalsformentalhealthpolicyreform.1.4.12.pdf>.

119. See Richard Glasgow, *Forced Medication of Criminal Defendants and the Unintended Consequences of Sell v. United States*, 21 J. CONTEMP. HEALTH L. & POL'Y 235, 253 (2005); Satel, *supra* note 3.

120. Editorial, *Halfway on Kendra's Law*, N.Y. DAILY NEWS, Jan. 22, 2013, <http://www.nydailynews.com/opinion/halfway-kendra-law-article-1.1244483> (stating the new amendments included provisions to extend the maximum term of forced treatment orders, create statewide enforcement, and mandate the evaluation of state prison inmates being discharged from

Legislation to revise existing mental health laws is under consideration in at least a half-dozen states A New York bill requiring mental health practitioners to warn the authorities about potentially dangerous patients was signed into law on [January 15, 2013]. In Washington, President Obama has ordered “a national dialogue” on mental health, and a variety of bills addressing mental health issues are percolating on Capitol Hill.¹²¹

The proposals being considered across the nation “include strengthening mental health services, lowering the threshold for involuntary commitment and increasing requirements for reporting worrisome patients to the authorities.”¹²² In February 2013, a bipartisan group of senators, citing renewed urgency due to the Newtown shootings, introduced legislation that “would put in place standards for about 2,000 ‘federally qualified’ community behavioral health centers, requiring them to provide such services as substance abuse treatment and 24-hour crisis care” in return for being able to bill Medicaid for their services.¹²³ This, of course, is different from but reminiscent of President John F. Kennedy’s original plan.

Thus, the law is currently in a state of great flux. Newtown has caused a long overdue reassessment of a system that is “fragmented and drastically inadequate.”¹²⁴ But while mental health advocates find some of the proposals appealing, others are troublesome—particularly the reporting requirements that might discourage patients from seeking care or providing full disclosure to physicians.¹²⁵ The emphasis of the reforms seems to be on prevention of violence and

state-run psychiatric facilities). But the new provisions do not require evaluations of those mentally ill housed in locally run jails, psychiatric wards in non-state hospitals, or those housed in secure state-run psychiatric facilities who have been found not guilty by reason of insanity. *See id.*

121. Erica Goode & Jack Healy, *Focus on Mental Health Laws to Curb Violence is Unfair, Some Say*, N.Y. TIMES, Jan. 31, 2013, <http://www.nytimes.com/2013/02/01/us/focus-on-mental-health-laws-to-curb-violence-is-unfair-some-say.html?ref=mentalhealthanddisorders>.

122. *Id.*

123. Brady Dennis & Paul Kane, *Measure Would Strengthen Mental Health-care System*, WASH. POST, Feb. 7, 2013, http://www.washingtonpost.com/national/health-science/measure-would-strengthen-mental-health-care-system/2013/02/07/dd64db44-714d-11e2-ac36-3d8d9dcaa2e2_story.html?wpisrc=nl_headlines.

124. Goode & Healey, *supra* note 121.

125. *See id.*; Benedict Carey & Anemona Hartocollis, *Warning Signs of Violent Acts Often Unclear*, N.Y. TIMES, Jan. 15, 2013, <http://www.nytimes.com/2013/01/16/health/breaking-link-of-violence-and-mental-illness.html?ref=mentalhealthanddisorders>.

access to services—which is laudable, but not sufficient. The lack of resources for mental health treatment has been a tremendous problem, but leading a person to water is only the first step in quenching thirst. What if the person refuses to drink? The next section examines the current science and its implications for that question.

III. INSIGHTS FROM SCIENCE

Human brains are “the most complexly organized things in the known universe.”¹²⁶ A single cubic millimeter of brain tissue contains approximately one hundred million synaptic connections between neurons, and a cubic centimeter has as many synaptic connections as there are stars in the Milky Way galaxy.¹²⁷ The brain’s “hundred billion neurons and several hundred trillion synaptic connections can process and exchange prodigious amounts of information over a distributed neural network in the matter of milliseconds.”¹²⁸ Dr. Eric Kandel, a Nobel Prize winning neuroscientist and professor at Columbia University, asserts that severe mental illnesses, such as schizophrenia, are the most complicated illnesses in all of medicine, because they not only involve the body’s most complex organ, but also the most complex functions of that organ.¹²⁹

Why did *Nature*, the premiere science journal, assert that this is “[a] decade for psychiatric disorders,” and that there are “many ways in which the understanding and treatment of conditions such as schizophrenia are ripe for a revolution”?¹³⁰ The reasons include the tremendous pace of scientific advances that are providing new insight into the nature of severe mental illnesses like schizophrenia. Indeed, knowledge of the human brain is expanding exponentially.¹³¹

126. Eddy Nahmias, *Is Neuroscience the Death of Free Will?*, N.Y. TIMES OPINIONATOR (Nov. 13, 2007, 5:25 PM), <http://opinionator.blogs.nytimes.com/2011/11/13/is-neuroscience-the-death-of-free-will/>.

127. See DAVID EAGLEMAN, *INCognito: THE SECRET LIVES OF THE BRAIN* 1–2 (2011).

128. Rene Marois & Jason Ivanoff, *Capacity Limits of Information Processing in the Brain*, 9 TRENDS IN COGNITIVE SCI. 296, 296 (2005), available at <http://www.sciencedirect.com/science/article/pii/S1364661305001178>.

129. *Charlie Rose: The Mentally Ill Brain* (television broadcast June 22, 2010), available at <http://www.charlierose.com/view/interview/11078>.

130. Editorial, *supra* note 8.

131. Henry T. Greely, *Neuroscience and Criminal Justice: Not Responsibility but Treatment*, 56 U. KAN. L. REV. 1103, 1137 (2008).

New techniques such as genome-wide association studies, sophisticated brain imaging, and optical manipulation of neural circuits provide opportunities to discover the neural circuitry underlying cognitive dysfunction and to develop better prediction, treatment, and prevention options.¹³² Indeed, these exciting new technologies that allow for unprecedented insight into the brain, coupled with the brain's incredible complexity, have led prominent scholars to label this not just the decade of psychiatric disorders, but also the century of the brain.¹³³ This claim was further supported by the 2013 State of the Union announcement of a new decade-long government funded effort to map the active human brain.¹³⁴

The purpose of this section is to examine this developing science regarding schizophrenia and to consider the implications for issues surrounding the involuntary treatment debate. In doing so, this Article falls within a relatively new field of research that draws connections between neuroscience and law. The growth of scholarship in this field that some call "neurolaw" has been astounding—a survey in 2009 found "a 300 [percent] increase over the number [of related scholarly articles] published just five years earlier, and . . . a 2,000 [percent] increase over the number published a decade before."¹³⁵

Despite the explosive growth of neurolaw literature, the scholarship has not included a broad-based and in-depth analysis of the relation of recent progress in the brain sciences to the involuntary treatment of the severely mentally ill. Very few articles have touched on some of these issues, but with a significantly narrower or simply

132. Editorial, *supra* note 8.

133. For example, Eric Kandel, a Nobel Prize-winning neuroscientist, predicted that just as the gene was the target of biological sciences in the second half of the 20th century, the new technologies allowing unprecedented study of the brain will make it the main focus of the biological sciences for the 21st century. *Charlie Rose: The Great Mysteries of the Human Brain*, (television broadcast Oct. 29, 2009), available at <http://www.charlierose.com/view/interview/10694>. Hank Greely, Director for the Center of Law and Biosciences at Stanford University, also said that "neuroscience is going to be the most fascinating science of this coming century . . . and it's going to be the most socially important." *Stanford's Hank Greely on Research Advances vs. Social Challenges*, NAT'L INST. MENTAL HEALTH (Aug. 17, 2012), <http://www.nimh.nih.gov/news/media/video/stanfords-hank-greely-on-research-advances-vs-social-challenges.shtml>.

134. See John Markoff, *Obama Seeking to Boost Study of Human Brain*, N.Y. TIMES, Feb. 17, 2013, http://www.nytimes.com/2013/02/18/science/project-seeks-to-build-map-of-human-brain.html?_r=0.

135. Francis X. Shen, *The Law and Neuroscience Bibliography: Navigating the Emerging Field of Neurolaw*, 38 INT'L J. LEGAL INFO. 352, 357 (2010).

different focus.¹³⁶ This Article fills that gap by examining recent scientific advances in the study of the brain and mental illness and how those advances should illuminate the thorny issue of when to forcibly medicate a patient who is severely mentally ill. The Article focuses on schizophrenia as an example of “one of the most complex of all mental health disorders.”¹³⁷

A. Schizophrenia—the Nature and Symptoms of the Disease

Schizophrenia is a severe brain disorder that affects approximately 1 percent of Americans¹³⁸ and twenty-four million people worldwide.¹³⁹ It is a chronic and often disabling condition with no known cure, but treatment may relieve the patient of many symptoms.¹⁴⁰ Generally schizophrenia manifests itself with paranoid delusions and auditory hallucinations either in late adolescence or early adulthood, “with a peak between ages [eighteen and twenty-five], when the prefrontal cortex [an area of the brain] is still developing.”¹⁴¹ But there is evidence that it is a neurodevelopmental disorder and that psychosis is “a late, potentially preventable stage of the illness.”¹⁴²

Schizophrenia’s effects vary widely, and relapse and remission cycles are common.¹⁴³ The symptoms of schizophrenia are categorized as positive, negative, and cognitive. Positive symptoms are psychotic behaviors that can wax and wane. They include

136. See, e.g., Joanmarie Ilaria Davoli, *Still Stuck in the Cuckoo’s Nest: Why Do Courts Continue to Rely on Antiquated Mental Illness Research?*, 69 TENN. L. REV. 987 (2002); Rodney J.S. Deaton, *Neuroscience and the In Corpore-Ted First Amendment*, 4 FIRST AMEND. L. REV. 181 (2006); Douglas Mossman, *Unbuckling the “Chemical Straitjacket”*: *The Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis*, 39 SAN DIEGO L. REV. 1033 (2002); Rachel A. Scherer, *Toward A Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventive Outpatient Treatment*, 4 IND. HEALTH L. REV. 361, 362 (2007).

137. *Schizophrenia*, JOHN HOPKINS MED. HEALTH LIBR., http://www.hopkinsmedicine.org/healthlibrary/conditions/mental_health_disorders/schizophrenia_85,P00762/ (last visited Sept. 21, 2013).

138. NIMH, SCHIZOPHRENIA, *supra* note 26, at 5.

139. *Schizophrenia*, WORLD HEALTH ORG., http://www.who.int/mental_health/management/schizophrenia/en/index.html (last visited Sept. 21, 2013).

140. See NIMH, SCHIZOPHRENIA, *supra* note 26, at 1.

141. Thomas Insel, *Rethinking Schizophrenia*, 468 NATURE 187, 188 (2010), available at <http://www.nature.com/nature/journal/v468/n7321/full/nature09552.html>.

142. *Id.* at 187.

143. *Frequently Asked Questions about Schizophrenia*, BRAIN & BEHAV. RES. FOUND., <http://bbrfoundation.org/frequently-asked-questions-about-schizophrenia> (last visited Sept. 21, 2013).

hallucinations (these may involve any of the senses but are most often voices), delusions (non-cultural false beliefs that do not yield to logic and are often bizarre—examples include believing thoughts can kill others, that neighbors are controlling one’s own behavior through magnetic waves, radio stations are broadcasting one’s thoughts to others, or paranoid delusions that others are conspiring harm), thought disorders (often manifested in trouble organizing or connecting thoughts logically and may result in garbled speech), and movement disorders (sometimes manifested in performing certain repeated motions or becoming catatonic).¹⁴⁴

Negative symptoms involve loss of function in areas such as emotion and motivation. They include flat affect (lack of facial expression), talking in a flat voice, lack of ability to feel pleasure or begin and sustain planned activities, and social withdrawal.¹⁴⁵

Cognitive symptoms include poor executive functioning, working memory, focus, or attention. Cognitive symptoms can be severely disabling of efforts to lead a normal life.¹⁴⁶ “Violence is not a symptom of schizophrenia—only a tiny proportion of sufferers with the condition are homicidal.”¹⁴⁷ People with the disease are generally not violent.¹⁴⁸ However, there is increased risk as compared to the general population, and factors that some claim markedly increase the risk of violence include substance abuse and acute psychotic symptoms.¹⁴⁹ “Research has suggested that those with schizophrenia whose psychotic symptoms are controlled are no more violent than those without [severe mental illness]. It’s likely that treatment not only helps ease the symptoms of mental illness, but also curbs the potential for violence as well.”¹⁵⁰ While the risk of being a victim of violence from a person with schizophrenia is very

144. NIMH, SCHIZOPHRENIA, *supra* note 26, at 3.

145. *Id.*

146. *Id.*

147. Editorial, *Combating Schizophrenia*, 468 NATURE 133, 133 (2010), available at <http://www.nature.com/nature/journal/v468/n7321/full/468133a.html>.

148. NIMH, SCHIZOPHRENIA, *supra* note 26, at 5.

149. Elizabeth Walsh et al., *Violence and Schizophrenia: Examining the Evidence*, 180 BRIT. J. PSYCHIATRY 490, 490–95 (2002).

150. Thomas Insel, *Director’s Blog: Understanding Severe Mental Illness*, NAT’L INST. MENTAL HEALTH (Jan. 11, 2011), <http://www.nimh.nih.gov/about/director/2011/understanding-severe-mental-illness.shtml>. The severely mentally ill are far more often the victims rather than perpetrators of violence—they are “11 times more likely to be victims of violent crime than the general population.” *Id.*

small, people with the illness commit suicide at a much higher rate than the general population. Approximately 10 percent of patients die by suicide—most of them young adult males.¹⁵¹

Studies of brains of schizophrenic patients have shown a number of differences from those of the general population—including altered function of certain neurotransmitters, decreased white and gray brain matter, enlarged ventricles,¹⁵² “reduced hippocampal and cortical volume, abnormal cytoarchitecture, reduced neuronal density in superficial cortical layers, decreased neuron size, and reduced dendritic arborization and dendritic spine density.”¹⁵³

While these differences have been documented at population levels, there are currently no tests to diagnose schizophrenia in an individual.¹⁵⁴ However, there are promising studies that suggest such tests may be available in the future. For example, a recent study was able to distinguish between mentally healthy and schizophrenic individuals with 98.3 percent accuracy by using a series of tests that detected eye-movement abnormalities associated with the disorder that were independent of mental state at the time of testing.¹⁵⁵

Until such methods can be further verified and perfected, diagnoses today are made by monitoring symptoms over a period of time.¹⁵⁶ Scientists are currently searching for biomarkers that might aid not only with diagnosis but lead to more insight regarding what is causing the disease. For example, researchers found that among a group of young people identified as at risk for the disease, a subfield of the hippocampus was abnormally active in those that did develop schizophrenia.¹⁵⁷

151. NIMH, SCHIZOPHRENIA, *supra* note 26, at 5.

152. Editorial, *supra* note 8, at 9; NIMH, SCHIZOPHRENIA, *supra* note 26, at 6.

153. Frankie H.F. Lee et al., *Disc1 Point Mutations in Mice Affect Development of the Cerebral Cortex*, 31 J. NEUROSCIENCE 3197–206 (Mar. 2011), available at <http://www.jneurosci.org/content/31/9/3197.full?sid=fbe768b6-e3b7-48bb-82e3-47237bc5e68c>.

154. *New Research to Identify and Treat Schizophrenia Early*, N.Y. PRESBYTERIAN HOSP., COLUM. U. (Apr. 27, 2010), <http://nyp.org/advances/new-research-treat-schizophrenia-early.html>.

155. Philip J. Benson et al., *Simple Viewing Tests Can Detect Eye Movement Abnormalities That Distinguish Schizophrenia Cases from Controls with Exceptional Accuracy*, 72 BIOLOGICAL PSYCHIATRY 716, 716 (2012).

156. See *Frequently Asked Questions about Schizophrenia*, *supra* note 142.

157. *New Research to Identify and Treat Schizophrenia Early*, *supra* note 153.

1. Mysterious Causes

“After a century of studying schizophrenia, the cause of the disorder remains unknown.”¹⁵⁸ However, there is evidence that genetic, environmental, and experiential factors play a part in who develops the disease.

While only 1 percent of the population develops schizophrenia, it occurs in 10 percent of those with a first-generation relative who suffers from the disease—and the odds increase to 40 to 65 percent for an identical twin.¹⁵⁹ Scientists believe no single gene causes the disease on its own.¹⁶⁰ “Genetic risk factors are numerous, with 50 to 100 gene mutations and variations reported each year as associated with schizophrenia.”¹⁶¹

Studies of babies born during a famine (both the Dutch Hunger Winter of World War II and the Chinese famine from 1959–61) show that they had double the chance of developing schizophrenia due to malnutrition in the womb.¹⁶² Other “[n]ongenetic risk factors include [but are not limited to] infection during fetal life, brain injury, an anoxia at birth, trauma in childhood, abuse of street drugs and steroids, brain lesions, psychosocial stress, isolation, smoking, and excess coffee.”¹⁶³

Determining the precise causal factors is difficult, because “the signs and symptoms are the same, regardless of the cause. They are the same whether one has had a brain injury and developed schizophrenia, or whether one has smoked too much cannabis and developed schizophrenia.”¹⁶⁴ This similarity in symptoms has been assumed to suggest a common molecular pathway for the disease,¹⁶⁵

158. *Insel, supra* note 140, at 187.

159. NIMH, SCHIZOPHRENIA, *supra* note 26, at 6.

160. *Id.*

161. Philip Seeman, *All Roads to Schizophrenia Lead to Dopamine Supersensitivity and Elevated Dopamine D2High Receptors*, 17 *CNS NEUROSCIENCE & THERAPEUTICS* 118–32 (Apr. 2011), available at <http://onlinelibrary.wiley.com/doi/10.1111/j.1755-5949.2010.00162.x/full>.

162. John McGrath et al., *Prevention and Schizophrenia—The Role of Dietary Factors*, 37 *SCHIZOPHRENIA BULL.* 272–83 (Mar. 2011), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3044637/>.

163. Seeman, *supra* note 160, at 118.

164. *Id.*

165. *Id.* at 118–19.

but a very recent study questions whether there is some variation on that front among at least a minority of schizophrenic patients.¹⁶⁶

2. Treatments for Schizophrenia

Because there is no known cure, treatment for schizophrenia focuses on managing its symptoms. Currently available drugs can serve to quiet the positive symptoms of psychosis (for most, though not all, patients) but “fail[] to reverse the development of deficits in brain capacity that are most prominently expressed as the negative symptoms and cognition impairments.”¹⁶⁷ Patients may therefore “remain disabled and dysfunctional from deficits in capacities for feeling, thinking, working, and caring.”¹⁶⁸

Drugs alone, therefore, are generally essential but not sufficient for optimal treatment of schizophrenia. Experts recommend that patients also undergo regular psychosocial treatment of various kinds.¹⁶⁹ Patients who do regularly receive such treatment are more likely to continue taking their medications and are less likely to relapse or be hospitalized.¹⁷⁰

Professor Elyn Saks has explained that therapy helps patients on numerous levels, including with the ability to (1) identify, cope with, or avoid stressors; (2) develop psychological mindedness (by which she means stronger observational skills for analyzing what is going on in one’s own mind, and thus increased ability to have healthier reactions to it); and (3) come to terms with the tremendous blow to self-esteem that often accompanies patients’ recognition of their severe mental illness. Indeed, Elyn Saks believes that had she received either drugs without therapy or therapy without drugs, her original prognosis that she would never be able to live independently

166. “Our findings suggest that there may be a different molecular mechanism leading to schizophrenia in patients who do not respond to anti-psychotic medication. Identifying the precise molecular pathway particularly in these patients is of utmost importance and will help inform the development of much-needed novel treatments.” *Research May Explain Why Some People With Schizophrenia Do Not Respond to Treatment*, MEDICAL XPRESS (Nov. 29, 2012), <http://medicalxpress.com/news/2012-11-people-schizophrenia-treatment.html#jCp> (citing Arisme Demjaha et al., *Dopamine Synthesis Capacity in Patients with Treatment-Resistant Schizophrenia*, 169 AM. J. PSYCHIATRY 1203 (Nov. 2012)), available at <http://ajp.psychiatryonline.org/article.aspx?articleid=1377137>).

167. McGlashan, *supra* note 12, at 902.

168. *Id.*

169. See NIMH, SCHIZOPHRENIA, *supra* note 26, at 11–13.

170. *Id.*

(let alone become a distinguished, award-winning professor) would have been correct.¹⁷¹

As discussed in further detail below, there are serious limitations and risks associated with presently available medications, complicating the issue of when it might be appropriate to forcibly medicate the severely mentally ill. This Article examines some of the current research on potential new treatments—but regarding medical treatments for the psychotic symptoms, “[f]rustratingly, the effectiveness of medications has stalled.”¹⁷² Over the more-than-half century these medications have been available, they have advanced predominantly “not in their efficacy but in a reduction [though not an elimination] of their debilitating side effects.”¹⁷³

The sections that follow examine scientific research regarding the vital importance of early medical intervention for long-term prognosis, the serious side effects of medications, and the effects that changes in the brain can cause in behavior and personality—and how all these factors do (or ought to) influence the involuntary treatment debate.

B. The Medical Significance of Early Treatment

Extensive research shows that for a psychotic illness like schizophrenia, “early identification . . . is paramount and can affect long-term outcome.”¹⁷⁴ Indeed, “[t]he longer the duration between the onset of serious psychosis and treatment, the more likely long-term disability will result.”¹⁷⁵

171. *Charlie Rose: The Mentally Ill Brain*, *supra* note 129.

172. Editorial, *supra* note 8, at 9.

173. *Id.*

174. See, e.g., Mark Taylor et al., *Advances in the Understanding and Challenges Facing the Management of First-Episode Schizophrenia*, 26 J. PSYCHOPHARMACOLOGY 3, 3–5 (May 2012), available at http://jop.sagepub.com/content/26/5_suppl/3.full#ref-8.

175. Christopher Slobogin, Sell’s *Conundrums: The Right of Incompetent Defendants to Refuse Anti-Psychotic Medication*, 89 WASH. U. L. REV. 1523, 1530 n.43 (2012) (citing Max Marshall et al., *Association Between Duration of Untreated Psychosis and Outcome in Cohorts of “First-Episode” Patients: A Systematic Review*, 62 ARCHIVES GEN. PSYCHIATRY 975 (2005)); see AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 309 (4th ed. 2000) (explaining that “treatment with antipsychotic medication soon after the onset of the illness” is associated with a better prognosis); MARVIN I. HERZ & STEPHEN R. MARDER, SCHIZOPHRENIA: COMPREHENSIVE TREATMENT AND MANAGEMENT 152 (2002) (“[P]rolonged psychotic episodes may be associated with enduring damage”); JEFFREY A. LIEBERMAN ET AL., TEXTBOOK OF SCHIZOPHRENIA 356 (2006) (“[M]eta-analysis of 42 research reports from 28 studies found that shorter duration of untreated psychosis was associated with greater response to antipsychotic treatment, including improvement in severity of global psychopathology, positive

Thomas McGlashan, a now emeritus professor of psychiatry at Yale School of Medicine, explained that from a study he conducted of 281 Scandinavian patients, there are indications that an untreated psychotic state is itself dangerous to one's long-term prognosis. "It looks like the longer the period of time before treatment, the worse off the patients are not only when they come into treatment, but how they respond to treatment."¹⁷⁶ He 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 ultimately determined by the original brain pathophysiology.¹⁷⁷

Evidence suggests that "schizophrenia is a progressive brain disease."¹⁷⁸ Brain scans show schizophrenia causing loss of grey matter—reflecting the (at least presently) irreversible destruction of neural synapses.¹⁷⁹ Jeffrey Lieberman, Professor of Psychiatry at Columbia University, explains that "[t]he whole thrust of early intervention is to prevent this loss from occurring."¹⁸⁰

Because of the evidence regarding the importance of early intervention for long-term prognosis, the National Institute of Mental Health (NIMH) has funded a research project that is presently ongoing to try to develop effective methods of early intervention. The project, known as Recovery After an Initial Schizophrenic Episode (RAISE), involves two independent research teams,

symptoms, negative symptoms, and functional outcomes.") (citations omitted); *see also* Klein, *supra* note 64, at 394 n.175 ("Early treatment is most likely to be effective.").

176. *Earlier Diagnosis of Schizophrenia Improves Results of Treatment*, YALE SCH. OF MED. (Feb. 26, 2004), <http://medicine.yale.edu/news/article.aspx?id=3456> (quoting Thomas H. McGlashan).

177. Thomas H. McGlashan, *Schizophrenia in Translation: Is Active Psychosis Neurotoxic?*, 32 SCHIZOPHRENIA BULL. 609, 611–13 (2006), available at <http://schizophreniabulletin.oxfordjournals.org/content/32/4/609.full>.

178. Taylor et al., *supra* note 173, at 3.

179. *New Research to Identify and Treat Schizophrenia Early*, *supra* note 154.

180. *Id.*

community clinics across the nation, and treatment models that “focus on intervening as soon as possible after the first episode of schizophrenia . . . [and] integrate[] medication, psychosocial therapies, family involvement, rehabilitation services, and supported employment, all aimed at promoting symptom reduction and improving life functioning.”¹⁸¹

Thus, early treatment is linked not only with better outcomes, but better response to medications and less irreversible damage to the brain. This evidence suggests that the early period of the disease is critical, and patient welfare interests weigh most strongly in favor of medical intervention during those early years. The same evidence would also support long-term autonomy interests in early intervention in that the patient’s mental abilities will be better preserved and thus allow for a fuller range of personal possibilities and choices in the future.

C. Safety and Effectiveness of Proposed Treatments

In *Harper*, the Supreme Court focused heavily on the serious side effects that were possible from antipsychotic drugs in determining that there was “no doubt that . . . [Mr. Harper] possess[ed] a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment.”¹⁸²

The side effects that concerned the *Harper* court included “acute dystonia, a severe involuntary spasm of the upper body, tongue, throat or eyes” (though the trial court found this condition could be detected and remedied within minutes by taking the medication Cogentin); “akathisia (motor restlessness, often characterized by an inability to sit still), neuroleptic malignant syndrome (a relatively rare condition which can lead to death from cardiac dysfunction), and tardive dyskinesia,” a potentially irreversible neurological

181. *Recovery After an Initial Schizophrenia Episode (RAISE): A Research Project of the NIMH, NAT'L INST. MENTAL HEALTH*, <http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml> (last visited Sept. 21, 2013).

182. *Washington v. Harper*, 494 U.S. 210, 221–22 (1990) (emphasis added). The dissent argued that the liberty interest was not only important because of potential side effects of the drugs, but also because any “violation of a person’s bodily integrity is an invasion of his or her liberty” and “is degrading if it overrides a competent person’s choice to reject a specific form of medical treatment.” *Id.* at 237 (Stevens, J., concurring and dissenting in part). But neither dissent nor majority would argue against the proposition that an invasion of liberty is “particularly intrusive if it creates a substantial risk of death or injury.” *See id.*

disorder “that is characterized by involuntary, uncontrollable movements of various muscles, especially around the face.”¹⁸³ The Court acknowledged that there was conflicting evidence regarding the frequency, severity, and reversibility of the tardive dyskinesia side effect, but declared that “[a] fair reading of the evidence” suggested that 10 percent to 25 percent of patients receiving antipsychotic medications exhibited its symptoms—60 percent of those that exhibited the symptoms had only “mild or minimal” effects and 10 percent had severe symptoms.¹⁸⁴

Harper was decided in 1990 and therefore did not focus on the atypical or second-generation antipsychotic medications, the first of which started to become broadly available in roughly the same time period.¹⁸⁵ These drugs are generally less likely to have the neurological side effects of the first-generation options.¹⁸⁶ There is especially decreased risk for the side effects of tardive dyskinesia and neuroleptic malignant syndrome.¹⁸⁷

However, these second-generation drugs continue to carry substantial risk of serious negative side effects.¹⁸⁸ Depending on the

183. *Id.* at 229–30 (majority opinion).

184. *Id.* at 230.

185. Douglas Mossman & Jill L. Steinberg, *Promoting, Prescribing, and Pushing Pills: Understanding the Lessons of Antipsychotic Drug Litigation*, 13 MICH. ST. U. J. MED. & L. 263, 279 (2009).

186. MELTON ET AL., *supra* note 29, at 382; Richard A. Friedman, *A Call for Caution on Antipsychotic Drugs*, N.Y. TIMES, Sept. 24, 2012, http://www.nytimes.com/2012/09/25/health/a-call-for-caution-in-the-use-of-antipsychotic-drugs.html?_r=0. At least one recent study has called into question whether second-generation drugs really do have clinically significant differences in extrapyramidal side effects, but that study’s methods of analysis and conclusions have been criticized. See Henk S. Temmingh, *Extrapyramidal Side-Effects and Antipsychotics: Are Second-Generation Agents Still Indicated?*, 201 BRITISH J. PSYCHIATRY 247, 247 (2012), available at <http://bjp.repsych.org/content/201/3/247.1.short>. The article criticized is Michael J. Peluso et al., *Extrapyramidal Motor Side-Effects of First- and Second-Generation Antipsychotic Drugs*, 200 BRITISH J. PSYCHIATRY 387 (Mar. 22, 2012), available at <http://bjp.repsych.org/content/200/5/387.fall>. Another recent study confirms that second-generation antipsychotics offer an extrapyramidal side effects advantage over first-generation drugs in first episode psychosis. See Peter M Haddad et al., *Antipsychotic Drugs and Extrapyramidal Side Effects in First Episode Psychosis: A Systemic Review of Head-Head Comparisons*, 26 J. PSYCHOPHARMACOLOGY 15, 24–25 (May 2012), available at http://jop.sagepub.com/content/26/5_suppl/15.short.

187. MELTON ET AL., *supra* note 29 at 382; Friedman, *supra* note 186.

188. See Christopher Slobogin, *supra* note 175, at 1542 (“The drugs used to treat psychosis—including the so-called second-generation atypicals—all can have serious side effects, are frequently administered in unnecessarily large doses or are not good drugs for the particular person being treated, and are ineffective for anywhere from a quarter to a third of those to whom they are administered.”) (citing RICHARD P. BENTALL, DOCTORING THE MIND: IS OUR CURRENT TREATMENT OF MENTAL ILLNESS REALLY ANY GOOD? 222–24 (2009)).

specific drug prescribed and the body chemistry of the individual patient, these side effects may include increased blood sugar, elevated lipids and cholesterol, weight gain, diabetes, diminished sexual desire, digestion problems, dizziness, drowsiness, anxiety, insomnia, rapid heart rate, and agitation.¹⁸⁹ Patients taking clozapine (one of the second-generation drugs) also have a small risk of developing agranulocytosis, which is potentially fatal.¹⁹⁰ Patients using clozapine must therefore be monitored by frequent blood tests—especially in the first six months of treatment when development of agranulocytosis is most likely.¹⁹¹ Second-generation drugs are generally “less effective than they could be because over time, they turn off a gene that helps reduce symptoms of psychosis.”¹⁹²

Only clozapine has been shown to be significantly more effective in controlling psychotic symptoms than other first- or second-generation antipsychotic drugs.¹⁹³ But because of a variety of factors, including the cost and inconvenience of frequent blood tests, FDA restrictions, and medical risks, the drug is generally prescribed only as a final resort when other antipsychotics have proven ineffective for the patient.¹⁹⁴

Dr. Herbert Meltzer, a prominent expert on antipsychotic medications at Northwestern University, has explained that currently approximately 70 percent of schizophrenics can be successfully treated with antipsychotic medications other than clozapine. Of the 30 percent untreatable by those drugs, another approximate 70 percent can be successfully treated by clozapine. Clozapine also reduces the risk of suicide for schizophrenic patients by

189. MELTON ET AL., *supra* note 29, at 382.

190. *Unbuckling the “Chemical Straitjacket,” supra* note 136, at 1070–71.

191. *Id.* at 1071.

192. Gary Stix, *The Grand Challenge of Schizophrenia Drugs*, SCIENTIFIC AMERICAN (Sept. 21, 2012), <http://blogs.scientificamerican.com/talking-back/2012/09/21/the-grand-challenge-of-schizophrenia-drugs/> (summarizing the findings of Steve Hyman, former Harvard provost and director of the National Institute of Mental Health).

193. See *Questions and Answers About the NIMH Clinical Antipsychotic Trials of Intervention Effectiveness Study (CATIE)—Phase 2 Results*, NAT’L INST. MENTAL HEALTH (Apr. 1, 2006), <http://www.nimh.nih.gov/trials/practical/catie/phase2results.shtml>.

194. Mossman, *supra* note 136, at 1071–73.

approximately 80 percent but can be lethal to roughly one in ten thousand patients.¹⁹⁵

Thus, medications are unquestionably effective for the large majority of patients—but it may take some trial and error to discover which drug is the best match for which patient. And for a small minority, no drug will effectively treat psychosis. For the latter group, clearly patient welfare cannot trump the autonomy concerns. Unfortunately, however, there is currently no way to know who falls in that small minority before experimenting with different drugs for the patient.

Indeed, scientific studies have made it increasingly clear that both side effects and probable consequences of refusing treatment are highly variable depending on the individual and the drugs involved.¹⁹⁶ Thus in determining whether drugs are in a schizophrenic person's best interest or are "medically appropriate," an individualized assessment, including a patient's medical history and consideration of past reactions to specific drugs, is necessary.

In the near future, it may also be possible to do some relevant genetic analysis. For example, two studies published in 2012 found "two genetic variants associated with the substantial, rapid weight gain occurring in nearly half the patients treated with antipsychotic medications."¹⁹⁷ "These results could eventually be used to identify which patients have the variations, enabling clinicians to choose strategies to prevent this serious side effect and offer more personalized treatment."¹⁹⁸

195. Herbert Meltzer, Address at Psychotropic Medication and the Law Symposium at The Saks Institute for Mental Health Law, Policy, and Ethics: Development and Utilization of Drugs for Treating Psychotic Disorders (Mar. 22, 2012), video available at http://weblaw.usc.edu/centers/saks/psychotropic_medication.cfm.

196. See Francis J. McMahon & Thomas R. Insel, *Pharmacogenomics and Personalized Medicine in Neuropsychiatry*, 74 NEURON 773, 773–76 (June 2012), available at <http://www.sciencedirect.com/science/article/pii/S089662731200431X>.

197. *Genetic Link to Rapid Weight Gain from Antipsychotics Discovered*, THE CENTRE FOR ADDICTION AND MENTAL HEALTH (CAMH) (July 17, 2012), http://www.camh.ca/en/hospital/about_camh/newsroom/news_releases_media_advisories_and_backgrounders/current_year/Pages/Genetic-link-to-rapid-weight-gain-from-antipsychotics-discovered.aspx. The studies published were: Malhotra AK et al., *Association Between Common Variants Near the Melanocortin 4 Receptor Gene and Severe Antipsychotic Drug-Induced Weight Gain*, 69 ARCHIVES GEN. PSYCHIATRY, 904, 904–12 (Sept. 2012); NI Chowdhury et al., *Genetic Association Study Between Antipsychotic-Induced Weight Gain and the Melanocortin-4 Receptor Gene*, PHARMACOGENOMICS J. (Feb. 7, 2012), available at <http://www.nature.com/tbj/journal/vaop/ncurrent/full/tbj201166a.html>.

198. *Genetic Link to Rapid Weight Gain from Antipsychotics Discovered*, *supra* note 197.

Another study aimed at developing means to assist in the prediction of a patient's response to antipsychotic drugs examined magnetic resonance (MR) imaging of patients' brain structure. The study concluded that among patients suffering a first-episode of schizophrenia, those that responded well to the tested antipsychotics had greater cortical thickness and asymmetry in certain regions of the brain. These "findings are consistent with the hypothesis that plasticity and cortical thickness may be more preserved in responders and that MR imaging may assist in the prediction of antipsychotic drug response in patients experiencing a first-episode of schizophrenia."¹⁹⁹

For the time being, however, finding the appropriate drug for a patient generally remains a trial-and-error process that can subject the patient to highly undesirable and dangerous side effects. But in weighing patient welfare interests in light of those side effects, one must also consider the alternative—full-blown psychosis—and likely consequences in its wake. A recent study shows that for the large majority of schizophrenic patients, the effects of no medication are a greater mortal danger to health than the side effects patients may understandably wish to avoid.

That study was conducted by one of the world's leading epidemiologists, Professor Jari Tiihonen, MD. Published in 2009, the study examined mortality rates of 66,881 schizophrenic patients. The study concluded that "[l]ong-term cumulative exposure (7–11 years) to *any antipsychotic treatment* was associated with lower mortality than was no drug use."²⁰⁰ Therefore, the greatest risk of premature death for a schizophrenic patient was not from side effects of antipsychotic medications, but from choosing to refrain from any antipsychotic medication.²⁰¹

Thus, although there has not been much progress in developing new drugs in the last several decades (and further research in that

199. Philip R. Szesko, *Magnetic Resonance Imaging Predictors of Treatment Response in First-Episode Schizophrenia*, 38 SCHIZOPHRENIA BULL. 569, 569 (Nov. 2010), available at <http://schizophreniabulletin.oxfordjournals.org/content/38/3/569.short>.

200. Jari Tiihonen et al., *11-Year Follow-Up of Mortality in Patients with Schizophrenia: A Population-Based Cohort Study (FIN11 Study)*, 374 THE LANCET 620, 620 (Aug. 22, 2009), available at [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(09\)60742-X/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60742-X/abstract) (emphasis added); see also Meltzer, *supra* note 194 (discussing the Tiihonen article).

201. See Tiihonen et al., *supra* note 200, at 620; Meltzer, *supra* note 195.

area is sorely needed),²⁰² there has been progress in research regarding which individuals may be more or less susceptible to the side effects of those drugs that are currently available and the potential consequences of refusing medication altogether. As Justice Kennedy predicted, “[t]he state of our knowledge of antipsychotic drugs and their side effects is evolving,”²⁰³ and the legal community should adjust its analysis as scientific developments surface. For now, that would include a highly individualized analysis of a patient’s likely response to specified medications (and the likely consequence of abstaining) when determining if medication is in the patient’s best medical interest—and thus how heavily the patient welfare interest should weigh in the balance. Although presently that analysis is generally a question of medical history, the science suggests that, in the future, there will be other types of analyses that will be available to better predict a particular patient’s response to specific drugs. While it would seem that generally patient welfare would weigh in favor of any patient with severe symptoms of schizophrenia being subject to medication, that may not be true in cases where all available drugs have proved fruitless or where biomarkers might predict particularly severe responses to the available drugs.

D. Personhood

If autonomy is concerned with protecting the rights and freedoms of the individual person, we must have some concept of what “personhood” is.²⁰⁴ Mental illness can confuse the personhood issue because the sick self and the healthy self may be at odds in various ways and in ways that are not always easy to determine.²⁰⁵ Professor Elyn Saks explains that “it is hard to say when a new self has come into being (rather than simply being a changed self) and

202. “Medication development for mental disorders has stalled over the past three decades. . . . Recently, many major pharmaceutical companies have all but abandoned drug discovery efforts for mental illness.” McMahon & Insel, *supra* note 196, at 773.

203. *Riggins v. Nevada*, 504 U.S. 127, 145 (1992) (Kennedy, J., concurring).

204. For a greater discussion of theories of autonomy, see *supra* Part II.B.

205. The differences between the sick self and the healthy self may be more of a shifting spectrum than a true dichotomy.

when the new self has *become* the true self or is simply a temporary aberration.”²⁰⁶ She concludes:

Surely a self that is unimpaired is in some sense “better” than a self that is impaired. It has more skills and more options. Impairments are limitations, and, all else being equal, it is better not to suffer limitations. Value choices are problematic in some ways, but some value choices seem so right and good that we should feel fine about making them.²⁰⁷

If we accept the healthy self as the true self (a proposition most would probably accept if applying a Rawlsian veil),²⁰⁸ then autonomy interests weigh in favor of protecting that self’s choices over the impaired self’s choices when the two are in conflict. If the healthy self would welcome treatment but the sick self would not, autonomy would weigh in favor of forcing treatment—not only because it honors the true self’s desires but also because it opens options for the individual. The healthy self has far more ability to function and prosper than the self that is allowed to remain psychotic. However, determining the absent healthy self’s true desires may be no easy matter. This section explores the science behind various conditions that may cause the impaired self to express different desires than the healthy self.

1. Anosognosia

The word “anosognosia” combines the Greek words for disease, “nosos,” and knowledge, “gnosis,” literally meaning “to not know a disease.”²⁰⁹ It is distinguishable from denial in that the latter is “a psychological coping mechanism . . . [A] defense mechanism that protects the individual from distress.”²¹⁰ By contrast, anosognosia in

206. SAKS, *supra* note 48, at 204.

207. *Id.* at 204–05.

208. See generally John Rawls, A THEORY OF JUSTICE 12, 136–37 (1971) (explaining that principles of justice are best constructed from behind a veil of ignorance that eliminates knowledge of individuating characteristics). In this case I refer to not knowing whether one would contract schizophrenia or a similar disease in the future.

209. *Anosognosia—Frequently Asked Questions*, TREATMENT ADVOCACY CTR., <http://treatmentadvocacycenter.org/component/content/article/1790>.

210. Mounir Ouzir et al., *Insight in Schizophrenia: From Conceptualization to Neuroscience*, 66 PSYCHIATRY AND CLINICAL NEUROSCIENCES 167, 169 (Apr. 2012), available at <http://onlinelibrary.wiley.com/doi/10.1111/j.1440-1819.2012.02325.x/full#b2>.

schizophrenia “has an anatomical basis and is caused by damage to the brain by the disease process.”²¹¹

A World Health Organization study found that 50 to 80 percent of schizophrenic patients worldwide suffered from either partial or complete lack of insight into their mental disorder.²¹² Fifty percent of those with schizophrenia in the United States would translate to approximately 1.5 million people who lack awareness regarding their condition.²¹³ This inability to recognize one’s own illness or aspects thereof, also called anosognosia,²¹⁴ can “occur[] in both schizophrenia and right hemisphere lesions [of the brain] due to stroke, dementia, and traumatic brain injury.”²¹⁵ Such “lack of insight in schizophrenia appears to be self-specific, as most patients recognize symptoms in other patients, but fail to do so in themselves. . . . impl[y]ing that lack of insight may be caused by disturbed abilities of self-referential processing.”²¹⁶

The consequences of anosognosia for the schizophrenic patient can be severe. “Preserved insight into illness has been suggested to be predictive of outcome in patients with schizophrenia.”²¹⁷ Studies have associated poor insight in schizophrenia “with defects in cognitive functions such as attention, memory, language, executive functioning and social cognition . . . poor treatment compliance, poor

211. *The Anatomical Basis of Anosognosia-Background*, TREATMENT ADVOCACY CTR., <http://www.treatmentadvocacycenter.org/about-us/our-reports-and-studies/2143> (last updated May 2013).

212. Ouzir et al., *supra* note 210, at 167 (citing WT Carpenter, Jr., et al., *Flexible System for the Diagnosis of Schizophrenia: Report From the WHO International Pilot Study of Schizophrenia*, 182 SCI. 1275, 1275–78 (1973)).

213. See Celso Arango & Xavier Amador, *Lessons Learned About Poor Insight*, 37 SCHIZOPHRENIA BULL. 27 (Dec. 2010), available at <http://schizophreniabulletin.oxfordjournals.org/content/37/1/27.short#>.

214. “Insight, however, may not be viewed as a simple balance between awareness and unawareness of illness. For example, . . . some patients may recognize signs of illness but attribute them to causes other than abnormalities in their mental states.” Ouzir et al., *supra* note 210, at 168 (citing X.F. Amador et al., *Awareness of Illness in Schizophrenia*, 17 SCHIZOPHRENIA BULL. 113, 113–32 (1991)).

215. Philip Gerretsen et al., *Frontotemporoparietal Asymmetry and Lack of Illness Awareness in Schizophrenia*, 34 HUM. BRAIN MAPPING 1035, 1035 (May 2013), available at <http://onlinelibrary.wiley.com/doi/10.1002/hbm.21490/abstract?deniedAccessCustomisedMessage=&userIsAuthenticated=false>.

216. Edith J. Liemburg et al., *Reduced Connectivity in the Self-Processing Network of Schizophrenia Patients with Poor Insight*, 7 PLOS ONE e42707 (2012), <http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0042707>.

217. C. Faget-Agius et al., *Schizophrenia With Preserved Insight is Associated With Increased Perfusion of the Precuneus*, 37 J. PSYCHIATRY NEUROSCIENCE 297 (Sept. 2012), available at <http://www.ncbi.nlm.nih.gov/pubmed?term=faget-agius%20schizophrenia%20insight>.

social and interpersonal functioning, poor prognosis, and higher risk of relapse.”²¹⁸ Additionally, “poor insight may increase the incidence of depression, hopelessness, low self-esteem and more generally poor quality of life.”²¹⁹

Multiple studies have also found that lack of insight is associated with disorganized symptoms, but not all studies have been consistent in their findings in this regard.²²⁰ “Disorganization in patients with schizophrenia represents the most direct clinical expression of mental dissociation and may preclude the capacity to engage in abstract thinking needed to reflect rationally on their anomalous experiences, leaving the individual with schizophrenia without a coherent concept of normality.”²²¹

Furthermore, because patients who deny they are ill often refuse medication, they can be subject to all the consequences associated with non-adherence to treatment, including “arrest, homelessness, hospitalization, violence and similar outcomes. . . . [P]eople who know they are sick seek help before their condition becomes dire. People who are unaware they are ill do not.”²²²

While it is undisputed that many schizophrenic patients deny they are sick or seem to lack other awareness regarding their disease, there is dispute among the scholarly community as to how many of these people are in denial and how many (if any) are truly unable (at least temporarily) to recognize their illness due to anosognosia.²²³ One study concluded that “the weakness of the existing relationship between insight and severity of symptomatology on the one hand, and between insight and emotional state on the other hand, suggests

218. Ouzir et al., *supra* note 208, at 167.

219. *Id.* However, the studies are not all consistent. For example, some studies have linked good insight with more severe depression or greater suicide risk, while other studies have found no such correlation; *see id.* at 172.

220. *Id.* at 168.

221. *Id.*

222. *Why We Talk about Anosognosia*, TREATMENT ADVOCACY CTR. (Aug. 2012), <http://www.treatmentadvocacycenter.org/about-us/our-blog/69-no-state/2142-why-we-talk-about-anosognosia>.

223. *See, e.g.*, SAKS, *supra* note 48, at 242 n.30 (“Whether we should think of denial as an understandable psychological defense or as a symptom of an illness is unclear. . . . Some commentators . . . make much of the idea that denial may have neurophysiological correlates. But surely everything mental does, so I’m not sure how far this observation takes us.”); E. Fuller Torrey, *Anosognosia, Denial and the New Antipsychiatry*, TREATMENT ADVOC. CENTER (Oct. 2012), <http://www.treatmentadvocacycenter.org/problem/anosognosia/2178#torrey-response>. .

that both psychodynamic [denial] and clinical [anosognosia] models are not sufficient explanatory models.”²²⁴

But there is continually mounting evidence that lack of awareness is associated with abnormalities in the brain of schizophrenic patients and thus may not be simply due to normal coping mechanisms. Two decades ago there were approximately ten empirical studies on the lack of insight into illness in schizophrenic patients, whereas now there are hundreds.²²⁵ Some of the most recent studies regarding the relationship of poor insight into illness in schizophrenia and defects in the brain have included the following findings:

- “[There is] a relationship between anosognosia and hemispheric asymmetry in schizophrenia, supporting previous volume-based MRI studies in schizophrenia that found a relationship between illness unawareness and reduced right hemisphere gray matter volume.”²²⁶
- “[There is] a link between known regional brain abnormalities [in the cortical midline structures and the frontopolar cortex] and the manifestation of poor insight in schizophrenia.”²²⁷
- “[S]chizophrenia with preserved insight is associated with greater [cerebral blood flow in] the precuneus, a brain area known to be involved in self-consciousness, suggesting a compensatory mechanism of fronto-temporal impairment.”²²⁸
- “[S]chizophrenia patients with relatively preserved insight showed stronger connectivity than patients with poor insight in the anterior cingulate cortex and precuneus, both key regions in self-reflective processing. These findings tentatively support the hypothesis that poor insight may be related to impaired self-related processing.”²²⁹

224. Ouzir et al., *supra* note 210, at 169.

225. Arango & Amador, *supra* note 213, at 27.

226. Gerretsen et al., *supra* note 215, at 1035.

227. Tuukka T. Raji et al., *Association of Poor Insight in Schizophrenia With Structure and Function of Cortical Midline Structures and Frontopolar Cortex*, 139 SCHIZOPHRENIA RES. 27, 27 (Aug. 2012), available at <http://www.ncbi.nlm.nih.gov/pubmed/22664168>.

228. Faget-Agius et al., *supra* note 217, at 297.

229. Liemburg et al., *supra* note 216, at 6.

- “Impaired insight in schizophrenia implicates a complex neural circuitry: white matter deficits in fronto-temporo brain regions are linked to symptom unawareness; compromised temporal and parietal white matter regions are involved in the misattribution of symptoms. These findings suggest the multidimensional construct of insight has multiple neural determinants.”²³⁰
- “[P]oorer awareness of illness was associated with regional [cortical] thinning in the left middle frontal and inferior temporal gyri. Poorer awareness of treatment need and efficacy was associated with cortical thinning in the left medial frontal gyrus, precuneus and temporal gyri. . . . The results confirm predictions derived from the anosognosia . . . account and assert that regional thickness in frontal cortex is associated with awareness of illness in the early phase of psychosis [The study also] suggests that the neural signature of insight involves a network of brain structures, and not only the frontal lobes as previously suggested.”²³¹

Other studies have found a relationship between poor insight in schizophrenic patients and “reduced total brain volume, ventricular enlargement, frontal lobe atrophy, reduced frontal lobe volume, and gray matter deficits” in various regions of the brain.²³² But not all studies are consistent in their findings.

Other studies . . . have not found any significant correlations between lack of insight and total brain volume, total ventricular volume and gray or white matter volumes in the prefrontal region. This inconsistency could arise from the complex nature of insight and the use of a variety of insight assessments.²³³

230. Daniel Antonius et al., *White Matter Integrity and Lack of Insight in Schizophrenia and Schizoaffective Disorder*, 128 SCHIZOPHRENIA RES. 76, 77 (May 2011), available at <http://www.ncbi.nlm.nih.gov/pubmed/21429714>.

231. Lisa Buchy et al., *Cortical Thickness Is Associated With Poor Insight in First-Episode Psychosis*, 45 J. PSYCHIATRY RES. 781, 781 (June 2011), available at <http://www.ncbi.nlm.nih.gov/pubmed/21092987>.

232. Ouzir, *supra* note 210, at 174.

233. *Id.*

The American Psychiatric Association's official classification of mental disorders contained in the Diagnostic and Statistical Manual of Mental Disorders (DSM) undertook a revision of its section on schizophrenia in 2000 to reflect emerging scientific consensus.²³⁴ Even though less evidence was available over a decade ago, the DSM sided with anosognosia over denial. The relevant provision states:

A majority of individuals with schizophrenia have poor insight regarding the fact that they have a psychotic illness. Evidence suggests that poor insight is a manifestation of the illness rather than a coping strategy. It may be comparable to the lack of awareness of neurological deficits seen in stroke, termed *anosognosia*. This symptom predisposes the individual to noncompliance with treatment and has been found to be predictive of higher relapse rates, increased number of involuntary hospital admissions, poorer psychosocial functioning, and poorer course of illness.²³⁵

The implications of anosognosia to the involuntary treatment debate are manifold. "For example, can a person truly give informed consent for treatment of an illness that he cannot see? How is legal competency affected? What should state laws, policies and resources look like in addressing this?"²³⁶

If we believe a mentally ill person has the capacity to make an informed, rational decision regarding refusing medication, there is a greater natural tendency to respect the choice (even if it is a decision we don't believe is in the patient's best interest) as a valid exercise of agency and civil rights. But if we believe there is brain damage from the schizophrenia that impairs the patient's ability to make an informed, rational choice, it drastically changes the equation. We are no longer respecting a person's informed choice, rather we are protecting an inadequately informed delusion.²³⁷ And if patients cannot recognize their illness, and medication is in their best interests, it is not clear that their autonomy interests should weigh

234. Arango & Amador, *supra* note 213, at 27.

235. *Id.* (quoting DSM-IV 304 (Am. Psychiatric Ass'n Press, 2000)).

236. David Hager, "Anosognosia Is Blindness"—*Personally Speaking*, TREATMENT ADVOCACY CTR. (2011), <http://www.treatmentadvocacycenter.org/about-us/our-blog/69-no-state/2083-anosognosia-is-blindness-personally-speaking>.

237. See Torrey, *supra* note 223.

supreme—for perhaps if they could recognize the illness, they would accept treatment.

Professor Elyn Saks argues that even if the reasons for denial are illness-based (which she does not concede), this “is no reason for not respecting the choices based on them. . . . Respecting autonomy is extremely important, and we demonstrate our commitment to it when we respect the autonomy of those whose decision-making is somewhat (though not grossly) compromised.”²³⁸

In response, I argue that not knowing one is ill is a “gross impairment” when the decision is whether to take medication. If you do not believe you are ill, it would never make sense to take these powerful brain-altering medications. Indeed, at least one study has shown that the most common reason for individuals with severe psychiatric disorders to not take their medication was that they did not believe they were ill.²³⁹ Other studies have usually found a strong association between the two.²⁴⁰

2. Potential Effects of Changes in Brain Chemistry or Structure on Personality and Choices

There are now many documented examples of how a person’s personality and choices may be changed when a person’s brain is altered by injury or illness. David Eagleman, a renowned neuroscientist, has explained that even slight changes in one’s brain chemistry can cause large changes in behavior.²⁴¹ Such changes highlight the complexity of the autonomy issue when trying to distinguish the “real” self from the self whose

238. SAKS, *supra* note 48, at 108.

239. *Why Individuals With Severe Psychiatric Disorders Often Do Not Take Their Medications-Background*, TREATMENT ADVOCACY CTR. (Apr. 2011), <http://treatmentadvocacycenter.org/resources/consequences-of-lack-of-treatment/anosognosia/1375-why-individuals-with-severe-psychiatric-disorders-often-do-not-take-their-medications> (citing Ronald C. Kessler et al., *The Prevalence and Correlates of Untreated Serious Mental Illness*, 36 HEALTH SERVICES RES. 987, 996 (2001)).

240. *See id.* But while “[t]he majority of studies support the assumption that insight is associated with adherence during treatment phase . . . the association with long-term adherence remains unclear. Insight correlates with better long-term functioning, but this might be explained by its association with symptoms.” 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), available at <http://www.ncbi.nlm.nih.gov/pubmed/17289653?dopt=Abstract>.

241. EAGLEMAN, *supra* note 127, at 157.

choices may be affected by mental illness.

In the case of a severe mental illness like schizophrenia, the symptoms can clearly change the perceptions and thought processes of the individual—even when not rendering a person irrational. A relatively new field known as “decision neuroscience” studies what happens in human brains during decision making and endeavors to map thinking on a cellular level.²⁴² One expert in the field, C. Daniel Salzman at Columbia University School of Medicine, explained that for many psychiatric disorders, patients that are symptomatic are frequently making poor decisions about numerous things throughout the day If you’ve ever had a friend or family member with depression, you can see they are not making decisions the way they normally do. So there clearly has to be dysfunction in the neurocircuits of psychiatric patients affecting their decisions.²⁴³

One study of the decision-making process of schizophrenic patients found that those “with prominent positive symptoms were unable to feel regret, and to learn from what they could have obtained with a different choice. This impairment contributes strongly to the inability of these patients to generate adaptive behavior in individual and social environments.”²⁴⁴ However, other schizophrenic patients without the prominent positive symptoms reacted similarly to the healthy controls in the study except that they exhibited more risk-seeking behavior.²⁴⁵

Of course none of this necessarily indicates that the healthy self would prefer medication when the unhealthy self refuses. But these examples do suggest that there can be significant differences in the expressed desires and choices of the two selves due to the illness. These examples also suggest that, though not always rising to the level of incompetence, these individuals’ decision-making process may be impaired by disease. This Article does not take the position that society should thus disregard the decisions and desires of the

242. *The Neuroscience of Decision Making*, THE KAVLI FOUND. (Aug. 2011), <http://www.kavlifoundation.org/science-spotlights/neuroscience-of-decision-making>.

243. Quoted in *The Neuroscience of Decision Making*, *supra* note 242 (emphasis added).

244. Marion Larquet et al., *Impaired Decision Making in Schizophrenia and Orbitofrontal Cortex Lesion Patients*, 116 SCHIZOPHRENIA RES. 266, 272 (2010), available at http://dornsife.usc.edu/assets/sites/472/docs/Larquet_Coricelli_Schizophrenia_Research_2010.pdf.

245. *Id.* at 271.

severely mentally ill. But it does argue that under some circumstances this may be justification for weighing autonomy interests (insofar as they relate to the desires expressed by the ill individual) less strongly than for those with illnesses that do not target the brain in the same degree.

IV. PROPOSED REFORM

A. *Finding the Proper Balance*

How should all these scientific insights influence finding the proper balance between autonomy and patient welfare? In terms of patient welfare, weighing on the side of forcible intervention is not just the patient's suffering, but also the vital importance of early treatment, without which irreversible damage may occur and long-term prognosis worsens. Early treatment may also prevent suicide (certainly clozapine has been shown to be very effective in doing so)—and suicide is a substantial risk for schizophrenia patients, especially in early years.²⁴⁶

Although patient welfare initially seems to weigh against forced treatment when one considers the serious potential side effects of the current antipsychotic drugs, the emerging science suggests that, even if better drugs are not on the immediate horizon, more and more individualized analysis will be possible to determine which patients will have which reactions to which drugs. Thus, there will be greater capacity to tailor treatment in ways that minimize serious side effects. And a patient-welfare analysis cannot be complete without evaluating the severity of the case, and thus whether the side effects are a better or worse condition than the untreated disease for the patient. In cases of severe psychosis, there is broad-based consensus that the best outcomes generally come from consistent medication coupled with counseling.²⁴⁷

Then there are issues of autonomy. When should a patient be able to decide for himself whether the untreated disease is better or worse than taking medications? Or simply that he or she wants to refuse them on different bases? Some have objected to involuntary

246. Brian A. Palmer et al., *The Lifetime Risk of Suicide in Schizophrenia: A Reexamination*, 62 ARCHIVES OF GEN. PSYCHIATRY 247, 250 (2005), available at <http://archpsyc.jamanetwork.com/article.aspx?articleid=208392>.

247. See discussion *supra* Part III.A.2.

treatment on the grounds that outside the context of mental illness society generally allows people to refuse medication if they wish, even for what most might consider irrational reasons.²⁴⁸ Is there something fundamentally different about mental illness that should overcome an equal protection argument of that kind?

There are fundamental differences because of the way changes in brain chemistry and structure can change personality and decision-making, and even change one's ability to recognize one's own disease. The fundamental difference is that with the severely mentally ill, their illness targets and may drastically affect the necessary organ for decision-making. A person may still appear competent in a technical sense (with the ability to reason at least at some level), while making dramatically different decisions than the person would have made before illness or injury or chemical changes affected the brain.

But even if one is willing to accept the healthy self as the true self whose wishes ought to be respected (not a position all accept, but one this Article assumes is correct), how can one determine what the healthy self would have wanted? For perhaps both sick and healthy self would agree that the medications are undesirable regardless of the physical consequences of refusing treatment. Severely mentally ill people may have rational reasons for refusing medication.

Elyn Saks has explained that mentally ill patients' rational reasons for refusing medication (not necessarily wise ones—but reasons that are not based on delusions or hallucinations) generally fall within one of five categories: (1) concerns regarding side effects (not only the possible physical and mental side effects previously discussed, but also the attendant stigma of visible side effects for conditions such as movement disorders); (2) some patients may prefer the mentally ill state due to factors such as the bleakness of reality and relief of pain that may come with active psychosis, the care and attention it fosters from others, identifying the illness with one's true self, or a desire to punish oneself; (3) a "desire to avoid narcissistic injury," which is "[r]ationalized as a belief that one shouldn't rely on crutches" or "as a desire to improve on one's own;" (4) denial; and (5) reactivity—meaning the patient may use refusal of

248. See, e.g., SAKS, *supra* note 48, at 86.

the medication as bargaining power, a vent for negative emotions, or to control caregivers in some way.²⁴⁹

She argues that with the exception of side effect concerns that may be moderated by actual experience with the drugs, the rest of these concerns may not necessarily change after a round of forced medication.²⁵⁰ Indeed, forcible medication may exacerbate some of these objections. While she agrees that the severely mentally ill are generally better off when they take their medications willingly, she thinks it too great an affront to autonomy to disregard such rational refusals under most circumstances. Instead she supports therapeutic efforts to try to help patients accept treatment willingly.²⁵¹

Professor Christopher Slobogin likewise would define competence broadly in order to respect most patients' treatment decisions despite the potential existence of significant pathology. He advocates the "basic rationality and self-regard standard," according to which a "person should have to understand the relevant facts, be free of any fixed, false beliefs about those facts, and be willing to exercise decision-making authority."²⁵²

The positions of Saks and Slobogin gain significant support from evidence that consensual treatment is generally more effective than forced treatment for mentally ill patients.²⁵³ The evidence that medication accompanied by therapy is far more successful than either of those approaches alone also supports the theory, because therapy requires a greater degree of mental compliance than does an injection of antipsychotics. Furthermore, Slobogin explains that the pragmatists among us should note that "psychiatric treatments are not always effective and carry significant risks; . . . experiencing decompensation may trigger the necessary motivation to try treatment; . . . lifelong medication is . . . a very expensive proposition; . . . some untreatable people who are presently in hospitals should not be there," and that "a robust right to refuse

249. *Id.* at 97.

250. *Id.* at 96.

251. *Id.*

252. CHRISTOPHER SLOBOGIN, *MINDING JUSTICE: LAWS THAT DEPRIVE PEOPLE WITH MENTAL DISABILITY OF LIFE AND LIBERTY* 233–34 (2006). Slobogin explains that "the ultimate inquiry should focus on the extent to which the person believes 'facts' for which there is no evidence . . ." *Id.* at 244.

253. SAKS, *supra* note 48, at 236 n.8.

encourages dialogue between doctor and patient that is all too rare when the patient is mentally disabled.”²⁵⁴

Given these ambiguities and tensions between autonomy and patient welfare, the proper standard for involuntary treatment cannot entirely favor one interest over the other. Society already recognizes a justification for involuntary treatment in some situations of danger and incompetence. But those terms are generally so severely defined that they do not justify involuntary treatment for people who are actively and severely psychotic and clearly not reasoning in a normal fashion. Mike Earley is an illustrative example—someone who was so sick that he broke into a house to have a bubble bath and wrapped tinfoil around his head to keep people in the TV from reading his thoughts—and yet his father could not get him committed or involuntarily treated until his father lied about Mike having threatened his father’s life.²⁵⁵ One doctor judged Mike’s competence by such facts as Mike’s ability to name the president of the United States and count backwards by sevens, despite recognizing his “odd” behavior.²⁵⁶ This example also demonstrates the issue of external costs to society when psychotic patients refuse treatment. Such costs are not limited to physical violence and may be of a fundamentally different nature than the costs associated with those who refuse treatment for other types of physical illness.

B. A New Standard: Widening the Safety Net to Match Current Data

The new standard I propose to add to existing involuntary treatment laws is that (1) if a person is suffering from a severe psychotic episode, (2) earnest efforts have been made to convince the patient to voluntarily take medication—including discussion regarding why the patient objects and possible alternatives that could meet those concerns, (3) and medication is in their best medical interest, then (4) involuntary treatment should be allowed at least during the first two years of treated illness (measured from the first date of treatment following a severe psychotic break) or age twenty-seven, whichever is later. I would also require that therapy be offered as a companion to antipsychotic drugs due to the evidence that both

254. SLOBOGIN, *supra* note 252, at 245.

255. See EARLEY, *supra* note 13, at 20–21

256. *Id.* at 14–15, 21–25.

are necessary for optimal outcomes, and I would allow the involuntary medication to continue so long as deemed necessary under the current best medical evidence to provide mental stability. I would also require that the medication be offered under an outpatient program if that is deemed possible—thus the patient could remain in the community so long as he or she continued to comply with the medication and counseling order. If a person were forcibly medicated under this provision, I would also allow an exception to the privacy laws regarding medical records for adult immediate family members or other primary caregivers—so long as they could demonstrate that they have the best interests of the patient in mind and will participate in an approved education program tailored to supporting someone with the patient's condition. A patient could contest that exception and be represented by counsel in doing so.

Why two years and why age twenty-seven? The rationale for twenty-seven years is that psychotic breaks for a disease like schizophrenia peak from eighteen to twenty-five—when the brain is still maturing.²⁵⁷ This period seems to be a crucial one in brain development and manifestation of the disease. Putting the age at twenty-seven would ensure both that patients can be medicated during the crucial period of brain maturation and that all who have their first psychotic break within the peak period will have at least two years of leeway for getting needed treatment when their symptoms become severe. Because treatment in the initial years of illness is so critical to long term prognosis and prevention of irreversible injury—I would allow the two years from whenever a patient first begins being treated for severe psychosis—even if it is after age twenty-seven.

But drawing lines in shifting sand is always difficult. Both the two-year and age-twenty-seven limits may need to be revised as research progresses. For example, given that men tend to develop schizophrenia earlier than women (age 15–24 for men as compared to age 25–34 for women),²⁵⁸ perhaps science will reveal a basis for creating different involuntary treatment standards for the two genders. In the future, science may also be better able to distinguish between the effects of psychosis on the brain as caused by different

257. See Insel, *supra* note 141, at 188.

258. *Schizophrenia*, N.Y. TIMES HEALTH GUIDE, <http://health.nytimes.com/health/guides/disease/schizophrenia/risk-factors.html> (last visited February 5, 2014)

diseases (or different stages of disease) on the psychotic spectrum,²⁵⁹ which might also require creation of multiple involuntary treatment standards or other refinements.

It is important to note that the time limits in the proposed standard are not meant to override other laws that allow for involuntary treatment under different circumstances in various states—for example laws based on dangerousness or an assessment of likely deterioration based on past experience. This standard would simply serve as an additional tool for early intervention.

Why choose these time limits rather than simply adhering to a previously proposed reform that would allow “one free shot” of involuntary treatment for first-time, serious psychoses if medication is likely to be of benefit?²⁶⁰ Professor Elyn Saks stresses that this “one shot” standard would allow a patient to experience the benefits of medication and thus have a fuller understanding of the choice to accept or refuse medication in the future.²⁶¹ Another author supports a similar standard because:

(1) it would soften the trauma of a first episode, assisting families in their attempts to intervene before their loved ones’ lives are in complete disarray and their episodes escalate to the point of violence; (2) it would expand access to early, effective treatment, which gives individuals experiencing their first major episodes the best chance for a healthy long-term prognosis; and (3) it would cut down health care costs paid by government programs.²⁶²

While the “one shot” standard is preferable to the present status of the law, it still overemphasizes immediate autonomy at the expense of both long-term autonomy and patient welfare. It would still allow a clearly psychotic individual whose reasoning capacity is unquestionably affected by illness to refuse medication despite it

259. See *Diagnosis and Interventions*, NAT’L ALLIANCE ON MENTAL ILLNESS, http://www.nami.org/Content/NavigationMenu/First_Episode/Diagnosis_and_Interventions.htm (last visited Aug. 20, 2014).

260. See SAKS, *supra* note 48, at 89–90; Adam G. Gerhardstein, Comment, *A First Episode Standard for Involuntary Treatment*, 10 U. ST. THOMAS L.J. 469. (Gerhardstein’s definition of the standard is different in some minor respects); Winick et al., *supra* note 113, at 99.

261. SAKS, *supra* note 48, at 89–90. Elyn Saks also proposes that, once stabilized by the medications, patients should be free to “self-bind”—commit to whether they want medication forcibly applied in the future if they are in a psychotic state. *Id.* at 91.

262. Gerhardstein, *supra* note 260, at 2.

being in his or her best medical interest—so long as the “one free shot” had been spent. It makes no prolonged exception for the early years of the illness when studies show treatment is vital to long-term outcome and the suicide risk is highest. Indeed, suicide is over three times more likely at the earliest stages of schizophrenia.²⁶³

Autonomy does not lose all weight under the circumstances of severe and active psychoses. Patients experiencing such episodes have not lost their humanity or their consequent need to be valued, heard, and respected. Indeed, the new standard reflects this respect for human dignity and autonomy in requiring that forced medication never be administered absent earnest efforts to first convince a patient to voluntarily comply—including exploring why the patient is resistant and whether there are alternatives that could address those concerns. This provision of the standard is also meant to address the research showing that people who voluntarily comply with treatment tend to respond better than those forcibly treated.²⁶⁴

But the hope that efforts to reason with severely psychotic patients would be adequately successful in convincing the severely mentally ill to continue taking medications that are necessary for their health and ability to function in society is clearly a fallacy. A recent study has shown that “[w]hen patients with schizophrenia discontinue oral antipsychotic therapy soon after initiation, as is common, chances are not good that they will become adherent to the therapy later in their illness.”²⁶⁵ Dr. Bruce J. Wong from the University of Pennsylvania, who presented the study at the 2012 U.S. Psychiatric and Mental Health Congress, explained that “[e]arly noncompliance begets later noncompliance— . . . so if you’re going to manage compliance, manage it early There are many suggestions for fostering compliance in the literature, but none are very successful.”²⁶⁶ Results from the CATIE study show that up to 74 percent of schizophrenic patients discontinue medication soon after initiation.²⁶⁷

263. See Palmer et al., *supra* note 246.

264. See, e.g., SLOBOGIN, *supra* note 252, at 245 (citing Richard Rogers and Christopher Webster, *Assessing Treatability in Mentally Disordered Offenders*, 13 LAW & HUM. BEHAV. 19, 20–21 (1989)).

265. Nancy A. Melville, *Noncompliance With Schizophrenia Therapy Usually Persists*, MEDSCAPE MED. NEWS (Nov. 10, 2012), <http://www.medscape.com/viewarticle/774271>.

266. *Id.*

267. *Id.*

Given these statistics, having the medications administered once forcibly is not likely to adequately address the problem of noncompliance and its effects. In making policies regarding treatment, society cannot ignore the scientific evidence that “recurrent psychotic episodes correlate with brain tissue loss in the frontal, parietal, and temporal lobes, and with worsening treatment response.”²⁶⁸ Couple this with the fact that a person’s judgment is inevitably impaired by severe and active psychosis, and that a symptom of the disease may be to not have insight that one is sick at all, it would seem that patient welfare should outweigh immediate autonomy interests during severe psychosis, at least under some circumstances.

The privacy waiver also protects patient welfare interests. The support a patient receives from family and loved ones can be critical to recovery. Indeed, research has shown that when families receive specialized education and training directed at helping them understand the patient’s illness and how to offer support, outcomes improve for patients on multiple levels.

Published clinical trials have provided consistent evidence on family interventions reducing psychotic relapses, having a positive effect on family relationships and reducing overall costs of care Recent meta-analyses have confirmed that . . . family interventions reduce patients’ relapse rate and hospital admissions, improve patients’ compliance to antipsychotic drug treatments, and improve social impairment²⁶⁹

268. Jeffrey A. Lieberman, *The Case for Early Psychosis Intervention*, 2007 Annual Sessions of the Am. Psychiatric Ass’n, May 22, 2007. See summary: Randall, F. White, *Medscape Perspectives on the 2007 Annual Sessions of the American Psychiatric Association: May 22, 2007*, MEDSCAPE MED. NEWS (May 23, 2007), <http://www.medscape.com/viewarticle/557112>.

269. Tomas, *supra* note 10, at 588; see also M. Giron et al., *Efficacy and Effectiveness of Individual Family Intervention on Social and Clinical Functioning and Family Burden in Severe Schizophrenia: A 2-Year Randomized Controlled Study*, 40 PSYCHOL. MED. 73 (2010), available at <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=6778348> (“Family intervention was associated with fewer clinical relapses, hospitalizations and major incidents, and an improvement in positive and negative symptoms, social role performance, social relations, employment and family burden. . . . Family intervention is effective in severe schizophrenia independently of compliance and prognostic factors.”); Thomas C. Jewell et al., *Partnering With Families: Multiple Family Group Psychoeducation for Schizophrenia*, 65 J. OF CLINICAL PSYCHOLOGY 868 (Aug. 2009), available at <http://onlinelibrary.wiley.com/doi/10.1002/jclp.20610/abstract> (discussing family intervention as an effective means of reducing relapses and rehospitalization, especially when families are trained about the mental disorder and ways to

But privacy laws often act as a barrier to family members or other primary caregivers from understanding what is occurring or how best to help. To account for rare cases where there are malicious intentions in seeking private medical information, I would allow the patient to contest such waivers.

Factors that would protect against unnecessary encroachment on autonomy in this standard include (1) time limits, (2) the fact that the psychotic episode would have to be severe, and (3) that the intervention would have to be in the patient's best medical interest. This latter point would require individualized analysis about the potential effects of specific medications upon the patient at hand, given both the patient's medical history and the current research regarding biomarkers and likely reactions to specific drugs. The patient would have to be given a drug that achieves an appropriate balance between likely effectiveness and potential side effects. If an acceptable balance could not be achieved—if, for example, all available drugs had been tried in the past without effect—then the patient's refusal should be honored.

There are multiple problems this standard addresses that are not met by the "one free shot" method. First, patients often hope and/or believe (rightly or wrongly) that they will not revert to psychosis if they go off their medications. Thus, the fact that patients stop their medication does not necessarily mean that they have decided while in their "right mind" that they do not want medication if the psychosis resurfaces. They may have wanted that help if psychosis recurred—but the psychosis itself may alter the decision they make in the moment of crisis.²⁷⁰ Second, the process of finding an effective

be supportive throughout the recovery process); Insel, *supra* note 141 ("[A]n aggressive focus on cognition along with family support may prove surprisingly effective for preempting or forestalling psychosis.").

270. This brings up the issue of self-binding while mentally stable, which Elyn Saks supports. See SAKS, *supra* note 47, at 91. I do not include such a provision in this standard partly because it would not allow actively psychotic individuals who had self-bound to no medication to change their minds. To not allow a patient to choose what is in the patient's best medical interest at any point seems unconscionable. I understand the logic of respecting the mentally stable choices—especially when the psychotic condition is congruent with incompetency. But given the complexity of the brain and all that science both does and does not understand about what may be affecting a severely mentally ill person's choices, it seems there are insufficient scientific or moral grounds for ever barring medication from a person who clearly needs it and expresses a desire for it. Self-binding in favor of medication (so long as that remains in the patient's best medical interest) would be acceptable as it does not raise the same concerns. This topic may be

drug for a specific patient is currently often a trial-and-error process. Therefore, the fact that a patient is unsatisfied with the effect of one drug does not mean the patient could not find a satisfactory balance between effectiveness and side effects with a different antipsychotic. Third, a patient may be refusing drugs on the irrational and false basis of not believing he or she is sick due to anosognosia. Fourth, if psychotic episodes are permanently damaging the brain in ever increasing proportions, allowing patients to refuse help will be severely limiting the range of freedom to make autonomous choices in the future.

V. OVERCOMING POTENTIAL CONSTITUTIONAL CONCERNS

As explained previously, a constitutional right to refuse has been argued on multiple grounds.²⁷¹ This section will not attempt to address every possible constitutional attack of this proposed standard, but will address some of the principal arguments that could be made. An underlying assumption derived from the scientific evidence previously discussed in this Article is that a psychotic break, in and of itself, does constitute a significant “danger to self” and thus provides at least one of the valid interests in intervention.²⁷² The patient’s “grave disability” or “need for treatment” are arguably other such interests.²⁷³

A. Liberty Interest

As discussed earlier in this Article, the Supreme Court has interpreted the Constitution as protecting a liberty interest in refusing antipsychotic drugs—but that liberty is not absolute. Other interests can override it, and the strength of the liberty interest was influenced

worthy of its own article as advanced directives have increased in popularity across a variety of circumstances.

271. See MELTON et al., *supra* note 29 and accompanying text; see also Mossman, *supra* note 136, at 1129–38 (explaining how courts have held that the First, Fifth, Eighth, and Fourteenth Amendments, along with the Right of Privacy, ensure a right to refuse).

272. See, e.g., *Washington v. Harper*, 494 U.S. 210, 225–26 (1990) (upholding a policy that allowed forced medication in a prison environment if the prisoner was a danger to self or others); *O’Connor v. Donaldson*, 422 U.S. 563, 575 (1975) (identifying dangerousness as one of the key factors in determining whether involuntary commitment is justified).

273. See, e.g., *Harper*, 494 U.S. at 225–26; *Parham v. J.R.*, 442 U.S. 584, 618 (1979) (suggesting that “need for treatment” may be a sufficient interest to overcome liberty interests in the context of minor children institutionalized by their parents or guardians).

by the severity of the possible side effects in *Harper*—a case that was heard before second-generation drugs were widely used.²⁷⁴

An interesting example of a court weighing the side effects in terms of a liberty interest occurred in the case involving Jared Loughner, the man who shot former Representative Giffords, killed six, and wounded twelve others in Tucson in 2011.²⁷⁵ In an order that same year from the Ninth Circuit, reviewing the district court's decision to continue Loughner's involuntarily treatment, the court initially ignored second-generation advances in psychotic drugs.²⁷⁶ It cited *Harper* as authority for the fact that side effects can be fatal, and such side effects were one of the factors that the court relied on in barring involuntary treatment, at least temporarily.²⁷⁷ But a later opinion in the same case allowed involuntary treatment and noted that:

[S]ome of the Court's concerns in *Harper* have been lessened to some extent by significant pharmacological advances. . . . [T]he frequency of tardive dyskinesia is a fifth or one-tenth of what it was before; neuroleptic malignant syndrome is vanishingly rare; extrapyramidal effects (Parkinson-like disorders) that had an incidence rate of 75 [percent] with Haldol occur very rarely, at the same level as with a placebo; and akathisia is also markedly less frequent.²⁷⁸

While the less serious side effects of second-generation antipsychotics and the apparently upcoming advances in personalizing treatment do not eliminate the liberty interest in refusing medication, they do somewhat reduce its gravity. And cases from the Supreme Court have continually made room for the fact that an "overriding justification"²⁷⁹ may overcome a person's liberty interest to refuse medication (even when first-generation drugs are

274. See *Harper*, 494 U.S. 210.

275. Michael Muskal, *Jared Loughner Sentenced to Life in Tucson Mass Shooting*, L.A. TIMES, Nov. 8, 2012, <http://articles.latimes.com/2012/nov/08/nation/la-na-nn-jared-loughner-life-in-prison-20121108>.

276. *United States v. Loughner*, No. 11-10339, 2011 WL 2694294, at *1-2 (9th Cir. July 12, 2011) (order "enjoining the Bureau of Prisons from forcibly medicating Loughner with psychotropic drugs").

277. *Id.* at *1.

278. *United States v. Loughner*, 672 F.3d 731, 745 n.10 (9th Cir. 2012).

279. See, e.g., *Riggins v. Nevada*, 504 U.S. 127, 135 (1992).

involved). “Grave disability,” “need for treatment,” and “danger to self,” whose definitions could all certainly be broadened to include a severe psychotic episode, are arguably among those potentially overriding interests.

B. First Amendment

In his concurrence in *Riggins*, Justice Kennedy explained that the right for an accused to testify in his or her own words is “related to the Fifth Amendment choice to speak [with the] ‘unfettered exercise of his own will.’”²⁸⁰ He expressed concern that “medication of the type here prescribed may be for the very purpose of imposing constraints on the defendant’s own will, and for that reason its legitimacy is put in grave doubt.”²⁸¹

The interests involved in a criminal proceeding and how they should factor into the involuntary treatment debate are beyond the scope of this Article—which looks at involuntary treatment in a more general sense. But while Justice Kennedy and the other Justices did not address the First Amendment directly in that case, the concern expressed above clearly related to how much the drugs were interfering with the free thought processes of the mind that contribute to free speech as well. The First Amendment has been used as the basis for objection to forced medication in other cases.²⁸²

To engage with the question of whether antipsychotics unduly interfere with rights of free speech, free thought, or free will (three rather weighty autonomy interests), one must have some understanding of what antipsychotic medications are doing to the brain. Unfortunately, however, the science is not entirely clear.

The brain contains certain chemicals called neurotransmitters that transmit signals between nerve cells.²⁸³ “All currently approved antipsychotic medications block dopamine receptors.”²⁸⁴ Some also affect the neurotransmitter serotonin.²⁸⁵ Because of “the tight

280. *Id.* at 145 (Kennedy, J., concurring) (quoting *Rock v. Arkansas*, 483 U.S. 44, 53 (1987)).

281. *Id.*

282. *See, e.g.*, *United States v. Gomes*, 289 F.3d 71 (2d Cir. 2002); *United States v. Brandon*, 158 F.3d 947 (6th Cir. 1998); *United States v. Weston*, 36 F. Supp. 2d 7 (D.D.C. 1999); *State v. Adams*, 888 P.2d 1207 (Wash. Ct. App. 1995).

283. *See Mossman, supra* note 135, at 1053.

284. Demjaha et al., *supra* note 166, at 1203.

285. *Schizophrenia, Treatment and Drugs*, MAYO CLINIC, <http://www.mayoclinic.org/diseases-conditions/schizophrenia/basics/treatment/con-20021077> (last visited Sept. 21, 2013).

correlation between the clinical potency and the [specific dopamine receptor]-blocking action” scientists had theorized that “dopamine overactivity could be the common denominator in the psychotic element of schizophrenia.”²⁸⁶

Known as the “dopamine hypothesis,” it became clear with further research that the hypothesis had weaknesses, for some patients failed to respond to treatment despite highly successful blockades of a specific dopamine receptor, and other patients responded well to treatment with a much lower blockade rate.²⁸⁷ The dopamine hypothesis has necessarily been “[r]efined and modified in . . . intervening years” but to this “date remains central to the pathophysiology of schizophrenia.”²⁸⁸ Recent studies suggest that “dopaminergic excess may . . . be an early pathogenic condition leading to irreversible cortical dysfunction.”²⁸⁹

Thus, although scientists have evidence-supported hypotheses as to how these drugs work, and have discovered some of their functions in the brain, it is not yet certain why some people respond well and others do not, nor why a drug like clozapine has superior antipsychotic effect to the other antipsychotic drugs.²⁹⁰

When they are successful, these drugs do eliminate or reduce positive symptoms of schizophrenia such as hallucinations, agitation, and delusions.²⁹¹ Hallucinations and agitation generally recede within days, while delusions generally take several weeks to subside—but there is no absolute rule due to the variety of people’s responses to antipsychotic medications.²⁹²

286. Philip Seeman & Shitij Kapur, *Schizophrenia: More Dopamine, More D2 Receptors*, 97 PROC. NAT’L. ACAD. SCI. U.S.A. 7673, 7673–75 (July 5, 2000), available at <http://bjp.rcpsych.org/content/181/4/271.fullhttp://www.ncbi.nlm.nih.gov/pmc/articles/PMC33999/>.

287. See H. M. Jones and L.S. Pilowsky, *Dopamine and Antipsychotic Drug Action Revisited*, 181 BRITISH J. PSYCHIATRY 271, 271–75 (2002).

288. Rebecca Kuepper et al., *The Dopamine Dysfunction in Psychosis Revisited: New Insights Into Topography and Course*, in 212 CURRENT ANTI-PSYCHOTICS, HANDBOOK OF EXPERIMENTAL PHARMACOLOGY 79 (Gerhard Gross & Mark A. Geyer eds., 2012).

289. *Id.*

290. “Although many attempts have been made to explain clozapine’s superior antipsychotic effect, the [mechanism of action] is still poorly understood.” Magdalena Nord & Lars Farde, *Antipsychotic Occupancy of Dopamine Receptors in Schizophrenia*, 17 CNS NEUROSCIENCE & THERAPEUTICS 97 (Apr. 2011), available at <http://onlinelibrary.wiley.com/doi/10.1111/j.1755-5949.2010.00222.x/full>.

291. NIMH, SCHIZOPHRENIA, *supra* note 25, at 10.

292. *Id.*

Therefore, it is true that antipsychotic drugs change the thought processes of psychotic patients, but they do not, in the words of one court, seize “control of . . . mind and thoughts.”²⁹³ The typical medical view of the issue was explained well by Professor Douglas Mossman:

[P]ersons who are psychotic have severely impaired thinking abilities, and antipsychotic medications can, by reducing this impairment, improve thinking and thereby confer greater freedom of expression on their recipients. . . . Psychosis is itself involuntary mind control of the most extensive kind and itself represents the most severe intrusion on the integrity of the human being. . . . psychotropic medications do not alter a patient’s thoughts about specific political or social issues. Properly administered, they improve a psychotic patient’s ability to think about whatever he wishes. . . . Neuroleptics are to psychosis what eye glasses are to myopia: both interventions remove impediments to perception; neither proscribes particular thoughts or actions, though both may enhance decision making and the ability to respond.²⁹⁴

Although the metaphor of eyeglasses makes an interesting point, it is also illustrative of some chinks in the medical viewpoint. First, eyeglasses carry no risk of dangerous side effects. Second, they are not so intrusive or irreversible as a foreign substance entering the body. And third, while it is true that there is no mind control in terms of specifically implanted thoughts on any particular topic, the drugs do alter the mind by “suppress[ing] psychotic thoughts.”²⁹⁵

However, on the latter point (the one most relevant to the First Amendment argument), I agree with Professor Elyn Saks that the drugs are not “invidiously mind-controlling in any sense of the word[, but] [a]s the drugs improve [or change] . . . we will have to grapple with these issues further.”²⁹⁶ Due to the lack of present or recent progress on the drug front for psychotic diseases like schizophrenia, this analysis remains unchanged.²⁹⁷ The drugs alter

293. *State v. Perry*, 610 So. 2d 746, 747 (La. 1992).

294. Mossman, *supra* note 136, at 1130–31 (quotations and citations omitted).

295. SAKS, *supra* note 48, at 110.

296. *Id.* at 116.

297. *See* Editorial, *supra* note 8.

the mind, but the changes are toward allowing the patient to once again form his or her own more reality-based thoughts. The drugs are thus arguably not destroying autonomy but enhancing it—especially when one considers the implications on freedom to make other choices. A psychotic individual is not nearly as free as a stable-minded one to choose to pursue an education, a job, and meaningful relationships due to the intellectual limitations imposed by the illness.

But if later drugs were shown to encroach too much on the integrity of the personhood of a patient, the “stakes [might] change.”²⁹⁸ Science has in the not-too-distant past been quick to embrace methods that later were deemed far too great an encroachment in just that sense.²⁹⁹ “The ethical problem pivots on how much a state should be able to change its citizens.”³⁰⁰

It is worth noting that the Supreme Court arguably has shown some signs of agreement with the position that the First Amendment is not violated by involuntary administration of antipsychotics. One court explained:

We note that the petitioner in *Sell* claimed that he had a “fundamental, first amendment right to avoid forced medication aimed at changing the way he thinks.” The standard articulated in *Sell* did not, however, require that the trial court consider a defendant’s First Amendment rights in determining whether involuntary medication is proper. The United States Supreme Court, thus, implicitly rejected the petitioner’s claim that an incompetent

298. SAKS, *supra* note 48, at 116.

299. For example, Egas Moniz won the Nobel Prize in 1949 for inventing prefrontal lobotomies, which are now “remembered as one of the most spectacular failures in the history of medicine.” Jenell Johnson, *A Dark History: Memories of Lobotomy in the New Era of Psychosurgery*, 1 MED. STUDIES 367, 367 (2009), available at <http://link.springer.com/article/10.1007%2Fs12376-009-0031-7?LI=true#page-2>. “Lobotomies for mental illness fell out of favor in the 1960s because of the development of effective antipsychotic medications, misuse of the procedure, and a growing unease among doctors with the confusion and stupor that resulted from the operation.” Barron H. Lerner, *When Lobotomy Was Seen as Advanced*, N.Y. TIMES, Dec. 19, 2011, http://www.nytimes.com/2011/12/20/health/report-on-eva-peron-recalls-time-when-lobotomy-was-embraced.html?_r=0.

300. EAGLEMAN, *supra* note 127, at 181–82.

defendant has a First Amendment right to avoid involuntary medication.³⁰¹

C. *Less Intrusive Means*

One of the relevant factors in both *Riggins* and *Sell* was whether “less intrusive means” than forcible administration of antipsychotic drugs were available.³⁰² Have scientific developments produced less intrusive means of treating an illness like schizophrenia? The short answer is “no.” Antipsychotic drugs are still the most effective known means of controlling the positive symptoms of a disease like schizophrenia.

As discussed previously, there has been progress toward developing a more personalized approach to treatment. Dr. Meltzer explains that just as the current cutting edge breakthroughs in cancer research stem from genetic identification of what mutation has caused the cancer and then developing specific therapies, Dr. Meltzer states that science is “just at the threshold” of such developments in treating severe mental illnesses within the Psychotic Spectrum.³⁰³

He and other scholars have been highly critical of the NIMH’s Clinical Antipsychotic Trials of Intervention Effectiveness Study (CATIE) that has periodically released findings beginning in 2005 regarding the treatment of schizophrenia: Dr. Meltzer called the study “miserably designed” for the purposes asserted.³⁰⁴ But he would presumably agree with the study’s lead author that “the medications had significant differences and that the treatment should be individualized.”³⁰⁵ An individualized approach would presumably be less intrusive in that it could be more effective and provide less

301. *State v. Jacobs*, 828 A.2d 587, 589 n.3 (Conn. 2003). *Sell* also recognized that refusals may be overridden if the government interest is sufficiently strong. *Sell v. United States*, 539 U.S. 166, 178–79 (2003).

302. *See Sell*, 539 U.S. at 179; *Riggins v. Nevada*, 504 U.S. 127, 135 (1992).

303. Meltzer, *supra* note 195.

304. *Id.*; *Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE)*, NAT’L INST. MENTAL HEALTH, <http://www.nimh.nih.gov/trials/practical/catie/index.shtml>; *see, e.g., Brakel & Davis, supra* note 83, at 522 (discussing the uselessness of the CATIE study from a legal policy standpoint because of the numerous limitations placed upon the study); Samuel Jan Brakel, *Searching for the Therapy in Therapeutic Jurisprudence*, 33 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 455, 499 n.59 (2007) (expressing the various follies of the CATIE trial including the type of drugs compared, biased influences of drug company funding, and other various shortcomings of the methodology of the trial).

305. Mossman & Steinberg, *supra* note 185, at 294 (citing Jeffrey A. Lieberman, *What the CATIE Study Means for Clinical Practice*, 57 PSYCHIATRIC SERVICES 1075 (2006)).

severe side effects for the patient, but it would still involve the forced administration of antipsychotic drugs.

For non-positive symptoms of schizophrenia, however, there are new discoveries of possibly effective treatments that would be less intrusive than the forced administration of drugs. For example, in February 2012, a study was published showing improvement in reality-monitoring among schizophrenic patients who attended eighty hours of computerized cognitive training.³⁰⁶ “Reality-monitoring is the ability to separate the inner world from outer reality. . . . It is a complex cognitive function that is impaired in schizophrenia.”³⁰⁷

Brain scans also showed that this improvement correlated with increased activity in the medial prefrontal cortex—a region of the brain that supports self-referential cognition. And recovery of activity in that brain region was associated with improved social functioning six months later.³⁰⁸ The study suggests that “the neural impairments in schizophrenia are not immutably fixed but may be amenable to well-designed interventions that target restoration of neural system functioning.”³⁰⁹ These findings “set[] the groundwork for what could be a new treatment approach in psychiatric illness—a new tool we could use in addition to medication, psychotherapeutic approaches or cognitive behavioral approaches.”³¹⁰

Indeed, the NIMH is currently funding a trial at eleven U.S. research centers to evaluate the effectiveness of computer-based treatment of cognitive impairment in schizophrenia for potential

306. Karuna Subramaniam et al., *Computerized Cognitive Training Restores Neural Activity within the Reality Monitoring Network in Schizophrenia*, 73 NEURON 842 (Feb. 2012), available at <http://www.sciencedirect.com/science/article/pii/S0896627312000499>.

307. Karuna Subramaniam, the study’s first author, quoted in Rick Nauert, *Computer Therapy for Schizophrenia*, PSYCHCENTRAL (Mar. 1, 2012), <http://psychcentral.com/news/2012/03/01/computer-therapy-for-schizophrenia/35457.html>.

308. Subramaniam et al., *supra* note 306.

309. Jason Bardi, *Schizophrenia Patients’ Ability to Monitor Reality May Be Helped by Computerized Training: UCSF Study Shows Digital Cognitive Training Improves Brain Function And Behavior for People with Schizophrenia*, UCSF (Feb. 28, 2012), <http://www.ucsf.edu/news/2012/02/11567/schizophrenia-patients-ability-monitor-reality-may-be-helped-computerized> (quoting Sophia Vinogradov, MD, the study’s senior author and professor and interim associate chief of staff for mental health at SFVAMC and interim vice chair of psychiatry at UCSF).

310. *Id.* (quoting Karuna Subramaniam).

FDA approval.³¹¹ Currently there are no FDA-approved treatments for cognitive impairments—a “devastating aspect of the illness.”³¹²

Certainly such treatments would be less intrusive than forced medication, since they do not involve inserting a foreign substance into the body. But these new developments are not entirely helpful to the “less intrusive” analysis for several reasons. The computer-based treatments do not currently address the psychosis, delusions, and hallucinations associated with the positive symptoms of schizophrenia. Therefore, they cannot be viewed as an alternative, but rather an addition to psychotropic medications.

If at some point less intrusive means that could treat the positive symptoms of schizophrenia were discovered or developed, this would be relevant to allowing a patient to choose that form of treatment rather than forced drugging. A patient would likely do so if the concern was the severity of side effects of the drugs (as it often is). But if a patient refused all types of treatment, perhaps either because the patient did not believe or did not want to believe he or she was ill, it would be impossible to force compliance with a method such as computer training. Thus if a court were to decide forced treatment was appropriate, it would presumably have to resort to forced administration of antipsychotics rather than such less intrusive treatments—unless a court order (or threat thereof) convinced the patient to willingly submit to treatment. But as science now stands, there is no alternative to drugs for stemming the positive symptoms of schizophrenia.

Thus, at least in the context of the present scientific model, the standard proposed above should be able to withstand common constitutional challenges.

VI. CONCLUSION

In a perfect world, society would eliminate stigma and find a complete cure without side effects for these severe mental illnesses

311. *FDA to Evaluate Computer-Based Treatment for Cognitive Symptoms in Schizophrenia*, BRAIN & BEHAVIOR RES. FOUND. (June 28, 2012), <http://bbrfoundation.org/brain-matters-discoveries/fda-to-evaluate-computer-based-treatment-for-cognitive-symptoms-in>.

312. *Id.*; see also *Researchers Evaluate Computer-based Treatment for People with Schizophrenia: Study Offers Hope for the Most-Costly Mental Illness in the United States*, DALLAS MORNING NEWS (June 27, 2012), <http://www.mediawebsite.net/danews/story/?catSetID=7007&catID=290937&nrid=160511845&page=1> (quoting Dr. Richard Keefe, stating that “there are no FDA-approved treatments for this devastating aspect of the illness.”).

that patients would gladly take on their own volition. As that prospect looks distant under the current scientific regime, society must strike a balance between autonomy and patient welfare that is not blind to the unique limitations on decision-making for severely mentally ill patients—especially during episodes of active psychosis. And as scientific insights into these diseases accelerate, we must be willing to revise standards to logically reflect that increased understanding. This is one such effort. It, too, should be subject to revision as the science and studies of outcomes continue to progress.