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## Consent, Informed: Rethinking Informed Consent & Competency for Patients with Schizophrenia & Anosognosia

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# CONSENT, INFORMED: RETHINKING INFORMED CONSENT & COMPETENCY FOR PATIENTS WITH SCHIZOPHRENIA & ANOSOGNOSIA

**Abstract:** Anosognosia is a common symptom of schizophrenia and schizoaffective disorder that renders individuals unable to understand that they are living with a disease. This symptom often leads people to refuse anti-psychotic medication, and may increase an individual's likelihood of becoming homeless or incarcerated. When courts find individuals to be a danger to others or themselves, states can impose involuntary commitment. When a state grants involuntary commitment, however, a court may find the individual remains competent to refuse medication. This Note argues that documented anosognosia requires a finding of incompetency, whether people are a danger to themselves or not. Science suggests that a person with severe anosognosia lacks the insight to refuse treatment. This Note proposes a novel statutory definition of competency, encompassing the specific needs of people with anosognosia, and grapples with the significant interests at stake in taking away an individual's right to choose or refuse treatment, including antipsychotic medication.

## INTRODUCTION

Imagine you are in your second year of college.<sup>1</sup> You know you have a serious mental illness, but have agreed to take daily medication to manage your symptoms. For the first few months, you check in with your family and keep them updated on your condition, therapy, and medications. After several successful months on medication, you know that you can control your own symp-

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<sup>1</sup> The introduction's story is adapted from Ron Powers' historical novel and memoir that details his sons' struggles with mental illness, which is exacerbated by anosognosia, a symptom of mental illness that makes it difficult for individuals to see that they are sick. *See* RON POWERS, *NO ONE CARES ABOUT CRAZY PEOPLE: THE CHAOS AND HEARTBREAK OF MENTAL HEALTH IN AMERICA* 26–27, 292–95 (2017) (defining anosognosia and describing the author's experience of trying to help his son accept treatment for schizoaffective disorder after deciding to stop taking his medication). There are many other documented accounts of individuals who have anosognosia. *See generally* XAVIER AMADOR, *I AM NOT SICK I DON'T NEED HELP! HOW TO HELP SOMEONE WITH MENTAL ILLNESS ACCEPT TREATMENT* (10th ed. 2012) (offering a step-by-step approach for people attempting to help individuals accept treatment); Abigail Jones, *What Schizophrenia Does to Families*, *WASH. POST MAG.*, (Jan. 13, 2020), <https://www.washingtonpost.com/magazine/2020/01/13/what-schizophrenia-does-families-why-mental-health-system-cant-keep-up/?arc404=true> [<https://perma.cc/G3HR-XX8Z>] (describing a family's struggle with its son's diagnosis of schizophrenia and his challenges over the years). In fact, one study found that more than half of people with schizophrenia have no awareness of their illness. AMADOR, *supra*, at 13.

toms and no longer need your medication. You stop taking your medication because everything is fine and you do not have any kind of mental illness—who is your family to tell *you* something about your *own* condition? Your family visits, reminds you that you have a mental illness, and begs you to get back on your medication. You refuse because you know you do not have an illness. Your doctor finds that you are competent to refuse treatment because you can understand the risks and benefits of the treatment, even though you cannot see you are sick.<sup>2</sup> You refuse medication, and eventually, you must drop out of college due to your lack of control over your symptoms. Because you are refusing medication, your family cannot help you find a way out of the situation. You are not violent, so the state cannot impose involuntary commitment.<sup>3</sup> But you eventually become homeless, disconnected from family, and experience worsening symptoms because of the lack of medication.<sup>4</sup>

This representative story is an example of the effects of anosognosia, a symptom of schizophrenia, on a person with mental illness.<sup>5</sup> Anosognosia causes individuals to lack insight into their own condition.<sup>6</sup> Anosognosia leads individuals to feel as though there is nothing wrong with them, and may increase the likelihood of refusing medication, becoming homeless, or being arrested.<sup>7</sup> As one scholar wrote: “As if the symptoms of schizophrenia were not devastating enough in themselves, nature has added a cruel joke, a seemingly valueless yet powerful barrier between the sufferer and professionals reaching out to help. The cruel joke is called anosognosia.”<sup>8</sup>

Beyond the personal effects of anosognosia, the symptom can have important legal implications as well.<sup>9</sup> For example, informed consent occurs

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<sup>2</sup> See *infra* notes 139–161 (summarizing different theories of competency to give informed consent, which may require a person to understand the risks and benefits of a particular treatment before declining to give informed consent).

<sup>3</sup> See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice* 3–4 (2019), <https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf> [<https://perma.cc/8B9W-7DSR>]. Although some states have started to use other standards for involuntary treatment, historically, patients have had to be a danger to themselves or others to be committed. See *id.* at 8 (tracing the history of the dangerousness requirement, and noting that some states have adopted new standards, such as a showing that an individual may suffer a “serious emotional injury” if they are not committed).

<sup>4</sup> See M. Carmela Epright, *Coercing Future Freedom: Consent and Capacities for Autonomous Choice*, 38 J.L. MED. & ETHICS 799, 805 (2010) (suggesting that treatment can improve an individual’s lack of insight, a symptom of the disease).

<sup>5</sup> *Anosognosia*, NAT’L ALL. ON MENTAL ILLNESS, <https://www.nami.org/learn-more/mental-health-conditions/related-conditions/anosognosia> [<https://perma.cc/BFU8-K7GQ>].

<sup>6</sup> *Id.*

<sup>7</sup> AMADOR, *supra* note 1, at 39 (describing anosognosia as “unawareness of deficits, symptoms, or signs of illness”); *Anosognosia*, *supra* note 5.

<sup>8</sup> POWERS, *supra* note 1, at 26–27.

<sup>9</sup> See *infra* Part II (outlining that courts may apply competency statutes to people with anosognosia differently than to those who do not suffer from the symptom).

when a patient either accepts or declines treatment, following a doctor's explanation of risks involved in the procedure.<sup>10</sup> In order for a patient to give informed consent, a doctor must first find that the patient is competent.<sup>11</sup> Generally, the law presumes that adults are competent to give informed consent.<sup>12</sup> A number of factors influence a competency determination, including the person's ability to comprehend the information the doctor shares, apply the information to his or her own circumstances, and rationally make the decision to consent or refuse to consent.<sup>13</sup> Although it may seem logical that a person who cannot see his or her illness cannot give informed consent, as he or she lacks any awareness of the illness, the law is inconsistent—in some jurisdictions, denial of illness warrants incompetency, but in others, it does not.<sup>14</sup>

This Note explores the challenges of developing a legal solution to this issue. Part I of this Note discusses the modern approaches to informed consent, the constitutional requirement of patient autonomy, the challenges of schizophrenia and anosognosia, and the history of the U.S. mental health system.<sup>15</sup> Part II examines differing opinions of the application of existing informed consent and competency law to patients with anosognosia.<sup>16</sup> Part III argues that specific reform of the statutory definition of competency is necessary to ensure that the legal system is in sync with the science available today.<sup>17</sup>

## I. PATIENT AUTONOMY AND SCHIZOPHRENIA: A HISTORY

The United States has a complex relationship with the treatment of people with mental illness.<sup>18</sup> Initially, states separated people with mental illness from the general population and forced them into asylums, sometimes subjected to

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<sup>10</sup> *Consent*, BLACK'S LAW DICTIONARY (11th ed. 2019).

<sup>11</sup> *See infra* notes 132–136 and accompanying text (explaining that incompetent patients cannot make decisions about their treatment).

<sup>12</sup> STEVEN E. PEGALIS, AMERICAN LAW OF MEDICAL MALPRACTICE § 4:1 (3d ed. 2019).

<sup>13</sup> *See infra* notes 138–164 and accompanying text (describing statutory elements of a competency determination).

<sup>14</sup> *See* Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945, 977 (1991) [hereinafter Saks, *Competency to Refuse Treatment*] (explaining that decisions regarding treatment competency “ha[ve] received little attention in the law”); *see also* Elyn R. Saks, *Competency to Refuse Medication: Revisiting the Role of Denial of Mental Illness in Capacity Determinations*, 22 S. CAL. REV. L. & SOC. JUST. 167, 170 (2013) [hereinafter Saks, *Revisiting the Role of Denial of Mental Illness in Capacity Determinations*] (describing the varied judicial approaches to determining capacity for patients with mental illness).

<sup>15</sup> *See infra* Part I.

<sup>16</sup> *See infra* Part II.

<sup>17</sup> *See infra* Part III.

<sup>18</sup> *See generally* E. FULLER TORREY, AMERICAN PSYCHOSIS: HOW THE FEDERAL GOVERNMENT DESTROYED THE MENTAL ILLNESS TREATMENT SYSTEM (2014) (explaining how the federal government treated individuals with mental illnesses from the early twentieth century through the early 2000s).

abuse under the guise of treatment.<sup>19</sup> Beginning in the 1950s, however, patients were released from these facilities, and often left without any support from the government or medical professionals.<sup>20</sup> Today, individuals with mental illness have a variety of options for treatment, although remnants of historical treatment styles—such as involuntary commitment—still exist.<sup>21</sup>

Section A of this Part provides a brief history of the U.S. mental health system, including institutionalization, deinstitutionalization, and the evolution of antipsychotic medication.<sup>22</sup> Section B describes schizophrenia, one type of serious mental illness.<sup>23</sup> Section C of this Part explains the informed consent doctrine.<sup>24</sup> In addition, Section C outlines different standards and approaches for competency determinations, a prerequisite for informed consent.<sup>25</sup> Finally, Section D explains involuntary and voluntary treatment methods available for individuals with schizophrenia and other types of serious mental illness.<sup>26</sup>

### *A. Mental Illness in the United States: A Brief History*

Since the 1400s scholars have documented the housing of people with mental illness at in-patient facilities.<sup>27</sup> Institutionalization began in the United States in the 1750s, with the creation of America's first hospital, Philadelphia Hospital.<sup>28</sup> A general hospital, Philadelphia Hospital treated some mentally ill patients in its basement.<sup>29</sup> A number of other hospitals for people with mental illness opened after Philadelphia Hospital.<sup>30</sup> In 1841, a British reformer, Dorothea Dix, toured hospitals across the United States to understand the patients' conditions and determine potential fixes to the system.<sup>31</sup> Appalled by the atroc-

<sup>19</sup> See *infra* notes 27–64 and accompanying text.

<sup>20</sup> TORREY, *supra* note 18, at 33.

<sup>21</sup> See *infra* Part I.D.

<sup>22</sup> See *infra* Part I.A.

<sup>23</sup> See *infra* Part I.B.

<sup>24</sup> See *infra* Part I.C.

<sup>25</sup> See *infra* Part I.C.

<sup>26</sup> See *infra* Part I.D.

<sup>27</sup> POWERS, *supra* note 1, at 59–61. Bethlem, the first documented asylum in England, is notorious for atrocities it committed against its patients. *Id.* Staff at Bethlem treated patients less than humanely, sometimes beating, shackling, or chaining them to the walls of the building. *Id.* at 62.

<sup>28</sup> *Id.* at 67.

<sup>29</sup> *Id.* “Institutionalization” refers to the theory underlying the early treatment of people with mental illness. *Id.* at 67–76. During this time, states housed people living with mental illness in facilities. *Id.* at 68. The time period of institutionalization reflected a growing fear of “madness” among U.S. citizens. *Id.* at 69. For example, on Sundays at Philadelphia Hospital, people from the town could go to the hospital and watch the patients, who were in horrible condition. *Id.* at 68. The individuals were treated as entertainment, not patients. See *id.*

<sup>30</sup> POWERS, *supra* note 1, at 68.

<sup>31</sup> *Id.* at 66–72. Dorothea Dix was essential to the establishment of care for people with mental illness in the United States. See Manon S. Parry, *Dorothea Dix (1802–1887)*, 94 AM. PUB. HEALTH ASS'N 622, 624 (2004), <https://ajph.aphapublications.org/doi/epub/10.2105/AJPH.2005.079152> [<https://>

ities she witnessed, including men and women with mental illness restrained by shackles and beaten, Dix founded thirty-two additional facilities across the United States between 1841 and 1880 in an attempt to expand access and provide better, less crowded treatment to patients.<sup>32</sup> Although an admirable attempt to fix the system, these facilities did little to rectify the horrors that occurred at the earlier state-sponsored centers.<sup>33</sup>

In the 1950s and early 1960s, mental health reformers aimed to create a federal mental health program to fix the shortcomings of the state-sponsored facilities through an overhaul of the system.<sup>34</sup> To encourage new research and changes to the mental health system, Congress passed a bill establishing the bipartisan Joint Commission on Mental Illness and Health (the Joint Commission).<sup>35</sup> The Joint Commission called for the end of state psychiatric facilities,

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perma.cc/68FK-9X98]. Famously, Dix submitted a report to the Legislature of Massachusetts regarding the state of asylums in the Commonwealth. *Id.* at 622. Dix called upon the legislature to make changes to the state of these facilities, citing her notes from the visits to the institutions. *See id.* at 622–23. Notably, she argued for legislation to address the problems at the facilities, stating: “It is the Commonwealth, not its integral parts, that is accountable for most of the abuses . . . I repeat it, it is defective legislation which perpetuates and multiples these abuses.” *Id.* at 623 (quoting DOROTHEA DIX, MEMORIAL TO THE LEGISLATURE OF MASSACHUSETTS (Boston, Munroe & Francis 1843)). Specifically, Dix noted that she saw men and women with mental illness “chained, naked, beaten with rods, and lashed into obedience.” *Id.* (quoting DIX, *supra* (emphasis removed)).

<sup>32</sup> POWERS, *supra* note 1, at 66–72. *See generally* Parry, *supra* note 31 (explaining Dorothea Dix’s tour).

<sup>33</sup> POWERS, *supra* note 1, at 75 (explaining that although the atrocities at the new asylums were not as horrible as those in earlier facilities, problems remained). Americans became more aware of the horrors of state mental health facilities with the publication in *Life Magazine* of *Bedlam 1946: Most U.S. Mental Hospitals Are a Shame and Disgrace*. *See* ESMÉ WEIJUN WANG, THE COLLECTED SCHIZOPHRENIAS 106 (2018) (describing the impact of the *Life Magazine* article on the American psyche); *see also* Albert Q. Maisel, *Bedlam 1946: Most U.S. Mental Hospitals Are a Shame and a Disgrace*, LIFE MAG., May 6, 1946, at 102. The article described these facilities as “little more than concentration camps on the Belsen pattern.” Maisel, *supra*, at 102; *see also* WANG, *supra*, at 106 (describing the *Life Magazine* article). Not only did the article include descriptions of the facilities, the article also included pictures. Maisel, *supra*, at 103–12; *see also* E. FULLER TORREY, NOWHERE TO GO: THE TRAGIC ODYSSEY OF THE HOMELESS MENTALLY ILL 2 (1988) (suggesting that the pictures carried even more impact than the text of the article). Arguably, showing the public these haunting images contributed to the rejection of asylums in the 1950s. *See* TORREY, *supra*, at 2–4.

<sup>34</sup> TORREY, *supra* note 18, at 30. Many stakeholders supported the creation of a federal mental health plan, including the American Psychiatric Association and then-Senator John F. Kennedy. *Id.* One notable reformer was Dr. Robert H. Felix, a member of the U.S. Public Health Service. *Id.* at 17. Felix aimed to reform the U.S. mental health system through an out-patient program that would replace the current state system. *Id.* Felix was the first director of the National Institute of Mental Health (NIMH) and shaped the community-based program later adopted in the United States. *Id.*

<sup>35</sup> *See id.* at 30. (describing the creation of the Joint Commission on Mental Illness and Health (the Joint Commission)). Thirty-six different “participating agencies” comprised the Joint Commission. *Id.* Notable stakeholders included the American Academy of Neurology, the U.S. Department of Justice, the American Medical Association, and the American Academy of Pediatrics, among many others. *Id.* at 30–31. After several public hearings regarding the best way forward for a federal mental health program in the United States, the Joint Commission obtained an increase in the NIMH budget. *Id.* at 31.

which it referred to as “bankrupt beyond remedy.”<sup>36</sup> In addition to monetary aid, the Joint Commission sought to implement community-based clinics to replace the state facilities.<sup>37</sup> The medical professionals at these clinics aimed to find and treat people with mental illness early in the progression of their disease, and in the community, without forcing the patients into facilities.<sup>38</sup> At the time of the Joint Commission’s creation, reformers proposed federal grants to states for the creation of these community mental health programs.<sup>39</sup>

Antipsychotic medications also began to appear in the 1950s.<sup>40</sup> The first medication was chlorpromazine, which helped to reduce side effects of psychosis by decreasing the positive symptoms of schizophrenia.<sup>41</sup> Some experts saw that the new medications could provide an opportunity for patients to be deinstitutionalized by helping to moderate the most obviously severe symptoms.<sup>42</sup> In addition, after doctors and researchers introduced medications, state hospitals could use less invasive tactics.<sup>43</sup> Although some heralded these early antipsychotics—often referred to as “first-generation” antipsychotics—for

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<sup>36</sup> *Id.* at 44. Most notably, the Joint Commission’s report suggested that immense federal funding would be required to help states treat their citizens living with mental illness. *Id.* at 32.

<sup>37</sup> *Id.* at 20. The goal of these community treatment centers was to give patients treatment in the community, rather than in facilities. *Id.* In addition, these centers were focused on prevention. TORREY, *supra* note 33, at 69. Dr. Felix aimed to provide “one out-patient mental health clinic for each 100,000 of the population.” TORREY, *supra* note 18, at 21. President Kennedy stated that the goal of these community health centers was replacing “reliance on the cold mercy of custodial isolation” with “the open warmth of community concern and capability.” *Id.* at 55. (quoting President John F. Kennedy, Special Message on Mental Illness and Mental Retardation, (Feb. 5, 1963)).

<sup>38</sup> TORREY, *supra* note 18, at 20. Federal community health centers opened in 1966, and were required to offer five services to patients: “inpatient beds, partial hospitalization beds, 24-hour emergency evaluations, outpatient services, and consultation/education.” *Id.* at 62. In 1974, an additional seven services were added to the program including patient screening before patients were admitted to hospitals, care for patients following release from hospitals, new facilities for patients recently released from hospitals, and four special programs, one each for children, the elderly, people with drug addiction, and people with alcohol addiction. *Id.* at 84.

<sup>39</sup> *Id.* at 24.

<sup>40</sup> *Id.* at 32; see Douglas Mossman, *Unbuckling the “Chemical Straitjacket”: The Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis*, 39 SAN DIEGO L. REV. 1033, 1063–64 (2002) (“Before the introduction of chlorpromazine in 1953, most individuals with schizophrenia were destined to spend their entire adult lives within large, often remote psychiatric hospitals.” (quoting Donald C. Goff, *A 23-Year-Old Man with Schizophrenia*, 287 J. AM. MED. ASS’N 3249, 3256 (2002))).

<sup>41</sup> Mossman, *supra* note 40, at 1062–63. Positive symptoms are “*additional* behaviors not generally seen in healthy people.” NAT’L INST. MENTAL HEALTH, SCHIZOPHRENIA 2 (2019), [https://www.nimh.nih.gov/health/publications/schizophrenia/19-mh-8082-schizophrenia\\_155669.pdf](https://www.nimh.nih.gov/health/publications/schizophrenia/19-mh-8082-schizophrenia_155669.pdf) [<https://perma.cc/8MDS-KAGY>]. Positive symptoms include hallucinations, delusions, thought disorders, and movement disorders. *Id.*; see *infra* notes 81–82 and accompanying text (discussing positive and negative symptoms).

<sup>42</sup> Mossman, *supra* note 40, at 1065 (explaining how new medications facilitated deinstitutionalization).

<sup>43</sup> See *id.* at 1064–65 (comparing the lives of individuals in mental facilities before and after the introduction of antipsychotic medications).

their ability to help quell symptoms, they had significant drawbacks for patients.<sup>44</sup> First, the antipsychotics did not have a high rate of success.<sup>45</sup> Second, the antipsychotics from this time period often carried extreme side effects, such as “stiffness, diminished facial expression, tremors, and restlessness.”<sup>46</sup> The side effects caused many people to stop using the drugs.<sup>47</sup>

Thus, deinstitutionalization began in 1956.<sup>48</sup> Patients at state and federal mental health facilities were discharged, largely in response to the new federal programming and bolstered by the promise of new medications for people with severe mental illness.<sup>49</sup> The federal program caused many asylums to close, and promoted replacing them with community mental health centers.<sup>50</sup> Some scholars argued that closing the facilities was a win for patients.<sup>51</sup> Asylums would no longer subject individuals to the documented horrors of under-educated staff and inhumane conditions.<sup>52</sup> In addition, deinstitutionalization allowed individual patients who had full insight into their condition, moderate symptoms, and familial

<sup>44</sup> See *id.* at 1068–69 (explaining that these novel antipsychotics had negative side effects for patients); see also E. FULLER TORREY, *SURVIVING SCHIZOPHRENIA: A FAMILY MANUAL* 183 (6th ed. 2013) (explaining that antipsychotics introduced prior to 1990 are referred to as “first-generation”).

<sup>45</sup> Mossman, *supra* note 40, at 1068–69.

<sup>46</sup> *Id.* These side effects are problematic because they can be permanent. *Id.* at 1069. In addition, patients may experience weight gain and an increase in blood sugar content, which can lead to diabetes. TORREY, *supra* note 44, at 185.

<sup>47</sup> Mossman, *supra* note 40, at 1068–69. Noncompliance rates with these earlier medications were as high as 40%. *Id.*

<sup>48</sup> TORREY, *supra* note 18, at 33. “Deinstitutionalization” refers to the process of releasing patients with mental illness from state hospitals. *Id.* In 1955, 558,922 people with mental illness lived in state facilities. *Id.* The following year, 7,532 fewer people lived in these facilities. *Id.* This decrease in patients in facilities was the first in more than one hundred years. *Id.* Even before the government officially implemented the federal community health program, states began to create their own outpatient programs. *Id.* at 52. President Kennedy officially signed the federal program into legislation in October 1963. *Id.* at 58.

<sup>49</sup> *Id.* at 32–33 (describing the impact of antipsychotic medications on deinstitutionalization).

<sup>50</sup> See *id.* at 44 (summarizing the decision making involved in reducing the number of state-sponsored asylums). Although there was a strong push to close U.S. asylums, those advocating on behalf of the closures had little experience working in state facilities, and did not propose fixing what already existed. *Id.* In 1961, Gerald Caplan published *An Approach to Community Mental Health*, which accelerated acceptance of community mental health centers. *Id.* at 46. In addition, people developed other groups to help individuals with mental illness, such as “Schizophrenics Anonymous” and “Recovery Inc.” *Id.* at 94.

<sup>51</sup> *Id.* at 44–45, 94.

<sup>52</sup> See *id.* at 93 (explaining that releasing patients from facilities was “logical and humane”). Arguably, deinstitutionalization was the first attempt in U.S. history to bring individuals with mental illness into society, representing a shift in opinions regarding those with these illnesses. Leonard S. Rubenstein, *Reflections on Freedom, Abandonment, and Deinstitutionalization*, in *CHOICE & RESPONSIBILITY: LEGAL AND ETHICAL DILEMMAS IN SERVICES FOR PERSONS WITH MENTAL DISABILITIES* 53, 58 (Clarence J. Sundram ed., 1994). For the first time, these individuals were “suddenly to be brought not only into light, but also into the neighborhood.” *Id.*



support the opportunity to thrive.<sup>53</sup> Other scholars, however, criticized the community-based programs as under-researched and under-planned by, for example, not determining where released patients would live and how these programs would handle patients who refused to accept treatment.<sup>54</sup>

In 1980, President Ronald Regan overhauled the government's response to the mental health crisis by implementing block grant funding to the states.<sup>55</sup>

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<sup>53</sup> TORREY, *supra* note 18, at 94. Furthermore, some patients also were released to areas that had strong programs for rehabilitation. *Id.* One restaurant, the Eden Express, offered a program for people with mental illness to learn to cook and work in the restaurant business. *Id.* From 1980 to 1999, the program worked with seven hundred people with mental illness. *Id.* 80% of individuals who enrolled in the program completed it. *Id.* Of those who completed the training, 94% went on to find jobs. *Id.*

<sup>54</sup> *Id.* at 57 (explaining that no researchers conducted studies demonstrating that the community approach would prevent mental illness or catch the progression of the disease early). The program Congress passed had a number of issues, including focusing on prevention without authoritative science available at the time to understand how psychiatric diseases developed, closing state-sponsored facilities without clear plans for where patients discharged from the facilities would reside, and failing to provide a path forward for coordination between the federal and state governments. *See id.* at 58–59 (explaining the flaws of the community mental health center plan). In Justice Anthony Kennedy's 1999 concurrence in the Supreme Court case *Olmstead v. L.C.*, he raised concerns regarding deinstitutionalization. *See* 527 U.S. 581, 609 (1999) (Kennedy, J., concurring in judgment). *Olmstead* considered the antidiscrimination provision of the Americans with Disabilities Act of 1990. *Id.* at 587 (majority opinion). Quoting E. Fuller Torrey, an expert on mental illness, Justice Kennedy noted that the "self-determination" granted to individuals with mental illness by deinstitutionalization may only mean "that the person has a choice of soup kitchens," due to the lack of structural support offered by the government to these patients. *Id.* at 609 (Kennedy, J., concurring in judgment) (quoting E. FULLER TORREY, *OUT OF THE SHADOWS* 11 (1997)). Justice Kennedy was concerned that, for those with serious mental illness and without any treatment, "the most dreaded of confinements can be the imprisonment inflicted by his own mind, which shuts reality out and subjects him to the torment of voices and images beyond our own powers to describe." *Id.* at 609–10.

<sup>55</sup> TORREY, *supra* note 33, at 197. Block grants are a type of federal funding that "allow the states to allocate federal funds among competing programs that fall under the same subject heading." Janet Varon, *Passing the Bucks: Procedural Protections Under Federal Block Grants*, 18 HARV. C.R.-C.L. L. REV. 231, 236 (1983). Unlike other methods of federal funding, block grants provide states the opportunity to "design programs, define eligibility, criteria, or even eliminate a program," so long as the funding is used within the broad definition of the federal grant. *Id.* Critics of block grants emphasize that this type of funding can have an adverse impact on lower-income individuals for two primary reasons. *Id.* at 232. First, in tandem with the choice to use block grants for funding, Congress may actually decrease the amount of funding given to states, leaving states unable to effectively implement critical programs. *Id.* Second, if Congress uses block grants, it is unlikely that there will be federal regulations in place that act "as a shield to protect poor groups and regions which may need services but have comparatively little political influence." *Id.* The community-based program was already suffering prior to President Reagan's tenure. TORREY, *supra* note 33, at 181. From 1970 to 1972, President Richard Nixon repeatedly attempted to cutback funding to the programs. *Id.* at 184. During his presidency from 1977 to 1981, President James "Jimmy" Carter tried to help people with mental illness by creating a new program, the Community Support Program, but did not attempt to fix the existing program. *Id.* at 194–95; *see James Carter*, WHITE HOUSE, <https://www.whitehouse.gov/about-the-white-house/presidents/james-carter/> [<https://perma.cc/P2EW-PQJM>] (providing details of President Carter's tenure). In 1981, President Reagan implemented federal block grants in the Omnibus Budget Reconciliation Act, aiming to encourage the states to take control of their own programming. TORREY, *supra* note 33, at 197. These block grants, however, constituted less than 5% of the

When Congress first introduced the community-based program, it told the states that the federal community health centers would replace the state mental hospitals.<sup>56</sup> States closed their facilities in reliance upon the federal program.<sup>57</sup> But without the federal funding, the states could not uphold the community-based programs.<sup>58</sup> The changes in funding essentially ended the community-based program, which created organizational challenges for state programs and federal programs to work in tandem.<sup>59</sup>

Scholars argue that the policy decision to release patients into the community for community-based treatment failed to consider scientific evidence that many individuals lacked insight into their condition.<sup>60</sup> Patients without insight arguably needed caretaker and facility structure to remain compliant with medication.<sup>61</sup> Although community-based treatments allowed patients to interact with society, patients who needed medications did not always have the resources and support necessary to continue their medical treatment.<sup>62</sup>

Deinstitutionalization also correlated with an increase in the number of incarcerated mentally ill individuals.<sup>63</sup> The percentage of people with serious mental illnesses in prisons rose from 5% in the 1970s to between 20% and 40% in 2012.<sup>64</sup> In California, for example, studies demonstrated that there was

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total federal funding for people with mental illness, giving the states little means to maintain community programs. *Id.* at 198.

<sup>56</sup> TORREY, *supra* note 18, at 88–89.

<sup>57</sup> *Id.* at 89–90.

<sup>58</sup> *Id.*

<sup>59</sup> See David L. Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process*, 75 COLUM. L. REV. 897, 907 (1975) (describing the “folly” of removing patients from state facilities without first ensuring proper funding and support at community health centers); see also TORREY, *supra* note 18, at 90 (describing the fatal flaw of the original federal mental health program to coordinate with state governments). Dr. Felix, the creator of the community-based program stated, in 1984, that the “result [of the community-based program] is not what we intended.” TORREY, *supra* note 18, at 17.

<sup>60</sup> See, e.g., Paul F. Stavis, *Why Prisons Are Brim-Full of the Mentally Ill: Is Their Incarceration a Solution or a Sign of Failure?*, 11 GEO. MASON U. C.R. L.J. 157, 176 (2000) (explaining the shortcomings of plans to release patients from psychiatric hospitals into communities).

<sup>61</sup> See *id.* (suggesting that many patients with mental illness require more structure in their treatment plans to succeed).

<sup>62</sup> *Id.*; see Bazelon, *supra* note 59, at 908 (“The real problem is that deinstitutionalization also represents a ‘standardized response’ to a multitude of individual problems . . . not all patients will be helped by autonomy in the community.”).

<sup>63</sup> See Stavis, *supra* note 60, at 176 (“These individuals, rather than being the *metaphorical* ‘prisoners of psychiatry’ . . . are increasingly becoming *real* prisoners of our nation’s jails.”).

<sup>64</sup> TORREY, *supra* note 18, at 117. Prisoners with mental illness tend to have longer stays in correctional institutions than other prisoners. *Id.* at 118. At Rikers Island in New York, the average prison stay is forty-two days for individuals without mental illness. *Id.* For prisoners with mental illness, however, the average stay is 215 days. *Id.* Prisoners victimize those with mental illness more than others. See *id.* at 119. One study determined that one out of twelve male prisoners with mental illness reported “sexual victimization” in a six-month period, although only one in thirty-three male prisoners without mental illness reported victimization in the same period. *Id.* Finally, prisoners with mental illness are significantly more expensive to house than prisoners without mental illness. *Id.* A 2007

a significant uptick in people with mental illness in state prisons from the early 1970s to the early 2000s.<sup>65</sup> Closing the facilities in California meant many patients became homeless, and eventually ended up in jail.<sup>66</sup> Today, it is more probable that a person with mental illness will receive treatment if incarcerated than if attempting to find treatment in a mental health facility or hospital.<sup>67</sup>

Many individuals who receive treatment in jails have severe mental illness.<sup>68</sup> One form of severe mental illness, and the primary focus of this Note, is schizophrenia.<sup>69</sup> The following Section discusses schizophrenia in detail, including its perception in society, theories of its origin, and symptoms of the disorder, including anosognosia, which affects more than fifty percent of patients with schizophrenia and causes a severe lack of insight into one's own mental illness.<sup>70</sup>

### *B. Schizophrenia: A Complex and Multi-Faceted Disease*

Schizophrenia is a widely discussed, and arguably widely misunderstood, disease.<sup>71</sup> The media frequently characterizes people with schizophrenia as

study of Florida's Broward County Jail determined that prisoners with mental illness cost \$130 per day. *Id.* In contrast, it cost \$80 per day to house prisoners without mental illness. *Id.*

<sup>65</sup> Darrell Steinberg et al., STANFORD L. SCH. THREE STRIKES PROJECT, WHEN DID PRISONS BECOME ACCEPTABLE MENTAL HEALTHCARE FACILITIES? 2 (2015), [https://law.stanford.edu/wp-content/uploads/sites/default/files/publication/863745/doc/slspublic/Report\\_v12.pdf](https://law.stanford.edu/wp-content/uploads/sites/default/files/publication/863745/doc/slspublic/Report_v12.pdf) [<https://perma.cc/A9KG-EXEH>]. When California reduced the size and number of its state mental health facilities, its legislature planned for the funding formerly used at the state facilities to go toward community health programs for these same patients. *Id.* at 6. The funding never reached the community health programs, as then-Governor Ronald Reagan vetoed the change in funding twice, first in 1972 and then in 1973. *Id.* Following the vetoes, the funding was inconsistent, leading to varying degrees of service for the patients across the state. *Id.*

<sup>66</sup> See Craig Haney, *Expert Analysis: The Tragic Case of Mentally Ill Prisoners in California*, in WHEN DID PRISONS BECOME ACCEPTABLE MENTAL HEALTHCARE FACILITIES?, *supra* note 65, at 7 (explaining that people with mental illness tend to have risk factors, like homelessness, that may lead to incarceration and that in California "there are almost no public psychiatric beds available for individuals with serious mental illnesses"); WHEN DID PRISONS BECOME ACCEPTABLE MENTAL HEALTHCARE FACILITIES?, *supra* note 65, at 6; see also TORREY, *supra* note 18, at 124 (describing the increase in the population of homeless individuals with mental illness). Following deinstitutionalization, studies suggest that more than 30% of homeless people have a serious mental illness. TORREY, *supra* note 18, at 124. In a 2010 study of the United States, researchers determined that there are 650,000 homeless people in the country. *Id.* Extrapolating from the study, 216,000 of those individuals live with a mental illness. *Id.*

<sup>67</sup> Haney, *supra* note 66, at 7. In the United States today, approximately 350,000 prisoners are living with mental illness, nearly ten times the population of people with mental illness living in U.S. psychiatric facilities. *Id.*

<sup>68</sup> See *id.* (explaining that many patients in prisons are living with mental illness and receiving treatment in prisons).

<sup>69</sup> See *infra* notes 77–82 and accompanying text (describing schizophrenia).

<sup>70</sup> See *infra* Part I.B.

<sup>71</sup> Schizophrenia is a serious mental illness that alters an individual's ability to think clearly, feel emotion, and conform their behavior to convention. See *Schizophrenia*, NAT'L INST. MENTAL HEALTH, <https://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml> [<https://perma.cc/6A32-8TKC>]; see also TORREY, *supra* note 44, at 76–89 (describing other psychiatric conditions that people may

violent individuals, with symptoms of deviant behavior or hallucinations that doctors must treat with electroshock therapy or other antiquated treatments.<sup>72</sup> In reality, however, only a small population of patients are violent, deviant behavior and hallucinations are rarer than other symptoms, and antipsychotic medication is the modern standard for treatment of the disease.<sup>73</sup>

Many theories exist about what causes schizophrenia, including genetics, neurochemicals, neurological development, and infection.<sup>74</sup> Over time, scientists and other experts have debunked other theories of the disease's origin, such as "bad families" or "evil spirits".<sup>75</sup> Approximately 20,000,000 people

confuse with schizophrenia); WANG, *supra* note 33, at 3 ("People speak of schizophrenics as though they were dead without being dead, gone in the eyes of those around them.").

<sup>72</sup> See Patricia R. Owen, *Portrayals of Schizophrenia by Entertainment Media: A Content Analysis of Contemporary Movies*, 63 PSYCHIATRIC SERVS. 655, 655–56 (2012). One study analyzed forty-two characters with schizophrenia in movies, and found that thirty-five of them engaged in violence. *Id.* at 657. Some refer to this trope of violence as the "homicidal maniac," which is one of the most prevalent stereotypes of people with schizophrenia depicted in movies. *Id.* at 655. Violent depictions of people with schizophrenia in movies may contribute to the public perception that these individuals are unsafe. *See id.* at 658. In addition, people with schizophrenia may be further stigmatized due to these inaccurate depictions. *See id.*

<sup>73</sup> *Id.* at 655–56. One study reviewed more than four hundred movies that depicted the treatment of schizophrenia. *Id.* at 656. Of the four hundred movies, only one showed antipsychotic medication as the treatment for the disease, although these treatments are considered "first-line" for schizophrenia. *Id.*

<sup>74</sup> TORREY, *supra* note 44, at 134–44. Genetic theories suggest that schizophrenia is caused by a family's gene pool. *Id.* at 134. It is unlikely that genetics alone cause the disorder, however, as an identical twin of an individual with schizophrenia has only about a 30% likelihood of having the illness. *Id.* This research suggests that other factors contribute to the onset of schizophrenia. *Id.* Neurochemical theories allege that chemicals in the brain called neurotransmitters cause schizophrenia. *Id.* at 136. For example, some researchers allege that abnormalities in the neurotransmitter dopamine causes schizophrenia. *Id.* Researches believed this theory because early antipsychotics aimed to block dopamine to help ameliorate symptoms of the disease. *Id.* Although schizophrenia impacts neurotransmitters, experts debate whether the abnormalities cause the disease or whether they are a symptom. *See id.* at 137. Developmental theories suggest that an incident during the development of an individual's brain causes schizophrenia. *Id.* Developmental theories are popular today. *Id.* Developmental theorists argue that any kind of agent could cause the problem, including drugs, alcohol, medication, stressful incidents, poor nutrition, genetic abnormalities, or environmental influences. *Id.* These theorists believe that once the developmental incident occurs during brain development, the individual is more likely to develop schizophrenia. *Id.* Infection theories suggest that "infectious agents," in concert with a genetic predisposition toward schizophrenia, cause the disease to manifest in an individual. *Id.* at 138–39. An example of an-infectious agent is *Toxoplasma gondii*, a parasite. *Id.* at 139; see *Parasites—Toxoplasmosis (Toxoplasma Infection)*, CTRS. FOR DISEASE CONTROL & PREVENTION, [https://www.cdc.gov/parasites/toxoplasmosis/gen\\_info/faqs.html](https://www.cdc.gov/parasites/toxoplasmosis/gen_info/faqs.html) [<https://perma.cc/U3BJ-P9QH>]. Infection theorists suggest that those infected with these agents who are also predisposed to schizophrenia have a strong chance of developing the disease. TORREY, *supra* note 44, at 139–40.

<sup>75</sup> TORREY, *supra* note 44, at 144–47. The "bad families" theory of schizophrenia was prominent in the 1950s. *Id.* at 145. This theory suggested that individuals were more likely to have schizophrenia if they were born into families that had poor interactions with one another. *Id.* Similarly, other theorists suggested that individuals who had families that were too critical, antagonistic, or overbearing were more likely to manifest schizophrenia. *Id.* Scientists debunked this theory, too. *Id.* The "evil spirits" theory refers to the idea that an infestation of "evil spirits" in the mind of the individual with

worldwide live with schizophrenia, and it affects roughly 1% of the U.S. adult population.<sup>76</sup> Schizophrenia is a neurodevelopmental disorder that causes a person to have difficulty thinking, feeling, and acting conventionally.<sup>77</sup> Although the root of the word “schizophrenia” comes from Greek words meaning “a mind that is divided or torn apart,” split personality is a different, less common, psychiatric condition.<sup>78</sup> There is no singular symptom that is considered the hallmark of schizophrenia.<sup>79</sup> Historically, doctors characterized schizophrenia by delusions, hallucinations, and disorganized speech or behavior.<sup>80</sup> New research, however, has revealed a plethora of symptoms of the disease, which fall into two categories: positive symptoms and negative symptoms.<sup>81</sup> Positive symptoms are those that add to a patient’s personality or affect, and negative symptoms are those that cause a person with schizophrenia to withdraw from social interaction.<sup>82</sup>

Schizophrenia typically manifests in early adulthood.<sup>83</sup> The disease is challenging to diagnose, as symptoms may come and go.<sup>84</sup> The Diagnostic and Statistical Manual of Mental Disorders (DSM) provides the criteria for a diagnosis of schizophrenia in the United States.<sup>85</sup> Due to the disease’s stigma and

the disease causes schizophrenia. *Id.* In some parts of the world, people still believe this theory is accurate. *Id.*

<sup>76</sup> *Schizophrenia*, WORLD HEALTH ORG., <https://www.who.int/news-room/fact-sheets/detail/schizophrenia> [<https://perma.cc/39NU-PF2J>]; see also WANG, *supra* note 33, at 4 (describing the prevalence of schizophrenia).

<sup>77</sup> NAT’L INST. MENTAL HEALTH, *supra* note 41. Neurodevelopmental disorders are a group of disorders that have symptoms of brain impairment and are characterized by patients having difficulty communicating and behaving. A.P. Mullin et al., *Neurodevelopmental Disorders: Mechanisms and Boundary Definitions from Genomes, Interactomes and Proteomes*, TRANSLATIONAL PSYCHIATRY, 2013, at 1, 1. Included in the group is autism spectrum disorder, schizophrenia, and attention deficit/hyperactivity disorder. *Id.*

<sup>78</sup> Mossman, *supra* note 40, at 1046; see also TORREY, *supra* note 44, at 75–76.

<sup>79</sup> TORREY, *supra* note 44, at 59.

<sup>80</sup> Douglas Mossman & Jill L. Steinberg, *Promoting, Prescribing, and Pushing Pills: Understanding the Lessons of Antipsychotic Drug Litigation*, 13 MICH. STATE U. J. MED. & L. 263, 269 (2009).

<sup>81</sup> NAT’L INST. MENTAL HEALTH, *supra* note 41.

<sup>82</sup> *Id.* Positive symptoms need not be present at all times, and may increase or decrease over the lifespan of the individual with schizophrenia. See *id.* Some refer to positive symptoms as “psychotic symptoms.” Dora W. Klein, *When Coercion Lacks Care: Competency to Make Medical Treatment Decisions and Parens Patriae Civil Commitments*, 45 U. MICH. J.L. REFORM 561, 581 (2012). Negative symptoms include difficulty following through with plans, lacking facial affects, having trouble feeling happiness, speaking infrequently, and struggling with decision-making. Mossman & Steinberg, *supra* note 80, at 269.

<sup>83</sup> Mossman & Steinberg, *supra* note 80, at 269; see also ELYN R. SAKS, *THE CENTER CANNOT HOLD: MY JOURNEY THROUGH MADNESS* 34–35 (2007) (describing the author’s schizophrenia onset as a student at Vanderbilt University).

<sup>84</sup> TORREY, *supra* note 44, at 61.

<sup>85</sup> See *id.* To encompass all the different ways in which schizophrenia may manifest, the Diagnostic and Statistical Manual of Mental Disorders (DSM) includes a list of positive and negative symptoms and other criteria for a clinician to diagnose the disease appropriately. *Id.*; AM. PSYCHIATRIC

its painful history, clinicians will not give a diagnosis until they are certain it is schizophrenia.<sup>86</sup> Clinicians require symptoms of the disease to occur for at least six months before making a diagnosis of schizophrenia.<sup>87</sup> This waiting period is different from typical diagnostic practice, and reflects the seriousness of the disease and the implications of the diagnosis.<sup>88</sup>

Currently, no medication or treatment can cure schizophrenia.<sup>89</sup> All treatments available only help alleviate symptoms.<sup>90</sup> Antipsychotic medication is the only successful treatment method for active, positive symptoms of schizophrenia, and negative symptoms remain difficult to treat.<sup>91</sup> Research suggests

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ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 99–105 (5th ed. 2013). The DSM-V, the most recent iteration of the manual, lists the following requirements for schizophrenia, as related in *Surviving Schizophrenia: A Family Manual*:

- A. Two or more of the following symptoms must be present for a significant portion of time during a one-month period.
  1. delusions
  2. hallucinations
  3. disorganized speech
  4. catatonia or other grossly abnormal psychomotor behavior
  5. “negative” symptoms, e.g. restricted affect, asociality
- B. Significant decreased function at work, in interpersonal relations, or in self-care.
- C. At least one month of active symptoms (criteria A) unless successfully treated and at least six months of all symptoms (prodromal, active, and residual).
- D. Does not meet criteria for schizoaffective disorder, and symptoms of psychosis are not caused by substance abuse.

AM. PSYCHIATRIC ASS'N, *supra*, 99–105; TORREY, *supra* note 44, at 61.

<sup>86</sup> See TORREY, *supra* note 44, at 61 (referring to the historically negative implications of a schizophrenia diagnosis, and emphasizing the care doctors must take in diagnosing people with the disease).

<sup>87</sup> See *id.* In the past, clinicians were too eager to give a schizophrenia diagnosis, and individuals with other disorders were wrongfully diagnosed. *Id.*

<sup>88</sup> See *id.* (describing the process for obtaining a schizophrenia diagnosis). In practice, when a clinician first suspects that a patient may have schizophrenia, the clinician writes “rule out schizophrenia” in the patient notes. *Id.* This is an indefinite diagnosis, which allows the clinician to further observe the patient until a diagnosis can be confirmed. See *id.* Schizophrenia diagnoses rely heavily on the subjective observations of clinicians. *Id.* at 62. There is no objective test for schizophrenia. See *id.* (explaining that there is no blood or other test that would diagnose the disease with certainty).

<sup>89</sup> Klein, *supra* note 82, at 581.

<sup>90</sup> *Id.*

<sup>91</sup> *Id.* at 582. Negative symptoms, such as a lack of affect or motivation, do not respond as well to antipsychotic medication as positive symptoms. Mossman & Steinberg, *supra* note 80, at 274 n.55. Historically, researchers theorized that negative symptoms would not be responsive to medication. Gary Remington et al., *Treating Negative Symptoms in Schizophrenia: An Update*, CURRENT TREATMENT OPTIONS PSYCHIATRY, June 2016, at 133, 135. Although researchers have tried numerous different treatments for negative symptoms, no treatment has conclusively been successful to date. *Id.* at 144. Doctors are conducting trials to determine whether antidepressant medications are effective to treat negative symptoms. *Id.* at 136. One potential reason for the failure of these studies is the difficulty of differentiating between negative symptoms of schizophrenia and other secondary conditions, like depression. *Id.* at 144. Scientists recognize that the treatment of negative symptoms is an “unmet

that leaving positive symptoms untreated may make future treatment less successful.<sup>92</sup> Medication, however, may not have the same results in each patient.<sup>93</sup> Some patients may experience a complete dissipation of symptoms, while others may see little to no change.<sup>94</sup> Although clinicians often consider antipsychotic medications as critical for the treatment of schizophrenia, therapy can also be beneficial.<sup>95</sup> Those who attend therapy may be more likely to take their medication, and may have lower rates of relapse or hospitalization.<sup>96</sup>

It is not uncommon for a person with severe mental illness to deny his or her diagnosis.<sup>97</sup> But simple denial, which may be considered a “coping mechanism,” is different from anosognosia, a researched symptom of schizophrenia.<sup>98</sup> Anosognosia is a symptom that causes patients to lack insight into their

need” in the field, however, pathways to successfully identifying treatments remain unclear. *Id.* at 145.

<sup>92</sup> See Klein, *supra* note 82, at 582–83 (explaining the dangers of leaving symptoms of schizophrenia untreated for long periods of time).

<sup>93</sup> *Id.* at 581.

<sup>94</sup> See *id.* (describing the different effects antipsychotic medications may have on patients). Scientists discovered clozapine in 1989, marking a major development in schizophrenia treatment. Mossman, *supra* note 40, at 1069–70. Unlike chlorpromazine, clozapine does not cause extreme side effects and is effective for a larger percentage of patients. *Id.* at 1068, 1070–71. Clozapine does carry a risk, however, of causing a potentially fatal blood disorder, which means patients must undergo monitoring and testing. *Id.* at 1070–71. Clozapine and its progeny are often referred to as “second-generation” antipsychotics; although other medications have become available, clozapine is still referred to as the “gold standard” of medication for schizophrenia. TORREY, *supra* note 44, at 183, 191–93. Clinicians developed an alternative method for the administration of medications for psychosis, which requires a periodic injection of antipsychotic medication. POWERS, *supra* note 1, at 27. Colloquially referred to as the “depot” method, it requires individuals to come to a treatment center periodically to receive their dosage in one deposit, rather than requiring patients to take an oral medication daily. *Id.* The phrase comes from French, with “depot” referring to the “place of deposit.” *Id.* Typically, the medication is administered monthly. *Id.* at 28. The results of this method of treatment are mixed. *Id.* In one study, the use of the depot method reduced medication relapse. *Id.* A different study determined, however, that the depot method offered no strong benefit to patients. *Id.* Although these studies present mixed results, this treatment method may be useful for patients with a lack of insight into their condition, who may agree to take medication one day and reach a different conclusion on another day. See *id.* at 27.

<sup>95</sup> See Elizabeth Bennion, *A Right to Remain Psychotic? A New Standard for Involuntary Treatment*, 47 LOY. L.A. L. REV. 251, 282 (2013) (explaining treatment options for schizophrenia).

<sup>96</sup> *Id.*

<sup>97</sup> See AMADOR, *supra* note 1, at 34–35 (discussing the possibility that patients may be refusing medication as a coping mechanism for their diagnosis).

<sup>98</sup> See Bennion, *supra* note 95, at 291 (explaining anosognosia); TREATMENT ADVOC. CTR., SERIOUS MENTAL ILLNESS AND ANOSOGNOSIA (2016), <https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-and-anosognosia.pdf> [<https://perma.cc/NY2C-JA49>] (describing the difference between anosognosia and denial). Anosognosia is caused by anatomy and “physical damage to the brain.” TREATMENT ADVOC. CTR., *supra*, at 1. Denial, however, is psychological. *Id.* As of 2016, twenty-two studies have considered whether there are physical differences in the brain of people with schizophrenia suffering from anosognosia and those without the symptom. *Id.* at 2. Twenty of the twenty-two studies found “significant differences” in the structure of the brain of those with anosognosia. *Id.* Notably, three studies only tested people with schizophrenia who had never been treated by medication, decreasing the possibility that differences in brain chemistry occurred due to

own condition, and thus renders them unaware of their illness.<sup>99</sup> When patients have poor insight because of anosognosia, they have deficits in their ability to understand and appreciate their illness.<sup>100</sup> Roughly fifty percent of people with schizophrenia suffer from anosognosia.<sup>101</sup> Anosognosia is not specific to schizophrenia; the symptom also manifests in Alzheimer's disease, dementia, and other diseases caused by lesions in the right hemisphere of the brain, such as traumatic brain injuries.<sup>102</sup> Unlike denial, damage to the brain causes people with schizophrenia to develop anosognosia.<sup>103</sup> Most studies have determined that anosognosia is linked to disease-based damage in the brain, disproving any suggestion that people with anosognosia are merely denying their illness.<sup>104</sup> In fact, in 2000, the American Psychiatric Association updated the DSM to reflect new findings showing that poor insight is a symptom of schizophrenia, not a patient strategy to cope with an individual's condition.<sup>105</sup>

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medication rather than the disease. *Id.* The goal of this Note is not to debate whether anosognosia is or is not a legitimate symptom, however, it will at some points reference differing opinions regarding the extent to which anosognosia can be considered scientifically present, as the debate is pertinent to a new approach to informed consent for this patient population. *See infra* notes 217–229 and accompanying text (summarizing scholars' critiques of anosognosia as a symptom of schizophrenia, and not mere denial).

<sup>99</sup> TREATMENT ADVOC. CTR., *supra* note 98, at 1. The term anosognosia stems from two Greek words: "nosos," meaning disease, and "gnosis," meaning knowledge. Bennion, *supra* note 95, at 291. Taken together, the phrase translates as "to not know a disease." *Id.* Initially, anosognosia had a narrow definition. Douglas S. Lehrer & Jennifer Lorenz, *Anosognosia in Schizophrenia: Hidden in Plain Sight*, INNOVATIONS IN CLINICAL NEUROSCIENCE, May–June 2014, at 10, 12–13. Joseph Babinski, a French neurologist in the early 1900s, crafted the term and used it only in narrow circumstances for specific brain injuries. *Id.* Today, anosognosia has a broader application, stretching to any "neurologically based denial of illness and unawareness of disability." *Id.* at 13.

<sup>100</sup> Nicholas Kontos et al., "Poor Insight": *A Capacity Perspective on Treatment Refusal in Serious Mental Illness*, 67 PSYCHIATRIC SERVS. 1254, 1255 (2016).

<sup>101</sup> *See* TREATMENT ADVOC. CTR., *supra* note 98, at 1. The symptom manifests in approximately 40% of people living with bipolar disorder, another type of serious mental illness. *Id.*

<sup>102</sup> *See* Bennion, *supra* note 95, at 292; *see also* TORREY, *supra* note 44, at 48 (explaining that decreased insight is found in other brain disorders, such as Alzheimer's disease); Philip Gerretsen et al., *Frontotemporoparietal Asymmetry and Lack of Illness Awareness in Schizophrenia*, 34 HUM. BRAIN MAPPING 1035, 1035 (2013) (describing other conditions that may have anosognosia as a symptom).

<sup>103</sup> Bennion, *supra* note 95, at 292; *see also* Xavier F. Amador & Andrew A. Shiva, *Insight into Schizophrenia: Anosognosia, Competency, and Civil Liberties*, 11 GEO. MASON U. C.R. L.J. 25, 25 (2000) (explaining that poor insight in people with schizophrenia usually is due to problems in the brain, not denial). To determine whether a patient is in denial or instead suffering from anosognosia, three factors should be considered: (1) whether the lack of insight has lasted over a period of months or years, (2) whether the lack of insight is "fixed," meaning it does not change even if presented with evidence, and (3) whether the person offers absurd explanations to persuade others that they do not have an illness. AMADOR, *supra* note 1, at 49.

<sup>104</sup> Amador & Shiva, *supra* note 103, at 30.

<sup>105</sup> Bennion, *supra* note 95, at 296 (quoting DSM-IV 304). The DSM provides doctors with a guide for diagnosing various mental illnesses. *DSM-5: Frequently Asked Questions*, AM. PSYCHIATRIC ASS'N, <https://www.psychiatry.org/psychiatrists/practice/dsm/feedback-and-questions/frequently-asked-questions> [<https://perma.cc/Q24L-V6H4>]. The DSM includes "descriptions, symptoms, and



The severity of a patient's anosognosia may vary.<sup>106</sup> Some patients lack all knowledge of their illness, but others may be aware of some of the illness's symptoms.<sup>107</sup> Patients' anosognosia may worsen if the symptoms of their disease go untreated.<sup>108</sup> Patients who take medication may regain insight, suggesting individuals with anosognosia may require medical intervention to improve their likelihood of recovery from their lack of insight.<sup>109</sup>

The consequences of anosognosia for people with schizophrenia can be significant.<sup>110</sup> Studies link anosognosia to decreased adherence to medication protocols, increased relapse rates, higher numbers of involuntary admissions to hospitals, and worsened brain functioning.<sup>111</sup> Failing to take medication may be problematic, as new research suggests medications may stay the progression of schizophrenia or significantly reduce the disease's symptoms.<sup>112</sup>

Although medication may be the best option for a patient with schizophrenia and anosognosia, prior to administering medication, the doctor must explain the pros and cons of accepting the treatment and ask for the patient's informed consent.<sup>113</sup> After hearing the doctor's opinion, individuals generally have the right to refuse treatment.<sup>114</sup> If a judge finds a patient incompetent, however, which may be at issue for patients with schizophrenia, he or she does not maintain that right.<sup>115</sup> The following Section explains the doctrine of informed consent and four theories of competency.<sup>116</sup>

other criteria for diagnosing mental disorders." *Id.* Experts review the DSM periodically to ensure that it reflects modern science. *Id.*

<sup>106</sup> Lehrer & Lorenz, *supra* note 99, at 15.

<sup>107</sup> Amador & Shiva, *supra* note 103, at 27. Anosognosia may leave a person's belief about that person's self "stranded in time." AMADOR, *supra* note 1, at 38. A person may "believe they have all the same abilities and the same prospects they enjoyed prior to the onset of their illnesses." *Id.*

<sup>108</sup> Epright, *supra* note 4, at 803.

<sup>109</sup> *See id.* (referencing research that indicates patients may be able to obtain insight into their condition with medication).

<sup>110</sup> Bennion, *supra* note 95, at 296 (quoting DSM-IV 304).

<sup>111</sup> *Id.*

<sup>112</sup> *See* Mossman, *supra* note 40, at 1048 n.71 (explaining that modern science demonstrates the ability of antipsychotic drugs to "quell" schizophrenia's symptoms); *see also* Bennion, *supra* note 95, at 284 (describing new research suggesting that when patients do not accept treatment, their brains may lose more brain matter, suggesting that "early [treatment] intervention is to prevent this loss from occurring").

<sup>113</sup> W.M. Moldoff, Annotation, *Malpractice: Physician's Duty to Inform Patient of Nature and Hazards of Disease or Treatment*, 79 A.L.R. 2d 1028, § 1 (1961) (explaining that a physician must disclose any material risks to the patient prior to administering treatment).

<sup>114</sup> PEGALIS, *supra* note 12, § 4:1.

<sup>115</sup> *See infra* notes 132–136 and accompanying text (explaining what occurs when a patient is determined incompetent).

<sup>116</sup> *See infra* Part I.C.

### C. Informed Consent & Patient Competency Determinations

In general, physicians must provide patients with the information necessary to make an educated decision regarding their treatment.<sup>117</sup> Physicians must act for their patients' interests alone.<sup>118</sup> There are two primary standards for disclosure: one requires disclosure of risks a "reasonable medical practitioner" would give a patient and the other requires the physician to disclose risks that a reasonable, prudent patient would want to know before consenting to treatment.<sup>119</sup> After a physician discloses the risks of the medical procedure or treatment, it is up to their patients to determine whether they would like to accept the doctor's suggestion.<sup>120</sup>

Informed consent is rooted in the essential assumption of the Anglo-American legal tradition that all individuals have the right to make their own choices.<sup>121</sup> Often referred to as the "right to refuse treatment" in the medical context, the right has evolved through four different sources: federal and state constitutions, state statutes, and the common law.<sup>122</sup> When individuals are considered competent to make decisions, a doctor cannot ignore their choices—even if the doctor thinks it is unwise.<sup>123</sup> Patients' autonomous decisions are based upon their personal virtues, and doctors must respect them.<sup>124</sup> There are exceptions to the general requirement of disclosure, such as emergency situa-

<sup>117</sup> Moldoff, *supra* note 113, § 1.

<sup>118</sup> See Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 916 (1994) (describing the physician's obligation to act on behalf of the patient's interests, not the doctor's preferences).

<sup>119</sup> *Id.* There are, broadly, two different theories of how much information physicians are required to disclose to their patients. *Id.* at 903. "Idealists" argue that physicians should inform their patients about every minutia of the treatment, finding few pieces of information immaterial to a patient decision. *Id.* Typically, judges and medical theorists fall into the idealist camp. *Id.* In contrast, "realists," a group largely comprised of medical practitioners, suggest that the additional patient anxiety and billed time occurring with extensive disclosures cuts against the core of informed consent. *Id.* at 904. "Realists" focus on the material risks. *Id.*

<sup>120</sup> Moldoff, *supra* note 113, § 1.

<sup>121</sup> *Natanson v. Kline*, 350 P.2d 1093, 1104 (Kan. 1960) ("Anglo-American law starts with the premise of thorough-going self determination."); see also *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972) (reiterating that patients' right to choose their treatment is the "root premise . . . fundamental in American jurisprudence"); ROBERT F. SCHOPP, COMPETENCE, CONDEMNATION AND COMMITMENT: AN INTEGRATED THEORY OF MENTAL HEALTH LAW 64 (2001) (describing autonomy as a "core value" considered in modern health care decision).

<sup>122</sup> Kevin R. Wolff, Note, *Determining Patient Competency in Treatment Refusal Cases*, 24 GA. L. REV. 733, 737–38 (1990). The first state case focused on the right to refuse treatment was *In re Quinlan*, in 1976, in which the New Jersey Supreme Court determined that the right to privacy under the Fourteenth Amendment was "broad enough" to encompass a patient's right to refuse lifesaving treatment. 355 A.2d 647, 663 (N.J. 1976); see also Wolff, *supra*, at 737–38 (describing the findings of the court in *In re Quinlan*).

<sup>123</sup> *Natanson*, 350 P.2d at 1104. Even when doctors, using their medical judgment, believe that a treatment is necessary, patients have the right to choose. See *id.*

<sup>124</sup> SCHOPP, *supra* note 121, at 65. A patient's virtues may include "self-reflection, direction, reliance, and control; moral authenticity and independence; and responsibility for self." *Id.*

tions or, most importantly for this Note, when a judge finds a patient legally incompetent to consent to treatment.<sup>125</sup>

The law generally considers adults competent to make their own treatment decisions under the law.<sup>126</sup> When a question of a patient's legal competency arises, a physician must assess the medical capabilities of the patient to make decisions.<sup>127</sup> In the medical profession, this assessment is often referred to as determining a patient's capacity, a different test than legal competency.<sup>128</sup> Although various capacity tests exist in the medical profession, each test requires a careful consideration of the patient's autonomy and other interests at stake.<sup>129</sup> A doctor usually bases the capacity determination on the patient's ability to do the following: understand the situation, communicate a choice to the physician, appreciate the potential outcomes of an illness, reason or rationalize generally, and consider the pros and cons of treatment.<sup>130</sup>

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<sup>125</sup> See Schuck, *supra* note 118, at 919 (explaining the variety of situations in which informed consent to treatment is not required). Other examples of exceptions to informed consent include when disclosure would negatively impact a patient's well-being, when there are blatantly obvious risks, when a treatment is so basic that danger is considered "remote," and when it is reasonable for the doctor to be unaware of the risk. *Id.*

<sup>126</sup> PEGALIS, *supra* note 12, § 4:1. "Competency" is a legal term referring to the "mental ability to understand problems and make decisions." *Competency*, BLACK'S LAW DICTIONARY, *supra* note 10; see also Wolff, *supra* note 122, at 743 (describing the legal definition of competency). There are many different types of competency in the U.S. legal tradition; the focus of this Note is the competency of a patient to refuse treatment. See *supra* notes 122–125 and accompanying text; *infra* notes 126–130 (summarizing medical competency, at issue in this Note); see also Wolff, *supra* note 122, at 743 (explaining that there are many different types of competency and stating that each type has its own test). Finding an individual competent to stand trial, for example, requires a different legal test than a determination of whether an individual is competent to make independent medical decisions. *Id.* The presumption of competency to refuse treatment extends to patients with mental illness. *In re Qawi*, 81 P.3d 224, 233 (Cal. 2004). For patients with mental illness, the presumption rests on the premise that mental illness does not necessarily affect every aspect of the individual's brain. See *id.* Even with a mental illness, an individual may still have the capacity to understand treatments, illness, and health. *Id.* Thus, the court should also presume an individual with mental illness is competent, unless a judge finds that such individual cannot meet the legal requirements of competency. See *id.*

<sup>127</sup> Wolff, *supra* note 122, at 743–44. Importantly, the doctor's determination of capacity is different than the legal determination of competency. Jessica Wilen Berg et al., *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 RUTGERS L. REV. 345, 348–49 (1996). Typically, only a judge can find someone *legally* incompetent. *Id.* at 348. Doctors, in contrast, complete *medical* capacity determinations. *Id.* at 348–49. When a state legislature creates its competency standard, it weighs the severity of *medical* incapacity required for a finding of *legal* incompetence. *Id.* at 349.

<sup>128</sup> Wolff, *supra* note 122, at 744; see also Berg et al., *supra* note 127, at 348–49 (explaining the difference between a doctor's determination of medical capacity and a legal determination of competency).

<sup>129</sup> Wolff, *supra* note 122, at 744.

<sup>130</sup> See Joyeeta G. Dastidar & Andy Odden, *How Do I Determine if My Patient Has Decision-Making Capacity?*, THE HOSPITALIST (Aug. 2011), <https://www.the-hospitalist.org/hospitalist/article/124731/how-do-i-determine-if-my-patient-has-decision-making-capacity> [<https://perma.cc/QK88-KJFF>] (explaining considerations doctors must take into account when determining whether a patient has the capacity to make treatment decisions). Doctors may employ clinical tools to determine capaci-

When patients dispute a physician's determination of medical capacity, a judge must make a legal competency determination; there is, however, no general consensus among approaches to competency determinations.<sup>131</sup> If an individual is found incompetent, such individual will not be able to make treatment decisions directly.<sup>132</sup> After a judge finds a patient incompetent, a patient's representative, acting as a surrogate, will make decisions on behalf of the patient.<sup>133</sup> There are two standards of surrogate decision making.<sup>134</sup> The "best interests" standard aims to make decisions that promote the patient's best interests.<sup>135</sup> The "substituted judgment" standard, in contrast, requires the surrogate to stand in the shoes of the patient and make the choice the surrogate believes the patient would make if they were competent.<sup>136</sup>

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ty, such as the MacArthur Competence Assessment Tools for Treatment. *Id.* These tools allow doctors to assign scores for the capacity factors. *Id.* When a doctor determines that an individual is incompetent, the individual then lacks the ability to make autonomous decisions. SCHOPP, *supra* note 121, at 66. Arguably, certain mental illnesses may cause a patient to lack the ability to make rational, autonomous decisions due to the illness's impact upon the patient's thinking abilities. *Id.*

<sup>131</sup> Berg et al., *supra* note 127, at 348–49.

<sup>132</sup> See Kathleen Knepper, *The Importance of Establishing Competence in Cases Involving the Involuntary Administration of Psychotropic Medications*, 20 LAW & PSYCH. REV. 97, 104–05 (1996) (explaining the process following a patient's classification as incompetent).

<sup>133</sup> See *id.* (describing how an incompetent patient's treatment decisions are made).

<sup>134</sup> See *id.* (providing an overview of the two different standards used when a surrogate makes decisions for a patient).

<sup>135</sup> *Id.* at 105. When a court is faced with an adult who has never been competent or a case involving a child, it will usually apply the "best interests" standard of surrogate decision making. See *id.* Adults who have never had competency and children are similar. *Id.* Neither group has ever been competent under the law. *Id.* Therefore, surrogate decision making would be ineffective for these individuals because neither group has ever been in the position to describe what they would want while competent to choose. *Id.*

<sup>136</sup> *Id.* at 105–06. When a court considers the competency of an adult who is currently incompetent but, in the past, was competent, it typically applies the "substituted judgment" standard. *Id.* The "substituted judgment" standard is rooted in the English common law. Peter Skinner, *Tipping the Scales: How Guardianship of Brandon Has Upset Massachusetts' Balanced Substituted Judgment Doctrine*, 40 B.C. L. REV. 969, 970 (1999). At common law, there were two types of individuals with mental illnesses: the "lunatic" and the "idiot." *Id.* at 970–71. The "idiot" was never competent and had no ability to regain competency. *Id.* The "lunatic," however, was not born incompetent and could regain competency, which warranted different treatment under the law. *Id.* at 971. In England, the King controlled the "idiot's" property until that person's time of death, and could take any profits flowing from the property. *Id.* The King could not, by contrast, take the profits of the "lunatic's" land because that person could recover competency at any moment. *Id.* Thus, the "lunatic" is analogous to the formerly competent patient, which warrants the use of the "substituted judgment" standard. See *id.* The "substituted judgment" standard applies in this context because the individual has had the opportunity, while competent, to describe treatment preferences. Knepper, *supra* note 132, at 105. In these cases, the surrogate should be a person that is familiar with the patient and will effectuate the patient's judgment. *Id.* at 106.

There are at least four prominent legal competency theories, identified by experts and most competency statutes integrate one or more of these theories.<sup>137</sup> The following subsections will briefly address each of these theories in turn.<sup>138</sup>

### 1. The Patient Can Make a Choice

The first theory, the mere “ability to communicate a choice,” requires the least rigorous review of the patient’s capabilities.<sup>139</sup> Under this theory, when a patient can communicate a decision, the patient is deemed competent.<sup>140</sup> Even if a patient’s basis for the decision is thought to be untenable, a judge applying this standard must consider the patient competent because of the patient’s ability to make any choice at all.<sup>141</sup> Essentially, only patients in comas or vegetative states are deemed incompetent under this theory.<sup>142</sup> This theory of competency protects a patient’s autonomy more than any other standard.<sup>143</sup> Furthermore, it may also be considered the most dependable theory, subject to the least amount of interpretation.<sup>144</sup> All a trier of fact must consider is whether the individual communicated some choice.<sup>145</sup>

The ability to communicate a choice, however, has never in and of itself been sufficient to establish competency; courts and state legislatures have not

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<sup>137</sup> Berg et al., *supra* note 127, at 347 (explaining that competency standards across the United States vary significantly and there is a need for an “authoritative framework” for competency); Wolff, *supra* note 122, at 744–49 (describing five different doctrines of competency). Scholars have identified these four, over-arching theories in their extensive review of competency law. Berg et al., *supra* note 127, at 351. These experts conducted a review of legal competency statutes, and identified four clear components of statutes: (1) the patient can make a choice; (2) the patient can understand, but not appreciate, the information; (3) the patient can understand *and* appreciate the information; and (4) the patient understands, appreciates, and makes a rational decision. *Id.*; see also BRUCE J. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT 349 (1997) (describing the four common theories of competency and their origin). For example, the Idaho competency statute requires a court to find that an individual can “achieve a rudimentary understanding of the purpose, nature, and possible risks and benefits of a decision, after conscientious efforts at explanation” to be competent. IDAHO CODE § 66-402(9) (2020). In Alaska, however, a court must consider whether a person can make rational decisions about their treatment to be competent. ALASKA STAT. § 47.30.837(1) (2020). Both of these statutes incorporate some (or all) of the theories listed above. See *id.* (listing the requirements for competency in Alaska); IDAHO CODE § 66-402(9) (defining the competency standard in Idaho); see also Berg et al., *supra* note 127, at 351 (providing an overview of the different components of legal competency statutes).

<sup>138</sup> See *infra* notes 139–164 and accompanying text (describing the four theories of competency).

<sup>139</sup> See Berg et al., *supra* note 127, at 352 (explaining the “least stringent” approach to competency, the “[a]bility to [c]ommunicate a [c]hoice”).

<sup>140</sup> *Id.*

<sup>141</sup> *Id.* at 353.

<sup>142</sup> *Id.*

<sup>143</sup> *Id.* Scholars may consider this standard the “least paternalistic” because nothing more than a patient’s choice is required. Wolff, *supra* note 122, at 744–45. There is no room for interpretation. *Id.*

<sup>144</sup> Wolff, *supra* note 122, at 744–45.

<sup>145</sup> *Id.*

used the theory of choice alone to determine competency.<sup>146</sup> Instead, communication of a choice is typically one component of a competency theory that also encompasses other elements, such as the ability to understand the information presented.<sup>147</sup>

## 2. The Patient Can Understand—But Cannot Appreciate—the Information

A second theory—the one most often used in the United States—tests whether a patient can understand the information presented.<sup>148</sup> This is a slightly higher standard than the ability to communicate a choice.<sup>149</sup> In jurisdictions that use this theory, courts require an individual to “comprehend the concepts involved” but the patient need not fully appreciate the situation.<sup>150</sup> Thus, a patient would solely need to understand what a disease or symptom is, but not appreciate that the symptom or disease is applicable to the patient him or herself.<sup>151</sup>

For example, Idaho adopts the “understanding” theory of competency.<sup>152</sup> Idaho’s statute requires doctors to find patients incompetent if they have the “inability . . . to achieve a rudimentary understanding of the purpose, nature, and possible risks and benefits of a decision.”<sup>153</sup>

## 3. The Patient Can Understand *and* Appreciate the Information

A third theory, which tests the patient even more stringently than the two theories described above, requires the patient to both understand the information presented and understand that the information presented is applicable

<sup>146</sup> Berg et al., *supra* note 127, at 353.

<sup>147</sup> *Id.* For example, in 1986, in *In re O'Brien*, the Supreme Court of New York County, New York, considered a patient’s competency. See 517 N.Y.S.2d 346, 346 (Sup. Ct. 1986). A patient on life support was able to communicate by squeezing the hand of another person, and sometimes shaking his head yes or no. *Id.* at 347. Although the patient was able to answer some questions, the court determined that the seriousness of the patient’s refusal of life-saving treatment could not be decided on the basis of a nod. *Id.* at 348. The court did not want to rely on a gesture that could be mere annoyance to determine whether the patient was able to make a choice. *Id.* Thus, the court determined that the patient was incompetent to make decisions regarding the removal of life-saving treatment. *Id.*

<sup>148</sup> See Berg et al., *supra* note 127, at 353 (describing a theory that requires the patient to merely understand the information presented to be deemed competent).

<sup>149</sup> See *id.* (describing the second theory of competency tests). This theory, generally recognized by legal theorists, seems on par with the “pure understanding” view, which “deems a person competent if he can assimilate the information that the caregiver provides.” See Saks, *Competency to Refuse Treatment*, *supra* note 14, at 952. Like the “ability to understand,” the “pure understanding” view merely requires the patient to comprehend the information offered by the doctor but not necessarily accept it as true. See *id.*

<sup>150</sup> Berg et al., *supra* note 127, at 353–54.

<sup>151</sup> *Id.*

<sup>152</sup> IDAHO CODE § 66-402(9) (2020). The Idaho statute requires the patient to “achieve a rudimentary understanding of the purpose, nature, and possible risks and benefits of a decision, after conscientious efforts at explanation” to be competent. *Id.*

<sup>153</sup> *Id.*

to the patient.<sup>154</sup> If a jurisdiction uses this theory, the patient must understand the information and appreciate the fact that the information applies to the patient and may carry certain consequences for the patient.<sup>155</sup>

Statutes that require an individual to “understand and appreciate” may vary.<sup>156</sup> For example, in Alaska, the relevant statute explicitly requires patients to appreciate that they have an impairment to be deemed competent.<sup>157</sup> In contrast, in Tennessee, the statute merely requires that patients are “able to understand and appreciate the nature and consequences” of their treatment decisions.<sup>158</sup>

#### 4. The Patient Understands, Appreciates, and Makes a Rational Decision

Finally, some theories of competency require that a patient fulfills the requirements of the aforementioned third theory *and* makes a rational decision about treatment.<sup>159</sup> This approach examines whether the patient is capable of

<sup>154</sup> See Berg et al., *supra* note 127, at 355–57 (describing this view of competency). One prominent theorist refers to this as the “understanding and belief” theory of competency, which requires that the patient both comprehend the information offered by the provider and also believe that the information is true. See Saks, *Competency to Refuse Treatment*, *supra* note 14, at 955. In practice, when a jurisdiction uses the “understanding and belief” theory, it requires the patient’s beliefs about the doctor’s statements to be completely irrational for a finding of incompetence. See *id.* at 956. This Note will further explore the impact these different standards have upon people with schizophrenia, and more specifically, those with the symptom of anosognosia, in Part II. See *infra* notes 202–263 and accompanying text. In 1978, in *Lane v. Candura*, the Massachusetts Appeals Court granted a finding of competence when a woman refused to amputate her gangrened leg. See 376 N.E.2d 1232, 1233 (Mass. App. Ct. 1978). Although the court referred to her refusal as irrational, it determined that her acts were “not the uninformed decision of a person incapable of appreciating the nature and consequences of her act.” *Id.* at 1236. Thus, the patient could refuse amputation, even though her view of the situation was arguably irrational. *Id.*

<sup>155</sup> Berg et al., *supra* note 127, at 356–57. If a statute does not explicitly state “understand and appreciate” and solely requires the individual to “appreciate,” “understanding” is typically read into the statute. *Id.* at 355 n.29.

<sup>156</sup> Compare ALASKA STAT. § 47.30.837(1) (2020) (explicitly requiring the patient to appreciate that he or she has an impairment), with TENN. CODE ANN. § 32-11-103(1) (2020) (stating that a competent person is one who “is able to understand and appreciate the nature and consequences of a decision to accept or refuse treatment”).

<sup>157</sup> ALASKA STAT. § 47.30.837(1). The Alaska statute has an additional component that requires the patient to make rational decisions; for a robust discussion of the statute see *infra* notes 159–164 and accompanying text.

<sup>158</sup> TENN. CODE ANN. § 32-11-103(1); see also TEX. HEALTH & SAFETY CODE ANN. § 313.002(5) (West 2019) (requiring the patient to “understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to any proposed treatment decisions” to be competent).

<sup>159</sup> See Saks, *Competency to Refuse Treatment*, *supra* note 14, at 956–57 (describing the “full reasoning” approach to competency); see also Berg et al., *supra* note 127, at 357–58 (explaining the competency approach that requires patients to be able to “manipulate information rationally”). When a competency statute or standard includes this type of rationality requirement, the focus of the standard is upon the patient’s thought-process, not so much on the patient’s final decision about the treatment. Berg et al., *supra* note 127, at 357. When this type of test is at issue, “a patient who can understand,

logically making a decision about treatment by considering all of the information offered and weighing the pros and cons of the proposed treatment.<sup>160</sup> For example, in Alabama, individuals are considered incompetent when they become impaired “to the extent of lacking sufficient understanding or capacity to make or communicate responsible decisions.”<sup>161</sup> A court may struggle to apply this type of competency statute, as it requires the adjudicator to apply its own standards of what comprises a “rational” decision.<sup>162</sup>

Although competent patients with schizophrenia retain the right to refuse medication, they may still be subject to involuntary commitment.<sup>163</sup> The following Section explains the difference between the legal standard for incompetency and the legal standard for involuntary commitment, and also describes the treatment options currently available to patients with schizophrenia.<sup>164</sup>

#### *D. Treating Schizophrenia & Severe Mental Illness: Involuntary and Voluntary Methods*

From the 1940s to 1970s, when state facilities were the norm for treating people with mental illness, the only legal requirement for involuntary treatment, including involuntary antipsychotic medication or other invasive treatments, was a judicial review of a doctor’s determination that a patient had a mental illness and that the patient required treatment.<sup>165</sup> At that time, patients could be given antipsychotic medications involuntarily because the standard for involuntary treatment was identical to that for involuntary commitment.<sup>166</sup> This lenient standard led to the institutionalization of more than 500,000 people with mental illness by the mid-1950s.<sup>167</sup>

appreciate and communicate a decision may still be impaired because she is unable to process information logically.” *Id.*

<sup>160</sup> Berg et al., *supra* note 127, at 357–58.

<sup>161</sup> ALA. CODE § 26-2A-20(8) (2020); *see also* Berg et al., *supra* note 127, at 360 (referring to state statutes utilizing the rational decision-making standard). Alaska’s statute contains a rational decision-making element, which requires the patient to “assimilate relevant facts” and “participate in treatment decisions by means of a rational thought process.” ALASKA STAT. § 47.30.837(1).

<sup>162</sup> Berg et al., *supra* note 127, at 358 (explaining the rational decision-making approach to competency and briefly discussing how a judge should apply the standard).

<sup>163</sup> *See infra* notes 186–190 and accompanying text (describing the differences between the involuntary commitment standard and incompetency standard).

<sup>164</sup> *See infra* Part I.D.

<sup>165</sup> Richard C. Boldt, *Perspectives on Outpatient Commitment*, 49 NEW ENG. L. REV. 39, 42 (2014). At this time, there was a presumption that people with mental illness should be institutionalized, and this presumption was essentially impossible to rebut. *Id.* at 44.

<sup>166</sup> *See* Dennis E. Cichon, *The Right to “Just Say No”: A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 LA. L. REV. 283, 315 (1992) (explaining that historically individuals with mental illness in institutions were not subject to informed consent doctrine).

<sup>167</sup> Boldt, *supra* note 165, at 42.



There were two primary reasons courts at this time did not grant these patients the right to refuse medication once institutionalized.<sup>168</sup> First, some courts did not want to extend tort liability to doctors at institutions.<sup>169</sup> Second, there was a nearly universal belief that individuals in institutions were per se incompetent to make any decisions regarding treatment, including the administration of antipsychotic medications or other intrusive therapies.<sup>170</sup> For example, in 1976, in *Price v. Sheppard*, the Supreme Court of Minnesota considered whether an involuntarily institutionalized patient could receive electroshock therapy against his will.<sup>171</sup> The court determined that after the state met its burden for institutionalizing an individual, it had the right to make decisions about the person's

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<sup>168</sup> Cichon, *supra* note 166, at 315.

<sup>169</sup> *Id.*; see also *Rogers v. Okin*, 478 F. Supp. 1342, 1383 (D. Mass. 1979) (holding that tort liability does not apply to doctors treating patients with mental illness that have been involuntarily institutionalized), *aff'd in part and rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291 (1982) (holding that new Massachusetts laws required reconsideration of whether a patient, held involuntarily in a psychiatric institution, could refuse antipsychotic medication). In 1979, in *Rogers v. Okin*, the District Court for the District of Massachusetts held that individuals in institutions could not recover damages against doctors who treated them with antipsychotic medications against their will. *Id.* at 1383–84. The plaintiffs contended that the unwanted touching and restraining required to administer the treatment sufficiently met the elements of battery. *Id.* The court, however, decided that the intentional tort could not apply to the activities occurring within a state mental institution. *Id.* at 1384. The court determined that once patients are in an institution for treatment of a psychiatric disorder, they have consented to all touching or force that is “reasonably necessary” for their treatment. *Id.* Battery could not apply because it requires non-consensual touching. *Id.* The theory of consent to all “reasonably necessary” touching applies whether patients are in the institution voluntarily or involuntarily. *Id.* Rather than a theory of intentional tort, the court determined that malpractice would be more appropriate. *Id.* Thus, the plaintiffs would need to show that the defendant's conduct was not within the standards of reasonable medical practice in a psychiatric institution to succeed on their claims. *Id.*

<sup>170</sup> Cichon, *supra* note 166, at 315.

<sup>171</sup> See 239 N.W.2d 905, 911 (Minn. 1976) (holding that the administration of twenty electroshock treatments against the will of a patient held involuntarily at a state hospital did not violate the plaintiff's rights). Electroshock therapy, known today as electroconvulsive therapy, aims to alter an individual's brain chemistry and may lessen the symptoms of some mental illnesses. *Electroconvulsive Therapy (ECT)*, MAYO CLINIC, <https://www.mayoclinic.org/tests-procedures/electroconvulsive-therapy/about/pac-20393894> [<https://perma.cc/H972-SCX7>]. It can be used as a treatment for severe or treatment-resistant depression, mania, and some symptoms of schizophrenia and dementia. *Id.* Early electroconvulsive therapies were dangerous and the therapy was also used to “control difficult patients and to maintain order on wards,” rather than to help patients. Jonathan Sadowsky, *Electroconvulsive Therapy: A History of Controversy, but Also of Help*, SCI. AM. (Jan. 13, 2017), <https://www.scientificamerican.com/article/electroconvulsive-therapy-a-history-of-controversy-but-also-of-help/> [<https://perma.cc/F876-H9RM>]. Today, doctors administer anesthesia to avoid seizures and physical pain. *Id.*

treatment.<sup>172</sup> If the state found that a treatment was in the best interest of the patient, it could impose the treatment.<sup>173</sup>

In the 1960s, as the trend toward deinstitutionalization expanded, prominent legal decisions and journal publications exposed the atrocities occurring at institutions for people with mental illness, which led to a change in the standard for institutionalization.<sup>174</sup> The new involuntary commitment standard required a judicial determination, proven by the state with clear and convincing evidence, that an individual (1) had a mental illness and (2) was a danger to himself, herself, or others.<sup>175</sup> This new standard is often referred to as the “dangerousness standard.”<sup>176</sup> It reflected a general trend towards a presumption of competence

<sup>172</sup> See *Price*, 239 N.W.2d at 911. The court underscored that commitment requires a showing that the individual is mentally ill and thus cannot make decisions regarding treatment. See *id.* The court reasoned that if an individual is committed, such individual clearly cannot make *any* decision about treatment, including whether to take medication. See *id.*

<sup>173</sup> See *id.* (explaining that once a patient is held in a facility, the state can make virtually any decisions on the patient’s behalf).

<sup>174</sup> See *Boldt*, *supra* note 165, at 42–43 (explaining the change in the involuntary treatment standard).

<sup>175</sup> See *id.* at 43–45. Two important cases led the charge in revising the standard for involuntary commitment. *Id.* In 1972, in *Lessard v. Schmidt*, the District Court for the Eastern District of Wisconsin considered whether an involuntary commitment statute was constitutional. See 349 F. Supp. 1078, 1082 (E.D. Wis. 1972). The plaintiffs, a class of people on involuntary holds in Wisconsin, argued that the statute was unconstitutional because it did not require the state to show that “society has a compelling interest” in depriving them of their liberty. *Id.* at 1084. The court determined that involuntary commitment was warranted when “the proper burden of proof is satisfied and dangerousness is based upon a finding of a recent overt act, attempt or threat to do substantial harm to oneself or another.” *Id.* at 1093. The court drew a comparison between mental and physical illness, suggesting that people with physical ailments are “allowed the choice of whether to undergo hospitalization and treatment or not,” and determined that people with mental illness should also have the same opportunity for choice. *Id.* at 1094.

In 1979, in *Addington v. Texas*, the Supreme Court considered the appropriate standard of evidence for civil commitment. See 441 U.S. 418, 419–20 (1979); see also *Boldt*, *supra* note 165, at 43 (describing the landmark decisions leading to a change in the standard for involuntary civil commitment). In *Addington*, the Supreme Court determined that states have a “legitimate interest under [their] *parens patriae* powers in providing care to [their] citizens who are unable because of emotional disorders to care for themselves.” 441 U.S. at 426. The Court noted, however, that this interest is limited, and most states require a showing that the patient is a danger to self or others. *Id.* In addressing the standard of evidence required for civil commitment, the Court noted that a standard of beyond a reasonable doubt is untenable for determining psychiatric conditions. *Id.* at 430. Certainty is difficult to establish for psychiatric diagnoses because of the “subtleties and nuances” involved in diagnosing these diseases. *Id.* In addition, the Court found that the burden of a preponderance of the evidence failed the appropriate level of due process, and landed upon a standard of at least “clear and convincing” evidence. *Id.* at 432–33.

<sup>176</sup> SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 3, at 3. The “dangerousness standard” refers to the requirement that a patient must present as a danger to self or others to be subject to involuntary commitment. See *id.* at 4. The goal of commitment based on dangerousness is to protect the public, not necessarily the patient. See *id.* Instead of imposing the dangerousness standard, some states find that involuntary treatment may be warranted when an individual has a “grave disability” or is likely to endure “serious deterioration” as a result of a mental illness. *Id.* at 9–10. These statutes, however, may still include a dangerousness component. *Id.* at 9. An individual may

for all individuals to refuse or accept treatment.<sup>177</sup> The old standard—a mere showing of a need for treatment—was alleged to be too paternalistic.<sup>178</sup>

The new standard represented a shift in application of a state's *parens patriae* power.<sup>179</sup> *Parens patriae* refers to a state's power to intervene when individuals do not have the capacity to care for themselves.<sup>180</sup> The states saw these early standards, requiring a showing of a mere need for treatment, as part of the state's *parens patriae* power to help those with mental illness who otherwise may not have received aid.<sup>181</sup> The dangerousness standard, however, represented a shift in how states viewed people with mental illness.<sup>182</sup> Rather than

have a "grave disability" when such individual cannot obtain basic necessities, such as food, a place to live, water, and clothing. *See id.* There is some confusion regarding the state's ability to subject an individual to involuntary commitment without a showing of dangerousness. *See id.* at 10. In 1975, in *O'Connor v. Donaldson*, the Supreme Court considered the case of Kenneth Donaldson, a patient with mental illness who was held in a facility for nearly fifteen years. *See* 422 U.S. 563, 564–65 (1975). There was no evidence that Donaldson was a danger to himself or others, and the basis of his confinement at the hospital was "care, maintenance, and treatment" under a Florida commitment statute. *Id.* at 565–66. The Court did not explicitly state that dangerousness was required for civil commitment, but determined that a state "cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." *Id.* at 576. Earlier in the opinion, however, the Court indicated that dangerousness is required for civil commitment. *Id.* at 575 ("[T]here is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom."). Some argue that this statement from the Supreme Court indicates that dangerousness is required for civil commitment, however, the Court has not explicitly weighed in on the issue. *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 3, at 10–11 (suggesting that the Supreme Court's decision in *O'Connor* may not explicitly require dangerousness as an element of the involuntary commitment statute). Although these standards at first blush may seem more lenient than the dangerousness standard, they may require a showing that a person is likely to become dangerous, which is a high bar. *See id.* at 9–11 (describing the "grave disability" and "serious deterioration" standard requirements). In some states, a finding of incompetency may be a factor for commitment, however, incompetency alone is insufficient for involuntary treatment today. *Id.* at 12.

<sup>177</sup> *See* Boldt, *supra* note 165, at 42–43 (describing the new approach to competency).

<sup>178</sup> *See* Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CALIF. L. REV. 54, 54–55 (1982) (explaining how involuntary commitment is paternalistic). The prior involuntary commitment standard, a mere need for treatment, was often criticized for being too great an exercise of the state's police power and for failing to require a substantial state interest before imposing civil commitment upon individuals. *See id.* (describing the problematic nature of old involuntary commitment standards and the shift to the new involuntary commitment statutes).

<sup>179</sup> *See* Boldt, *supra* note 165, at 45 (describing a new application of a state's *parens patriae* power). *Parens patriae*, in the medical context, may be applicable "when people are so disabled that they do not recognize their own need for treatment or cannot provide their own basic needs" due to their illness. TORREY, *supra* note 44, at 162. "*Parens patriae*" refers to the state's role as the protector of those who do not have the ability to protect themselves. *Parens Patriae*, BLACK'S LAW DICTIONARY, *supra* note 10.

<sup>180</sup> *Parens Patriae*, *supra* note 179.

<sup>181</sup> *See* Boldt, *supra* note 165, at 45 (explaining a shift in the understanding of a state's involuntary commitment power from *parens patriae* to the police power to protect the public from dangerous individuals).

<sup>182</sup> *Id.*

seeing these individuals as having no autonomy and requiring the state's help, the new standard only allows the state to intervene when there is a strong competing interest, like safety, aligned with the state's police power.<sup>183</sup> Although the dangerousness standard better protects patient autonomy, critics allege the standard fails to focus on healing.<sup>184</sup> Instead, the standard considers whether patients are likely to cause injury to themselves or others, placing treatment of the disease as a secondary consideration.<sup>185</sup>

Today, meeting the requirements for involuntary commitment under the dangerousness standard does not necessarily mean a patient is incompetent to refuse treatment.<sup>186</sup> The criteria for commitment is different than the criteria for incompetency.<sup>187</sup> The dangerousness standard requires a showing that patients pose a harm to themselves or others.<sup>188</sup> A finding of incompetency, on the other hand, considers patients' abilities to understand the doctor's proposed treatment, among other requirements.<sup>189</sup> Thus, patients can be involuntarily committed based on dangerousness, but, if competent, may retain the right to refuse treatment.<sup>190</sup>

States have recently adopted new programs, referred to as "assisted outpatient treatment" or "involuntary outpatient treatment," that offer court-

<sup>183</sup> *Id.*

<sup>184</sup> Kontos et al., *supra* note 100, at 1255. Critics suggest that there is a discrepancy between the treatment of individuals with mental illness and those suffering from physical ailments. *Id.* When a patient has a physical illness, the primary concern is healing the disease and ensuring the patient receives the best possible treatment. *See id.* For mental illness, in contrast, the focus shifts from healing the individual to protecting others from danger. *Id.* In the case of mental illness, hospitalizations may "resemble protective custody more than they do clinical care." *Id.* In the case of "Mr. C," an example patient described in one article, the difference in treatment between mental illness and physical illness is particularly profound. *See id.* at 1254. Mr. C was a homeless man living with schizophrenia. *Id.* Mr. C was brought to the emergency room against his will because he had a severe infection in his leg. *Id.* He refused amputation. *Id.* The doctors determined that he lacked the capacity to refuse treatment, successfully obtained a medical guardianship, and moved forward with the amputation against his will. *Id.* After Mr. C recovered from surgery, he was taken to a psychiatric facility. *Id.* The goal of his psychiatric treatment was solely to help facilitate his *physical* recovery from surgery, not his *mental* recovery from schizophrenia. *Id.* at 1255. Although, in this case, Mr. C did eventually receive treatment for his schizophrenia, it was only due to his urgent physical condition that the state was willing to intervene. *Id.*

<sup>185</sup> *See id.* at 1255 (explaining that there are significant differences in the hospitalization of individuals for physical illness and for mental illness).

<sup>186</sup> *See* Cichon, *supra* note 166, at 348–49 (explaining the difference between a finding of incompetency and a finding of dangerousness that warrants commitment).

<sup>187</sup> *See id.* (clarifying that a patient may be committed but still competent to refuse aspects of the treatment).

<sup>188</sup> *See* Boldt, *supra* note 165, at 44–45 (describing the requirements for civil commitment).

<sup>189</sup> *See supra* notes 117–155 and accompanying text (explaining the different requirements for a finding of competency).

<sup>190</sup> *See* Cichon, *supra* note 166, at 349–50; *see also* Kontos et al., *supra* note 100, at 1255 (explaining that patients retain the ability to decline medication even when they are committed involuntarily).

mandated, involuntary treatment in the community, rather than in hospital-based facilities.<sup>191</sup> These programs apply to people with mental illness who meet specific statutory requirements, such as a history of hospitalizations or criminal activity.<sup>192</sup> For example, in 1999, New York passed a law, colloquially referred to as “Kendra’s Law,” which allows involuntary outpatient treatment.<sup>193</sup> The law applies to those who, as determined by a doctor, need supervision to thrive in the community, have previously failed to comply with treatments, will not accept voluntary treatment, and have acted violently or threatened violence within the previous four years.<sup>194</sup> Kendra’s Law is credited with reducing the arrests and violent acts of people with mental illness, lowering New York cost expenditures, lessening the volume of psychiatric hospitaliza-

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<sup>191</sup> *Features and News*, TREATMENT ADVOC. CTR., <https://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/3096-we-did-it-with-unanimous-support-hr-2646-passes-out-of-committee> [<https://perma.cc/7N24-2BDH>]. Assisted outpatient treatment may include several different elements. See *In re K.L.*, 806 N.E.2d 480, 482 (N.Y. 2004). For example, in 2004, in *In re K.L.*, the New York Court of Appeals described an assisted outpatient treatment order that required the patient to comply with case management, blood tests, therapy with psychiatrists, and medication. *Id.*

<sup>192</sup> *What Is AOT?*, TREATMENT ADVOC. CTR., <https://www.treatmentadvocacycenter.org/storage/documents/aot-one-pager.pdf> [<https://perma.cc/2ARS-VMJH>].

<sup>193</sup> See Michael L. Perlin, *Therapeutic Jurisprudence and Outpatient Commitment Law: Kendra’s Law and Case Study*, 9 PSYCHOL. PUB. POL’Y & L. 183, 194–95 (2003) (explaining Kendra’s Law); see also NY MENTAL HYG. LAW § 9.60 (Consol. 2020). Kendra’s Law focuses on care coordination through case management. NY MENTAL HYG. LAW § 9.60. The care mandated may include different services, such as: involuntary antipsychotic medication, tests to ensure the patient takes his or her medication, full-day or partial-day programs, therapy in individual or group settings, treatment for alcohol or substance abuse, drug or alcohol testing, mandated living arrangements, and more. See *id.* (describing the type of treatment that can be required under Kendra’s Law).

<sup>194</sup> Perlin, *supra* note 193, at 194–95. Additionally, the person must be at least eighteen and living with mental illness for Kendra’s Law to apply. *Id.* Obtaining assisted outpatient treatment for an individual under Kendra’s Law requires a petition by a person who cares for the individual, such as a parent, spouse, or treating physician. See *id.* at 195. Following the petition, a court will hold a hearing, during which a physician must testify to the fact that assisted outpatient treatment is the “least restrictive alternative available.” *Id.* If the court finds by clear and convincing evidence that the individual meets the requirements of the statute, the individual will be required to attend assisted outpatient treatment, which may include involuntary medication, for up to six months. *Id.* Kendra’s Law is named for Kendra Webdale, who died tragically at age 32 after being pushed into the path of a New York City subway train. Nicholas Tantillo, *The Story Behind Kendra’s Law*, WAMC NE. PUB. RADIO (May 21, 2017), <https://www.wamc.org/post/story-behind-kendra-s-law> [<https://perma.cc/WE8T-4KTA>]. The person who pushed Kendra, Andrew Goldstein, was a 29-year-old man, living in Queens with a history of serious mental illness. *Id.* Although Goldstein had been subjected to in-patient hospitalization for his illness, he had not been forced to stay for long. *Id.* Kendra’s death led the New York Attorney General’s Office to take account of its legislation on the topic of mental illness to determine if any “gaps” existed. *Id.* After reviewing the available information, the attorney general’s office landed upon assisted outpatient treatment, which led to the inception of Kendra’s Law. *Id.* Not all members of the New York Assembly supported the law, as some felt that the law “stigmatizes people with mental health problems.” *Id.* To compromise with these members, Kendra’s Law requires a vote to extend the law every five years. *Id.*

tion, cutting down rates of homelessness for people with mental illness, and decreasing incarceration rates of people with mental illness.<sup>195</sup>

In contrast to involuntary methods of treatment, when patients recognize their illness and accept treatment, they may voluntarily enter a facility of their choice, which may or may not include medication as part of the treatment plan.<sup>196</sup> Those who have experienced both voluntary and involuntary treatment emphasize the benefits of voluntary treatment.<sup>197</sup> It is heralded as the best option because patients are more likely to comply with treatment when they have accepted their illness and seek help from medical professionals.<sup>198</sup> Patients with anosognosia, however, may be unlikely to enter treatment voluntarily because of their inability to recognize their illness.<sup>199</sup> Not only does anosognosia potentially make it difficult for a patient to accept treatment, but it also can make a competency finding challenging.<sup>200</sup> This Note's next Part discusses three competing approaches to competency for patients with schizophrenia and anosognosia.<sup>201</sup>

## II. A MATTER OF OPINION: APPLYING COMPETENCY THEORIES TO INDIVIDUALS WITH SCHIZOPHRENIA & ANOSOGNOSIA

Legal scholars disagree about the competency of individuals with schizophrenia and symptoms of anosognosia.<sup>202</sup> Some would find patients incompe-

<sup>195</sup> *What Is AOT?*, *supra* note 192. According to the Treatment Advocacy Center, of people with mental illness, “77% fewer experienced psychiatric hospitalization, 74% fewer experienced homelessness, 83% fewer experienced arrest, [and] 87% fewer experienced incarceration.” *Id.*

<sup>196</sup> TORREY, *supra* note 44, at 162.

<sup>197</sup> *See, e.g.*, WANG, *supra* note 33, at 110. In her book of personal essays, Wang describes her experience living with schizophrenia, including her involuntary treatment at various hospitals. *Id.* Wang suggests that “there are inevitable parallels between involuntary hospitalization and incarceration.” *Id.* Although Wang acknowledges that involuntary commitment may sometimes be needed, personally “it has never felt useful to [her].” *Id.* at 108.

<sup>198</sup> *See* WINICK, *supra* note 137, at 328 (explaining that when patients choose to seek treatment, they may have a more successful treatment outcome). Individuals that choose to seek treatment may feel more personally committed to getting well, and may be more likely to show up for their scheduled treatments because they chose their path forward. *Id.* at 329–30.

<sup>199</sup> TORREY, *supra* note 44, at 162.

<sup>200</sup> *See infra* Part II (summarizing courts' disparate applications of competency tests to patients with anosognosia and the accompanying varied outcomes).

<sup>201</sup> *See infra* Part II.

<sup>202</sup> *Compare Saks, Revisiting the Role of Denial of Mental Illness in Capacity Determinations*, *supra* note 14, at 171 (explaining that denial of illness, without other symptoms or incorrect beliefs, is insufficient to warrant a finding of incompetency), *with* Epright, *supra* note 4, at 805 (explaining that when patients are unable to understand that they are sick, they cannot meet the requisite requirements for informed consent, rendering them incompetent). As one scholar noted, “competence, like beauty, lies very much in the eye of the beholder.” Judi Chamberlin, *The Right to Be Wrong*, in *CHOICE & RESPONSIBILITY: LEGAL AND ETHICAL DILEMMAS IN SERVICES FOR PERSONS WITH MENTAL DISABILITIES*, *supra* note 52, at 45, 49. It is important to remember that states may have different types of competency statutes that apply different theories of competency; due to the inconsistencies among statutes, it is not always possible to make direct comparisons. *Compare* IDAHO Code § 66-402(9) (2020) (stating that an individual must “achieve a rudimentary understanding of the purpose, nature,

tent if they exhibit signs of anosognosia.<sup>203</sup> Others would only find patients with anosognosia incompetent if they exhibit additional, obvious symptoms of the disease, like severe delusions or violence.<sup>204</sup> Similarly, courts applying state competency standards inconsistently weigh anosognosia in their decisions; some find that anosognosia warrants incompetency, while others do not.<sup>205</sup> This Part explains three competing theories of competency as applied to individuals with anosognosia, and describes the benefits of each application.<sup>206</sup> Section A describes the theory that anosognosia is insufficient for a finding of incompetency.<sup>207</sup> Section B outlines the idea that anosognosia, in concert with other symptoms, can be sufficient for a finding of incompetency.<sup>208</sup> Section C summarizes the theory that anosognosia renders a patient incompetent.<sup>209</sup>

### A. A Patient with Anosognosia Is Competent

In 1994, in *In re Virgil D.*, the Supreme Court of Wisconsin held that an individual with schizophrenia who was unable to recognize his illness was competent to refuse antipsychotic medication.<sup>210</sup> There, the competency statute required a patient to comprehend the benefits and risks of a treatment and treatment alternatives to be competent to refuse a treatment.<sup>211</sup> The Court of Appeals of Wisconsin had determined that the patient's inability to understand

and possible risks and benefits of a decision, after conscientious efforts at explanation" to be competent), with ALASKA STAT. § 47.30.837(1) (2020) (requiring that an individual can make rational decisions about treatment to be competent). This Part aims to demonstrate the different court applications of the standard when a patient has anosognosia and describe legal theorists' views of anosognosia's impact on competency. See *infra* notes 210–263 and accompanying text (analyzing three different approaches to competency as applied to individuals with schizophrenia and anosognosia).

<sup>203</sup> See Epright, *supra* note 4, at 805 (suggesting that when patients do not have insight into their condition, they do not have the ability to exercise a choice).

<sup>204</sup> See Saks, *Revisiting the Role of Denial of Mental Illness in Capacity Determinations*, *supra* note 14, at 168 (arguing that a patient's lack of insight or denial of illness is insufficient to warrant incompetency, unless there is evidence the lack of insight stems from a "patently false belief," such as believing the treating physician is a "malevolent devil").

<sup>205</sup> Compare *People v. D.A.*, No. B278615, 2017 LEXIS 5786, at \*1 (Cal. Ct. App. Aug. 23, 2017) (determining that an individual with anosognosia and schizophrenia lacked the competency to refuse treatment), with *In re Virgil D.*, 524 N.W.2d 894, 895 (Wis. 1994) (holding that a patient with anosognosia and schizophrenia maintained the competency to refuse treatment).

<sup>206</sup> See *infra* Part II.

<sup>207</sup> See *infra* Part II.A.

<sup>208</sup> See *infra* Part II.B.

<sup>209</sup> See *infra* Part II.C.

<sup>210</sup> 524 N.W.2d at 895. The Supreme Court of Wisconsin's 1994 decision *In re Virgil D.* does not specifically refer to the patient's denial as anosognosia; it only stated that he "did not recognize that he was mentally ill." See *id.* at 896. The court described the psychiatrist's description of the patient, however, which suggests that the individual's lack of insight was so pervasive as to equate to anosognosia. See *id.* at 899 n.8 (recounting the testimony of the individual's psychiatrist, which described the individual as "not hav[ing] an insight into the nature of his illness").

<sup>211</sup> *Id.* at 898; see also WIS. STAT. § 51.61(g)(4) (2020) (defining competency to refuse treatment in Wisconsin, the statute at issue in *In re Virgil D.*).

his illness warranted incompetency under this statute.<sup>212</sup> Rejecting the reasoning of the Court of Appeals and reversing its decision, the Supreme Court of Wisconsin found that the statute did not require individuals to understand that they were sick.<sup>213</sup> Instead, the plain statutory language required patients to understand the effects, benefits, and risks of a particular treatment.<sup>214</sup> Because the patient in *In re Virgil D.* was able to understand these elements, it did not matter that he could not understand his sickness, and the patient was thus competent to refuse treatment.<sup>215</sup>

There are considerable benefits to finding a patient with anosognosia competent.<sup>216</sup> First, a diagnosis of a psychiatric condition may not be certain, and a finding of schizophrenia could potentially be disproven.<sup>217</sup> A plethora of theories of mental illness exist, and two similarly educated psychiatrists may have different opinions of a patient's illness.<sup>218</sup> *Addington v. Texas*, a 1979 Supreme Court decision where the Court determined that the burden of proof beyond a reasonable doubt could not be used in civil commitment hearings, reflects the challenge of diagnosing patients with mental illnesses.<sup>219</sup> In its decision, the Court relied on the premise that psychiatry is imprecise, underscoring the fact that a psychiatric condition is difficult to demonstrate to a certainty.<sup>220</sup> Thus, hinging a compe-

<sup>212</sup> See *In re Virgil D.*, 524 N.W.2d at 895 (explaining the procedural history of the case); see also WIS. STAT. § 51.61(g)(4) (omitting any requirement that individuals understand that they are sick to be found competent).

<sup>213</sup> *In re Virgil D.*, 524 N.W.2d at 895.

<sup>214</sup> See *id.* (stating the statutory requirements in Wisconsin for a finding of incompetency); see also WIS. STAT. § 51.61(g)(4) (defining competency under Wisconsin law).

<sup>215</sup> See *In re Virgil D.*, 524 N.W.2d. at 900 (concluding that the patient was competent to refuse treatment because he was able to comprehend the “advantages and disadvantages of, and the alternatives to, accepting medication” even without understanding he had schizophrenia). The court emphasized the importance of patient autonomy in its decision. See *id.* Although the court may disagree with the decision a patient makes, the sole role of the court is to apply the prescribed statute. *Id.* The court emphasized that it is not its role to determine what is in the best interest of patients when they are determined to be competent to choose. See *id.*

<sup>216</sup> See *infra* notes 217–228 and accompanying text.

<sup>217</sup> Saks, *Competency to Refuse Treatment*, *supra* note 14, at 989.

<sup>218</sup> *Id.* For example, some psychiatrists believe that the cause of mental illness is solely environmental, although others believe that mental illness is caused by chemical imbalances in the brain. *Id.* Additionally, diagnosing mental illness largely relies on psychiatrists, not concrete tests. See Saks, *Revisiting the Role of Denial of Mental Illness in Capacity Determinations*, *supra* note 14, at 175. Unlike an x-ray, which would concretely show a broken bone, tests for mental illness rely on more subjective psychiatric evaluations. *Id.* It is easier for a patient to deny a finding of mental illness, on the basis of a doctor's opinion, than a finding of a broken bone, on the basis of a visible x-ray. *Id.*

<sup>219</sup> 441 U.S. 418, 430 (1979).

<sup>220</sup> See *id.* (explaining that certainty is difficult to establish for psychiatric conditions because of the “subtleties and nuances” of these diseases).



tency determination upon a symptom of a psychiatric condition may not be certain enough for some to justify incompetency.<sup>221</sup>

Second, the stigma of mental illness may lead patients to deny their condition.<sup>222</sup> The media still misunderstands mental illness, often portraying individuals with schizophrenia as violent.<sup>223</sup> Patients that repeatedly deny their illness may not be suffering from anosognosia, but instead avoiding the stigma of being diagnosed with mental illness.<sup>224</sup>

Third, finding patients incompetent any time they denied a supposed illness could have severe implications.<sup>225</sup> For example, it could become possible for governments or other actors to hold those with radical political opinions incompetent when accused of being mentally ill and in denial.<sup>226</sup>

Finally, patients' lack of insight may not rise to the level of anosognosia or be sufficiently pervasive to warrant a finding of incompetency.<sup>227</sup> Without a documented history of patients' behavior, it may be difficult to determine whether they are in denial or living with anosognosia.<sup>228</sup> Thus, finding patients with anosognosia competent may have significant benefits, as it may account for potential inconsistencies in diagnosis and protect those who may be in denial.<sup>229</sup>

### *B. A Patient Denying Obvious Symptoms or Holding Erroneous Beliefs Due to Anosognosia Is Incompetent*

When a patient's anosognosia is coupled with absurd beliefs or leads to denial of verifiable symptoms of schizophrenia, one prominent theorist suggests a finding of incompetency is warranted.<sup>230</sup> For example, when an individual denies an objectively apparent symptom such as insomnia, a finding of

<sup>221</sup> See *id.* (emphasizing that psychiatry is imprecise); see also Saks, *Revisiting the Role of Denial of Mental Illness in Capacity Determinations*, *supra* note 14, at 175 (suggesting that a finding of mental illness is less concrete than determining whether an individual has a physical ailment).

<sup>222</sup> See Saks, *Competency to Refuse Treatment*, *supra* note 14, at 990 (suggesting that some patients may deny their illness to avoid stigmatization by peers). One study suggests that a patient's feelings of embarrassment are a barrier to seeking treatment. CTRS. FOR DISEASE CONTROL & PREVENTION ET AL., ATTITUDES TOWARD MENTAL ILLNESS: RESULTS FROM THE BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM 1, 4 (2012), [https://www.cdc.gov/hrqol/Mental\\_Health\\_Reports/pdf/BRFSS\\_Full%20Report.pdf](https://www.cdc.gov/hrqol/Mental_Health_Reports/pdf/BRFSS_Full%20Report.pdf) [<https://perma.cc/MJL5-BLUA>].

<sup>223</sup> Owen, *supra* note 72, at 655.

<sup>224</sup> Saks, *Competency to Refuse Treatment*, *supra* note 14, at 990.

<sup>225</sup> *Id.* at 992.

<sup>226</sup> See *id.* (describing the concern that allowing any denial of mental illness as a finding of incompetency could lead to individuals being committed wrongfully for fringe ideas).

<sup>227</sup> See AMADOR, *supra* note 1, at 49 (providing a framework for determining whether a patient is denying his or her illness or suffering from anosognosia).

<sup>228</sup> See *id.* (describing the difference between denial and anosognosia).

<sup>229</sup> See *supra* notes 216–228 and accompanying text.

<sup>230</sup> See Saks, *Revisiting the Role of Denial of Mental Illness in Capacity Determinations*, *supra* note 14, at 181 (arguing that a court should only find individuals incompetent when they deny schizophrenia and its obvious, verifiable symptoms).

incompetency would be justified.<sup>231</sup> Denying a quantifiable symptom demonstrates that the individual's mental processing is so broken down that such individual is incompetent.<sup>232</sup> Applying the same logic, patients that deny their illness because they believe the symptoms arise as a result of an infestation of evil spirits should be found incompetent.<sup>233</sup> In these cases, a finding of incompetency is warranted because the patient's lack of insight into the condition significantly warps reality.<sup>234</sup> In both circumstances, there is clear evidence that the patient has delusions and symptoms of schizophrenia.<sup>235</sup> Coupled with lack of insight, this is cause for a finding of incompetency.<sup>236</sup>

When a patient's denial of illness is caused by delusions or the patient denies visible symptoms, there may be less cause for concern that a court is wrongfully taking away a patient's right to refuse treatment.<sup>237</sup> Requiring gross denial of symptoms or plainly false beliefs *and* denial of objectively apparent symptoms of the illness may help mitigate concerns that a patient is in denial or misdiagnosed with a psychiatric condition.<sup>238</sup> The requirement of a clear denial of symptoms or completely absurd belief may lend more certainty to a psychiatric diagnosis of schizophrenia and anosognosia.<sup>239</sup> For example, when a patient reports no difficulty sleeping but there is clear evidence of insomnia,

<sup>231</sup> Saks, *Competency to Refuse Treatment*, *supra* note 14, at 991. Elyn R. Saks, a prominent legal theorist who lives with schizophrenia, suggests that when a patient's denial of an illness is based on "patently false beliefs," a judge should find the patient incompetent. *See* Saks, *Revisiting the Role of Denial of Mental Illness in Capacity Determinations*, *supra* note 14, at 168 (describing the patently false belief theory). *See generally* SAKS, *supra* note 83 (describing Saks's personal journey with schizophrenia). A "patently false belief," difficult to define in the absolute, is a belief that significantly distorts reality. *See* Saks, *Revisiting the Role of Denial of Mental Illness in Capacity Determinations*, *supra* note 14, at 168 (explaining the definition of a patently false belief). Saks describes examples of what is *not* a "patently false belief" in her article: neither an individual's belief that the individual's doctor is not acting in the patient's best interests nor that an antipsychotic is going to harm the individual would be patently false beliefs. *Id.* These beliefs would not warrant incompetency. *Id.* In contrast, Saks suggests that a patient who believes the doctor is the devil or an evil being holds a patently false belief. *Id.* This belief distorts reality so significantly that it would warrant incompetency under Saks' framework. *Id.*

<sup>232</sup> *See* Saks, *Revisiting the Role of Denial of Mental Illness in Capacity Determinations*, *supra* note 14, at 181 (explaining that when patients deny observable symptoms they should be considered incompetent).

<sup>233</sup> *See id.* at 168 (describing beliefs that are patently false and warrant a finding of incompetency).

<sup>234</sup> *See id.* (explaining when beliefs are so false that they show an incompetency to make decisions about treatment).

<sup>235</sup> *See id.* at 182 (suggesting that incompetency must be demonstrated by concrete evidence).

<sup>236</sup> *See id.* (arguing that findings of incompetency require clear evidence that patients are unable to understand their situation).

<sup>237</sup> *See id.* (explaining the benefits of requiring that a patient have clear symptoms and denial for a finding of incompetency).

<sup>238</sup> *Id.*

<sup>239</sup> *See id.*

a doctor has direct evidence of a denial of a symptom.<sup>240</sup> Similarly, when a patient reports a belief that the doctor is an evil demon, the doctor has clear evidence that the patient is experiencing delusions.<sup>241</sup> Denial of an apparent symptom clearly demonstrates that a patient cannot understand a diagnosis or appreciate its impact, which are requirements of many informed consent statutes.<sup>242</sup> Additionally, this view may encourage patients and doctors to thoroughly explore the individual's reasoning.<sup>243</sup>

### *C. A Patient with Anosognosia Is Incompetent*

When a patient has severe anosognosia, a court may find the individual is incapable of giving informed consent and therefore is incompetent.<sup>244</sup> For example, in 2017, in *People v. D.A.*, a California appellate court held that an individual with schizophrenia and severe anosognosia was incompetent and could not give informed consent.<sup>245</sup> As a result, the court upheld the involuntary administration of antipsychotic medication.<sup>246</sup> The court emphasized the testimony of the patient's doctor, who stated that the patient did not understand he had schizophrenia and thus refused to take his medication.<sup>247</sup> The doctor testified that as a result of the lack of medication, the patient became paranoid, endured both visual and auditory hallucinations, had disordered thought-processes, and felt persecuted by those trying to treat him.<sup>248</sup> The court consid-

<sup>240</sup> See Saks, *Competency to Refuse Treatment*, *supra* note 14, at 991 (explaining that when a patient's beliefs "grossly distort reality," an incompetency finding is warranted).

<sup>241</sup> See *id.* (suggesting that absurd beliefs and denial of illness warrant incompetency).

<sup>242</sup> See *id.* (arguing that a patient's absurd beliefs, accompanied by denial of illness, can clearly demonstrate incompetency).

<sup>243</sup> See Elyn R. Saks, *Some Thoughts on Denial of Mental Illness*, 166 AM. J. PSYCHIATRY 972, 973 (2009) (explaining that using this standard to determine a patient's competency may encourage patients and doctors to explore the reasons a patient may deny illness).

<sup>244</sup> See *People v. D.A.*, No. B278615, 2017 LEXIS 5786, at \*1 (Cal. Ct. App. Aug. 23, 2017) (finding a patient with schizophrenia, severe anosognosia, and some history of violence incompetent to make decisions regarding his treatment).

<sup>245</sup> *Id.*

<sup>246</sup> *Id.* The appellant in the California Court of Appeal's 2017 case *People v. D.A.* was a prisoner released on parole. *Id.* Under California law, when a prisoner meets certain statutory criteria, the prisoner can be required to attend involuntary treatment as a condition of parole. See CAL. PENAL CODE § 2962 (West 2020). To meet the requirements of this statute, the prisoner's illness must be a cause or contributing factor for the crime the individual committed. *Id.* Regardless of the specific statute at issue, the court must still apply a competency test to determine whether a patient has a right to refuse the involuntary treatment. See *D.A.*, 2017 LEXIS 5786, at \*4 (applying a competency test to determine whether the individual is competent to refuse involuntary administration of antipsychotic medication).

<sup>247</sup> See *D.A.*, 2017 LEXIS 5786, at \*2–3 (explaining the testimony of appellant's doctor, who described anosognosia as analogous to "being color blind"). The appellant's doctor explained that anosognosia was the root cause of the appellant's refusal of medication. See *id.*

<sup>248</sup> *Id.* The appellant believed his symptoms were a result of stress, rather than schizophrenia. *Id.* The patient testified that he did not "have a problem" with the medication itself. *Id.* at \*3. Instead, he

ered the patient's ignorance of his symptoms and diagnosis, and found that he was unable to weigh the pros and cons of medication.<sup>249</sup> The patient could not rationally participate in his treatment decision because of his lack of insight.<sup>250</sup> Thus, the court determined he was incompetent and upheld the order allowing the doctor to administer antipsychotic medication involuntarily.<sup>251</sup>

A finding of incompetency on the basis of anosognosia may be warranted because there is evidence that the symptom interferes with patients' ability to make decisions about their treatment.<sup>252</sup> The doctrine of informed consent aims to protect patient autonomy.<sup>253</sup> Competency tests effectuate this goal by ensuring patients who are able to make their own decisions are granted this right.<sup>254</sup> Psychiatric conditions directly affect parts of the brain that allow individuals to think and make decisions rationally and understand the likelihood of events happening in the future.<sup>255</sup> Arguably, without proper insight into their conditions, individuals cannot be making a free choice.<sup>256</sup> Instead, the choice has been made by the disease because it has infiltrated their decision-making ca-

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disagreed with the underlying schizophrenia diagnosis that formed the basis of his prescription for antipsychotics. *Id.*

<sup>249</sup> *Id.* at \*4–6.

<sup>250</sup> *Id.* California considers three factors when determining whether a person in this situation is competent to refuse treatment. *Id.* at \*4. The Court must consider the following:

- (1) whether the patient is aware of his mental illness; (2) whether the patient understands the benefits and risks of treatment as well as the alternatives to treatment; and (3) whether the patient is able to understand and evaluate the information regarding informed consent and participate in the treatment decision by rational thought process.

*Id.*

<sup>251</sup> *Id.* at \*6.

<sup>252</sup> See Knepper, *supra* note 132, at 103 (suggesting that competency determinations should consider whether a patient makes a decision due to a medical condition, rather than free, autonomous thought); see also SCHOPP, *supra* note 121, at 66 (explaining that some psychiatric disorders “undermine the autonomous capacities required to meet the threshold” for competency). These concerns are especially great for patients with schizophrenia because of the lack of insight that frequently accompanies the disease. Knepper, *supra* note 132, at 103.

<sup>253</sup> WINICK, *supra* note 137, at 346.

<sup>254</sup> See *id.* at 348 (explaining that even when patients make seemingly ridiculous decisions, if they are competent, the decisions must be respected).

<sup>255</sup> See Epright, *supra* note 4, at 804 (describing the parts of the brain that psychiatric conditions implicate). Generally, scholars accept that psychotic diseases, like bipolar disorder and schizophrenia, affect the prefrontal cortex and dorsal lateral prefrontal cortex. *Id.* These two parts of the brain are responsible for an individual's ability to make rational choices with autonomy. *Id.* Brain scans show that individuals with schizophrenia have defects in these parts of the brain. *Id.* at 804. Although treatment outcomes may improve when patients choose their own treatments, it is unclear whether patients in the midst of psychosis can make the meaningful choice. WINICK, *supra* note 137, at 334–35.

<sup>256</sup> See Epright, *supra* note 4, at 805 (explaining that when individuals lack insight into their condition because a disease is blocking their ability to understand the situation, choices they make are not freely given).

capacity.<sup>257</sup> Allowing patients with poor insight to decline medication is not necessarily effectuating their free choice, which is the goal of informed consent, because the disease dictates the choice.<sup>258</sup> Therefore, a finding of incompetency on the basis of anosognosia may help doctors best determine and effectuate a patient's autonomous choice.<sup>259</sup>

Not only could finding patients incompetent on the basis of anosognosia help to effectuate their autonomous choice in the present, it also may help retain patients' ability to choose in the long-term.<sup>260</sup> Over a long period, leaving schizophrenia and anosognosia untreated can cause patients to completely lose insight.<sup>261</sup> When patients with anosognosia refuse treatment in the present, they may be making a decision *never* to treat because their lack of insight will likely

<sup>257</sup> See *id.* (arguing that when patients have no insight into their condition because the disease is affecting their brain, the disease itself is choosing to deny treatment, not the patients).

<sup>258</sup> See *id.* at 805 (suggesting that allowing a patient with anosognosia to deny treatment does not effectuate the patient's autonomous choice). In 1986, in *Colorado v. Connelly*, the Supreme Court addressed whether a confession made by an individual with schizophrenia must be suppressed because the illness interfered with his ability to make a voluntary confession using his own "free will." 479 U.S. 157, 159 (1986). The Court determined that the individual's illness did not render the confession inadmissible because it was still voluntary. See *id.* Justice William Brennan in dissent, however, critiqued the Court's logic. *Id.* at 174 (Brennan, J., dissenting). Justice Brennan emphasized that the state trial court determined the individual had not given his voluntary confession because "he exercised a choice . . . mandated by auditory hallucination, [that] had no basis in reality, and . . . [was] the product of psychotic break with reality" and a testifying doctor stated he was "unable 'to make free and rational choices' due to auditory hallucinations." *Id.* at 175. Because the confession came as a result of the individual's mental illness, Justice Brennan found that it could not be considered the result of the patient's free will or an autonomous decision-making process. See *id.* at 174–75 (explaining that the individual's confession was inadmissible because it was not the product of the his free will). The logic Justice Brennan uses in his dissent is similar to that of experts who would find a patient incompetent on the basis of anosognosia. Compare *id.* (arguing that a patient with mental illness is not acting voluntarily when such patient confesses to a crime because the illness affects the decision-making process), with Epright, *supra* note 4, at 805 (suggesting that a patient's refusal to accept medication is not the individual's volitional act but instead a manifestation of the patient's illness). In both instances, the patient is not acting with free will but instead is influenced by illness. *Connelly*, 479 U.S. at 174–75 (Brennan, J., dissenting); Epright, *supra* note 4, at 805.

<sup>259</sup> See Epright, *supra* note 4, at 804–05 (explaining that schizophrenia has an impact on parts of the brain responsible for free-thinking and choice, and that imposing treatment that helps patients gain insight may help these individuals best exercise choice); see also *Connelly*, 479 U.S. at 175 (Brennan, J., dissenting) (arguing that a patient with schizophrenia had not given a voluntary confession because it was the result of his mental illness).

<sup>260</sup> Epright, *supra* note 4, at 804–05. Arguably, informed consent is not meant to be forward-looking. See *id.* A finding of incompetency on the basis that patients may in the *future* lose all ability to have insight into their condition is not effectuating the patients' present desires, but instead considering their capacity in the future. See *id.* Thus, this broader approach to patient autonomy may not be persuasive to those that stringently apply informed consent laws or theories. See *id.* Some may be persuaded, however, by the possibility that patients' anosognosia could eventually cause them to become violent, which may place other people at risk. See *id.*

<sup>261</sup> See *id.* (suggesting that when a patient with anosognosia decides to refuse treatment in the present, it "is tantamount to selling one's self into slavery" because the decision will "likely result in an inability to make any and all future decisions").

worsen without treatment over time.<sup>262</sup> Some argue that if the goal of informed consent is to effectuate autonomy, ensuring patients' long-term autonomy is best done by finding patients with anosognosia incompetent in the present.<sup>263</sup>

Thus, there are three competing theories of competency as applied to patients with schizophrenia and anosognosia, leading to inconsistent outcomes for patients.<sup>264</sup> Part III will explain why a patient with documented anosognosia should be found incompetent, aligned with Section C of this Part, and propose a model statute that helps standardize the approach to competency for patients with this symptom.<sup>265</sup>

### III. A PATH FORWARD FOR COMPETENCY DETERMINATIONS: ENSURING DOCUMENTED ANOSOGNOSIA WARRANTS INCOMPETENCY

As discussed in Parts I and II, informed consent laws across the United States vary on the basis of judicial interpretation and statutory construction.<sup>266</sup> Not all statutory schemes require patients to appreciate their illness to be competent to refuse treatment, and even in those that do, the definition of "appreciate" may vary.<sup>267</sup> This Part argues that anosognosia should warrant a finding of incompetency, aligning with the theory described in Section C of Part II.<sup>268</sup> Additionally, this Part argues that specific statutory language, similar to that in Alaska's competency statute, is necessary to ensure the statute is inclusive of individuals with anosognosia.<sup>269</sup> Section A of this Part explains why statutory definitions of competency must include the element of "appreciation."<sup>270</sup> Finally, Section B proposes a model statutory definition for competency that properly accounts for patients' ability to appreciate their illness.<sup>271</sup>

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<sup>262</sup> *Id.*

<sup>263</sup> *See id.* at 805 (explaining that future autonomy is best protected by finding a patient with anosognosia incompetent in the present).

<sup>264</sup> *See supra* Part II.

<sup>265</sup> *See infra* Part III.

<sup>266</sup> Berg et al., *supra* note 127, at 347.

<sup>267</sup> Compare ALASKA STAT., § 47.30.837(d)(1) (2020) (requiring that patients appreciate that they have an impairment to be competent), with TENN. CODE ANN. § 32-11-103(1) (2020) (requiring that patients "appreciate the nature and consequences" of their treatment decisions to be competent).

<sup>268</sup> *See infra* notes 272–307 and accompanying text (proposing a novel statutory definition of competency that ensures a patient with anosognosia is found incompetent); *see supra* Part II.C. (describing the theory of competency that would find a patient with anosognosia incompetent).

<sup>269</sup> *See infra* notes 291–300 and accompanying text (explaining the benefits of explicit statutory language).

<sup>270</sup> *See infra* Part III.A.

<sup>271</sup> *See infra* Part III.B.

*A. Appreciation of Illness Is Fundamental to the Goals of Informed Consent and Necessary for a Finding of Competency*

Underlying informed consent doctrine is the goal of respecting a patient's autonomous choice.<sup>272</sup> Humans formulate choices in the brain.<sup>273</sup> If an illness directly affects the part of the brain that contributes to a person's ability to freely make choices, the illness or symptom must be considered in the competency determination.<sup>274</sup> When an illness impacts the part of the brain that bears upon rational thinking, it cannot be said that the patient is actually acting with autonomy.<sup>275</sup> The response is involuntary, the disease is thinking for the patient.<sup>276</sup>

Evidence indicates that schizophrenia directly impacts parts of the brain responsible for an individual's decision making.<sup>277</sup> Anosognosia impacts an individual's ability to think rationally, and directly affects the brain's ability to accurately process information.<sup>278</sup> Further, when a person with schizophrenia denies his or her illness and refuses treatment, it is likely that the patient's condition will deteriorate, rendering the individual even less likely to make autonomous choices in the future.<sup>279</sup> When the brain continues to deteriorate, insight may worsen, creating potential long-term repercussions for the patient's present refusal of medication.<sup>280</sup> Arguably, informed consent should focus solely on a patient's current state of mind.<sup>281</sup> But when a patient's decision in the pre-

<sup>272</sup> See *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972) (describing the goal of informed consent as the patient making his or her own decision about treatment).

<sup>273</sup> See Epright, *supra* note 4, at 804 (explaining the documented effect schizophrenia has on parts of the brain responsible for making choices).

<sup>274</sup> See *id.* at 804–05 (suggesting that anosognosia and schizophrenia implicate areas of the brain that help individuals formulate thoughts and make choices about their treatment, and arguing that, as a result of the disease's impact on these areas, patients may not be acting with autonomy); see also *Colorado v. Connelly*, 479 U.S. 157, 174–75 (1986) (Brennan, J., dissenting) (arguing that an individual's confession was involuntary and not the product of his free will because he confessed as a result of his schizophrenia symptoms).

<sup>275</sup> See Epright, *supra* note 4, at 804 (explaining how an illness can implicate parts of the brain that affect a patient's ability to make decisions).

<sup>276</sup> See *id.* (describing how a disease can infiltrate a patient's brain and affect the patient's decision-making capacity); see also *Connelly*, 479 U.S. at 174–75 (Brennan, J., dissenting) (suggesting that a confession is involuntary when it is the result of an individual's mental illness).

<sup>277</sup> See Epright, *supra* note 4, at 804 (explaining the documented effect schizophrenia has on parts of the brain responsible for the patient's decision-making process).

<sup>278</sup> See POWERS, *supra* note 1, at 27 (describing the direct effect anosognosia has on the brain).

<sup>279</sup> See Epright, *supra* note 4, at 804 (explaining that schizophrenia may be correlated with other psychiatric conditions, like dementia, that cause brain and insight impairment); see also Lehrer & Lorenz, *supra* note 99, at 15 (suggesting that medication that improves a patient's insight "could have a tremendous" effect upon an individual's success in treatment).

<sup>280</sup> See Epright, *supra* note 4, at 804 (explaining that a patient's refusal of treatment in the present may lead to disease progression and future increases in insight deficits). In fact, because the progressive lack of insight may become extreme, a patient's present refusal may actually act as a blanket refusal for the present and future. See *id.*

<sup>281</sup> See *infra* notes 202–263 and accompanying text (describing the factors considered in varying theories of competency determinations, which focus on the patient's present, not future, capabilities).

sent will effectively serve as the only meaningful opportunity to decide, considering future implications of the decision is warranted.<sup>282</sup>

Thus, if the goal of informed consent is to effectuate a patient choice, informed consent must determine whether a patient can appreciate the illness.<sup>283</sup> Illnesses of the brain have the potential to obfuscate a patient's actual decision making.<sup>284</sup> To fully determine whether a choice is autonomous, it is necessary to determine whether patients are able to appreciate that they *have* an illness.<sup>285</sup> Section B will offer model statutory language that ensures patients' ability to understand their illness is encompassed in the definition of competency.<sup>286</sup>

### *B. A Path Forward: Balancing Patient Autonomy and Modern Understandings of Mental Illness*

Currently, some jurisdictions already require patients to "appreciate" their illness to be competent to refuse treatment.<sup>287</sup> Although the goal of including "appreciate" in a competency statute is to ensure the patient understands that the doctor's treatment suggestions apply to the patient, exact statutory language varies.<sup>288</sup> For example, in Alaska, the statutory definition of competency explicitly requires patients to appreciate that they have an impairment, among

<sup>282</sup> See Epright, *supra* note 4, at 800. Considering a patient's future capacity also reflects the fact that the harm schizophrenia causes to a patient may be categorized as "slow harm." Kontos et al., *supra* note 100, at 1255. "Slow harms," like becoming homeless, are not the focus of medical competency determinations. See *id.* Medical determinations of competency typically focus on the patient's immediate capacities and the "fast harms," like suicide, that the patient may currently present with. See *id.*

<sup>283</sup> See Epright, *supra* note 4, at 804 (explaining that anosognosia, which causes patients to lack awareness of their illness, impacts parts of the brain that control decision-making abilities). Using only the "understanding" theory of competency is insufficient to ensure that patients are aware that they are sick. See *supra* notes 148–153 and accompanying text (explaining the application of the "understanding" theory of competency).

<sup>284</sup> See TORREY, *supra* note 18, at 141 (suggesting that patients with anosognosia are not making decisions freely because positive symptoms, such as hallucinations or delusions, control their decision-making processes).

<sup>285</sup> See Epright, *supra* note 4, at 804 (arguing that consent cannot be considered informed for patients with anosognosia if they are not receiving treatment because the disease has affected the ability of the patients to make decisions).

<sup>286</sup> See *infra* Part III.B.

<sup>287</sup> See *Lane v. Candura*, 376 N.E.2d 1232, 1233 (Mass. App. Ct. 1978) (holding that a woman with gangrene was competent to refuse treatment because she appreciated the implications of her refusal); see also Berg et al., *supra* note 127, at 382 (explaining that many jurisdictions have adopted the appreciation standard). Adoption of the appreciation standard may ensure that those who lack the insight to understand that they are ill are considered incompetent. Berg et al., *supra* note 127, at 382. The "appreciation" standard requires that patients understand what the doctor is saying to them, and apply what the doctor is saying to themselves. See *id.* at 355 (explaining the appreciation standard of competency).

<sup>288</sup> Compare ALASKA STAT. § 47.30.837(d)(1) (2020) (using specific language and requirements in the competency definition), with TENN. CODE ANN. § 32-11-103(1) (2020) (using less specific language in the definition of competency).



other requirements.<sup>289</sup> Tennessee's statute, however, is less specific and requires that patients be able "to understand and appreciate the nature and consequences" of their treatment decision.<sup>290</sup>

Alaska's statutory language provides the clarity necessary to ensure that anosognosia is considered in a judge's competency determination, and should act as a starting point for model statutory language.<sup>291</sup> The statute explicitly states that patients who deny their condition in the face of significant evidence that the disease exists cannot be competent.<sup>292</sup> Even Alaska's statute, however, could be more clear.<sup>293</sup> Additional clarity would serve two important purposes.<sup>294</sup> First, concrete statutory language would protect patients who have insight into their condition but, for their own reasons, do not want to undergo treatment.<sup>295</sup> Unlike vague "appreciate" standards, such as Tennessee's statute that requires patients to "appreciate the nature and consequences" of their treatment decisions, specific language would ensure that only those who have medically documented anosognosia and not mere denial are found incompetent.<sup>296</sup> Protecting patient autonomy is essential to the doctrine of informed consent, and clear statutory language would help to serve this purpose.<sup>297</sup> Sec-

<sup>289</sup> ALASKA STAT. § 47.30.837(d)(1).

<sup>290</sup> TENN. CODE ANN. § 32-11-103(1). Texas's statute provides a definition for incapacity, which can be used to extrapolate a definition for competency, and includes language that is similar to the Tennessee statute. *See* TEX. HEALTH & SAFETY CODE ANN. § 313.002(5) (West 2019) (finding individuals incapacitated when they are "lacking the ability . . . to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to any proposed treatment decisions"); *see also* TENN. CODE ANN. § 32-11-103(1) (stating that a "competent person" is one "who is able to understand and appreciate the nature and consequences of a decision to accept or refuse treatment").

<sup>291</sup> *See* ALASKA STAT. § 47.30.837(d)(1) (requiring that patients acknowledge their illness when there is "substantial evidence of its existence" to be competent).

<sup>292</sup> *Id.*

<sup>293</sup> *See infra* notes 303–307 (proposing additional language to ensure that the statute is specific enough to protect patient autonomy).

<sup>294</sup> *See infra* notes 295–299 and accompanying text (explaining how the proposed statutory language will improve the state of competency determinations in the United States).

<sup>295</sup> *See* Natanson v. Kline, 350 P.2d 1093, 1104 (Kan. 1960) (explaining that even when a doctor may disagree with a competent patient's choice about treatment, the doctor cannot "substitute his own judgement for that of the patient").

<sup>296</sup> *See* TENN. CODE ANN. § 32-11-103(1) (2020) (omitting any requirement that individuals be aware that they have an illness to be competent, and including statutory language that patients "appreciate the nature and consequences" of their treatment decision-making); AMADOR, *supra* note 1, at 49 (describing the elements of a test to determine whether a patient has anosognosia).

<sup>297</sup> *See supra* notes 121–124 and accompanying text (describing the fundamental premise of informed consent as patient autonomy). In addition, clear statutory language ensures that doctors and judges will not be able to revert competency decisions to the state of institutionalization. *See supra* notes 165–173 and accompanying text (describing the lenient standard for involuntary commitment from the 1940s to 1970s, which resulted in mass institutionalization of people with mental illness). At that time, patients were found to be per se incompetent if they had a mental illness. *See supra* notes 165–173 and accompanying text (summarizing the standard for involuntary commitment during the 1940s to 1970s). Statutory safeguards ensure that individuals will only be found incompetent if they

ond, explicit language ensures that judges cannot impose their own beliefs about denial into their statutory interpretation.<sup>298</sup> Finally, specific language ensures that the statute reflects the best science available to test for anosognosia.<sup>299</sup>

The proposed model statute would incorporate Alaska’s existing language and include additional requirements to safeguard individual’s rights to choose treatment.<sup>300</sup>

“Competent” means that the patient:

- (A) Has the ability to assimilate relevant facts and to appreciate and understand the patient’s situation with regard to those facts, and;<sup>301</sup>
- (B) Appreciates that the patient has a mental illness or impairment, if the evidence so indicates;<sup>302</sup>
  - a. Patients’ denial of his or her mental illness is evidence that the patient lacks the capability to make treatment decisions when the patient’s denial constitutes anosognosia, a significant deficit in insight.<sup>303</sup> Denial is evidence of anosognosia when it has lasted over a period of at least six months, the denial does not change even if the individual is presented with evidence, and the individual offers other absurd explanations to persuade others that he or she does not have an illness.<sup>304</sup>
    - i. The lack of insight must be documented during a period of at least six months, and a doctor must be willing

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meet specific criteria, and remain free to make their own decisions if they do not meet one of the statutory requirements, protecting the patient and the goals of the informed consent doctrine. *See supra* notes 121–124 and accompanying text (explaining that the doctrine of informed consent aims to protect the personal beliefs and virtues of individuals and safeguard patients from rogue decisions of doctors).

<sup>298</sup> *See supra* notes 131–136 and accompanying text (indicating that some informed consent statutes may allow judges to impose their own beliefs upon patients).

<sup>299</sup> *See supra* notes 131–136 and accompanying text (explaining that there are a variety of competency statutes and no clear consensus among approaches, suggesting a need for consistency among statutory approaches to reflect new scientific discoveries).

<sup>300</sup> ALASKA STAT. § 47.30.837(d)(1) (2020); *see* AMADOR, *supra* note 1, at 49 (explaining that doctors should test whether a patient has anosognosia or denial as an assessment of the individual’s schizophrenia).

<sup>301</sup> ALASKA STAT. § 47.30.837(d)(1). This language is taken directly from the Alaska statute. *Id.*

<sup>302</sup> *Id.* This language is taken directly from the Alaska statute. *Id.*

<sup>303</sup> AMADOR, *supra* note 1, at 49. Section B(a) begins the proposed addition to the statute.

<sup>304</sup> *See id.* (explaining that doctors should test whether a patient has anosognosia or denial as an assessment of the individual’s schizophrenia). Xavier Amador, an expert on serious mental illness and the author of *I Am Not Sick I Don’t Need Help! How to Help Someone with Mental Illness Accept Treatment*, argues that anosognosia is present in the circumstances outlined in the proposed model statute. *Id.*

to testify to the patient's lack of insight as a symptom of his or her disease, not mere denial.<sup>305</sup>

- b. If a patient is found incompetent under Section B, he or she may be administered antipsychotic medication involuntarily, if appropriate.<sup>306</sup> When and if the patient obtains insight into his or her medical condition, the patient's capacity must be reassessed by a medical professional and the patient's competency must be reassessed by a judge.<sup>307</sup>

Ultimately, a revised and specific competency statute would benefit patients.<sup>308</sup> Specific statutory language ensures that only patients suffering from anosognosia, as opposed to denial, are captured by the statute, and also reflects the goals of informed consent.<sup>309</sup> In addition, the proposed statute aims to protect the patient's autonomous choice by requiring a reconsideration of the patient's competency after a course of medication; this reflects the premise that antipsychotic medication can help patients gain insight into their condition.<sup>310</sup> Thus, the proposed statute would help to ensure the patient's autonomous choice is honored at all stages of treatment.<sup>311</sup>

## CONCLUSION

Getting treatment for schizophrenia or other serious mental illness is a difficult, multi-faceted process in the United States. Even after patients agree to treatment or is involuntary committed, they may maintain the right to refuse medication, arguably the most effective method of treating schizophrenia. Although patients should have the right to refuse treatment when they are truly competent to decide, new science demonstrates that brain disorders directly

<sup>305</sup> See AMADOR, *supra* note 1, at 49.

<sup>306</sup> See *People v. D.A.*, No. B278615, 2017 LEXIS 5786, at \*1 (Cal. Ct. App. Aug. 23, 2017) (finding that an individual with severe anosognosia was incompetent, and ordering the involuntary administration of antipsychotic medication).

<sup>307</sup> See *supra* notes 126–136 and accompanying text (describing the relationship between a medical professional's capacity determination and a judge's legal competency determination). Requiring a reassessment of competency following the patient's forced medication ensures that patient autonomy will be respected, which is the goal of informed consent. See *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972) (explaining that the doctrine of informed consent aims to ensure the patient's decision-making is reflected in treatment). If a person gains insight into a condition and subsequently wishes to refuse further treatment, the doctor should respect the individual's wishes, even if considered absurd or counter-intuitive to treating the patient. WINICK, *supra* note 137, at 348.

<sup>308</sup> See *supra* notes 295–297 and accompanying text (describing the benefits of specific statutory language).

<sup>309</sup> See *supra* notes 295–297 and accompanying text (suggesting that specific language protects patients from wrongfully being found incompetent).

<sup>310</sup> See Epright, *supra* note 4, at 803 (stating that medication may help to improve a patient's insight).

<sup>311</sup> See *supra* notes 301–307 and accompanying text (explaining the proposed statute).

affect decision-making abilities. When a condition affects these parts of the brain or blocks patients' awareness of their condition, there must be a better answer.

Competency statutes must reflect modern science. Ensuring that judges consider documented anosognosia in the competency determination helps effectuate the best science available. Including statutory safeguards, such as documentation and doctor testimony, protects individuals who are in denial or have other reasons to refuse treatment. Adoption of this model competency statute would ensure patient autonomy is balanced against modern science, and help patients who lack insight into their condition get treatment.

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