CONDITIONAL RELEASE AND CONSENT TO TREATMENT

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This article takes up the question of how the right to refuse treatment operates in the context of conditional release from inpatient psychiatric commitment. Part One explores the practice of conditional release from inpatient psychiatric care as a form of outpatient commitment and describes the range of substantive and procedural approaches that are used to structure these step-down arrangements. Part Two then takes up the legal and policy questions associated with the right to grant or withhold consent to medication in the context of psychiatric treatment. Part Three concludes by considering how the doctrines described in Part Two map onto the practices set out in Part One and offers some suggestions for reconciling the competing interests at play.

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Over the past forty-five years, the locus of care[1] for persons with severe, chronic mental illness has shifted from state and municipal hospitals to community-based providers delivering psychiatric and other behavioral health services primarily on an outpatient basis.[2] More recently, in response to concerns that this process of deinstitutionalization has failed to meet the needs of many persons with severe mental illness,[3] jurisdictions throughout the United States have deployed legal mechanisms that extend treatment coercion from the inpatient setting into the community.[4] Variously termed outpatient commitment, mandated outpatient treatment, or assisted outpatient treatment,[5] these efforts have been driven by a concern that many individuals in the community living with chronic severe mental illness do not voluntarily seek or maintain needed treatment, particularly medication-based treatment involving antipsychotic drugs.[6] Notwithstanding their reluctance to obtain or adhere to treatment, many individuals within this target population also are underserved by the public mental health system due to a significant lack of resources devoted to community-based treatment.[7] As a consequence, outpatient commitment initiatives produce a range of outcomes, but appear to be most effective when they are

1. While some judges and other writers distinguish between "care," especially custodial care, and mental health "treatment," *see, e.g.*, Chief Justice Burger's concurring opinion in *O'Connor v. Donaldson*, 422 U.S. 563, 578-89 (1975), the word "care" as used in this Article is meant to include treatment interventions as well as other services provided to patients with mental illness.

2. *See* W. LAWRENCE FITCH & JEFFREY W. SWANSON, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM: HISTORICAL TRENDS AND PRINCIPLES FOR LAW AND PRACTICE 7 (2019); *see also* Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 CARDOZO L. REV. 1, 9 (2012); Richard C. Boldt, *Emergency Detention and Involuntary Hospitalization: Assessing the Front End of the Civil Commitment Process*, 10 DREXEL L. REV. 1, 44–52 (2017).

3. *See generally* E. FULLER TORREY, THE INSANITY OFFENSE: HOW AMERICA'S FAILURE TO TREAT THE SERIOUSLY MENTALLY ILL ENDANGERS ITS CITIZENS (2008); Rael Jean Isaac & Samuel Jan Brakel, *Subverting Good Intentions: A Brief History of Mental Health Law "Reform,"* 2 CORNELL J.L. & PUB. POL'Y 89, 90–91 (1992).

4. *See* Policy Surveillance Program Staff, *Involuntary Outpatient Commitment Laws*, POLICY SURVEILLANCE PROGRAM: A LAWATLAS PROJECT (Mar. 2016), http://lawatlas.org/datasets/involuntary-outpatient-commitment-1442865639 (providing a state-by-state legal survey of the features of outpatient commitment statutes) [hereinafter LAWATLAS].

5. *See* AM. PSYCHIATRIC ASS'N, MANDATORY OUTPATIENT TREATMENT: RESOURCE DOCUMENT 2 (APA Document 199907, 1999), https://www.psychiatry.org/getattachment/2663ffd8-d5d5-44bd-8903-fe660a95d413/Resource-Document-1999-Mandatory-Outpatient.pdf [hereinafter APA RESOURCE DOCUMENT].

6. *See* FITCH & SWANSON, *supra* note 2, at 13–14.

7. *See id.* at 14; *see also* Michael L. Perlin, *Decoding Right to Refuse Treatment Law*, 16 INT'L J.L. & PSYCHIATRY 151, 160 (1993) ("[C]ommunity mental health services have never been truly accessible to former state hospital patients . . . .").

accompanied by an infusion of dedicated treatment and supportive services earmarked for the target population.[8]

Outpatient commitment can be organized in a variety of ways.[9] Some jurisdictions authorize courts to issue mandatory community treatment orders based on the same legal criteria (i.e., dangerousness to self or others) that apply to inpatient civil commitment.[10] Other jurisdictions have begun to implement a form of outpatient commitment in which the judicial decision-maker is authorized to order outpatient treatment based on criteria that are broader than those applicable to ordinary civil commitment and that focus on an individual's deteriorating clinical and practical functioning rather than a showing of current dangerousness.[11] A third form of mandated outpatient commitment, which was in place in many jurisdictions even before the other two approaches were adopted more widely, applies to patients who are released from inpatient hospitalization on the condition that they comply with an enumerated set of obligations, most often centering on compliance with a medication regimen.[12] This "step-down" conditional release model may involve a judicial decision-maker or, depending on state law, may be driven entirely by clinicians at the facility making the release determination.[13] In some jurisdictions, the step-down conditional release arrangement is based on an assessment that the patient no longer meets the state law requirements for inpatient commitment, particularly that she is no longer dangerous to herself or to others.[14] In other jurisdictions, conditional release reflects a judgment that the patient, although still subject to civil commitment under the ordinary inpatient commitment criteria, can safely be treated in a less restrictive setting in the community.[15]

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8. *See* APA RESOURCE DOCUMENT, *supra* note 5, at 7. A great deal has been written both in support of and criticizing the trend toward community-based treatment coercion. *See generally* Richard C. Boldt, *Perspectives on Outpatient Commitment*, 49 NEW ENG. L. REV. 39, 44–50 (2014) (setting out the competing positions); *see also* TORREY, *supra* note 3; Erik Roskes, *"Assisted Outpatient Treatment": An Example of Newspeak?*, 64 PSYCHIATRIC SERVS. 1179 (2013).

9. *See* APA RESOURCE DOCUMENT, *supra* note 5, at 2; Boldt, *supra* note 8, at 58–63; FITCH & SWANSON, *supra* note 2, at 15–17.

10. *See* Boldt, *supra* note 8, at 58–59.

11. *See id.* at 60–61; *see also* FITCH & SWANSON, *supra* note 2, at 16–17.

12. *See* Boldt, *supra* note 8, at 58.

13. *See* APA RESOURCE DOCUMENT, *supra* note 5, at 2.

14. *See, e.g.*, IND. CODE ANN. § 12-26-14-7 (West 1992) ("[T]he superintendent of the facility in which the individual is committed . . . may place the individual on outpatient status" if the individual "is not likely to be either dangerous or gravely disabled if the individual continues to follow the therapy program . . . .").

15. IDAHO CODE ANN. §§ 66-329, 337 (West 2022), for example, provide both for "conditional discharge" and for "termination" of inpatient commitments. Conditional discharge is permitted if the patient continues to meet the statutory criteria for commitment, while termination results from a determination that the patient no longer meets the statutory standard for commitment. The authorization

The first and second models of outpatient commitment identified above have received a fair amount of attention in the literature.[16] The conditional release alternative has been less carefully studied,[17] and one issue in particular has evaded detailed analysis. This under-evaluated question concerns the relationship between the substantive and procedural rules governing conditional release and the body of legal authority applicable in a given jurisdiction regulating the ability of individuals to grant or withhold consent to receive psychiatric treatment. If the individual eligible for conditional release is an inpatient in a jurisdiction that grants civilly committed patients significant authority to refuse antipsychotic medications absent emergency circumstances or a judicial finding of incompetency to make treatment decisions,[18] the imposition against the wishes of the patient of a medication condition by hospital clinicians or by a reviewing court may be inappropriate, particularly if the inpatient subject to discharge no longer meets the state's legal standards for involuntary hospitalization.[19] There is a range of coercive possibilities in this regard. The patient could be subject to forced medication in the form of a physically imposed depot injection, with the effects of the drug persisting for days or weeks.[20] Or the patient could be obligated to agree to the self-administration of antipsychotic drugs as a quid-pro-quo for being released from custody.[21] Such a constrained choice might be regarded as "voluntary," but would be problematic in a jurisdiction where an individual who has been stabilized in the hospital and is no longer dangerous to herself or others is otherwise entitled to discharge simply by virtue of the

for conditional discharge to outpatient treatment reflects this jurisdiction's adoption of the "least restrictive alternatives" doctrine, which holds that patients, even those subject to involuntary treatment, should be cared for in the community if their circumstances permit outpatient treatment that is likely to be safe and effective. On the least restrictive alternatives doctrine, *see generally* Jan C. Costello & James J. Preis, *Beyond Least Restrictive Alternative: A Constitutional Right to Treatment for Mentally Disabled Persons in the Community*, 20 LOY. L.A. L. REV. 1527 (1987).

16. *See* sources cited in FITCH & SWANSON, *supra* note 2.

17. *But see* Steven P. Segal & Philip M. Burgess, *Conditional Release: A Less Restrictive Alternative to Hospitalization?*, 57 PSYCHIATRIC SERVS. 1600 (2006) (studying the conditional release of nearly 9,000 psychiatric patients in Australia between 1990 and 2000).

18. *See, e.g.*, MASS. GEN. LAWS ANN. ch. 123, § 8B(d) (West 1992) (governing the rights of committed persons to withhold consent to treatment with antipsychotic medications).

19. Even though conditional release often is a form of mandated outpatient commitment, and compliance with an antipsychotic medication requirement is almost always a condition of release, a competent individual subject to this form of outpatient commitment may retain the right to refuse such treatment—to withhold informed consent with respect to medication. *See, e.g.*, *id.*

20. *See* BARBARA A. WEINER & ROBERT M. WETTSTEIN, LEGAL ISSUES IN MENTAL HEALTH CARE 131 (1993); APA RESOURCE DOCUMENT, *supra* note 5, at 8.

21. *See, e.g.*, N.H. REV. STAT. ANN. § 135-C:50 (2020) ("The administrator . . . may grant a conditional discharge under this chapter to any person who consents, by an informed decision, to participate in continuing treatment on an out-patient basis . . . ."); *cf.* TENN. CODE ANN. § 33-6-603 (West 2010) ("Before approving the outpatient treatment plan, the releasing facility and the outpatient qualified mental health professional shall obtain the service recipient's consent to the plan to the extent practical . . . .").

straightforward application of the jurisdiction's civil commitment criteria. And even if the governing civil commitment law permits continuing supervision on the prophylactic grounds of predictable deterioration, an underlying legal right held by all competent psychiatric patients to grant or withhold informed consent to treatment[22] may be inconsistent with the constraint associated with a "voluntary" quid-pro-quo arrangement under which the patient trades a medication obligation in exchange for placement in a community-based setting. The resolution of this question likely will turn on how the jurisdiction defines competence, on the definition of "informed consent" that governs in the circumstances, and on how the elements of informed consent are operationalized in practice.[23]

In the middle of the twentieth century, civil commitment decisions in most U.S. jurisdictions were made by physicians on a need-for-treatment basis.[24] Consistent with the premises of this "medical model," the determination that a patient with severe mental illness required inpatient psychiatric care generated an assumption that the patient was not competent to exercise the decisional autonomy ordinarily accorded adults making other medical/surgical treatment decisions. That is, the determination to involuntarily hospitalize a psychiatric patient necessarily carried a finding of incompetency to make treatment decisions, including decisions with respect to antipsychotic medications.[25] As one writer put it: "Allowing an involuntarily hospitalized person to refuse treatment is inconsistent with the objective of the hospitalization."[26]

Beginning in the 1970s, the medical model gave way throughout the United States to a more formal legal rights-based approach to civil commitment.[27] Physicians panels were replaced by judicial decision-makers, paternalistic need-for-treatment criteria were supplanted by criteria centered on the prediction of a patient's dangerousness to self or others, and courts began to recognize "some substantial patient interest in a right to refuse treatment," even in the context of involuntary

22. "Being an inpatient or a patient in the community with involuntary commitment to treatment does not mean one is incompetent to make treatment decisions." Hal S. Wortzel, *The Right to Refuse Treatment*, 23 PSYCHIATRIC TIMES 30 (2006).

23. For a useful framework for evaluating competency and the capacity of patients to provide informed consent, *see* Paul S. Appelbaum & Thomas Grisso, *Mental Illness and Competence to Consent to Treatment*, 19 LAW & HUM. BEHAV. 105, 110 (1995). For a further discussion of competency, *see* Bruce J. Winick, *The Side Effects of Incompetency Labeling and the Implications for Mental Health Law*, 1 PSYCH., PUB. POL'Y, & L. 6, 41 (1995).

24. *See* PAUL S. APPELBAUM & THOMAS G. GUTHEIL, CLINICAL HANDBOOK OF PSYCHIATRY & THE LAW 40 (4th ed. 2007).

25. *See id.* at 38–39.

26. Jennifer Fischer, *A Comparative Look at the Right to Refuse Treatment for Involuntarily Hospitalized Persons with a Mental Illness*, 29 HASTINGS INT'L & COMPAR. L. REV. 153, 155 (2006).

27. *See* FITCH & SWANSON, *supra* note 2, at 3–6.

hospitalization.[28] In 1990, the U.S. Supreme Court in *Washington v. Harper* recognized that individuals have interests under the Due Process Clauses of the Fifth and Fourteenth Amendments that apply to forced medication decisions.[29] Other courts and commentators have linked a right to refuse such treatment to common law doctrines governing the intentional tort of battery and the role that consent plays in the application of that tort in the medical context.[30] As the question was taken up by lower federal courts and state courts, a variety of approaches developed. In broad terms, federal courts of appeals generally adopted a more permissive approach, as did some state supreme courts. Decisions falling into this category tended to permit the imposition of psychiatric treatment, including involuntary medication, without a formal finding of patient incompetence, based on a professional judgment standard that the U.S. Supreme Court had articulated in a different context.[31] Other state courts, however, often relying on state constitutional provisions, articulated a more libertarian approach that required active judicial oversight, a formal determination of legal incompetence, and the application of a substituted judgment standard as prerequisites to involuntary medication practices.[32]

With this range of legal approaches in mind, this article addresses the question of how the right to refuse treatment operates in the context of conditional release from inpatient psychiatric commitment. The discussion proceeds as follows: Part One explores the practice of conditional release from inpatient psychiatric care as a form of outpatient commitment and describes the range of substantive and procedural approaches that are used to structure these step-down arrangements. Part Two then takes up the legal and policy questions associated with the right to grant or withhold consent to medication in the context of psychiatric treatment. Part Three concludes by considering how the doctrines described in Part Two map onto the practices set out in Part One and offers some suggestions for reconciling the competing interests at play.

I. CONDITIONAL RELEASE AS A FORM OF OUTPATIENT COMMITMENT

In a highly influential report issued in 2019 by the Substance Abuse and Mental Health Services Administration, the authors, W. Lawrence Fitch[33] and Jeffrey W.

28. Wortzel, *supra* note 22.

29. 494 U.S. 210 (1990); *see also* Sell v. United States, 539 U.S. 166 (2003).

30. Barry R. Furrow, *Damage Remedies and Institutional Reform: The Right to Refuse Treatment*, 10 LAW, MED., & HEALTH CARE 152, 152 (1982); WEINER & WETTSTEIN, *supra* note 20, at 128–29.

31. *See, e.g.*, Rennie v. Klein, 720 F.2d 266 (3d Cir. 1983) (relying in part on the "professional judgment" standard articulated by the U.S. Supreme Court in *Youngberg v. Romeo*, 457 U.S. 307 (1982)).

32. *See, e.g.*, Rogers v. Comm'r of Dep't of Mental Health, 458 N.E.2d 308 (Mass. 1983).

33. Fitch has a faculty affiliation at the University of Maryland Carey School of Law.

Swanson,[34] trace the history of civil commitment law and practice in the United States and locate the increasing use of outpatient commitment in the context of that chronological account.[35] The report, entitled *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice*, offers a cautious endorsement of legally mandated outpatient commitment, including the use of conditional release from involuntary psychiatric hospitalization.[36] Importantly, the report supports the use of outpatient commitment, including the obligation to adhere to medication requirements, even in the absence of a finding that the mandated individual is legally incompetent to make treatment decisions, and based on substantive criteria broader than those typically governing inpatient commitment determinations.[37]

Like others who have chronicled the history of deinstitutionalization in the last quarter of the twentieth century, Fitch and Swanson note that changes in how behavioral health care is financed – in particular, privatization and the development of managed care – played a key role in the decline of state mental hospitals.[38] In addition, these authors emphasize "late century" legal reforms that installed dangerousness as an essential criterion for civil commitment.[39] As these legal reforms evolved, civil commitment standards across the U.S. came to embrace a common set of elements. Virtually every state now requires clear and convincing evidence[40] that a person subject to commitment has a mental illness or other significant mental

34. Swanson is on the faculty at the Duke University School of Medicine.

35. *See* FITCH & SWANSON, *supra* note 2, at 2–21.

36. *See id.* at 15–16, 32.

37. *See id.* at 32 (asserting that because preventative outpatient commitment "addresses risks of harm that are less immediate" than those required for inpatient commitment, "respect for personal autonomy may require an additional finding of impairment in the person's understanding of the nature of his or her mental illness and the treatment proposed," but that "[f]ull legal incompetency . . . should not be required").

38. *See id.* at 7–8 (discussing changes in Medicaid laws, managed care and the imposition of "strict medical necessity criteria for insurance reimbursement," and the impact of federal disability rights laws); *see also* Boldt, *supra* note 2, at 5–6.

39. FITCH & SWANSON, *supra* note 2, at 3–6. The U.S. Supreme Court's most relevant pronouncement on the constitutional requirements for involuntary hospitalization, *O'Connor v. Donaldson*, seems to suggest that dangerousness is a necessary element, although the Court's opinion is subject to an alternative interpretation that does not necessarily require dangerousness. 422 U.S. 563 (1975).

40. This evidentiary standard derives from the U.S. Supreme Court's decision in *Addington v. Texas*, where the Court considered whether states should be obligated to prove each of the elements required for civil commitment beyond a reasonable doubt, as they are required to do in criminal cases. 441 U.S. 418, 425–31 (1979). Observing that the costs to individual liberty of false positives, while significant in cases involving involuntary hospitalization, are less than in criminal cases, the Court concluded that a standard of clear and convincing evidence is sufficient under the Due Process Clause of the Fourteenth Amendment. *Id.*

disability[41] that creates a need for treatment, and that renders the individual dangerous to self or others or, in some states, unable to provide for basic essential needs.[42]

Despite credible research evidence that the adoption of these libertarian civil commitment laws played, at best, a minor role in the decline of long-term inpatient psychiatric hospitalizations,[43] a chorus of commentators and activists offered strenuous objections to the substantive limitations that most jurisdictions placed on the state's ability to mandate psychiatric treatment for chronic psychiatric patients who struggled to adjust outside of the hospital.[44] As early as 1975, prominent psychiatrist Alan Stone suggested an alternative approach that ultimately found expression in a model civil commitment statute promulgated by the American Psychiatric Association in the early 1980s.[45] The key feature of the APA's model statute was that it would authorize coercive state intervention before an individual decompensated to meet the ordinary dangerous to self or others standard for civil commitment; instead, the model provision permitted civil commitment on a preventative basis in instances in which there was credible evidence that an individual with serious

41. Some states have separate substantive and/or procedural standards for the involuntary commitment of persons with intellectual disabilities. In a few jurisdictions, for this population, the dangerousness criterion is removed and a need for treatment standard is employed instead. *See, e.g.*, ARK. CODE ANN. § 20-48-404(1) (2019). The application of different procedural rules for the civil commitment of persons with intellectual disabilities was upheld by the U.S. Supreme Court in *Heller v. Doe*, 509 U.S. 312, 347–48 (1993). Note also that separate rules may apply to persons who have substance use disorders, *see, e.g.*, FLA. STAT. ANN. § 397.311 (2020), and those with an antisocial personality disorder that makes them likely to engage in acts of sexual violence, *see, e.g.*, Kansas Sexually Violent Predator Act, KAN. STAT. ANN. § 59-29a01 (2015) (upheld in Kansas v. Hendricks, 521 U.S. 346, 350 (1997)).

42. *See* FITCH & SWANSON, *supra* note 2, at 11–12.

43. *See* R. Michael Bagby & Leslie Atkinson, *The Effects of Legislative Reform on Civil Commitment Admission Rates: A Critical Analysis*, 6 BEHAV. SCIS. & L. 45, 58–59 (1988); *see also* Sarah Cleveland et al., *Do Dangerousness-Oriented Commitment Laws Restrict Hospitalization of Patients Who Need Treatment? A Test*, 40 HOSP. & CMTY. PSYCHIATRY 266, 269–70 (1989); *see generally* PAUL S. APPELBAUM, ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE (1994).

44. *See, e.g.*, Isaac & Brakel, *supra* note 3, at 102–06. Fitch and Swanson discuss a widely cited letter published by the *American Journal of Psychiatry* in 1973 by psychiatrist Darryl Treffert. *See* FITCH & SWANSON, *supra* note 2, at 6 (discussing Darold A. Treffert, *"Dying with their Rights On,"* 130 AM. J. PSYCHIATRY 1041 (1973)); *see also* Boldt, *supra* note 8, at 44–46 (describing the critics of deinstitutionalization).

45. *See* ALAN A. STONE & CLIFFORD D. STROMBERG, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION 25–37 (1975) (discussing dangerousness as a central criterion for determining whether preventative civil commitment is necessary); Clifford D. Stromberg & Alan A. Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 HARV. J. ON LEGIS. 275, 330 (1983) (printing a portion of the model statute that discusses a person's dangerousness as a criterion necessary for third-day commitment).

mental illness was on the verge of collapse.[46] In recent years, some states have adopted a version of this deterioration standard and have deployed it particularly as the basis for a form of prophylactic outpatient commitment.[47]

The critics of a more rights-protective approach have pointed out that while the overall number of inpatient psychiatric beds in the United States has declined dramatically, the number of annual hospital admissions has not.[48] In place of long-term inpatient psychiatric care, the system has come to offer a revolving door for many chronic patients who are admitted briefly for acute care and then released to the community where they often fail to connect with outpatient treatment services and either fall into homelessness and eventual return to the hospital (frequently via the emergency department) or are swept into the criminal legal system.[49] The critics have pointed out that "the comprehensive community-based care system that was envisioned to meet the complex needs of persons with severe, disabling disorders such as schizophrenia never fully materialized," and that the "medicines alone were never quite as effective as promised – at least not for everyone . . . ."[50] But they emphasize even more what they perceive to be the inherent limitations of voluntary psychiatric treatment, at least for some persons living in the community with severe mental illness.[51]

Advocates for a more aggressive civil commitment system, including E. Fuller Torrey of the Treatment Advocacy Center, have argued that the cognitive and

46. *See generally* Stromberg & Stone, *supra* note 45; *see also* Am. Psychiatric Ass'n, *Guidelines for Legislation on the Psychiatric Hospitalization of Adults*, 140 AM. J. PSYCHIATRY 672, 673–74 (1983).

47. *See* FITCH & SWANSON, *supra* note 2, at 10, 20; *see also* LAWATLAS, *supra* note 4.

48. *See* APA RESOURCE DOCUMENT, *supra* note 5, at 2.

49. On the "revolving cycle" of failure, *see* Guido R. Zanni & Paul F. Stavis, *The Effectiveness and Ethical Justification of Psychiatric Outpatient Commitment*, 7 AM. J. BIOETHICS 31, 33 (2007). The argument that overly restrictive civil commitment laws and inadequate inpatient treatment resources have significantly contributed to homelessness and criminal system involvement among persons with severe mental illness has been pressed with great force by E. Fuller Torrey and the Treatment Advocacy Center. *See generally* TORREY, *supra* note 3. One version of this argument has been framed in terms of the theory of "trans-institutionalization," which asserts that a "reduced reliance on and capacity for inpatient services, including state mental hospitals, has unduly shifted the management of persons with chronic mental illness to the criminal justice system and other public systems responsible for homelessness and like problems . . . ." Boldt, *supra* note 2, at 9. The trans-institutionalization theory has been questioned by others who have described it as a "reductionist narrative" that "mistakenly draw[s] a causal connection between two merely correlated trends: the decline in availability of state psychiatric hospital beds and the rise in prevalence of [serious mental illness] in jails and prisons." Seth J. Prins, *Does Transinstitutionalization Explain the Overrepresentation of People with Serious Mental Illnesses in the Criminal Justice System?*, 47 CMTY. MENTAL HEALTH J. 716, 720 (2011); *see also* Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 80–88 (1991).

50. FITCH & SWANSON, *supra* note 2, at 13.

51. *See* APA RESOURCE DOCUMENT, *supra* note 5, at 1–2.

affective symptoms associated with some severe mental illnesses can render individuals with these disabilities incapable of making reasonable treatment decisions, even if their impairments do not reach the level of legal incompetency.[52] In particular, they point to an organic condition known as anosognosia, a dysfunction in the right side of the brain that is said to interfere with the ability of some persons with schizophrenia to recognize their symptoms,[53] as support for a public health approach that weighs the treatment needs of these individuals more heavily than their competing interest in autonomy or self-determination.[54] Whether driven by the confounding effects of this organic brain disorder or by the commonly experienced negative side-effects of antipsychotic medications that often make patients uncomfortable (or worse),[55] it became clear by the last decade of the twentieth century that "a growing number of young adult chronic patients do not accept the need for [medication-based] treatment, and many of them cannot be treated involuntarily because they fail to meet the strict behavioral criteria of . . . commitment laws designed to limit the use of involuntary hospitalization."[56]

A. Policies and Recommendations for Outpatient Commitment

With these concerns in mind, the Council on Psychiatry and Law of the American Psychiatric Association prepared a *Resource Document* calling for the increased use of outpatient commitment, including mandated outpatient treatment imposed as a condition of release from inpatient care, which was approved by the APA in 1999.[57] With a few key refinements, the recommendations contained in this 1999 *Resource Document* were adopted once again by the APA in 2020 in its *Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment*,[58] and are mirrored as well by the SAMHSA white

52. *See The Anatomical Basis of Anosognosia (Lack of Awareness of Illness)*, TREATMENT ADVOC. CTR., http://www.treatmentadvocacycenter.org/about-us/our-reports-and-studies/2143 (last updated May 2013).

53. *See id.*; *see generally* CHRISTOPHER SLOBOGIN ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 1109 (7th ed. 2020).

54. A useful framework for organizing these competing interests in the context of public health policy making was developed by Thomas Beauchamp and James Childress. The Beauchamp and Childress framework calls upon decision-makers to evaluate policy choices in terms of four factors: respect for autonomy; non-maleficence; beneficence; and justice. *See* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 13 (7th ed. 2013). The interests held by patients in self-determination implicate the value of autonomy, while their interest in receiving needed treatment goes to beneficence. *See id.* at 82, 214–15.

55. *See* Michael J. Peluso et al., *Extrapyramidal Motor Side-Effects of First- and Second-Generation Antipsychotic Drugs*, 200 BRIT. J. PSYCHIATRY 387, 387 (2012).

56. APA RESOURCE DOCUMENT, *supra* note 5, at 2.

57. *See id.*

58. *See* AM. PSYCHIATRIC ASS'N, POSITION STATEMENT ON INVOLUNTARY OUTPATIENT COMMITMENT AND RELATED PROGRAMS OF ASSISTED OUTPATIENT TREATMENT 2–4 (2020),

paper authored by Fitch and Swanson.[59] Each of these sets of recommendations applies to mandated outpatient treatment initiatives that target patients being released from inpatient hospitalization as well as patients already in the community.[60] Their essential policy prescriptions do not differentiate significantly between step-down outpatient commitment efforts and mandated outpatient programs that target non-hospitalized individuals. The recommendations contained in the APA's 1999 *Resource Document*, for example, are meant to cover all forms of mandatory outpatient treatment.[61] To be eligible for outpatient commitment, a person must: 1) suffer from a severe mental disorder that "substantially impairs behavior as manifested by recent disturbed behavior"; 2) be in need of treatment now "in order to prevent a relapse or severe deterioration that would predictably result in the person [becoming a danger to himself or others or becoming substantially unable to care for him or herself in the foreseeable future]"; 3) be "unlikely to seek or comply with needed treatment"; and 4) have been hospitalized within the previous two years and have "failed to comply on more than one occasion with the prescribed course of treatment outside the hospital."[62] If these criteria are met, and if an appropriate outpatient treatment plan has been formulated and accepted by the responsible treatment facility, then the *Resource Document* endorses the use of a court order to implement mandated outpatient treatment.[63]

The APA's *Resource Document* makes clear that the organization's support for mandated outpatient treatment is intended not "principally to protect the public, but to [sic] rather to enable severely ill patients to receive the treatment they need, with potential benefits to themselves and to the community."[64] Notwithstanding this "need-for-treatment approach," outpatient commitment statutes adopted in North Carolina and New York, two jurisdictions that were leaders in this field and that were sites for significant research on the efficacy of these efforts, instead focus on dangerousness as the key criterion.[65] To be sure, these jurisdictions (and others that

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https://www.psychiatry.org/getattachment/d50db97b-59aa-4dd4-a0ec-d09b4e19112e/Position-Involuntary-Outpatient-Commitment.pdf [hereinafter APA POSITION STATEMENT].

59. *See* FITCH & SWANSON, *supra* note 2, at 13–32.

60. *See* APA RESOURCE DOCUMENT, *supra* note 5; *see also* APA POSITION STATEMENT, *supra* note 58, at 2-4; FITCH & SWANSON, *supra* note 2, at 32.

61. *See* APA RESOURCE DOCUMENT, *supra* note 5, at 2.

62. *Id.* at 6.

63. *Id.*

64. *Id.* at 6.

65. *See* N.Y. MENTAL HYGIENE LAW § 9.60(c) (McKinney 2022) (explaining that New York permits the court to order outpatient treatment if an individual, *inter alia*, "is in need of assisted outpatient treatment *in order to prevent a relapse or deterioration which would be likely to result in* serious harm to the person or others . . . .") (emphasis added); *see also* N.C. GEN. STAT. ANN. § 122C-263(d)(1)(c) (2023) (stating that North Carolina permits a court to order outpatient treatment based on a finding,

followed their lead) do not require evidence that the patient's disability presents an imminent threat of harm to self or others, instead emphasizing that to be eligible a patient's treatment history and other circumstances should support a prediction of "likely deterioration leading to dangerousness" in the future.[66] By grounding the prediction of future dangerousness in specific evidence of a patient's past history of treatment and relapse, the *Resource Document* concludes that these jurisdictions strike a "useful compromise position" between those who favor a need for treatment approach and others who would limit coercive state interventions to only those who present a clear risk of present dangerousness.[67]

Embedded within all of these proposals is a significant shift in emphasis from the APA's earlier approach regarding coercive treatment interventions to prevent deterioration. The earlier stance was "predicated on the patient's [in]capacity to make an informed treatment decision,"[68] whereas the recommendations in the *Resource Document*, the 2020 *Position Statement*, and the Fitch and Swanson white paper all permit mandated outpatient treatment even in the absence of a finding of incompetence, so long as the patient "as a result of his or her mental illness, is 'unlikely to voluntarily participate in the recommended treatment.'"[69] This a crucial change in policy, especially with respect to mandated medication conditions, and especially in jurisdictions that otherwise require a finding of incompetence to overcome medication refusals.[70]

Fitch and Swanson acknowledge that "[w]hether an individual's impairment in decision-making ability must rise to the level of current legal incompetence . . . is an interesting question."[71] They point out that a finding of incompetence—which, to be sure, is a fraught legal concept[72] – often is required for "medication over objection" even for patients who are involuntarily hospitalized, but they are reassured because "medications entail risks not associated with most other outpatient services."[73] However, because medication compliance is generally a condition of

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inter alia, that "the respondent is in need of treatment in *order to prevent further disability or deterioration that would predictably result in dangerousness* . . . .") (emphasis added).

66. APA RESOURCE DOCUMENT, *supra* note 5, at 6.

67. *Id.*

68. *Id.*

69. *Id.*; *see also* APA POSITION STATEMENT, *supra* note 58, at 2; FITCH & SWANSON, *supra* note 2, at 32.

70. *See, e.g.*, MASS. GEN. LAWS ANN. ch. 123, § 8B(d) (West 1992).

71. FITCH & SWANSON, *supra* note 2, at 24.

72. *See generally* Bruce J. Winick, *The Side Effects of Incompetency Labeling and the Implications for Mental Health Law*, 1 PSYCH., PUB. POL'Y, & L. 6 (1995); *see* APPELBAUM & GUTHEIL, *supra* note 24, at 215–16; *see also* Richard C. Boldt, *The "Voluntary" Inpatient Treatment of Adults Under Guardianship*, 60 VILL. L. REV. 1, 19–24 (2015).

73. FITCH & SWANSON, *supra* note 2, at 24.

mandated outpatient treatment,[74] including conditional release, this reassuring distinction is unlikely to be of much help. Fitch and Swanson also suggest that a finding of legal incompetence probably should not be required for outpatient commitment given the "relative unenforceability" of these treatment orders.[75] Others have likewise argued that mandated outpatient treatment regimens imposed on patients who do not meet the ordinary standard for inpatient commitment nevertheless can pass constitutional muster precisely because there is no penalty for noncompliance, other than becoming subject to evaluation for involuntary hospitalization.[76] Indeed, the New York Court of Appeals took this position in *In re K.L.*, in upholding that state's Kendra's Law.[77] There were indications in that opinion, however, that the Court's conclusion would have been different if the statute at issue had permitted involuntary medication.[78] In light of this caution, it is indeed an "interesting question" whether that Court and others presented with the issue would sanction a form of outpatient commitment in which a hospitalized patient who is competent and otherwise eligible for release is compelled to agree to a medication condition to gain that release.[79]

The policy guidelines for outpatient commitment adopted in the SAMHSA white paper reflect the view that a formal finding of legal incompetency should not be required for mandated outpatient treatment.[80] "[R]espect for personal autonomy," they observe, "may require an additional finding of impairment in the person's understanding of the nature of his or her mental illness and the treatment proposed . . . . Full legal incompetency, however, should not be required."[81] The authors support this position by arguing that severe mental illness may compromise an individual's decision-making abilities, even if the impairment falls short of legal incompetency.[82] This "time-limited override" of the patient's wishes, they explain, is thus permissible because the treatment refusal is likely to be "inauthentic" given the circumstances.[83] The APA's *Resource Document* similarly takes the position

74. *See* APA RESOURCE DOCUMENT, *supra* note 5, at 8.

75. FITCH & SWANSON, *supra* note 2, at 24.

76. *See In re* K.L., 806 N.E.2d 480, 484–85 (N.Y. 2004).

77. *See id.* at 485 ("[A] violation of the order, standing alone, ultimately carries no sanction . . . [but] simply triggers heightened scrutiny on the part of the physician, who must then determine whether the patient may be in need of involuntary hospitalization" under the ordinary standards applicable for inpatient commitment).

78. *See* FITCH & SWANSON, *supra* note 2, at 17 n.20 ("Had the law authorized involuntary administration of medications . . . it is not likely the [New York] Court would have ruled as it did.").

79. *Id.* at 24.

80. *See generally id.*

81. *Id.* at 32.

82. *See id.*

83. *Id.* at 24–25.

that legal incompetence should not be a prerequisite for outpatient commitment.[84] Such incompetence "may be difficult to prove in some clinical circumstances that are otherwise appropriate for mandatory outpatient treatment," and therefore a lesser showing, that the patient's illness makes her voluntary participation in treatment "unlikely," should be sufficient.[85]

While the nature and degree of disruption to a patient's decision-making capacity required for conditional discharge or other outpatient commitment is one variable to consider, the level of coercion associated with a medication requirement is another important variable. Fitch and Swanson's observation about the "relative unenforceability" of these outpatient treatment orders notwithstanding, many jurisdictions authorize designated treatment professionals to arrange for noncompliant patients to be taken into custody and transported for evaluation and possible rehospitalization.[86] In this respect, conditional discharge and other forms of mandated outpatient commitment assign to clinicians "dual roles as therapists and social control agents," and create the potential for "role conflicts" that require behavioral health professionals "to clarify their roles, responsibilities, and relationships with patients."[87]

Drawing on the Program for Assertive Community Treatment, a model of community-based treatment for chronic psychiatric patients,[88] some suggest that clinicians can ameliorate this role conflict by employing strategies short of formal enforcement when patients resist complying with treatment obligations, including medication requirements.[89] "This means that they continue care and continue to offer services even when the patient is reluctant or not cooperative. Providers and patients at times 'agree to disagree' with each other but continue the treatment relationship even during periods of patient noncompliance."[90] The hope in these instances is that, by keeping patients "in contact with services," reluctant patients will experience improved social functioning, reduced hospitalization, and perhaps be more likely to comply with medication conditions over time.[91]

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84. *Id.*; APA RESOURCE DOCUMENT, *supra* note 5, at 6.

85. APA RESOURCE DOCUMENT, *supra* note 5, at 6.

86. *See id.* at 8; *see also, e.g.*, IND. CODE ANN. § 12-26-14-9 (West 1993); S.D. CODIFIED LAWS § 27A-10-9.4 (2012).

87. APA RESOURCE DOCUMENT, *supra* note 5, at 7.

88. *See generally* Susan D. Phillips et al., *Moving Assertive Community Treatment into Standard Practice*, 52 PSYCHIATRIC SERVS. 771 (2001).

89. *See* APA RESOURCE DOCUMENT, *supra* note 5, at 7.

90. *Id.*

91. *Id.*; WEINER & WETTSTEIN, *supra* note 20, at 131–32:

> Some illness-related or treatment-related refusals can be relatively easily dealt with by changing medication type and dosage; other refusals clearly demand much more of a

The possibility that assertive community treatment operating within an ongoing treatment alliance between patient and clinician may encourage voluntary medication compliance by some reluctant patients does not, however, remove the perceived need for other mechanisms to deal with those patients who remain noncompliant. The APA *Resource Document* takes the position that "[a]fter reasonable effort is exerted . . . if the patient remains in substantial noncompliance with the treatment the statute must contain a mechanism for some forcible intervention to promote compliance."[92] The laws in some jurisdictions authorize responsible clinicians to trigger a process whereby a law enforcement official takes the noncompliant patient into custody for transport to an outpatient facility for a short period of evaluation "where it can be hoped that the patient will be persuaded to accept the prescribed treatment."[93] In other states the clinician must seek the authorization of a judge before the patient is taken into custody.[94] Under either approach, the threat of detention and transportation may operate as a significant limitation on the practical ability of patients to resist medication-based psychiatric treatment in the outpatient setting.

Of course, there is an important difference between, on the one hand, the constrained choice to accept medication in order to gain a conditional discharge from inpatient status or to avoid being detained and transported to a treatment facility and, on the other hand, the imposition of antipsychotic medication against a patient's will by physical force. In the 1980s, the APA's position was that medications should not be physically forced on patients subject to outpatient commitment.[95] By 1999, the APA's *Resource Document* had cautiously moved down the road toward approving forced medication by endorsing "aggressive measures" to promote medication compliance.[96] It observed that "the threat of force may be needed for a small subpopulation of severely and chronically mentally ill patients who 'fail' mandatory outpatient treatment programs."[97] Nevertheless, the APA *Resource Document* did "not make a recommendation about whether mandatory outpatient treatment

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> commitment in time and energy from staff. Efforts to educate the patient and the family about the nature of the illness and the need for treatment may also be helpful.

Id.

92. APA RESOURCE DOCUMENT, *supra* note 5, at 8.

93. *Id.*; *see, e.g.*, S.D. CODIFIED LAWS §§ 27A-10-9.4–9.5 (2012); VT. STAT. ANN. tit. 18, § 8008(b) (West 1977).

94. *See* APA RESOURCE DOCUMENT, *supra* note 5, at 8; *see, e.g.*, MICH. COMP. LAWS ANN. § 330.1475 (West 2019).

95. *See* DAVID STARRETT ET AL., INVOLUNTARY COMMITMENT TO OUTPATIENT TREATMENT: REPORT OF THE TASK FORCE ON INVOLUNTARY OUTPATIENT COMMITMENT 8 (Am. Psychiatric Ass'n, 1987), https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/task-force-reports/tfr1987_InvoluntaryCommitment.pdf.

96. APA RESOURCE DOCUMENT, *supra* note 5, at 9.

97. *Id.*

statutes should either permit or preclude forced medication. Although legislation in some states has permitted forced medication, the constitutionality of this practice is uncertain."[98] If forced medication were to be permitted in these circumstances, the APA draftspersons concluded, "it should be allowed only if a court specifically finds that the patient lacks the capacity to make an informed decision regarding his or her need for the medication."[99] Notably, by 2020 the APA's *Position Statement* had abandoned much of the caution of the earlier documents.[100] The organization's position now is that involuntary administration of medication may be authorized as part of the involuntary commitment order if the authorization is based on a "separate review and approval consistent with the state's process for authorizing involuntary administration of medication on an outpatient basis."[101] SAMHSA's Fitch and Swanson report that "with only rare exceptions, no legal mechanisms exist for forced medication in an outpatient setting."[102] However, as we shall see, the law in some states can now be read to permit such an authorization even absent an express finding of incompetence.[103]

B. State Laws Governing Conditional Release from Involuntary Psychiatric Hospitalization

There is great variation among the states in how the practice of conditional release from inpatient psychiatric care is authorized and regulated.[104] Traditionally, conditional release was understood as distinct from outpatient commitment in that the former was authorized by treatment personnel while the latter was the result of court order.[105] A review of the governing statutes in all fifty states reveals that this distinction is still maintained in some jurisdictions. In New York, for example, the law distinguishes between the "conditional release" of inpatients versus their "discharge" to assisted outpatient treatment.[106] Terminology also varies widely from

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98. *Id.*
99. *Id.*
100. *See* APA POSITION STATEMENT, *supra* note 58, at 3.
101. *Id.*
102. FITCH & SWANSON, *supra* note 2, at 14 n.15.
103. *See infra* note 253 and accompanying text.
104. *See* discussion *infra* pp. 20–22.
105. *See* WEINER & WETTSTEIN, *supra* note 20, at 59.
106. N.Y. MENTAL HYGIENE LAW § 29.15(b)(1) (McKinney 2021) provides:

> A patient may be conditionally released, rather than discharged, when in the opinion of staff familiar with the patient's case history, the clinical needs of such patient warrant this more restrictive placement, provided, however, that . . . an involuntary patient may be conditionally released only for the remainder of the authorized retention period . . . .

Id. The statute further provides that:

state to state, with some jurisdictions authorizing "convalescent leave"[107] or "convalescent status,"[108] while others recognize "conditional discharge" upon the

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> In the case of an involuntary patient on conditional release, the director may terminate the conditional release and order the patient to return to the facility at any time during the period for which retention was authorized, if, in the director's judgment, the patient needs in-patient care and treatment and the conditional release is no longer appropriate . . . .

Id. § 29.15(e).

A discharge, by contrast, concludes the period of retention. Upon discharge, however, an individual may be subject to New York's assisted outpatient treatment provision, Kendra's Law, if a court determines that she meets the criteria for assisted outpatient treatment. *See id.* § 9.60 (McKinney 2022); Roskes, *supra* note 8, at 1179 (noting that this statutory provision is known as Kendra's Law).

107. *See, e.g.*, KY. REV. STAT. ANN. § 202A.181(1)-(2) (West 1988), which states:

> An authorized staff physician may release an involuntary patient on convalescent leave status when the physician concludes that the patient would not present a danger or a threat of danger to self or others if provided with continued medical supervision in a less restrictive alternative mode of treatment. Release on convalescent leave status shall include notification to the hospitalizing court. Release on convalescent leave status does not terminate the involuntary hospitalization order and shall include provisions for the development of a treatment plan jointly by the hospital and by a provider of outpatient care for follow-up care by the provider and for the continual monitoring of that patient's condition by the provider. . . . If there is reason to believe that it is to the best interest of the patient to be rehospitalized, the secretary or an authorized staff physician of the hospital may issue an order for the immediate rehospitalization of the patient. Such an order, if not voluntarily complied with, shall, upon the endorsement by a judge of any court of the county in which the patient is a resident or is present, authorize any health or police officer to take the patient into custody and transport him to the responsible hospital.

Id. In Wyoming, the law authorizes a hospital to "release an improved patient on convalescent leave" if the hospital "has determined that the patient is likely to follow the conditions the hospital determines necessary for the patient . . . [and] the patient will not likely be a danger to himself or others during convalescent leave . . . ." WYO. STAT. ANN. § 25-10-127 (West 2016). The hospital must "include a plan of treatment on an outpatient or nonhospital basis and other provisions for continuing responsibility of the patient by the hospital." *Id.*

108. The relevant statute in Maine authorizes the chief administrative officer of a psychiatric hospital or other mental health facility to

> [R]elease an improved patient on convalescent status when the chief administrative officer believes that the release is in the best interest of the patient and . . . the patient does not pose a likelihood of serious harm . . . . Release on convalescent status may include provisions for continuing responsibility to and by the psychiatric hospital, including a plan of treatment on an outpatient or nonhospital basis.

ME. REV. STAT. ANN. tit. 34-B, § 3870 (2007). If the conditions attendant to the convalescent status are not met by the patient, the law provides that:

> [A]n involuntarily committed patient on convalescent leave may be returned to the psychiatric hospital if . . . [b]ased upon clear and convincing evidence that return to the psychiatric hospital is in the patient's best interest or that the patient poses a likelihood of serious harm, [and] the District Court Judge or justice of the peace approves return to the psychiatric hospital.

Id.

consent of the patient.[109] Still others simply permit civilly committed patients to be placed in outpatient settings on conditions as a manifestation of the states' statutory least restrictive alternative requirement.[110]

Given this wide variation in format and terminology, it is not surprising that the relevant statutory provisions are to be found in different portions of each state's mental health and disability code. Some state legislatures address conditional release in the context of statutory provisions governing the periodic review of the status of civilly committed inpatients and the mechanisms for release when commitment criteria no longer persist.[111] Other states embed their conditional release provisions within sections dealing with other forms of mandatory outpatient treatment, including the outpatient commitment of persons not already in treatment.[112]

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109. *See, e.g.*, N.H. REV. STAT. ANN. § 135-C:50 (2020), which provides:

> The administrator, or designee, of a receiving facility may grant a conditional discharge under this chapter to any person who consents, by an informed decision, to participate in continuing treatment on an out-patient basis, who agrees to be subject to any rules adopted by the commissioner relative to conditional discharge, and who understands the conditions of his or her discharge. The administrator of the facility or the administrator's designee shall prepare, deliver a copy of, and read to the person being conditionally discharged a written statement of the conditions of conditional discharge and a warning that violation of those conditions may result in revocation of the conditional discharge pursuant to RSA 135-C:51.

Id.

110. In Rhode Island, for example, "[t]he official in charge of any facility . . . shall discharge any patient certified or admitted pursuant to the provisions of this chapter, when: (1) Suitable alternatives to certification or admission are available . . . ." R.I. GEN. LAWS ANN. § 40.1-5-11 (West 2023).

111. States have a legal obligation periodically to evaluate the status of patients being held involuntarily for treatment. In the leading case of *Fasulo v. Arafeh*, 378 A.2d 553, 556-57 (Conn. 1977), the Supreme Court of Connecticut struck down that state's indeterminate civil commitment statute, holding that the Connecticut constitution's due process clause requires the state periodically to review the status of all civilly committed patients. The Court explained:

> [S]ince the state's power to confine is premised on the individual's present mental status, the original involuntary commitment proceeding can only establish that the state may confine the individual at the time of the hearing and for the foreseeable period during which that status is unlikely to change. Upon the expiration of that period, the state's power to deprive the patient of his liberty lapses and any further confinement must be justified anew.

Id.

The leading text in this field notes that "virtually every state now requires, in line with the holding in *Fasulo*, that a review hearing be held after a certain period of involuntary treatment." *See* SLOBOGIN ET AL., *supra* note 53, at 969.

112. *See, e.g.*, N.C. GEN. STAT. ANN. § 122C-277 (1991), which provides that:

> [T]he attending physician shall discharge a committed respondent unconditionally at any time he determines that the respondent is no longer in need of inpatient commitment. However, if the attending physician determines that the respondent meets the criteria for outpatient commitment [as set out in the statutory section governing outpatient commitment] . . . he may request the clerk to calendar a supplemental hearing to determine whether an outpatient commitment order shall be issued.

Many states provide for the conditional release of psychiatric inpatients whose hospitalization is the result of their involvement in the criminal legal system.[113] The statutory authorization for the conditional release of these forensic inpatients often appears in a state's criminal procedure code and typically provides for more intensive regulation of the release of these persons than other forms of conditional release.[114]

SAMHSA's Fitch and Swanson explain that early forms of outpatient commitment—those based on the least restrictive alternatives doctrine and others that were step-down conditional release determinations—"were mostly non-controversial, but, from a clinical standpoint, they were not very practical."[115] This is because patients who met the state's dangerousness criterion for civil commitment were unlikely to be placed in outpatient treatment settings by "risk-averse" psychiatrists, while those who were no longer dangerous and thus no longer met the civil commitment criteria could be safely discharged and were entitled to release without conditions.[116] Following the promulgation of the APA's model commitment statute in the 1980s,[117] however, some states began enacting preventive outpatient commitment laws under which a person who is not currently dangerous to self or others

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Id.

113. *See* STARRETT ET AL., *supra* note 95, at 2–3.

114. *See, e.g.*, COLO. REV. STAT. ANN. § 16-8-115(3) (West 2023). This Article does not focus on forensic conditional release, which can be understood as a sort of shadow parole practice, because the range of permissible legal coercion in that context is likely to be broader than that which applies to patients subject to the ordinary civil commitment authority of the state. Writing for the majority in *Washington v. Harper*, Justice Kennedy observed that "[t]he extent of a prisoner's right under the [Due Process] Clause to avoid the unwanted administration of antipsychotic drugs must be defined in the context of the inmate's confinement." Washington v. Harper, 494 U.S. 210, 222 (1990). Kennedy went on to state:

> We hold that, given the requirements of the prison environment, the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest.

Id. at 227.

Of course, the state police power interests are somewhat different when the prisoner is considered for conditional release, because he or she, if released, will not be in the "prison environment." *Id.* Nevertheless, the general tenor of the *Harper* decision is that the government has somewhat greater discretion in the exercise of its police powers when the rights holder has become subject to treatment due to involvement in the criminal legal system. *See Harper*, 494 U.S. 210.

115. FITCH & SWANSON, *supra* note 2, at 16.

116. *See id.* Following a similar logic, Slobogin and colleagues raise the question whether conditional release programs are "permissible exercises of state power," given that "[m]ost statutes imply, if they do not state explicitly, that those patients who are conditionally released no longer meet inpatient commitment standards." SLOBOGIN ET AL., *supra* note 53, at 972 (*see In re* True, 645 P.2d 891, 898 (Idaho 1982)). These authors then ask, "under what authority may the state continue to maintain *any* control over the patient?" *Id.*

117. *See* Stromberg & Stone, *supra* note 45, at 330.

and thus not subject to inpatient commitment could still be subject to court ordered outpatient treatment on the basis of prophylactic criteria that focus on the individual's past treatment history and predictable deterioration.[118] In these states, conditional release is more likely to be provided for in the jurisdiction's preventive outpatient commitment statute and may not require a determination that the patient meets the more demanding dangerousness standard for inpatient commitment.[119] These prophylactic conditional release arrangements are also more likely to operate without requiring that the patient agree to (or provide informed consent for) the treatment conditions contained in the release order.[120] By contrast, jurisdictions that provide for the release of inpatients to some form of convalescent status on the premise that they no longer present a significant risk of harm to self or others may permit these patients to exercise more choice over whether to consent to treatment conditions, including medication obligations.[121] Occupying a middle position, a few states now authorize the conditional release of non-dangerous patients but require the clinician or court making the release decision to determine that the individual's ongoing safety is likely to be dependent on continuing medical supervision.[122]

There are different approaches to the question of consent in the jurisdictions that require patients voluntarily to agree to medication conditions as part of the release determination. In Tennessee, the law permits an inpatient to be discharged to mandatory outpatient treatment if a clinician determines that the individual is not likely to comply with treatment absent supervision.[123] The provision requires officials to "consult" with the patient regarding the treatment plan and to obtain her consent to the plan "to the extent practical."[124] Although there are no reported cases in which this statutory language has been interpreted, a plain reading would suggest that this consent provision is hortatory rather than required. By contrast, the law in Vermont authorizes conditional release "subject to the patient's agreement to participate in . . . treatment . . . ."[125] Presumably, this language makes the patient's

118. *See* SLOBOGIN ET AL., *supra* note 53, at 892.

119. For a state-by-state legal survey of the features of outpatient commitment statutes, *see* LAWATLAS, *supra* note 4.

120. *See id.*; *see also, e.g.*, 405 ILL. COMP. STAT. ANN. 5/2-107.1 (2018).

121. In Vermont, for example, "[a] conditional discharge may be granted subject to the patient's agreement to participate in outpatient, after-care, or follow-up treatment programs . . . ." VT. STAT. ANN. tit. 18, § 8007(d) (West 1977), and in New Hampshire "[t]he administrator, or designee, of a receiving facility may grant a conditional discharge under this chapter to any person who consents, by an informed decision, to participate in continuing treatment on an out-patient basis, who agrees to be subject to any rules adopted by the commissioner relative to conditional discharge, and who understands the conditions of his or her discharge." N.H. REV. STAT. ANN. § 135-C:50 (2020).

122. *See, e.g.*, KY. REV. STAT. ANN. § 202A.181(1) (West 1988).

123. *See* TENN. CODE ANN. § 33-6-603(a) (West 2010).

124. *Id.*

125. VT. STAT. ANN. tit. 18, § 8007 (West 1977).

consent a requirement, the withholding of which would prevent her conditional release. In New York, which permits conditional "release" for the duration of the authorized retention period as well as "discharge" from inpatient commitment upon conditions,[126] the governing statute recognizes a right held by the patient to withhold informed consent to the conditions for discharge.[127] In contrast no similar informed consent provision is provided for the conditional release option.[128] And in New Hampshire, the hospital administrator may grant a conditional discharge to an individual who "consents, by an informed decision," to participate in treatment.[129]

In summary, although some form of conditional release or discharge from involuntary hospitalization is available in virtually every jurisdiction, there is considerable variation with respect to the criteria by which the decision is made, the decision-maker authorized to approve a patient's release or discharge on conditions, the mechanisms for supervision and possible revocation, and the role that patient consultation and consent plays in formulating the conditions that govern the patient's release or discharge from inpatient status.

II. CONSENT TO TREATMENT

The right of most competent adults to refuse medical treatment is grounded in the common law doctrine of informed consent and buttressed by interests recognized in both state and federal constitutional law.[130] At common law, individuals have long held a legally protected interest in being free from unconsented bodily contact, including the provision of unwanted medical care.[131] Over time, courts and commentators have identified and refined the components that render consent to treatment legally effective. Essentially, legally adequate consent turns on three elements: the provision of relevant information; to a legally competent person; exercising choice that is voluntary and knowing.[132] As the doctrine has evolved within the common law of torts, a health-care provider's obligation to provide sufficient

126. *See* N.Y. MENTAL HYGIENE LAW § 29.15(b) (McKinney 2021).

127. The relevant section provides that "[n]o patient shall be required, as a condition precedent to his discharge, to agree to the terms of a written service plan. If after the advisability of following the program proposed in the written service plan has been explained to the patient who has been discharged or who is to be discharged, such patient expresses his objection to such program or any part thereof, a notation of such objection shall be made in the patient's records." *Id.* § 29.15(k).

128. *See id.* § 29.15(b)(1).

129. N.H. REV. STAT. ANN. § 135-C:50 (2020); *Cf.* MICH. COMP. LAWS ANN. § 330.1478 (West 2019) (providing for voluntary treatment upon discharge from either inpatient commitment or assisted outpatient commitment).

130. *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 268 (1990).

131. *See, e.g.*, Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626, 633 (Mass. 1986); Thor v. Superior Ct., 855 P.2d 375, 384 (Cal. 1993).

132. *See* WEINER & WETTSTEIN, *supra* note 20, at 115–16.

information to support an informed decision by her patient is not only essential to avoid liability for battery, but also recognized as a legal duty the breach of which may expose the provider to liability for professional negligence or malpractice.[133]

With respect to the requirement of legal competence, the law generally assumes that adult patients who have not been adjudicated incompetent retain the capacity to grant or withhold consent to treatment, even if their "clinical competence"[134] has been compromised by significant mental illness or other mental disability, and even if they have been involuntarily hospitalized following a civil commitment hearing.[135] The requirement that consent be granted voluntarily "means it cannot be made under a threat of force, coercion, compulsion, fraud, duress, deceit, or some other external influence or pressure."[136] Of course, many difficult choices that the law regards as voluntary nevertheless are constrained by circumstance and situation. The fact that a decision-maker may regard all of her available choices as unappealing or disfavored does not render her choice involuntary. In the context of an institutionalized psychiatric patient, however, it may be more challenging to ensure that a decision to accept treatment is sufficiently voluntary to satisfy the requirements of informed consent.[137]

The right to refuse medical treatment also implicates interests protected under the U.S. Constitution and many state constitutions.[138] In *Cruzan v. Director, Missouri Dep't of Health*, the U.S. Supreme Court addressed the right of individuals to refuse unwanted medical interventions.[139] Although the Court's majority recognized the authority of the state to impose reasonable restrictions on this right, it "assumed" and "strongly suggested" that the Due Process Clause of the Fourteenth

133. *See* Canterbury v. Spence, 464 F.2d 772, 790 (D.C. Cir. 1972).

134. "The term *clinical competence* generally refers to the functional ability of the patient to consent to or refuse medical and psychiatric intervention." WEINER & WETTSTEIN, *supra* note 20, at 116. While there is no single or universal measure of clinical competence, a series of factors developed by Paul Appelbaum and Loren Roth are often identified as the basis for measuring functional decision-making capacity. *See generally* Paul S. Appelbaum & Loren H. Roth, *Competency to Consent to Research: A Psychiatric Overview*, 39 ARCHIVES GEN. PSYCHIATRY 951 (1982). These factors include the ability to communicate a decision, the ability to understand basic information relevant to the decision, the ability to weigh the risks and benefits of competing choices, and the ability to appreciate the consequences of the decision. *Id.* A patient may retain legal competence even if she lacks clinical competence, as measured by one or more of the Appelbaum and Roth factors. *Id.*

135. Traditionally, involuntary hospitalization pursuant to a civil commitment proceeding created a legal presumption of incapacity to grant or withhold consent to treatment. *See* Boldt, *supra* note 72, at 17–18. Many U.S. jurisdictions have now abrogated that rule and require a separate incompetency adjudication before depriving patients of the right to exercise informed consent. *Id.*

136. WEINER & WETTSTEIN, *supra* note 20, at 117.

137. *See id.* at 117–18.

138. Cruzan v. Dir., Missouri Dep't of Health, 497 U.S. 261, 261 (1990).

139. *Id.*

Amendment protects the right of an individual to refuse unwanted lifesaving medical treatment.[140] Although the Supreme Court has not resolved with finality the question of what rights psychiatric patients have to refuse treatment, including unwanted antipsychotic medications, two decisions by the Court, *Washington v. Harper*[141] and *Sell v. United States*,[142] clearly recognized that they have interests under the Due Process Clauses that apply to forced medication decisions.[143] Other courts have explored the possibility of a patient's right to refuse antipsychotic drugs based on a constitutional interest in freedom of thought or mentation, privacy or bodily autonomy, the free exercise of religion, and freedom from cruel and unusual punishment.[144]

The freedom of mentation theory and the cruel and unusual punishment argument largely have not served as the basis for judicial decisions protecting the right of patients to refuse psychiatric treatment.[145] With respect to the free exercise claim, an early federal trial court decision involving a psychiatric patient who was a Christian Scientist, *Winters v. Miller*, held:

> [A] limitation on religious practices is proper when there is a compelling public interest which conflicts with the individual's private religious interest. In such circumstances the government may protect and promote the general health, safety and welfare of its citizens even where the result proves to be inconvenient or offensive to an individual's religious belief without the government's invading the liberties protected by the First and Fourteenth Amendments.[146]

On appeal, a panel of the Second Circuit Court of Appeals clarified that in a nonemergency, competent mentally ill persons do retain the right to refuse medication based on their religious beliefs.[147]

The privacy/bodily autonomy argument has prevailed in a number of instances. Some courts have recognized a federal constitutional liberty interest in withholding consent to treatment with antipsychotic medications, while still upholding state

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140. *Id.* at 278–79.

141. Washington v. Harper, 494 U.S. 210, 236 (1990).

142. Sell v. United States, 539 U.S. 166, 169 (2003).

143. *Id.* at 178–79.

144. *See generally* Perlin, *supra* note 7 (discussing cases that explore a patient's right to refuse antipsychotic drugs); *see also* WEINER & WETTSTEIN, *supra* note 20, at 124–25.

145. *See* WEINER & WETTSTEIN, *supra* note 20, at 124.

146. Winters v. Miller, 306 F. Supp. 1158, 1169 (E.D.N.Y. 1969).

147. Winters v. Miller, 446 F.2d 65, 65, 70 (2d Cir. 1971).

procedures for overriding the patient's refusal.[148] Other courts have grounded psychiatric patients' right to refuse medications on state constitutional provisions or state statutes.[149] In *Anderson v. Arizona*, for example, the Arizona Supreme Court held that in nonemergency situations state law provides patients who have not been adjudicated incompetent a right to refuse,[150] and in *Opinion of the Justices*, the New Hampshire Supreme Court relied on the state constitution to find that the forcible administration of antipsychotic medications is not permitted in the absence of a judicial determination of incompetency.[151]

A. Rennie v. Klein, Rogers v. Commissioner *and their Aftermath*

Two cases from the early 1980s, *Rennie v. Klein*[152] and *Rogers v. Commissioner*,[153] have provided the framework for much of the judicial and legislative doctrine that has developed at the state level to regulate the rights of involuntarily hospitalized psychiatric patients to grant or withhold consent to treatment with antipsychotic medications. Both cases involved complicated litigation histories. *Rennie* was one of the first cases to establish that an involuntarily hospitalized psychiatric patient has a qualified constitutional right to refuse antipsychotic medications.[154] The litigation commenced in 1977, when John Rennie, a patient at a state psychiatric hospital in New Jersey sought an injunction in federal district court to prevent the hospital from involuntarily administering him antipsychotic drugs.[155] Rennie had developed severe chronic mental illness in his early thirties and had been hospitalized and released a number of times in the following years.[156] As his symptoms worsened, staff at the hospital became concerned that Rennie might harm

148. *See, e.g.*, Project Release v. Prevost, 722 F.2d 960, 965–66, 980–81 (2d Cir. 1983) (refusing patients can be medicated in nonemergency situations pursuant to a three-tiered administrative review process); *see also In re* Guardianship of Roe, 421 N.E.2d 40, 42, 51 (Mass. 1981) (finding a right to refuse antipsychotic medication on both federal and state constitutional grounds).

149. *See* Anderson v. Arizona, 663 P.2d 570, 579 (Ariz. Ct. App. 1982); *see also* Op. of the Justs., 465 A.2d 484, 490 (N.H. 1983).

150. *Anderson*, 663 P.2d at 570.

151. *Op. of the Justs.*, 465 A.2d at 490. Similar decisions have been reached in a number of other states. *See, e.g.*, *In re* K.K.B., 609 P.2d 747, 751 (Okla. 1980) (competent psychiatric patient retains right to refuse medication absent emergency or judicial finding of incompetency and appointment of guardian); Riese v. St. Mary's Hosp. & Med. Ctr., 271 Cal. Rptr. 199, 213 (Cal. Ct. App. 1987) (finding a statutory right to refuse antipsychotic medication in a nonemergency situation absent a court finding of incompetency).

152. Rennie v. Klein, 720 F.2d 266 (3d Cir. 1983).

153. Rogers v. Comm'r of Dep't of Mental Health, 458 N.E.2d 308 (Mass. 1983).

154. *Rennie*, 720 F.2d at 269.

155. Rennie v. Klein, 462 F. Supp. 1131, 1134–35 (D.N.J. 1978).

156. *Id.* at 1135–36.

himself or others on the ward; consequently, they administered, against his wishes, prolixin, an injectable antipsychotic medication.[157]

Although initially an individual action, the litigation was expanded to include a class of all patients who were involuntarily hospitalized in state facilities in New Jersey.[158] In a detailed and widely read decision following a lengthy series of evidentiary hearings, District Judge Stanley Brotman rejected Rennie's argument that forced antipsychotic medication violates a patient's right to mentation under the First Amendment and right to be free from cruel and unusual punishment under the Eighth Amendment.[159] However, he found a constitutionally significant right to privacy implicated by the practice, given a psychiatric patient's interest in "protect[ing] one's mental processes from governmental interference."[160] The right, however, is not without qualification, explained Brotman.[161] The judge noted that, when a patient's refusal of treatment is a product of his or her underlying disease, the state's police power and *parens patriae* power might be sufficient to overcome the patient's constitutional right to refuse.[162] To effectuate decision-making that balanced these competing interests, Brotman ordered the state to provide treatment-resistant patients a series of due process protections, including the provision of patient advocates and other hearing rights.[163]

The trial court's decision in *Rennie* was appealed by the state to the Third Circuit.[164] That court upheld Judge Brotman's determination that involuntarily hospitalized patients have a qualified constitutional right to refuse, but reversed his ruling with respect to the procedures required to satisfy the state's constitutional obligations in cases involving involuntary medication.[165] The appeals court endorsed an alternative process for evaluating involuntary medication decisions, which had been promulgated by New Jersey's Division of Mental Health but found to be inadequate by Judge Brotman.[166] This administrative alternative permitted a treatment refusal to be reviewed by the treatment team and then by the medical director or his or her designee but did not require a due process hearing.[167] The U.S. Supreme Court

157. *Id.* at 1134–39.
158. Rennie v. Klein, 476 F. Supp. 1294, 1298 (D.N.J. 1979).
159. *Rennie*, 462 F. Supp. at 1143–45.
160. *Id.* at 1144.
161. *Id.* at 1145–48.
162. *Id.*
163. *Rennie*, 476 F. Supp. at 1313–15.
164. Rennie v. Klein, 653 F.2d 836, 836 (3d Cir. 1981) (en banc).
165. *Id.* at 845–51.
166. *Id.* at 849–52.
167. *See Rennie*, 462 F. Supp. at 1148–51 (reprinting Administrative Bulletin 78-3 as an appendix).

granted certiorari[168] and then remanded the case to the Third Circuit to reconsider its decision in light of the Court's then-recent decision in *Youngberg v. Romeo,* which had set out a "professional judgment" standard to evaluate the rights of involuntarily hospitalized psychiatric patients.[169] In the end, the Third Circuit concluded that a medical decision to administer medication involuntarily would be presumed valid if the procedures set out in the administrative policy adopted by the state's Division of Mental Health had been followed, absent a showing that the decision was a "substantial departure from accepted professional judgment, practice or standards."[170]

While the *Rennie* decision ultimately placed the weight of decision-making authority for contested psychiatric medication decisions in the hands of medical professionals, the *Rogers* case recognized judicial authority as primary when involuntarily committed patients resist the administration of antipsychotic drugs.[171] The litigation also began in the late 1970s, when patients at Boston State Hospital filed a class action in federal district court challenging the hospital's involuntary medication practices.[172] The state initially took the position, which had been the traditional view in most American jurisdictions, that patients who were involuntarily committed to hospital care were presumed to be incompetent to make treatment decisions, including decisions with respect to antipsychotic medications.[173] The district court rejected this position, holding that civilly committed psychiatric patients retain a presumption of competence to make treatment decisions, except in emergency situations where there was a substantial likelihood of harm to the patient or others.[174] On appeal, the First Circuit agreed that involuntarily hospitalized patients retain certain rights with respect to the refusal of antipsychotic medications but disagreed with the trial court's view that those rights could be abrogated only in emergencies.[175] Instead, with respect to the state's police powers, the appellate court advanced a balancing approach in which clinicians would be empowered to weigh the interests of patients in refusing treatment against the interests of the state in preventing harm.[176] To exercise the state's authority as *parens patriae*, the court required a determination of incompetency.[177] Once again, the case made its way to the U.S. Supreme Court, and once again that Court remanded to the Court of

168. Rennie v. Klein, 458 U.S. 1119 (1982).
169. Youngberg v. Romeo, 457 U.S. 307, 321–23 (1982).
170. Rennie v. Klein, 720 F.2d 266, 269 (3d Cir. 1983) (quoting *Youngberg*, 457 U.S. at 323).
171. Rogers v. Comm'r of Dep't of Mental Health, 458 N.E.2d 308, 314–19 (Mass. 1983).
172. Rogers v. Okin, 478 F. Supp. 1342, 1352 (D. Mass. 1979).
173. *Id.*
174. *Id.* at 1361–62, 1365–69.
175. *Id.* at 1370; Rogers v. Okin, 634 F.2d 650 (1st Cir. 1980).
176. *Rogers*, 634 F.2d at 656–57.
177. *Id.* at 657.

Appeals, in this instance to make a determination of the legal position of the parties under Massachusetts state law.[178] On remand, the First Circuit certified a series of questions with respect to state law to the Supreme Judicial Court of Massachusetts, whose decision essentially resolved the litigation.[179] This decision, *Rogers v. Commissioner of Department of Mental Health,* proved to be influential in the development of legal standards governing the right to refuse treatment developed subsequently in a number of other states.[180]

The Massachusetts Supreme Court's analysis was grounded in its conclusion that civil commitment or involuntary psychiatric hospitalization does not automatically support a determination of incompetency to make treatment decisions.[181] The Massachusetts court did agree that the state's police powers were sufficient to support involuntary administration of antipsychotic medications in emergencies or when necessary "to prevent the immediate, substantial, and irreversible deterioration of a serious mental illness."[182] In general, however, the court concluded that, absent an emergency, involuntary medication requires a judicial determination of incompetency along with a substituted judgment determination that the patient would have consented to the antipsychotic medication if competent.[183]

The *Rogers* decision was the culmination of a process of doctrinal elaboration by the Supreme Judicial Court of Massachusetts that took place over a six-year period.[184] The starting point was in 1977, when the court decided *Superintendent of Belchertown State School v. Saikewicz*.[185] That case involved an elderly patient, Joseph Saikewicz, who was profoundly intellectually disabled and who suffered from leukemia.[186] Mr. Saikewicz's guardian sought to withhold consent to cancer treatment.[187] The Massachusetts Supreme Court held that there is "a general right in all persons," competent and incompetent, "to refuse medical treatment in appropriate circumstances."[188] To safeguard this right, the court set out a process of substitute decision-making for incompetent patients, which became the foundation for the substitute decision-making component subsequently included in the *Rogers*

178. Mills v. Rogers, 457 U.S. 291, 291 (1982).
179. *Id.* at 292.
180. Rogers v. Comm'r of Dep't of Mental Health, 458 N.E.2d 308, 308 (Mass. 1983).
181. *Id.*
182. *Id.* at 311 (internal quotations omitted).
183. *Id.* at 314–15.
184. *Id.*
185. 370 N.E.2d 417, 418 (Mass. 1977).
186. *Id.*
187. *Id.*
188. *Id.* at 427.

decision.[189] Pursuant to that process, the court concluded that Saikewicz, if competent, would have refused treatment and thus his guardian was permitted to withhold consent to treatment on his behalf.[190] Although the *Saikewicz* case did not involve a civilly committed psychiatric patient, it established an important set of predicates that ultimately lead to the position the court took in *Rogers*.

The next development under Massachusetts law was the 1981 case, In re *Guardianship of Roe*.[191] This litigation involved a psychiatric patient's refusal of antipsychotic medication, although it did not involve a patient who was involuntarily hospitalized.[192] Roe's guardian, his father, had consented to the administration of the medication even though Roe had objected.[193] The court's assessment of this conflict contained two key elements.[194] First, the court held that mentally ill patients, even when adjudicated incompetent and assigned a guardian, retain certain essential rights with respect to the granting or withholding of consent to treatment with antipsychotic drugs.[195] Thus, the court explained: "[I]n the absence of an independent finding of incompetency to make treatment decisions, we cannot assume that a mentally ill ward lacks the capacity to make a treatment decision of this magnitude."[196] Second, picking up on the notion of substituted judgment recognized in *Saikewicz*, the Court held that when a psychiatric patient does lack capacity to decide, their expressed preference is "entitled to serious consideration" by the substitute decision-maker and that decision ordinarily should rest with a judicial actor.[197]

Both of these elements were reiterated and reinforced in *Rogers*, and the Massachusetts Supreme Court's opinion in that case was studied by and cited in the decisions of a number of other state courts.[198] To be sure, *Rogers*'s substitute judgement requirement–that the involuntary administration of medication depends upon an assessment of what the patient would have agreed to if competent–was not widely adopted by courts in other jurisdictions, although it did find expression in some states' statutory formulations.[199] On the other hand, numerous state courts

189. *Id.* at 431.

190. *Id.* at 435.

191. 421 N.E.2d 40 (Mass. 1981).

192. *Id.* at 43.

193. *Id.* at 43–44.

194. *Id.* at 45–57.

195. *Id.* at 51–55.

196. *Id.* at 55.

197. *Id.* at 56–57.

198. *See, e.g.*, Steele v. Hamilton Cnty. Cmty. Mental Health Bd., 736 N.E.2d 10, 20–21 (Ohio 2000); *In re* Guardianship of Ingram, 689 P.2d 1363, 1370 (Wash. 1984).

199. *See, e.g.*, MINN. STAT. ANN. § 253B.092(7)(b) (West 2020) ("If the patient clearly stated what the patient would choose to do in this situation when the patient had the capacity to make a reasoned decision, the patient's wishes must be followed."); N.M. STAT. ANN. § 43-1-15(F) (West 2009)

adopted the Massachusetts Supreme Court's position that a judicial determination of incompetence is required before a refusing patient can be given antipsychotic drugs, at least in the absence of an emergency that threatens the wellbeing of the patient or others.[200] Thus, in *Rivers v. Katz*, the New York Court of Appeals held that before administering involuntary antipsychotic medications, state officials must establish by clear and convincing evidence presented before a judicial decision-maker that "the patient lacks the capacity to determine the course of his own treatment."[201] The Court grounded this requirement in the "firmly established principle of the common law of New York that every individual 'of adult years and sound mind has a right to determine what shall be done with his own body' . . . and to control the course of his medical treatment."[202] The Court also characterized the relevant interest in privacy as one protected by the State's constitution.[203]

Similarly, in *Riese v. St. Mary's Hospital & Medical Center,* the California Court of Appeals held that, absent an emergency or a judicial determination of incompetence, an involuntarily hospitalized patient's consent was required before antipsychotic drugs could be administered.[204] Moreover, the Court explained that to determine whether an involuntary patient has the requisite competency to consent to treatment with antipsychotic drugs, a court

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> In making a decision, the treatment guardian shall consult with the client and consider the client's expressed opinions, if any, even if those opinions do not constitute valid consent or rejection of treatment. The treatment guardian shall give consideration to previous decisions made by the client in similar circumstances when the client was able to make treatment decisions.

Id.; WASH. REV. CODE ANN. § 71.05.217(1)(j)(ii) (West 2021) ("If the patient is unable to make a rational and informed decision about consenting to or refusing the proposed treatment, the court shall make a substituted judgment for the patient as if he or she were competent to make such a determination.").

200. *E.g.*, Rivers v. Katz, 495 N.E.2d 337 (N.Y. 1986).

201. *Id.* at 344.

202. *Id.* at 341.

203. *Id.* This constitutional right to privacy, explained the New York Court of Appeals, is an essential element of:

> our system of a free government, where notions of individual autonomy and free choice are cherished, [so that] it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires.

Id.

204. Riese v. St. Mary's Hosp. & Med. Ctr., 271 Cal. Rptr. 199 (Cal. Ct. App. 1987). The Court of Appeal recognized the then-dominant federal standard was one of deference to the professional judgment of treatment professionals; however, relying primarily on the language of California's Lanterman–Petris–Short Act, the Court concluded that the question of competence to make treatment decisions should rest primarily with the court. *Id.* at 210–11.

> should focus primarily upon three factors: (a) whether the patient is aware of his or her situation (e.g., if the court is satisfied of the existence of psychosis, does the individual acknowledge that condition); (b) whether the patient is able to understand the benefits and the risks of, as well as the alternatives to, the proposed intervention . . .; and (c) whether the patient is able to understand and to knowingly and intelligently evaluate the information required to be given patients whose informed consent is sought . . . and otherwise participate in the treatment decision by means of rational thought processes.[205]

In 1985, the Supreme Court of Colorado, in *People v. Medina*, also recognized the right of a competent psychiatric patient to refuse antipsychotic medications.[206] In that case, a thirty-four-year-old man who had been committed to a mental health facility for long-term treatment refused the antipsychotic medication that his doctors sought to administer to him.[207] The Court ruled that unless there is an emergency that poses an immediate and substantial threat to the life or safety of the patient or others in the institution, antipsychotic medicine may be administered to a nonconsenting mentally ill patient

> only after the trial court conducts a full and fair adversary hearing on the treatment decision and is satisfied by clear and convincing evidence that: (1) the patient is incompetent to effectively participate in the treatment decision; (2) treatment by antipsychotic medication is necessary to prevent a significant and likely long-term deterioration in the patient's mental condition or to prevent the likelihood of the patient's causing serious harm to himself or others in the institution; (3) a less intrusive treatment alternative is not available; and (4) the patient's need for treatment by antipsychotic medication is sufficiently compelling to override any bona fide and legitimate interest of the patient in refusing treatment.[208]

The *Medina* Court's decision to require trial courts in that state to make specific enumerated findings beyond a threshold determination with respect to the patient's incapacity to make a treatment decision is characteristic of the approach adopted by several other state appellate courts. Not infrequently, these opinions require a finding, in line with *Medina*, that the involuntary administration of the proposed medication is the least intrusive or least restrictive intervention available in light of the

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205. *Id.* at 211–212. The Court further explained: "With respect to this last consideration, it has with reason been urged that 'the appropriate test is a negative one: in the absence of a clear link between an individual's delusional or hallucinatory perceptions and his ultimate decision,' it should be assumed 'that he is utilizing rational modes of thought.'" *Id.* (citation omitted).

206. 705 P.2d 961 (Colo. 1985).

207. *Id.*

208. *Id.* at 963–64.

patient's circumstances.[209] In addition, some decisions require a judicial evaluation of the relative risks and benefits associated with the antipsychotic drugs to be administered,[210] while others require judicial decision-makers to consider whether involuntary medication is necessary to prevent significant deterioration in the patient's condition or to bring about a shorter period of inpatient hospitalization.[211] These considerations have also found their way into statutes that many states have adopted to govern the involuntary medication of hospitalized psychiatric patients.[212]

While some state courts relied primarily on state constitutional law principles to ground the right of competent psychiatric patients to refuse unwanted medications,[213] others based their recognition of this right on state statutes that had codified the elements developed in cases such as *Rogers* and *Rivers v. Katz.*[214] The New Hampshire Supreme Court, in addressing questions propounded to the court by that state's senate as to the constitutionality of proposed legislation governing involuntary medication, concluded that the relevant statutory language failed constitutional muster precisely because it did not comport with fundamental principles of due process.[215] The justices determined that patients have a right under the Due Process Clause of the New Hampshire Constitution "to be free from unjustified intrusion upon their personal security," which includes the right to refuse unwanted medical or psychiatric treatment.[216] Although that right is not absolute, explained the court, since the state retains a police power interest in involuntary medication in emergencies and a *parens patriae* interest when a proper judicial determination of

209. *See, e.g.*, Steele v. Hamilton Cnty. Cmty. Mental Health Bd., 736 N.E.2d 10, 20–21 (Ohio 2000); *In re* L.A., 912 A.2d 977, 980 (Vt. 2006).

210. *See, e.g.*, *In re* L.A., 912 A.2d at 980.

211. *See, e.g.*, D.T. v. Dep't of Hum. Servs., 269 P.3d 96, 100 (Or. Ct. App. 2011).

212. *See infra* notes 240-242, 258 and accompanying text.

213. In *Jarvis v. Levine*, for example, the Minnesota Supreme Court held that the legal protections recognized in an earlier decision to protect psychiatric patients facing psychosurgery and electroshock treatments also applied to patients refusing treatment with antipsychotic drugs. 418 N.W.2d 139, 148 (Minn. 1988). In explaining this ruling, the Court stated: "This holding is specifically made under Minn. Const. art. I, §§ 1, 2, 10 and not pursuant to any law or provision of the United States Constitution." *Id.* Similarly, in *Steele v. Hamilton County Community Mental Health Board*, the Supreme Court of Ohio, in holding that an involuntarily hospitalized patient retains the right to refuse antipsychotic medications absent an emergency or a judicial finding of lack of capacity, explained that "[t]he right to refuse medical treatment is a fundamental right in our country, where personal security, bodily integrity, and autonomy are cherished liberties. These liberties were not created by statute or case law. Rather, they are rights inherent in every individual." 736 N.E.2d 10, 15 (Ohio 2000) (quoting and citing OHIO CONST. art. I, § 1).

214. *See, e.g.*, *In re* L.A., 912 A.2d at 980.

215. Op. of the Justs., 465 A.2d 484, 491 (N.H. 1983).

216. *Id.* at 488–89.

incompetency has been made, the proposed statute failed to provide adequate safeguards to satisfy both the State's substantive and procedural due process guarantees.[217]

In In re *L.A.*, by contrast, the Vermont Supreme Court relied not on the federal or state constitution but solely on the authority of the relevant state statute to reverse a family court decision granting the State's petition for involuntary psychiatric medication.[218] The Supreme Court began its analysis by noting that, pursuant to the express language of the Vermont Statute, "[i]t is the policy of the general assembly to work towards a mental health system that does not require coercion or the use of involuntary medication."[219] The Court then set out a two-step process for determining whether to authorize the administration of antipsychotic medications, which it derived directly from the governing statutory provision.[220] First, a family court considering a petition must determine whether the patient is competent based on "whether the person is able to make a decision and appreciate the consequences of that decision."[221] If the patient is determined to be competent to refuse treatment, the petition must be rejected, even if the medications would be in their objective best interests.[222] If, on the other hand, the court finds that the patient is not capable of making an informed and competent decision, a second inquiry must be undertaken in which the court evaluates the patient's religious convictions (if any), the impact of the medication decision on the patient's relationship with her family or other household members, the potential side effects of the drug, its likely risks and benefits, and whether any less intrusive alternative is available.[223] A consideration of these factors, explained the state Supreme Court, could lead to a decision not to authorize involuntary administration of antipsychotic medications even if the patient is found to lack capacity to make a treatment decision.[224]

The Vermont Supreme Court had important things to say about the competence required under the statute either to consent to or refuse medications. If a patient can understand the consequences of refusing medication, explained the court, the statute prohibits its involuntary administration.[225] The consequences the patient must be able to appreciate, however, "must be real, and not imaginary or delusional. Nevertheless, the statute requires only that [the] patient appreciate those consequences,

217. *Id.* at 489–90.
218. 912 A.2d at 984.
219. *Id.* at 979 (quoting VT. STAT. ANN. tit. 18, § 7629(c) (2014)).
220. *Id.* at 980.
221. *Id.* at 979 (citing VT. STAT. ANN. tit. 18, § 7625(c) (West 2023)).
222. *See id.*
223. *See id.* at 982–83.
224. *Id.* at 980–81 (citing VT. STAT. ANN. tit. 18, § 7629(c) (2014)).
225. *Id.* at 981.

not that he make the best decision in light of those consequences, or that he agree with his psychiatrist."[226] In this respect, the competence required under the Vermont statutory scheme may be a more demanding standard than the capacity required in some other states. For example, the Ohio Supreme Court, in *Steele v. Hamilton County Community Mental Health Board*, held that a court need not adjudicate a patient as incompetent to authorize involuntary medication, but only that the patient "lacks the capacity to decide for himself whether he should take the drugs."[227] Similarly, an Iowa appellate court held that a psychiatric patient has no right to refuse antipsychotic medications, even in the absence of a judicial finding of incompetency, if a judge finds that there is a need for treatment and the patient is unable "to make an informed judgment due to the presence of mental illness."[228] These cases articulate a range of competency standards that fall along a continuum marked by full legal competence at one end and some version of clinical competence at the other.[229] In a few jurisdictions, state appellate courts have rejected such a continuum altogether and have adopted instead the view of the Third Circuit in *Rennie v. Klein* that the involuntary administration of antipsychotic medications is permissible based on a professional judgment standard, even absent a finding of patient incompetence or incapacity to make a treatment decision.[230] Thus, in *Large v. Superior Court*, the Supreme Court of Arizona held that the state's Due Process Clause permits the involuntary administration of antipsychotic drugs "for purposes of *treatment* if it is authorized by proper procedural regulations, and if the drug administration is approved by qualified medical judgment *and* is prescribed for valid medical reasons."[231] On balance, however, the majority of state appellate courts that have considered the question have held that involuntary psychiatric medication is permissible only in an emergency or following a determination that the patient is not capable of making a competent treatment decision.[232]

B. State Statutes Governing the Right to Consent to or Refuse Antipsychotic Medications

The rights of involuntarily hospitalized psychiatric patients to consent to or refuse antipsychotic medications are also governed by statute in virtually every

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226. *Id.* at 981–82.

227. 736 N.E.2d 10, 19 (Ohio 2000) (quoting Rivers v. Katz, 495 N.E.2d 337, 343 (N.Y. 1986)).

228. *In re* R.M.P., 521 N.W.2d 765, 767 (Iowa Ct. App. 1994).

229. *See generally* Appelbaum & Roth, *supra* note 134 (noting the difference between "legal competence" and "clinical competence").

230. 720 F.2d 266, 273–75 (3d Cir. 1983).

231. 714 P.2d 399, 409 (Ariz. 1986). It is worth noting that the patient in *Large* was an inmate who had been convicted of a criminal offense. *Id.*

232. *See id.*

state.[233] While there is general agreement that states retain the authority under their police powers to administer antipsychotic drugs in emergency situations,[234] there is considerable state-by-state variation in how these state laws define a qualifying emergency and in identifying who is entitled to make the determination that an emergency exists.[235] The statutes in some states define a qualifying emergency by reference to circumstances that pose a direct and imminent threat of serious bodily harm to the patient, to other patients, or to clinical staff.[236] Provisions in other states adopt a more expansive view in which significant deterioration in the patient's functioning or an acceleration of psychotic symptoms are included as elements supporting the use of the state's powers to administer involuntary medications.[237]

With respect to the states' *parens patriae* powers, statutory provisions vary even more widely from jurisdiction to jurisdiction regarding the rights of

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233. *See* WEINER & WETTSTEIN, *supra* note 20, at 129–30.

234. *See id.*

235. In some states, clinicians are authorized to make the determination that an emergency exists sufficient for involuntary medication. *See, e.g.*, MINN. STAT. ANN. § 253B.092(3) (West 2020) ("A treating medical practitioner may administer neuroleptic medication to a patient who does not have capacity to make a decision regarding administration of the medication if the patient is in an emergency situation."); OKLA. STAT. ANN. tit. 43A, § 5-204(B) (West 2019) ("Treatment and medication may be administered to a nonconsenting individual upon the written order of the physician who: 1. Has personally examined the consumer; [and] 2. Finds the medication or treatment is necessary to protect the consumer, the facility or others from serious bodily harm . . . ."). In a few states, however, the decision to administer antipsychotic medications because of the immediate risk of serious injury to the patient or others requires judicial authorization. *See, e.g.*, CONN. GEN. STAT. ANN. § 17a-543(f) (West 2007)

> The Probate Court may authorize the administration of medication to the patient pursuant to this subdivision if the court finds by clear and convincing evidence that . . . without medication, the psychiatric disabilities with which the patient has been diagnosed will continue unabated and place the patient or others in direct threat of harm.

Id.

236. *See, e.g.*, CAL. WELF. & INST. CODE § 5008(m) (West 2024) ("'Emergency' means a situation in which action to impose treatment over the person's objection is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient or others, and it is impracticable to first gain consent."); 405 ILL. COMP. STAT. ANN. 5/2-107(a) (2015) (stating if therapeutic services, including medications, are refused "they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available."); OKLA. STAT. ANN. tit. 43A, § 5-204(B) (West 2019).

237. *See, e.g.*, CONN. GEN. STAT. ANN. § 17a-543(d) (West 2007) (permitting involuntary medication for up to thirty days if "there is substantial probability that without such medication for the treatment of the psychiatric disabilities of the patient the condition of the patient will rapidly deteriorate . . . ."); WASH. REV. CODE ANN. § 71.05.215(1) (West 2020)

> [A person has a] right to refuse antipsychotic medication unless it is determined that the failure to medicate may result in a likelihood of serious harm or substantial deterioration or substantially prolong the length of involuntary commitment and there is no less intrusive course of treatment than medication in the best interest of that person.

Id.

psychiatric patients to refuse treatment in the absence of an emergency. In general, however, these statutes fall into two broad categories. State law provisions that comprise the first, most rights-protective group prohibit the involuntary administration of medications absent a judicial finding that the patient lacks capacity to exercise informed consent,[238] coupled with some set of additional requirements that the relevant judicial officer must find before approving a petition for forced medication.[239] These additional requirements might include a determination that the proposed medication is the least intrusive alternative available,[240] that its likely benefits outweigh its risks,[241] that is medically necessary for the effective treatment of the patient's condition,[242] or that the choice to administer antipsychotic drugs reflects what the patient would want if she were competent.[243]

The laws in this first category restricting the involuntary administration of antipsychotic medications in nonemergency situations vary in how they characterize the impaired decision-making capacity required to override a patient's refusal. Some provisions employ the language of legal incompetence, which presumably implicates the jurisdiction's rules governing incompetency determinations more generally, including the appointment of legal guardians and other substitute decision-makers.[244] The statutes in other states use the language of incapacity, which

238. The statutes in some states set out the elements necessary for informed consent. *See, e.g.*, CAL. WELF. & INST. CODE § 5326.2 (West 2023).

239. *See, e.g.*, CAL. WELF. & INST. CODE § 5332(b) (West 2002); KY. REV. STAT. ANN. § 202A.196(3)(c) (West 1988); VT. STAT. ANN. tit. 18, § 7627(c)(5) (West 2014).

240. *See, e.g.*, CAL. WELF. & INST. CODE § 5332(b) (West 2002) (involuntary medication permitted "only when treatment staff have considered and determined that treatment alternatives to involuntary medication are unlikely to meet the needs of the patient"); KY. REV. STAT. ANN. § 202A.196(3)(c) (West 1988) (in evaluating whether to order involuntary medication, the District Court shall consider, *inter alia*, "[w]hether any less restrictive alternative treatment exists"); VT. STAT. ANN. tit. 18, § 7627(c)(5) (West 2014) (court must consider, *inter alia*, "the various treatment alternatives available, which may or may not include medication").

241. *See, e.g.*, 405 ILL. COMP. STAT. ANN. 5/2-107.1 (2018) (court may authorize the involuntary administration of antipsychotic medications if it finds, *inter alia*, "[t]hat the benefits of the treatment outweigh the harm"); VT. STAT. ANN. tit. 18, § 7627(c)(4) (West 2014) (court must consider, *inter alia*, "the risks and benefits of the proposed medication . . .").

242. *See, e.g.*, VA. CODE ANN. § 37.2-1101(G) (West 2012)

> Prior to authorizing treatment pursuant to this section, the court shall find . . . [t]hat the person who is the subject of the petition is unlikely to become capable of making an informed decision or of communicating an informed decision within the time required for decision; and [t]hat the proposed treatment is in the best interest of the person and is medically and ethically appropriate . . . .

Id.

243. *See, e.g.*, MINN. STAT. ANN. § 253B.092(7)(b) (West 2020).

244. *See, e.g.*, WIS. STAT. ANN. § 55.14(3)(b) (West 2022) (defining the statutory phrase "not competent to refuse psychotropic medication").

may or may not overlap completely with the concept of legal incompetence.[245] The Supreme Court of New Hampshire, in *Opinion of the Justices*, explained that a finding as required by statute "that '[t]he patient, because of physical or mental condition [is] unable to make an informed decision . . . with respect to the medical or psychiatric treatment offered . . . .' is the equivalent of a finding of incompetency and, as such, would be a sufficient basis for the State's exercise of its *parens patriae* power."[246] By contrast, the Ohio Supreme Court, in *Steele v. Hamilton County Community Mental Health Board*, determined that "a person need not be *adjudicated incompetent* before the state's *parens patriae* power is legitimately invoked in a forced medication case."[247] It is sufficient, said the court, that a judge "finds by clear and convincing evidence that the patient lacks the capacity to give or withhold informed consent regarding treatment."[248]

Often, these statutes and the state appellate court decisions interpreting them focus on the judgment of patients to make an informed decision and on the degree to which that judgment is thought to be impaired as a result of mental illness. For example, the relevant provision in Michigan, in setting out the elements of informed consent, requires a court to consider the "[c]omprehension" of the patient with respect to the "personal implications" of the medication decision and the "[v]oluntariness" of that decision.[249] In Oregon, implementing regulations provide: "A person committed to the Division may be deemed unable to consent to or refuse, withhold, or withdraw consent to a significant procedure only if the person currently demonstrates an inability to reasonably comprehend and weigh the risks and benefits of the proposed procedure, alternative procedures, or no treatment at all . . . ."[250] Similarly, in South Dakota the law permits a court to grant a petition for involuntary administration of medication only if it finds the patient is "incapable of consenting to such treatment because the person's judgment is so affected by mental illness

245. *See, e.g.*, ME. REV. STAT. tit. 34-B, § 3864(7-A) (2021)

> The court may grant a psychiatric hospital power to implement a recommended treatment plan without a person's consent for up to 120 days or until the end of the commitment, whichever is sooner, if upon application the court finds . . . [t]hat the person lacks the capacity to make an informed decision regarding treatment . . . .

Id.; TEX. HEALTH & SAFETY CODE ANN. § 574.106(a-1) (West 2023) ("The court may issue an order under this section only if the court finds by clear and convincing evidence . . . that the patient lacks the capacity to make a decision regarding the administration of the proposed medication . . . .").

246. Op. of the Justs., 465 A.2d 484, 490 (N.H. 1983).

247. 736 N.E.2d 10, 20 (Ohio 2000) (emphasis in original).

248. *Id.* The Court went on to explain, "[w]e believe that requiring an adjudication of general incompetence in these cases would result in the unnecessary removal of additional civil rights particularly when a specific finding of lack of capacity regarding treatment is sufficient." *Id.*

249. MICH. ADMIN. CODE R 330.7003(1)(c)-(d) (1998).

250. OR. ADMIN. R. 309-114-0010(2)(a) (2018).

that the person lacks the capacity to make a competent, voluntary, and knowing decision concerning such treatment."[251]

In a minority of states, the relevant statutes authorize the involuntary administration of antipsychotic medications even when the patient has not been adjudicated incompetent or determined to have an impaired capacity to make a reasoned treatment decision.[252] The provisions that comprise this second category of state laws are less rights-protective because they permit involuntary treatment in situations where the decision-maker determines that antipsychotic medications are in the patient's best interest even though the patient has withheld informed consent.[253] In

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251. S.D. CODIFIED LAWS § 27A-12-3.13 (2012). In South Carolina, a psychiatric patient may not be given treatment except by express and informed consent. *See* S.C. CODE ANN. § 44-22-140 (2022). A "patient unable to consent" is defined as "a patient unable to appreciate the nature and implications of his condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner." S.C. CODE ANN. § 44-22-10(12) (2015).

252. *See, e.g.*, MD. CODE ANN., HEALTH-GEN. § 10-708(b) (West 2018) ("Medication may not be administered to an individual who refuses the medication, except . . . [i]n a nonemergency, when the individual is hospitalized involuntarily or committed for treatment by order of a court and the medication is approved by a panel under the provisions of this section."); N.C. GEN. STAT. ANN. § 122C-57(e) (2019)

> [Treatment] may be given despite the refusal of the client . . . [when] in the professional judgment, as documented in the client's record, of the treating physician and a second physician, who is either the director of clinical services of the facility, or the director's designee, that any of the following is true: (1) The client, without the benefit of the specific treatment measure, is incapable of participating in any available treatment plan which will give the client a realistic opportunity of improving the client's condition. (2) There is, without the benefit of the specific treatment measure, a significant possibility that the client will harm self or others before improvement of the client's condition is realized.

Id.; WASH. REV. CODE ANN. § 71.05.215(1) (West 2020).

253. *See, e.g.*, N.D. CENT. CODE ANN. § 25-03.1-18.1(1) (West 2017)

> [A] mental health professional may request authorization from the court to treat an individual under a mental health treatment order with prescribed medication . . . [if the court finds:] (1) That the proposed prescribed medication is clinically appropriate and necessary to effectively treat the patient and that the patient is a person requiring treatment; (2) That the patient was offered that treatment and refused it or that the patient lacks the capacity to make or communicate a responsible decision about that treatment; (3) That prescribed medication is the least restrictive form of intervention necessary to meet the treatment needs of the patient; and (4) That the benefits of the treatment outweigh the known risks to the patient.

Id.; *see also* W. VA. CODE ANN. § 27-6A-10(b) (West 2021) ("An individual with health care decision-making capacity may refuse medications or other management unless court-ordered to be treated . . . ."). In Montana, "[t]he court may authorize the chief medical officer of a facility or a physician designated by the court to administer appropriate medication involuntarily if the court finds that involuntary medication is necessary to protect the respondent or the public or to facilitate effective treatment." MONT. CODE ANN. § 53-21-127(6) (West 2017). In its decision in *In re Mental Health of S.C.*, the Montana Supreme Court explained that the state legislature's enactment of this statute permitting involuntary antipsychotic medication replaced the common law right to informed consent. 15 P.3d 861,

effect, this group of state statutes adopts a more paternalistic approach than the relatively libertarian stance reflected in the first group.

Statutory language in many states formally recognizes that involuntary hospitalization does not extinguish the array of civil rights held by patients, including the right to enter into a contract, to marry, or to vote.[254] Frequently, these statutes include the right to grant or withhold informed consent to psychiatric treatment as an additional legal entitlement.[255] In the few jurisdictions that have retained the rule that civil commitment necessarily constitutes an adjudication of incompetence to make treatment decisions, no additional judicial or clinical evaluation of capacity is required for forced medication.[256] By contrast, in the states whose statutes fall in

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863 (Mont. 2000). The Court held that this was not a violation of due process under either the U.S. or state constitution, even though the statute does not require a finding of incompetency, because the finding of "mental disorder" as required under the statute is defined as an "impairment that has a substantial adverse effect on . . . cognitive and volitional functions." *Id.* at 863.

254. *See, e.g.*, LA. STAT. ANN. § 28:171(A) (2018)

> No patient in a treatment facility pursuant to this Chapter shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the state of Louisiana, or the Constitution of the United States solely because of his status as a patient in a treatment facility. These rights, benefits, and privileges include, but are not limited to, civil service status; the right to vote; the right to privacy; rights relating to the granting, renewal, forfeiture, or denial of a license or permit for which the patient is otherwise eligible; and the right to enter contractual relationships and to manage property.

Id.; N.J. STAT. ANN. § 30:4-24.2(a) (West 2013)

> [N]o patient shall be deprived of any civil right solely because of receipt of treatment under the provisions of this Title nor shall the treatment modify or vary any legal or civil right of any patient, including, but not limited to, the right to register for and to vote at elections, or rights relating to the granting, forfeiture, or denial of a license, permit, privilege, or benefit pursuant to any law.

Id.; R.I. GEN. LAWS ANN. § 40.1-5-5(h) (West 2023)

> A person shall not, solely by reason of the person's admission or certification to a facility for examination or care and treatment under the provisions of this chapter, thereby be deemed incompetent to manage the person's affairs; to contract; to hold or seek a professional, occupational, or vehicle operator's license; to make a will; or for any other purpose.

Id.

255. *See, e.g.*, CAL. WELF. & INST. CODE § 5331 (West 2012) ("No person may be presumed to be incompetent because he or she has been evaluated or treated for mental disorder or chronic alcoholism, regardless of whether such evaluation or treatment was voluntarily or involuntarily received."); *see also* LA. STAT. ANN. § 28:171(B) (2018) ("No patient in a treatment facility shall be presumed incompetent, nor shall such person be held incompetent except as determined by a court of competent jurisdiction. The determination of incompetence shall be separate from the judicial determination of whether the person is a proper subject for involuntary commitment."); *see also* N.J. STAT. ANN. § 30:4-24.2(c) (West 2013) ("No patient may be presumed to be incapacitated because of an examination or treatment for mental illness, regardless of whether the evaluation or treatment was voluntarily or involuntarily received.").

256. *See In re Mental Health of S.C.*, 15 P.3d at 863 (holding that the statutory elements required for civil commitment are sufficient to establish "a substantial adverse effect on [] cognitive and

the first category identified above, absent an emergency, the right to withhold consent shields psychiatric patients from involuntary medication decisions until a judicial officer has determined that they lack the competence or capacity to make a reasoned decision. In addition to ensuring that patients with capacity are protected from involuntary medication, the regulations in some of these jurisdictions also articulate the conditions under which legally adequate consent to treatment must be obtained.[257] Typically, these more detailed provisions require that patients receive adequate information about the proposed treatment and its alternatives[258] and that they have access to independent advisors or advocates.[259] In addition, a few require that patients be permitted to exercise their choice free of duress, coercion, or compulsion.[260]

This array of approaches to balancing the individual liberty interests held by psychiatric patients against the competing police power and *parens patriae* interests advanced by state actors can be assessed using an analytic framework developed by Thomas Beauchamp and James Childress. The Beauchamp and Childress framework, which has been influential in both academic philosophy and applied ethics, sets out four factors for evaluating public health policy: respect for autonomy, nonmaleficence, beneficence, and justice.[261] State statutes that acknowledge the right of psychiatric patients to withhold consent to treatment, absent a recognized emergency or a judicial finding of incompetence, prioritize autonomy (or self-determination) as an independent value that weighs heavily on the state's exercise of its authority as *parens patriae*. The relative benefits and negative consequences that flow from the involuntary administration of antipsychotic drugs have been and will

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volitional functions" necessary for involuntary medication); *see also* KAN. STAT. ANN. § 59-2976(e) (West 1996) ("[M]edication may be administered over the patient's objection.").

257. *See, e.g.*, MICH. ADMIN. CODE R 330.7003 (1998).

258. *See, e.g.*, OR. ADMIN. R. 309-114-0010(3) (2018)

> The person from whom informed consent to a significant procedure is sought shall be given information, orally and in writing, the substance of which is to be found on the treating physician's or psychiatric nurse practitioner's informed consent form. In the case of medication, there shall be attached a preprinted information sheet on the risks and benefits of the medication . . . .

Id.

259. *See, e.g.*, S.D. CODIFIED LAWS § 27A-12-3.14 (2014).

260. *See, e.g.*, OR. ADMIN. R. § 309-114-0010(5) (2018)

> Consent to a proposed significant procedure must be given voluntarily, free of any duress or coercion . . . . [T]he decision to refuse, withhold or withdraw consent previously given shall not result in the denial of any other benefit, privilege, or service solely on the basis of refusing, withholding or withdrawing consent.

Id.; *cf.* WIS. STAT. ANN. § 55.14(1)(a) (West 2022) ("'Involuntary administration of psychotropic medication' means . . . [r]equiring an individual to take psychotropic medication as a condition of receiving privileges or benefits.").

261. *See generally* BEAUCHAMP & CHILDRESS, *supra* note 54.

continue to be strenuously debated.[262] Nevertheless, the practice of treating incompetent patients with these medications in some limited circumstances may advance the state's interest in beneficence, and there may be instances where the benefits of treatment outweigh the unwanted side-effects and other negative sequelae often associated with forced medication, such that the obligation of non-maleficence will also be satisfied. But, a baseline norm rooted in the autonomy principle and protective of voluntary choice, at least with respect to patients who pose no immediate risk of harm to self or others and who are able to live outside of the structure of a hospital, comports most closely with the weight of legal authority as reflected in foundational cases in this area that interpret state constitutional guarantees of due process and privacy as well as the state legislative choices reflected in the statutes that regulate medication practices in a majority of U.S. jurisdictions.

III. THE CONSENT PARADOX

The first part of this article describes the practice of releasing psychiatric patients from involuntary hospitalization on the condition that they adhere to an antipsychotic medication regimen. The discussion locates this practice in the context of an increasing use of outpatient commitment in many jurisdictions in the United States and explores the range of legal structures and practical administrative considerations that govern conditional release.[263] The second part of this article takes up the right to refuse treatment and the doctrine of informed consent. In most jurisdictions, psychiatric patients, including those who are civilly committed, retain significant legal discretion to refuse antipsychotic medications.[264] The caselaw and statutory rules developed in each state to regulate the administration of these drugs recognize that the right to refuse is a qualified right, subject to the states' police powers interest in protecting the wellbeing of the patient and others and the states' *parens patriae* powers to make treatment decisions that advance the best interests of patients who are unable to exercise competent choice on their own behalf.[265] While state law varies considerably from one jurisdiction to the next, the governing doctrine in a majority of states protects patients who have not been adjudicated incompetent to make treatment decisions by requiring that they voluntarily agree to the administration of antipsychotic drugs.[266] The question that this portion of this

262. *See generally* COMM. ON GOV'T POL'Y, GRP. FOR THE ADVANCEMENT OF PSYCHIATRY, FORCED INTO TREATMENT: THE ROLE OF COERCION IN CLINICAL PRACTICE (1994); FITCH & SWANSON, *supra* note 2, at 24; *see generally* Alexander D. Brooks, *The Right to Refuse Antipsychotic Medication: Law and Policy*, 39 RUTGERS L. REV. 339 (1987); *see generally* Douglas Mossman, *Unbuckling the "Chemical Straitjacket": The Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis*, 39 SAN DIEGO L. REV. 1033 (2002).

263. *See supra* notes 104–129 and accompanying text.

264. *See supra* notes 234–251 and accompanying text.

265. *See* WEINER & WETTSTEIN, *supra* note 20, at 129–30.

266. *See supra* notes 207–18 and accompanying text.

article takes up is whether conditioning the release of psychiatric patients from involuntary hospitalization on their agreement to take antipsychotic medications is consistent with either the formal legal rights of these patients or the broader set of interests in voluntary choice and patient self-determination that these legal obligations are intended to protect. In addition, this discussion addresses the mechanisms that are available, or could be made available, to clinicians, courts, and others to mediate the competing interests in autonomy, beneficence, and non-maleficence that are held respectively by patients and the state.

The practice of conditioning release from inpatient psychiatric care on a patient's agreement to adhere to a medication regimen is a response to the perceived tendency of many patients to reject this form of treatment.[267] Inherent in this practice is the assumption that individuals with severe chronic mental illness are more likely to succeed outside the hospital if they are maintained on antipsychotic drugs, and the related assumption that the therapeutic advantages that compliant patients gain outweigh the harms associated with the long-term administration of these medications.[268] These assumptions may not hold in all, or even a sufficient number of, cases to support the widespread practice of using legal coercion to ensure medication compliance for persons outside the hospital, at least absent significant procedural protections to ensure careful decision-making in individual cases.

The medications most often used as antipsychotics are a class commonly referred to as "atypical" drugs, along with a second, older class of neuroleptic medications.[269] Both classes carry significant risks and both produce inconsistent therapeutic results.[270] Many of the foundational cases from the 1970s and 1980s that recognized the right of psychiatric patients to refuse antipsychotic medications (absent an emergency or other specified findings) contain careful discussions of the evidence introduced in those cases regarding the uneven efficacy and troubling side effects produced by the older neuroleptic medications then commonly used to treat

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267. *See* Steven J. Schwartz & Cathy E. Costanzo, *Compelling Treatment in the Community: Distorted Doctrines and Violated Values*, 20 LOY. L.A. L. REV. 1329, 1380 (1987).

268. *See* TORREY, *supra* note 3, at 152.

269. *See* SLOBOGIN ET AL., *supra* note 53, at 35–39.

270. *See generally* Martin Harrow et al., *A 20-Year Multi-Followup Longitudinal Study Assessing Whether Antipsychotic Medications Contribute to Work Functioning in Schizophrenia*, 256 PSYCHIATRY RSCH. 267 (2017); Beng-Choon Ho et al., *Long-Term Antipsychotic Treatment and Brain Volumes: A Longitudinal Study of First-Episode Schizophrenia*, 68 ARCHIVES GEN. PSYCHIATRY 128, 133-34 (2011); Jeffrey A. Lieberman et al., *Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia*, 353 NEW ENG. J. MED. 1209 (2005); *see generally* Jose Luis Turabian, *Psychotropic Drugs Originate Permanent Biological Changes that Go Against of Resolution of Mental Health Problems. A View from the General Medicine*, 1 J. ADDICTIVE DISORDERS & MENTAL HEALTH 1 (2021); *see generally* Stefan Weinmann et al., *Influence of Antipsychotics on Mortality in Schizophrenia: Systematic Review*, 113 SCHIZOPHRENIA RSCH. 1 (2009).

patients with schizophrenia and other mental illnesses that produce psychosis.[271] The research on these "first generation" neuroleptic drugs documented their "serious limitations and drawbacks."[272] Up to one-half of patients "show[ed] no response or only a partial one."[273] In addition, even when these medications were effective at reducing the "positive" symptoms experienced by patients with schizophrenia (i.e., hallucinations and delusions), they had "little impact on these individuals' functioning[,]" which is a product as well of their "negative" symptoms, including "disruptions to normal emotions and behavior. . . ."[274] The side effects of these medications, in turn, were substantial and often severe.[275] Common complaints included tremors, stiffness, and restlessness, and some patients developed disabling neuromotor syndromes, including tardive dyskinesia.[276]

In the 1990s, a second generation of antipsychotic medications, generally referred to as "atypical" drugs, became available to treat patients with serious mental illnesses.[277] Initially, it was thought that these second-generation atypicals were more efficacious in reducing symptoms and less likely to trigger the side effects that most concerned patients, their advocates, and the courts that had considered the question of involuntary administration of antipsychotic medications.[278] Over time, however, the research and clinical observation both revealed that the newer drugs also had significant limitations in terms of their overall efficacy and that they also carried a serious set of risks and side effects that made the choice to administer them problematic for many patients.[279] Early reports indicated that the newer atypicals were likely to be more effective in the "30% to 60% of individuals with schizophrenia who do not respond to the older drugs . . . ."[280] More recent data has raised doubts about that early optimism, however, and "[s]ome experts now assert that . . . [the second generation atypicals] are 'no more efficacious, do not improve specific symptoms, [and] have no clearly different side effect profiles'" than the older first-

271. *See, e.g.*, Riese v. St. Mary's Hosp. & Med. Ctr., 271 Cal. Rptr. 199, 202–04 (Cal. Ct. App. 1987); Rennie v. Klein, 462 F. Supp. 1131, 1136–38 (D.N.J. 1978); People v. Medina, 705 P.2d 961, 965 (Colo. 1985).

272. SLOBOGIN ET AL., *supra* note 53, at 37.

273. *Id.*

274. *Id.* at 36.

275. *Id.* at 37.

276. *Id.*

277. *Id.* at 38.

278. *See id.* at 38–39 (discussing and citing Christoph U. Correll et al., *Lower Risk for Tardive Dyskinesia Associated with Second-Generation Antipsychotics: A Systematic Review of 1-Year Studies*, 161 AM. J. PSYCHIATRY 414 (2004); Christine Rummel-Kluge et al., *Second-Generation Antipsychotic Drugs and Extrapyramidal Side Effects: A Systematic Review and Meta-analysis of Head-to-Head Comparisons*, 38 SCHIZOPHRENIA BULL. 167 (2012)).

279. *Id.* at 39.

280. *Id.* at 38.

generation medications.[281] Particularly with respect to side effects, the newer drugs also appear to fail the test. Douglas Mossman, a psychiatrist and forensic expert has explained:

> [Many of] the newer drugs, though much more tolerable, still carry some risk of the neurological side effects that alarmed courts in the 1970s and 1980s. Second, the newer drugs appear to place patients at more risk than neuroleptics of developing troublesome metabolic conditions, including obesity, alterations in lipid metabolism, and diabetes mellitus. Though these conditions are not as uncomfortable as the acute neurological side effects induced by [older, first-generation] neuroleptics, they are sources of concern for doctors and patients and should receive courts' consideration as well.[282]

Considering the two classes of medications together, it appears that they can produce a helpful initial response in up to three-quarters of patients with schizophrenia.[283] Nevertheless, careful studies show that "despite taking maintenance medication after recovering from an acute psychotic episode, about one-fourth of individuals with schizophrenia experience a relapse in any given year . . . ."[284] When evaluated alongside the significant negative side effects that are common to both classes of antipsychotic medications, it is apparent that the choice to undergo maintenance treatment with these drugs involves a complex judgment of relative benefits and risks, rather than the simple narrative of therapeutic benefit offered by advocates for the use of legal coercion, including medication compliance requirements for conditional discharge from involuntary hospitalization.

While the resistance to treatment observed in this population often is considered a symptom of the disease,[285] an alternative account is available under which "treatment noncompliance" can be understood, at least in some cases, as a reasonable response to the uneven efficacy and significant downside consequences of maintenance therapy with antipsychotic medications. A patient's evaluation of the relative

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281. *Id.* at 39 (quoting and citing Peter Tyrer & Tim Kendall, *The Spurious Advance of Antipsychotic Drug Therapy*, 373 LANCET 4, 4–5 (2009)); *see also* Lieberman et al., *supra* note 270, at 1209 (stating newer atypical antipsychotics are not significantly more effective than older neuroleptics).

282. Mossman, *supra* note 262, at 1148.

283. SLOBOGIN ET AL., *supra* note 53, at 50-51 (discussing and citing Stefan Leucht et al., *Antipsychotic Drugs Versus Placebo for Relapse Prevention in Schizophrenia: A Systematic Review and Meta-Analysis*, 379 Lancet 2063 (2012)).

284. *Id.* at 50–51.

285. *See* Schwartz & Costanzo, *supra* note 267, at 1381; Boldt, *supra* note 8, at 47. The refusal of patients to take antipsychotic drugs frequently is offered as evidence of "anosognosia." *See* Awais Aftab, *Reconsidering Care and Coercion in Psychiatry: Kathleen Flaherty, JD*, PSYCHIATRIC TIMES (Apr. 21, 2021), https://www.psychiatrictimes.com/view/care-coercion-psychiatry.

risks and benefits of a proposed treatment and available alternative treatments is a crucial component of informed consent.[286] Ensuring that patients, who are capable, have the opportunity to engage in a thoughtful decision-making process, in turn, is essential to advancing the broader objective of patient engagement generally associated with successful treatment outside of the hospital setting.

Indeed, the success of outpatient commitment in all its various forms necessarily depends on the willingness of patients to cooperate with the treatment orders attached to their release or issued by judges.[287] As one analysis has put it, "[w]hereas commitment to an institution is implemented by a system of locked doors . . . court-ordered outpatient treatment cannot be so easily mandated."[288] Enforcement mechanisms for court-ordered outpatient commitment are soft at best, mostly consisting of the distant threat that noncompliant patients may be transported to a clinic or emergency department for evaluation and, if they meet criteria, inpatient hospitalization.[289] Moreover, the need for the voluntary cooperation of patients eligible for conditional release from inpatient hospitalization is even more apparent. The rules governing conditional release tend to be explicit in requiring the consent of participants, as patients typically must agree to the conditions that are attached to their release, including the requirement that they self-administer antipsychotic medications.[290]

This reliance on the voluntary participation of patients, especially with respect to medication compliance, presents something of a paradox. On the one hand, the legal coercion associated with outpatient commitment, either as a step-down from inpatient hospitalization or as applied to patients identified in the community, is justified by the premise that these patients are unlikely to comply with prescribed treatment absent the legal obligations imposed by the state. On the other hand,

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286. *See* Grainne Neilson & Gary Chaimowitz, *Informed Consent to Treatment in Psychiatry*, 60 CANADIAN J. PSYCHIATRY 1, 4–5 (2015); *see also* Debra A. Pinals, *Informed Consent: Is Your Patient Competent to Refuse Treatment?*, 8 CURRENT PSYCHIATRY 33, 41 (2009).

287. *See* Marcia L. Meldrum et al., *Implementation Status of Assisted Outpatient Treatment Programs: A National Survey*, 67 PSYCHIATRIC SERVS. 630, 633 (2016).

288. Schwartz & Costanzo, *supra* note 267, at 1382.

289. *See* Meldrum et al., *supra* note 287, at 633. It is important to note that the increased surveillance, potential law enforcement involvement, and ongoing threat of involuntary hospitalization associated with conditional release and other forms of outpatient commitment often are experienced as, and in fact can be, deeply coercive. In addition, there is some evidence of race and class disparities in the class of patients subject to community supervision and in the frequency of enforcement against patients deemed noncompliant. *See* Jeffrey Swanson et al., *Racial Disparities in Involuntary Outpatient Commitment: Are They Real?*, 28 HEALTH AFFS. 816 (2009). To the extent that race or class disparities are endemic to the practice of conditional release, the fourth Beauchamp and Childress factor, justice, is implicated. *See* BEAUCHAMP & CHILDRESS, *supra* note 54, at 13.

290. *See supra* notes 123–29 and accompanying text.

virtually all agree that these legal interventions cannot succeed absent the cooperation of these very same individuals.[291]

As noted in Part One of this article, conditional release programs take a variety of procedural forms. In some jurisdictions, hospitalized patients become eligible for conditional release when hospital officials determine that the criteria for civil commitment, especially dangerousness to self or others or grave disability, no longer pertain.[292] In other settings, conditional release is authorized under a least restrictive alternatives requirement when clinicians conclude that patients, who may still be subject to civil commitment, can safely be treated in a community-based setting.[293] Still, other jurisdictions assign conditional release decision-making to judicial officers who may use the statutory criteria (often centered on a prediction of deterioration and future dangerousness) that applies to other outpatient commitment decisions.[294]

Regardless of the procedural form followed for effectuating conditional release, as noted in Part Two, most states restrict the involuntary administration of antipsychotic medications to patients who either pose an imminent threat of harm to self or others or who lack decision-making capacity.[295] Because medication compliance is almost always a condition of release, patient consent to treatment is likely a precondition for a patient's conditional release. This brings us back to the paradox noted above: the very patients who are thought to be so unreliable that ongoing conditions must be attached to their release from confinement are also accorded the legal right to withhold consent to the medication-based treatment that is the key condition for their release.

Several possibilities for unraveling this knot warrant consideration. The governing statutes in virtually every state suspend the right of patients to refuse medications in emergency situations where there is strong evidence of imminent danger to the patient or others.[296] This exercise of the states' police powers is unlikely to provide a solution to the problem of recalcitrant patients subject to conditional release from involuntary hospitalization, however, because inherent in the practice of conditional release is the judgment that the subject patient either presents no

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291. *See, e.g.*, Schwartz & Costanzo, *supra* note 267, at 1382 n.244. Schwartz and Costanzo make a related observation. "If only compliant individuals will be considered for compulsory treatment, but client consent vitiates the legal basis (to say nothing of the practical reason) for the coercion, outpatient commitment might be a viable option for a null class." *Id.*

292. *See supra* note 14 and accompanying text.

293. *See supra* note 15 and accompanying text.

294. *See supra* notes 118–19 and accompanying text.

295. *See supra* notes 234–51 and accompanying text.

296. *See supra* notes 234–36 and accompanying text.

imminent threat of physical danger to self or others or, in the alternative, that ongoing treatment with antipsychotic medications will guard against decompensation and future dangerousness.[297] Under either possibility, the statutory requirement of a present, *imminent* risk of serious bodily harm is missing. While an increasing number of states have enacted outpatient commitment statutes that permit courts to mandate outpatient treatment for patients who are not imminently dangerous but present a substantial risk of deterioration and future dangerousness if left untreated,[298] this form of supervised community treatment generally requires judicial authorization and is inconsistent with the imposition of medication conditions by hospital officials that is typical in many jurisdictions' conditional release practices.[299] If a prediction of deterioration and future dangerousness is to be the basis for maintaining state supervision over patients in the community, the decision should be made by a court implementing appropriate statutory authority which reflects a considered legislative judgment that such broadened criteria represents a sensible balancing of autonomy, beneficence, and non-maleficence.[300]

The more likely possibility for managing the paradox involves unpacking the concept of informed consent itself. As noted earlier, legally adequate consent turns on three elements: the provision of relevant information; to a legally competent person; exercising choice that is voluntary and knowing.[301] While there is reason to believe that doctors often fail to disclose the significant variance in drug efficacy and the serious side effects of antipsychotics to patients, the second and third elements of informed consent are potentially more problematic. As one commentary puts it: "[P]roponents candidly admit that coerced community care is designed to

297. *See supra* notes 14–15 and accompanying text.

298. *See* LAWATLAS, *supra* note 4; *see also* Meldrum et al., *supra* note 287, at 633. Fitch and Swanson explain that "under a preventive outpatient commitment law, a person with mental illness who [i]s not currently dangerous, and therefore not legally committable to a hospital, could be ordered to community treatment on the basis of a complex clinical assessment and prediction about the future." FITCH & SWANSON, *supra* note 2, at 16. They discuss the North Carolina statute as one example, which includes as a criterion that, given "'the respondent's psychiatric history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predicably result in dangerousness . . . .'" *Id.* (citing N.C. GEN. STAT. § 122C-261(c) (West 2023)).

299. *See supra* note 11 and accompanying text.

300. Even if the decision to impose step-down conditions is made by an appropriate court pursuant to appropriate statutory authority, it is important that the governing statute expressly abrogates the right of competent patients to refuse antipsychotic medications. The outpatient commitment statutes in some states contain language to this effect, but not all do. *See, e.g.*, LA. STAT. ANN. § 28:71(D) (2021) ("The court may order the respondent to self-administer psychotropic drugs or order the administration of such drugs by authorized personnel as part of an involuntary outpatient treatment program. The order shall specify the type of psychotropic drugs and it shall be effective for the duration of such involuntary outpatient treatment."). In contrast, statutes in some other states expressly prohibit the involuntary administration of medications as part of outpatient treatment. *See, e.g.*, N.J. STAT. ANN. § 30:4-27.2(jj) (West 2020).

301. *See* WEINER & WETTSTEIN, *supra* note 20, at 115–16.

'abrogate[] the right[s] of competent people to refuse treatment.'"[302] This is so because the practice of mandating medication compliance as a condition of release from the hospital frequently centers on patients who are competent as a formal legal matter but who would otherwise resist treatment given the uneven benefits and significant costs in taking antipsychotic drugs. "Thus, the issue is not competency but rather preference: when a person chooses not to take the drugs which a psychiatrist deems necessary, and some form of psychological deterioration is predicted to follow, coercion is considered desirable."[303]

The elements of competency and voluntariness each require further consideration in this context. Advocates for supervised community-based treatment argue that clinical capacity rather than legal competence ought to be the governing standard for determining when a patient's preferences should give way to a treatment mandate.[304] On this account, the distortion of a patient's judgment in evaluating the risks and benefits of treatment occasioned by severe mental illness constitutes a sufficient basis in fact (if not precisely sufficient under current law in some jurisdictions) to override the patient's preference to the contrary.[305] If this is to be the basis for imposing maintenance drugs as a condition of release, especially for patients who otherwise no longer meet the requirements for involuntary

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302. Schwartz & Costanzo, *supra* note 267, at 1384.

303. *Id.*

304. On the distinction between legal competence and clinical capacity, *see* Neilson & Chaimowitz, *supra* note 286, at 8 ("Competence is a legal state, not a medical one."); *see also* Pinals, *supra* note 286, at 35 ("[C]linicians use the construct of 'capacity' rather than 'competence' because competence is a legal term that can be determined only by a judge."). Fitch and Swanson explore this distinction in the context of their discussion of the North Carolina statute, which requires a finding that the patient's "illness limits or negates [her] ability to make an informed decision to seek voluntarily or comply with recommended treatment." FITCH & SWANSON, *supra* note 2, at 16 (citing N.C. GEN. STAT. § 122C-261(d) (West 2023)). They explain that:

> The meaning and practical implication of this criterion regarding impaired decision-making is somewhat ambiguous. It is notable that the criterion seems to require a clinical determination of at least some degree of illness-related diminished capacity to make an "informed decision" . . . At the same time, the criterion clearly does not meet the legal standard for mental incompetence . . . .

Id. at 16 n.19.

Fitch and Swanson conclude:

> This ambiguity serves both the paternalistic and libertarian sides of the outpatient commitment debate . . . on the one hand justifying the intervention of outpatient commitment in the best interests of a person whose capacity to make a fully informed decision is diminished, while on the other hand seeming to undermine the state's authority to override a clear treatment refusal by a person who may lack sound judgment but is not mentally incompetent (and whose wishes, thus, should still be honored).

Id. at 16–17 n.19.

305. *See* Ben Bursten, *Posthospital Mandatory Outpatient Treatment*, 143 AM. J. PSYCHIATRY 1255, 1256 (1986); *see also* Jeffrey L. Geller, *Rights, Wrongs, and the Dilemma of Coerced Community Treatment*, 143 AM. J. PSYCHIATRY 1259, 1261 (1986).

hospitalization, then the governing statutes in the jurisdiction ought to reflect that policy decision. In addition, mandatory medication conditions probably should be reserved for patients subject to formal outpatient commitment ordered pursuant to appropriate statutory authority and following a judicialized process that satisfies reasonable notions of due process.[306]

Given the uneven efficacy of antipsychotic medications for some patients and the serious side effects they produce, doctors should give careful, individualized consideration to ensure that patients, who otherwise may be eligible for unconditional release because they are no longer dangerous to self or others, are incapable of exercising reasonable judgment in deciding to accept or refuse a maintenance regimen as an outpatient. While it may be difficult to distinguish the patient who refuses antipsychotic medication following a considered evaluation of relative costs and benefits from one who refuses because of impaired judgment resulting from an underlying mental illness, a careful process of individualized decision-making by an independent judicial officer offers the best promise of maintaining some modicum of accuracy in this determination.[307] Importantly, the question should not be

306. *See, e.g.*, Steele v. Hamilton Cnty. Cmty. Mental Health Bd., 736 N.E.2d 10, 22 (Ohio 2000) (setting out due process requirements for involuntary medication decision).

307. To be sure, the Supreme Court in *Parham v. J.R.* observed that "[d]ue process has never been thought to require that the neutral and detached trier of fact be law trained or a judicial or administrative officer. Surely, this is the case as to medical decisions for 'neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments.'" 442 U.S. 584, 607 (1979) (quoting *In re* Roger S., 569 P.2d 1286, 1299 (Cal. 1977)). On the other hand, Judge David Bazelon famously explained that, while medical decision-makers should be authorized to determine the clinical needs of individuals with severe mental disabilities, judicial decision-makers must be accorded the power to ensure that the process of balancing clinical and public safety interests with the liberty interests of individual patients is accomplished rationally and with procedural regularity. David L. Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process*, 75 COLUM. L. REV. 897, 910 (1975). Bazelon wrote:

> There is a central but limited role for courts in [the system for involuntarily hospitalizing disturbed or disturbing individuals]—that role is to guide professional decisionmaking, and may be best described by the familiar model of judicial review of administrative decisionmaking. Courts must determine whether there has been a full exploration of all relevant facts, opposing views and possible alternatives, whether the results of the exploration relate rationally to the ultimate decision, and whether constitutional and statutory procedural safeguards have been faithfully observed. Our function is thus not to determine whether the decisions taken by those charged with handling disturbed or disturbing individuals are correct or wise—but whether they are rational in the manner I have just described. . . . [S]tate intervention involves a serious compromise of individual rights and hence a difficult balancing of power between the state and the individual . . . Courts have traditionally been the protector of individual rights against state power. . . . We cannot delegate this responsibility to the medical professions. Those disciplines are, naturally enough, oriented toward helping people by treating them. Their value system assumes that disturbed or disturbing individuals need treatment, that medical disciplines can provide it, and that attempts to resist it are misguided or delusionary. The medical disciplines can no more judge the legitimacy

whether the patient's preference is objectively the best choice but rather whether it reflects the patient's considered appreciation of the competing interests at stake, as well as her ongoing values, religious beliefs, family circumstances, and the like.

That consent to receive antipsychotic medications also requires a voluntary decision by the patient is an even more challenging requirement. In general, "[c]onsent should be voluntary and free from conditions, circumstances or external influences that may limit, influence or control choice. Many conditions may conflict with voluntariness and render patients vulnerable to consenting to treatment they do not desire . . . ."[308] The relevant provisions in some jurisdictions make explicit that consent given under duress or in circumstances where it is conditioned on the receipt of benefits or the avoidance of penalties is not sufficiently voluntary to support a decision to receive treatment.[309] Even in states without such express statutory or regulatory language, there are powerful arguments that the inherent coerciveness of a psychiatric hospital may render patient consent less than fully voluntary.[310] The power disparities operating between patients with mental illnesses and physicians and other professionals within a psychiatric hospital create inherent challenges for ensuring that patient consent to treatment is voluntary.[311] "Particular care and

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of state intervention into the lives of disturbed or disturbing individuals than a prosecutor can judge the guilt of a person he has accused.

Id.

308. Neilson & Chaimowitz, *supra* note 286, at 6.

309. *See, e.g.*, OR. ADMIN. R. 309-114-0010(5) (2018)

> Consent to a proposed significant procedure must be given voluntarily, free of any duress or coercion . . . . [T]he decision to refuse, withhold or withdraw consent previously given shall not result in the denial of any other benefit, privilege, or service solely on the basis of refusing, withholding or withdrawing consent.

Id.

310. *See* Pinals, *supra* note 286, at 34 ("In treatment settings as well, a patient's circumstances might be considered coercive."). *Cf.* Lisa E. Smilan, *The Revised Common Rule and Mental Illness: Enduring Gaps in Protections*, 46 AM. J. L. & MED. 413, 417 n.26 (2020) (involuntarily hospitalized patients are not expressly protected as vulnerable subjects under the revised common rule, but "because of the inherently coercive nature of that environment and the relationship between institutionalized patient[s] and mental health provider[s,]" they should be).

311. Neilson and Chaimowitz analogize consent to a contractual arrangement and note that:

> Central to any contract is the requirement that there be a mutual understanding of, and agreement about, the expectations of each party. However, in the medical context, the relationship between the parties is somewhat unique . . . . This demands that the physician behave with a high degree of integrity (called the fiduciary duty).

Neilson & Chaimowitz, *supra* note 286, at 3. The placement of trust and confidence in the physician that calls forth her special fiduciary obligations is made all the more demanding when the patient's status as an involuntary patient limits her freedom to depart the hospital. As noted earlier, conditional discharge and other forms of mandated outpatient commitment assign to clinicians "dual roles as therapists and social control agents" and create the potential for "role conflict[s]" that require behavioral health professionals "to clarify their roles, responsibilities, and relationships with patients." APA RESOURCE DOCUMENT, *supra* note 5, at 7.

attention should be paid when seeking consent from especially vulnerable people . . . such as involuntarily detained patients . . . ."[312] The distorting influence of these power imbalances is only exacerbated when the patient's discharge from confinement depends on her agreeing to treatment that, all things considered, she wishes to refuse. In fact, as noted earlier, patient refusal of care itself often becomes pathologized as a symptom of the patient's disease rather than a product of her genuine considered preference.[313]

Instead of conditioning a patient's release on her agreement to a medication condition, a better approach is to focus on building a durable therapeutic alliance between the patient and the clinicians who are providing her care. Substantive discussion between patients and providers about the pros and cons of the antipsychotic drugs available as maintenance therapies should be a part of the discharge planning that precedes a patient's release from the hospital. Central to those discussions is the practice of obtaining informed consent. "The process of consent is the dialogue that facilitates adequate disclosure of relevant information, and promotes appropriate understanding of the relative merits of, and reasonable alternatives to, the treatments proposed."[314] This process model of consent requires: that the patient's role be understood "as that of an inquisitive consumer who may challenge the physician's authority in the quest for information;" that "the clinician challenges the patient's preconceived beliefs about his or her illness and educates the patient;" and that the patient "must be allowed to consider his or her own values in weighing medical decisions . . . includ[ing] the patient's ability to tolerate side effects, willingness to take risks, and own sense of quality of life."[315]

Opponents of legal coercion as a tool for encouraging medication compliance in outpatient care argue that "[p]eople recover when they have a choice among alternative treatments and services, when they are empowered to make their own decisions and take responsibility for their lives, and when they are offered hope."[316] They point out that "long-term autonomy is undermined if the mandated treatment is experienced as so coercive that it alienates the patient or prevents the formation of trust within the provider-patient relationship."[317] Proponents of the legal supervision of outpatient treatment argue in response that patients with impaired

312. Neilson & Chaimowitz, *supra* note 286, at 6.

313. *See supra* note 251 and accompanying text.

314. Neilson & Chaimowitz, *supra* note 286, at 4.

315. Pinals, *supra* note 286, at 42 (discussing C.W. Lidz et al., *Two Models of Implementing Informed Consent*, 148 ARCHIVES INTERNAL MED. 1385 (1988)).

316. FITCH & SWANSON, *supra* note 2, at 26 (quoting E.S. Kramer, *Don't Force Patients into Mental Health Programs*, HARTFORD COURANT (Sept. 25, 1999), https://www.courant.com/1999/09/25/dont-force-patients-into-mental-health-programs/).

317. *Id.* at 25.

judgment who make "inauthentic treatment refusal[s]" are not well served by libertarian rules that prevent a "time-limited override" of their treatment refusal.[318] Instead, the proponents assert that "the assumption of 'voluntariness' is undermined by the fact that no rational person would choose the suffering and risks that untreated mental illness entails."[319]

These competing perspectives on outpatient commitment, which apply as well to the practice of conditional discharge, operate as part of a polarized debate. But individuals with severe chronic mental illnesses are not a monolith. As a group, they exhibit a range of capacities and incapacities with respect to treatment decisions. Unlike legal competence, which is a binary concept, patient capacity operates as a continuum.[320] Clinicians should not assume, absent clear indications to the contrary, that civilly committed patients lack sufficient capacity to participate in the process of planning for their own treatment. Patients whose judgment is so impaired that they cannot engage in a process of building consent, whose treatment refusal is in fact "inauthentic," properly may be made subject to legal supervision following a judicial determination of incompetency. For all other patients, however, a process of decision-making that includes a consideration, on the one hand, of the material benefits that many patients derive from antipsychotic medications, and on the other, the limitations of maintenance drugs and the possibilities of non-drug-based treatments in combination with other forms of pharmacotherapy,[321] is more likely to promote patient autonomy and ensure that broader interests in beneficence and nonmaleficence are maximized.

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318. *Id.* at 24–25.

319. *Id.* at 26.

320. *See* Neilson & Chaimowitz, *supra* note 286, at 4.

321. On the advantages and limitations of maintenance treatment with antipsychotic drugs, *see generally* Lex Wunderink et al., *Recovery in Remitted First-Episode Psychosis at 7 Years of Follow-Up of an Early Dose Reduction/Discontinuation or Maintenance Treatment Strategy*, 70 JAMA PSYCHIATRY 913 (2013) (outcomes following early discontinuation of antipsychotic medication); *see generally* Nancy Sohler et al., *Weighing the Evidence for Harm From Long-Term Treatment with Antipsychotic Medications: A Systematic Review*, 86 AM. J. ORTHOPSYCHIATRY 477 (2016) (disadvantages of long-term treatment with anti-psychotic medications); *see generally* J. Moilanen et al., *Characteristics of Subjects with Schizophrenia Spectrum Disorder with and without Antipsychotic Medication—A 10-year Follow-Up of the Northern Finland 1966 Birth Cohort Study*, 28 EUR. PSYCHIATRY 53 (2013) (patients with schizophrenia taking antipsychotic medications and those not taking antipsychotic medications are equally likely to relapse); *see generally* Martin Harrow et al., *Does Treatment of Schizophrenia with Antipsychotic Medications Eliminate or Reduce Psychosis? A 20-Year Multi-Follow-Up Study*, 44 PSYCH. MED. 3007 (2014) (symptom reduction and long-term prognosis not improved by maintenance with antipsychotic).

IV. CONCLUSION

The practice of releasing involuntarily hospitalized psychiatric patients on the condition that they comply with an antipsychotic medication regimen, like other forms of legally supervised community treatment for persons with mental illnesses, rests on a paradox. The patients who are thought to be sufficiently unreliable that ongoing conditions must be attached to their release from confinement are also, in most states, accorded the legal right to withhold consent to the medication-based treatment that is the key condition for their release. No ready mechanism for resolving this paradox is likely to be entirely successful. Some patients resist antipsychotic medications because their judgment is profoundly impaired by their underlying disability. But others make a reasoned decision that, given their individual circumstances, the long-term benefits of protracted maintenance therapy with these drugs are outweighed by their costs. Absent significant evidence of serious incapacity, the law should presume that patients otherwise eligible for release to outpatient status are capable of participating in a voluntary process for the formulation of a treatment plan in the community. To ensure that this process is truly voluntary, release should not be conditioned on a legally competent patient's decision to accept or refuse proposed treatment with antipsychotic drugs. When a voluntary treatment plan developed within a functioning patient-provider treatment alliance is possible, the respective interests of patients and the state in autonomy, beneficence, and nonmaleficence are best served. Treatment coercion attached to release decisions should be reserved for the small subset of patients who have been adjudicated legally incompetent to participate in this decision-making process.