

INVOLUNTARY OUTPATIENT COMMITMENT: THE LIMITS OF PREVENTION

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Preventive outpatient commitment laws require people with mental illnesses to participate in mental health treatment before they meet the criteria for inpatient civil commitment—clear and convincing evidence of mental illness and dangerousness to self or others. These laws apply to people who are chronically ill but not imminently dangerous. Most outpatient commitment laws do not require a judicial determination of incompetence, nor do they require a criminal charge or a criminal conviction. As such, outpatient commitment statutes unearth an old question on law, ethics, and the limits of prevention: under what circumstances can we impose substantial restraints on individual liberty because we believe a person is likely to harm himself or others before he actually has done so?

Although most authors rest the moral justification for outpatient commitment on a mental impairment—be it impaired insight, decisional-incapacity or incompetence to refuse treatment, this Article claims that government interventions into self-regarding harm and other-regarding harm require distinct moral justifications. When our primary concern is one of self-regarding harm, a court order to participate in outpatient treatment may be appropriate, but only for people with mental illnesses who are incompetent to make treatment decisions on their own. If, however, we are concerned about harm to others, a court order to participate in outpatient treatment may be appropriate, but only for people with mental illnesses who lack the moral capacities for criminal responsibility—either because they are unlikely to appreciate the wrongfulness of their conduct or because they are unable to conform their conduct to the requirements of the law.

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INTRODUCTION

In the years since deinstitutionalization, one of the most important questions in mental health policy is this: how can we care for psychiatric patients in the community who need treatment but resist treatment nonetheless?

The problem is particularly apparent for people with chronic mental illnesses who are high utilizers of inpatient care—so called “revolving door patients.” These patients improve when they are hospitalized and treated with psychotropic medications but frequently stop taking their medications shortly after they are released, creating a cycle of relapse and rehospitalization.¹ Eventually, revolving door patients will deteriorate and meet the criteria for inpatient civil commitment—clear and convincing evidence of mental illness and dangerousness to self or others. However, involuntary outpatient commitment laws permit courts to intervene and order people with mental illnesses to comply with treatment in the community. A subtype of involuntary outpatient commitment—known as preventive outpatient commitment—permits court-ordered treatment for people with mental illnesses who do not satisfy the criteria for inpatient commitment. Proponents of these laws tout them as a solution to the revolving door problem.²

Forty-two states and the District of Columbia have involuntary outpatient commitment laws.³ At least nine jurisdictions permit preventive outpatient

1. Joan B. Gerbasi et al., *Resource Document on Mandatory Outpatient Treatment*, 28 J. AM. ACAD. PSYCHIATRY & L. 127, 128 (2000). Many revolving door patients have been diagnosed with schizophrenia or schizoaffective disorder. These patients impose an enormous economic burden on the healthcare system due to the high cost of hospitalization. See Thomas W. Haywood et al., *Predicting the “Revolving Door” Phenomenon Among Patients with Schizophrenic, Schizoaffective, and Affective Disorders*, 152 AM. J. PSYCHIATRY 856 (1995); Patricia Thieda et al., *An Economic Review of Compliance with Medication Therapy in the Treatment of Schizophrenia*, 54 PSYCHIATRIC SERVICES 508 (2003); Peter J. Welden & Mark Olfson, *Cost of Relapse in Schizophrenia*, 21 SCHIZOPHRENIA BULLETIN 419 (1995).

2. See, e.g., Gerbasi et al., *supra* note 1; Ken Kress, *An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa*, 85 IOWA L. REV. 1269 (2000).

3. ALA. CODE § 22-52-10.2 (Westlaw through 2014 Sess.); ALASKA STAT. ANN. § 47.30.795 (West, Westlaw through 2014 Sess.); ARIZ. REV. STAT. ANN. § 36-540 (Westlaw through 2014 Sess.); ARK. CODE ANN. § 20-47-214(b)(1) (West, Westlaw through 2014 Sess.); CAL. WELF. & INST. CODE § 5346 (West, Westlaw through 2014 Sess.) (“Laura’s Law”); COLO. REV. STAT. ANN. § 27-65-111 (West, Westlaw through 2014 Sess.); DEL. CODE ANN. tit. 16, § 5010(2) (West, Westlaw through 2014 Sess.); D.C. CODE § 21-545(b)(2) (Westlaw through 2014 Sess.); FLA. STAT. ANN. § 394.4655 (West, Westlaw through 2014 Sess.); GA. CODE ANN. § 37-3-81.1(2) (West, Westlaw through 2014 Sess.); HAW. REV. STAT. § 334-121 (West, Westlaw through 2014 Sess.); IDAHO CODE ANN. § 66-339A (1998) (repealed 1998); 405 ILL. COMP. STAT. 5 / 3-751 (West, Westlaw through 2014 Sess.); IND. CODE ANN. § 12-26-14-1 (West, Westlaw through 2014 Sess.); IOWA CODE ANN. § 229.13 (West, Westlaw through 2014 Sess.); KAN. STAT. ANN. § 59-2967 (West, Westlaw through 2014 Sess.); KY. REV. STAT. ANN. § 202A.081(1) (West, Westlaw through 2014 Sess.); LA. REV. STAT. ANN. § 28:55(E)(1) (Westlaw through 2014 Sess.); ME. REV. STAT. ANN. tit. 34-B, § 3873-A (Westlaw through 2014 Sess.); MICH. COMP. LAWS ANN. § 330.1468 (West, Westlaw through 2014 Sess.) (“Kevin’s Law”); MINN. STAT. ANN. § 253B.065(5)(b) (West, Westlaw through 2014 Sess.); MISS. CODE ANN. § 41-21-73(4) (West, Westlaw through 2014 Sess.); MO. ANN. STAT. § 632.330(2) (West, Westlaw through 2014 Sess.); MONT. CODE ANN. § 53-21-127(2) (West, Westlaw through 2013 Sess. 1996); NEB. REV. STAT. ANN. § 71-909 (West, Westlaw through 2014 Sess.); NEV. REV. STAT. ANN. § 433A.310 (West, Westlaw through 2014 Sess.); N.H. REV. STAT. ANN. § 135-C:1 (Westlaw through 2014 Sess.); N.J.

commitment.⁴ Several states, including California, New Jersey, Florida, and Michigan, have enacted involuntary outpatient commitment statutes of both varieties in recent years. Although some states rarely use their outpatient commitment laws, other states have been more aggressive.⁵ Since New York established its outpatient commitment program in 1999, 12,218 New Yorkers have been under a court order to participate in mental health treatment.⁶ The shootings in Newtown, Connecticut; Aurora, Colorado; and Isla Vista, California have prompted other states, including Connecticut, Nevada, and Pennsylvania, to consider adopting outpatient commitment statutes or strengthening existing provisions.⁷ In Congress, The Helping Families in

STAT. ANN. § 30:4-27.8a (West, Westlaw through 2014 Sess.) (“Gregory’s Law”); N.Y. MENTAL HYG. LAW § 9.60(C) (McKinney, Westlaw through 2014 Sess.) (“Kendra’s Law”); N.C. GEN. STAT. ANN. § 122C-263(d)(1) (West, Westlaw through 2014 Sess.); N.D. CENT. CODE § 25-03.1-20(1) (West, Westlaw through 2013); OHIO REV. CODE ANN. § 5122.15(C) (West, Westlaw through 2014 Sess.); OKLA. STAT. ANN. tit. 43A, § 5-415E (West, Westlaw through 2014 Sess.); OR. REV. STAT. ANN. § 426.130(1)(a)(C)(ii) (West, Westlaw through 2014 Sess.); 50 PA. STAT. ANN. § 7304 (West, Westlaw through 2014 Sess.); R.I. GEN. LAWS ANN. § 40.1-5-8(j) (West, Westlaw through 2014 Sess.); S.C. CODE ANN. § 44-17-580 (Westlaw through 2013 Sess.); S.D. CODIFIED LAWS § 27A-9-10.1 (2000) (repealed 1991); TEX. HEALTH & SAFETY CODE ANN. § 574.034(b) (West, Westlaw through 2013 Sess.); UTAH CODE ANN. § 62A-15-631 (West, Westlaw through 2014 Sess.); VT. STAT. ANN. tit. 18, § 7618 (West, Westlaw through 2014 Sess.); VA. CODE ANN. § 37.2-817 (West, Westlaw through 2014 Sess.); WASH. REV. CODE ANN. § 71.05.240 (West, Westlaw through 2014 Sess.); W. VA. CODE ANN. § 27-1-9 (West, Westlaw through 2014 Sess.); WIS. STAT. ANN. § 51.20 (West, Westlaw through 2013 Sess.); WYO. STAT. ANN. § 25-10-110(j) (West, Westlaw through 2014 Sess.). The six states without outpatient commitment laws are Connecticut, Maryland, Massachusetts, New Hampshire, New Mexico and Tennessee. *See also* Mark R. Munetz et al., *Commentary: Capacity-Based Involuntary Outpatient Treatment*, 28 J. AM. ACAD. PSYCHIATRY & L. 145 (2000) (discussing use of medication guardianship orders in Massachusetts, a state without an outpatient commitment statute).

4. CAL. WELF. & INST. CODE § 5346 (West, Westlaw through 2014 Sess.) (“Laura’s Law”); FLA. STAT. ANN. § 394.4655 (West, Westlaw through 2014 Sess.); GA. CODE ANN. § 37-3-81.1(2) (West, Westlaw through 2014 Sess.); HAW. REV. STAT. § 334-121 (West, Westlaw through 2014 Sess.); IDAHO CODE ANN. 66-339A (1998) (repealed 1998); MINN. STAT. ANN. § 253B.065(5)(b) (West, Westlaw through 2014 Sess.); N.Y. MENTAL HYG. LAW § 9.60(C) (McKinney, Westlaw through 2014 Sess.) (“Kendra’s Law”); N.C. GEN. STAT. ANN. § 122C-263(d)(1) (West, Westlaw through 2014 Sess.); TEX. HEALTH & SAFETY CODE ANN. § 574.034(b) (West, Westlaw through 2013 Sess.).

5. *See, e.g.*, John Petrila & Annette Christy, *Florida’s Outpatient Commitment Law: A Lesson in Failed Reform?*, 59 PSYCHIATRIC SERVICES 21, 21 (2008) (“In a state with a population that is approaching 19 million people, there have been a total of 71 orders for outpatient commitment in nearly three years.”); *see also* RISDON N. SLATE, JACQUELINE K. BUFFINGTON-VOLLUM & W. WESLEY JOHNSON, *THE CRIMINALIZATION OF MENTAL ILLNESS: CRISIS AND OPPORTUNITY FOR THE JUSTICE SYSTEM* 226 (2d ed. 2013).

6. N.Y. STATE OFFICE OF MENTAL HEALTH, ASSISTED OUTPATIENT TREATMENT REPORTS [hereinafter N.Y. OMH AOT REPORTS], <http://bi.omh.ny.gov/aot/statistics?p=under-court-order> (last visited Nov. 28, 2014).

7. *See, e.g.*, NY Secure Ammunition and Firearms Enforcement (SAFE) Act, ch. 1, 2013 N.Y. Sess. Laws 1 (McKinney) [hereinafter SAFE Act] (expanding outpatient commitment law in New York); *see also* S. 452, Gen. Assemb., Feb. Sess. (Conn. 2012) (proposing involuntary outpatient commitment in Connecticut); H. 550, 197th Gen. Assemb., Reg. Sess. (Pa. 2013) (proposing an assisted outpatient treatment amendment to

Mental Health Crisis Act (H.R. 3717) would authorize \$60 million dollars in federal grants over four years to implement outpatient commitment programs.⁸ Although outpatient commitment orders were first introduced in the United States, they are also an international phenomenon. Outpatient commitment laws exist in Israel, Canada, Australia, and New Zealand.⁹ Amendments to the 1983 Mental Health Act introduced outpatient commitment orders to England and Wales in November 2008.¹⁰

Several states have modeled their outpatient commitment statutes on New York's preventive outpatient commitment law, known as Kendra's Law.¹¹ New York passed Kendra's Law in memory of Kendra Webdale, a young woman who was pushed to her death in front of an oncoming train by Andrew Goldstein, a man with untreated schizophrenia. Under Kendra's Law, a court can order a person with a mental illness to participate in an "assisted outpatient treatment" (AOT) program. A typical AOT order includes a host of interventions designed to improve medication compliance in the community, among them—periodic blood tests or urinalysis to determine compliance with prescribed medications; counseling and toxicology screens for patients with a history of substance abuse; group therapy, day or partial day programming; and supervised living arrangements.¹² For those who are not under a supervised housing requirement, courts will sometimes order an assertive community treatment (ACT) team to visit the patient's home.

Much of the controversy surrounding outpatient commitment has focused on the legal rights of people with mental disabilities and whether these laws are an effective solution to hospital recidivism.¹³ Yet even if these laws are effective and fall within the wide boundaries set by constitutional norms, hard

the Mental Health Procedures Act in Pennsylvania). *See generally* Arielle Levin Becker, *After Newtown: A Rethinking of Connecticut Law on Outpatient Commitment*, CONN. MIRROR (Jan. 2, 2013), <http://ctmirror.org/after-newtown-rethinking-connecticut-law-outpatient-commitment> [hereinafter Becker, *After Newtown*]; Arielle Levin Becker, *A Judge's Frustrations Lead to Proposal, Outcry from Advocates*, CONN. MIRROR (Mar. 30, 2012), <http://ctmirror.org/judges-frustrations-lead-proposal-outcry-advocates> [hereinafter Becker, *Judge's Frustrations*].

8. H.R. 3717, 113th Cong. (2013).

9. RACHEL CHURCHILL ET AL., KINGS COLL. LONDON, INST. OF PSYCHIATRY, INTERNATIONAL EXPERIENCES OF USING COMMUNITY TREATMENT ORDERS 28 (2007); *see also*, John Dawson, *Fault-lines in Community Treatment Order Legislation*, 29 INT'L J.L. & PSYCHIATRY 482 (2006) (discussing outpatient commitment legislation in six British Commonwealth Jurisdictions).

10. The introduction of community treatment orders in England and Wales has sparked a heated debate. *See generally* Mark Taylor, *Community Treatment Orders and Their Use in the UK*, 16 ADVANCES IN PSYCHIATRIC TREATMENT 260 (2010).

11. N.Y. MENTAL HYG. LAW § 9.60 (a)(1) (McKinney, Westlaw through 2014 Sess.).

12. *Id.*

13. *See, e.g.*, Michael Allen & Vicki Fox Smith, *Opening Pandora's Box: The Practical and Legal Dangers of Involuntary Outpatient Commitment*, 52 PSYCHIATRIC SERVICES 342 (2001); Jennifer Honig & Susan Stefan, *New Research Continues to Challenge the Need for Outpatient Commitment*, 31 NEW. ENG. J. ON CRIM & CIV. CONFINEMENT 109 (2005).

moral questions remain. The central concern of this Article can be thought of in terms of the following question: under what circumstances can we impose substantial restraints on individual liberty because we believe a person is likely to harm himself or others before he has actually done so?

Supporters of Kendra's Law rest the moral justification for intervention on harm to self and others. Yet by itself, harm fails to provide a principled distinction between people with mental illnesses and others who might also refuse treatment. Consider the alcoholic who persists in driving drunk. We could easily imagine a Kendra's Law for people with substance abuse disorders—replete with weekly Alcoholics Anonymous meetings, toxicology tests, and home visits where ACT teams conduct “bottle checks” instead of pill checks. Such a regime would pay dividends in preventable deaths due to vehicular homicide, yet we do not have one. Instead we rely on the criminal law to deter these harms.

Resting the argument for assisted outpatient treatment on harm to self seems equally problematic. We do not require people with diabetes to take medications that have the power to prevent blindness, amputation, coma, and death. Nor do we require smokers to stop smoking any more than we require people with cardiovascular disease or high cholesterol to participate in classes on the dangers of inactivity and a fatty diet. As a general matter, courts do not intervene in self-regarding treatment decisions, without a finding of incompetence, no matter how grave the potential harm.

Supporters of outpatient commitment contend that quite unlike people with diabetes, cardiovascular disease and high cholesterol, many people with major mental illnesses like schizophrenia, bipolar disorder, and depression lack insight into their illnesses, and when combined with a substantial risk of harm to self or others, this lack of insight provides sufficient justification for court ordered treatment, even when they do not meet the legal definition of incompetence.¹⁴ In psychiatry the term “insight” refers to a person's awareness that he or she is suffering from a mental disorder.¹⁵ Conventional definitions of competence to refuse treatment include insight as an element of competence. In recent years, the notion that impaired insight provides a moral justification for outpatient commitment has grown tremendously in popularity and influence. I will argue that impaired insight fails to provide a strong justification for outpatient commitment.

Most authors on bioethics and mental health law rest the moral justification for outpatient commitment on a mental impairment—be it impaired insight, decisional-incapacity, or incompetence to refuse treatment.¹⁶ What should we

14. See, e.g., Xavier F. Amador & Andrew A. Shiva, *Insight into Schizophrenia: Anosognosia, Competency, and Civil Liberties*, 11 GEO. MASON U. C.R. L.J. 25 (2000); E. Fuller Torrey & Mary Zdanowicz, *Outpatient Commitment: What, Why, and for Whom?*, 52 PSYCHIATRIC SERVICES 337 (2001).

15. See *infra* notes 329-34 and accompanying text.

16. See, e.g., Eric Dale, *Is Supervised Community Treatment Ethically Justifiable?*, 36 J. MED. ETHICS 271 (2009) (concluding that supervised community treatment is justifiable

say about a person who presents a substantial risk of harm to others by virtue of mental illness but who is competent to refuse treatment nonetheless? One response is to do nothing and claim that our hands are tied until the person commits or attempts a crime.¹⁷ Below I argue that a court order to participate in outpatient treatment may be permissible notwithstanding a finding of incompetence. Our challenge, however, will be to distinguish persons with mental disorders who are appropriately subject to preventive intervention through outpatient commitment from others whose dangerous behaviors are more appropriately controlled by the criminal law.

Part II.A sets the stage for discussion by providing a brief history of institutionalization, deinstitutionalization, and their critics, with a focus on the circumstances leading to Kendra's Law in New York. Part II.B describes preventive outpatient commitment laws in New York, California, and North Carolina. Part II.C discusses empirical research on outpatient commitment, while Part II.D examines constitutional challenges to outpatient commitment laws. Part III opens the analytic section of this Article by refuting common justifications for outpatient commitment. There is a place for outpatient commitment, but in their current form outpatient commitment statutes violate basic moral norms. To that end, Part IV develops a rights-based moral framework for involuntary outpatient commitment.¹⁸ I begin by contrasting consequentialist with non-consequentialist theories of moral justification. From a utilitarian outlook, individual rights have no moral force aside from their contribution to utility; however, the framework I present in Part IV is a distinctly liberal one. It denies that moral rights can be infringed simply because doing so would produce gains in utility.

for people with severe mental disorders who are incompetent to make treatment decisions); John Dawson & George Szukler, *Fusion of Mental Health and Incapacity Legislation*, 188 BR. J. OF PSYCHIATRY 504 (2006) (proposing a single incapacity standard to govern involuntary treatment for physical and mental illnesses); Howard H. Goldman, *Outpatient Commitment Reexamined: A Third Way*, 65 PSYCHIATRIC SERVICES 816, 816 (2014) (proposing a "decisional capacity" standard for outpatient commitment); Michael A. Hoge & Elizabeth Grottole, *The Case Against Outpatient Commitment*, 28 J. AM. ACAD. PSYCHIATRY & L. 165 (2000) (challenging the legitimacy of outpatient commitment for patients who are neither incompetent nor imminently dangerous); Mark R. Munetz, *Commentary: Capacity-Based Involuntary Outpatient Treatment*, 28 J. AM. ACAD. PSYCHIATRY & L. 145 (2000); Mark R. Munetz et al., *The Ethics of Mandatory Community Treatment*, 31 J. AM. ACAD. PSYCHIATRY & L. 173 (2003) (claiming that outpatient commitment may be justified for people who lack decision-making capacity); Elyn R. Saks, *Involuntary Outpatient Commitment*, 9 PSYCHOL. PUB. POL'Y & L. 94, 95 (2003) (proposing "one free shot" of preventive outpatient commitment when patients are incompetent to refuse treatment, but otherwise requiring a judicial determination of incompetence thereafter); Torrey & Zdanowicz, *supra* note 14, at 337 (describing impaired illness awareness as a moral justification for outpatient commitment).

17. See, e.g., Dawson & Szukler, *supra* note 16, at 504.

18. See RONALD DWORKIN, *TAKING RIGHTS SERIOUSLY* 171-72 (1977) (distinguishing rights-based moral theories from goal-based, or utilitarian, moral theories). I borrow the term "rights-based theory" from Dworkin.

Although most bioethicists claim that outpatient commitment orders are justifiable if they are limited to people who are incompetent to refuse treatment or otherwise cognitively impaired, one of the important claims in Part IV is that government interventions into self-regarding harm and other-regarding harm require distinct moral justifications. When our primary concern is one of self-regarding harm, Part IV contends that a court order to participate in outpatient treatment may be appropriate, but only for people with mental illnesses who are unable to make competent treatment decisions on their own. In contrast to other authors on competence, I argue that “appreciation,” the legal correlate of insight, should have no role to play in our thinking about competence.

At times, we will also worry that a decision to refuse outpatient treatment could not only result in harm to oneself, but also harm to others. Criminal law scholars have long understood civil commitment as an alternative system of social control for dangerous yet morally non-responsible, persons.¹⁹ Still, they disagree on the indicia of moral non-responsibility. In Part IV, I argue that when our primary concern is one of other-regarding harm, a court order to participate in outpatient treatment may be appropriate, but only for people with mental disorders who lack the moral capacities for criminal responsibility—either because they are unlikely to appreciate the wrongfulness of their conduct or because they are unable to conform their conduct to the requirements of the law.

I. THE RISE OF OUTPATIENT COMMITMENT

A. *Deinstitutionalization*

1. The (Broken) Promise of Community Mental Health

During the first half of the twentieth century, civil commitment decisions were predicated on the “best interests” of the patient and left in the hands of physicians or family members.²⁰ Most civil commitments were accomplished with a two physician certificate, whereby patients were hospitalized on the statement of two physicians that they were suffering from a mental disorder and

19. See, e.g., ROBERT F. SCHOPP, COMPETENCE, CONDEMNATION, AND COMMITMENT: AN INTEGRATED THEORY OF MENTAL HEALTH LAW (2001); Gary Watson, *The Insanity Defense*, in THE ROUTLEDGE COMPANION TO PHILOSOPHY OF LAW (Andrei Marmor, ed. 2012); Bruce Winick, CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL 60 (2005); Adam J. Falk, *Sex Offenders, Mental Illness and Criminal Responsibility: The Constitutional Boundaries of Civil Commitment after Kansas v. Hendricks*, 25 AM. J. L. & MED. 117 (1999); Stephen J. Morse, *Rationality and Responsibility*, 74 S. CAL. L. REV. 251 (2000); Paul H. Robinson, *Foreword: The Criminal-Civil Distinction and Dangerous Blameless Offenders*, 83 J. CRIM. L. & CRIMINOLOGY 693 (1993); Stephen J. Schulhofer, *Two Systems of Social Protection: Comment on the Civil-Criminal Distinction, with Particular Reference to Sexually Violent Predator Laws*, 7 J. CONTEMP. LEGAL ISSUES 69 (1996).

20. PAUL S. APPELBAUM, ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE 18-22, 129 (1994).

in need of care or treatment.²¹ In most states, commitment could be achieved without a hearing, without counsel, and without a legal remedy, aside from a writ of habeas corpus.²² By the mid-1950s, when the number of institutionalized psychiatric patients reached its peak, more than 550,000 inpatients resided in state mental hospitals.²³ By the mid-1980s, however, fewer than 120,000 psychiatric patients resided in state hospitals.²⁴

Several factors encouraged a shift toward community mental health care. During the late 1950s, attitudes toward institutional psychiatry began to change.²⁵ Social scientists questioned the ability of psychiatrists to diagnose mental illness reliably²⁶ while labeling theorists²⁷ and radical anti-psychiatrists²⁸ insisted that psychiatric diagnoses were no more than convenient labels designed to suppress nonconforming behavior. So labeled, persons deemed mentally ill would in turn reproduce more disturbed behavior. A further critique of psychiatry came from the civil rights movement. Civil rights organizations argued that inpatient commitment standards were vague, overbroad, and void for failure to consider less restrictive alternatives to involuntary hospitalization.²⁹ A third critique concerned the benefits of long-term hospitalization.³⁰ In the years following World War II, a series of exposés called attention to deplorable conditions in state hospitals.³¹ For the first time,

21. See N.Y. MENTAL HYG. LAW § 9.27(a) (McKinney, Westlaw through 2014 Sess.) (authorizing non-emergency involuntary civil commitment if two physicians examine the committee and certify that he or she is mentally ill and “in need of involuntary care and treatment.”); see also AM. BAR FOUND., *THE MENTALLY DISABLED AND THE LAW* 63-65 (1961).

22. ALBERT DEUTSCH, *THE MENTALLY ILL IN AMERICA: A HISTORY OF THEIR CARE AND TREATMENT FROM COLONIAL TIMES* 414, 436 (1949).

23. H. Richard Lamb, *Deinstitutionalization at the Beginning of the New Millenium*, in *DEINSTITUTIONALIZATION: PROBLEMS AND PROMISE* 3, 3 (Richard H. Lamb & Linda E. Weinberger eds., 2001).

24. GERALD N. GROB, *THE MAD AMONG US: THE HISTORY OF THE CARE OF AMERICA’S MENTALLY ILL* 291 (1994).

25. APPELBAUM, *supra* note 20, at 4-10.

26. Symposium, *On Being Sane in Insane Places*, 13 *SANTA CLARA LAW* 379 (1973).

27. R.D. LAING, *THE POLITICS OF EXPERIENCE* 78-79 (1967) (“Those who are diagnosed as schizophrenic are not ill but are reacting in a sane and rationale way to the intolerable emotional pressures placed on them by society and their families.”); THOMAS SCHEFF, *BEING MENTALLY ILL: A SOCIOLOGICAL THEORY* (Aldine 1966).

28. See THOMAS SZAZ, *THE MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT* (1961).

29. *Lessard v. Schmidt*, 349 F. Supp. 1078, 1093 (E.D. Wis. 1972).

30. See generally ERVING GOFFMAN, *ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES* (1961) (describing psychiatric hospitals as “total institutions” in which people with mental disorders lose their identities and take on the dehumanizing, and ultimately debilitating, role of “patient”)

31. See ALBERT DEUTSCH, *THE SHAME OF THE STATES* (1948).

the emergence of psychotropic medications also offered the possibility of treating people with mental illnesses in the community.³²

Changes in federal policy accelerated the transition to community mental health care. In 1963, President Kennedy called for “a bold new approach” to treating mental illness, one that relied upon “new knowledge and new drugs,” to treat people in communities rather than hospitals.³³ The centerpiece of his approach was the Community Mental Health Act.³⁴ The Act provided \$150 million in federal grants for constructing community mental health centers (CMHCs).³⁵ Two years later, a second federal law provided grants for staffing mental health centers.³⁶ Equally important were amendments to the Social Security Act, resulting in the creation of Medicare and Medicaid.³⁷ When Congress passed Medicaid in 1965, the federal government excluded Medicaid payments for psychiatric services rendered in state hospitals. In response, states discharged large numbers of former inpatients to nursing homes and other congregate care arrangements where Medicaid reimbursement was available.³⁸ A few years later, Supplemental Security Income (SSI) provided financial support for people with mental illnesses.³⁹

While some former inpatients did well in the community, many others did not. Far fewer community mental health centers were created than anticipated, making it difficult for former inpatients to access care.⁴⁰ The Community Mental Health Act aimed to create 1500 mental health centers nationwide, but by 1980, only 754 centers received federal funding.⁴¹ Community mental health centers (CMHCs) were intended to replace state mental hospitals, but the regulations governing CMHCs made no mention of how these centers would coordinate with state hospitals or provide aftercare for former patients.⁴² The inpatient populations of state mental hospitals declined throughout the 1960s and 1970s; however, the decline was largely unrelated to community mental health centers. Most CMHCs served a very different population.⁴³ CMHCs

32. EDWARD SHORTER, A HISTORY OF PSYCHIATRY: FROM THE ERA OF THE ASYLUM TO THE AGE OF PROZAC 279-80 (1997).

33. President John F. Kennedy, Speech to the 88th Congress: Special Message to Congress on Mental Illness and Mental Retardation, *available at* <http://www.jfklibrary.org/Asset-Viewer/Archives/JFKPOF-052-012.aspx>.

34. Pub. L. No. 88-164, 77 Stat. 282 (1963) (also known as the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963).

35. GROB, *supra* note 24, at 258.

36. Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965, Pub. L. No. 89-105, 77 Stat. 282 (1965).

37. The Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965).

38. APPELBAUM, *supra* note 20, at 50-51.

39. Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972).

40. GROB, *supra* note 24, at 283-87.

41. *Id.* at 262.

42. E. FULLER TORREY, AMERICAN PSYCHOSIS HOW THE FEDERAL GOVERNMENT DESTROYED THE MENTAL ILLNESS TREATMENT SYSTEM 62 (2013).

43. GROB, *supra* note 24, at 264.

generally catered to the interests of the affluent “worried well,” namely, patients with emotional problems, and frequently personal problems, rather than people with severe mental disorders who were being discharged from state hospitals.⁴⁴

2. A Changing Legal Landscape

At the same time, the criteria for involuntary civil commitment were also changing. In *Lessard v. Schmidt*, the Federal District Court for the Eastern District of Wisconsin issued a landmark opinion on civil commitment law.⁴⁵ Prior to *Lessard*, Wisconsin law permitted a judge or jury to order civil commitment if the court was satisfied that the person was mentally ill or infirm and “a proper subject for custody and treatment” based on a preponderance of the evidence.⁴⁶ *Lessard* held that the statute was unconstitutional insofar as it permitted civil commitment without proof of mental illness and dangerousness to self or others beyond a reasonable doubt. The district court held that states must prove dangerousness based on “a recent overt act, attempt or threat to do substantial harm to oneself or another.”⁴⁷ In addition, *Lessard* required states to establish that there was an extreme likelihood that the person would do “immediate harm to himself or others” if not confined.⁴⁸ The district court also mandated a panoply of procedural due process protections, including timely and effective notice of the “charges” justifying detention, the right to a jury trial, the right to adversary counsel, and the privilege against self-incrimination.

Several years later, the Supreme Court heard substantive and procedural due process challenges to civil commitment in *O'Connor v. Donaldson*⁴⁹ and *Addington v. Texas*.⁵⁰ *Donaldson* began when Kenneth Donaldson brought suit, alleging that the Florida State Hospital and its superintendent intentionally and maliciously deprived him of his liberty.⁵¹ Uncontroverted testimony adduced at trial established that Donaldson was not dangerous and that the hospital was not treating his illness but instead had only provided non-curative “milieu therapy.”⁵² In a unanimous opinion, the Supreme Court held that “a finding of ‘mental illness’ alone cannot justify a State’s locking a person up against his will and keeping him indefinitely in simple custodial confinement.”⁵³

44. TORREY, *supra* note 42, at 78; *see also*, RAE JEAN ISAAC & VIRGINIA C. ARMAT, MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL 95-96 (1990).

45. *Lessard v. Schmidt*, 349 F. Supp. 1078, 1093 (E.D. Wis. 1972).

46. *Id.* at 1093 (citation omitted).

47. *Id.*

48. *Id.*

49. 422 U.S. 563 (1975).

50. 441 U.S. 418 (1979).

51. *Donaldson*, 422 U.S. at 565.

52. *Id.* at 569 (citation omitted).

53. *Id.* at 575.

“[W]ithout more,” Justice Stewart wrote, a state cannot confine “a nondangerous individual who is capable of surviving safely in freedom” on his own or with assistance from friends and family.⁵⁴

The Supreme Court turned to the standard of proof for civil commitment proceedings in *Addington v. Texas*.⁵⁵ *Addington* claimed that civil commitment by less than proof beyond a reasonable doubt violated his right to procedural due process. In an opinion by Chief Justice Burger, the Supreme Court held that while the individual interest in the outcome of a civil commitment proceeding is of sufficient gravity to require more than a preponderance of the evidence, the Fourteenth Amendment requires no more than “clear and convincing evidence.”⁵⁶ Given the uncertainty of prediction and the fallibility of diagnosis, the Chief Justice concluded that proof beyond a reasonable doubt would impose a standard that states cannot meet.⁵⁷

In the years following *Lessard*, *Donaldson*, and *Addington*, states modified their civil commitment laws. By the end of the 1970s, every state raised the

54. *Id.* at 576. The Court did little to clarify the meaning of the phrase “without more,” leading some observers to conclude that, by itself, *Donaldson* would not preclude the involuntary civil commitment of a nondangerous person with a mental illness if the state also provided treatment. Indeed, Justice Stewart wrote, “[t]here is accordingly, no occasion in this case to decide whether the provision of treatment, standing alone, can ever constitutionally justify involuntary confinement In its present posture this case involves not involuntary treatment but simply involuntary custodial confinement.” *Donaldson*, 422 U.S. at 574 n.10 (1975). That language, along with the phrase “without more,” has led some commentators to conclude that the Court did not announce a dangerousness requirement in *Donaldson*, and therefore, inpatient civil commitment does not require proof of dangerousness. *See, e.g.*, Geoffrey Linburn, *Donaldson Revisited: Is Dangerousness a Constitutional Requirement for Civil Commitment?*, 26 J. AM. ACAD. PSYCHIATRY L. 343 (1998); BRIAN STETTIN, TREATMENT ADVOCACY CTR., MENTAL HEALTH COMMITMENT LAWS: A SURVEY OF THE STATES (2014), <http://www.tacreports.org/storage/documents/2014-state-survey-abridged.pdf>; Jeffrey Geller & Jonathan Stanley, *Settling Doubts About the Constitutionality of Outpatient Commitment*, 31 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 127, 132 (2005). Nonetheless, in subsequent opinions, the Supreme Court has clearly stated that civil commitment requires clear and convincing evidence of both mental illness and dangerousness. *See, e.g.*, *Jones v. United States*, 463 U.S. 354, 362 (1983) (interpreting *Addington v. Texas*, 441 U.S. 418, 426-27 (1979), as holding that “the Due Process Clause requires the Government in a civil-commitment proceeding to demonstrate by clear and convincing evidence that the individual is mentally ill and dangerous”); *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992) (citation omitted) (“The State may . . . confine a mentally ill person if it shows by ‘clear and convincing evidence that the individual is mentally ill and dangerous.’”).

55. 441 U.S. 418 (1979).

56. *Id.* at 433.

57. *Id.* at 430. *Addington* left the term “clear and convincing evidence” undefined; however, lower courts have defined clear and convincing evidence as evidence that makes the existence of a fact “highly probable,” or “much more probable than its falsity.” *Ausch v. St. Paul Fire & Marine Ins. Co.*, 511 N.Y.S.2d 919, 921-22 (N.Y. App. Div. 1987) (approving jury instruction that used “highly probable” language to describe clear and convincing evidence); *Chenango Mut. Ins. Co. v. Charles*, 652 N.Y.S.2d 134, 136 (N.Y. App. Div. 1997) (specifying that clear and convincing evidence standard requires “high probability”).

threshold for inpatient civil commitment from mental illness and the need for treatment based on a preponderance of the evidence to clear and convincing evidence of mental illness and dangerousness to self or others.⁵⁸ Although not required by *Donaldson* or *Addington*, several states required proof of dangerousness to self or others based on a “recent overt act”⁵⁹ or a substantial risk of “imminent harm”⁶⁰ in accordance with the district court decision in *Lessard v. Schmidt*. In the same way, states mandated procedural due process protections, including notice, the right to counsel, the right to confront and cross-examine witnesses, and the right to appeal.⁶¹

58. APPELBAUM, *supra* note 20, at 28 (1994). The precise formulation of dangerousness to self or others varied from state to state. Some states implemented a “grave disability” standard as an alternative to the more rigorous “dangerousness to self standard.” *See, e.g.*, Lanterman-Petris-Short Act, CAL. WELF. & INST. CODE §§ 5008(h)(1), 5150, 5250 (West, Westlaw through 2013-2014 Sess.) (allowing civil commitment for a person who “as a result of a mental disorder, is a danger to others, or to himself, or gravely disabled,” where “gravely disabled” shall mean that the person is “unable to provide for his basic personal needs for food, clothing and shelter”). Other states regarded a “substantial risk” or “likelihood” of serious harm as sufficient to meet the dangerousness requirement. *See, e.g.*, N.Y. MENTAL HYG. LAW § 9.37 (McKinney, Westlaw through 2014 Sess.) (permitting involuntary hospitalization of a person whose mental illness is “likely to result in serious harm to himself or others,” where a “likelihood of serious harm” shall mean: (1) “substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself,” or (2) “a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear or serious physical harm”).

59. *See* 1975 ALA. ACTS 2562, 2566 (Act No. 1226, § 10); CAL. WELF. & INST. CODE §§ 5260, 5300 (West, Westlaw through 2013-2014 Sess.); MASS. GEN. LAWS ANN. ch. 123, § 1 (West, Westlaw through 2014 Sess.); NEB. REV. STAT. ANN. § 71-908 [ME: Law transferred to 71-908](West, Westlaw through 2014 Sess.); N.C. GEN. STAT. § 122C-268 (West, Westlaw through 2014 Sess.); WASH. REV. CODE ANN. § 71.05.020 (West, Westlaw through 2014 Sess.); 1975 WIS. STAT. ANN. § 51.20 (West, Westlaw through 2013 Sess.); *see also* Commonwealth *ex rel.* Finken v. Roop, 339 A.2d 764, 778-79 (1975) (specifying that commitment requires “the commission of some overt act”); *Doremus v. Farrell*, 407 F. Supp. 509, 514-15 (D. Neb. 1975) (holding that due process and equal protection require that “the threat of harm has been evidenced by a recent overt act or threat.”); JOHN PARRY, CIVIL MENTAL DISABILITY LAW, EVIDENCE AND TESTIMONY: A COMPREHENSIVE REFERENCE MANUAL FOR JUDGES AND MENTAL DISABILITY PROFESSIONALS 476-77 (2010) (discussing state trend to eliminate imminence and overt act requirements).

60. *See, e.g.*, CAL. WELF. & INST. CODE §§ 5260(a), 5300 (West, Westlaw through 2013-2014 Sess.); GA. CODE ANN. § 37-3-1(9.1) (West, Westlaw through 2014 Sess.); HAW. REV. STAT. ANN. § 334-60.2 (West, Westlaw, through 2014 Sess.); MONT. CODE ANN. § 53-21-126. (West, Westlaw through 2013 Sess.); OHIO REV. CODE ANN. § 5122.01 (West, Westlaw through 2013-2014 Sess.); VA. CODE ANN. § 37.2-814 (West, Westlaw through 1976).

61. *See, e.g.*, ARIZ. REV. STAT. ANN. §§ 36-536-540 (Westlaw through 2014 Sess.) (providing notice, counsel, hearing); CAL. WELF. & INST. CODE § 5350 (West, Westlaw through 2014 Sess.) (providing notice, counsel, hearing, and jury trial); TEX. REV. CIV. STAT. ANN. art. 5547, §§ 40-57 (Vernon 1958 & Supp. 1978)(providing, at the time, notice, counsel, jury trial, and right to appeal).

In a series of cases beginning with *Rennie v. Klein*⁶² and *Rogers v. Okin*,⁶³ psychiatric inpatients also gained the right to refuse anti-psychotic treatment. Prior to *Rennie* and *Rogers*, hospitals assumed that involuntary commitment extinguished the patient's liberty interests, including the right of a competent person to refuse treatment.⁶⁴ However, in both cases, courts concluded that committed patients were presumptively competent to make treatment decisions.⁶⁵ Therefore, without a legal determination of incompetence, patients could not be medicated, except in an emergency when failing to do so would be likely to result in substantial harm to the patient or others.⁶⁶

3. "Rotting with Their Rights On"

As states began to modify the laws governing inpatient hospitalization, critics argued that the new rules went too far. Psychiatrists began to describe cases in which people with serious mental illnesses were not hospitalized either because they were not "imminently or potentially dangerous," or they lacked suicidal intent.⁶⁷ In a recurrent theme, critics argued that people with serious mental illnesses were in effect "rotting with their rights on."⁶⁸

By the late 1980s, the well-publicized cases of Joyce Brown and Larry Hogue came to symbolize the failures of the public mental health system. Joyce Brown, who preferred the name "Billie Boggs," first appeared on the streets of Manhattan in 1987.⁶⁹ Boggs lived on the corner of Second Avenue and 65th Street, urinating and defecating on the sidewalk, burning dollar bills, and screaming obscenities when assistance was offered.⁷⁰ In October 1987, Ms. Boggs was picked up by a local program designed to remove people with mental illnesses from the streets when their lives were threatened by severe weather and hypothermia.⁷¹ When the program attempted to hospitalize her,

62. 653 F.2d 836 (3d Cir. 1981).

63. 634 F.2d 650 (1st Cir. 1980).

64. *Rennie*, 653 F.2d at 843; *Rogers*, 634 F.2d at 657.

65. *Rennie*, 653 F.2d at 846; *Rogers*, 634 F.2d at 658.

66. *Rennie*, 653 F.2d at 852; *Rogers*, 634 F.2d at 654.

67. See Darold A. Treffert, *Dying with Their Rights on*, 2 PRISM 47, 49 (1974); Paul Chadoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 496 (1976).

68. See Paul Appelbaum, "Rotting with Their Rights On": *Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients*, 7 BULL. AM. ACAD. PSYCHIATRY & L. 306 (1979); Paul S. Appelbaum & Thomas G. Gutheil, *The Boston Hospital Case: "Involuntary Mind Control, The Constitutional Right to Rot."* 75 AM. J. PUB. HEALTH, 722 (1985). Psychiatrists were not uniformly resistant to changes in civil commitment law. Cf., Seymour L. Halleck, *A Troubled View of Current Trends in Forensic Psychiatry*, 2 J. PSYCHIATRY & L. 135, 147 (1974) ("Many of us have long anguished over the power we hold over patients and have welcomed greater community control of that power.").

69. GROB, *supra* note 24, at 302.

70. Jeanie Kasindorf, *The Real Story of Billie Boggs: Was Koch Right or the Civil Libertarians?*, N.Y. MAG., May 2, 1988, at 36, 37.

71. *Id.* at 41.

Ms. Boggs filed a lawsuit with assistance from the New York Civil Liberties Union.⁷²

The psychiatrists who testified during her trial disagreed as to whether Ms. Boggs was mentally ill.⁷³ Even if Boggs were mentally ill, the trial court held that the hospital failed to establish a “substantial risk of physical harm.”⁷⁴ There was no evidence that Boggs was suicidal, and she was able to meet her essential needs for food, clothing, and shelter.⁷⁵ “It cannot be reasoned that because Joyce Brown is homeless[,] she is mentally ill,” the court wrote.⁷⁶ “What must be proved is that because she is mentally ill she is incapable of providing herself with food, clothing, and shelter.”⁷⁷ Boggs used the money she received from panhandling to buy one meal each day, and the doctors for the petitioner agreed that she was not malnourished and in “good physical condition.”⁷⁸

The Appellate Division reversed, finding the trial court’s conclusions as to mental illness to be against the weight of evidence.⁷⁹ In a vigorous dissent, two members of the court agreed that Ms. Boggs was mentally ill but found the evidence on dangerousness to be “highly questionable.”⁸⁰ Ms. Boggs had never assaulted anyone; she stayed warm by lying next to an air vent; and she was never observed to be physically ill.⁸¹ Ms. Boggs was released from the hospital one month later when a court held that she could not be medicated against her will.⁸² Thereafter, Boggs enjoyed a brief stint as a national celebrity. She appeared on *60 Minutes* and *Donahue*, and in February 1988, she appeared as a guest speaker at Harvard Law School.⁸³ Yet only a few weeks later, the symptoms of her psychosis reappeared, and Boggs was once again panhandling on the streets of Manhattan.⁸⁴

Several years later, Larry Hogue gained notoriety among New Yorkers as “the Wild Man of 96th Street.”⁸⁵ Hogue epitomized the revolving door problem

72. *Id.* at 37.

73. *In re Boggs*, 522 N.Y.S.2d 407, 410 (N.Y. Sup. Ct. 1987).

74. *Id.* at 411.

75. *Id.* at 412.

76. *Id.*

77. *Id.*

78. *Id.*

79. *Boggs v. N.Y.C. Health & Hosp. Corp.*, 523 N.Y.S.2d 71, 86 (N.Y. App. Div. 1987).

80. *Id.* at 91.

81. *Id.* at 92.

82. *See Matter of Boggs*, 70 N.Y.2d 981 (1988); Josh Barbanell, *Joyce Brown Obtains a Ban On Medicine*, N.Y. TIMES, Jan. 16, 1988, at 29.

83. Kasindorf, *supra* note 71, at 44.

84. Rick Hampson, *After a Brief Encounter with Fame, Homeless Billie Boggs Fades Away*, FREE LANCE STAR, June 3, 1991, at 17.

85. Leigh Remizowski et al., *The Wild Man of 96th St., Larry Hogue, Caught by Police on Upper West Side*, N.Y. DAILY NEWS, May 30, 2009, http://articles.nydailynews.com/2009-05-30/local/17922790_1_96th-larry-hogue-drug-habit.

and, for opponents of civil commitment reform, his case also underscored the need for an outpatient commitment law.⁸⁶ For years, Hogue terrorized New Yorkers on Manhattan's Upper West Side by siphoning gasoline from parked cars, igniting newspapers soaked with gas, and then stuffing them into tailpipes.⁸⁷ Over the years, witnesses also observed Hogue jumping into oncoming traffic and threatening people on the street with a nail-studded club.⁸⁸ In 1988, Hogue was convicted of reckless endangerment for pushing a teenage girl in front of an oncoming truck.⁸⁹ Yet because these incidents never resulted in serious injury, Hogue never spent more than a year in jail.⁹⁰ As a patient at Creedmoor Hospital, Hogue was diagnosed with bipolar disorder, crack addiction, and a traumatic brain injury.⁹¹ According to his doctors, when Hogue was hospitalized and no longer abusing drugs, he was calm and amiable. Yet, when he was no longer a danger to others, hospitals could no longer hold him against his will.⁹² Following his release, Hogue would inevitably stop taking his medications and revert to using drugs, leading him to behave in ways that once again rendered him a danger to himself and others and subject him to rehospitalization.⁹³

By the early 1990s, the idea for an outpatient commitment law was already well underway in the New York State Legislature. In 1994, the Legislature established a pilot outpatient commitment program at Bellevue Hospital in lower Manhattan.⁹⁴ In a twist of fate, Andrew Goldstein visited the psychiatric emergency room of Bellevue Hospital on at least two occasions in 1998, during the tenure of the pilot program, complaining of auditory hallucinations and sleep deprivation.⁹⁵ After a few days in the hospital, Goldstein was released.⁹⁶ A subsequent investigation into the quality of care Andrew Goldstein received found that Goldstein repeatedly sought help for hallucinations and delusions.⁹⁷ In the two-year period between early 1997 and January 1999, Goldstein voluntarily admitted himself to state hospitals no fewer than thirteen times.⁹⁸

86. E. Fuller Torrey, "The System Is Crazier Than He Is," CITY JOURNAL (1998).

87. Seltzer v. Hogue, 594 N.Y.S.2d 781, 782 (N.Y. App. Div. 1993).

88. Remizowski, *supra* note 85.

89. Richard Perez-Pena, *Crack Addict Found Able to Face Trial*, N.Y. TIMES, Dec. 8, 1992, at B3.

90. *Id.*

91. *Hogue*, 594 N.Y.S.2d at 783.

92. Richard Perez-Pena, *Mentally Ill Man Who Abused Drugs Is Freed*, N.Y. TIMES, Feb. 5, 1993, Sec. B2.

93. GROB, *supra* note 24, at 304.

94. N.Y. MENTAL HYG. LAW § 41.55 (McKinney, Westlaw through 2014 Sess.).

95. See Michael Winerip, *Bedlam on the Streets*, N.Y. TIMES, May 23, 1999, at 42.

96. *Id.*

97. N.Y. STATE COMM'N ON QUALITY OF CARE FOR THE MENTALLY DISABLED, IN THE MATTER OF DAVID DIX: A REPORT BY THE NEW YORK STATE COMMISSION ON QUALITY OF CARE FOR THE MENTALLY DISABLED AND THE MENTAL HYGIENE MEDICAL REVIEW BOARD (1999).

98. *Id.*

On more than one occasion, Goldstein requested long-term hospitalization at Creedmoor.⁹⁹ However, more often than not, he was turned down. Under tremendous pressure to cut costs and reduce the number of inpatients, the hospital could do little more than place Goldstein on a waiting list.

Several months later, in January 1999, Andrew Goldstein pushed Kendra Webdale in front of an oncoming subway train. In Albany, former Attorney General Elliot Spitzer seized the opportunity to create a permanent outpatient commitment program in New York. In a statement to the press, Spitzer alluded to the problems associated with deinstitutionalization:

It is clear that the law must be changed to protect both the public and the mentally ill from danger The movement to deinstitutionalize has proven to be a double-edged sword. Most individuals can and do function well in society, but others with severe mental illness who are not taking their prescribed medication can be a serious threat to themselves and the public.¹⁰⁰

Three months later Julio Perez, a homeless man suffering from paranoid schizophrenia, pushed Edgar Rivera into the path of an oncoming train, severing both of his legs.¹⁰¹ According to his attorney, Perez harbored a delusional belief that a conspiratorial network of Mexican assassins was trying to kill him. Perez pushed Rivera, believing Rivera to be part of that network.¹⁰² In recent years, the shootings in Newtown, Connecticut and Isla Vista, California have led to a renewed interest in preventive outpatient treatment.¹⁰³

B. Preventive Outpatient Commitment

Preventive outpatient commitment is only one of at least three types of outpatient commitment. The first, conditional release, applies to patients who have been hospitalized and released on the condition that they will comply with a treatment plan in the community. Outpatient commitment might also be used as a less restrictive alternative to hospitalization for patients who meet the criteria for inpatient commitment but who can be treated safely in the

99. *Id.*

100. Eliot Spitzer, *Is Kendra's Law the Answer?; Yes; Adversary System*, 221 N.Y. L.J. 1 (1999); Press Release, N.Y. State Office of the Attorney Gen., Spitzer Proposes Mental Illness Legislation (Jan. 28, 1999), <http://www.ag.ny.gov/press-release/spitzer-proposes-mental-illness-legislation>; see also Press Release, N.Y. State Office of the Attorney Gen., Speaker Silver Joins Attorney General Spitzer in Calling for Passage of Kendra's Law, <http://www.ag.ny.gov/press-release/speaker-silver-joins-attorney-general-spitzer-calling-passage-kendras-law>.

101. Andrew Jacobs, *Man Is Pushed in the Subway and Loses Legs*, N.Y. TIMES, Apr. 29, 1999, at A1.

102. The Associated Press, *Jury Finds Subway Pusher Guilty of Attempted Murder*, N.Y. TIMES, Oct. 22, 2000, at 239.

103. See, e.g., Becker, *After Newtown, supra* note 7; *Conn. Debates Mandatory Outpatient Treatment for Mentally Ill* (NPR Broadcast, Jan. 29, 2013); Siobhan Hughes, *Isla Vista Rampage Reanimates Debate over Mental-Health Bill*, WALL ST. J., May 28, 2014, <http://online.wsj.com/articles/isla-vista-rampage-reanimates-debate-over-mental-health-bill-1401321183>.

community nonetheless. Preventive outpatient commitment laws are a third, and far more controversial, form of commitment. Preventive outpatient commitment laws require people with mental illnesses to participate in treatment even though they do not meet the criteria for inpatient commitment. Part II provides a brief description of three well-known preventive outpatient commitment statutes in New York, California, and North Carolina.

1. New York

a. Mechanics

Under Kendra's Law a court may order a person who is eighteen years of age or older to comply with an assisted outpatient treatment plan if the court finds by clear and convincing evidence that the subject of the treatment plan meets the following criteria. He or she must be suffering from a mental illness and "unlikely to survive safely in the community without supervision, based on a clinical determination."¹⁰⁴ The court must also find that a history of treatment noncompliance has either: (i) been a significant factor leading to hospitalization at least twice within the last thirty-six months, or (ii) resulted in one or more acts of violent behavior toward self or others within the last forty-eight months, or at least a threat or attempt at serious physical harm to self or others within the last forty-eight months.¹⁰⁵ In addition, the petitioner must provide clear and convincing evidence that the subject of the petition is unlikely to participate in outpatient treatment voluntarily "as a result of his or her mental illness."¹⁰⁶ Assisted outpatient treatment must be necessary to prevent a relapse or deterioration, "which would be likely to result in serious harm to the person or others."¹⁰⁷ Finally, the person must be likely to benefit from treatment, and assisted outpatient treatment must be the least restrictive form of treatment available.¹⁰⁸ In some states, an assisted outpatient treatment order requires evidence that the person lacks the capacity to make a treatment decision.¹⁰⁹ However, Kendra's Law does not include an incapacity requirement.¹¹⁰

104. N.Y. MENTAL HYG. LAW § 9.60(c)(2)-(3) (McKinney, Westlaw through 2014 Sess.).

105. *Id.* § 9.60(c)(4)(i)-(ii).

106. *Id.* § 9.60(c)(5).

107. *Id.* § 9.60(c)(6).

108. *Id.* § 9.60(c)(7), (h)(4).

109. *See, e.g.*, HAW. REV. STAT. § 334-121(5) (West, Westlaw through 2014 Sess.) (requiring evidence that "[t]he person's current mental status or the nature of the person's disorder limits or negates the person's ability to make an informed decision to voluntarily seek or comply with recommended treatment"); N.C. GEN. STAT. ANN. § 122C-271(a) (West, Westlaw through 2014 Sess.) (permitting outpatient commitment if the person's mental illness "limits or negates his ability to make an informed decision to seek voluntarily or comply with recommended treatment").

110. The absence of an incapacity or incompetence requirement in Kendra's Law has been the subject of considerable controversy. *See infra* note 187 and accompanying text.

Kendra's Law limits the class of persons who may petition for assisted outpatient treatment to the following: (i) persons eighteen years of age or older with whom the subject of the petition resides; (ii) the parent, spouse, sibling or child of the subject of the petition; (iii) the director of a hospital in which the subject of the petition is hospitalized; (iv) the director of a charitable organization; or (v) a qualified psychiatrist or psychologist.¹¹¹ Petitions for assisted outpatient treatment must be accompanied by an affirmation or affidavit from a physician—other than the petitioner—stating that he or she has personally examined the subject of the petition no more than ten days prior to submitting the petition, recommends assisted outpatient treatment, and is able to testify during a hearing on the petition.¹¹²

In New York, involuntary hospitalization requires a finding that the subject of a petition for inpatient commitment presents “a substantial risk of physical harm” to self or others.¹¹³ By contrast, Kendra's Law permits outpatient commitment, largely on the ground that treatment noncompliance has led to multiple hospitalizations and without outpatient commitment, the person is likely to decompensate, becoming a danger to himself or others. The result is that the subject of an AOT petition can be ordered to comply with treatment, even though at present he or she does not present a substantial risk of physical harm to self or others. If the subject of the petition meets the criteria for AOT, the court may order assisted outpatient treatment for up to one year.¹¹⁴ Thirty days prior to the expiration of an AOT order, the petitioner may seek continued assisted outpatient treatment for up to one year.¹¹⁵

Under Kendra's Law, a court may order a person to self-administer psychotropic drugs or accept the administration of such drugs by authorized personnel.¹¹⁶ However, like most outpatient commitment statutes, Kendra's Law does not authorize forced administration of medication over the patient's objection.¹¹⁷ If a patient refuses to comply with any aspect of the AOT order, and a physician determines that the patient may be in need of involuntary

111. N.Y. MENTAL HYG. LAW §§ 9.60(e)(1)(i)-(vi) (McKinney, Westlaw through 2014 Sess.).

112. *Id.* § 9.60(e)(3)(i).

113. N.Y. MENTAL HYG. LAW §§ 9.37(a)(1)-(2) (McKinney, Westlaw through 2014 Sess.).

114. N.Y. MENTAL HYG. LAW § 9.60(k) (McKinney, Westlaw through 2014 Sess.).

115. *Id.*

116. *Id.* § 9.60(h)(i).

117. If a person requires medication, a clinician may petition the court for an order to administer medication over his or her objection. The court will schedule a “*Rivers* hearing” to determine whether the person lacks the capacity to make a treatment decision. If the court concludes that the person lacks the capacity to make a treatment decision, the court must determine whether “the proposed treatment is narrowly tailored to give substantive effect to the patient's liberty interest, taking into consideration all relevant circumstances, including the patient's best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments.” *Rivers v. Katz*, 67 N.Y.2d 485, 497 (N.Y. 1986). The state bears the burden to establish each of these elements by clear and convincing evidence.

hospitalization, patients may be removed from the community and detained in a hospital where they can be held for up to seventy-two hours to determine whether they meet the criteria for inpatient civil commitment.¹¹⁸

b. Program Implementation

New York spends about \$32 million dollars each year on the assisted outpatient treatment program.¹¹⁹ In addition to funding the AOT Program, New York spends \$125 million dollars each year on enhanced community services to benefit people in the AOT program as well as people who received voluntary mental health services outside of the AOT program.¹²⁰

According to the New York State Office of Mental Health, 12,421 New Yorkers have been ordered to participate in the assisted outpatient treatment program since the program began in November 1999.¹²¹ A large majority of AOT cases (70%) are concentrated in New York City, and the vast majority of AOT petitions (84%) are filed before the subject of the petition has been discharged from the hospital.¹²² Nineteen percent of AOT orders are in place for six months or less, 81% of AOT orders are in place for six months or more and 23% of AOT orders are in place for thirty months or more.¹²³ Most AOT recipients are men—of whom about half are white, 21% are African American and 30% are Hispanic. Three-quarters of AOT recipients have been diagnosed with schizophrenia; 20% have a diagnosis of bipolar disorder,¹²⁴ and a sizeable number (43%) have a comorbid substance abuse disorder.¹²⁵

118. N.Y. MENTAL HYG. LAW § 9.60(n); *see also* SAFE Act, *supra* note 7 (strengthening state gun control laws by: (i) extends Kendra's Law for two years from its original sunset date of June 30, 2015 to June 30, 2017; (ii) extends the maximum duration of an initial AOT order from 6 months to 1 year; (iii) mandates a review by the local director of community services within 30 days prior to the expiration of an AOT order; (iv) authorizes AOT treatment order across county lines; and (v) requires a clinical assessment for an inmate committed to a state correctional facility from a psychiatric hospital prior to discharge).

119. Spending on the AOT Program includes \$9.55 million on case managers, \$15 million for a medication grant program, \$4.4 million for prison and jail discharge managers, \$2.4 million for AOT oversight programs, and \$0.65 million on drug monitoring. MARTIN S. SWARTZ ET AL., NEW YORK STATE ASSISTED OUTPATIENT TREATMENT PROGRAM EVALUATION 46 (2009), *available at* <http://www.omh.ny.gov>.

120. *Id.* The New York State Office of Mental Health has used those funds to increase the number of assertive community treatment teams and intensive case managers, while also developing a Single Point of Access Program (SPOA).

121. N.Y. OMH AOT REPORTS, <http://bi.omh.state.ny.us/aot/characteristics> (last visited Dec. 31, 2014).

122. MARTIN S. SWARTZ ET AL., NEW YORK STATE ASSISTED OUTPATIENT TREATMENT PROGRAM EVALUATION 6 (2009), *available at* <http://www.omh.ny.gov>.

123. N.Y. OMH AOT REPORTS, <http://bi.omh.ny.gov/aot/statistics?p=time-in-aot> (last visited June 20, 2014).

124. N.Y. OMH AOT REPORTS, <http://bi.omh.ny.gov/aot/characteristics?p=diagnosis-diagnosis> (last visited June 20, 2014).

125. N.Y. OMH AOT REPORTS, <http://bi.omh.ny.gov/aot/characteristics?p=diagnosis-alcohol-sub-abuse> (last visited June 20, 2014).

2. California

Like Kendra's Law, California's outpatient commitment statute—known as Laura's Law—was passed in response to an act of violence. The State Legislature named Laura's Law in memory of Laura Wilcox, a nineteen-year-old college sophomore, who was volunteering at a mental health clinic in Nevada City, California, when Scott Thorpe entered the clinic and opened fire.¹²⁶ Thorpe shot and killed Wilcox and another volunteer and then drove to a restaurant where he shot and killed the manager.¹²⁷ Scott Thorpe had a long history of mental illness, including a delusional belief that the FBI was trying to poison him and compel him to see an incompetent psychiatrist.¹²⁸

Laura's Law was modeled on Kendra's Law, and most of the criteria for issuing an assisted outpatient treatment order are the same. Under Laura's Law, a court may order a person to comply with an assisted outpatient treatment order if it finds by clear and convincing evidence that the person is: (i) eighteen years of age or older; (ii) suffering from a mental illness; and (iii) unlikely to survive safely in the community without supervision.¹²⁹ The petitioner must also establish that a history of treatment noncompliance has resulted either in (i) hospitalization or treatment at least twice within the last thirty-six months or (ii) one or more acts of serious and violent behavior toward self or others (or threats or attempts at such acts) within the last forty-eight months.¹³⁰ Like Kendra's Law, the subject of a court order must be likely to benefit from assisted outpatient treatment, and the petitioner must establish that treatment is necessary to prevent a relapse or deterioration.¹³¹

Laura's Law also includes several requirements that are far more restrictive than Kendra's Law. To qualify for an assisted outpatient treatment order under Laura's Law, the petitioner must establish that the person's condition is "substantially deteriorating,"¹³² while Kendra's Law only requires evidence that the person is likely to deteriorate without outpatient treatment.¹³³ Similarly, Kendra's Law requires evidence that the person is unlikely to participate in outpatient treatment voluntarily,¹³⁴ however, Laura's Law requires evidence that the person has actually been given the opportunity to participate in outpatient treatment program and failed to do so.¹³⁵ In contrast to

126. Logan Jenkins, *As County Considers Laura's Law A Mother Reflects*, UNION-TRIB. SAN DIEGO, Mar. 8, 2013, <http://www.utsandiego.com/news/2013/mar/08/laura-law-county-nevada>.

127. Editorial, *Why It's Called Laura's Law*, S.F. CHRON., May 1, 2002, at A20.

128. *Id.*

129. CAL. WELF. & INST. CODE §§ 5346(a)(1)-(3) (West, Westlaw through 2014 Sess.).

130. *Id.* §§ 5346(a)(4)(A), (B).

131. *Id.* §§ 5346(a)(8)-(9).

132. *Id.* § 5346(a)(6).

133. N.Y. MENTAL HYG. LAW § 9.60(c)(6) (McKinney, Westlaw through 2014 Sess.).

134. *Id.* § 9.60(c)(5).

135. CAL. WELF. & INST. CODE § 5346(a)(6).

Kendra's Law, friends, family members, and clinicians may ask the county mental health department to petition a court for outpatient treatment, but only the county mental health director, or a designee, may file the petition.¹³⁶

Laura's Law was passed in 2002 and signed into law by Governor Gray Davis. Yet the statute only applies in counties where the board of supervisors authorizes the implementation of Laura's Law.¹³⁷ Laura's Law imposes a long list of requirements on any county that wants to create an assisted outpatient treatment program. In order to create an AOT program, counties must provide mobile mental health teams with high staff-to-client ratios of no more than ten clients per provider, develop plans for outreach to families with severely mentally ill adults, and develop a plan for housing clients.¹³⁸ Counties must provide services for seriously mentally ill adults who are under twenty-five years old and at risk of homelessness, as well as culturally appropriate services for women from diverse ethnic backgrounds, including supportive housing that accepts children, substance abuse programs that address gender specific trauma, and vocational programs that are sensitive to the needs of women.¹³⁹

Further, any county that provides assisted outpatient treatment under Laura's Law must provide the same services to persons who seek them voluntarily.¹⁴⁰ Counties must also show that voluntary mental health services will not be reduced by creating an assisted outpatient treatment program.¹⁴¹ Counties can use state mental health funds to implement Laura's Law.¹⁴² However, in contrast to New York, where the passage of Kendra's Law coincided with an annual infusion of \$157 million dollars into the state mental health budget, California has not made new funds available to implement Laura's Law, and the mental health budget in California is substantially underfunded.¹⁴³ Of California's fifty-eight counties, thus far, only Nevada County (where Laura Wilcox lived), San Francisco County, Orange County, and Los Angeles County have implemented assisted outpatient treatment programs.¹⁴⁴

136. *Id.* § 5346(b)(1).

137. CAL. WELF. & INST. CODE § 5348(a) (West, Westlaw through 2014 Sess.).

138. *Id.* §§ 5348(a)(1), (2)(B).

139. *Id.* §§ 5348(a)(2)(H)-(I).

140. *Id.* § 5348(b).

141. CAL. WELF. & INST. CODE § 5349 (West, Westlaw through 2014 Sess.).

142. *Id.*

143. See Paul S. Appelbaum, *Ambivalence Codified: California's New Outpatient Commitment Statute*, 54 PSYCHIATRIC SERVICES 26, 27 (2003) (characterizing Laura's Law as "a sham").

144. Jill Cowan & Paloma Esquivel, *Addressing the Mentally Ill: O.C. is the First Large County in California to Implement Laura's Law*, L.A. TIMES, May 14, 2014, at AA.1; Abby Sewell, *L.A. County to Expand Laura's Law Mental-Illness Treatment Program*, L.A. TIMES, July 15, 2014, <http://www.latimes.com/local/countygovernment/la-me-lauras-law-20140716-story.html>.

3. North Carolina

Long before New York and California established their outpatient commitment programs, North Carolina became the first state to enact a preventive outpatient commitment statute in 1983.¹⁴⁵ Under the North Carolina statute, any person who knows an individual to be mentally ill and a danger to himself or others and in need of treatment may petition a court for an order to take the person into custody for an examination by a psychologist or a physician.¹⁴⁶ If the person meets the criteria for outpatient commitment, the examiner may recommend outpatient commitment and notify the court.¹⁴⁷ Unless the person also meets the criteria for inpatient commitment, the person must be released from custody and returned to his or her home.¹⁴⁸

A North Carolina court may order outpatient treatment if it finds by clear, cogent, and convincing evidence that the person is (i) mentally ill; (ii) capable of surviving safely in the community with supervision; and (iii) needs treatment to prevent further disability or deterioration which would “predictably result in dangerousness.”¹⁴⁹ Unlike most states, the North Carolina outpatient commitment statute contains an incapacity requirement. An outpatient commitment order under North Carolina law requires evidence that the person’s mental illness “limits or negates his ability to make an informed decision to seek voluntarily or comply with recommended treatment.”¹⁵⁰ If a person refuses to comply with an outpatient treatment plan, providers are required to make “all reasonable effort” to encourage cooperation.¹⁵¹ The person may be taken into custody to determine whether he or she meets the criteria for inpatient commitment.¹⁵²

North Carolina does not permit medication by force without evidence of an immediate danger to self or others.¹⁵³ However, patients might believe they will be forced to take their medications nonetheless. In a study of 306 outpatients in North Carolina, 82.7% of respondents believed that they were required to take their medications, even though North Carolina law does not

145. Erica F. King, *Outpatient Civil Commitment in North Carolina: Constitutional and Policy Concerns*, 58 LAW & CONTEMP. PROBS. 251 (1995).

146. See N.C. GEN. STAT. ANN. § 122C-261(a) (West, Westlaw through 2014 Sess.) (requiring that once the person has been admitted to a hospital, an examination must take place within twenty-four hours); N.C. GEN. STAT. ANN. § 122C-267(a) (West, Westlaw through 2014 Sess.) (requiring that a hearing must take place no more than ten days after the person was initially taken into custody).

147. N.C. GEN. STAT. ANN. § 122C-264(a) (West, Westlaw through 2014 Sess.).

148. N.C. GEN. STAT. ANN. § 122C-263(d) (West, Westlaw through 2014 Sess.).

149. *Id.*

150. N.C. GEN. STAT. ANN. § 122C-271(a)(1) (West, Westlaw through 2014 Sess.).

151. N.C. GEN. STAT. ANN. § 122C-273(a)(1) (West, Westlaw through 2014 Sess.).

152. N.C. GEN. STAT. ANN. § 122C-273(a)(2).

153. N.C. GEN. STAT. ANN. § 122C-273(a)(3).

authorize providers to force medication over an outpatient's objection.¹⁵⁴ As the authors note, outpatients may have believed that they can be forced to comply with medication since they may have observed or experienced forced medication in an inpatient setting.¹⁵⁵

C. *Empirical Research on Effectiveness*

The moral limits on our ability to intervene in the lives of people with mental illnesses before they harm themselves or others are the primary subject matter of this Article. Parts IV and V explore that terrain. Before turning to those questions, I shall briefly summarize debates on the effectiveness of outpatient commitment and the constitutional legitimacy of these laws in Parts II.C and II.D. Although the major contribution of this Article is not to resolve either of those debates, understanding each of them frames the normative discussion in which I engage.

After two generations of research on involuntary outpatient commitment, the empirical evidence on effectiveness is mixed at best.¹⁵⁶ However, recent studies suggest that participation in a well-funded outpatient commitment program may be associated with significant benefits for people with mental illnesses, including fewer hospitalizations, shorter hospital stays, and a greater likelihood of receiving appropriate psychotropic medications. I am willing to assume that outpatient commitment laws are associated with these benefits. Nonetheless, in Part IV, I argue that the special respect we owe to persons as moral agents prevents us from trading their liberties for mere gains in utility.

1. Randomized Controlled Trials

There have been three randomized controlled trials of outpatient commitment. In the Duke Mental Health Study, 331 involuntarily hospitalized patients, who were awaiting discharge on an outpatient commitment order in North Carolina, were randomly assigned to receive outpatient commitment or have their commitment order dismissed.¹⁵⁷ Patients in both groups were given

154. Randy Borum et al., *Consumer Perceptions of Involuntary Outpatient Commitment*, 50 PSYCHIATRIC SERVICES 1489 (1999).

155. *Id.* at 1490. Critics of outpatient commitment argue that failing to educate patients on the consequences of treatment noncompliance violates basic principles of informed consent. See, e.g., BRUCE J. WINICK, CIVIL COMMITMENT, A THERAPEUTIC JURISPRUDENCE MODEL, 254 (2005) (characterizing the approach as "subterfuge."); Michael A. Hoge & Elizabeth Grottole, *The Case Against Outpatient Commitment*, 28 J. AM. ACAD. PSYCHIATRY & L. 165, 167 (2000).

156. See M. SUSAN RIDGELY, ET AL., RAND HEALTH: RAND INSTITUTE FOR CIVIL JUSTICE, THE EFFECTIVENESS OF INVOLUNTARY OUTPATIENT TREATMENT: EMPIRICAL EVIDENCE AND THE EXPERIENCE OF EIGHT STATES 17-22 (2001) (summarizing early research on outpatient commitment).

157. Marvin S. Swartz et al., *A Randomized Controlled Trial of Outpatient Commitment in North Carolina*, 52 PSYCHIATRIC SERVICES 325 (2001).

case managers and outpatient treatment at one of four area mental health programs. Researchers found that when the duration of the outpatient commitment order was not taken into account, the outcomes of interest—hospital readmissions, hospital days, and violent behavior—did not differ significantly between the control group and the experimental group.¹⁵⁸ The study also found that patients who had extended periods of outpatient commitment (180 days or more) and intensive outpatient treatment (seven service days per month on average) had 57% fewer hospital readmissions and twenty fewer hospital days per month when compared to the control group.¹⁵⁹ The study found a similar relationship between outpatient commitment and violence. Outpatient commitment did not reduce the risk of violence among patients with fewer than three service visits per month. However, patients with sustained outpatient commitment orders of 180 days or more and three or more service visits per month were significantly less likely to be violent (twenty-four versus forty-eight percent).¹⁶⁰ While a court order alone cannot improve patient outcomes, the researchers hypothesized that court orders might have worked by incentivizing providers to prioritize treatment and motivating patients to comply.¹⁶¹

The methods employed by the Duke Mental Health Study had some limitations. For example, the researchers used a stringent adherence protocol in which sheriffs obtained pick-up orders for patients who missed three or more consecutive appointments and clinicians promptly rescheduled missed appointments.¹⁶² However, enforcement of outpatient commitment orders may be less rigorous in practice, thereby limiting the generalizability of their findings to non-clinical settings.¹⁶³

The second randomized controlled trial of outpatient commitment took place at Bellevue Hospital in New York.¹⁶⁴ Seventy-eight patients were randomly assigned to receive assisted outpatient treatment, and sixty-four patients were assigned to a control group in which they did not receive court

158. *Id.* at 327.

159. *Id.*

160. *Id.*; see also Jeffrey W. Swanson et al., *Involuntary Out-patient Commitment and Reduction in Violent Behaviour in Persons with Severe Mental Illness*, 176 BRIT. J. PSYCHIATRY 324 (2000); Swartz et al., *supra* note 158, at 326.

161. *Id.* at 329 n.157.

162. Virginia Aldigé Hiday et al., *Impact of Outpatient Commitment on Victimization of People with Severe Mental Illness*, 159 AM. J. PSYCHIATRY 1403, 1405 (2002).

163. Further, although patients were randomly assigned to the outpatient commitment group or the control group, the amount of time on outpatient commitment was not randomly assigned. Patients who no longer met the criteria for outpatient commitment did not have their orders renewed. However, since patients with a greater risk of poor outcomes were more likely to have their outpatient commitment orders renewed, any selection effects would have reduced the likelihood of finding a positive effect for outpatient commitment. See also, George Szmukler & Matthew Hotopf, *Effectiveness of Involuntary Outpatient Commitment*, 158 AM. J. PSYCHIATRY 653 (2001) (offering a critique of the Duke Mental Health Study).

164. Henry J. Steadman et al., *Assessing the New York City Involuntary Outpatient Commitment Pilot Program*, 52 PSYCHIATRIC SERVICES 330 (2001).

ordered treatment.¹⁶⁵ Both groups received case management, psychiatric aftercare, and a residential placement. If a patient was in the assisted outpatient treatment group, the treatment plan was formalized by a court order. In contrast to the Duke Study, after a twelve month follow-up, the Bellevue Study found no statistically significant differences between the AOT group and the non-AOT group across all outcomes, namely rehospitalization rates, hospital days, arrest rates, quality of life, and psychiatric symptoms.¹⁶⁶ Nor did service providers note significant differences in treatment adherence between the two groups.¹⁶⁷ Like the Duke Study, however, the methods used in the Bellevue Study had several disadvantages. For example, AOT orders were not consistently enforced in the Bellevue Study which might have diminished some of the difference between the AOT group and the non-AOT group.¹⁶⁸

Even if outpatient commitment orders were effective, a systematic review by the Cochrane Collaboration highlighted a further concern: the numbers needed to treat in order to produce such an effect might be unacceptably high.¹⁶⁹ The Cochrane Collaboration conducted a meta-analysis of randomized controlled trials of outpatient commitment for people with mental disorders. At the time, there were only two—the Duke Mental Health Study and the Bellevue Study. The authors concluded that outpatient commitment orders were not an effective alternative to voluntary treatment since courts would have to issue eighty-five outpatient commitment orders to prevent one hospital readmission, twenty-seven outpatient commitment orders to prevent one episode of homelessness, and 238 outpatient commitment orders to prevent one arrest.¹⁷⁰

Findings from a third trial of outpatient commitment in England and Wales have reignited the debate over the effectiveness of outpatient commitment orders in the United States.¹⁷¹ Participants in the Oxford Community Treatment Order Evaluation Trial (OCTET) were randomly assigned to an experimental group, which included a community treatment order (CTO) or treatment as

165. *Id.* at 331.

166. *Id.* at 332-33.

167. *Id.* at 330.

168. *Id.* at 335; see also Howard Telson, *Outpatient Commitment in New York: From Pilot Program to State Law*, 11 GEO. MASON U. C.R. L.J. 41 (2000) (offering a detailed discussion and criticism of the pilot program).

169. STEVE R. KISLEY, LESLIE A. CAMPBELL & NEIL J. PRESTON, THE COCHRANE COLLABORATION, COMPULSORY COMMUNITY AND INVOLUNTARY OUTPATIENT TREATMENT FOR PEOPLE WITH SEVERE MENTAL DISORDERS 19 (2011), Cochrane Database of Systematic Reviews 2011, Issue 2, Article No. CD004408, DOI: 10.1002/14651858.CD004408.pub3.

170. *Id.* at 2.

171. See, e.g., Jeffrey Swanson & Marvin Swartz, *Why the Evidence for Outpatient Commitment Is Good Enough*, 65 PSYCHIATRIC SERVICES 808 (2014) (commenting on OCTET); TREATMENT ADVOC. CENTER, NO RELEVANCE TO ASSISTED OUTPATIENT TREATMENT (AOT) IN THE OCTET STUDY OF ENGLISH COMPULSORY TREATMENT, <http://www.treatmentadvocacycenter.org/storage/documents/Research/may2013-octet-study.pdf>.

usual (i.e., a “leave of absence” under Section 17 of the Mental Health Act).¹⁷² A Section 17 leave of absence allows patients to leave the hospital for days or weeks, with less monitoring, while remaining subject to recall. Community treatment orders resemble outpatient commitment orders in the U.S. insofar as CTOs can direct patients to take medications outside of the hospital and subject patients to intensive monitoring, but they do not authorize clinicians to administer medications by force.¹⁷³ The primary outcome of interest was whether patients were readmitted to a hospital during the twelve-month study period. The study found no statistically significant differences between patients on community treatment orders and patients on a leave of absence, with respect to hospitalization rates, time to readmission, and hospital days over the twelve-month study period.¹⁷⁴

The results from the OCTET evaluation have also been challenged on methodological grounds. Critics argue that OCTET was not adequately designed to determine whether outpatient commitment orders are more effective than voluntary treatment for people with mental illnesses.¹⁷⁵ The control condition in OCTET was a Section 17 leave of absence, not voluntary treatment. A Section 17 leave in the United Kingdom involves supervised community treatment, including clinical monitoring and the power to recall patients to the hospital, therefore it is not surprising that the study did not find statistically significant differences between the control condition and community treatment orders.¹⁷⁶

2. Observational and Quasi-Experimental Designs

Supporters of outpatient commitment argue that the findings from a 2009 evaluation of the assisted outpatient treatment program in New York are sufficient to demonstrate that court ordered treatment is probably more effective for hard-to-reach populations than voluntary services alone. The study, led by Marvin Swartz and Jeffrey Swanson, compared people who received assertive community treatment with a court order to people who received assertive community treatment without a court order.¹⁷⁷ Among

172. Tom Burns et al., *Community Treatment Orders for Patients with Psychosis (OCTET): A Randomised Controlled Trial*, 381 LANCET 1627 (2013).

173. *Id.* at 1629.

174. *Id.* at 1631.

175. *See, e.g.*, Swanson & Swartz, *supra* note 171 (discussing a critique of the methods used in OCTET).

176. *Id.* at 810.

177. MARVIN S. SWARTZ ET AL., NEW YORK STATE ASSISTED OUTPATIENT TREATMENT PROGRAM EVALUATION (2009), available at <http://www.omh.ny.gov>; Assertive Community Treatment (ACT) Teams provide treatment and intensive case management for patients in the community. ACT Teams are interdisciplinary teams of ten to twelve professionals, including a case manager, a psychiatrist, a social worker, nurses, vocational, and substance abuse counselors and peer counselors. DEP'T OF HEALTH AND HUMAN SERVICES: U.S. PUBLIC HEALTH SERV., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 286-87 (1999).

people who received assertive community treatment in the AOT program for twelve months or more, hospitalizations were reduced by about one-half—from seventy-four percent at baseline to thirty-six percent.¹⁷⁸ By contrast, among people who only participated in assertive community treatment without a court order, psychiatric hospitalizations were reduced by about one-third—from sixty-three percent at baseline to fifty-eight percent after twelve months.¹⁷⁹

Swartz and Swanson also asked whether AOT recipients were less likely to be hospitalized and more likely to receive appropriate medications when compared with their own experience before participating in the assisted outpatient treatment program. Researchers examined Medicaid data, hospital records and case manager reports for 2839 people who were enrolled in the AOT program and Medicaid at any time between January 1999 and March 2007.¹⁸⁰ The study found that participation in the AOT program was associated with a substantial reduction in the probability of a psychiatric hospitalization and the number of days hospitalized. The probability of a psychiatric hospitalization for the average AOT recipient dropped from fourteen percent prior to AOT to eleven percent during the first six months of AOT, and to nine percent during the next seven to twelve months of AOT.¹⁸¹ The study reported similar reductions in the average duration of a hospital stay—from eighteen days before AOT to eleven hospital days during the first six months of AOT and ten hospital days during the next seven to twelve months of AOT.¹⁸² By examining Medicaid claims data and the dates when prescriptions were filled, researchers were also able to calculate the proportion of days in each month that AOT recipients would have had an adequate supply of medication. The percentage of AOT recipients who had an adequate supply of medication during eighty percent of the month or more increased from thirty-five percent prior to AOT to forty-four percent during the first six months of AOT and then to fifty percent during the next seven to twelve months of AOT.¹⁸³

The same 2009 study by Swartz and Swanson found that people who participated in the AOT program were less likely to be arrested than their counterparts in voluntary treatment.¹⁸⁴ If AOT orders were kept in place for six months or more, AOT recipients were more likely to have the right medications and less likely to be hospitalized, even after the court order ended.¹⁸⁵

178. SWARTZ ET AL., *supra* note 177, at 27.

179. *Id.*

180. *Id.* at 28.

181. *Id.* at 29.

182. *Id.* at 30.

183. *Id.* at 31.

184. *Id.* at 23; *see also* Allison R. Gilbert et al., *Reductions in Arrest Under Assisted Outpatient Treatment in New York*, 61 PSYCHIATRIC SERVICES 996 (2010).

185. SWARTZ ET AL., *supra* note 177, at 39-41; *see also* Richard A. Van Dorn, *Continuing Medication and Hospitalization Outcomes After Assisted Outpatient Treatment in New York*, 61 PSYCHIATRIC SERVICES 982 (2010).

Yet as the authors concede, the study findings are not without limitations.¹⁸⁶ The study used a matching design to compare AOT recipients to people who received treatment voluntarily. However, since a matching design would only allow the authors to control for observed, but not unobserved covariates, the findings from a matched design are less definitive than the results of a careful randomized controlled trial. Nor are the findings from New York's assisted outpatient treatment program clearly generalizable to other states like California, where AOT programs are underfunded.

Debate about whether outpatient commitment laws are an effective solution to the problem of revolving door hospitalizations for people with mental illnesses will undoubtedly continue. For the purposes of this Article, I am willing to bracket this uncertainty while I discuss the moral questions these laws raise. Before turning to that discussion, I will outline the constitutional framework in which these laws operate.

D. Constitutional Challenges

The legal controversy surrounding outpatient commitment has focused on the substantive and procedural due process rights of people with mental illnesses.¹⁸⁷ Although the U.S. Supreme Court has yet to consider the constitutional questions presented by outpatient commitment, the Court has recognized a liberty interest in refusing unwanted medical treatment¹⁸⁸ as well as a liberty interest in refusing unwanted antipsychotic medication,¹⁸⁹ both arising from the Due Process Clause.

The leading case on the constitutionality of outpatient commitment came from the New York Court of Appeals in *In re K.L.*¹⁹⁰ K.L. alleged that

186. SWARTZ ET AL., *supra* note 177, at 51.

187. See, e.g., Jennifer Gutterman, *Waging a War on Drugs: Administering a Lethal Dose to Kendra's Law*, 68 FORDHAM L. REV. 2401 (1999); Erin O'Connor, *Is Kendra's Law a Keeper? How Kendra's Law Erodes Fundamentally the Rights of the Mentally Ill*, 11 J.L. & POL'Y 313 (2002); Susan Stefan, *Preventive Outpatient Commitment: The Concept and its Pitfalls*, 11 MENTAL & PHYSICAL DISABILITY L. REP. 288 (1987). But see Jeffrey Geller & Jonathan A. Stanley, *Settling the Doubts About the Constitutionality of Outpatient Commitment*, 31 NEW ENG. J. ON CRIM & CIV. CONFINEMENT 127 (2005); Illisa Watnick, *A Constitutional Analysis of Kendra's Law: New York's Solution for the Treatment of the Chronically Mentally Ill*, 149 U. PA. L. REV. 1181 (2001) (arguing that Kendra's Law does not violate substantive due process).

188. *Cruzan ex rel. Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 279 n.7 (1990) ("Although many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional right of privacy, we have never so held. We believe this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest.").

189. *Mills v. Rogers*, 457 U.S. 291, 299 (1982) (asserting that "the Constitution recognizes a liberty interest in avoiding the unwanted administration of antipsychotic drugs"); *Washington v. Harper*, 494 U.S. 210 (1990); *Riggins v. Nevada*, 504 U.S. 127 (1992).

190. *In re K.L.*, 806 N.E.2d 480 (N.Y. 2004).

Kendra's Law violates due process because it does not require a judicial determination of incapacity before a court may order a person to comply with an assisted outpatient treatment plan.¹⁹¹ In pressing his claims, K.L. relied upon *Rivers v. Katz*, where the New York Court of Appeals discussed the circumstances in which a hospital can administer antipsychotic medication to an involuntarily committed patient against his or her will.¹⁹² Drawing upon familiar language from Justice Cardozo in *Schloendorff v. Society of New York Hospital*, the Court of Appeals in *Rivers* declared: "[i]t is a firmly established principle of the common law of New York that every individual 'of adult years and sound mind has a right to determine what shall be done with his [or her] own body.'"¹⁹³ Moreover:

In our system of a free government where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy This right extends equally to mentally ill persons who are not to be treated as persons of lesser status or dignity because of their illness.¹⁹⁴

In *Rivers*, the New York Court of Appeals observed that the right of a competent person to refuse treatment safeguards is an individual interest in autonomy, an interest which is no less important simply because the rightholder has been diagnosed with a mental illness. The Court of Appeals affirmed a fundamental right to refuse treatment in *Rivers*, but noted that the right to refuse treatment is not absolute and instead may yield to compelling state interests.¹⁹⁵ Importantly, however, the *Rivers* Court held that while the State has the *parens patriae* power to provide treatment to people who are unable to care for themselves due to mental illness, "[f]or the State to invoke this interest, 'the individual himself must be incapable of making a competent decision concerning treatment on his own. Otherwise, the very justification for the state's purposed exercise of its *parens patriae* power—its citizen's inability to care for himself * * * would be missing.'"¹⁹⁶ Therefore, the Court reasoned, when a patient refuses to consent to antipsychotic drugs, there must be a judicial hearing to determine whether the patient has the capacity to make a reasoned treatment decision before a hospital may administer drugs pursuant to the *parens patriae* power.¹⁹⁷

The Court of Appeals rejected the *Rivers* analogy in *In re K.L.* and declined to strike Kendra's Law on substantive due process grounds. In contrast to the circumstances at issue in *Rivers*, AOT patients cannot be forced to accept

191. *Id.* at 483-84.

192. *Rivers v. Katz*, 67 N.Y.2d 485 (1986); *In re K.L.*, 806 N.E.2d at 484.

193. *Id.* at 493 (citing *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129 (1914)).

194. *Id.* at 493.

195. *Id.* at 495.

196. *Id.* at 496 (citing *Rogers v. Okin*, 634 F.2d 650, 657 (1980)).

197. *Id.* at 498.

antipsychotic medications. Since the force of an assisted outpatient treatment order “lies solely in the compulsion generally felt by law-abiding citizens to comply with court directions,” the Court of Appeals characterized the restraint on the right to refuse treatment as “minimal.”¹⁹⁸ Moreover, the Court concluded that assisted outpatient treatment orders are an appropriate exercise of the State’s *parens patriae* power since an AOT order requires several findings, including evidence that the person is unlikely to survive safely in the community without supervision; a history of treatment noncompliance; and evidence that the person is unlikely to comply with treatment voluntarily.¹⁹⁹ The Court also found ample authority for Kendra’s Law in the State’s police power to “protect the community from the dangerous tendencies of some who are mentally ill.”²⁰⁰

In the same way, the Court of Appeals summarily rejected K.L.’s procedural due process claim. K.L. alleged that failing to provide notice and a hearing before a noncompliant patient may be removed from the community and detained in a hospital violates procedural due process.²⁰¹ The Court of Appeals agreed that involuntary hospitalization constitutes a substantial deprivation of liberty. Nonetheless, the Court concluded that the State’s interest in removing patients, previously found to be at risk of relapse or deterioration, outweighs the patient’s liberty interests in freedom from an unwanted hospitalization. Nor was the Court persuaded that the Fourth Amendment requires probable cause before a physician can remove a noncompliant patient. Since the statute directs physicians to use their “clinical judgment,” it “necessarily contemplates that the [removal] determination will be based on the physician’s reasonable belief that the patient is in need of such care.”²⁰²

The Court of Appeals was equally unpersuaded by the plaintiff’s equal protection arguments. Without a judicial determination of incapacity, the plaintiffs maintained that Kendra’s Law violates equal protection since persons under guardianship and involuntarily committed psychiatric patients are entitled to an incapacity hearing before they can be medicated against their will.²⁰³ The Court of Appeals simply reiterated that an assisted outpatient treatment order does not authorize the use of force to administer medication, and as a result, “[t]he statute thus in no way treats similarly situated persons differently.”²⁰⁴

Whatever one might think about the plaintiff’s equal protection or Fourth Amendment claims, the reasoning employed by the Court of Appeals stands on shaky ground. The Court employed an unduly narrow interpretation of the

198. *Id.* at 485.

199. *Id.* at 498.

200. *Id.* at 485 (internal quotations omitted).

201. *Id.* at 486.

202. *Id.* at 487-88.

203. *Id.* at 486.

204. *Id.*

rights announced in *Schloendorff* and *Rivers*. Undoubtedly, the right to refuse treatment comprehends not only the right to refuse antipsychotic medications, but also the right to refuse outpatient treatment; individual or group therapy; day or partial day programming; supervised living arrangements; substance abuse counseling; and home visits by assertive community treatment teams—all hallmarks of the typical AOT order. Second, the Court of Appeals alluded to the “dangerous tendencies” of the mentally ill as a justification for state action through police power. Yet large epidemiological studies have consistently shown that most people with mental illnesses are no more dangerous than anyone else, and more importantly, social science has progressed beyond thinking of dangerousness as a property of the person.²⁰⁵ Current approaches to risk assessment regard the risk of violence as an interaction between clinical characteristics, demographic factors and the person’s environment.²⁰⁶

Finally, in contrast to *Rivers*, the Court of Appeals employed a dangerously expansive interpretation of the requirements for state action under the *parens patriae* power. In *Rivers*, the Court of Appeals held that for the State to compel treatment through its *parens patriae* authority, it must be the case that the individual is incapable of making a competent treatment decision on his own. Otherwise the primary justification for invoking *parens patriae* authority “would be missing.”²⁰⁷ Yet in *In re K.L.*, the Court of Appeals reasoned that assisted outpatient treatment orders are an appropriate exercise of the State’s *parens patriae* power—even without evidence of incapacity—since an AOT order requires several other findings, including: evidence that the person is unlikely to survive safely without treatment; the person has a history of treatment noncompliance; the person needs assisted outpatient treatment; and the person would benefit from assisted outpatient treatment.²⁰⁸ The same logic would justify intrusions into the decisions of cancer patients and diabetics without a clear stopping point. Yet we do not require these patients to accept medical treatment simply because the person needs treatment or would benefit from treatment. Nor should we. As the Court of Appeals observed in *Rivers*, in our liberal democracy, where individual interests in privacy and personal autonomy in treatment decisions are protected, “the right of a competent adult to refuse medical treatment must be honored, even though the recommended treatment may be beneficial or even necessary to preserve the patient’s life.”²⁰⁹

205. See, e.g., Henry J. Steadman, *From Dangerousness to Risk Assessment of Community Violence: Taking Stock at the Turn of the Century*, 28 J AM. ACAD. PSYCHIATRY & L. 265 (2000).

206. MARC J. ACKERMAN, *ESSENTIALS OF FORENSIC PSYCHOLOGICAL ASSESSMENT* 160 (2010); see also Sue E. Estroff & Catherine Zimmer, *Social Networks, Social Support and Violence*, in *VIOLENCE AND MENTAL DISORDER: DEVELOPMENTS IN RISK ASSESSMENT* 259, 271 (John Monahan & Henry J. Steadman eds., 1994) (observing that “violence seldom happens unilaterally” and is instead influenced by complex interpersonal histories, mutual hostility and longstanding family disputes.).

207. *Rivers v. Katz*, 67 N.Y.2d 485, 496 (N.Y. 1986).

208. *In re K.L.*, 806 N.E.2d 480, 485-86 (N.Y. 2004).

209. *Rivers*, 67 N.Y.2d at 493.

II. MORAL JUSTIFICATIONS AND PUBLIC POLICY RATIONALES

In *In re K.L.*, the New York Court of Appeals mapped the constitutional boundaries of government authority to compel outpatient commitment without passing judgment on the wisdom of these laws or the moral claims that citizens might have. In Part III, I examine and refute common arguments for outpatient commitment based on harm to others, harm to self, and impaired insight.

A. *Harm to Others*

Supporters of outpatient commitment have argued that in many cases of actual or threatened violence by a person with a mental illness, the perpetrator was either not being treated for his or her mental disorder or not taking prescribed medications.²¹⁰ Moreover, most of these incidents, many of them homicides, could have been prevented if there were laws in place to insist that people with mental illnesses participate in treatment whether they want to or not.²¹¹ What should we make of these claims? Part III.A reviews empirical evidence on the relationship between mental illness and violence. Although support for outpatient commitment stems from high profile acts of violence committed by people with mental illnesses, most violent crimes are not committed by people with mental illnesses, and most people with mental illnesses are no more violent than anyone else. A second argument concedes that most people with mental illnesses are no more dangerous than members of the general population, but insists that a subgroup of people with mental illnesses *are* more dangerous.²¹² To that end, involuntary outpatient commitment laws are necessary to prevent tragedies, like the death of Kendra Webdale, from happening again.²¹³ Call this the preventable tragedies argument.²¹⁴

As the remainder of Part III.A asserts, the problem with this argument is twofold. First, using involuntary outpatient commitment to prevent tragedies, such as the Webdale incident, from happening again presumes that we have a reasonably reliable way to identify people with mental illnesses who are likely to be violent and distinguish them from those who are not. However, clinical predictions of violence are only slightly better than chance. Second, even if we

210. Ken Kress, *An Argument for Assisted Outpatient Treatment for People with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa*, 85 IOWA L. REV. 1269, 1283 (2000).

211. *Id.*

212. See, e.g., E. Fuller Torrey, *Violent Behavior by Individuals with Serious Mental Illness*, in INSIGHT AND PSYCHOSIS 269 (Xavier Amador & Anthony S. David eds., 1998).

213. Ilissa L. Watnick, Comment, *A Constitutional Analysis of Kendra's Law: New York's Solution for Treatment of the Chronically Mentally Ill*, 149 U. PA. L. REV. 1181, 1183 (2001).

214. See, e.g., *The Preventable Tragedies Database*, TREATMENT ADVOC. CENTER, <http://www.treatmentadvocacycenter.org/home-page/71-featured-articles/2014-how-google-and-the-media-shape-our-preventable-tragedies-database>.

were able to identify people with mental illnesses who are likely to be violent, we can identify statistically significant associations between violence and any number of risk factors—age and violence, gender and violence, income and violence, educational attainment, and violence. However, as a general matter, the other-regarding harms we aim to prevent through outpatient commitment are addressed retrospectively, through the criminal justice system. Even if we were able to identify a subgroup of the population as very likely to engage in violence, courts will not impose limits on their freedom in order to prevent the very serious crimes that they are likely to commit. Proponents of the preventable tragedies argument will need to explain why people with mental illnesses should be treated differently.

1. Violence and Mental Illness

a. Community Surveys

Several epidemiological studies have found a modest association between mental illness and violence. In a seminal study on violence and mental disorder, Jeffrey Swanson and colleagues analyzed data drawn from the Epidemiological Catchment Area Study conducted by the National Institute of Mental Health.²¹⁵ As part of the study, 10,000 randomly chosen adults were interviewed to establish the prevalence of mental disorder. Study participants were also asked to self-report violent behaviors during the past year (e.g., injuring a spouse or partner, getting into physical fights, or using a weapon). The study found that schizophrenia, bipolar disorder, and major depression were associated with a fourfold increase in the odds of violence within one year, after controlling for sociodemographic variables such as age, gender, socioeconomic status, ethnicity, and race (odds ratio = 3.94).²¹⁶ However, the study also found that substance abuse was associated with a far greater risk of violence (odds ratio = 13.67).²¹⁷ To put these numbers in perspective, the authors also estimated the attributable risk of violence associated with mental disorder. Since serious mental illnesses are rare, people with a diagnosis of mental disorder alone only accounted for about four to five percent of the total violence in the population over the course of one year.²¹⁸ By contrast, since violence was more common among drug and alcohol abusers, and since there were more substance abusers in the community, the attributable risk of violence among substance abusers was considerably higher, on the order of twenty-seven percent.²¹⁹

215. Jeffrey W. Swanson, *Mental Disorder, Substance Abuse, and Community Violence: An Epidemiological Approach*, in *Violence and Mental Disorder* 101 (John Monahan & Henry J. Steadman eds., 1994).

216. *Id.* at 130.

217. *Id.*

218. *Id.* at 118.

219. *Id.*; see also Heather L. Stuart & Julio E. Arboleda-Flórez, *A Public Health Perspective on Violent Offenses Among Persons with Mental Illness*, 52 *PSYCHIATRIC*

Findings from the landmark MacArthur Violence Risk Assessment Study also underscore the relationship between mental illness, substance abuse, and violence. The MacArthur Study followed 951 psychiatric patients for one year after they were discharged from acute psychiatric units.²²⁰ In contrast to the Epidemiological Catchment Area Study, researchers used three sources of information to determine the prevalence of violence—interviews with patients, interviews with collateral informants (usually a family member), as well as hospital and arrest records. In the MacArthur study, “violence” included battery that resulted in a physical injury, sexual assault, assault with a weapon, or threats with a weapon. Consistent with prior research in this area, substance abuse emerged as an important risk factor for violence. Among patients with both an Axis I mental disorder—e.g. schizophrenia, major depression, or bipolar disorder—and a substance abuse disorder the one-year prevalence of violence was 31.1%, compared to 17.9% among patients without a substance abuse disorder.²²¹

Focusing on one study site, Pittsburgh, Pennsylvania, researchers then compared violence among discharged psychiatric patients to the prevalence of violence among others living in the same neighborhood. Once again, substance abuse emerged as a significant risk factor for violence. The study found that discharged psychiatric patients without a substance abuse problem were no more likely to engage in violence than other people living in the same neighborhood without a substance abuse problem. However, the presence of a substance abuse problem raised the prevalence of violence among discharged patients and the comparison group. The prevalence of violence among patients who reported symptoms of substance abuse was significantly higher than the prevalence of violence among others in their neighborhood.²²² Discharged patients were also more likely to report drug and alcohol abuse than community controls.²²³ Contrary to public fears of street violence involving people with mental illnesses, the targets of violence were usually family members or

SERVICES 654 (2001) (finding that approximately three percent of violent offenses could be attributed to individuals who had a principal diagnosis of any non-substance abuse related mental disorder).

220. Henry J. Steadman et al., *Violence by People Discharged from Acute Psychiatric Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES GEN. PSYCHIATRY 393 (1998).

221. *Id.* at 399.

222. *Id.* at 400.

223. *Id.* at 400; see also Eric B. Elbogen & Sally C. Johnson, *The Intricate Link Between Violence and Mental Disorder*, 66 ARCHIVES GEN. PSYCHIATRY 152 (2009) (finding that incidence of violence was higher for people with severe mental illnesses but only significantly so for people with a co-occurring substance abuse or substance dependence disorder); E. Fuller Torrey, Jonathan Stanley, John Monahan, Henry J. Steadman & the MacArthur Study Group, *The MacArthur Violence Risk Assessment Study Revisited: Two Views Ten Years After its Initial Publication*, 59 PSYCHIATRIC SERVICES 147 (2008) (debating design of the MacArthur Study). *But see* Sally Satel & D.J. Jaffe, *Violent Fantasies*, 50 NAT'L REV. 36 (1998) (offering a critique of the MacArthur Study).

friends, and most incidents occurred in the home. Nor were there significant differences between patients and community controls.²²⁴

Only a few studies have investigated the number of homicides committed each year by people with mental illnesses in the United States. Some of them suggest a similar relationship between substance abuse, mental illness and the targets of violence. For example, a 1994 study by the Justice Department found that of the 20,680 homicides reported in 1988, only 4.3% or 889 of those homicides were committed by someone with a history of mental illness.²²⁵ The same study reported that 64.4% of the defendants charged in those cases were under the influence of alcohol at the time of the offense. More recent work in this area suggests that the number of homicides attributable to people with mental illnesses might be somewhat higher. A 2008 study conducted by Matejkowski and colleagues found that of the 518 people convicted of murder in Indiana between 1990 and 2002, 95 of them or 18% had a record diagnosis of mental illness.²²⁶ The most common diagnosis was depression, followed by schizophrenia and other psychotic disorders. In addition, more than half of all offenders with a mental disorder also had a history of alcohol and drug abuse. Most victims were family members or a companion, and most homicides occurred in the home of the offender or a shared residence of the victim and the offender.²²⁷

b. Psychosis and Violence

Researchers have also investigated the relationship between psychosis and violence.²²⁸ In a 1992 study on the relationship between psychosis and violence, Bruce Link and colleagues compared arrest rates and self-reported acts of violence among psychiatric patients, residing in the Washington Heights area of New York City, to people who had never received mental health treatment, residing in the same neighborhood.²²⁹ The study found that 15% of the community sample who had never received treatment from a mental health

224. Steadman et al., *supra* note 220, at 399.

225. JOHN M. DAWSON & PATRICK A. LANGAN, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, MURDER IN FAMILIES 4 (1994).

226. Jason C. Matejkowski et al., *Characteristics of Persons with Severe Mental Illness Who Have Been Incarcerated for Murder*, 36 J. AM. ACAD. PSYCHIATRY & L. 74, 76 (2008).

227. *Id.* at 79.

228. Psychosis is not itself a mental disorder, but rather a general term for a cluster of psychiatric symptoms, primarily delusions and hallucinations. The *Diagnostic and Statistical Manual of Mental Disorders* defines delusions as “fixed beliefs that are not amenable to change in light of conflicting evidence.” AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: FIFTH EDITION 87 (2013). Hallucinations are perceptions without an external stimulus. *Id.*. Common delusions include the belief that thoughts have been removed from the patient's mind by an outside force (thought withdrawal) and that thoughts have been placed into the patient's mind (thought insertion).

229. Bruce G. Link et al., *The Violent and Illegal Behavior of Mental Patients Reconsidered*, 57 AM. SOC. REV. 275, 278 (1992).

professional reported fighting within the last five years, compared to 29% of repeat psychiatric patients.²³⁰ Link and colleagues then controlled for psychotic symptoms using a scale derived from the Psychiatric Epidemiology Research Interview (PERI). After controlling for psychotic symptoms, the study found that being a repeat psychiatric patient was no longer a statistically significant predictor of violence. Instead, much of the difference between psychiatric patients and community controls could be explained by the level of psychotic symptoms.²³¹ Moreover, even among residents who had never been treated for a psychiatric disorder, psychotic symptoms were associated with violence.

In further analyses, Link and colleagues found that three symptoms of psychosis termed “threat/control-override” symptoms were associated with significant increases in violent behavior, even after controlling for sociodemographic variables and other psychotic symptoms.²³² The symptoms included feeling that your mind has been dominated by forces beyond your control, that thoughts put into your head were not your own, and that people wished to do you harm.²³³ Similarly, using data from the Epidemiological Catchment Area Study, Jeffrey Swanson and colleagues found that respondents who reported one or more threat/control-override symptoms were more than twice as likely to report violence during the previous year, compared to respondents who reported other psychotic symptoms, and six times more likely to report violence compared to people without a mental disorder.²³⁴

However, as Link and colleagues caution, when compared to the risk of violence associated with age, gender and socioeconomic status, the risk of violence associated with psychotic symptomatology is relatively modest.²³⁵ For example, gender was far more predictive of arrests, fighting, and ever hurting someone badly than status as a former or repeat psychiatric patient.²³⁶ Moreover, not all studies have found an association between psychotic symptoms and violence. Some studies, including analyses using ECA data, have not found an association between TCO symptoms and violence when

230. *Id.* at 283.

231. *Id.* at 288.

232. Bruce G. Link & Ann Stueve, *Psychotic Symptoms and the Violent/Illegal Behavior of Mental Patients Compared to Community Controls*, in *VIOLENCE AND MENTAL DISORDER* 137 (John Monahan & Henry J. Steadman eds., 1994).

233. *Id.* at 143; *see also* Bruce Link & Ann Stueve, *Psychotic Symptoms and Violent Behaviors: Probing the Components of the “Threat/Control-Override” Symptoms*, 33 *SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY* S55 (1998) (finding that both threat and control-override delusions predicted were independently associated with violent behavior).

234. Jeffrey W. Swanson et al., *Psychotic Symptoms and Disorders and the Risk of Violent Behaviour in the Community*, 6 *CRIM. BEHAV. & MENTAL HEALTH* 309 (1996).

235. Link et al., *supra* note 229, at 290.

236. *See also* Eric B. Elbogen & Sally Johnson, *The Intricate Link Between Violence and Mental Disorder*, 66 *ARCHIVES OF GEN. PSYCHIATRY* 152 (2009) (finding that mental illness alone did not predict future violence; however, age, gender, having completed less than a high school education, a history of violence, and a history of juvenile detention, accounted for one quarter of the variance in violent behavior).

controlling for the effects of treatment noncompliance or the presence of a substance abuse disorder.²³⁷ Using data from the MacArthur Study, Paul Appelbaum and colleagues found that delusions were not associated with an increased risk of violent behavior, nor were particular threat/control-override (TCO) symptoms associated with a greater risk of violence.²³⁸ To the contrary, the study found that patients with threat/control-override delusions were significantly less likely to engage in violence than patients without similar delusions. Appelbaum and colleagues note that people who experience chronic psychosis also tend to experience social withdrawal and smaller social networks. The authors hypothesize that with smaller social networks, people who experience chronic psychosis might have fewer interpersonal interactions, and thus fewer relationships that lead to violence.²³⁹

2. Risk Assessment and Violence

Most studies suggest that by itself mental illness is at best a poor predictor of violence. Instead, situational and demographic factors such as being young, male, and unemployed with a history of violence appear to be better predictors.²⁴⁰ Even then, predictions of violence are notoriously difficult.

237. Jeffrey Swanson et al., *Violence and Severe Mental Disorder in Clinical and Community Populations: The Effects of Psychotic Symptoms, Comorbidity, and Lack of Treatment*, 60 PSYCHIATRY 1 (1997).

238. Paul Appelbaum et al., *Violence and Delusions: Data from the MacArthur Violence Risk Assessment Study*, 157 AM. J. OF PSYCHIATRY 566 (2000); see also Thomas Stompe et al., *Schizophrenia, Delusional Symptoms, and Violence: The Threat/Control-Override Concept Reexamined*, 30 SCHIZOPHRENIA BULL. 31 (2004) (finding that threat/control-override symptoms were not associated with violence in a retrospective study of male offenders with schizophrenia).

239. See Appelbaum et al., *supra* note 237; see also Louise G. Braham et al., *Acting on Command Hallucinations and Dangerous Behavior: A Critique of the Major Findings in the Last Decade*, 24 CLINICAL PSYCHOL. REV. 513 (2003) (noting the relationship between command hallucinations and violence); Sue Estroff et al., *The Influence of Social Networks and Social Support on Violence by Persons with Serious Mental Illness*, 45 HOSP. & COMMUNITY PSYCHIATRY 669 (finding that respondents with larger networks, and those whose networks primarily consisted of relatives, were more likely to threaten violence). One might think when people with mental illnesses, like schizophrenia, hear command hallucinations they comply unthinkingly. However, the relationship between command hallucinations and violence is a complicated one, mediated by multiple psychological processes, including beliefs about the voice, the content of the command, and the consequences of noncompliance.

240. See Jeffrey Swanson et al., *Violent Behavior Preceding Hospitalization Among Persons with Severe Mental Illness*, 23 LAW & HUM. BEHAV. 185 (noting that, while clinical diagnosis and symptom variables were not significantly associated with violence, violent behavior among revolving door patients was associated with substance abuse, young age, a history of victimization); Jeffrey Swanson et al., *Violence and Psychiatric Disorder in the Community: Evidence from the Epidemiologic Catchment Area Surveys*, 41 HOSP. & COMMUNITY PSYCHIATRY 761, 763 (1990) (finding that being young, male, and of a low socioeconomic status was associated with violent behavior); see also Jeffrey Swanson et al., *The Social-Environmental Context of Violent Behavior in Persons Treated for Severe Mental Illness*, 92 AM. J. PUB. HEALTH 1523 (2002) (noting that “[p]sychopathology per se seldom

Owing to the low base rate of violent crime, even the best methods will produce a large number of false positives. For example, a well-known study on risk assessment and violence, conducted by Charles Lidz and colleagues, found that clinical predictions of violence were only slightly better than chance.²⁴¹ The study involved two groups of psychiatric patients matched on age, race, gender, and admission status. One group consisted of patients who were predicted to be violent by clinicians; the other was a comparison group of patients who were not predicted to be violent.

Lidz and colleagues assessed the accuracy of clinical judgments by calculating the sensitivity and specificity of their predictions. Sensitivity (the true positive rate) measures the proportion of true positives that are correctly identified. Specificity (the true negative rate) measures the proportion of true negatives that are correctly identified. Clinicians accurately identified 60% of patients who turned out to be violent and 58% of patients who turned out to be nonviolent.²⁴² As a result, the study reported a considerable number of false negatives and false positives. 129 patients who were not predicted to be violent were in fact violent, and 167 patients who were predicted to be violent during the study period did not engage in violence.²⁴³

A second approach to risk assessment uses statistical or actuarial methods to assess the risk of violence. Clinical approaches to risk assessment depend on a clinician to estimate the risk of violence based on his or her clinical judgment; however, actuarial methods are based on a standardized list of validated risk factors, such as age, gender, and past history of violence. Most studies have shown that actuarial methods tend to be more accurate than clinical predictions.²⁴⁴ For example, using data from the Lidz study, William Gardner and colleagues found that actuarial methods had lower false positive rates and lower false negative rates when compared to clinical prediction.²⁴⁵ Actuarial predictions based only on the patient's history of violence were also more

leads to assaultiveness," but may converge with other risk factors such as violent victimization and exposure to violence to increase the risk of violent behavior); Estroff et al., *supra* note 238; Virginia Hiday, *The Social Context of Mental Illness and Violence*, 36 J. HEALTH & SOC. BEHAV. 122 (1995).

241. Charles W. Lidz et al., *The Accuracy of Predictions of Violence to Others*, 269 J. AM. MED. ASS'N 1007 (1993).

242. *Id.* at 1009. Sensitivity or the true positive rate of 60% equals the number of true positives (i.e., the 190 patients who were predicted to be violence and were in fact violent) divided by the sum of the true positives and the false negatives (i.e., the 129 patients who were not predicted to be violent but were violent). Specificity or the true negative rate of 58% equals the number of true negatives (i.e., 228 comparison patients who were not violent) divided by the sum of the true negatives and the false positives (the 167 patients who were predicted to be violent but were not violent).

243. *Id.*

244. See William M. Grove & Paul Meehl, *Comparative Efficiency of Informal (Subjective, Impressionistic) and Formal (Mechanical, Algorithmic) Prediction Procedures: The Clinical-Statistical Controversy*, 2 PSYCHOL. PUB. POL'Y. & L. 293 (1996).

245. See William Gardner et al., *Clinical Versus Actuarial Predictions of Violence in Patients with Mental Illnesses*, 64 J. CONSULTING & CLINICAL PSYCHOL. 602 (1996).

accurate than clinical predictions of violence. Using only the patient's history of violence, an actuarial model was able to identify 71% of patients who were violent, while clinical methods only identified 62% of patients who engaged in violence.²⁴⁶

Although several studies have shown that actuarial risk assessments tend to be more accurate than clinical predictions, most outpatient commitment laws do not require actuarial assessments. Nor are actuarial methods often used, since they can be time-consuming and cumbersome.²⁴⁷ Moreover, as David Cooke and Christine Michie have observed, "it is a statistical truism that "the mean of a distribution tells us about everyone, [and] yet no one."²⁴⁸ Actuarial assessments estimate the likelihood of future violence based on the behavior of a group. However, any significant social, psychological, or environmental differences between the individual and the group can increase or decrease the likelihood of violence.²⁴⁹ Further, studies consistently show that a history of violence, and, in particular, a recent overt act of violence, are among the best predictors of future violence.²⁵⁰ However, most outpatient commitment laws do not require a recent act of violence. For example, under Kendra's Law, a court may order outpatient commitment if, in addition to proof on all other elements, a history of treatment noncompliance has resulted in one of more acts of violence toward others within the last forty-eight months, or even a threat or attempt at serious physical harm toward others within the last forty-eight months.²⁵¹

For people with serious and persistent mental illnesses, being misclassified as dangerous can have serious consequences. Even when participation in an assisted outpatient treatment program offers a less restrictive alternative to hospitalization, a court order to participate in group therapy burdens the liberty interests of persons who are predicted to be violent, but who are in fact not violent. Courts will sometimes order an assertive community treatment team to visit the patient's home, further burdening the outpatient's interest in privacy.

246. *Id.* at 607.

247. See John Monahan et al., *Developing a Clinically Useful Actuarial Tool for Assessing Violence Risk*, 176 BRIT. J. PSYCHIATRY 312 (2000).

248. David J. Cooke & Christine Michie, *Limitations of Diagnostic Precision and Predictive Utility in the Individual Case: A Challenge for Forensic Practice*, 34 LAW & HUM BEHAVIOR 259, 259 (2010); see Jennifer L. Skeem & John Monahan, *Current Directions in Violence Risk Assessment*, 20 PSYCHOL. MED. 38 (2011), for an argument that group data can be useful for individual cases; see also David J. Cooke & Christine Michie, *Violence and Risk Assessment: Challenging the Illusion of Certainty*, in DANGEROUS PEOPLE: POLICY, PREDICTION, AND PRACTICE 147 (Bernadette McSherry & Patrick Keyzer eds., 2011).

249. See JOHN PARRY, CIVIL MENTAL DISABILITY LAW, EVIDENCE AND TESTIMONY 669 (2010).

250. See Douglass Mossman et al., *Risky Business Versus Overt Acts: What Relevance Do "Actuarial," Probabilistic Risk Assessments Have for Judicial Decisions on Involuntary Psychiatric Hospitalizations?*, 11 HOUS. J. HEALTH L. & POL'Y 365 (2011).

251. N.Y. MENTAL HYG. LAW § 9.60(c)(2)(4)(i)-(ii) (McKinney, Westlaw through 2014 Sess.).

There are also system wide costs. With an overemphasis on dangerousness, states risk diverting limited resources toward programs for people with mental illnesses who are thought to be dangerous, and away from the majority of people with mental illnesses who are not dangerous.

3. The Criminal-Civil Distinction

Suppose, however, that at least when combined with a substance abuse disorder, mental illness gives us good reason to suspect a heightened risk of violence. In addition, suppose we are able to predict violence to a reasonable degree of certainty. What justifies assisted outpatient treatment based on our suspicion that, at some point in the future, the subject of a court order might harm others before he has actually done so? As a general matter the other-regarding harms we aim to prevent through outpatient commitment are addressed through the deterrent and retributive functions of the criminal justice system.

The Supreme Court has yet to address the constitutionality of outpatient commitment. However, in *Kansas v. Hendricks* and *Kansas v. Crane* the Court considered an analogous problem that arises when states use civil commitment to detain sex offenders beyond the expiration of their criminal sentences.²⁵² In both cases, the Court narrowed the class of offenders eligible for civil commitment to those whose “mental abnormality” rendered them dangerous beyond their control. Writing for the Court in *Crane*, Justice Breyer averred:

It is enough to say that there must be proof of serious difficulty in controlling behavior. And this, when viewed in light of such features of the case as the nature of the psychiatric diagnosis and the severity of the mental abnormality itself, must be sufficient to distinguish the dangerous sexual offender whose serious mental illness, abnormality, or disorder subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case.²⁵³

Echoing *Hendricks*, Justice Breyer added that the distinction is a necessary one “lest civil commitment [should] become a mechanism for retribution or general deterrence—functions properly those of criminal law, not civil commitment.”²⁵⁴ In both *Hendricks* and *Crane*, the Supreme Court reaffirmed the criminal justice system as the preferred approach to garden variety criminal conduct. The underlying assumption of the criminal law is that most of us have at least a normal capacity to understand what the law requires, and most of us have at least a normal capacity to order our conduct within the wide boundaries set by legal norms. When culpable agents breach legal norms of their own volition, we describe their conduct as a “crime” meriting “punishment” rather

252. *Kansas v. Hendricks*, 521 U.S. 346 (1997); *Kansas v. Crane*, 534 U.S. 407 (2002).

253. *Crane*, 534 U.S. at 413.

254. *Id.* at 412 (internal quotations omitted).

than a “breach” creating “liability.”²⁵⁵ In doing so, we communicate reprobation for wrongdoing while also addressing the offender as a moral agent. By contrast, the moral legitimacy of civil commitment rests on its limitation to persons who lack the capacities for moral responsibility or criminal responsibility. As Allen Buchanan and Dan Brock write, “[i]f the dangerous mentally ill are justifiably treated differently, it must be because they are not capable of responsibly controlling their behavior that is dangerous to others as required by criminal prohibitions.”²⁵⁶

In the same way, the Supreme Court limited sex offender commitments to those whose mental abnormalities rendered them unable to control their behavior. Even so, critics argue that the Court’s inability-to-control formulation is vastly overbroad and unworkable. As Christopher Slobogin writes, “evidence that the impulses experienced by addicts, sexual offenders and people with psychosis are stronger than those that lead people to commit typical crime is hard to come by; burglars recidivate at least as much as sex offenders, and white collar criminals are probably just as ‘driven’ by urges, albeit for things like wealth, fame or power rather than (or perhaps in addition to) drugs or sex.”²⁵⁷ To that end, a second approach rejects the volitional impairment approach entirely. Adherents to this view—foremost among them, Eric Janus, Robert Schopp and Stephen Morse—argue that police power commitments are appropriate, but only for those who are, in essence, “too sick to deserve punishment.”²⁵⁸ As Stephen Morse writes, “[f]or reasons much studied and theorized about, but in fact not very well understood, some unfortunate people are so irrational, so grossly out of touch with reality, that ascribing responsibility to them is a travesty according to any but the most extravagantly libertarian account of human agency.”²⁵⁹ If under the grip of delusional beliefs such an agent were to strike out at a perceived threatener, she would not be morally responsible for her actions and therefore not deserving of legal punishment.

My own view, to be developed in Part IV, rests on a combination of both approaches. Under certain circumstances, outpatient commitment may be appropriate for people with mental illnesses who are irrational in the way

255. Paul H. Robinson, *Foreword: The Criminal-Civil Distinction and Dangerous Blameless Offenders*, 83 J. CRIM. L. & CRIMINOLOGY, 693 (1993).

256. ALLEN E. BUCHANAN & DAN W. BROCK, DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING 329 (1990).

257. CHRISTOPHER SLOBOGIN, MINDING JUSTICE: LAWS THAT DEPRIVE PEOPLE WITH MENTAL ILLNESSES OF LIFE AND LIBERTY, 131 (2006).

258. Eric S. Janus, Hendricks *and the Moral Terrain of Police Power Civil Commitment*, 4 PSYCHOL. PUB. POL’Y & L. 297, 298 (quoting *Millard v. Harris*, 406 F.2d 964, 969 (D.C. Cir. 1968)); accord ROBERT F. SCHOPP, COMPETENCE, CONDEMNATION AND COMMITMENT 148-51 (2001); Robert F. Schopp, *Outpatient Civil Commitment: A Dangerous Charade or a Component of a Comprehensive Institution of Civil Commitment?*, 9 PSYCHOL. PUB. POL’Y & L. 33, 46 (2003).

259. Stephen Morse, *Blame and Danger: An Essay on Preventive Detention*, 76 B.U. L. REV. 113, 123 (1996).

Morse suggests. Alternatively, outpatient commitment might be appropriate for people with mental illnesses who are unable to control their behavior. Before offering an alternative approach to outpatient commitment determinations, Part III will press on to examine further justifications for outpatient commitment.

B. *Harm to Self*

Violent crimes involving people with mental illnesses have fueled an interest in preventive outpatient commitment. Yet supporters of outpatient commitment have also argued that court orders to participate in treatment are amply justified by the risk of serious harms to oneself.²⁶⁰ On any given night in the United States, roughly 650,000 people are homeless, and 1.5 million are homeless at some point during the year.²⁶¹ An estimated twenty-six percent of sheltered persons who are homeless have a severe mental illness.²⁶² For people with severe and persistent mental illnesses, the failure to comply with prescribed medications can increase the risk of homelessness.²⁶³ Although we tend to think of people with mental illnesses as much more likely to commit violent crimes than others, studies have shown that people with mental illnesses are actually far more likely to be the victims of violent crime, rather than the perpetrators of violent crime, when compared to members of the general public.²⁶⁴ It may be that psychiatric symptoms such as thought disorganization, impaired reality testing, poor impulse control, and poor problem solving abilities impeded the ability to perceive risks and protect oneself.²⁶⁵

For others, treatment noncompliance will lead predictably to incarceration, often for nonviolent offenses such as trespass, loitering, and disorderly conduct.²⁶⁶ Of the nearly 2 million inmates held in jails and prisons, an

260. John Kip Cornwell & Raymond Deeney, *Exposing the Myths Surrounding Outpatient Commitment for Individuals with Chronic Mental Illness*, 9 PSYCHOL. PUB. POL'Y & L. 209 (2003); Kress, *supra* note 2.

261. U.S. DEP'T OF HOUS. & URBAN DEV., THE 2010 ANNUAL HOMELESS ASSESSMENT REPORT TO CONGRESS i-ii (2010).

262. *Id.* at 18. By comparison, the National Institute of Mental Health estimates that 4.1% of all adults in the United States aged 18 or older—approximately 9.6 million adults—had a serious mental illness in 2012. See *Serious Mental Illness (SMI) Among U.S. Adults*, NIMH, <http://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml> (last visited Nov. 4, 2014).

263. Mark Olfson, *Predicting Medication Noncompliance After Hospital Discharge Among Patients with Schizophrenia*, 51 PSYCHIATRIC SERVICES 216, 220 (2000).

264. Linda A. Teplin et al., *Crime Victimization in Adults with Severe Mental Illness: Comparison with the National Crime Victimization Survey*, 62 ARCHIVES GEN. PSYCHIATRY 911 (2005) (finding that more than one quarter of persons with a serious mental illness had been victims of a violent crime in the past year, a rate more than eleven times higher than the general population rates even after controlling for demographic factors).

265. *Id.*

266. NAT'L ASS'N OF MENTAL HEALTH PLANNING & ADVISORY COUNCILS, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., JAIL DIVERSION: STRATEGIES FOR PERSONS WITH

estimated 300,000 suffer from a major mental illness.²⁶⁷ Left untreated, people with severe and persistent mental illnesses are also more likely to commit suicide.²⁶⁸

The legislative findings for Kendra's Law suggest that an important purpose of the assisted outpatient treatment program is to improve the wellbeing of people with mental disorders:

The legislature . . . finds that some mentally ill persons, because of their illness, have great difficulty taking responsibility for their own care, and often reject the outpatient treatment offered to them on a voluntary basis The legislature therefore finds that assisted outpatient treatment as provided in this act is compassionate, not punitive, will restore patients' dignity, and will enable mentally ill persons to lead more productive and satisfying lives.²⁶⁹

Supporters of involuntary outpatient commitment view these laws as a compassionate, commonsense response to the symptoms of a failing mental health system—homelessness, victimization, incarceration, and suicide.²⁷⁰ Opponents view them as “a glaring example of paternalism gone awry.”²⁷¹ The difference between them goes to a longstanding conflict between champions of liberalism and their critics. For strong supporters of involuntary outpatient commitment—like critics of civil commitment reform before them—the idea that people with mental illnesses should be “free to rot” seems unfathomable. Yet liberal commitments to neutrality limit the power of governments to enforce any particular conception of the good life. Parallel commitments to autonomy and personal sovereignty limit the power of governments to prevent citizens from harming no one other than themselves. The same liberal commitments to autonomy led the New York Court of Appeals to uphold the right of a competent person to refuse treatment in *Rivers v. Katz*, notwithstanding a diagnosis of mental illness.

The question for liberalism is this: when—if ever—is paternalism justified? I shall define paternalism in Gerald Dworkin's terms. On his view, A behaves paternalistically toward B by doing (or omitting) C if—(i) C (or its omission) interferes with the liberty or autonomy of B; (ii) A does so without

SERIOUS MENTAL ILLNESS 4 (2005), available at <http://www.namhpac.org/PDFs/01/jaildiversion.pdf>.

267. Fred E. Markowitz, *Mental Illness, Crime and Violence: Risk, Context and Social Control*, 16 *AGGRESSION & VIOLENT BEHAV.* 36, 38 (2011); see also PAULA M. DITION, BUREAU OF JUSTICE STATISTICS, SPECIAL REPORT: MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS (1999).

268. Brian Kenneth Ahmedani et al., *Suicide Thoughts and Attempts and Psychiatric Treatment Utilization: Informing Prevention Strategies*, 63 *PSYCHIATRIC SERVICES* 186 (2012).

269. Mental Hygiene—Community-Based Settings—Kendra's Law, ch. 408, S.5762-A, 1999 N.Y. Sess. Law (codified as amended at N.Y. MENTAL HYG. LAW § 9.60 (McKinney, Westlaw through 2014 Sess.)).

270. See E. FULLER TORREY, *THE INSANITY OFFENSE: HOW AMERICA'S FAILURE TO TREAT THE SERIOUSLY MENTALLY ILL ENDANGERS ITS CITIZENS* (2008); Torrey & Zdanowicz, *supra* note 14, at 340.

271. Munetz, et al., *supra* note 16, at 145.

the consent of B; and (iii) A does so because A believes C will improve the welfare or in some way promote the interests, values, or good of B.²⁷² In short, for Dworkin, paternalism involves interfering with another person, against her will, because doing so will make her better off. We can distinguish two varieties of paternalism—hard and soft. Hard paternalism is the view that governments may intervene to protect competent adults from the harmful consequences of their fully voluntary self-regarding behavior.²⁷³ Soft paternalism holds that states may intervene to prevent harmful self-regarding conduct when, and only when, that conduct is substantially nonvoluntary, or when intervention is necessary to determine whether the conduct is substantially nonvoluntary.²⁷⁴ Non-state actors may behave paternalistically, to be sure, but my concern here is with the moral limits on government action.

As philosopher Joel Feinberg observed, “[p]aternalism is something we often *accuse* people of,” in large part because paternalism is usually thought to show inadequate respect for personal autonomy.²⁷⁵ Yet, given the context of our discussion, two questions immediately arise. What do we mean by autonomy? Further, is autonomy something we have reason to value when a person has a serious mental illness? To oppose involuntary mental health treatment on civil liberty or autonomy grounds is, as one commentator writes, a case of “autonomy gone mad.”²⁷⁶ To be autonomous in any real sense—in any sense that we are obligated to respect—presupposes a capacity for rational understanding or rational choice, capacities that are significantly diminished when a person is severely and persistently mentally ill. Others question whether there are real liberty interests to contend with here at all:

We argue that the real liberty question regarding individuals with severe psychiatric disorders is whether they are in fact free when ill. If one’s thoughts and behavior are driven by a disease process of the brain over which one has no control, is this truly liberty? “Medication can free victims from their illnesses—free them from the Bastille of their psychoses—and restore their dignity, their free will, and the meaningful exercise of their liberties.”²⁷⁷

Part III.B examines these questions. I begin by expounding Feinberg’s conception of autonomy. I then defend his approach against a few criticisms. I argue that Joel Feinberg’s theory of autonomy has sufficient room to accommodate people with mental illnesses. Nor is it incoherent to claim that persons with mental illnesses have interests in autonomy that we are obligated to respect. I then turn to the justifications for paternalistic intervention. My aim here will be to clarify the meaning of personal autonomy and the moral basis

272. Gerald Dworkin, *Paternalism*, STAN. ENCYCLOPEDIA PHIL., <http://plato.stanford.edu/entries/paternalism> (offering Dworkin’s most recent definition of paternalism).

273. 3 JOEL FEINBERG, *THE MORAL LIMITS OF THE CRIMINAL LAW* 12 (1986)

274. *Id.*

275. *Id.* at 4.

276. Alfred Tauber, *Autonomy Gone Mad*, 10 PHIL. CONTEMP. WORLD 75 (2003).

277. Torrey & Zdanowicz, *supra* note 14, at 341 (quoting Herschel Hardin, *Uncivil Liberties*, VANCOUVER SUN, July 22, 1993, at A15).

for paternalistic intervention and, in doing so, clarify our thinking for the hard cases that will inevitably arise when a person refuses mental health treatment.

1. Autonomy Defined

In his seminal treatise on paternalism, *Harm to Self: The Moral Limits of the Criminal Law*, Joel Feinberg elucidates four conceptions of autonomy: autonomy as the *capacity* to govern oneself; autonomy as the *actual condition* of self-government; autonomy as a *character ideal*; and autonomy as the *sovereign authority* to govern oneself.²⁷⁸

Feinberg understands autonomy to involve both the capacity for self-government and the actual condition of self-government. He defines the capacity for self-government as the capacity to make rational choices.²⁷⁹ For Feinberg and others, the capacity to make rational choices is a threshold concept. “Some competent persons are no doubt more richly endowed with intelligence, judgment, and other relevant capabilities than others,” he writes, “but above the appropriate threshold they are deemed no more competent (qualified) than the others at the ‘task’ of living their own lives according to their own values as they choose.”²⁸⁰

In Feinberg’s view, a person might possess the capacity for self-government—insofar as he has the capacity to make rational choices—but be less than fully autonomous because he does not actually govern himself. There are many ways in which a person might fall short of the actual condition of self-government. “I do not govern myself if you overpower me by brute force,” or if “poverty reduces me to abject dependence on the assistance of others.”²⁸¹ Nor am I autonomous if I am no more than “the mouthpiece of other persons or forces.”²⁸² He writes, “[a]utonomy, so understood, refers to a congeries of virtues,” among them, a person’s interest in being “his own man,” or “her own woman,” her interest in maintaining a distinct self-identity, and importantly, personal authenticity.²⁸³

A person is authentic to the extent that, unlike both the inner-directed and the other-directed person, he can and does subject his opinions and tastes to rational scrutiny. He is authentic to the extent that he can and does alter his convictions for reasons of his own, and does this without guilt or anxiety.²⁸⁴

A conception of autonomy, Feinberg adds, can include the notion of autonomy as “an attractive ideal for human character,”²⁸⁵ with the result that “it

278. FEINBERG, *supra* note 273, at 27-51.

279. *Id.* at 28.

280. *Id.* at 30.

281. *Id.* at 31.

282. *Id.* at 32.

283. *Id.* at 31-32.

284. *Id.* at 33.

285. *Id.* at 31.

is better to be autonomous than not,” all other things being equal.²⁸⁶ In the same way, others have said that a person might value autonomy because she derives pleasure from exercising her capacity for autonomy.²⁸⁷ Or a person might value autonomy because she derives self-respect from being recognized by others as “the kind of creature” who is capable of exercising autonomy.²⁸⁸

Feinberg understands the core of autonomy as the sovereign authority to govern oneself.

The life that a person threatens by his own rashness is after all *his* life; it *belongs* to him and to no one else. For that reason alone, he must be the one to decide—for better or worse—what is to be done with it in that private realm where the interests of others are not directly involved.²⁸⁹

So construed, autonomy involves the sovereign right of self-determination within the boundaries of the personal domain, not unlike the sovereign rights of an autonomous nation-state within its own borders. “My personal domain,” Feinberg writes, consists of the body, privacy interests and “critical life-decisions,” such as what to study or what to career to pursue, and all decisions that are chiefly or primarily self-regarding.²⁹⁰

From John Stuart Mill, Feinberg borrows a useful, albeit imperfect, distinction between self-regarding and other-regarding harm. With minor alternations, I shall rely these definitions as well. Self-regarding harms are those which “chiefly,” “primarily,” or “directly” frustrate the interests of the decision-maker.²⁹¹ Beyond the personal domain are other-regarding harms which “directly and in the first instance affect the choices and sensibilities of other persons.”²⁹²

2. Conceptual Hurdles and Replies

Feinberg’s account privileges authenticity as an element of autonomy. “To the degree to which a person is autonomous he is not merely the mouthpiece of other persons or forces,” he observes.²⁹³ “Rather his tastes, opinions, ideals, goals, values and preferences are all authentically *his*.”²⁹⁴

286. *Id.* at 45. Here Feinberg anticipates the critique from communitarianism: “The ideal of the autonomous person is that of an authentic individual whose self-determination is as complete as is consistent with the requirement that he is, of course, a member of a community.” *Id.* at 47.

287. See GERALD DWORIN, *THE THEORY AND PRACTICE OF AUTONOMY* 112 (1988) (“[T]he process of thinking about, reflecting upon, choosing among preferences is a source of satisfaction to individuals.”).

288. *Id.*

289. FEINBERG, *supra* note 273, at 59.

290. *Id.* at 54-55.

291. *Id.* at 56.

292. *Id.*

293. *Id.* at 32.

294. *Id.*

Feinberg's conception of autonomy as authenticity has natural purchase in a discussion of mental illness. Consider first a person who is intoxicated. After party, it might be quite natural to say, "Please excuse my friend. He has had too much to drink this evening and he is not himself." The claim here is that the person's behavior does not reflect his true self, but rather the influence of alcohol.²⁹⁵ In the same way, people with mental illnesses sometimes experience their symptoms as alien or ego dystonic. In the years before he pushed Kendra Webdale to her death, Andrew Goldstein believed that he was being controlled by someone (named Larry) who inhabited his body and removed his brain.²⁹⁶ When a person refuses treatment in the grip of such a delusion, we will wonder whether his treatment preferences are truly his own. Authenticity conditions are common in the literature on autonomy.²⁹⁷ In Part IV.A, I will argue that the authenticity problem explains much of our dilemma when a person refuses treatment for unusual reasons.²⁹⁸

Still, an account of autonomy that incorporates a notion of authenticity must overcome a few challenges. First, in what sense does autonomy demand that we alter our convictions for reasons of our own? If we take authenticity to require that all of our beliefs are entirely our own, then as Feinberg concedes, "nothing resembling rational reflection can ever get started."²⁹⁹ The requirement that we engage in rational reflection on our convictions is too demanding. Nonetheless, Feinberg has a more modest claim in mind—through a process of critical reflection, the reasons for our actions can become our own. In this way authenticity arises through a process of self-creation and "self-re-creation."³⁰⁰

There is a further sense in which we might question whether it is appropriate to describe tastes, preferences, goals, or values as authentically one's own. Although at times I may act owing to greed, vanity, or foolishness, I do not endorse these character traits. Indeed I may see them as unfortunate character flaws that I would rather not have. Yet, when greed, vanity, and foolishness supply reasons for my actions, are those actions no longer autonomous, insofar as I am inclined to deny that these reasons are authentically my own? Here we can distinguish theories in which autonomy requires second-order identification with first order desires, from accounts in which authenticity requires merely that the agent would acknowledge (or at

295. NOMY ARPALY, *UNPRINCIPLED VIRTUE: AN INQUIRY INTO MORAL AGENCY* 123 (2003).

296. CHARLES PATRICK EWING, *INSANITY: MURDER, MADNESS AND THE LAW* 115 (2008).

297. See Natalie Stoljar, *Theories of Autonomy*, in *PRINCIPLES OF HEALTH CARE ETHICS* 11, 14 (R.E. Aschroft et al. eds., 2007); Timothy Kolke, *Procedural vs. Substantive Theories of Autonomy: Reinterpreting the Connection Between Good Values and Autonomy*, *PROLEGOMENA* 1 (2003).

298. See *infra* notes 383-400 and accompanying text.

299. FEINBERG, *supra* note 273, at 33.

300. *Id.* at 35 (emphasis in original).

least others would acknowledge) that the reasons for the agent's actions were not at all alien to him, but "for better or worse part of the way he is."³⁰¹ For Feinberg, authenticity involves the latter. The result is that for Feinberg, the excuse we make for our drunken friend is merely a metaphor, while delusions reported by Andrew Goldstein would be sufficient to cast doubt on his treatment preferences.

Others might respond that autonomy does not require authenticity at all. For Gerald Dworkin, what matters is not that my reasons are my own, but rather than I have the *capacity* to question whether I will identify with or reject the reasons for my actions.³⁰² The relevant capacity is the ability to engage in second-order reflection on our first order motivations and the ability to choose those motivations if desired.³⁰³ By "identify with," I understand Dworkin to mean that a person identifies with the reasons underlying her actions when she has made those reasons her own, or comes to see them as her own.³⁰⁴ In Dworkin's view, a conception of autonomy worthy of our respect must meet several other constraints, foremost among them, a requirement of procedural independence.³⁰⁵ A person would not count as autonomous under Dworkin's view if he has been hypnotized into identifying with his first-order motivations, otherwise coerced, manipulated, or subliminally influenced. While Dworkin rejects authenticity or any other substantive rider on autonomy, by itself, a procedural account of autonomy is not one we ought to adopt.

For Dworkin, a conception of autonomy that insists on a condition of substantive independence such as authenticity would be inconsistent with other values we hold: loyalty, objectivity, commitment, benevolence, and love.³⁰⁶ Dworkin thinks that if a person wants to conduct his life in accordance with the principle that he should do what others tell him to do, we should not, by virtue of that reason, fail to count him as autonomous. To use Dworkin's example, if a person wants to conduct his life in accordance with the following—"[d]o whatever my mother or my buddies or my leader or my priest tells me to do"—then so long as that person has not been manipulated in ways that violate procedural independence, we should count that person as autonomous.³⁰⁷

Yet, we would not be hard pressed to reconcile authenticity with a commitment to each of these values. As Dworkin rightly points out,

301. Compare FEINBERG, *supra* note 273, at 165, with Harry G. Frankfurt, *Freedom of the Will and the Concept of a Person*, in *FREE WILL* 322, 327-30 (Gary Watson ed., 2003) (asserting that autonomy requires second-order identification with first-order desires).

302. DWORKIN, *supra* note 287, at 15-20.

303. *Id.* at 20.

304. As in the following: "A person may identify with the influences that motivate him, assimilate them to himself, view himself as the kind of person who wishes to be moved in particular ways. Or, he may resent being motivated in certain ways, be alienated from those influences, prefer to be the kind of person who is motivated in different ways." *Id.* at 15.

305. *Id.* at 16.

306. *Id.* at 21.

307. *Id.*

commitments to each of these values—loyalty, objectivity, benevolence and love—will sometimes require that we put the interests of others ahead of our own. However, authenticity only requires that our reasons for acting out of loyalty or benevolence are in some sense our own. In other words, authenticity only requires that we do not put the interests of others ahead of our own because our mothers said so or because altruism is in vogue, but rather because, at some point, upon reflection we realize that we have reason to value loyalty, objectivity, benevolence, and love, independent of the fact that someone else told us to do so. The fact that the people we respect—our mothers, our buddies, our leaders or our priests—steered us in this direction is not inconsistent with authenticity, or autonomy, nor is it enough.

3. Autonomy and Mental Illness

In *Rivers v. Katz*, the New York Court of Appeals upheld the right to refuse treatment on autonomy grounds.³⁰⁸ With Feinberg's taxonomy in hand, we are now in a position to understand the meaning (or meanings) of autonomy and the myriad autonomy interests of people who are subject to outpatient commitment orders.

Consider the interest in autonomy as sovereignty. Because outpatient commitment orders are less restrictive than inpatient commitment, and since these laws do not permit the use of force to administer medication over a person's objection, there is a tendency to view the intrusion on personal sovereignty as "minimal," and therefore without serious moral consequence.³⁰⁹ Yet sovereignty, as Feinberg declares, is "an all or nothing concept . . ." In the political model, a nation's sovereignty is equally infringed by a single foreign fishing boat in its territorial waters as by a squadron of fighter jets flying over its capital city."³¹⁰ A person is entitled to sovereign authority over her domain, no matter how trivial the intrusion may seem to others. We would not describe the presence of the fishing boat as an inconsequential forfeiture of sovereignty, any more than we should characterize an order to participate in group therapy—for several hours a day, several days a week—as a trivial intrusion on personal autonomy.

For good reason, some who are ordered to participate in outpatient treatment on wholly paternalistic grounds will feel not merely irked, annoyed, or inconvenienced, but rather belittled and demeaned. The essence of their grievance includes both an interest in autonomy as personal sovereignty, as well as an interest in autonomy as an ideal of character or human flourishing.

308. 67 N.Y.2d 485, 497-98 (1986); see also *supra* text accompanying note 194.

309. But see Jessica Wilen Berg & Richard Bonnie, *When Push Comes to Shove*, in *COERCION AND AGGRESSIVE COMMUNITY TREATMENT* 169, 172-77 (Deborah L. Dennis & John Monahan eds., 1996) (claiming that while outpatient commitment might impose fewer restrictions on physical liberty, "in many ways it may be more intrusive with regard to a person's privacy interests" owing primarily to warrantless removal procedures).

310. FEINBERG, *supra* note 273, at 55.

Earlier I said that a person might value autonomy because she wants to be viewed by others as “the kind of creature” who is capable of exercising autonomy.³¹¹ A respondent who appeared in court to contest a petition to renew his assisted outpatient treatment order put the point well:

Q: Why do you want to graduate, what is the big deal about graduating?

A: The big deal is I have to successfully accomplish things I need to accomplish in my life I want to move forward in my life I want to have a plaque that I could show myself I did this.³¹²

On a Wednesday morning in Brooklyn, the respondent appeared in court to contest the petition, dressed in a jacket and tie, with his partner and their two-year-old daughter in tow.³¹³ He explained that he would continue taking his medications and talking with his counselor, and that he would continue group therapy but no longer wanted to be on a court order:

Q: What’s the difference between being on a Court Order as opposed to not being on one?

A: I feel like I am in jail I don’t know the doctors I just want to . . . handle what I have to handle and [without] anything above my head. I just want to handle without a Court Order.³¹⁴

For the respondent, it mattered immensely that he was able to show himself and his family that he had “accomplished” something by graduating and handling his mental health treatment without being perceived as someone who requires the oversight of a court order. For him, the injury of outpatient commitment was an injury to his interest in autonomy as an ideal of human character or excellence, as well as an injury to his interest in personal sovereignty.

We can expect cases where mental disorder compromises personal autonomy and casts doubt on the authenticity of a person’s preferences. Schizophrenia, bipolar disorder, and depression can impair the ability to reason and, in turn, the capacity for self-government. In the grip of mania, a person with bipolar disorder might refuse treatment because he has come to see himself as invincible, with no need for treatment. A person with clinical depression might refuse treatment because, owing to depression, he sees himself as beyond hope and his life as no longer valuable.

However, not all of the reasons a person might offer for refusing treatment are so obviously distorted by mental illness. As Elyn Saks writes, when a person refuses treatment, it may be that she is expressing “a legitimate preference for the symptoms over the cure.”³¹⁵ Anti-psychotic medications are

311. DWORKIN, *supra* note 287, at 112.

312. In the Matter of the Application of Adam Karpati, Director of Community Services of the Dep’t of Health and Mental Hygiene for an Order Authorizing and Additional Period of Assisted Outpatient Treatment for John Doe at 29 (N.Y. Sup. Ct. 2010) (No. 300202/10) (transcript on file with author).

313. The author was in the courtroom during the hearing.

314. In the Matter of the Application of Adam Karpati, *supra* note 312, at 31.

315. Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945, 990 (1991).

effective, but many of them have adverse side effects including sedation, sexual dysfunction, and weight gain, as well as an elevated risk of cardiovascular disease and diabetes.³¹⁶ People who are able to function in spite of their illness might oppose additional orders of assisted outpatient treatment because they find it difficult to go to work or school when they are required to participate in a partial day program for several days a week. Some might not like their clinicians, while others who have already participated in the program might find group therapy sessions repetitive and unhelpful. Many people with serious mental disorders—particularly those who are well enough to qualify as candidates for outpatient (rather than inpatient) commitment—are capable of forming preferences about treatment that are the product of reasonably rational reflection on their treatment experiences and goals. Respect for their autonomy requires respect for their treatment preferences even when others think they are imprudent.

4. When—If Ever—Is Paternalism Justified?

a. Retrospective Endorsement Theories

Some scholars contend that involuntary mental health treatment can be justified on a theory of retrospective endorsement.³¹⁷ The claim here is that even when people initially refuse treatment, once they have recovered from an episode of illness, in retrospect, some will be grateful that they were compelled to accept treatment at a time when they could not think rationally about their needs.³¹⁸

Although many clinicians have patients who feel this way, retrospective endorsement theories of paternalism quickly run into problems. Liberal theorists have largely rejected subsequent consent theories of paternalism on conceptual grounds. We are after an *ex ante* justification for paternalism; at best, a subsequent consent theory can only provide a normative justification for an act that has already taken place.³¹⁹ Moreover, empirical studies on so-called “thank you theories” of civil commitment have produced mixed results. A large randomized controlled trial of outpatient commitment in North Carolina found

316. Monika Edlinger et al., *Factors Influencing the Choice of New Generation Antipsychotic Medication in the Treatment of Patients with Schizophrenia*, 113 SCHIZOPHRENIA RES. 246, 249-50 (2009).

317. See, e.g., ALAN STONE, MENTAL HEALTH AND THE LAW: A SYSTEM IN TRANSITION 18-19 (1975) (advancing his “thank you” theory of civil commitment).

318. DEBRA A. PINALS & DOUGLAS MOSSMAN, EVALUATION FOR CIVIL COMMITMENT 82 (2012).

319. Douglas Husak, *Paternalism and Consent*, in THE ETHICS OF CONSENT 107 (Franklin G. Miller & Alan Wertheimer eds., 2009); DONALD VANDEVEER, PATERNALISTIC INTERVENTIONS: THE MORAL BOUNDS OF BENEVOLENCE 66-69 (1986).

little evidence to support a retrospective endorsement theory.³²⁰ Instead, as the authors note, most study participants did not endorse the benefits of outpatient treatment either because they did not believe that [outpatient commitment] was effective, or because they refused to believe that they needed treatment, or both.³²¹

b. The Soft Paternalist Strategy

I shall adopt a soft paternalist theory of intervention and consider objections from hard paternalism in Part V. Soft paternalism holds that government interventions into self-regarding harm are justified when, and only when, the actions or choices of the person concerned are substantially nonvoluntary, or when temporary intervention is necessary to determine whether the person's choices or actions are substantially nonvoluntary. John Stuart Mill offers a famous example:

If either a public officer or anyone else saw a person attempting to cross a bridge which had been ascertained to be unsafe, and there were no time to warn him of his danger, they might seize him and turn him back without any real infringement of his liberty; for *liberty consists in doing what one desires*, and he does not desire to fall in the river.³²²

If we see someone about to cross an unsafe bridge, we may pull him out of harm's way if there is no time to warn him. According to Mill, since "liberty consists in doing what one desires," we do not violate his interests in liberty. In the same way, Feinberg contends that when governments intervene in self-regarding harm, the concern should not be with the wisdom or prudence of a person's choice, "but rather with whether or not the choice is truly his" own.³²³

Both philosophers recognize defects of reason as a justification for intervention into self-regarding harm. For example, the harm principle takes a strong position against paternalism;³²⁴ Mill, however, hastens to add: "[i]t is, perhaps, hardly necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties."³²⁵ Similarly, Feinberg enumerates a list of "voluntariness-vitiating" factors—ignorance, coercion, drugs, and of course, "derangement."³²⁶ Thus, one liberal answer to the question posed above is that we may intervene into self-regarding conduct

320. Marvin Swartz et al., *Endorsement of A Personal Benefit Among Persons with Severe Mental Illness*, 9 PSYCH. PUB. POL'Y & L. 70, 90 (2003).

321. *Id.* at 75-77.

322. JOHN STUART MILL, ON LIBERTY 12 (Elizabeth Rapport ed., 1978) (emphasis added).

323. FEINBERG, *supra* note 273, at 12.

324. *See* MILL, *supra* note 322, at 12 ("The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.")

325. *Id.*

326. FEINBERG, *supra* note 273, at 12.

when that conduct is rendered substantially nonvoluntary by mental impairment.

In recent years, the notion that schizophrenia and bipolar disorder can cause damage to parts of the brain has grown tremendously as a moral justification for involuntary outpatient commitment.³²⁷ The argument is that damage to certain parts of the brain causes impaired insight and therefore we have reason to interfere with the treatment decisions of people who have been diagnosed with these disorders. In Part III.C, I argue that we should reject the impaired insight argument.

C. *Impaired Insight*

One might think that outpatient commitment orders are justified by virtue of the fact that, unlike people with general medical conditions, people with mental illnesses lack the capacity to make treatment decisions on their own. Therefore, courts may order outpatient treatment for them. But not all people with mental illnesses are incompetent to make treatment decisions,³²⁸ and most outpatient commitment laws do not require a determination of incompetence. Instead supporters of involuntary outpatient commitment, foremost among them psychiatrist E. Fuller Torrey, argue that outpatient commitment should be considered for anyone with a severe psychiatric disorder who lacks insight into his or her illness and is at risk of harming themselves or others.³²⁹

1. Impaired Insight Defined

In psychiatry, the term “insight” generally refers to the patient’s awareness that he or she is suffering from an illness. In an early and influential paper on the psychopathology of insight, Aubrey Lewis described insight as “a correct

327. See, e.g., 113 CONG. REC. H6749-50 (daily ed. July 24, 2014) (statement of Rep. Murphy) (discussing anosognosia and The Helping Families in Mental Health Crisis Act, H.R. 3717); Kress, *supra* note 2, at 1274; Torrey & Zdanowicz, *supra* note 14, at 338; see also Dale, *supra* note 16 (discussing impaired insight); Guido Zanni et al., *The Effectiveness and Ethical Justification of Psychiatric Outpatient Commitment*, 7 AM. J. BIOETHICS 31, 33 (2007) (discussing anosognosia as an important justification for outpatient commitment);

328. See generally Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study III*, LAW & HUM. BEHAV. 149, 169-72 (1995) (discussing three measures of competence—understanding, appreciation, and reasoning). The MacArthur Treatment Competence Study found that patients with schizophrenia and depression were more likely to show decisional deficits when compared to patients with heart disease and a non-medically ill control group. However, despite the overall poorer performance of the mentally ill patients, on any given measure of competence, most patients with schizophrenia did not score below patients with heart disease or the non-medically ill control group. Instead the generally poorer performance of people with schizophrenia was attributed to a minority of patients within the group whose symptoms were most severe.

329. E. Fuller Torrey & Mary Zdanowicz, *Outpatient Commitment: What, Why and for Whom?*, 52 PSYCHIATRIC SERVICES 337 (2001).

attitude toward morbid change in oneself.”³³⁰ Modern approaches define insight along similar dimensions. In a foundational article on insight and psychosis, Anthony David conceptualized insight along three distinct, though overlapping dimensions—(i) recognition that one has a mental illness; (ii) compliance with treatment; and (iii) the ability to relabel unusual mental events, such as delusions and hallucinations, as pathological.³³¹

Xavier Amador and D.H. Strauss have advanced a similar model in which insight consists of two components—(i) awareness of illness and (ii) attribution of illness.³³² As Amador and Kronengold write: “[u]nawareness of illness reflects an individual’s failure to acknowledge the presence of a specific defect or sign of illness even when confronted with it by an examiner,” while incorrect attribution, on the other hand, “reflects the individual’s expressed belief that the specific deficit, sign or consequence of illness does not stem from mental dysfunction.”³³³ The widely used Scale to Assess Unawareness of Mental Disorder (SUMD) based on their model allows interviewers to assess current and retrospective awareness of having a mental disorder. Interviewers use the SUMD to assess awareness of particular signs and symptoms of mental disorder, awareness of treatment benefits, and the psychosocial consequences of having a disorder.³³⁴

2. The Neuroscience of Insight

In the debate surrounding Kendra’s Law, neuroscientific evidence regarding the biological basis of impaired insight has played an important role in the moral justification for outpatient commitment. E. Fuller Torrey and Mary Zdanowicz write:

We argue that outpatient commitment is needed because many individuals with severe psychiatric illness lack awareness of their illness. This deficit is biologically based and is not the same thing as psychological denial. Both schizophrenia and bipolar disorder affect the prefrontal cortex, which is used for insight and understanding one’s needs. When this area of the brain is damaged, the person loses self-awareness.³³⁵

330. Aubrey Lewis, *The Psychopathology of Insight*, 14 BRIT. J. PSYCHOL. 332, 333 (1934); see also Anthony S. David, “To See Ourselves as Others See Us: Aubrey Lewis’s *Insight*,” 175 BRIT. J. PSYCHOL. 210 (1999).

331. Anthony S. David, *Insight and Psychosis*, 156 BRIT. J. PSYCHIATRY 798, 805 (1990).

332. Xavier F. Amador & D.H. Strauss, *Poor Insight in Schizophrenia*, 64 PSYCHIATRIC Q. 305, 307 (1993).

333. Xavier F. Amador & Henry Kronengold, *The Description and Meaning of Insight in Psychosis*, in *INSIGHT AND PSYCHOSIS: AWARENESS OF ILLNESS IN SCHIZOPHRENIA AND RELATED DISORDERS* 17 (Xavier F. Amador & Anthony S. David eds., 1998).

334. Xavier F. Amador et al., *The Assessment of Insight in Psychosis*, 150 AM. J. PSYCHIATRY 873 (1993).

335. Torrey & Zdanowicz, *supra* note 14, at 338.

Torrey and Zdanowicz are outspoken proponents of outpatient commitment and the directors of the Treatment Advocacy Center, a non-profit organization dedicated to eliminating barriers associated with the treatment of mental illness and promoting outpatient commitment laws.³³⁶ Torrey and Zdanowicz argue that impaired illness awareness, common among patients with schizophrenia, resembles anosognosia among patients with neurological disorders such as Alzheimer's disease, or patients who have suffered a stroke.³³⁷ In classic cases of anosognosia, paraplegic patients who have suffered damage to the right hemisphere of the brain will deny that they are paralyzed on the left side of the body. When confronted with the affected limb, anosognostic patients sometimes insist that the limb is not their own or express indifference in response to their paralysis.³³⁸ In the same way, it is not uncommon for patients with schizophrenia to deny the symptoms of mental illness. A study by Xavier Amador and colleagues assessed more than 400 patients with psychotic disorder and found that nearly 60% of patients with schizophrenia were unaware of having a mental illness. When asked whether they had any mental, psychiatric, or emotional problems, most patients answered with an emphatic "no."³³⁹ When compared to patients with bipolar disorder or schizoaffective disorder, patients with schizophrenia were also less likely to acknowledge specific symptoms of mental disorder, including delusions, hallucinations, thought disorder, and blunted affect.

Torrey and Zdanowicz argue that impaired illness awareness is biologically based and therefore distinguishable from mere psychological denial. For Torrey and Zdanowicz, the neurobiological basis of impaired illness awareness furnishes a critical distinction between people with mental illnesses and other people with general medical conditions who sometimes refuse treatment. As the authors write, we can assume that when people with heart disease or arthritis refuse treatment, "their cognitive functioning and awareness of their illness are intact"; however, "one cannot make this assumption about an individual who has a severe psychiatric disorder."³⁴⁰ In the same way, other supporters of outpatient commitment argue that community treatment orders are justified for those whose "brain disorders prevent them from making an informed decision."³⁴¹

Although plausible, arguments along these lines are not without their problems. First, while many studies have found a significant relationship between impaired insight and poor performance on tests of frontal lobe

336. *Who We Are and What We Do*, TREATMENT ADVOC. CENTER, <http://www.treatmentadvocacycenter.org/about-us> (last visited Dec. 14, 2014).

337. Torrey & Zdanowicz, *supra* note 14, at 337.

338. See Amador & Kronengold, *supra* note 333, at 26.

339. Xavier F. Amador et al., *Awareness of Illness in Schizophrenia*, 51 SCHIZOPHRENIA BULL. 826, 828-29 (1994).

340. Torrey & Zdanowicz, *supra* note 14, at 338.

341. Dale, *supra* note 16, at 274 (quoting Mark R. Munetz et al., *The Ethics of Mandatory Community Treatment*, 31 J. AM. ACAD. PSYCHIATRY & L. 173, 175 (2003)).

function, many studies of comparable design and quality have not.³⁴² Researchers have also used magnetic resonance imaging scans to examine the relationship between impaired insight and structural abnormalities in the brain, but here again the findings are inconsistent.³⁴³

Instead, the empirical literature suggests that there multiple pathways to impaired insight, and many of them have little or nothing to do with cognitive impairment. In some instances, a denial of mental illness may result from psychological denial regarding the severity of symptoms. Researchers posit that at least for some patients the pretense of illness unawareness is a coping mechanism whereby the symptoms of psychosis are recast as positive events or avoided in order to avoid the stigma of schizophrenia.³⁴⁴ Similarly, a person might deny that he has a mental illness because he believes that he has been wrongly diagnosed with a mental illness or at the very least misdiagnosed. For the same reasons, a person might deny the benefits of treatment or understate the consequences of refusing treatment because in his experience he has been overmedicated or inappropriately medicated. We know that African American men—who are often the subject of court-ordered outpatient treatment—are significantly more likely to be misdiagnosed with schizophrenia, giving them good reason to challenge their diagnoses and the benefits of treatment in court.³⁴⁵

Even when a person is prepared to acknowledge troubling or distressing symptoms to himself, stigma surrounding the term “mental illness” can sometimes cause a person to deny that his experience is properly classified as a mental illness. For others, a denial of mental illness will stem from a fundamental difference of opinion about what it means to have an “illness.” Whether a person understands himself as ill will depend on his experience of what it means to be ill, the meaning of the term “illness” in the world around him, and his observation of others who have been classified as ill.

342. See generally IVANA S. MARKOVÁ, *INSIGHT IN PSYCHIATRY* 103 (2005) (reviewing the empirical literature on insight and psychosis).

343. See, e.g., Laura Flashman et al., *Smaller Brain Size Associated with Unawareness of Illness in Patients with Schizophrenia*, 157 *AM. J. PSYCHIATRY* 1167 (2000). But see S.L. Rossell et al., *Insight: Its Relationship with Cognitive Function, Brain Volume and Symptoms in Schizophrenia*, 33 *PSYCHOL. MED.* 111 (2003) (finding no association between insight and neuroanatomical measures, including white- and grey-matter volume).

344. Michael Startup, *Awareness of One's Own and Others' Schizophrenic Illness*, 26 *SCHIZOPHRENIA RES.* 203, 203 (1997); see also Paul Lysaker et al., *Patterns of Neurocognitive Deficits and Unawareness of Illness in Schizophrenia*, 191 *J. NERVOUS & MENTAL DISEASE* 38 (2003) (positing that subgroups of patients with poor insight may show poor insight for different reasons including poor cognition and poor reality testing as well as a tendency to deny unpleasant things).

345. See Arnold Barnes, *Race and Hospital Diagnoses of Schizophrenia and Mood Disorders*, 53 *SOC. WORK* 77, 80 (2008). See generally JONATHAN MENZEL, *THE PROTEST PSYCHOSIS: HOW SCHIZOPHRENIA BECAME A BLACK DISEASE* (2011).

3. Impaired Insight in The Courtroom

Evidence regarding impaired insight can also play a role in assisted outpatient commitment hearings.³⁴⁶ For example, although Kendra's Law does not use the term "insight," court-ordered outpatient treatment requires evidence that "as a result of his or her mental illness," the subject of a petition for AOT is unlikely to participate in outpatient treatment voluntarily.³⁴⁷ In the same way, the legislative findings for Kendra's Law note that there are some people with mental illnesses who are capable of surviving safely in the community but often reject voluntary outpatient treatment "because of their illness."³⁴⁸ To that end, it is not uncommon for clinicians to reference poor insight as evidence that the person is unlikely to cooperate with outpatient treatment absent court ordered supervision.³⁴⁹

Clinical judgments regarding the patient's level of insight are extraordinarily difficult to challenge in court. Accounts from patients regarding their illness are routinely discounted. Judgments about insight may also depend on the patient's attitudes toward treatment and whether patients agree with their diagnosis. For example, in a small study where psychiatrists were asked to describe their understanding of insight and its relationship to diagnosing schizophrenia, researchers found that psychiatrists tended to construct insight as the patients' ability "to conceptualize what is happening to them in terms of the dominant model of mental illness."³⁵⁰ The authors continued: "[n]ot only is the patient supposed to understand that they are ill, but crucially, they are to

346. See generally Candice T. Player, *Outpatient Commitment and Procedural Due Process*, 38 INT'L J.L. & PSYCHIATRY (forthcoming 2015) (on file with author) (finding that in a little more than half of the contested cases observed, psychiatrists testified that the respondent lacked insight into his or her mental illness or the need for treatment). Researchers in the United States have paid little attention to the role of impaired insight in outpatient commitment proceedings. Observers in England, New Zealand and Australia have, however, questioned the role of insight in the deliberation of mental health tribunals. These tribunals are responsible for issuing community treatment orders and deciding whether to discharge patients. See, e.g., Kate Diesfeld, *Insights on "Insight": The Impact of Extra-Legislative Factors on Decisions to Discharge Detained Patients*, in INVOLUNTARY DETENTION AND THERAPEUTIC JURISPRUDENCE: INTERNATIONAL PERSPECTIVES ON CIVIL COMMITMENT (Kate Diesfeld & Ian R. Freckelton eds., 2003); John Dawson & Richard Mullen, *Insight and Use of Community Treatment Orders*, 17 J. MENTAL HEALTH 269, 278 (2008) (finding that impaired insight was a reason for continuing treatment orders in a qualitative study of forty-two outpatients, clinicians, and caregivers in New Zealand).

347. N.Y. MENTAL HYG. LAW § 9.60(c)(5) (2006) (McKinney, Westlaw through 2014 Sess.).

348. Mental Hygiene—Community-Based Settings—Kendra's Law, ch. 408, S.5762-A, 1999 N.Y. Sess. Law (codified as amended at N.Y. MENTAL HYG. LAW § 9.60 (McKinney, Westlaw through 2014 Sess.).

349. See generally Player, *supra* note 346.

350. Dariusz Galasinski & Konrad Opalinski, *Psychiatrists' Accounts of Insight*, 22 QUALITATIVE HEALTH RES. 1460, 1463 (2012).

adopt and accept the psychiatric view and understanding of their experiences.”³⁵¹

An attorney who represents respondents in assisted outpatient treatment proceedings expressed a similar frustration. When her clients are asked whether they have a mental illness, she explained that “doctors are looking for a very specific answer to that question” even though many of her clients would prefer to describe their symptoms as the product of a “chemical imbalance” or anything other than a mental illness.³⁵² The same attorney wondered whether her clients would ever be able to verbalize the symptoms of their mental illnesses in a way that would convince the court of their insightfulness.

It may be that we underestimate what it would require to enter a courtroom, sit before a judge, and make an oral argument on one’s own behalf. The ideal respondent would describe her symptoms in detail, eloquently remarking on the textbook definition of her illness and her particular illness experience. However, when respondents fall short of this standard, what are we really hearing? How much of their lackluster testimony is the result of poor education, lack of preparation, anxiety, or the foreignness of the forum and the foreignness of the task itself?

The attorney felt that what should matter in these proceedings is whether her clients are actually complying with treatment. However, even if insight were a function of the respondent’s behavior, it would be incredibly difficult for the respondent to convince the court that a period of treatment compliance during the preceding AOT order was the result of greater insight. The problem for trial judge is plain—how can a judge know whether a period of treatment compliance was the product of greater insight or the threat of a seventy-two hour hospitalization?

4. An Objection from Autonomy

Thus far, I have argued that we ought to reject impaired insight as a morally significant distinction between people with mental illnesses and others on largely epistemic grounds. However, impaired insight approaches are also vulnerable to objections from autonomy. To ask whether a person possess insight into his illness is to ask whether he recognizes his symptoms as the symptoms of a mental illness, whether he appreciates the seriousness of those symptoms, and whether he recognizes the need for treatment—in short, whether he possesses “a correct attitude toward morbid change in oneself.”³⁵³

351. *Id.* at 1465.

352. Interview with Jane Doe, Attorney, Mental Hygiene Legal Service, in New York, N.Y. (June 15, 2011) (on file with author).

353. Aubrey Lewis, *The Psychopathology of Insight*, 14 BRIT. J. PSYCHOL. 332, 333 (1934); see also Anthony S. David, “To See Ourselves as Others See Us,” 175 BRIT. J. PSYCHOL. 210 (1999).

In his work on paternalism, Joel Feinberg contends that autonomy refers to a multiplicity of virtues beyond an interest in self-determination, and foremost among them is a person's interest in being "his own man," or "her own woman," and importantly, her interest in maintaining a distinct self-identity.³⁵⁴ Feinberg's conception of autonomy captures much of what a person might find offensive about a clinical concept that require patients to endorse a biomedical understanding of their experience. In Part IV, I argue that we should reject impaired insight as a measure of diminished mental capacity and instead limit assisted outpatient treatment to people with mental illnesses who are unable to make competent treatment decisions on their own.

III. THE LIMITS OF PREVENTION

The central concern of this Article can be thought of in terms of the following question: under what circumstances can we impose substantial restraints on individual liberty because we believe a person is likely to harm himself or others before he has actually done so? Let me begin to answer this question by contrasting consequentialist and non-consequentialist theories of moral justification.

A utilitarian or consequentialist theory of outpatient commitment would ask whether, in the balance of benefits against harms, the good associated with outpatient commitment outweighs the harms associated with infringing personal autonomy and the right to refuse treatment. For a utilitarian the balance weighs heavily in favor of outpatient commitment. The harms to be avoided are grave—chronic homelessness, violent crime, violent victimization, incarceration, and suicide. In Part III we saw that although the evidence on effectiveness is mixed, at least under some circumstances, outpatient treatment orders are associated with substantial welfare gains—fewer hospitalizations, a greater likelihood of receiving appropriate medications, and fewer arrests. If we adopt the view of the Court of Appeals in *Matter of K.L.*, the interference with personal autonomy is minimal. Therefore we are unlikely to create more harms than we prevent by requiring people with mental illnesses to participate in outpatient treatment programs.

At the same time, utilitarian theories violate many of our intuitions about the special respect owed to persons.³⁵⁵ From a utilitarian outlook, rights have

354. FEINBERG, *supra* note 273, at 32.

355. See JOHN RAWLS, A THEORY OF JUSTICE 3-4 (1971). Rawls observes: Each person possesses an inviolability founded on justice that even the welfare of society as a whole cannot override. For this reason justice denies that the loss of freedom by some is made right by the greater good shared by others. Therefore in a just society the liberties of equal citizenship are taken as settled; the rights secured by justice are not subject to . . . the calculus of social interests.

Id. Here Rawls refers eloquently to "the liberties of equal citizenship." *Id.* Later in *Political Liberalism*, it becomes clear that he has in mind the liberties secured by the federal Constitution, including rights to privacy, secured by the Due Process Clause, and by extension—I argue—the liberty interest in refusing unwanted medical treatment. See JOHN

no moral force aside from their contribution to utility. Yet rights protect myriad interests in autonomy and reflect deeply held moral norms. Consider our earlier conceptions of autonomy and the right of a competent person to refuse treatment. For the person whose competence is being assessed, the right to accept or refuse treatment will often hold a combination of instrumental and non-instrumental value. Although the physician brings her knowledge of medicine and health to the doctor patient relationship, “health is only one value among many.”³⁵⁶ Once the physician has informed me of the risks and benefits associated with a particular treatment, I am in the best position to determine “which intervention, if any, best serves my wellbeing, as I conceive it.”³⁵⁷ Thus the right to make important treatment decisions may be instrumentally valuable in the promotion of wellbeing.

However, even when others are in a better position to make choices for us, most people want to make important choices about their own lives. Often our choices, ranging from the mundane and everyday, to important choices about how to live our lives, have both instrumental and non-instrumental value. For example, choices about medical treatment are likely to have considerable symbolic value.³⁵⁸ Most people who are competent to make decisions about medical treatment are permitted to do so. Therefore, I may value choice because without it, I will feel that the absence of choice is degrading. If I am a person of faith, I may value choices regarding medical treatment—including the choice to forego treatment—because it matters to me that I am able to incorporate elements of my faith into healing. In these moments, my choices about treatment may have considerable demonstrative value.

Part IV develops a nonconsequentialist or rights-based theory of outpatient commitment. The reasons for adopting a rights-based theory are intimately connected to our view of human beings as moral persons who are capable of autonomy, and indeed persons with many interests in autonomy.³⁵⁹ To advance a nonconsequentialist theory of outpatient commitment is not to say that consequences do not matter, but rather that given our view of persons, moral rights to non-interference cannot be infringed simply because doing so would produce gains in utility, social welfare, or even individual wellbeing. Part IV.A begins with self-regarding harm. When our primary concern is one of self-regarding harm, I argue that a court order to participate in outpatient treatment

RAWLS, *POLITICAL LIBERALISM* 227-28 (1993); *see also* DWORKIN, *supra* note 18, at 171-83 (1977) (rejecting utilitarianism as inconsistent with the inconsistent with rights of equal concern and respect owed to persons).

356. ALLEN E. BUCHANAN & DAN W. BROCK, *DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING* 30 (1990).

357. *Id.*

358. *See* T.M. Scanlon, *The Tanner Lectures on Human Values* at Brasenose College, Oxford University: *The Significance of Choice* (May 16, 23 & 28, 1986) (discussing the symbolic and demonstrative value of choice).

359. Dan W. Brock, *Involuntary Civil Commitment: The Moral Issues*, in *MENTAL ILLNESS: LAW AND PUBLIC POLICY* 147, 161 (Baruch A. Brody & H. Tristram Engelhardt, Jr. eds., 1980).

may be appropriate, but only for people with mental illnesses who are incompetent to make treatment decisions on their own.

In Part IV.B, I turn to the dilemma of other-regarding harm. Moral rights reflect a view of persons as moral agents who are not only capable of autonomy but moral responsibility. Although there is a large literature on moral responsibility, I shall rely on a theory of moral responsibility as responsiveness to reasons.³⁶⁰ By moral responsibility, I mean the ability to recognize both moral and prudential reasons for or against an action, the ability to understand how reasons fit with actions, and the ability to use reason to guide our actions.³⁶¹

A pre-crime system where agents identify and seize persons for crimes they are predicted to commit might produce gains in utility. Yet because we view human beings as unique in their capacities for moral agency, in a liberal society, the criminal process is—and must be—the primary mechanism by which governments deprive citizens of their liberty when they threaten harm to others. For reasons similar to those articulated by the Supreme Court in *Kansas v. Hendricks* and *Kansas v. Crane*, Part IV.B asserts that the moral legitimacy of outpatient commitment depends on a more explicit and principled limitation to people who are dangerous but also lacking in the moral capacities for criminal responsibility than is currently the case under outpatient commitment law.

A. *Harm to Self*

1. Competence to Refuse Treatment

Involuntary outpatient commitment may be appropriate for people with mental illnesses who are unable to make competent treatment decisions on their own. But what does competence entail? As Alan Buchanan and Dan Brock have observed, competence is always competence “to do something” at a particular time, under particular circumstances; therefore, the appropriate concept of competence is decision-relative and variable.³⁶² Second, settling on an appropriate competence standard is not simply a matter of settling on the correct test, but rather a process of balancing competing values and guarding against two kinds of error.³⁶³ The first error (Type I or false positive) results from choosing a standard of competence that is too low and failing to protect the person from the harmful consequences of his or her decisions when those decisions stem from serious defects in the capacity to decide. The second error

360. I rely on Fischer and Ravizza’s account of moral responsibility as responsiveness to reasons. JOHN MARTIN FISCHER & MARK RAVIZZA, *RESPONSIBILITY AND CONTROL: A THEORY OF MORAL RESPONSIBILITY* (1998).

361. *Id.* at 69.

362. BUCHANAN & BROCK, *supra* note 356, at 18.

363. *Id.* at 40-41.

(Type II or false negative) results when we choose a threshold for competence that is too high and fail to allow a person to make her own choices when she is able to do so.³⁶⁴

Like most authors on competence, I agree that competence to refuse treatment requires the ability to understand key facts involved in a decision to refuse treatment, the ability to engage in basic reasoning about those facts, the ability to reach a decision, and the ability to communicate a stable choice. However, in contrast to other authors on competence, I argue that an emphasis on appreciation or insight as a measure of competence is misplaced.³⁶⁵ Indeed “appreciation,” the legal correlate of insight, should have no role to play in our thinking about competence.

a. Understanding and Appreciation

A person who is competent to refuse treatment must possess at least a rudimentary understanding of the basic features of his illness and the proposed treatment plan. Whether he believes he has an illness or not, and whether he believes that treatment will help him or not, he must at least understand that his physician believes he has an illness and that his physician believes the recommended treatment could help him. Any less, and we would worry that the person is too impaired or too disoriented for us to view his treatment decisions as competent.

As to this element of competence, it should be enough that the person understands his decision in this basic factual sense—he is aware of his medical diagnosis, he can explain it in lay terms, and he understands the proposed treatment plan, as well as the primary risks and benefits associated with treatment. However, most authors on competence think that understanding should incorporate a notion of understanding as appreciation or insight.³⁶⁶ For

364. *Id.*

365. *See, e.g.,* THOMAS GRISSO & PAUL S. APPELBAUM, *ASSESSING COMPETENCE TO CONSENT TO TREATMENT: A GUIDE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS* 31 (1998) (recommending four functional abilities as the focus for assessments of competence to consent to treatment, including “the ability to appreciate the significance of information for one’s own situation, especially concerning one’s illness and the probable consequences of one’s treatment options”); *see also* Kathleen Glass, *Refining Definitions and Devising Instruments: Two Decades of Assessing Mental Competence*, 20 *INT’L J.L. & PSYCHIATRY* 5, 22 (proposing that “appreciation implies sufficient critical judgment or insight to value the information that has been comprehend” and when emotional or affective factors inhibit the formation a judgment regarding mental health treatment, that assessment should result in a finding of incompetence); Louis C. Charland, *Mental Competence and Value: The Problem of Normativity in the Assessment of Decision-Making Capacity*, 8 *PSYCHIATRY, PSYCHOL. & L.* 135, 136 (2001). *But see* Christopher Slobogin, *Appreciation as a Measure of Competency: Some Thoughts About the MacArthur Group’s Approach*, 2 *PSYCHOL. PUB. POL’Y & L.* 18 (1996).

366. *See, e.g.,* Grisso & Appelbaum, *supra* note 328, at 155-56 (1995) (discussing subtests of the MacArthur Competence Assessment Tool (MacCAT)—the Nonacknowledgement of Disorder subtest (NOD) and the Nonacknowledgement of

example, Buchanan and Brock contend that understanding requires the ability to “appreciate the nature and meaning of potential alternatives—what it would be like and ‘feel’ like to be in possible future states and to undergo various experiences—and to integrate this appreciation into one’s decision making.”³⁶⁷ In doing so, Buchanan and Brock invoke a weak notion of appreciation, one that requires no more than the ability to imagine what it would be like to experience a future health state.

Nonetheless, a stronger form of appreciation, advanced by Paul Appelbaum and Thomas Grisso, includes a notion of appreciation as agreement or acknowledgment of mental disorder. In the MacArthur Treatment Competence Study, Appelbaum and Grisso assert that competence consists of four abilities: the ability to communicate a choice; the ability to understand relevant information; the ability to manipulate information rationally; and importantly, the ability to appreciate the nature of the situation and its likely consequences.³⁶⁸ Appelbaum and Grisso define appreciation as “acknowledgment of illness and the potential value of treatment.”³⁶⁹ The authors concede that a person might disavow his diagnosis or fail to acknowledge the potential value of treatment for reasons other than a psychiatric disorder. For example, a person might deny the potential value of treatment owing to religious reasons or a history of unsuccessful interventions.³⁷⁰ Therefore, the authors contend that nonacknowledgment of disorder, or the consequences of non-treatment, should only qualify as a failure of appreciation when patients meet three criteria. First, the patient’s belief must be “substantially irrational, unrealistic, or a considerable distortion of reality.” The belief must also be “the consequences of impaired cognition or affect,” and finally, the belief must be “relevant to the patient’s treatment decision.”³⁷¹

The MacArthur Treatment Competence Study designed the Perceptions of Disorder test (POD) to measure appreciation. POD consists of two subtests—the Nonacknowledgment of Disorder test (NOD) and the Nonacknowledgment

Treatment subtest (NOT)). While the NOD is designed to assess the extent to which patients acknowledge the existence of their mental disorder, the NOT allows patients to rate their degree of agreement or disagreement in response to statements about their disorder and the potential benefits of treatment. *Id.*

367. BUCHANAN & BROCK, *supra* note 356, at 24; *see also* Charles M. Culver & Bernard Gert, *Inadequacy of Incompetence*, 68 MILBANK Q. 619 (1990) (arguing that a person is competent to decide whether to refuse treatment when she understands information relevant to making a treatment decision and “appreciate[s] how this information applies to oneself in one’s current situation”).

368. Paul Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment*, 19 LAW & HUM. BEHAV. 105, 109-11 (1995).

369. Thomas Grisso & Paul Appelbaum, *The MacArthur Treatment Competence Study II: Measures of Abilities Related to Competence to Consent to Treatment*, 19 LAW & HUM. BEHAV. 127, 128 (1995).

370. *Id.* at 132.

371. GRISSO & APPELBAUM, *supra* note 365, at 45-48.

of Treatment Potential test (NOT).³⁷² NOD assesses the extent to which patients acknowledge their mental disorder as well as their symptoms; their beliefs about the severity of their symptoms; and their ability to acknowledge the diagnosis in their hospital chart.³⁷³ Patients' beliefs about the severity of their symptoms are compared to their scores on the Brief Psychiatric Rating Scale (BPRS). Patients are given a score of "0" when they rate their symptoms as not severe when their symptoms are considered severe according to the Brief Psychiatric Rating Scale.

The Nonacknowledgment of Treatment subscale (NOT) assesses the extent to which patients acknowledge that treatment might help them, including their ability to acknowledge the relevance of treatment; the potential benefit of a particular treatment; and the likelihood of not improving without treatment.³⁷⁴ Patients who fail to acknowledge the potential value of treatment are asked to explain why and presented with a hypothetical. For example, when a patient believes that treatment will not help her because she is simply too sick, the examiner might respond: "Imagine that a doctor tells you that there is a treatment that has been shown in research to help 90% of people *with problems just as serious as yours*. Do you think this treatment might be of more benefit to you than getting no treatment at all?"³⁷⁵ Patients who "rigidly disavow" the value of treatment by indicating definitely or probably not on a six-point scale, in response to that hypothetical receive a score of "0" on that item.³⁷⁶

In accordance with Grisso and Appelbaum, philosopher Louis Charland has also endorsed a strong form of appreciation as a necessary element of competence.³⁷⁷ He writes: "Appreciation consists in an individual's ability to apply his or her current understanding of a given medical condition to him or herself. It is one thing to understand what schizophrenia is, but quite another to recognise that this information applies to you."³⁷⁸

Charland and I are in agreement here, but only in a weak sense. In order to meet the understanding prong of a competence test, it should be enough for a person to understand that a psychiatric assessment is an assessment of him, not some hypothetical person. Charland, however, intends something more. By "recognise," I take Charland to mean "agree" so that a person must agree that he has an illness called schizophrenia. However, on the view of competence I am proposing, agreement on diagnosis would require too much.

Approaches to competence that require some degree of "appreciation" will fail to account for instances of reasonable disagreement. A reasonable person might conclude that a particular treatment is "probably" or "definitely" unlikely

372. Grisso & Appelbaum, *supra* note 369, at 132.

373. *Id.*

374. *Id.*

375. *Id.* at 133.

376. *Id.*

377. Charland, *supra* note 365, at 143.

378. *Id.* at 136.

to help her, even if research has shown that treatment to help ninety percent of people with problems as serious as her own. The respondent might be pessimistic, though not pathologically so, or she might simply have good reason to believe that she has more in common with people who did not benefit from treatment. Appelbaum and Grisso acknowledge that a person might deny the potential value of treatment owing to a history of unsuccessful interventions. Still the Perception of Disorder Test (POD) would classify this disagreement as a rigid disavowal and thus a failure of appreciation.

Similarly, clinicians and patients may agree on most aspects of a case yet fail to agree on a diagnosis. A person might acknowledge feelings of sadness, fatigue, and loss of energy for most of the day, for more than two weeks—and indeed, acknowledge the recurrence of these feelings over time—yet express some ambivalence about whether he is experiencing a clinical depression. Clinicians and patients will sometimes disagree over whether feelings of sadness and depression are pathological or merely a normal reaction to external circumstances. Others may feel that their symptoms do not rise to the level of an illness.

Or consider a person who has been diagnosed with schizophrenia. Schizophrenia is a psychotic disorder characterized by hallucinations, delusions, disorganized speech, and disorganized behavior. Although symptoms of psychosis frequently accompany schizophrenia, a variety of medical conditions can include psychotic symptoms, including substance-induced psychosis, delusional disorder, and bipolar disorder.³⁷⁹ The positive symptoms of schizophrenia—delusions, hallucinations, and paranoia—resemble the symptoms of mania while the negative symptoms of schizophrenia—flattened affect, emotional withdrawal, and social isolation—can resemble depression, leading clinicians to confuse schizophrenia with bipolar disorder or vice versa.³⁸⁰

As I noted above, African American men tend to be overrepresented among patients who have been diagnosed with schizophrenia and underrepresented among patients who have been diagnosed with bipolar disorder and depression.³⁸¹ However, large epidemiological surveys designed to measure the prevalence of mental disorders have shown that the prevalence of schizophrenia, bipolar disorder, and depression does not vary by ethnicity. The clinical tendency to overdiagnose schizophrenia among African Americans might arise for any number of reasons, ranging from cultural differences in the expression of symptomatology to the cultural distance between clinician and

379. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 297-98 (Michael B. First ed., 2000).

380. Frederic C. Blow et al., *Ethnicity and Diagnostic Patterns in Veterans with Psychoses*, 39 SOC. PSYCHIATRY EPIDEMIOLOGY 841, 842 (2004).

381. See *supra* note 345 and accompanying text.

patient.³⁸² The result, however, is that a reasonable person might “recognise” that a diagnosis of schizophrenia applies to him yet insist that he has been wrongly diagnosed nonetheless.

b. Reasoning and Communication

Competence also requires an ability to reason about treatment and the ability to communicate a choice. What is required here is not perfect rationality but rather at least a basic ability to reach conclusions that are logically consistent with major and minor premises.³⁸³ Doing so will require an ability to weigh the risks and benefits of treatment against one’s values as well as at least a basic understanding of probabilities. For example, a person who is competent to refuse a recommended course of treatment should understand what it would mean for an outcome to be more likely than not.³⁸⁴

Most authors on competence agree that an assessment of competence should focus on the quality of the reasoning process rather than the rationality or reasonableness of the outcome.³⁸⁵ Our focus on the quality of the reasoning process should also include limits on the kinds of reasons that are permitted to factor into a competent decision. The problem, of course, lies in determining which reasons to exclude. Some reasons are irrelevant as obvious non-sequiturs and provide ready grounds for exclusion: I am refusing treatment because today is Tuesday.³⁸⁶ Other reasons are, to use Elyn Saks’ term, “patently false”: Zyprexa is made of green cheese; my psychiatrist is an alien.³⁸⁷

Saks defines patently false beliefs as beliefs that are “so unlikely that even the most superficial reading of the data will indicate their falsity.”³⁸⁸ Patently false beliefs are also distinguishable from simple delusions. To use her example, consider a patient who suffers from depression and thinks of herself as a bad person, although others think she is a very good person.³⁸⁹ Her belief may be false and a delusion, but it is not patently or indisputably false. If, on the other hand, she were to believe that she is an evil person because she committed mass murder, even though she had not, such a belief would be patently and demonstrably false. When a person harbors patently false beliefs

382. Lloyd H. Rogler, *Framing Research on Culture in Psychiatric Diagnosis: The Case of the DSM-IV*, 59 *PSYCHIATRY: INTERPERSONAL & BIOLOGICAL PROCESSES* 145, 147 (1996).

383. Paul Appelbaum & Thomas Grisso, *Assessing Patients’ Capacities to Consent to Treatment*, 319 *NEW ENG. J. MED.* 1635, 1636 (1988).

384. *Id.*

385. See, e.g., Charles M. Culver & Bernard Gert, *The Inadequacy of Competence*, 68 *MILBANK Q.* 619, 621 (1990); Benjamin Freedman, *Competence: Marginal and Otherwise*, 4 *INT’L J.L. & PSYCHIATRY* 53, 53 (1981).

386. See Freedman, *supra* note 385, at 64.

387. Elyn Saks, *Competency to Refuse Treatment*, 69 *N.C. L. REV.* 945, 956 (1991).

388. ELYN SAKS, *REFUSING CARE: FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL* 187 (2002).

389. *Id.* at 186-87.

despite evidence to the contrary, we have good reason to believe that he or she is incompetent to make treatment decisions.

Still, not all of the reasons one might offer for refusing treatment are obviously irrelevant or susceptible to ready proof as patently and demonstrably false. In the first category are factual questions that are susceptible to proof. In the second category are reasons based on beliefs, the most challenging of which may be reasons for treatment refusal based on religious beliefs. Consider the Jehovah's Witness who refuses a blood transfusion owing to his belief that the Bible prohibits ingesting blood and contains the word of God. We can neither prove nor disprove the existence of God, yet our commitment to religious pluralism necessitates some allowance for reasons of this kind to factor into treatment decisions.

And yet if we accept faith as a legitimate reason for treatment refusal in these circumstances, how can we distinguish the Jehovah's Witness from the person who refuses treatment, not owing to his belief in God, but owing to his belief that he *is* God? The Jesus delusion is the most common of all psychiatric delusions, combining both delusions of grandeur and persecution.³⁹⁰ Clinicians frequently encounter patients who believe they are Jesus, the Virgin Mary, or other figures of religious or historical importance, and a claim to be any one of them is virtually certain to result in a diagnosis of serious psychopathology.³⁹¹ For some, the Jesus delusion results from a confusion of similarities and identities—Jesus was a man with a blondish beard; I am a man with a blondish beard; therefore, I am Jesus.³⁹² We can imagine circumstances in which persons come to see themselves as Jesus in a merely metaphorical sense that can be clarified in conversation. In these circumstances, the Jesus delusion by itself would not be sufficient grounds to conclude that a person is incompetent to make treatment decisions. However, most of us probably want to say that a person who persists in his belief that he is in fact the risen son of God—and indeed refuses treatment for that reason—is not competent to make treatment decisions.

When confronted with this question, clinicians will ordinarily ask whether the patient's beliefs predate the treatment decision, whether the patient has previously behaved in ways that are consistent with those beliefs, and whether the patient's beliefs are reflective of religious views held by others.³⁹³ Insofar as we are interested in determining whether the patient's reasons for refusing treatment reflect genuine religious beliefs, the thought here is that if the beliefs are unconventional or idiosyncratic to the patient, they are more likely to indicate psychopathology.

390. Alan Gettis, *The Jesus Delusion: A Theoretical and Phenomenological Look*, 26 J. RELIGION & HEALTH 131, 131 (1997).

391. *Id.* at 132.

392. *Id.*

393. GRISSO & APPELBAUM, *supra* note 365, at 48.

However, in contrast to the dominant medical view, Elyn Saks argues that a normatively desirable standard would afford considerable protection to unconventional or idiosyncratic beliefs. Saks writes that while there may be some limits on what patients can believe, “limits that are too stringent severely curtail that patient’s freedom to be unconventional in their pursuit of truth.”³⁹⁴ Since many people hold distorted beliefs, we risk “discriminating against the mentally ill if we disable them based on their distortions.”³⁹⁵ Instead Saks draws the line at patently false beliefs, asserting that only patently false beliefs should disqualify a person from competence.

How should we think about this? Consider the following case study, involving Ricardo Jesus B.:

Several months before he came to us with a diagnosis of paranoid psychosis, Ricardo Jesus experienced a series of severe epileptic seizures. When the seizures ended, Ricardo developed a psychotic condition. His delusion consisted of the following—during the seizure, epileptic Ricardo died and Jesus B. survived. He, Ricardo, now Jesus B., had been in heaven seated at the right hand of the Father. The sick person, Ricardo who everyone in the village laughed at is dead. In his place Jesus B. survives. Jesus B. is not identical to Jesus Christ, but close to him since they bear the same name. In the hospital, Ricardo was always in a good mood and respected by other patients. One day he asked for a certificate of discharge so politely and with such irreproachable behavior, that we let him leave. He came back to us twice—always glad, emanating a naïve saintliness and telling anyone who wanted to hear him how happy he was to no longer be an epileptic at whom everyone laughed, and how happy he was to spread the good news to mortals, first to his neighbors in the little mountain village where he cares for his goats, and then to anyone else who is willing to receive it.³⁹⁶

The case study comes from Ottor Doerr and Óscar Velásquez in the Department of Psychiatry, University of Chile. Most of us would probably say that the doctors who released Ricardo B. were right to do so. With little or no risk of harm to himself, there is no reason to keep him in a hospital.

Suppose, however, that instead of spreading the good news to his neighbors, in a little mountain village in Chile, Ricardo B. now lives in New York City. Call him Ricardo C. He continues to believe that at least in some way he has been reincarnated as the son of God. Only now, his condition has deteriorated, and when offered the opportunity to participate in treatment, he asserts, “God does not take medication!”³⁹⁷ As a result, his condition deteriorates. Like Joyce Brown before him, Ricardo C. sleeps near hot air vents and in abandoned buildings for warmth. Although he has no money, no home, and nowhere to go, he manages to eke out a meager existence through charity. If we accept Elyn Saks view, then despite a diagnosis of psychosis and the

394. SAKS, *supra* note 388, at 182.

395. *Id.*

396. Otto Doerr & Óscar Velásquez, *The Encounter with God in Myth and Madness*, 2:12 PHIL. ETHICS & HUMAN. MED. 1, 5 (2007).

397. See TORREY, *supra* note 270, at 116.

obvious risk of serious harms to himself, courts would have no authority to intervene. His sincere belief that he is the son of God is neither irrelevant nor patently and demonstrably false; therefore, her standard imposes an absolute bar against intervention. By drawing the line at patently false beliefs, Saks protects the right to hold idiosyncratic ideas. However, in doing so she also overvalues the interest in autonomy.

Earlier I said that a conception of autonomy as authenticity has obvious purchase in a discussion of mental illness. When a person refuses treatment for such unusual religious reasons, we will wonder whether their preferences are truly their own or whether their preferences are a symptom of psychopathology. For a soft paternalist, the important question in these cases is whether the person's conduct is substantially nonvoluntary. The "patently and demonstrably false" standard advanced by Saks would impose an absolute bar against intervention, but for Feinberg, the important question is whether a person's choices are "voluntary enough."³⁹⁸ Feinberg proposes a variable standard of voluntariness: the riskier the conduct and more irrevocable the harm, the greater the degree of voluntariness that should be required if the person's conduct is to be permitted.³⁹⁹

Our concern for Ricardo C. stems primarily from the serious risk of morbidity and mortality associated with chronic homelessness. Exposure to extreme weather conditions, untreated medical illnesses, infection, and insufficient nutrition will often work together to increase the risk of death. In circumstances like this one, where the risks are sufficiently grave—and a person's capacity to make rational choices is sufficiently in question—a reasonable court might risk a Type II error and order outpatient commitment, including antipsychotic medication, in an effort to restore the person's ability to be self-governing. Reasonable minds might disagree. Perhaps under different circumstances, such as warmer weather or a city with a robust system of voluntary mental health services and dedicated outreach workers, a court might deny a petition for outpatient commitment and instead risk a Type I error if there are a robust safety net and private citizens who are willing to intervene.

Yet, like the bridge pedestrian, if a court were to grant a petition for outpatient commitment, once Ricardo C. regains the capacity to be self-governing, we must let him go. As Mill writes, the possibility that he might harm himself supplies good reason for "remonstrating with him," but not for "compelling him or visiting him with evil in case he do otherwise."⁴⁰⁰

2. Competence Without Insight

Above I proposed that we reject impaired insight as a measure of diminished mental capacity, so that people are free to make their own decisions

398. FEINBERG, *supra* note 273, at 118.

399. *Id.* at 118-20.

400. MILL, *supra* note 322, at 9.

about medical treatment unless they are incompetent to do so, without reference to appreciation. By focusing on the patient's recognition that he has an illness, the patient's ability to relabel unusual events as pathological, and compliance with medical treatment, an impaired insight standard simply asks the wrong question. When our primary concern is one of self-regarding harm, the central question in an outpatient commitment hearing should not be—do you *agree* with Doctor X about the causal origins of your symptoms and the need for treatment—as it would be if impaired insight were a measure of diminished capacity. Rather, the central question should be: “Do you *understand* that Doctor X believes that some of your thoughts and behaviors are attributable to Disease Y? Do you understand that according to Doctor X, consequences A, B, C, and D are likely to follow if you refuse the recommended course of treatment?” If the person understands the basic facts of his or her illness in this sense, then provided that his or reasons are at least neither irrelevant nor patently and demonstrably false, he or she is competent to make decisions regarding outpatient treatment and courts should not order outpatient treatment over his or her objection.

Focusing on whether the respondent is competent to refuse treatment has certain virtues when compared to the current regime. Whether the respondent truly appreciates the seriousness of his symptoms and the potential value of treatment can be difficult to discern, thereby increasing the risk of Type II errors and needless intrusions on autonomy. In the same way questions about whether the respondent truly appreciates the seriousness of his illness, the need for treatment rely too heavily on the respondent's credibility, and in turn increase the risk of error. As I noted above, when a person has been diagnosed with a mental illness, their perceptions of their own needs and their own illness experience are routinely discounted. Reframing the test in terms of competence would eliminate the need to determine whether the respondent is telling the truth when he promises to continue treatment voluntarily. Under the proposed approach, the important question would be whether the respondent is able to make an important treatment decision on his or her own.

B. *Harm to Others*

What should we say about a person who presents a substantial risk of harm to others by virtue of mental illness, but who is competent to refuse treatment nonetheless?

Following a fight with his mother, during which he “accidentally” pushed her to the ground, Gary, a 30-year-old man, was admitted to a psychiatric hospital with a diagnosis of paranoid schizophrenia. According to hospital records, Gary was “malodorous,” and “experiencing bizarre delusions,” including a delusional belief that he was growing extra body parts and being controlled by “Carrie,” who “likes to eat people's organs with a knife and fork.” During an inpatient therapy session, Gary threw a psychiatrist against a wall and struck a resident with his fists, claiming that he was “unable to control his arms.” After a few weeks in the hospital, the symptoms of

psychosis improve and Gary files a petition to be released from the hospital. During the hearing, Gary's mother testifies to Gary's history of assault, treatment noncompliance and substance abuse following his release from psychiatric hospitals. Doctors petition the court for assisted outpatient treatment in an effort to prevent a relapse of psychosis that would be likely to result in serious harm to others. Gary, however, refuses to participate in the program.⁴⁰¹

What should we do? Suppose Gary is competent to refuse treatment. He understands the basic features of his illness and the proposed treatment plan. By all accounts, his reasons for refusing treatment are neither irrelevant nor demonstrably false, and he is able to communicate a stable choice. Still, a fair outpatient commitment program could order Gary to participate in outpatient treatment, notwithstanding a finding of competence. Our challenge, however, will be to distinguish Gary—subject to preventive outpatient commitment—from others whose dangerous behaviors are more appropriately addressed through the criminal justice system.

To see the need for justification, consider the garden-variety recidivist. Call him Joe. Suppose Joe also has a long history of violent crime. Like Gary, the state is able to establish that without supervision—perhaps a supervised living arrangement or an anger management program—Joe is also very likely to harm others. What can we do? If Joe were to harass, stalk, or threaten a particular person, a court might issue a temporary restraining order. However, without clear and convincing evidence of a substantial threat against a particular person, courts will not impose limits on Joe's freedom in order to prevent the very serious crimes that he is likely to commit. Why? The underlying assumption of the criminal law is that most people understand the difference between right and wrong, and most people are able to conform their behavior to the requirements of the law.

In both *Kansas v. Hendricks* and *Kansas v. Crane*, the Supreme Court affirmed the deterrent and retributive functions of the criminal justice system as the preferred approach to handling garden variety criminal conduct. And in both cases, the Court held that states may use civil commitment to detain sex offenders beyond the expiration of their sentences when a mental abnormality makes it “difficult, if not impossible for the person to control his behavior.”⁴⁰² Yet as I noted above, critics argue that the Court's impaired control standard is at best confused and overbroad. Instead police power commitments are only appropriate for persons who are grossly irrational by virtue of mental illness or, in essence, “too sick to deserve punishment.”⁴⁰³

Part IV.B develops the intuition that persons who are appropriate candidates for outpatient commitment resemble persons who do not qualify for

401. EWING, *supra* note 296, at 114-27 (2008); IN THE MATTER OF DAVID DIX, *supra* note 97.

402. *Kansas v. Crane*, 534 U.S. 407, 411 (2002); *Kansas v. Hendricks*, 521 U.S. 346, 358 (1997).

403. Janus, *supra* note 258, at 298.

criminal punishment either because they are grossly irrational, as Stephen Morse argues, or because they are unable to conform their conduct to the requirements of the law. In American legal thought, the absence of these capacities provides a rationale for the insanity defense. However, in the remainder of Part IV, I want to suggest that the absence of these capacities can also identify persons who are appropriate candidates for outpatient civil commitment. Consider the following rule based on the Model Penal Code formulation of the insanity defense and Kendra's Law:

- (a) A person who is competent to refuse treatment may be ordered to participate in an outpatient treatment program if, in view of his history or current behavior, he is likely to harm others as defined in section (b) of this article; and
 - (1) as a result of mental illness, he is unlikely to appreciate the wrongfulness of his conduct; or
 - (2) as a result of mental illness, he lacks the capacity to conform his conduct to the requirements of the law.
- (b) As used in this article the words "likely to harm" shall mean a substantial risk of serious physical harm as manifested by homicidal or other violent behavior.

1. Cognitive Impairment

Under part (a)(1) of the proposed rule, a person who is competent to refuse treatment may be ordered to participate in outpatient treatment if, in view of his history or current behavior, he is likely to harm others, and as a result of a mental illness, he is unlikely to appreciate the wrongfulness of his conduct. Following the Model Penal Code, we can say that a person may be unlikely to appreciate the wrongfulness of his conduct if, in the past, he has failed to apprehend material circumstances as a result of a mental illness or "failed to apprehend the significance of his actions in some deeper sense."⁴⁰⁴ Suppose the fight that landed Gary in the hospital was not an "accident." Instead, Gary pushed his mother to the ground based on a delusional belief that his family was plotting against him and, indeed, trying to kill him. During an outpatient commitment hearing, Gary's sister testifies that her brother's delusional beliefs about their family are longstanding and all-encompassing. On several occasions Gary has choked her and thrown her to the ground. During the worst incident, he held a knife to her throat. On the stand his sister sobbed: "When I asked him, Gary, why?" he replied: "You're the devil. You came here to hurt me. Didn't you?" Later Gary testifies that the assault on his sister was sanctioned by God.

Earlier I said that a person may be morally responsible for his actions if the deliberative process leading to those actions is responsive to moral and prudential reasons. By moral reasons, I mean reasons arising from the moral duties that persons in a community owe to one another. Prudential reasons, on

404. MODEL PENAL CODE § 4.01 explanatory note (1981).

the other hand, are the practical or self-interested reasons that persons have for behaving in accord with moral norms. Gary might recognize his interest in avoiding prison as a prudential reason to refrain from assaulting his sister. He might even view her as the kind of creature whose status as a person gives rise to moral reasons to refrain from assault. Yet insofar as he views the attack on his sister as divinely sanctioned, he is not appropriately responsive to reasons in the way the law requires.

If he were to harm his sister, Gary would likely prevail on the cognitive arm of an insanity defense. Although Gary is legally innocent of a crime, the same cognitive impairments that exempt him from criminal punishment also provide a moral justification for a preventive measure. The more difficult question is this: what constitutes clear and convincing evidence that, as a result of a mental illness, a person is unlikely to appreciate the wrongfulness of his conduct? By definition, insanity defenses are backward-looking and driven by conduct that has already taken place. Although risk assessments are necessarily fraught, as I mentioned above, a past history of violence is one of the best predictors of violence. The fact that Gary has a long history of violent assault connected to his delusional beliefs suggests that without supervised medical treatment, he is likely to engage in similarly assaultive behavior.

2. Volitional Impairment

Alternatively, under part (a)(2) of the proposed rule, a person who is competent to refuse treatment may be ordered to participate in outpatient treatment if he is likely to harm others, and as a result of a mental illness, he lacks the capacity to conform his conduct to the law. Consistent with the Model Penal Code formulation, what is required here is not that the person manifests a total inability to conform his conduct to the law, but only that his impairment is not insubstantial.⁴⁰⁵ Consider the following statement from Andrew Goldstein. When questioned by the police, Goldstein attributed his actions to an “overwhelming urge.”

I walked to the far end of the platform As I'm walking I felt a sensation like something was entering me like a ghost or a spirit or something like that. While I was walking it fell out of me. When I have the sensation that something is entering me, I get the urge to push, shove or sidekick. As the train was coming—it—the feeling disappeared and came back several times

As I was standing on the platform, there was a woman standing waiting for the train. She was facing the incoming train and I was standing behind her. I got the urge to push, kick or punch

I feel like an aura, or a sensation like you're losing control of your motor systems. And then, you lose control of your senses and everything. And then you feel like something's entering you. Like you're being inhabited. I don't

405. *Id.*

know. But—and then, it’s like an overwhelming urge to strike out or push or punch⁴⁰⁶

Stephen Morse has long argued that courts should reject the notion of an “uncontrollable” urge or any other purported loss of control as a justifiable predicate for civil commitment.⁴⁰⁷ Along with Robert Schopp, Morse starts from the premise that civil commitment amounts to a massive curtailment of liberty, one that can only be justified by limiting its use to people who are not morally responsible for their conduct. On the other hand, Morse thinks that only a defect in the capacity for rationality can work as a coherent non-responsibility criterion.

Without canvassing all of his arguments, below I want to challenge some of the more important ones, and in doing so suggest that we have reason to reconsider the use of a volitional impairment standard for outpatient civil commitment. To begin, Morse rests his arguments on a thin conception of moral responsibility. Morse takes the capacity for rationality to be the defining—and indeed the singular—feature of moral responsibility. But why should that be the case? In various places, Morse writes that our capacity for reason distinguishes human beings from the rest of the natural world.⁴⁰⁸ Moreover, it is our capacity for rationality that explains why, as a general matter, our society does not confine for dangerousness alone, but instead treats human actors as moral agents who are capable of evaluating their conduct and responding to the law’s commands. Yet such a narrow conception of moral responsibility seems strangely lacking.

Suppose you invite me to a dinner party. Reluctantly, I accept. As dinner drags on, I twitch, I grimace, and I jerk as I wage a silent battle against the ticks and pops of Tourette’s Syndrome. I say to myself: “I know I’m a good person. I know I’m a good person. I won’t mention your husband’s beer belly,” but then, before I know it, out it slips: “Beer belly! Beer belly! Beer belly! BEER BELLY!” In my horror I knock over a bottle of wine and stain your new dress. I fully understand that I have done something wrong by offending my friend’s husband, but I could not help it. Morse takes the position that a mentally abnormal cause is merely a cause. “Whether a predisposing factor is produced by a mental disorder or by some other ‘normal’ or ‘abnormal’ cause makes no difference to whether the agent is responsible. A cause is just a cause, and causation per se is not an excuse.”⁴⁰⁹ It may be that Morse has conflated the fact that an action is fully attributable to an agent with moral responsibility. The disruption caused by offending your husband, knocking over a bottle of wine and staining your new dress is fully attributable to me, but my blameworthiness

406. EWING, *supra* note 296, at 116.

407. Stephen Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54, 59 (1982); see Stephen Morse, *Culpability and Control*, 142 U. PA. L. REV. 1587, 1608 (1994).

408. *E.g.*, Stephen Morse, *Uncontrollable Urges and Irrational People*, 88 VA. L. REV. 1025, 1065 (2002).

409. *Id.* at 1040.

is diminished to the extent that my outburst was caused by a neurological condition that is beyond my control.⁴¹⁰

Morse goes on to argue that control impairments are better understood as defects in the capacity for rationality. There is certainly a sense in which Goldstein's urge to "push, shove or sidekick" stems from a mental abnormality that we can understand, roughly, as a defect in rationality. On the other hand, the jurors who convicted him of second degree murder did not think so. In *People v. Andrew Goldstein*, Andrew Goldstein pled not guilty by reason of insanity.⁴¹¹ At trial prosecutors established that Goldstein knew that what he was doing was wrong and Goldstein conceded as much:

Prosecutor: Well, did you expect that she would go off the platform?

Goldstein: No. No. No. No. I would never push anybody off the tracks.

Prosecutor: Because you know it's wrong.

Goldstein: Yeah.⁴¹²

Even if Morse is right, and defenses based on a loss of control really are better understood as defects in the capacity for rationality, juries are unlikely to appreciate that subtlety. Instead jurors are more likely to understand their duty as applying the letter of the law, which means not reading a control defense into an insanity defense without clear textual support. In New York, the absence of a volitional impairment standard has clear implications for the insanity defense; as a result, Andrew Goldstein was found guilty, and indeed blameworthy, for the death of Kendra Webdale. However, the absence of volitional element would also have implications for an outpatient commitment statute. Without it, states would not have the power to reach someone like Andrew Goldstein.

The difficult question involves determining what would constitute clear and convincing evidence that, as a result of a mental illness, a person lacks the capacity to conform his conduct to the law. Once again the Supreme Court decisions in *Hendricks* and *Crane* offer some guidance. After *Hendricks* and *Crane*, state courts were left to determine the evidentiary requirements for

410. To bring the example full circle, contrast my actions to an outburst from my ill-mannered little brother who disrupts the dinner party, not owing to a neurological disorder, but because he is simply bored and ready to go home. Even though we are both fully in our right minds, with no obvious defects in the capacity for rationality, commonsense morality suggests that my outburst, though fully attributable to me, is less blameworthy than that of my brother. Morse might respond that I have made "the fundamental psycholegal error" by conflating causation with excuse. See, e.g., Stephen Morse, *Brain Overclaim Syndrome and Criminal Responsibility: A Diagnostic Note*, 3 OHIO ST. J. OF CRIM. L. 397, 411 (2006). But my claim here is not that causation itself excuses, but rather that an *abnormal* cause (though perhaps not a complete excuse) gives us good reason to view conduct as less blameworthy than it would be otherwise.

411. Affirmation and Memorandum for Defendant, *People v. Goldstein*, No. 00527/99 (N.Y. Sup. Ct. 1999).

412. EWING, *supra* note 296, at 117.

Crane's “serious difficulty in controlling behavior” requirement.⁴¹³ Some state courts rely heavily on expert testimony to determine whether the defendant has a serious difficulty controlling his or her behavior, while others rely on a combination of expert testimony and factual findings. For example in *In re Commitment of W.Z.*, the New Jersey Supreme Court found that W.Z. had serious difficulty controlling his behavior based on past acts of sexually motivated violence and several risk assessments, all but one placing him in a high-risk category.⁴¹⁴

Likewise in *United States v. Comstock*, the Supreme Court upheld the Adam Walsh Child Protection and Safety Act, a federal statute that authorizes civil commitment for sex offenders when their sentences have ended.⁴¹⁵ Following *Comstock*, the Federal Bureau of Prisons issued regulations designed to guide expert assessments as to whether the defendant has a “serious difficulty” controlling his or her behavior. Not unlike *In re Commitment of W.Z.*, the Federal Bureau of Prisons has said that relevant evidence might include evidence based on a risk assessment, as well as evidence of offending while under supervision. Relevant evidence might also include engaging in offenses when likely to get caught, statements of intent to reoffend, or an admission that the person experiences serious difficulty controlling his or her behavior.⁴¹⁶ Similarly, in outpatient commitment cases, courts might conclude that a person has a serious difficulty controlling his or her behavior based on events leading to a prior hospitalization. For example, Andrew Goldstein’s psychiatric record documents several instances in which Goldstein swung or punched at others for no apparent reason. And on more than one occasion before the death of Kendra Webdale, Goldstein complained of being unable to control his arms.⁴¹⁷

IV. OBJECTIONS AND CONCLUSIONS

Preventive outpatient commitment laws test the moral limits of our ability to intervene in the lives of people with mental disabilities before they harm themselves or others. I have argued that government interventions into self-regarding harm and other-regarding harm require distinct moral justifications. When our primary concern is one of self-regarding harm, I have argued that our inquiry ought to focus on whether the person is competent to refuse treatment. Without this limitation outpatient commitment programs fail to respect the autonomy interests of people with mental disorders. If, however, we are

413. See generally Janine Pierson *Construing Crane: Examining How State Courts Have Applied Its Lack-of-Control Standard*, 160 U. PA. L. REV. 1527 (2012) (surveying state appellate and supreme court approaches to the Supreme Court mandate in *Crane*).

414. 773 A.2d 97, 116 (2001).

415. 560 U.S. 126, 150 (2010).

416. Civil Commitment of a Sexually Dangerous Person, 73 Fed. Reg. 70,278, 70,281 (Nov. 20, 2008) (codified at 28 C.F.R. § 549.95).

417. IN THE MATTER OF DAVID DIX, *supra* note 97, at 1.

concerned about harm to others, our inquiry ought to focus on whether the person possesses the moral capacities for criminal responsibility. By not limiting outpatient commitment orders to people with mental disorders who are unable to appreciate the wrongfulness of their conduct or unable to control their behavior, involuntary outpatient commitment laws intrude on the purview of the criminal law, a result clearly disfavored by *Hendricks* and *Crane*.

An approach of this kind is likely to raise a few objections. The first is that my approach stems from an overvaluation of autonomy. Autonomy matters, but hard paternalists will argue that our interest in personal autonomy is not the only interest that matters. In support of hard paternalism, philosopher Richard Arneson claims that while the right to autonomy protects an important interest in self-determination, paternalistic interventions can interfere with that interest to a greater or lesser degree.⁴¹⁸ Therefore “if the consequences of not infringing the right are sufficiently bad and the interest that the right protects will suffer only a slight enough degree of frustration, one should in these circumstances act against the right.”⁴¹⁹ Alternatively, if “the good of the individual that is at stake is enormous,” and the interference in self-determination would be very slight, an absolute antipaternalism would be “fanaticism.”⁴²⁰ Yet who should determine whether the interference from paternalism is “very slight?” If the potential benefits to the individual are indeed “enormous,” and the person protests nonetheless, the person whose liberty is at stake may feel that the “interference” is in fact an invasion, even when the intervention seems slight to others.

Arneson arrives at hard paternalism by way of liberal utilitarianism. Having rejected a consequentialist justification for outpatient commitment, I will not belabor the point here. However, a utilitarian moral outlook in these cases fails to account for our intuitions about the noninstrumental values protected by upholding the right to refuse treatment. In the same way, Arneson’s justification for hard paternalism rests on a thin conception of autonomy. As I have argued, moral rights to autonomy protect more than “a person’s interest in voluntarily disposing of his lot in life.”⁴²¹ Insofar as we view autonomy as a defining feature of personhood, protecting the agent’s interest in autonomy also protects her interest in viewing herself and being viewed by others as a creature who is capable of autonomy.

Others have argued for hard paternalism from a public health or population perspective. The focus of public health is squarely on the health of populations or communities as a whole, rather than individuals. As Lawrence Gostin rightly points out, in the aggregate, even conduct that is primarily self-

418. Richard Arneson, *Joel Feinberg and the Justification of Hard Paternalism*, 11 LEGAL THEORY 259, 263 (2005).

419. *Id.* at 263.

420. *Id.* at 264.

421. *Id.*

regarding can have an adverse impact on social welfare.⁴²² On his view, these aggregate effects justify some degree of public health paternalism. Nonetheless, just as Arneson limited the case for hard paternalism to instances where the interference with autonomy is “very slight,” Gostin argues for hard paternalism when the intervention does not impose “a truly significant burden on individual liberty.”⁴²³ Neither is willing to surrender important individual interests to a utilitarian moral calculus or the welfare of the community as a whole.

Rights have costs, among them morbidity and mortality. An approach that restricts involuntary outpatient commitment to those who are incompetent to make treatment decisions or otherwise incompetent to bear the burdens of the criminal law would place many people with serious mental disorders beyond the scope of court ordered treatment. Yet respect for personal autonomy entails respect for the treatment choices of those who have the capacity to make them. In the same way, respect for moral agency has given us good reason to adopt a largely backward-looking criminal process as the primary mechanism to deprive citizens of their liberties when they threaten harm to others.

Supporters of outpatient commitment will argue that my approach is impervious to history. On their view, the current state of affairs in which prisons have become the new asylums and people with mental disorders cycle between jails, hospitals, and homeless began in the 1970s with the liberal dismantling of mental health law. But the problem here is our broken mental health system. Even the best studies on outpatient commitment have shown that a court order to participate in treatment only adds value when combined with intensive services.

Opponents of outpatient commitment will argue that these laws are a misguided, knee-jerk response to highly publicized acts of violence by a small number of people with mental disorders. On their view, outpatient commitment orders are unnecessary unless the person is incompetent to refuse treatment. However, the fact that an event is statistically rare does not mean that it is not cause for concern. Our cognitive and volitional capacities for moral responsibility lay the foundation upon which we base our claims to freedom from preventive intervention. Yet when these capacities are so impaired that a person can neither be deterred by the threat of hard treatment nor criminally responsible for his actions, governments may employ preventive outpatient commitment to protect others from harm.

There is a place for involuntary outpatient commitment, but these laws require both adequate resources to ensure that effective services are available and further amendment to protect the liberty interests of people with mental disorders.

422. Lawrence O. Gostin & Kieran G. Gostin, *A Broader Liberty: J.S. Mill, Paternalism and the Public's Health*, 123 *PUB. HEALTH* 214, 217 (2009).

423. *Id.* at 214.

