

*SYMPOSIUM:
GENDER, HEALTH AND THE CONSTITUTION*

**THE MISALIGNMENT OF MEDICAL CAPACITY AND
LEGAL COMPETENCE FOR PERINATAL PEOPLE WITH
SERIOUS MENTAL ILLNESS**

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INTRODUCTION

Consider a hypothetical scenario involving Jane, a 35-year-old perinatal woman with serious mental illness (SMI). Jane, who has a history of bipolar disorder, experiences a severe manic episode, resulting in her inpatient hospitalization. During this crisis, it was discovered that Jane was three months pregnant, and because her decision-making ability was substantially impaired, the court appointed a legal guardian to manage her affairs. Over time, Jane responds positively to treatment, and her psychiatrist concludes that she has regained the capacity to make medical decisions; however, despite this clinical assessment, the legal system continues to designate her as legally incompetent, effectively stripping her of the freedom to make her own healthcare choices.

This situation becomes particularly poignant when considering Jane's preferences for her childbirth plan. Jane expresses a desire for a

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home birth, assisted by a midwife. Her choices would be honored in a setting that genuinely respects medical autonomy, assuming she understood all relevant information and the associated risks. Nonetheless, due to her legal status, her wishes are likely to be doubted or overruled, ignoring her regained decision-making capacity in place of a more conservative, medically controlled birthing environment deemed safer by her guardians and the courts.

This dissonance between Jane's resolved medical condition and her persistent legal status underscores a failure to reconcile the dynamic nature of mental health with the static legal mechanisms of competency determination, whereby the legal system's inability to recognize her improved condition prolongs undue paternalism, infringing on her autonomy. This divergence, far from being merely conceptual, has profound implications for the rights of perinatal persons with SMI diagnoses (*i.e.*, schizophrenia and related psychotic disorders, bipolar disorder, and affective psychoses). Moreover, this approach not only denies the person's independence but also perpetuates stigma and the harmful narrative that those with SMI must depend on others to make decisions, invalidating their desires and wishes.

In this Article, we evaluate the misalignment of medical capacity and legal competence for perinatal people with SMI, an issue that has had limited discourse in legal academia. In Part I, we delineate the contours of these concepts, dissecting their theoretical underpinnings and practical applications. While medical capacity is often considered an iterative, context-specific determination, legal competence is typically treated as a rigid, binary legal categorization. In Part II, we scrutinize their discordance, illustrating how their disparate scope and aims lead to a precarious misalignment for people with fluctuating mental states, particularly perinatal people with SMI. In Part III, we propose solutions to harmonize the medical and legal paradigms. These solutions will address normative considerations and practical policy changes, aiming to protect the rights and well-being of individuals while ensuring that determinations are fair, accurate, and reflective of an individual's true abilities. We advocate for a paradigm shift away from the legal system's inflexible, protectionist approach towards a more nuanced, adaptable capacity assessment model that responds to the variable nature of living with mental illness.

I. DEFINING MEDICAL CAPACITY AND LEGAL COMPETENCE

A. *Medical Capacity*

Medical capacity¹ refers to the “functional determination of whether an individual patient has the ability to adequately make a specific decision . . . or perform a specific task.”² It is based on the patient’s baseline abilities, relates solely to the current situation, and weighs the potential severity of possible consequences.³ Crucially, it is both context and decision-specific. A patient can still make certain decisions even if they lack the capacity for other types of decision-making,⁴ and patients are presumed to be able to make medical decisions unless established otherwise.⁵

Research has primarily focused on the capacity for informed consent.⁶ The criteria for informed consent to medical care differ across states but are rooted in common law and have three main elements.⁷ Firstly, the patient must be given adequate information regarding the nature and purpose of proposed treatments, as well as the risks, benefits, and alternatives to the proposed therapy, including no treatment; secondly, their decision must be free from coercion; and lastly, they must have medical decision-making capacity.⁸ The standards for whether a patient meets this last element also differ across states but are generally based on evaluating four capabilities:⁹ comprehending the information presented, appreciating how the information relates to their

1. In clinical settings, the terms “capacity” and “competency” are often used interchangeably, causing confusion as the terms, which, although related, represent distinct concepts. Historically, “capacity” was utilized to denote a clinical assessment of decision-making abilities, while “competency” referred to a legal determination of an individual’s status. Yet, this distinction has become less relevant since the term “capacity” is more commonly used in legal contexts as well. See Jennifer Moye Daniel C. Marson & Barry Edelstein, *Assessment of Capacity in an Aging Society*, 68 AM. PSYCH. 158 (2013).

2. R. Ryan Darby & Bradford C. Dickerson, *Dementia, Decision Making, and Capacity*, 25 HARV. REV. PSYCHIATRY 270, 272 (2017). Capacity can pertain to choices, like financial matters or specific activities, such as driving.

3. Christopher Libby et al., *Competency and Capacity*, STATPEARLS (2023), <http://www.ncbi.nlm.nih.gov/books/NBK532862/> (last visited Sep 12, 2023).

4. See Darby & Dickerson, *supra* note 2, at 272.

5. Laura L. Sessums, Hanna Zembruska & Jeffrey L. Jackson, *Does This Patient Have Medical Decision-Making Capacity?* 306 JAMA 420, 420 (2011).

6. Paul S. Appelbaum & Thomas Grisso, *Assessing Patients’ Capacities to Consent to Treatment*, 319 NEW ENG. J. MED. 1635 (1988).

7. Paul S. Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study I: Mental Illness and Competence to Treatment*, 19 L. HUM. & BEHAV. 105, 105-06 (1995).

8. See *id.*

9. Sessums, *supra* note 5, at 421.

circumstances, rationally using the information to make decisions, and communicating choices.¹⁰

Issues of capacity often emerge when people make decisions that jeopardize their health, assets, property, or self and either lack insight or refuse help.¹¹ In such cases, healthcare professionals or relatives might question the individual's capacity and may seek authority for surrogate decision-making on the person's behalf.¹² One common solution is the use of a healthcare proxy, a dedicated medical document that appoints someone else to make healthcare decisions; however, when broader decisions involving legal or financial matters are at stake, a durable power of attorney becomes necessary, as it grants the designated person the authority to act more comprehensively.¹³ If an individual is deemed incapable of selecting or completing either a healthcare proxy or a durable power of attorney, it then often necessitates a more involved legal process, leading potentially to the appointment of a guardian or conservator to protect their interests.¹⁴ In other scenarios, the patient's immediate family acts as the surrogate decision-maker, given their understanding of the patient's wishes, supported by the common-law tradition of designating family members in such roles.¹⁵

Medical providers play a critical role in determining capacity. Any licensed physician, psychologist, physician assistant, or nurse practitioner can assess medical capacity, not just psychiatrists or providers with additional training and specialization in mental health.¹⁶ Still, the gold standard for capacity determination is a clinic evaluation by a provider trained to do the examination who has performed an extensive number of capacity evaluations; however, most clinicians fail to meet this standard.¹⁷ Furthermore, capacity decisions are usually made within clinical settings without formal adjudication, and even when cases advance to legal evaluations of competency, clinical input is typically crucial.¹⁸ A patient determined by a clinician to lack the capacity to make reasoned medical decisions is understood as *de facto incompetent*—incompetent, in fact, but

10. See Appelbaum & Grisso, *supra* note 6, at 1635-36.

11. Moye et al., *supra* note 1, at 159.

12. *See id.*

13. See Darby & Dickerson, *supra* note 2, at 273.

14. *See id.*

15. *See id.*

16. Libby et. al, *supra* note 3.

17. Sessums et al., *supra* note 5, at 421.

18. Jennifer Moye & Aanand D. Naik, *Preserving Rights for Individuals Facing Guardianship*, 305 JAMA 936 (2011).

not determined so by legal procedures.¹⁹ Thus, a clinical determination of incapacity doesn't change a person's legal status;²⁰ however, a legal finding of incompetency does.

B. Legal Competence

The simple definition of competency is the “ability of an individual to participate in legal proceedings.”²¹ As such, competence is a legal construct²² assessing whether an individual can make a legally relevant decision or action. Declaring someone incompetent is ultimately a judicial determination made by the court, and when an individual is adjudicated, they are referred to as *de jure incompetent*.²³ Moreover, competency spans several areas of decision-making, so courts make determinations in a task-specific manner to ensure that individuals retain as much autonomy as possible, although some statutes allow for general incompetency determinations that do not ensure this degree of autonomy.²⁴ For instance, while someone may be determined to be incompetent to make treatment decisions, they may be determined to be competent to make financial decisions.²⁵

In the medical context, a patient is considered legally competent until a court declares otherwise,²⁶ and disproving an individual's competence requires a hearing and presentation of evidence.²⁷ Here, a judge may solicit input from a patient's medical provider²⁸ and consider medical

19. Raphael J. Leo, *Competency and the Capacity to Make Treatment Decisions: A Primer for Primary Care Physicians*, 1 PRIMARY CARE COMPANION J. CLINICAL PSYCHIATRY 131, 132 (1999).

20. Daniel C. Marson, Katina Hebert & Andrea C. Solomon, *Assessing Civil Competencies in Older Adults with Dementia: Consent Capacity, Financial Capacity and Testamentary Capacity*, in 15 FORENSIC NEUROPSYCHOLOGY: A SCI. APPROACH 401, 403 (G.J. Larabee ed. 2005).

21. Libby et al., *supra* note 3; see also Jason Karlawish, *Assessment of Decision-Making Capacity in Adults*, UPTODATE (last visited Sept. 13, 2023), <https://www.uptodate.com/contents/assessment-of-decision-making-capacity-in-adults#H2075084397>.

22. Jessica Wilen Berg, Paul S. Appelbaum & Thomas Grisso, *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 RUTGERS L. REV. 345, 348 (1995).

23. Leo, *supra* note 19, at 131.

24. *Id.*

25. *Id.*

26. Arthur R. Derse, *Law and Ethics in Emergency Medicine*, 17 EMERGENCY MED. CLINICS OF N. AM. 307, 316 (1999).

27. See Libby et al., *supra* note 3.

28. Amy Tao & Jeffrey S. Janofsky, *Capacity, Competency, and Guardianship*, in JOHNS HOPKINS PSYCHIATRY GUIDE (2017) (available at www.hopkinsguides.com/hopkins/view/Johns_Hopkins_Psychiatry_Guide/787159/all/Capacity__Competency__and_Guardianship); Darby & Dickerson, *supra* note 2, at 4.

capacity findings as part of their competency decision-making process but will also weigh other sources of authority, such as statutes, case law precedent, and principles of equity and justice.²⁹ Although the legal standards used to assess competency to make medical decisions vary across jurisdictions, a balancing test generally requires evaluating the ability to: (1) communicate a choice by making known wishes regarding treatment;³⁰ (2) understand the relevant information by demonstrating the ability to comprehend the concepts involved;³¹ (3) appreciating the medical consequences of the situation by applying the information in a context-neutral sense to the particular situation;³² and (4) reasoning about treatment choices by employing a logical thought process to compare the risk and benefits of treatment options.³³

Additionally, with an estimated 60,000 to 94,000 individuals undergoing competency evaluations annually,³⁴ deciding whether someone is legally competent to stand trial (CST) occupies a significant position within the American legal system. About 20% of defendants in the U.S. evaluated for trial competency are deemed incompetent, with most diagnosed with a serious mental illness such as a psychotic illness.³⁵

The benchmark for evaluating trial competency in the United States was defined in *Dusky v. United States*.³⁶ In creating a constitutional standard in criminal cases,³⁷ the *Dusky* Court established two prongs for evaluation: (1) the sufficient present ability to assist counsel with a reasonable degree of rational understanding and (2) the ability to understand the proceedings rationally and factually.³⁸ Given the ambiguity of this standard, courts, and legislatures give mental health professionals a high degree of deference: absent state-specific guidance,

29. Marson et al., *supra* note 20, at 403.

30. See Wilen-Berg et al., *supra* note 22, at 352.

31. *Id.* at 352-54.

32. *Id.* at 355.

33. *Id.* at 357; see also Paul S. Appelbaum, *Assessment of Patients' Competence to Consent to Treatment*, 357 NEW ENG. J. MED. 1834, 1835-36 (2007).

34. Melanie A. Schneider, *Competency Restoration Across the United States* 42 (Dec. 23, 2021) (Ph.D. dissertation, Fairleigh Dickenson University) (ProQuest).

35. Robert E. Cochrane et al., *Guidelines for Determining Restorability of Competency to Stand Trial and Recommendations for Involuntary Treatment*, 66 J. FORENSIC SCIENCES 1201, 1202 (2021).

36. 362 U.S. 402 (1960).

37. Graham S. Danzer et al., *Competency Restoration for Adult Defendants in Different Treatment Environments*, 47 J. AM. ACAD. PSYCHIATRY L. 68, 69 (2019).

38. *Dusky v. United States*, 362 U.S. 402, 403 (1960) (“[T]he ‘test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him.’”).

mental health professionals are primarily responsible for defining and assessing competency.³⁹

If a *bona fide* doubt exists as to a defendant's competency, courts must consider it formally to avoid due process risks.⁴⁰ As such, courts may evaluate competency at any stage during legal proceedings. To do so, courts can order an evaluation from a psychologist or psychiatrist—and, in some states, social workers—who can contribute to the legal process by providing a written report to the court. Hearings are available but are not necessary if both parties agree with the findings and recommendations outlined by the evaluator's reports. In the event of a hearing, while evaluators might be asked to testify, courts will generally rely only on the written report. Even so, courts are designated as the final determiner of competency and are not obligated to follow the recommendations of an evaluator.⁴¹ Upon a declaration of incompetency, defendants are limited in their rights, including refusing treatment.

Unlike medical capacity, which functions as a continuous quality that may be present to a greater or lesser extent, legal competence is binary.⁴² Under the law, as such, a person is either entitled or not entitled to have their wishes respected regarding treatment.⁴³ Given this dualistic quality, following *Dusky*, concerns regarding whether incompetent defendants would be at heightened risk of being hospitalized for extended periods while being evaluated for competency—rather than going through a criminal proceeding—grew. The Court in *Jackson v. Indiana*⁴⁴ addressed this issue by holding that hospitalization related to competency must have a likelihood of restoration in the foreseeable future.⁴⁵ However, by failing to define “foreseeable future,” subsequent state interpretations have varied from shortening commitments and placing incompetent defendants in less restrictive settings, to limiting the maximum time an individual may be committed for restoration and requiring termination of proceedings when competence cannot be restored.⁴⁶

39. Amanda Beltrani & Patricia A. Zapf, *Competence to Stand Trial and Criminalization: An Overview of the Research*, 25 CNS SPECTRUMS 161, 162 (2020).

40. See *Drope v. Missouri*, 420 U.S. 162, 171-75 (1975); *Pate v. Robinson*, 383 U.S. 375, 377-78 (1966).

41. *State v. Heger*, 326 N.W.2d 855, 857 (N.D. 1982).

42. Alec Buchanan, *Mental Capacity, Legal Competence and Consent to Treatment*, 97 J. ROYAL SOC. OF MED. 415, 415 (2004).

43. *Id.*

44. *Jackson v. Indiana*, 406 U.S. 715, 738 (1972).

45. *Id.*

46. See Danzer et al., *supra* note 37, at 69.

Despite the flexibility in terminology and overlap in meaning,⁴⁷ legal competence remains a legal status that cannot be determined by healthcare practitioners.⁴⁸ As Melanie Mitchell—a direct care nurse—notes, although “[decision-making capacity] and competence are frequently used synonymously . . . [they] represent entirely different judgments about a patient’s ability to live and make choices.”⁴⁹ While a competency evaluation operates via legal proceedings, capacity is “determined through an exploration of the patient’s thought process through dialogue with the patient.”⁵⁰

II. MISALIGNMENT BETWEEN MEDICAL CAPACITY AND LEGAL COMPETENCE

A. *Who, When, and How*

As scholars have noted, medical capacity and legal competence are distinct yet intertwined concepts that are often conflated.⁵¹ Although both medical and legal capacity are concerned with determining an individual’s decision-making ability, they do so differently due to, in part, the scope and goals of each: while legal competence centers on an individual’s general right to exercise legal rights and bear responsibilities—in which medical capacity is typically only one component of the determination—medical capacity is solely focused on determining an individual’s capabilities to make medical decisions in a particular clinical situation. In some cases, these differing aims may require the determination of both medical capacity and legal competence for someone to be afforded medical decision-making authority; in this sense, “medical capacity is not the sole determinant of what will happen when a patient chooses a course of treatment that doctors consider against the patient’s best interests.”⁵²

Despite acknowledging that even if medical and legal capacity are conflated, they are nevertheless distinct, little scholarship has discussed the implications of the conflation—and less scholarship exists that exposes the risks resulting from the misalignment between the two

47. Karlawish, *supra* note 21.

48. *Id.*

49. Melanie A. Mitchell, *Assessing Patient Decision-Making Capacity: It’s About the Thought Process*, 41 J. EMERGENCY NURSING 307, 308 (2015).

50. *Id.*

51. See Appelbaum, *supra* note 33, at 1834 (“The terms ‘competence’ and ‘capacity’ are used interchangeably in this article, since the oft-cited distinctions between them—competence is said to refer to legal judgments, and capacity to clinical ones—are not consistently reflected in either legal or medical usage.”).

52. See Buchanan, *supra* note 42, at 418.

concepts. Maintaining the distinction is critical because, as Paul Appelbaum notes, “resorting to judicial review in every case of suspected impairment of capacity would probably bring both the medical and legal systems to a halt.”⁵³

Here, the misalignment derives from differences in who makes the determination, when it occurs, and the frequency in which it is evaluated. As previously discussed, while a judge determines legal competence, medical capacity is decided by a clinician. Although clinicians can contribute medical evidence towards a determination of legal competence, the determination ultimately rests on the court.⁵⁴ Second, while legal competence is determined through a legal proceeding, medical capacity is determined through a clinical process, typically a patient interview. Third, while legal competence can be evaluated only sparingly, medical capacity can be assessed more frequently.

Limitations to the frequency of legal competence determinations are partly due to barriers formed by the legal procedural process. This includes financial barriers, as a patient must have sufficient financial resources for representation. It is estimated that competency evaluations cost \$300 million annually in the U.S., costing approximately \$5,000 per defendant.⁵⁵ Despite the financial burden of such evaluations needed to restore competency, they often do not ensure long-term improved outcomes for affected populations. Other barriers are temporal because legal proceedings are often lengthy due to briefing and hearing requirements and emotional, as patients must present evidence and testimony to convey their decision-making ability. These barriers are further exacerbated as some states do not have statutory timelines for the competency process, including when an evaluation occurs, when the written report is created, when the hearing occurs, and when court-sanctioned treatment begins.⁵⁶

These differences result in a paradigm in which medical capacity can be continuously assessed, accounting for the natural fluctuations in mental health, but legal competence functions as a binary categorization in which an individual is entitled or not entitled to decision-making ability. In this sense, while an individual’s medical capacity may change daily, legal

53. See Appelbaum, *supra* note 33, at 1834.

54. See Libby et al., *supra* note 3.

55. Nathaniel P. Morris, Dale E. McNiel & Renée L. Binder, *Estimating Annual Numbers of Competency to Stand Trial Evaluations across the United States*, 49 J. AM. ACAD. PSYCHIATRY & L. 530 (2021).

56. COMM. ON REVISION OF THE PENAL CODE, *Staff Memorandum 2022-04, Competency to Stand Trial and Related Matters* at 14 (May 22, 2022), <http://www.clrc.ca.gov/CRPC/Pub/Memos/CRPC22-04.pdf> (“Competency to Stand Trial Memorandum”).

competence remains fixed until they present it again in court. Given the incongruence between medical capacity and legal competence, particularly procedurally and temporally, circumstances may occur where an individual with medical capacity may not be entitled to make medical decisions because they lack legal competence. Because of the risks of delaying decision-making authority due to the administrative burdens of competency determinations—courts are viewed as the “forum of last resort” in medical decision-making.⁵⁷

Few states have addressed the strains that the legal competency process imposes—and any acknowledgment focuses on strains primarily in the criminal context. For example, in California, mental health facilities have one year to restore a misdemeanor defendant to competence to stand trial or determine the defendant to be non-restorable.⁵⁸ However, the California hospital system has failed to keep up with the demand for competency restoration programs, resulting from an increase in the number of people deemed incompetent.⁵⁹ Imposing statutory timeframes at every step of the competency process is among the areas for further exploration proposed by the Committee on Revision of the Penal Code to address the lack of statutory timelines for evaluations, placement decisions, and starting restoration treatment.⁶⁰

Even if more states adopt a similar one-year statutory requirement for competency reevaluations and subsequently broaden it beyond the criminal context, as California demonstrates, state judicial systems may be unable to support this requirement. Furthermore, these twelve-month timeframe reforms still fail to address the needs of perinatal people with SMI who may remain without legal competency and decision-making capacity for the entire duration of pregnancy and some part of postpartum before a reevaluation is required.

B. Exposing the Stakes for Perinatal People with SMI

Pregnancy and postpartum are vulnerable periods for developing SMI or worsening pre-existing manifestations.⁶¹ SMI can manifest as either a progression of ongoing conditions or as a new emergence,

57. Leo, *supra* note 19, at 138.

58. Artha Gillis et al., *Characteristics of Misdemeanants Treated for Competency Restoration*, 44 J. AM. ACAD. PSYCHIATRY & L. 442, 443 (2016).

59. See Competency to Stand Trial Memorandum, *supra* note 56.

60. *Id.* at 14.

61. Sachin Nagendrappa et al., *Perinatal Mental Health Care for Women With Severe Mental Illness During the COVID-19 Pandemic in India—Challenges and Potential Solutions Based on Two Case Reports*, 2 FRONT GLOB. WOMEN'S HEALTH 648429 (2021).

commonly shortly after giving birth (*i.e.*, postpartum psychosis) and can cause significant distress, which may have lasting impacts on the woman's health, family, and the broader community.⁶² Childbirth is a powerful trigger of psychiatric episodes, which can cause substantial morbidity and mortality, with suicide a leading cause of maternal death.⁶³ Further, many women choose to stop their psychiatric medications during pregnancy, a decision that frequently exacerbates their mental health conditions.⁶⁴ Similarly, many healthcare professionals, due to misconceptions about the risks of medications during pregnancy, recommend their patients either reduce or cease these treatments altogether.⁶⁵

As such, perinatal people with SMI diagnoses are a vulnerable population, and SMI diagnoses are associated with adverse clinical outcomes in pregnancy and the postpartum period for both mother and child.⁶⁶ They are more likely to face challenges with contraceptive adherence, engage in unsafe sexual practices, experience unplanned and unwanted pregnancies, and be subjected to violence during pregnancy than their counterparts without such conditions.⁶⁷ Moreover, they have a heightened risk of substance abuse, medical comorbidities, and complications during pregnancy.⁶⁸ Nevertheless, research suggests a substantial portion of the link between SMI and negative health outcomes can be attributed to potentially modifiable conditions, and addressing risk factors throughout pregnancy and childbirth, coupled with enhancing the understanding of maternal SMI, plays a crucial role in diminishing the elevated risk.⁶⁹

In addition to medical risks associated with SMI diagnoses during the perinatal period, the stakes are equally as serious from a legal perspective. Perinatal people with SMI may find themselves at the crossroads between medical realities and legal standards, with evaluators failing to fully account for psychiatric symptoms' transient and

62. Ian Jones et al., *Bipolar Disorder, Affective Psychosis, and Schizophrenia in Pregnancy and the Post-Partum Period*, 384 *THE LANCET* 1789, 1789 (2014).

63. *Id.* at 1796.

64. Nina E. Ross et al., *Reproductive Decision-Making Capacity in Women With Psychiatric Illness: A Systematic Review*, 63 *J. ACAD. CONSULTATION-LIAISON PSYCHIATRY* 61, 62 (2022).

65. *Id.*

66. Clare L. Taylor et al., *The Characteristics and Health Needs of Pregnant Women with Schizophrenia Compared with Bipolar Disorder and Affective Psychoses*, 15 *BMC PSYCHIATRY* 88, 88 (2015).

67. Ross et al., *supra* note 64.

68. *Id.*

69. H. Heun-Johnson et al., *Association Between Maternal Serious Mental Illness and Adverse Birth Outcomes*, 39 *J. PERINATOLOGY* 737, 744 (2019).

circumstantial nature, jeopardizing their autonomy. More broadly, history and contemporary practices are replete with examples of our legal systems' transgressions of this ethical principle.⁷⁰

The 1927 Supreme Court ruling in *Buck v. Bell* stands out as a particularly horrid judgment.⁷¹ Chief Justice Oliver Wendell Holmes endorsed the involuntary sterilization of a woman considered "feeble-minded,"⁷² rationalizing it with the callous justification that "[t]hree generations of imbeciles are enough."⁷³ The Court rejected Carrie Bell's arguments that this practice violated the Eighth and Fourteenth Amendments to the U.S. Constitution, protecting U.S. citizens from "cruel and unusual punishment" and prohibiting a state from denying "any person within its jurisdiction the equal protection of the law," respectively. Consequently, as many as 70,000 Americans were forcibly sterilized during the 20th century, including people like Buck, who had been labeled "mentally deficient," as well as those who were deaf, blind, and diseased.⁷⁴

While involuntary sterilization is no longer as rampant, the presumption that certain populations cannot make informed decisions about their health remains prevalent. The presence of psychiatric illness does not automatically lead to a *de facto* finding that a patient lacks the capacity to make decisions concerning their health care. On the contrary, most patients with psychiatric illness retain decision-making capacity.⁷⁵ Additionally, most women with SMI diagnoses have children⁷⁶ despite consistent research demonstrating lower fertility rates than women in the general population.⁷⁷

70. See *Tennessee v. Lane*, 541 U.S. 509, 524 (2004) (chronicling extensive violations of the fundamental rights of individuals with disabilities, including numerous specific restrictions imposed on bodily autonomy). In a reproductive context, some disabled activists have construed the recent decision in *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022), as "an attack on bodily autonomy—particularly on women, disabled people, people of color, the LGBTQIA+ community, and other marginalized communities." Marissa Ditkowsky, *Disabled People Face Renewed Threats to Autonomy After Dobbs Decision*, NAT'L P'SHIP FOR WOMEN & FAMS. (2023), <https://nationalpartnership.org/disabled-people-face-renewed-threats-to-autonomy-after-dobbs-decision/> (last visited Jan 31, 2024).

71. *Buck v. Bell*, 274 U.S. 200 (1927).

72. *Id.* at 205.

73. *Id.* at 207.

74. *The Supreme Court Ruling That Led To 70,000 Forced Sterilizations*, NPR, Mar. 7, 2016, <https://www.npr.org/sections/health-shots/2016/03/07/469478098/the-supreme-court-ruling-that-led-to-70-000-forced-sterilizations> (last visited Oct. 3, 2023).

75. David Okai et al., *Mental Capacity in Psychiatric Patients: Systematic Review*, 191 BRIT. J. PSYCHIATRY 291, 286 (2007).

76. Taylor et al., *supra* note 66.

77. Jones et al., *supra* note 62.

Nevertheless, the legal system continues to sometimes intervene in involuntary, deeply intrusive, and trauma-inducing ways. A perinatal person with an SMI diagnosis might face involuntary commitment, medication, or medical procedures for their welfare or that of the fetus or newborn, underscoring the profound lack of agency many face due to the presumption of incompetence based on their mental health diagnoses. Additionally, the legal risks don't end with childbirth: Parents may encounter child custody challenges or confront interventions by child protective services based on presumptions about their capacity to care for their child.

III. CHALLENGING THE INCOMPATIBILITY

Challenging the incompatibility between medical capacity and legal competence requires a reconceptualization of competency that better aligns with medical capacity. Central to medical capacity is its fluidity, which can account for the even daily variation in an individual's ability to appreciate and make medical decisions. Legal competency, as discussed earlier, is rigid in comparison. This is due, in part, to the construction of competency: while medical capacity evolved from the demands of medicine and informed consent, legal competency as it relates to decision-making autonomy was conceived alongside the broader construction of competency to participate in legal proceedings.

The centrality of determining the ability to participate in legal proceedings in developing legal competency contributes to its misalignment with medical capacity because legal competency is a "broad concept encompassing many legally recognized activities" that addresses many aspects of decision-making. In this sense, legal competency is intentionally defined broadly to ensure its applicability to the diversity of legally recognized activities it aims to determine. Because of this broadness, legal competency fails to account for the particularized needs of medical capacity.

Aligning medical capacity and legal competence requires several interventions. The first is normative: legal systems must redefine legal competency to better mirror medical capacity's flexibility. The second is pragmatic: the procedure for evaluating and restoring competence must be amended to address the burdens of restoration and better respond to the variability of mental states. Reforming the procedural mechanisms of restoring competency, however, can address only the *loss* of autonomy. Thus, the third intervention is preventative: offering procedures for individuals with SMI to indicate their medical preferences before losing

capacity. We recommend psychiatric advance directives (PADs)—and, specifically, reproductive psychiatric advance directives—as a means through which individuals with SMI can retain their decision-making autonomy.

A. Addressing the Procedural Burdens

The current process used to determine legal competency for medical decision-making presents several limitations in meeting the needs of individuals with SMI. These limitations are derived due to, in part: (1) the overwhelming absence of statutory requirements for competency restoration in civil competency assessment; (2) the privileging of judicial opinion over medical testimony; and (3) the complexity of the restoration process—importantly, who can trigger civil competency restoration. Here, we offer pragmatic solutions aimed at mitigating these limitations. Indeed, our critiques of the process used to evaluate and restore legal competency are echoed within the scholarship that evaluates legal competency in criminal court.⁷⁸ We agree with the limitations presented by this scholarship and aim to add to the growing body of critical literature advocating for all individuals who lose competency—be it in a civil or criminal context.

First, the current process of determining legal competency does not establish standards for evaluations of competency and restoration in civil court. Of the states that outline a restoration timeline, they do so only in criminal court proceedings. Otherwise, some states have no provisions that outline requirements, while others have initiated task forces to address this absence.⁷⁹ For example, the Minnesota Community Task Force 2021 Report (“Minnesota Report”) recognized that the only source governing competency restoration—Rule 20.01—neither requires individuals to undergo competency restoration or participate in community restoration programs nor requires that restoration services be provided to individuals.⁸⁰ In reporting the standards of thirty states, the

78. Halloe Fader-Towe & Ethan Kelly., *Just and Well: Rethinking How States Approach Competency to Stand Trial*, CSG JUST. CTR (Oct. 2020), <https://csgjusticecenter.org/wp-content/uploads/2020/10/Just-and-Well27OCT2020.pdf>.

79. VERMONT DEP’T OF MENTAL HEALTH, *Prosecutorial Notification and Competency Restoration, Statutory Suggestions from a Victim’s Perspective* (Oct. 26, 2022), https://mentalhealth.vermont.gov/sites/mentalhealth/files/doc_library/Prosecutorial_Notification_Competency_Restoration_Statutory_Suggestions_Victim%27s_Perspective.pdf.

80. MINNESOTA DEP’T OF HUM. SERVS., *Legislative Report: Community Competency Restoration Task Force* (Feb. 2020), https://mn.gov/dhs/assets/crtf-interim-legislative-report_tcm1053-420861.pdf. As of present, this task force has not issued a report since 2021; the last recorded meeting was in 2020. See MINNESOTA DEP’T OF HEALTH & HUM. SERVS., *Community*

Minnesota Report states that re-evaluation—required by law or statute by 97% of respondent states—occurs typically between three to six months.⁸¹

In Virginia, for instance, individuals found to be incompetent to stand trial in criminal court are ordered to receive treatment to restore their trial competence.⁸² Although restoration can occur in both outpatient or inpatient settings, restoration is more commonly facilitated within the community or in jail and not in a hospital.⁸³ Generally, restoration evaluations are facilitated within six months of the initial determination of incompetency.⁸⁴ Despite such standards, CSG Justice Center reports that at least a dozen states are involved in litigation, alleging that they have failed to meet the constitutional standard of conducting the competency to stand trial evaluation within a “reasonable period of time.”⁸⁵

As such, absent the criminal context, there is no legal safeguard through which individuals deemed incompetent are guaranteed a timeframe to be re-evaluated and potentially restored. Without such guarantees, individuals without legal competency may not have their decision-making autonomy restored for extended periods. Under this apparatus, circumstances may arise whereby an individual seeks treatment with restored medical capacity yet cannot rely on a specified timeline for potential restoration of legal competency. Without the certainty of re-evaluation, individuals with SMI are left in limbo, in which they must either advocate for re-evaluation or trust their designated decision-maker to do so. This is particularly relevant in the reproductive period concerning decisions related to terminating a pregnancy; even with a designated decision-maker, the pregnant person without competency cannot authorize a pregnancy termination—despite termination being safer in early pregnancy. As such, delaying the restoration of competency and decision-making autonomy results in a particularly heightened risk in the perinatal period.

Competency Restoration Task Force, <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/behavioral-health/crtf/> (last visited Dec. 12, 2023).

81. *Id.* at 66.

82. VIRGINIA DEP’T OF BEHAV. HEALTH & DEV. SERVS., *Adult Outpatient Competency Restoration Manual for Community Services Boards & Behavioral Health Authorities*, <https://www.dbhds.virginia.gov/assets/doc/forensic/Adult-Outpatient-Restoration-Manual-for-CSBs-2018.pdf> (last visited Dec. 12, 2023).

83. *Id.* at 10-12.

84. *Id.* at 145.

85. FADER-TOWE & KELLY., *supra* note 79, at 4. *See* Trueblood v. Washington State Dep’t of Soc. & Health Servs., 822 F.3d 1037 (9th Cir. 2016) (holding that the state violated people’s constitutional right to due process because their CST process was too lengthy).

To mitigate this, at minimum, states should require that legal competency re-evaluations occur one year after the initial determination. To best address the needs of the reproductive period, states should provide further legal guarantees such that individuals who lose legal competency may petition for re-evaluation during pregnancy. In doing so, pregnant people deemed incompetent can be assured that they are entitled to re-evaluation during pregnancy. While implementing these statutory standards will guarantee a timeline through which legal competency can be restored, we believe the law can go further to guarantee the restoration of capacity by allowing challenges to legal incompetency once medical capacity is restored. Addressing the potential procedural insufficiencies resulting by more readily allowing challenges upon the restoration of medical capacity may include guidelines that outline temporal guidelines that trigger the challenge once the individual demonstrates medical capacity for a reasonable period. The determined “reasonable period” should reflect medical opinions on capacity and medical decision-making while concurrently ensuring the earliest time in which it is medically appropriate to challenge legal incompetency.

Second, the current process of legal competence determination privileges judicial opinion over medical testimony. While medical providers may provide a written evaluation of the individual before the court, they are not required to testify to their evaluation. Further, judges may depart from the evaluation and recommendation. As such, circumstances may arise in which a medical provider determines that an individual does have medical capacity and recommends maintaining or restoring legal capacity. Yet, the judge rules against the treating provider’s recommendation. In such situations, the judge’s evaluation of the individual’s medical decision-making ability—which is likely not informed by medical training—is privileged over the testimony submitted by the medical provider, who not only possesses more appropriate training to make the assessment but also knows the individual in the clinical context. Given that the qualities evaluated for legal capacity are psychiatric—in that its inquiry is into the ability to make decisions—privileging the judge’s opinion may result in a competency determination not grounded by the available medical evidence. To best uphold the value of the testimony of the treating medical provider, judges should defer to their evaluations.

Third, the current process of legal competency determination in civil court is, at best, ambiguous and, at worst, nonexistent. As mentioned, the statutory standards for legal competency restoration focus on incompetency designations in criminal court; as such, limited literature

discusses the process of restoring civil competency. Triggering civil competency restoration begins with a petitioning process initiated by a ward “or others.”⁸⁶ Following the petition, the restoration process mirrors that of the initial incompetency assessment, including court hearings, a competency evaluation, and a final hearing.⁸⁷ Despite the availability of civil competency restoration, requests for civil psychologists to conduct these evaluations are limited, with only 15% of those evaluations performed specifically for this purpose.⁸⁸

While the current literature has not yet identified what exactly contributes to the limited number of restoration evaluations, we believe that it may be due to, in part, procedural burdens related to who can trigger civil competence restoration and the costs and evidentiary standards associated with it. To the former, an individual deemed incompetent cannot trigger the restoration process because they lack the legal autonomy to initiate proceedings. Thus, the power to petition for restoration rests not on the individual seeking civil competency restoration, but on their ward or “others.” By removing this power from the individual, they cannot petition for restoration on their terms; instead, they must wait—and hope—that their ward determines that they can petition for restoration. This may lead to circumstances in which wards may take advantage of their power and refuse filing a restoration petition to retain the medical decision-making authority of the individual without competency.

To mitigate this possibility, legal structures should expand who can file a restoration petition to restore autonomy, beginning with the individual deemed incompetent. Furthermore, the treating medical provider should also be given the power to file a restoration process such that when they believe their patient has undergone sufficient intervention and has medical capacity restored, so, too, should their legal competency. Expanding such processes gives the individual without competency more agency in challenging their legal incompetence and triggering the restoration process.

To the latter, an individual who has lost competency faces significant procedural burdens in completing the civil competency restoration process. This process—much like the initial determination—bears financial and temporal costs. Requiring a traditional judicial hearing to

86. George J. Demakis et al., *Civil Competency Restoration: Initial Findings From Psychological-Based Civil Competency Evaluations*, 52 PROF. PSYCHOLOGY: RSCH. & PRAC. 104, 105 (2021).

87. *Id.*

88. *Id.* at 108.

restore legal competency implicates costs associated with retaining an attorney to advise the proceedings, securing a new competency evaluation, and other costs, including fees for the treating provider to testify in court. Such costs may disincentivize—or outright prevent—individuals deemed incompetent from seeking civil competency restoration. To mitigate this possibility, the restoration process should be amended towards a more informal process; for example, instead of a formal hearing, an informal hearing process that allows for the individual and their treating medical provider to provide evidence that details the interventions undergone since the initial incompetency determination, improvements in symptom presentation, and the evaluations used to restore medical capacity. This process obviates the need to hire external evaluators while centering the testimony and recommendations of the medical provider in the restoration process.

B. Restoring Autonomy Through Reproductive Psychiatric Advance Directives

The above interventions address the normative and procedural burdens resulting from the misalignment between medical capacity and legal competence. These solutions, however, cannot mitigate the loss of medical decision-making autonomy following the loss of medical and legal competency. In such circumstances, until capacity is restored, an individual cannot make medical decisions and must defer such decisions to a ward. While the individual may certainly make clear their medical preferences, wards are not bound to such preferences. They are ultimately able to make medical decisions that may contradict the individual's choices.

To mitigate the risks associated with being administered medical interventions against the individual's preferences, psychiatric advance directives (PADs) serve as a useful written, preventative tool for individuals to specify their medical preferences in advance of capacity loss.⁸⁹ In protecting the autonomy and self-determination of people with SMI, the PAD ensures that “their treatment choices are known and hopefully respected.”⁹⁰ We have previously proposed a PAD that specifically ensures that reproductive choices are included, called the

89. H. Murray & H.S. Wortzel, *Psychiatric Advance Directives: Origins, Benefits, Challenges, and Future Directions*, 25 J. PSYCH. PRAC. 303 (2019).

90. Emily C. Dossett et al., *Reproductive Psychiatric Advance Directives: Promoting Autonomy for Perinatal People with Serious Mental Illness Diagnoses*, ARCH. WOMEN'S MENTAL HEALTH (2023).

“Reproductive PAD,” to prevent adverse and potentially fatal outcomes.⁹¹ In tandem with the above interventions, perinatal people with SMI can have their medical preferences known before the loss of capacity and have the legal protections necessary to guarantee a speedy restoration of civil competency following adequate intervention. To further strengthen choice in medical decisions, alternative models to legal guardianship, such as Supported Decision-Making (SDM)—which involves the recruitment of an individual’s trusted supporters to enhance capacity—can be implemented.⁹² SDM provides a less restrictive alternative to guardianship by maintaining ultimate decision-making authority in the individual while allowing trusted individuals to clarify problems and options to the individual and, if needed, interpret and communicate the individual’s preferences.⁹³ SDM involves several elements to enhance individual autonomy, including the presentation of information, consultation with trusted supports, reaching a decision, and documenting the decision such that it is carried out and legally enforceable.⁹⁴ In tandem, SDM and PADs ensure that the individual maintains their ability to make the final decision.

CONCLUSION

As discussed, medical capacity is an iterative process, while legal competence, framed by most jurisdictions, is a static criterion. This is due, in part, to the scope and goals of legal capacity and legal competence. While legal competence allowing medical decision-making autonomy is generally derived from principles of legal competence, medical capacity is narrowly derived from the determination of medical decision-making autonomy. The resulting misalignment produces circumstances in which individuals without legal competence cannot make medical decisions despite having medical capacity. Such circumstances are particularly troubling for perinatal people with SMI because current legal mechanisms for competency restoration do not consider the timeline for pregnancy and postpartum; as a result, perinatal people do not have the guarantee of legal competency restoration in pregnancy or postpartum. Instead, a perinatal person with an SMI diagnosis might face involuntary commitment, medication, or medical procedures for their welfare or that of the fetus or

91. *Id.* at 2.

92. Dilip V. Jeste et al., *Supported Decision Making in Serious Mental Illness*, 81 *PSYCHIATRY* 28 (2018).

93. *Id.* at 5.

94. *Id.* at 6; *see id.* for a list of questions for individuals with SMI relevant to this process.

newborn, underscoring the profound lack of agency many face due to the presumption of incompetence based on their mental health diagnoses. These assumptions often continue in the postpartum period with child custody challenges and interventions by child protective services based on beliefs about their capacity to care for their child.

Challenging the incompatibility between medical capacity and legal competence requires a reconceptualization of competency that better aligns with medical capacity. Aligning medical capacity and legal competence requires normative interventions to redefine legal competency to better mirror the flexibility of medical capacity, pragmatic interventions to facilitate greater responsiveness of competency evaluations in variable mental states and preventative interventions that allow individuals with SMI to indicate their medical preferences to have their medical and reproductive preferences known that anticipates the potential loss of capacity. This paradigm shifts away from the legal system's inflexible, protectionist approach towards a more nuanced, adaptable capacity assessment, which will allow for the legal system to respond more effectively to the particular needs of people with SMI and the variable nature of living with mental illness.