

INVOLUNTARY TREATMENT OF THE MENTALLY ILL: AUTONOMY IS ASKING THE WRONG QUESTION

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INTRODUCTION

During most of 1987, Joyce Brown, a forty-year-old woman who was calling herself Billie Boggs after a television personality she admired, lived next to an air vent on Second Avenue in Manhattan.¹ Such homelessness is, regrettably, far from uncommon in New York City, and if all that Ms. Brown had done was sleep on the streets, she might never have achieved any more notoriety than any of the city's thousands of other homeless people.² Ms. Brown engaged in some additional behaviors, though, such as shouting obscenities at passersby and burning dollar bills.³ These behaviors attracted the attention of city mental health workers, who in October of 1987 took Ms. Brown from her spot on Second Avenue and began the process of committing her to Bellevue Hospital.⁴

Ms. Brown, aided by lawyers from the New York Civil Liberties Union, challenged the commitment, arguing that the state's evidence did not clearly and convincingly demonstrate that she was both mentally ill and a threat to her own or others' safety.⁵ A trial court agreed, denying the

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1. *In re Boggs*, 522 N.Y.S.2d 407, 408 (N.Y. Sup. Ct. 1987); *Boggs v. N.Y. City Health & Hosps. Corp.*, 523 N.Y.S.2d 71, 72 (N.Y. App. Div. 1987).

2. The number of homeless people living in New York City is a matter of some speculation. The city has just recently begun compiling statistics about the city's "street population," amid present concerns that the number of people sleeping on the streets is increasing. Leslie Kaufman & Kevin Flynn, *New York's Homeless, Back Out in the Open*, N.Y. TIMES, Oct. 13, 2002, at A1. More than 30,000 people sleep in the city's shelters on any given night. N.Y. CITY DEP'T OF HOMELESS SERVS., CRITICAL ACTIVITIES REPORT, TOTAL DHS SERVICES-FISCAL YEAR 2002, available at <http://www.nyc.gov/html/dhs/pdf/totalfy02.pdf> (last visited June 8, 2003). Many of these people, whether sleeping on the streets or in shelters, likely suffer from a mental illness. See Martha Minow, *Questioning Our Policies: Judge David L. Bazelon's Legacy for Mental Health Law*, 82 GEO. L.J. 7, 13 (1993) (noting that "studies do indicate that some thirty to forty percent of homeless people have some kind of mental illness").

3. *In re Boggs*, 522 N.Y.S.2d at 408.

4. *Id.*

5. *Id.* at 411-12. The Supreme Court has determined that in civil commitment cases, the Due Process Clause requires at least the "clear and convincing" standard of proof. *Addington v. Texas*, 441 U.S. 418, 432-33 (1979) (holding that a "burden equal to or greater than the 'clear and convincing' standard . . . is required to meet due process guarantees"). The Supreme Court has not, however, held that the Constitution allows involuntary treatment only when a person is a threat to her own or others' safety. Instead, so long as the provisions for commitment bear a reasonable relationship to the purpose for commitment, states have much discretion in determining the substantive standards for civil commitment. See *Jackson v. Indiana*, 406 U.S. 715, 738 (1972) (stating that "the nature and duration of commitment [must] bear some reasonable relation to the purpose for which the individual is

commitment order, and Bellevue eventually sent Ms. Brown back to live on the streets.⁶

In challenging her commitment, Ms. Brown became, for a brief time, a sort of civil liberty celebrity. The national media covered her story,⁷ and after leaving the hospital, she appeared on the *Donahue* television show and delivered a speech at Harvard Law School.⁸ Soon, however, she was back panhandling on Second Avenue; within a year, she was arrested for possession of heroin.⁹

The court that released Ms. Brown from involuntary treatment supported its decision with an appeal to "freedom": "Freedom, constitutionally guaranteed, is the right of all, no less of those who are mentally ill."¹⁰ Other courts have invoked similar concepts, such as "autonomy" and "liberty,"¹¹ in support of similar decisions denying orders of civil commitment.¹²

committed"); see also *Foucha v. Louisiana*, 504 U.S. 71, 119 (1992) (Thomas, J., dissenting) (noting that the Supreme Court "has never applied strict scrutiny to the substance of state laws involving involuntary confinement of the mentally ill"); *O'Connor v. Donaldson*, 422 U.S. 563, 573 (1975) ("[T]here is no reason now to decide whether . . . the State may compulsorily confine a nondangerous, mentally ill individual for the purpose of treatment.").

6. *In re Boggs*, 522 N.Y.S.2d at 412-13. The trial court's decision denying the commitment order was reversed on appeal. *Boggs v. N.Y. City Health & Hosps. Corp.*, 523 N.Y.S.2d 71, 87 (N.Y. App. Div. 1987). Despite this reversal, Bellevue released Ms. Brown when she refused to take psychotropic medications, and a state judge declined to issue an order compelling her to do so. John T. McQuiston, *Joyce Brown Held in Drug Case; Police Seize Heroin and Needles*, N.Y. TIMES, Sept. 8, 1988, at B3. Although Ms. Brown appealed the reversal, the New York Court of Appeals ruled that Ms. Brown's release rendered the appeal moot. *Boggs v. N.Y. City Health & Hosps. Corp.*, 520 N.E.2d 515, 516 (N.Y. 1988).

7. See, e.g., *Civil Liberty?*, WALL ST. J., Mar. 10, 1988, at A19; Margot Hornblower, *Down and Out—but Determined: Does a Mentally Disturbed Woman Have the Right to be Homeless?*, TIME, Nov. 23, 1987, at 29; Howard Kurtz, *Policy of Hospitalizing N.Y. Homeless Set Back: 'Professional' Street Person Ordered Freed*, WASH. POST, Nov. 13, 1987, at A3.

8. *Back on the Street Again*, TIME, Mar. 21, 1988, at 33.

9. McQuiston, *supra* note 6, at B3.

10. *In re Boggs*, 522 N.Y.S.2d at 412. From the record, it is not readily apparent which decision was correct: the trial court's decision denying the commitment or the appellate court's decision reversing the denial. The point of recounting the details of the case here, however, is not to criticize the trial court's decision to deny involuntary treatment but rather to criticize its suggestion that its decision was required by the principle of freedom.

11. While these concepts are similar, they are not exactly synonymous. For a detailed discussion of the relationship among these concepts, see, for example, 3 JOEL FEINBERG, *THE MORAL LIMITS OF THE CRIMINAL LAW: HARM TO SELF* 62-68 (1986) (comparing "the *de jure* as well as *de facto* senses" of autonomy, liberty, and freedom). For purposes of this essay, however, the terms "autonomy," "freedom," and "liberty" are used to mean simply the absence of government-imposed constraints on individual behavior. This seems to be the way those most opposed to involuntary treatment use these concepts. See, e.g., N. Y. Civil Liberties Union, *Legislative Memo: Kendra's Law* (criticizing an outpatient treatment law on the grounds that a person committed under the law "would not have any freedom to decide his or her own medical treatment, and he or she would not be free to conduct his or her live [sic] as he or she chooses"), available at <http://www.nyclu.org/involuntary.html> (last visited Feb. 24, 2003).

12. See, e.g., *In re H.G.*, 632 N.W.2d 458, 462 (N.D. 2001) ("The liberty interest of freedom from bodily restraint is of the highest order."); *In re Commitment of B.L.*, 787 A.2d 928, 938 (N.J.

Framing such decisions as a choice in favor of freedom over civil commitment, however, defines the interests that are at stake in these cases at too high a level of abstraction. Certainly, involuntary treatment can be "a massive curtailment of liberty."¹³ On the other hand, suggesting that "liberty" requires that a mentally ill person be allowed to refuse treatment merely begs the question. To consider an analogous problem from a different area of law, "free speech" is not an answer to the question of whether the First Amendment protects activities such as flag burning or false advertising; an answer requires an explanation of why the Free Speech Clause does or does not protect these activities.¹⁴ Similarly, "autonomy" is not an answer to the question of whether autonomy protects a mentally ill person's choice to refuse treatment. If autonomy does protect the choice to refuse treatment, it must be for a reason.

According to some commentators, the choice to refuse treatment is protected because the Constitution creates a "fundamental right" to refuse treatment,¹⁵ under the "right to privacy" established in *Griswold v. Connecticut* and *Roe v. Wade*.¹⁶ The Supreme Court, however, seems unlikely to embrace this argument.¹⁷ Alternatively, this essay suggests that

Super. Ct. App. Div. 2002) ("Involuntary civil commitment 'effects a great restraint on individual liberty.'" (quoting *In re S.L.*, 462 A.2d 1252, 1256 (N.J. 1983))).

13. *Vitek v. Jones*, 445 U.S. 480, 491 (1980) (quoting *Humphrey v. Cady*, 405 U.S. 504, 509 (1972)). Involuntary treatment can also be a "massive restoration of liberty." Paul F. Stavis, *Foreword, Symposium Issue: First Annual Forum on Mental Illness and the Law*, 11 GEO. MASON U. CIV. RTS. L.J. 1, 7 (2000) ("[F]or a person who is severely mentally ill, psychotically delusional, suitable to benefit from treatment and not competent to consent, refuse or even to seek treatment, then overriding the incompetent objection and rendering treatment should be termed as massive restoration of liberty."). The inherently ambiguous relationship between autonomy and involuntary treatment is discussed further *infra* Part I. A solution is proposed *infra* Part II.

14. See generally *Texas v. Johnson*, 491 U.S. 397 (1989) (explaining why flag burning is protected); *Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n.*, 447 U.S. 557 (1980) (listing criteria for determining when commercial speech is protected).

15. See, e.g., William M. Brooks, *Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs*, 31 IND. L. REV. 937, 993 (1998) (arguing that "it is inconceivable that the right to refuse medication can be characterized in a manner other than fundamental").

16. *Roe v. Wade*, 410 U.S. 113 (1973); *Griswold v. Connecticut*, 381 U.S. 479 (1965). Consistent with this argument, the New Jersey Supreme Court in *In re Quinlan* based its recognition of a right to refuse medical treatment in part on *Griswold* and *Roe*. *In re Quinlan*, 355 A.2d 647, 663 (N.J. 1976), *cert. denied sub nom.*, *Garger v. New Jersey*, 429 U.S. 922 (1976).

17. Recent Supreme Court decisions suggest an unwillingness to expand *Roe's* right to privacy beyond the particular interests already deemed to be protected by this right. For example, in *Washington v. Glucksberg*, the Court held that the right to privacy does not encompass an interest in committing assisted suicide. *Washington v. Glucksberg*, 521 U.S. 702, 728 (1997) (concluding that "the asserted 'right' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause"). In *Bowers v. Hardwick* the Court explicitly acknowledged its reluctance to recognize an ever-expanding right to privacy:

Nor are we inclined to take a more expansive view of our authority to discover

if autonomy does protect the choice to refuse treatment, the reason should be that the benefits, to someone who is mentally ill, of allowing this choice are greater than the benefits of not allowing this choice.¹⁸

The purpose of this essay is not to criticize current civil commitment statutes for allowing the government to administer involuntary treatment to too few people, or too many. Instead, the purpose is only to suggest that when legislatures develop, and when courts apply, statutes governing civil commitment, the interests at stake should be considered not at the abstract level of "freedom" or "autonomy," but rather at the concrete level of the consequences that are likely to result from providing or not providing involuntary treatment. Only by examining the particular interests that are likely to be affected can informed decisions be made about when involuntary treatment is appropriate.

This essay consists of three parts. Part I examines the problems with autonomy-based arguments both for and against involuntary treatment. Part II suggests that because the problems discussed in Part I are unresolvable, a

new fundamental rights imbedded in the Due Process Clause. The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution.

Bowers v. Hardwick, 478 U.S. 186, 194 (1986). Additionally, in *Cruzan v. Director, Missouri Department of Health* the Supreme Court seems to have indicated that it does not consider the interest in refusing medical treatment to be fundamental: "Although many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional right of privacy, we have never so held. We believe this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest." *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 279 n.7 (1990).

Another possible reason that the choice to refuse treatment is protected is the common law principle of informed consent, which allows for the recovery of damages when medical treatment is administered to someone who has not consented to the treatment. See, e.g., *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (noting that "a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages"). Despite this principle, conflicts between the government's need to protect the health and safety of its citizens and an individual's desire to refuse medical treatment are almost always resolved in favor of the government. See *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905) (upholding a compulsory vaccination law and noting, "According to settled principles the police power of a State must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety"); see also *Glucksberg*, 521 U.S. at 742 (Stevens, J., concurring) ("In most cases, the individual's constitutionally protected interest in his or her own physical autonomy, including the right to refuse unwanted medical treatment, will give way to the State's interest in preserving human life.").

18. Civil commitment can be based on either (or both) of two government powers: the police power and the *parens patriae* power. See *infra* notes 77-85 and accompanying text. Police power commitments are justified by the need to prevent harm to others, while *parens patriae* commitments are justified by the need to prevent harm to a mentally ill person himself. See *id.* In proposing that a mental illness might be sufficiently harmful to justify involuntary treatment independent of any additional harm that a mentally ill person might cause to himself or others because of his mental illness, see *infra* Part II, this essay necessarily concerns primarily *parens patriae* commitments.

completely different framework, one that acknowledges the unavoidable non-neutrality of any decision regarding involuntary treatment, would be more helpful to courts in deciding whether to allow such treatment. The framework discussed in this part would allow 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 by involuntary treatment, including the involuntary nature of the treatment. Part III focuses on several problematic issues relating to involuntary treatment, including imminent dangerousness, substituted judgment decision-making, and the least restrictive alternative doctrine. These issues, this part demonstrates, would become somewhat less problematic if the concern of courts was to maximize the overall well-being of those who are mentally ill, rather than to maximize only their autonomy.

I. AUTONOMY AND INVOLUNTARY TREATMENT: A TALE OF TWO ARGUMENTS

A. *The First Argument: Autonomy as Inconsistent with Involuntary Treatment*

Numerous commentators have criticized involuntary treatment as inconsistent with individual autonomy.¹⁹ These criticisms often are supported by grand-sounding proclamations, such as "Autonomous decisionmaking in matters affecting the body and mind is one of the most valued liberties in a civilized society,"²⁰ and "[T]he right to make significant decisions about one's body is rooted in the history and traditions of the American people."²¹

These criticisms usually are not, however, supported by explanations of why, exactly, autonomy is necessarily preferable to involuntary treatment. For example, Stephen Morse devoted an entire article—*A Preference for Liberty*—to a discussion of the harms of involuntary treatment, but failed to compare these harms to the harms of not treating serious mental illnesses.²² Certainly, as Morse indicates, involuntary

19. See, e.g., Brooks, *supra* note 15; Dennis E. Cichon, *The Right to "Just Say No": A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 L.A. L. REV. 283 (1992); Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54 (1982); Robert Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U. L. REV. 461 (1978).

20. Cichon, *supra* note 19, at 284.

21. Brooks, *supra* note 15, at 989.

22. See generally Morse, *supra* note 19. The closest Morse comes to considering the specific

treatment is in many ways undesirable. The real question, though, is whether, for someone who is seriously mentally ill, involuntary treatment is more undesirable than no treatment at all.²³

Some legal philosophers have advanced a more general argument against government actions limiting autonomy, claiming that decisions in favor of autonomy are desirable because they restrain the government from imposing its (majoritarian) values on people who do not share those values. For example, Ronald Dworkin has argued that "to treat all its citizens as free, or as independent, or with equal dignity," "government must be neutral on what might be called the question of the good life."²⁴ Similarly, Bruce Ackerman has proposed that the government may not advocate that "[one citizen's] conception of the good is better than that asserted by any of his fellow citizens."²⁵

harms of untreated mental illness is to propose that "the argument that freedom is illusory for some crazy persons because they lead lives of degradation and misery cannot be proven or quickly proves too much." *Id.* at 95. Morse overlooks, though, that the real harm might not be that the degradation and misery of a mental illness mean that "freedom is illusory"; the real harm might be simply the degradation and misery. For further discussion, see *infra* Part II.

Morse does indicate that "some clearly avoidable harm will come to individuals and to society" if, as he advocates, involuntary treatment is abolished. *Id.* at 57. But because he neglects to explain what this harm would be, his reader must accept his conclusion—that a world in which involuntary treatment is never administered would be a better place than a world in which involuntary treatment is sometimes administered—without being apprised of the specific consequences of not allowing involuntary treatment.

Finally, even Morse seems to waiver in his absolutist stance against involuntary treatment. Although Morse insists that "abolition of involuntary commitment would be a positive contribution to the climate of freedom in our society," *id.* at 98, he nevertheless indicates that "nonprotesting persons may be treated," *id.* at 95. Under ordinary circumstances, however, failing to protest cannot be considered having consented to treatment. According to the American Medical Association, "Informed consent is more than simply getting a patient to sign a written consent form. It is a process of communication between a patient and physician that results in the patient's *authorization or agreement* to undergo a specific medical intervention." AM. MED. ASS'N, INFORMED CONSENT, available at <http://www.ama-assn.org/ama/pub/category/4608.html> (emphasis added) (last visited June 9, 2003). Morse's willingness to risk infringing the autonomy of those who fail to affirmatively protest seems inconsistent with his argument that, as a matter of policy, erring on the side of liberty is always preferable to administering involuntary treatment.

23. See *Rogers v. Okin*, 634 F.2d 650, 660 (1st Cir. 1980) ("[A]ny treatment decision, including the decision not to treat, brings with it the potential for serious harm to the patient.").

24. RONALD DWORKIN, A MATTER OF PRINCIPLE 191 (1985); see also RONALD DWORKIN, TAKING RIGHTS SERIOUSLY 273 (1977) (arguing that the government "must not constrain liberty on the ground that one citizen's conception of the good life of one group is nobler or superior to another's"). The Supreme Court's abortion decisions seem to adopt this position. See, e.g., *Thornburgh v. Am. Coll. of Obstetricians and Gynecologists*, 476 U.S. 747, 777 (1986) (Stevens, J., concurring) ("[N]o individual should be compelled to surrender the freedom to make [reproductive decisions] for herself simply because her 'value preferences' are not shared by the majority."); *Roe v. Wade*, 410 U.S. 113, 162 (1973) (ruling that the state could not "adopt[] one theory of life").

25. BRUCE A. ACKERMAN, SOCIAL JUSTICE IN THE LIBERAL STATE 11 (1980).

This kind of neutrality, however, is not really possible. In deciding which liberties to constrain and which not to constrain, governments necessarily make judgments about the relative values of different conceptions of the good.²⁶ For example, in deciding that people may use deadly force only in response to an immediate threat of serious bodily harm, the government restricts the liberty of a woman who has been severely battered by her husband to kill him while he is asleep, even if she believes that this is the best way to save her own life.²⁷ This restriction implicitly values the life of the husband over the autonomy of the wife. Another example, less defensible in terms of preventing harm to others (one of the more broadly accepted bases for limiting autonomy),²⁸ is a statute requiring that all

26. See Gerald E. Frug, *Why Neutrality?*, 92 YALE L.J. 1591, 1591 (1983) (observing that "no government action can be value neutral"). Those who argue that the government should remain neutral do not believe that government "neutrality" actually achieves a neutral state of affairs but that it achieves a desirable state of affairs. Non-neutrality is unavoidable whether the neutrality at issue is neutrality of rationale, or "justificatory neutrality," or neutrality in fact, or "consequential neutrality." Cf. Will Kymlicka, *Liberal Individualism and Liberal Neutrality*, 99 ETHICS 883, 884 (1989) (distinguishing between "consequential and justificatory neutrality"). Even justificatory neutrality must rest at some point on a non-neutral conception of the good; the claim that neutrality is good is itself a non-neutral claim. As philosopher John Finnis has pointed out, arguments that government neutrality is necessary for avoiding inequality are "self-stultifying":

It is sometimes argued that to prefer, and seek to embody in legislation, some conception or range of conceptions of human flourishing is unjust because it is necessarily to treat with unequal concern and respect those members of the community whose conceptions of human good fall outside the preferred range and whose activities are or may therefore be restricted by the legislation. As an argument warranting opposition to such legislation this argument cannot be justified; it is self-stultifying.

JOHN FINNIS, *NATURAL LAW AND NATURAL RIGHTS* 221 (1980).

27. See, e.g., *State v. Norman*, 378 S.E.2d 8, 9 (N.C. 1989) (holding that "the evidence introduced in this case would not support a finding that the defendant killed her husband due to a reasonable fear of imminent death or great bodily harm, as is required before a defendant is entitled to jury instructions concerning either perfect or imperfect self-defense").

This observation is not meant to suggest that the law should be different. Rather, it indicates only that limiting the use of deadly force in self-defense to situations in which there exists an imminent threat of death or great bodily injury represents a judgment about the value of autonomy as compared to the value of human life. For an argument against allowing a woman who kills her abusive husband to argue self-defense, in the absence of an objective imminent danger, see Martin E. Veinsreideris, Comment, *The Prospective Effects of Modifying Existing Law to Accommodate Preemptive Self-Defense by Battered Women*, 149 U. PA. L. REV. 613 (2000). This example is also not meant to suggest that most or even many battered women who kill do so in the absence of an objective imminent threat of death or great bodily harm. See Holly Maguigan, *Battered Women and Self-Defense: Myths and Misconceptions in Current Reform Proposals*, 140 U. PA. L. REV. 379, 391-97 (1991) (reviewing appellate cases involving battered women who were convicted of homicide in the deaths of their abusers, and concluding that seventy five percent involved the kind of confrontation that would satisfy the typical requirements for self-defense).

28. While few would argue that preventing harm to others is not a valid basis for limiting autonomy, disagreements do exist regarding what counts as harm to others, and whether harm to others is the sole legitimate basis for limiting autonomy. Compare JOHN STUART MILL, *ON LIBERTY* 141

motorcyclists wear helmets.²⁹ The government can perhaps defend such a requirement in terms of the interest in reducing medical expenses.³⁰ Undoubtedly, though, at least part of the motive for enacting such a statute is the judgment that preventing people from being injured in motorcycle accidents is a greater good than allowing people the autonomy to choose not to wear helmets.³¹

Laws that restrict individual autonomy, whether for the purpose of preventing harm to others (e.g., laws limiting the use of deadly force in self-defense) or for the purpose of preventing harm to an individual himself (e.g., laws requiring that motorcyclists wear helmets), unavoidably represent government's ideas about the good life. It is not only in

(Gertrude Himmelfarb ed., Penguin Books 1974) (1859) (suggesting that only injury to the "constituted rights" of others can justify restricting autonomy), with 2 JOEL FEINBERG, *THE MORAL LIMITS OF THE CRIMINAL LAW: OFFENSE TO OTHERS* 5 (1985) (explaining that the law of nuisance recognizes legitimate reasons for restricting liberty to prevent "offense to others," including "unpleasant or uncomfortable experiences—affronts to sense or sensibility, disgust, shock, shame, embarrassment, annoyance, boredom, anger, fear, or humiliation—from which one cannot escape without unreasonable inconvenience or even harm"), and ROBERT P. GEORGE, *MAKING MEN MORAL: CIVIL LIBERTIES AND PUBLIC MORALITY* 71 (1993) ("A concern for social cohesion around a shared morality can justify some instances of the enforcement of morals, but only if that morality is true.").

29. For additional examples of rules that are generally understood to represent value judgments on the part of the government, see Gerald Dworkin, *Paternalism: Some Second Thoughts*, in *PATERNALISM* 105, 108 (Rolf Sartorius ed., 1983) (listing laws "requiring motorcyclists to wear helmets, hunters to wear brightly colored jackets, sailors to carry life-preservers, and drivers to wear seat-belts," as well as laws "preventing people from buying and using various things—bans on Red Dye No. 2, firecrackers, heroin"); David L. Shapiro, *Courts, Legislatures, and Paternalism*, 74 *VA. L. REV.* 519, 522 (1988) (listing "compulsory seatbelt laws, laws prohibiting the possession of drugs or literature considered harmful, and laws regulating or prohibiting conduct between consenting adults"). What seems to be less recognized is that many other rules represent governmental value judgments. For example, laws requiring that children attend school and that drugs be approved by the FDA are intended to prevent people from making decisions that the government considers unwise. These rules also, of course, can promote social utility, but then so might practically everything that promotes individual welfare. Considered broadly enough, any rule can be framed in utilitarian terms: just as citizens who have been educated are better for society, citizens who have not received head injuries in motorcycle accidents, or who are taking medications to alleviate their hallucinations or delusions, are better for society. Additionally, the determination that benefit to society is more valuable than individual autonomy is itself a value judgment.

30. See, e.g., *People v. Kohrig*, 498 N.E.2d 1158, 1166 (Ill. 1986) ("Because of the drain on private and public financial resources caused by highway accidents, society has a legitimate interest in minimizing injuries which result from such accidents.").

31. That this is a value judgment has not been lost on those who believe the opposite, that preventing people from harming themselves in motorcycle accidents is *not* a greater good than allowing people the autonomy to choose not to wear a seatbelt. See, e.g., *Am. Motorcycle Ass'n v. Davids*, 158 N.W.2d 72, 76 (Mich. Ct. App. 1968) (invalidating a compulsory motorcycle helmet statute and noting, "This statute has a relationship to the protection of the individual motorcyclist from himself, but not to the public health, safety and welfare"). However, a decision to not require motorcyclists to wear helmets would not necessarily be any less judgmental, given that it would represent a determination that the autonomy not to wear helmets is a greater good than the avoidance of head injuries. This point is discussed further *infra* note 57.

restricting autonomy, however, but also in allowing autonomy, that government weighs in on the question of what is good in life. Just as every governmental act that in some way restricts individual liberties embodies a judgment about what values are more valuable than autonomy,³² every decision that allows autonomous choices reflects a determination that autonomy is more valuable than a particular restriction of autonomy. A government decision that restricts individual choices is no less neutral than a government decision that allows individual choices.

In general, then, a decision to allow any choice is based on a judgment that allowing the choice is better than not allowing the choice. In the context of civil commitment of those who are mentally ill, a decision to allow the choice to refuse treatment is based on a judgment that not receiving any treatment is better than receiving involuntary treatment. This judgment, however, is at least arguably invalid in some circumstances. The least controversial circumstance in which not receiving any treatment might not be a greater good than receiving involuntary treatment is when the consequence of allowing someone to refuse treatment is that he causes injury to others.³³ Another circumstance is when the consequence of allowing someone to refuse treatment is that he remains isolated in his own confused, delusional world—a world where quite possibly, as Alice said of Wonderland, “everything is nonsense.”³⁴

Consider the case of Russell Weston, for example, charged with killing two Capitol police officers as he attempted to gain access to the secret time machine that would enable him to defeat cannibalistic enemies and stop the spread of a deadly plague.³⁵ Even apart from the immense harm that he

32. Cf. Wesley Newcomb Hohfeld, *Fundamental Legal Conceptions as Applied in Judicial Reasoning*, 26 YALE L.J. 710, 719–20 (1917) (pointing out that the decision to recognize a right precludes the recognition of incompatible liberties).

33. See *supra* note 28. The involuntary treatment of those who are a threat to the safety of others is discussed *infra* notes 77–84 and accompanying text.

34. “If I had a world of my own, everything would be nonsense. Nothing would be what it is because everything would be what it isn’t. And, contrariwise, what it is, it wouldn’t be and what it wouldn’t be, it would.” ALICE IN WONDERLAND (Disney 1951), based on LEWIS CARROLL, ALICE IN WONDERLAND (1865).

35. Judge Tatel of the D.C. Circuit Court of Appeals, quoting Weston’s statements to a government psychiatrist, described in detail Weston’s delusions about the time machine, which Weston calls the “Ruby Satellite System”:

Although the system was originally used infrequently, “those who are now in control are basically cannibals.” They have overused the system and “worn time down to 1/32 of one element of time,” spawning the development and spread of “Black Heva,” a disease similar to HIV or the plague. Black Heva “result[s] from human corpses rotting, turning black, and spreading the most deadliest disease known to mankind.” Black Heva will soon reach “epidemic proportions,” killing thirty-five percent of the people in the United States. System overuse also has

caused to others, the torment Weston himself experienced, because of unreal enemies that he could not recognize as unreal,³⁶ might have been so great as to justify the banishment of those enemies by involuntary treatment.³⁷ The task of courts in civil commitment cases should be to determine when the autonomy to refuse treatment is and when it is not a greater good than involuntary treatment. Decisions in favor of autonomy require justification no less than decisions in favor of involuntary treatment.³⁸

The argument that a decision in favor of autonomy requires justification might seem odd, given the widespread rejection of paternalism as a valid basis for government action.³⁹ But not even John Stuart Mill, whose "harm principle" is perhaps the best-known statement of anti-paternalism,⁴⁰

resulted in "computers not working right, bones being irregularly shaped, telephone poles and electric poles being uneven, buildings leaning, . . . rock structures distorting and swelling, [and] unequal ground swelling and wide spread earthquakes." Users can access the Ruby Satellite System through three different consoles, one of which is on the first floor of the U.S. Capitol and has the capacity to override the entire System. Located in the "great safe of the U.S. Senate," the override console is accessible through a "room that is entered by going in the front of the Capitol and taking a door to the left, next to the elevators." Because "time was running out," Weston had to get to the override console in the Capitol so that he could stem the spread of Black Heva and prevent further calamities.

United States v. Weston, 206 F.3d 9, 19-20 (D.C. Cir. 2000) (Tatel, J., concurring) (alterations in original).

36. Often, people suffering from psychotic symptoms are unable to recognize the symptoms as such. See *infra* note 70 and accompanying text.

37. This argument is developed further *infra* Part II.

38. This is not a constitutional argument; the Constitution generally does not require legislatures to justify their failure to enact statutes limiting individual choices. Among the few affirmative duties created by the Constitution are the duty to hold congressional elections, U.S. CONST. art. I, §§ 2-3, and the duty to dismantle segregated school systems, *Green v. County Sch. Bd. of New Kent County*, 391 U.S. 430, 437-38 (1968) (indicating that school districts have "the affirmative duty to take whatever steps might be necessary to convert to a unitary system in which racial discrimination would be eliminated root and branch"). Cf. *DeShaney v. Winnebago County Dep't of Soc. Servs.*, 489 U.S. 189, 200 (1989) (holding that a state could be held responsible, under the Due Process Clause, for failing to protect a minor child from an abusive parent only if "the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs"). On the other hand, under its *parens patriae* authority, the government has an obligation to care for those who are unable to care for themselves. See *O'Connor v. Donaldson*, 422 U.S. 563, 583 (1975) (noting that "the States are vested with the historic *parens patriae* power, including the duty to protect 'persons under legal disabilities to act for themselves'" (quoting *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 257 (1972))).

39. See, e.g., FEINBERG, *supra* note 11, at 98 (noting "our repugnance for legal paternalism"); Peter Huber, *The Old-New Division in Risk Regulation*, 69 VA. L. REV. 1025, 1103 (1983) (describing paternalism as "un-American"); Shapiro, *supra* note 29, at 519 ("[W]idely shared hostility to paternalism remains strong, if not invincible.").

40. "[T]he only purpose for which power can be rightfully exercised over any member of a

viewed autonomy as an intrinsic good, the pursuit of which needs no justification. Instead, Mill defended his opposition to paternalistic government actions on the grounds that government paternalism harms citizens' "mental development."⁴¹ Thus, Mill seems to have recognized that simply claiming that a government action infringes autonomy is an inadequate argument against the government action.

The argument that a decision in favor of autonomy requires justification is not meant, however, to suggest that some autonomously chosen behaviors, such as voluntarily seeking treatment for a mental illness, are not preferable to government mandated behaviors, such as receiving involuntary treatment.⁴² But civil commitment becomes a necessary option only when the realistic possibilities are involuntary treatment and no treatment at all. If treatment were autonomously chosen, then the government would not need to mandate treatment. The real question is whether, for someone who is seriously mentally ill, involuntary treatment is better than no treatment at all, not whether voluntary treatment is better than involuntary treatment.

civilized community, against his will, is to prevent harm to others." MILL, *supra* note 28, at 68. An argument for autonomy as an intrinsic good would not justify autonomy in terms of its consequences.

41. For example, Mill argued in defense of free speech that:

[I]t is not the minds of heretics that are deteriorated most by the ban The greatest harm done is to those who are not heretics, and whose whole mental development is cramped and their reason cowed by the fear of heresy. . . . No one can be a great thinker who does not recognize that as a thinker it is his first duty to follow his intellect to whatever conclusions it may lead.

Id. at 95; see also JOHN STUART MILL, CONSIDERATIONS ON REPRESENTATIVE GOVERNMENT 25 (Curran V. Shields ed., Bobbs-Merrill Co. 1958) (1848) ("[T]he most important point of excellence which any form of government can possess is to promote the virtue and intelligence of the people themselves.").

It is true that Mill does allude occasionally to an intrinsic value of autonomy; these allusions, though, are the exception rather than the rule. As Joel Feinberg has observed:

If [Mill] had committed himself to (instead of merely flirting with) the principle of unqualified respect for a person's voluntary choice *as such*, even when it is the choice of a loss of freedom, he could have remained adamantly opposed to paternalism even in the most extreme cases of self-harm, for he would then be committed to the view that there is something more important (even) than the avoidance of self-harm.

FEINBERG, *supra* note 11, at 76.

42. Of course, some behaviors are less desirable when they are autonomously chosen. A person who kills while under duress created by an external threat, for example, is less morally (and possibly legally) culpable than someone who makes an autonomous choice to kill. See JOSEPH RAZ, THE MORALITY OF FREEDOM 380 (1986) ("Is the autonomous wrongdoer a morally better person than the non-autonomous wrongdoer? Our intuitions rebel against such a view. It is surely the other way round. The wrongdoing casts a darker shadow on its perpetrator if it is autonomously done by him.").

B. The Second Argument: Autonomy as Requiring Involuntary Treatment

How real is the promise of individual autonomy for a confused person set adrift in a hostile world?⁴³

A different approach to the issue of involuntary treatment proposes that rather than preclude involuntary treatment, concern for autonomy requires involuntary treatment. This approach is based on the premise that autonomy is compromised when choices are made in response to symptoms of a mental illness.⁴⁴ Because symptoms of a mental illness limit autonomy, the treatment of those symptoms results in an increase in autonomy.⁴⁵

Those who generally oppose government decisions limiting autonomy might thus support involuntary treatment when someone's treatment refusal is motivated by the belief, for example, that all psychotropic medications have been poisoned by the CIA.⁴⁶ Consistent with such a position, Mill excepted from his opposition to paternalism those government actions that protect children, or adults who are "delirious, or in some state of excitement or absorption incompatible with the full use of the reflecting faculty."⁴⁷ Mill also proposed that the government may forbid certain choices if the result of those choices would be the loss of autonomy. For example, Mill suggested that the government can refuse to allow the autonomous choice to become a slave because slaves lack autonomy.⁴⁸

43. David L. Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process*, 75 COLUM. L. REV. 897, 907 (1975).

44. See, e.g., Harold I. Schwartz et al., *Autonomy and the Right to Refuse Treatment: Patients' Attitudes After Involuntary Medication*, 39 HOSP. & COMMUNITY PSYCHIATRY 1049, 1054 (1988) (arguing that "[s]trategies for protecting the autonomy of patients who refuse treatment must consider the erosion of autonomy that psychosis produces"); cf. *Addington v. Texas*, 441 U.S. 418, 429 (1979) (observing that "[o]ne who is suffering from a debilitating mental illness and in need of treatment is n[ot] wholly at liberty"); Elyn R. Saks, *Mental Health Law: Three Scholarly Traditions*, 74 S. CAL. L. REV. 295, 300 (2000) ("[I]t is arguable that when a patient is a 'person,' a full moral agent, and therefore competent to make choices, then, and only then, should we support her autonomy.").

45. See Thomas G. Gutheil, *In Search of True Freedom: Drug Refusal, Involuntary Medication, and "Rotting with Your Rights On"*, 137 AM. J. PSYCHIATRY 327, 327 (1980) ("[P]sychosis is itself involuntary mind control of the most extensive kind and itself represents the most severe 'intrusion on the integrity of a human being.' The physician seeks to liberate the patient from the chains of illness; the judge, from the chains of treatment.").

46. Cf. *infra* note 70 and accompanying text (indicating that people sometimes refuse treatment because of their delusions).

47. MILL, *supra* note 28, at 166.

48. Mill's argument was that:

[B]y selling himself for a slave, [a person] abdicates his liberty; he foregoes any future use of it beyond that single act. He therefore defeats, in his own case, the very purpose which is the justification of allowing him to dispose of himself. . . . The principle of freedom cannot require that he should be free not to be free. It is not freedom to be allowed to alienate his freedom.

Accepting Mill's argument, though, requires looking beyond "autonomy" and making a substantive evaluation of what is autonomously chosen.⁴⁹ Slavery is so harmful that governments are justified in preventing their citizens from choosing to become slaves, regardless of whether the choice to become a slave is autonomous.⁵⁰ On the other hand, some choices that result in a loss of autonomy, such as joining a religious order, are permitted by the government because the choices are beneficial.⁵¹ Whether these choices would still be beneficial if not autonomously chosen is a separate question, the answer to which is probably most often "no" but sometimes "yes."⁵² This question, however, is exactly the kind of question that courts should be asking with regard to involuntary treatment: whether, in a particular case, treatment that is not autonomously chosen would nevertheless be sufficiently beneficial to justify such treatment.

Id. at 173. Others have proposed that the government may justifiably limit autonomy regarding "first order choices" for the purpose of promoting autonomy regarding "second order choices." See, e.g., Cass R. Sunstein, *Legal Interference with Private Preferences*, 53 U. CHI. L. REV. 1129, 1140-45 (1986).

49. Cf. Dworkin, *supra* note 29, at 111 ("There is nothing in the idea of autonomy which precludes a person from saying: I want to be the kind of person who acts at the command of others. I define myself as a slave and endorse those attitudes and preferences. My autonomy consists in being a slave."); Anthony T. Kronman, *Paternalism and the Law of Contracts*, 92 YALE L.J. 763, 775 (1983) ("Why does a person's inability to enslave himself increase his self-control rather than diminish it?"); Margaret Jane Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1902 (1987) ("It is hard to see why Mill thought it obvious that the principle of negative freedom could not require the 'freedom not to be free;' only positive freedom clearly holds that a person *must* be free.").

50. See Robin West, *Submission, Choice, and Ethics: A Rejoinder to Judge Posner*, 99 HARV. L. REV. 1449, 1449-50 (1986) (suggesting that most people "believe that there are certain things we simply *should not sell* and that our laws should reflect this ethical prohibition: we should not sell our babies; we should not sell our bodies; we should not sell our sexuality; we should not sell our freedom; and we should not sell our mortal lives"). These prohibitions amount to more than the invalidity of certain contractual agreements. Cf. Kronman, *supra* note 49, at 764 (noting the invalidity of contracts purporting to waive the implied warranty of habitability in residential housing, the right to file for divorce or bankruptcy, or the "cooling off" period allowed for consumer transactions). Selling a person is a crime, even if none of the parties to the transaction ever object.

51. Some scholars have drawn a distinction between our own choices to restrict our autonomy and government actions that restrict our autonomy. See, e.g., Guido Calabresi & A. Douglas Melamed, *Property Rules, Liability Rules, and Inalienability: One View of the Cathedral*, 85 HARV. L. REV. 1089, 1113 (1972) (distinguishing between "self paternalism" and "true paternalism"). However, this distinction does not explain why the government should forbid us from making the self-paternalistic choice to restrict our autonomy by becoming a slave, if we happened to believe that we would be better off in the long run by sacrificing our freedom for whatever benefits we thought we would receive in return, but not forbid us from making the self-paternalistic choice to restrict our autonomy by, for example, joining the priesthood. An explanation requires looking beyond the source of the restriction and evaluating the nature of what is restricted.

52. For example, participating in religious practices is valuable only if the choice to participate is autonomous. See GEORGE, *supra* note 28, at 220 ("Any attempt by government to coerce religious faith and practice, even *true* religious faith and practice, will be futile at best, and is likely to impair people's participation in the good of religion.").

II. A STRAIGHTFORWARDLY PATERNALISTIC APPROACH

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 own powers to describe.⁵³

Whether involuntary treatment is inconsistent with respect for autonomy or is required to promote autonomy is a needlessly complicated and contradictory question. This essay suggests that the first step out of this autonomy conundrum is to recognize that whatever provisions for involuntary treatment a legislature decides to adopt, its decision is likely to be paternalistic.

Just as government neutrality is unattainable,⁵⁴ government paternalism is largely unavoidable.⁵⁵ Once the government asks the question—under what circumstances should a mentally ill person be allowed to refuse treatment, when his mental illness is causing harm to himself but not threatening the safety of others⁵⁶—then the answer cannot help but be paternalistic. The answer, whether it is to allow the choice to refuse treatment in all or some or no circumstances, reflects an inherently paterna-

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

54. See *supra* notes 26–32 and accompanying text.

55. Paternalism could be avoided only if the government adopted a strictly utilitarian approach, and considered only the good of society as a whole in deciding whether to allow involuntary treatment. Cf. JEREMY BENTHAM, AN INTRODUCTION TO THE PRINCIPLES OF MORALS AND LEGISLATION 12 (J.H. Burns & H.L.A. Hart eds., 1982) (1789) (asserting that an action is right to the extent that it promotes the greatest good for the greatest number); JOHN STUART MILL, UTILITARIANISM 24 (15th ed. 1907) (“[T]he happiness which forms the utilitarian standard of what is right in conduct, is not the agent’s own happiness, but that of all concerned.”). Such an approach could allow involuntary treatment of everyone, or not allow involuntary treatment of anyone, or anything in between, depending upon what policy the government determined would produce the greatest social utility. The danger of utilitarianism is that it provides no principled grounds for opposing morally untenable tradeoffs, such as allowing the conviction of an innocent person to increase deterrence or avoid social unrest (or allowing the civil commitment of someone who is disruptive but not mentally ill to promote family harmony). See Leo Katz, *Blackmail and Other Forms of Arm-Twisting*, 141 U. PA. L. REV. 1567, 1586 (1993) (“[A] simple utilitarian account of punishment . . . would permit the punishment of mere innocents for the sake of some utilitarian goal.”); Christopher J. Peters, *Foolish Consistency: On Equality, Integrity, and Justice in Stare Decisis*, 105 YALE L.J. 2031, 2042 n.38 (1996) (“[H]ad Bentham been convinced . . . that punishing innocents would produce utilitarian benefits outweighing its evils, a fortiori his philosophy would have compelled him to support the practice. . . . The logic of Mill’s utilitarianism too would have condoned the punishment of an innocent person to serve the end of greater total happiness . . .”).

56. When a mental illness creates a threat to others’ safety, involuntary treatment can be justified in terms of the government’s police power rather than its *parens patriae* authority (which can justify involuntary treatment when someone who is mentally ill is a threat to his own safety). This distinction is discussed further *infra* notes 95–97 and accompanying text.

listic determination about when the consequences of allowing the choice to refuse treatment are likely to be better than the consequences of not allowing this choice.⁵⁷

Making this determination, of when the consequences of allowing the choice to refuse treatment are likely to be better than the consequences of not allowing this choice, first requires an appreciation of the kinds of mental illnesses that someone who might need involuntary treatment is likely to experience.⁵⁸ Recent movies such as *A Beautiful Mind*,⁵⁹ and

57. The paternalism that exists when a legislature decides, based on its ideas about the best interests of those who are mentally ill, not ever to allow involuntary treatment (or only to allow involuntary treatment to prevent harm to others) is analytically the same as the paternalism that exists when a legislature decides to allow involuntary treatment to prevent harm to mentally ill persons themselves. A decision not to allow involuntary treatment, based on the government's determination of what would be in the best interests of those who are mentally ill, would not restrict liberty (in that it would allow the choice to refuse treatment). Nonetheless, it would be paternalistic because the decision to not restrict liberty would have been based on a substantive assessment of the consequences of not restricting liberty. Thus, paternalism is a function of a government's motive rather than an effect on individual choices. The same government decision can be paternalistic or not, depending upon the reason for the decision. For example, a decision to legalize marijuana because arresting, prosecuting, and punishing marijuana users is costing the government too much money would be a non-paternalistic decision that has the effect of increasing individual choices, whereas the same decision to legalize marijuana because the government has determined that marijuana is not harmful would be a paternalistic decision that has the same effect of increasing individual choices. (This example should not be construed as an argument in favor of legalizing marijuana. For a discussion of the harms of marijuana use, see ROBERT M. JULIEN, *A PRIMER OF DRUG ACTION* 213 (9th ed. 2001) (reporting, for example, "with the exception of the presence of THC in marijuana and nicotine in tobacco, both inhalants are remarkably similar, with marijuana smoke containing more tars and many of the same carcinogenic compounds identified in tobacco smoke").

Further, the observation that any decision, regarding involuntary treatment or anything else, can be paternalistic should demonstrate that allowing involuntary treatment does not necessarily mean that the government lacks equal respect or concern for those who are mentally ill. If the government necessarily treats with unequal respect or concern those who disagree with its decisions, then—given that nothing the government does ever generates unanimous public support—every decision of the government can be criticized for treating someone with a lack of equal respect or concern. What is important is that the government's decisions are correct, not that they are "neutral." Those who disagree with a particular decision might have a legitimate complaint that the decision-making process was flawed, or that the decision itself is wrong, but asserting only that the decision is not neutral is an empty criticism.

58. The best argument against involuntary treatment, or any other government decision involving a judgment about what is in a person's best interest, is that the person himself, and not the government, is in the best position to determine what is in the person's best interest. See Sunstein, *supra* note 48, at 1171 (asserting that the "troublesome nature" of paternalism "stems from the fact that the government is claiming to know better than the individual whether a particular course of action will serve that individual's interests"). While it may be true as a general rule that everyone is the best judge of his own best interests, there are numerous exceptions to this rule. The easiest cases are those in which a person's decision-making capacity is impaired. For example, the government can mandate that we cannot drive while intoxicated, as defined by a certain blood alcohol content, even though we may think that we are not too impaired to drive after a few beers, because intoxication impairs our ability to determine whether we are too impaired to drive. Similarly, the government can mandate that we cannot experiment with cocaine, because by the time we realized that cocaine is extremely addictive, we would

recent headlines such as *Texas Mother Convicted of Murder*,⁶⁰ have drawn our collective attention to the devastation that serious mental illnesses can cause.⁶¹ Not all mental illnesses, however, involve the extreme impairments experienced by John Nash or Andrea Yates. The seriousness of mental disorders recognized by the American Psychiatric Association ranges from the relatively nonserious, in cases of "adjustment disorder," which might amount to little more than an abnormal difficulty coping with such normal stressors as the breakup of a romantic relationship or the loss of a job,⁶² to the life-threateningly serious, in cases of severe mood or psychotic disorders.⁶³

The strongest case for involuntary treatment of course exists when someone is suffering from one of the more serious kinds of mental illnesses. Depression, for example, can be one such illness. Although most people have endured the occasional feelings of sadness that are a normal part of the human experience, the intense despair associated with a major depressive episode can be (literally) intolerable. As William Styron wrote in *Darkness Visible*, which recounts his own experience with the disorder, "the pain of severe depression is quite unimaginable to those who have not suffered it, and it kills in many instances because its anguish can no longer be borne."⁶⁴

already be addicted. And the government can mandate that we cannot refuse treatment for a mental illness if we are so mentally ill that we believe we are not ill at all. More generally, though, when the government adopts any policy that impacts people's choices, the government necessarily makes a determination about what choices would, or would not, be in people's interests.

59. *A BEAUTIFUL MIND* (Universal Studios/Dreamworks Pictures 2001). This movie is based on the biography of Princeton mathematician John Nash, who has been diagnosed with schizophrenia. See generally SYLVIA NASAR, *A BEAUTIFUL MIND* (1998).

60. Paul Duggan, *Texas Mother Convicted of Murder: Verdict Is Swift in Bathtub Drownings*, WASH. POST, Mar. 13, 2002, at A1. Andrea Yates was convicted of first-degree murder for drowning her children. *Id.* She had a history of postpartum depression and had been prescribed Haldol, the same medication used to treat psychotic disorders such as schizophrenia. Charles Krauthammer, *Not Guilty, Insane*, WASH. POST, Mar. 15, 2002, at A23.

61. One commentator wrote:

As a former psychiatrist, I found the film "A Beautiful Mind" brilliant in rendering to people who have never seen psychosis how compelling hallucinations can be. The movie substituted visual hallucinations (which are rare) for auditory hallucinations (which are far more common but less vivid on screen), but the idea is the same: These visions and voices are so powerful that they can be irresistible.

Krauthammer, *supra* note 60, at A23.

62. See AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 679 (4th ed., text revision 2000) [hereinafter DSM-IV-TR] ("The essential feature of an Adjustment Disorder is a psychological response to an identifiable stressor or stressors that results in the development of clinically significant emotional or behavioral symptoms.").

63. See *id.* at 375-76 (listing diagnostic criteria for Major Depressive Disorder); *id.* at 312 (listing diagnostic criteria for Schizophrenia).

64. WILLIAM STYRON, *DARKNESS VISIBLE: A MEMOIR OF MADNESS* 33 (1990).

Perhaps the most serious of all mental illnesses is schizophrenia, which involves impairments in virtually every aspect of psychological functioning.⁶⁵ An editorial in the periodical *Nature* suggested that “[s]chizophrenia is arguably the worst disease affecting mankind, even AIDS not excepted.”⁶⁶ Among the most disturbing features of schizophrenia are psychotic symptoms, such as hallucinations and delusions, which involve a loss of contact with reality.⁶⁷ As with depression, suicide is not uncommon: more than ten percent of people diagnosed with schizophrenia commit suicide, many during young adulthood.⁶⁸

Additionally, because their perceptions of and beliefs about the world do not correspond to reality, people who are experiencing psychotic symptoms are susceptible to serious, even fatal, accidents. Consider one account of the death of a man suffering from schizophrenia, an account that leaves unclear whether his death was an intended or an accidental occurrence:

Robert Lyttle was living the American Dream—a wife, two children, good job, nice house—before mental illness made his life a nightmare. Paranoid schizophrenia made Lyttle hear the devil’s voice talking to him through his television. It made him board up the windows and the doors in his home to protect his wife and children from demons. Lyttle’s fight with schizophrenia ended some time on Thanksgiving, when he lay down beside Interstate 70, just north of Troy, Ill., and died. A coroner’s jury ruled on Wednesday that Lyttle, 46, had died of hypothermia from exposure to the cold.⁶⁹

As if the symptoms of schizophrenia or depression were not bad enough, often a secondary effect of a serious mental illness is the inability

65. “The characteristic symptoms of [S]chizophrenia involve a range of cognitive and emotional dysfunctions that include perception, inferential thinking, language and communication, behavioral monitoring, affect, fluency and productivity of thought and speech, hedonic capacity, volition and drive, and attention.” DSM-IV-TR, *supra* note 62, at 299.

66. *Where Next with Psychiatric Illness?*, NATURE, Nov. 10, 1988, at 95.

67. See GERALD C. DAVISON & JOHN M. NEALE, ABNORMAL PSYCHOLOGY 284–85 (8th ed. 2001) (defining delusions as “beliefs held contrary to reality” and hallucinations as “sensory experiences in the absence of any stimulation from the environment”).

68. Alan Breier, *Introduction: A New Era in the Pharmacotherapy of Psychotic Disorders*, 62 J. CLINICAL PSYCHIATRY 3, 3 (2001) (“Schizophrenia is associated with an alarmingly high suicide rate of 10% that speaks to the forlornness caused by the illness.”); JULIEN, *supra* note 57, at 329 (“Schizophrenia is associated with an increased risk of suicide; approximately 10 to 15 percent of individuals with schizophrenia take their own lives, usually within the first 10 years of developing the disorder.”).

69. Trisha L. Howard, *Man Found Dead on I-70 Battled Illness*, ST. LOUIS POST-DISPATCH, Dec. 13, 2001, at C2.

to recognize delusions and hallucinations, or hopelessness and despair, as symptoms of the illness. Thus, caught in a vicious circle, people might refuse treatment for their illness because their illness prevents them from recognizing that they have an illness:

In the best of circumstances, people who need treatment for psychological disorders will seek it themselves. . . . Many people who have serious psychological problems do not recognize their need for treatment, however, or may refuse treatment for a variety of reasons. For example, a woman with persecutory delusions and hallucinations may fear treatment, believing that doctors are part of the conspiracy against her.⁷⁰

The argument has been made, on behalf of convicted prisoners found incompetent to be executed, that failing to treat a serious mental illness such as schizophrenia amounts to cruel and unusual punishment: “[T]o allow a prisoner to languish with a treatable psychosis would violate the Eighth Amendment”⁷¹ The moral force of this argument is no less applicable to people who have not been convicted of a crime. Allowing someone to remain so severely mentally ill that he boards up his house to keep out demons can be both cruel and unusual. Most of us would (and should) be appalled if a lifeguard stood by while a man was drowning in a lake and did nothing to try to help him. We probably would expect the lifeguard to pull the man from the lake even if he said he *wanted* to drown. Our understanding of normal human nature informs us that drowning is to be avoided. This same understanding ought to inform us that hearing the voice of the devil speaking through the television, for example, is similarly

70. SUSAN NOLEN-HOEKSEMA, *ABNORMAL PSYCHOLOGY* 686–87 (2d ed. 2001). Another leading abnormal psychology text describes the problem this way:

A major problem with *any* kind of treatment for schizophrenia is that many patients with schizophrenia lack insight into their impaired condition and refuse any treatment at all. As they don't believe they have an illness, they don't see the need for professional intervention, particularly when it includes hospitalization or drugs.

DAVISON & NEALE, *supra* note 67, at 304 (citations omitted); see also Trudi Kirk & Donald N. Bersoff, *How Many Procedural Safeguards Does It Take to Get a Psychiatrist to Leave the Lightbulb Unchanged? A Due Process Analysis of the MacArthur Treatment Competence Study*, 2 *PSYCHOL. PUB. POL'Y & L.* 45, 63–64 (1996) (“Persons diagnosed with schizophrenia or depression were less likely to acknowledge the potential benefits of treatment than were medically ill persons who were not diagnosed with mental illness. Neither of these findings is surprising. Denial is a symptom of schizophrenia, and hopelessness is a symptom of depression.”).

71. Brief for the American Psychiatric Association and the American Medical Association as Amici Curiae in Support of Petitioner at 25, *Perry v. Louisiana*, 498 U.S. 38 (1990) (No. 89-5120) (citing *Estelle v. Gamble*, 429 U.S. 97 (1976)).

to be avoided. The idea that being tormented by auditory hallucinations is a choice that the government should protect, in the name of "freedom" or "autonomy," reflects a profound misunderstanding of the nature of serious mental illnesses.

Admittedly, the drowning analogy can be pursued only so far. Involuntary treatment can rescue those afflicted with serious mental illnesses from extreme suffering; it can also, however, cause harms of its own. Some of the harms, such as medication side effects⁷² and the discomforts of hospitalization,⁷³ can result whether treatment is voluntary or involuntary. Treatment that is involuntary can cause additional harms. First, as critics such as the New York Civil Liberties Union have pointed out, receiving involuntary treatment means that someone has been limited in the ability "to decide his or her own medical treatment" and "to conduct his or her [life] as he or she chooses."⁷⁴ Also, involuntary treatment lacks some of the

72. For a discussion of the side effects of traditional antipsychotic drugs, see JULIEN, *supra* note 57, at 340-43 (describing such side effects as akathisia, dystonia, neuroleptic-induced parkinsonism, tardive dyskinesia, sedation, dry mouth, blurred vision, and hypotension); see also *Riggins v. Nevada*, 504 U.S. 127, 137 (1992) (indicating that antipsychotic medications might have made a defendant drowsy or confused); *Washington v. Harper*, 494 U.S. 210, 229-30 (1990) (listing similar side effects). Newer, "atypical" antipsychotics tend to cause fewer, and less severe, side effects. JULIEN, *supra*, at 335 ("The antipsychotic compounds being developed today all have demonstrable antipsychotic efficacy combined with encouragingly low extrapyramidal profiles and a low liability to produce tardive dyskinesia at therapeutic doses."). For a discussion of the side effects of antidepressant drugs, see *id.* at 297 (indicating, for example, that the side effects of Prozac include "anxiety, agitation, and insomnia" as well as "sexual dysfunction").

73. For a discussion of the possible harms of hospitalization, see *Parham v. J.R.*, 442 U.S. 584, 626 (1979) (Brennan, J., concurring in part and dissenting in part) ("Persons incarcerated in mental hospitals are not only deprived of their physical liberty, they are also deprived of friends, family, and community. Institutionalized mental patients must live in unnatural surroundings under the continuous and detailed control of strangers."); cf. *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975) ("[T]he mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution."). While these harms of hospitalization should be acknowledged, and every effort should be made to improve the quality of care administered in hospitals, it should be remembered that the alternative to hospitalization is not necessarily a happy, healthy home (or any home at all). Commenting on the alternatives to involuntary treatment, E. Fuller Torrey has observed that "[s]elf-determination" often means merely that the person has a choice of soup kitchens. The "least restrictive setting" frequently turns out to be a cardboard box, a jail cell, or a terror-filled existence plagued by both real and imaginary enemies." E. FULLER TORREY, *OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS* 11 (1997). See also Morse, *supra* note 19, at 77 (indicating that "commitment often occurs in cases where the person to be committed has no family or friends").

74. N. Y. Civil Liberties Union, *supra* note 11. Most assertions that we all should be free to conduct our lives as each of us chooses are made as if autonomy is an intrinsic good. However, whether the freedom to make choices is good often depends upon what is chosen. For example, when a teenager shaves his head and joins a group that judges others on the basis of race or religion, or a tabloid publishes hurtful although truthful information about a private person, it is difficult to see what is good, in an absolute, inherent sense, about these choices. Autonomy to make such choices might be the practical price that must be paid to ensure the freedom to make good choices. Cf. *N.Y. Times Co. v. Sullivan*, 376 U.S. 254, 271-72 (1964) (allowing that some false speech is protected under the First

therapeutic ingredients of voluntary treatment, such as the acknowledgment of a mental illness and the desire to participate in the treatment of that illness.⁷⁵

Given the magnitude of these harms, only the alleviation of the most severe symptoms of the most serious mental illnesses should justify involuntary treatment.⁷⁶ The magnitude of the harms caused by involuntary treatment should not, however, automatically or necessarily preclude such treatment. Instead, these harms should be among the factors a court considers when deciding whether, for a given person with a particular mental illness, the harms alleviated by involuntary treatment would be greater than the harms caused by involuntary treatment.

III. LOOKING BEYOND AUTONOMY: SOME PROBLEMATIC ISSUES MADE SOMEWHAT LESS PROBLEMATIC

A. *Imminent Danger of Physical Harm as a Precondition for Involuntary Treatment*

Two powers of the government can justify involuntary treatment: the police power and the *parens patriae* power. The police power can justify involuntary treatment when someone is a threat to the safety of others, while the *parens patriae* power can justify involuntary treatment when someone is a threat to his own safety.⁷⁷

Amendment to provide the necessary "breathing space" for free public debate). Tolerating the autonomy to make bad choices, though, is quite different from celebrating any choice, good or bad, simply because the choice is autonomous. See RAZ, *supra* note 42, at 417 ("Autonomous life is valuable only if it is spent in the pursuit of acceptable and valuable projects and relationships.").

75. Cf. Joel Haycock et al., *Mediating the Gap: Thinking about Alternatives to the Current Practice of Civil Commitment*, 20 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 265, 277 (1994) ("The most robust finding in the health care compliance literature is that treatment is enhanced, and compliance increased, when treatment represents a voluntary compact between patient and health care provider.").

76. The harms caused by involuntary treatment must be outweighed by sufficiently significant benefits. This means that involuntary treatment is not justified in cases in which someone might derive some slight or even moderate benefit from involuntary treatment. Thus, the descent down the slippery slope to the involuntary treatment of people who are merely bothersome or eccentric is avoided by allowing involuntary treatment only when the benefits of alleviating the symptoms of the illness are large enough to outweigh the harms of involuntary treatment. Benefit alone is not enough to justify involuntary treatment; the benefit must be so great as to outweigh the harms.

77. See *Addington v. Texas*, 441 U.S. 418, 426 (1979) ("The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill.").

Generally, people who are mentally ill are no more likely than anyone else to cause harm to others.⁷⁸ When a serious mental illness remains untreated, though, the incidence of aggressive and even violent behavior increases.⁷⁹ Several well-publicized tragedies in recent years have involved violent acts committed by people suffering from serious mental illnesses, particularly schizophrenia, after they stopped taking their medications.⁸⁰ For example, Russell Weston shot two police officers in the U.S. Capitol building, to save the world from cannibals;⁸¹ Andrea Yates drowned her five children, to save them from bad mothering;⁸² and, for reasons he could not articulate, Andrew Goldstein pushed Kendra Webdale in front of an oncoming subway train.⁸³ Based on its police power, the government can order (or in the cases of Weston, Yates, and Goldstein, might have ordered) involuntary treatment for the purpose of preventing someone who is mentally ill from causing harm to others.⁸⁴

78. Ken Kress, *An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa*, 85 IOWA L. REV. 1269, 1284 (2000) ("Recent research demonstrates that most individuals with mental illness are slightly less dangerous than the general public.").

79. *Id.* (noting that "a very small percentage of individuals with mental illness who are symptomatic, who are psychotic and perceive some threat to their well-being, or who have at least partly lost control of their actions are substantially more dangerous than the general public"); E. Fuller Torrey, *Violent Behavior by Individuals with Serious Mental Illness*, 45 HOSP. & COMMUNITY PSYCHIATRY 653, 659 (1994) ("The data, then, suggest that individuals with serious mental illnesses are *not* more dangerous than the general population *when they are taking their antipsychotic medication*. When they are not taking their medication, the existing data suggest that some of them are more dangerous.").

80. As one newspaper reported:

It is the most sensational cases of the untreated-turned-violent that make headlines: Russell Weston Jr., ruled incompetent to stand trial for killing two U.S. Capitol police officers; Sergei Babarin, who murdered a man and a woman at a Mormon library in Utah; John Salvi 3d, who shot to death two abortion-clinic workers in Brookline, Mass.; Mark Bechard, judged criminally insane for killing two nuns in Maine, and last month, another New York subway case, Julio Perez, charged with attempted murder for pushing a father of three in front of a rush-hour train, severing the man's legs.

Michael Winerip, *Bedlam on the Streets*, N.Y. TIMES, May 23, 1999, § 6 (Magazine), at 42, 46.

81. *United States v. Weston*, 206 F.3d 9, 11, 19 (D.C. Cir. 2000) (Tatel, J., concurring).

82. Duggan, *supra* note 60, at A12 ("[S]he thought [killing them] was the only thing in the world that could save her children from hellfire and damnation." (second alteration in original) (quoting statement of defense attorney)).

83. Nina Bernstein, *Hospitals Face Lawsuit by Kin of Victim in Subway Push*, N.Y. TIMES, May 25, 1999, at B1.

84. The difficulty, of course, is identifying which untreated mentally ill people will become violent. See, e.g., Randy K. Otto, *On the Ability of Mental Health Professionals to "Predict Dangerousness": A Commentary on Interpretations of the "Dangerousness" Literature*, 18 LAW & PSYCHOL. REV. 43, 63 (1994) (reviewing research regarding predictions of dangerousness, and characterizing the ability of mental health professionals to predict dangerousness as "better than chance").

In addition to its interest in preventing people who are mentally ill from causing harm to others, the government also has an interest in preventing people who are mentally ill from causing harm to themselves. As the Supreme Court has said, "the States are vested with the historic *parens patriae* power, including the duty to protect 'persons under legal disabilities to act for themselves.'"⁸⁵ Based on its *parens patriae* power, the government can order involuntary treatment to prevent a mentally ill person from causing harm to himself.

Usually, the kinds of harm that justify involuntary treatment are limited in two ways. First, in most jurisdictions, involuntary treatment is justified only if the harm is imminent.⁸⁶ The harm may be virtually certain to occur, but unless it is about to occur *now*, it does not justify involuntary treatment. Thus, someone who has stopped taking his medications one hundred times in the past, and every time has deteriorated so significantly that he is unable to meet his basic needs for food and shelter,⁸⁷ cannot be administered

85. *O'Connor v. Donaldson*, 422 U.S. 563, 583 (1975) (quoting *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 257 (1972)). The Court discussed this issue in detail in *Hawaii v. Standard Oil Co.*:

The concept of *parens patriae* is derived from the English constitutional system. As the system developed from its feudal beginnings, the King retained certain duties and powers, which were referred to as the "royal prerogative." These powers and duties were said to be exercised by the King in his capacity as "father of the country." Traditionally, the term was used to refer to the King's power as guardian of persons under legal disabilities to act for themselves. For example, Blackstone refers to the sovereign or his representative as "the general guardian of all infants, idiots, and lunatics," and as the superintendent of "all charitable uses in the kingdom." In the United States, the "royal prerogative" and the "*parens patriae*" function of the King passed to the States.

Standard Oil Co., 405 U.S. at 257 (citations and footnotes omitted); see also *Addington*, 441 U.S. at 426 (identifying a legitimate state interest under *parens patriae* power in caring for people who are unable to care for themselves); *Steele v. Hamilton County Cmty. Mental Health Bd.*, 736 N.E.2d 10, 18-19 (Ohio 2000) ("A second state interest [in addition to the police power] recognized by many courts to be sufficiently compelling to override a mentally ill patient's decision to refuse antipsychotic medication is the state's *parens patriae* power. Today, we too adopt the view that the state's *parens patriae* power can override a mentally ill patient's decision to refuse antipsychotic medication." (citations omitted)).

86. See, e.g., *Patten v. Nichols*, 274 F.3d 829, 840 (4th Cir. 2001) ("A person may be involuntarily committed in Virginia if there is probable cause to believe that the person 'presents an imminent danger to self or others as a result of mental illness, or is so seriously mentally ill as to be substantially unable to care for self,' and the person 'is incapable of volunteering or unwilling to volunteer for treatment.'" (quoting VA. CODE ANN. § 37.1-67.01)); *Büchte v. State*, 990 S.W.2d 539, 542 (Ark. 1999) (noting that under Arkansas law, the court must find probable cause to believe that "imminent danger of death or serious bodily harm" exists to justify involuntary commitment).

87. People who, because of a mental illness, are unable to provide for their own basic physical needs are usually said to be "gravely disabled." For example, the Supreme Court indicated in *Washington v. Harper* that under Washington law:

"Gravely disabled" means "a condition in which a person, as a result of a mental disorder: (a) [i]s in danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety, or (b) manifests severe

involuntary treatment immediately after he has stopped taking his medications for the one hundred and first time, but only *after* he has deteriorated for the one hundred and first time.⁸⁸ Second, in many jurisdictions, involuntary treatment is justified only if the harm is physical.⁸⁹ The emotional pain caused by a mental illness, although just as real as the pain caused by a physical injury, does not justify involuntary treatment.⁹⁰

On one hand, these limitations make sense as attempts to minimize the risk that someone will be committed to involuntary treatment who is not really in need of such treatment. Determining that someone will cause harm next week generally involves more speculation than determining that someone will cause harm in the next few hours. Similarly, assessing the severity of emotional harm is a more subjective task than assessing the severity of physical harm; the harm caused by not eating can be observed directly and quantified objectively, whereas the harm caused by hearing the voice of the devil speaking through the television cannot.

A better means for reducing the risk of erroneous commitments than these substantive limitations, however, would be the adoption of strict procedural rules.⁹¹ The Supreme Court has already held that the Due

deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety."

Washington v. Harper, 494 U.S. 210, 215 n.3 (1990) (alteration in original) (quoting WASH. REV. CODE § 71.05.020(1) (1987)); see also *O'Connor*, 422 U.S. at 574 n.9 (noting that "even if there is no foreseeable risk of self-injury or suicide, a person is literally 'dangerous to himself' if for physical or other reasons he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends"). For example, a California appellate court recently upheld the trial court's determination that a person, diagnosed with a mental illness, was gravely disabled because his deteriorating condition would lead to "assaults, walking in front of automobiles, refusing to leave his room or refusing to eat." Conservatorship of Guerrero, 81 Cal. Rptr.2d 541, 542 (Cal. Ct. App. 1999).

88. Some states have enacted "preventive commitment" statutes to address this problem. See, e.g., HAW. REV. STAT. § 334-121(4) (1993) (allowing involuntary outpatient treatment when a mentally ill person, "based on the person's treatment history and current behavior, is now in need of treatment in order to prevent a relapse or deterioration which would predictably result in the person becoming imminently dangerous to self or others").

89. See, e.g., IDAHO CODE § 66-317(k) (Michie Supp. 2002) (requiring a "substantial risk that physical harm will be inflicted by the proposed patient"); MISS. CODE ANN. § 41-21-61(e) (1972) (requiring "a substantial likelihood of physical harm to []self or others").

90. Some states have enacted "need for treatment" statutes to address this problem. See, e.g., TEX. HEALTH & SAFETY CODE ANN. § 574.034 (Vernon Supp. 2003) (listing as one of the criteria for involuntary treatment that a mentally ill person "will, if not treated, continue to . . . suffer severe and abnormal mental, emotional, or physical distress").

91. Cf. *Parham v. J. R.*, 442 U.S. 584, 606-07 (1979) (discussing procedures necessary for avoiding erroneous admissions of children by parental decision to state hospitals); *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976) (specifying factors to be considered in determining what procedures are required by the Due Process Clause).

Process Clause requires at least the clear and convincing standard of proof, "to reduce the chances that inappropriate commitments will be ordered."⁹² States are free to enact laws requiring greater procedural protections than those required by the Constitution, and thus a state could adopt the proof beyond a reasonable doubt standard.⁹³ Additional procedural protections are possible. For example, the decision to allow involuntary treatment could be made by a neutral party such as a judge or jury, rather than by a doctor who might have a personal investment in whether treatment is administered.⁹⁴ Also, commitment orders could provide for frequent review. Continuing to rely on substantive rules to reduce the risk of erroneous commitments means that those who are so depressed or delusional that they do not recognize their need for treatment, yet who are not an imminent threat to their own or others' physical safety, will continue to be denied any kind of treatment.

B. Parens Patriae and Surrogate Decisionmaking: Best Interests or Substituted Judgment?

Although courts generally consider the *parens patriae* power to be the source of the government's authority to compel treatment when someone is a danger to himself,⁹⁵ some courts have justified the involuntary treatment of someone who is a danger to himself in terms of the government's police power, rather than *parens patriae* authority. For example, in *Rivers v. Katz*, the New York Court of Appeals held that "[w]here the patient presents a danger to himself . . . the State may be warranted, in the exercise of its police power, in administering antipsychotic medication over the patient's objections."⁹⁶

When a court has determined that a person is unable to make treatment decisions for himself, whether the government's ability to order involuntary treatment is based on its police power or *parens patriae* power may make

92. *Addington*, 441 U.S. at 427.

93. See *Rogers v. Okin*, 634 F.2d 650, 659 n.6 (1st Cir. 1980) (indicating that "the federal Constitution does not mandate a reasonable doubt standard for commitment proceedings, yet Massachusetts employs such a standard" (citation omitted)).

94. The desirability of an adversarial-like hearing has been debated. Compare generally Paul S. Appelbaum, *Paternalism and the Role of the Mental Health Lawyer*, 34 HOSP. & COMMUNITY PSYCHIATRY 211 (1983) (proposing a nonadversarial role for attorneys in civil commitment proceedings), with Note, *The Role of Counsel in the Civil Commitment Process: A Theoretical Framework*, 84 YALE L.J. 1540 (1975) (supporting an adversarial role for attorneys in civil commitment proceedings). The point here is not to advocate for any specific kind of procedure, but only to indicate that procedures can be adopted that can minimize the risk of erroneous commitments.

95. See *supra* note 77 and accompanying text.

96. *Rivers v. Katz*, 495 N.E.2d 337, 343 (N.Y. 1986) (footnote and citations omitted).

little difference. In other cases, though, when a person is competent to make treatment decisions, courts have held that only the police power can justify involuntary treatment:

[T]he *sine qua non* for the state's use of its *parens patriae* power as justification for the forceful administration of mind-affecting drugs is a determination that the individual to whom the drugs are to be administered lacks the capacity to decide for himself whether he should take the drugs.⁹⁷

Competency to make treatment decisions is by no means a self-defining concept, however, and thus it is not surprising that different jurisdictions have adopted different tests for determining whether someone is competent to make treatment decisions for himself.⁹⁸ The more minimal tests of competency, or the tests that identify the greatest number of people as competent to make treatment decisions, require only the "actual communication of a decision."⁹⁹ These tests look only at a person's ability to express a decision, and ignore any irrationality of the thought process that produced the decision. More stringent tests require not only that the individual express a choice, but also that the individual's reasoning process be rational.¹⁰⁰

Interestingly, and indicative of the unhelpfulness of the concept of autonomy as a basis for determining when to allow involuntary treatment, both ends of the competency-test spectrum can be defended in terms of autonomy. Those who favor a stringent test of competency can argue that autonomous decisions require competence, and thus finding mentally ill people incompetent to make decisions regarding their medical treatment prevents them from making decisions that are not autonomous. Those who favor a more relaxed test can claim that in choosing whether to accept or refuse treatment, mentally ill people are making autonomous decisions.

97. *Rogers*, 634 F.2d at 657; cf. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990) ("The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.").

98. For a discussion of various competency tests, see RALPH REISNER ET AL., *LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS* 851-59 (3d ed. 1999).

99. Paul S. Appelbaum & Loren H. Roth, *Competency to Consent to Research: A Psychiatric Overview*, 39 ARCH. GEN. PSYCHIATRY 951, 952 (1982), quoted in REISNER ET AL., *supra* note 98, at 851; see also Robert D. Miller, *The Continuum of Coercion: Constitutional and Clinical Considerations in the Treatment of Mentally Disordered Persons*, 74 DENV. U. L. REV. 1169, 1198-99 (1997) (discussing different definitions of competence to make treatment decisions).

100. REISNER ET AL., *supra* note 98, at 855 (referring to a standard suggested by Duncan Kennedy, *Distributive and Paternalistic Motives in Contract and Tort Law, with Special Reference to Compulsory Terms and Unequal Bargaining Power*, 41 MD. L. REV. 563, 642-46 (1982)).

The malleability of the concept of competency has prompted some writers to express doubt that any standard can be developed that will reliably separate those who are capable of making a rational, informed, autonomous choice from those who are not capable of making such a choice. One study of the various tests of competency concluded:

The search for a single test of competency is a search for a Holy Grail. . . . In practice, judgments of competency go beyond semantics or straightforward applications of legal rules; such judgments reflect social considerations and societal biases as much as they reflect matters of law and medicine.¹⁰¹

Despite these conceptual difficulties, the government must—unless everyone, no matter how cognitively impaired, is to be allowed to refuse (or request) medical treatment—establish a standard for determining whether someone is competent to make his own treatment decisions. The government must then also establish a standard for determining how to make treatment decisions on behalf of those people who are found incompetent to make such decisions for themselves.

Courts generally follow one of two approaches to this kind of surrogate decision-making. The first approach attempts to advance the best interests of someone who is incapable of making a rational choice about what is in his best interest. Thus, one judge defined the *parens patriae* authority as the “power to act on behalf of an individual who does not have the mental capacity to act in his own best interests.”¹⁰² Other courts have adopted a “substituted judgment” standard rather than a “best interests” standard when someone is incompetent to make treatment decisions. These courts consider their role under the *parens patriae* power to “mak[e] treatment decisions as the individual himself would were he competent to do so.”¹⁰³

Although the substituted judgment standard has been proclaimed necessary for promoting autonomy,¹⁰⁴ several problems exist with this

101. Loren Roth et al., *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279, 283 (1977).

102. *Rennie v. Klein*, 653 F.2d 836, 856 (3d Cir. 1981) (Garth, J., concurring); accord *Rivers v. Katz*, 495 N.E.2d 337, 344 (N.Y. 1986) (indicating that if a person is not competent to make his own treatment decisions, the court must decide whether to administer medications based on “all relevant circumstances, including the patient’s best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments”).

103. *Rogers*, 634 F.2d at 661.

104. See, e.g., *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 431 (Mass. 1977) (“The ‘substituted judgment’ standard which we have described commends itself simply because of its straightforward respect for the integrity and autonomy of the individual.”); *In re Quinlan*, 355 A.2d 647, 664 (N.J. 1976), cert. denied sub nom., *Garger v. New Jersey*, 429 U.S. 922 (1976) (“The

argument. The first and most practical problem is the difficulty of determining, with any reasonable degree of certainty, what a mentally ill person would want, if he were not so mentally ill as to be unable to decide what he wants. In the most extreme cases, "[a]sking what such patients would decide is like asking, as one court put it, '[I]f it snowed all summer would it then be winter?'"¹⁰⁵

An additional, more theoretical problem is that a very tenuous thread connects the substituted judgment standard and autonomous decision-making. Regardless of whether, in a particular case, a court's substituted judgment is in fact the same as an incompetent person's actual judgment would have been were he competent to make a judgment, the real decision-maker is not the person who is incompetent but the court. The court might choose what the person who is incompetent would have chosen, but this is fortuity, not autonomy.¹⁰⁶

Finally, even if the substituted judgment standard were a theoretically and practically sound way for a court to advance the autonomy of someone who is incompetent to make treatment decisions, such a decision in favor of autonomy, albeit a "substituted autonomy," would still require justification. That the government *could* advance individual autonomy by following the substituted judgment standard does not necessarily mean that the government *should* follow the substituted judgment standard. As one commentator has asked, with respect to advance medical directives, why should autonomy automatically be valued above other values:

[W]hat happens when adherence to the patient's prior choice requires others to impose significant harm on her? If heeding a patient's former instructions would harm her in her current state, why must others act as her autonomy automatons? Why shouldn't mercy and compassion enter into the moral calculus in determining what should be done?¹⁰⁷

only practical way to prevent destruction of the right [to privacy] is to permit the guardian and family of Karen to render their best judgment . . . as to whether she would exercise it in these circumstances.").

105. Rebecca Dresser, *Missing Persons: Legal Perceptions of Incompetent Patients*, 46 RUTGERS L. REV. 609, 622 (1994) (quoting *In re Storar*, 420 N.E.2d 64, 73 (N.Y. 1981) (second alteration in original)).

106. See Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857, 879 (1992) ("The right of autonomy is the right to have your own choices respected, not to have someone else make the choice he believes you would (or should) have made.").

107. Dresser, *supra* note 105, at 633; see also Kadish, *supra* note 106, at 876-77 ("[I]f the ultimate value of autonomy is its intrinsic value, then one may without embarrassment make the equivalent claim for compassion.").

The same can be asked with respect to the refusal of treatment for a mental illness. Why is promoting autonomy necessarily a greater good than restoring competency, for example, or diminishing psychosis, or alleviating despair? In deciding to refuse treatment on behalf of an incompetent mentally ill person, a court is in effect deciding that it is better for him that he remains mentally ill and incompetent than that he is administered treatment he would not want. The substituted judgment standard does not magically transfer responsibility for a decision, either to allow or not allow the choice to refuse treatment, from the court that made the decision to the person on whose behalf the decision was made.

Further, in choosing as a matter of policy always to apply the substituted judgment standard rather than the best interests standard, a court, or a legislature, is implicitly deciding that in most cases, the overall benefits of the substituted judgment standard are greater than the overall benefits of the best interests standard. However, even if the substituted judgment standard does produce the most desirable result in most cases, the most desirable result could be achieved in even more cases by adopting an approach that explicitly considers whether the harms of allowing a mental illness to remain untreated would be greater than the harms of providing involuntary treatment. The best interests standard does not preclude a court from deciding that in some cases, a substituted judgment is what would be best.¹⁰⁸ On the other hand, the substituted judgment standard does preclude a court from considering anything other than what it thinks someone who is incompetent to make treatment decisions would want, if he were competent to make such decisions. The substituted judgment standard is in effect a heuristic for best interests. Heuristics are often helpful, especially when efficiency is important and accuracy can be sacrificed.¹⁰⁹ In deciding whether to allow involuntary treatment, however, given the magnitude of the interests at stake, a case-by-case determination of best interests would be more appropriate.

C. *The Least Restrictive Alternative*

Although the Supreme Court has never ruled on this issue, many other courts have held that when involuntary treatment is administered, it must be

108. Cf. Kadish, *supra* note 106, at 883 (arguing that "a helpful reorientation of the substituted-judgment standard . . . properly identifies the reason for consulting the patient's inferred preferences: not because it serves his autonomy, but because it furthers his best interests, on the view that making a treatment decision truest to the kind of person he was informs a best-interests judgment").

109. See HENRY GLEITMAN, *PSYCHOLOGY* 305 (4th ed. 1995) (defining heuristics as "strategies that buy efficiency at the cost of possible error").

the "least restrictive" means for advancing the government's interest in preventing a mentally ill person from harming himself or others.¹¹⁰ Further, many courts have indicated that they, or the legislatures whose statutes they are interpreting, consider involuntary hospitalization to be less restrictive than involuntary medications.¹¹¹ The result is that when someone is in need of involuntary treatment for a mental illness, a court might well allow involuntary hospitalization before it allows involuntary medication.¹¹²

110. See *Rennie v. Klein*, 653 F.2d 836, 846-47 (3d Cir. 1981) ("It appears that at least thirty-five jurisdictions explicitly or implicitly acknowledge the least restrictive doctrine in their statutes as applicable to treatment or involuntary commitment."); *DAVISON & NEALE*, *supra* note 67, at 547 ("In general terms, mental health professionals have to provide the treatment that restricts the patient's liberty to the least possible degree while remaining workable.")

111. In many jurisdictions, involuntary medication requires additional justification beyond the justification required for involuntary hospitalization. See, e.g., *Bee v. Greaves*, 744 F.2d 1387, 1396 (10th Cir. 1984) ("[L]ess restrictive alternatives, such as segregation . . . should be ruled out before resorting to psychotropic drugs."); *Rennie*, 653 F.2d at 844 ("[T]here is a difference of constitutional significance between simple involuntary confinement to a mental institution and commitment combined with enforced administration of antipsychotic drugs."); *Rogers*, 634 F.2d at 656 ("[R]easonable alternatives to the administration of antipsychotics must be ruled out."); *In re Orr*, 531 N.E.2d 64, 73 (Ill. App. Ct. 1988) ("[T]he trial court both exceeded statutory authority and failed to consider important factors and alternatives when it issued the order authorizing the State to forcibly medicate a person found subject to involuntary admission [to a mental health facility]."); *Rivers v. Katz*, 495 N.E.2d 337, 342-43 (N.Y. 1986) (rejecting "any argument that involuntarily committed patients lose their liberty interest in avoiding the unwanted administration of antipsychotic medication"); *Rogers v. Comm'r of the Dep't of Mental Health*, 458 N.E.2d 308, 312-15 (Mass. 1983) (distinguishing criteria for involuntary hospitalization from criteria for involuntary medication); see also *DAVISON & NEALE*, *supra* note 67, at 551 ("Although there is inconsistency across jurisdictions and the forensic picture is still developing, there is a trend toward granting even involuntarily committed patients certain rights to refuse psychoactive medication, based on the constitutional protections of freedom from physical invasion, freedom of thought, and the right to privacy.")

112. Until relatively recently, the only way to treat someone who, because of a serious mental illness, was likely to harm himself or others was to confine him to an "asylum." Many of these so-called asylums, however, resembled jails more than sanctuaries. *LAUREN B. ALLOY ET AL., ABNORMAL PSYCHOLOGY* 15-16 (7th ed. 1996) ("The practice of hospitalizing the psychologically disturbed is a very old one. . . . Most of these institutions were opened with the best of intentions, but the conditions in which their patients lived were often terrible.")

In the 1950s, researchers began to develop medications that were effective in alleviating some of the symptoms of the most debilitating mental illnesses, particularly schizophrenia. *DAVISON & NEALE*, *supra* note 67, at 304-05. Although these medications can be effective in treating some of the most serious symptoms of a mental illness, they cannot cure these illnesses the way penicillin can cure an infection; rather, they can control the symptoms the way insulin can control diabetes. See *id.* at 305 (noting that antipsychotic medications are "not a cure" for schizophrenia).

The development of these medications meant that people who otherwise probably would have spent their lives in institutions could be treated in the community. *ALLOY ET AL.*, *supra*, at 18-19 ("Patients who previously might have been locked away for long periods now moved to open wards or halfway houses, or into the community itself."). Communities, however, have largely failed to provide adequate care, resulting in a sort of revolving-door system whereby people are admitted to a psychiatric hospital, treated with psychotropic medications, and promptly released, only to stop taking their medications and then again require hospitalization. See *Kress*, *supra* note 78, at 1273 n.14 ("The term 'revolving-door' consumer is employed in the law and mental health literature to refer to those

Despite courts' greater willingness to allow involuntary hospitalization, deciding in the abstract which treatment is least restrictive can be difficult if not impossible. For people with major depression, hospitalization is probably the preferred involuntary treatment, when such treatment is necessary, not because it is less restrictive than medications but because antidepressant medications take three to six weeks to begin working.¹¹³ Further, alternative treatments, such as cognitive therapy, are sometimes as effective as medications in alleviating the symptoms of depression, and can be more effective than medications in preventing a recurrence of the disorder.¹¹⁴

Determining the preferred involuntary treatment for other disorders, such as schizophrenia, is more complicated. Unlike antidepressant medications, antipsychotic medications can be effective immediately,¹¹⁵ and usually are the only treatment that will alleviate psychotic symptoms.¹¹⁶ These medications have important drawbacks, however, including the risk of serious side effects.¹¹⁷ Further, medications are not the only way to prevent someone who is experiencing psychotic symptoms from physically harming himself or others; alternatives include not only hospitalization but

consumers of mental health services who are continuously in and out of inpatient psychiatric wards."); see also Samuel Jan Brakel, *Involuntary Institutionalization*, in SAMUEL JAN BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* 21, 31 (3d ed. 1985) ("[T]he ideal of community treatment has resulted in the abandonment of many mentally disabled persons to virtually unsupervised, unprotected lives in flophouses located in dangerous or delapidated [sic] areas or even in 'psychiatric ghettos' that have sprung up in some of our larger cities."); TORREY, *supra* note 73, at 11 ("For a substantial minority, however, deinstitutionalization has been a psychiatric *Titanic*.").

113. JULIEN, *supra* note 57, at 287.

114. See ALLOY ET AL., *supra* note 112, at 505, 509-10 (discussing studies that have found cognitive therapy as effective as drug treatment).

115. JULIEN, *supra* note 57, at 341 ("[C]hlorpromazine decreases paranoia, fear, hostility, and agitation In addition, chlorpromazine dramatically relieves the agitation, restlessness, and hyperactivity associated with an acute schizophrenic attack. The delusions and hallucinations are particularly sensitive to treatment.").

116. DAVISON & NEALE, *supra* note 67, at 308 (noting that "[a]ntipsychotic drugs are an indispensable part of treatment for schizophrenia"); John M. Kane, *Conventional Neuroleptic Treatment: Current Status, Future Role*, in *THE NEW PHARMACOTHERAPY OF SCHIZOPHRENIA* 89, 90 (Alan Breier ed., 1996) (noting that antipsychotic medications are "the primary modality in the treatment of an acute episode or an acute exacerbation of a schizophrenic illness").

117. See *supra* note 72.

also such additional measures as physical restraints and seclusion.¹¹⁸ These alternatives, though, are not clearly any more desirable than medications.¹¹⁹

A court's task should be to allow, in each particular case, whichever treatment is the best of the available options. For courts deciding what this best option is, the "least restrictive alternative" principle is not helpful. By what standard should a court decide whether receiving an injection once a month, or taking a pill once a day, is more or less restrictive than spending a month in seclusion? Instead of engaging in a futile attempt to identify the least restrictive treatment, a court's task should be to determine whether hospitalization or medication, or both, or neither, is the best means of treating someone who is suffering from a serious mental illness.

CONCLUSION

Scholars have lauded autonomy as "a moral entailment of personhood."¹²⁰ The Supreme Court similarly has declared:

[C]hoices central to personal dignity and autonomy[] are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life.¹²¹

In the abstract, such assertions seem unobjectionable and perhaps even indisputable, at least philosophically if not constitutionally. In the concreteness of real life, however, some people suffering from serious mental illnesses will, unless a court orders involuntary treatment, remain trapped in a world that to them seems truly to be a living hell. Arguments for autonomy sound somewhat hollow when they are considered at the

118. Russell Weston, for example, refused to take psychotropic medications voluntarily and spent more than two years in seclusion while the courts decided whether he could be administered involuntary medications for the purpose of rendering him competent to stand trial. See Anne Hull, *A Living Hell or a Life Saved? Capitol Shooter's Untreated Madness Fuels Legal and Ethical Debate*, WASH. POST, Jan. 23, 2001, at A1 ("Because Weston has received no treatment and could be dangerous, he has been kept in seclusion for more than two years, an unheard-of period of isolation in modern times.").

119. In one of the landmark "right to refuse" cases of the 1970s, the plaintiffs sought to enjoin a state hospital from the use of both involuntary medication and involuntary seclusion. *Rogers v. Okin*, 478 F. Supp. 1342, 1353 (D. Mass. 1979), *aff'd in part, rev'd in part*, *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980). See also Elyn Saks, Note, *The Use of Mechanical Restraints in Psychiatric Hospitals*, 95 YALE L.J. 1836, 1836-37 (1986) ("Between 1979 and 1982, nearly 30 psychiatric patients died in New York state from being restrained or secluded.").

120. Richard H. Fallon, Jr., *Two Senses of Autonomy*, 46 STAN. L. REV. 875, 878 (1994).

121. *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992).

particularized level of a man who boards up his house to protect his family from demons.¹²²

This essay has proposed that when deciding whether to allow involuntary treatment, the proper question for courts to ask is not whether autonomy is preferable to involuntary treatment, but whether no treatment at all is preferable to involuntary treatment. The answer to this question will depend, of course, upon the particular facts of each case. This essay has therefore not argued that all, or even many, mentally ill people who refuse voluntary treatment should be committed to involuntary treatment.

If courts were to ask whether, for someone who is mentally ill, the overall benefits of providing involuntary treatment would be greater than the overall benefits of not providing any treatment at all, the result might not be that any more people, or any fewer, would be committed to involuntary treatment. The advantage of this approach, then, would not be the number of people who were committed but the reason that anyone was committed. If courts considered the specific consequences of allowing as well as not allowing the choice to refuse treatment, then commitment decisions could be based on the concrete realities of living with an untreated mental illness as well as the concrete realities of living with involuntary treatment. Regardless of how many people were committed to involuntary treatment, they would have been committed for the right reasons, because the courts would have asked the right question.

122. See *supra* note 69 and accompanying text.