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SPECIAL ISSUE IN COLLABORATION WITH THE
SAKS INSTITUTE FOR MENTAL HEALTH LAW, POLICY, AND
ETHICS: PSYCHOTROPIC MEDICATION AND THE LAW

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Forcible Medication of Civil Committees: The Most Appropriate Standard

BY ELYN R. SAKS*

This article examines at what point doctors may forcibly medicate someone for the sake of his or her medical interests. The Supreme Court remanded a medication case in light of another case that looks at mechanically restraining someone with mental retardation.¹ It remanded another case because the state law was arguably more protective of patients than the federal constitution.² The Court has also looked at this in the case of criminal defendants and convicts.³ Its criminal cases, in the context of competency to stand trial, may also have a bearing on what standard to adopt.⁴

I suggest that the best standard for civil committees is the same one used for anyone facing a medical decision: that they may be forcibly treated only if they lack capacity or are in an emergency situation.⁵ This article asserts that this is consistent with the Court's positions and is the best standard normatively.

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1. See *Rennie v. Klein*, 458 U.S. 1119 (1982).

2. See *Mills v. Rogers*, 457 U.S. 291 (1982).

3. See *Washington v. Harper*, 494 U.S. 210 (1990).

4. See *Riggins v. Nevada*, 504 U.S. 127 (1992); see also *Sell v. United States*, 539 U.S. 166 (2003).

5. This view has been in the literature for some time. See, e.g., Stephan Beyer, Comment, *Madness and Medicine: The Forcible Administration of Psychotropic Drugs*, 1980 WIS. L. REV. 497 (1982); Jessica Litman, Note, *A Common Law Remedy for Forcible Medication of the Institutionalized Mentally Ill*, 82 COLUM. L. REV. 1720 (1982). A later, extensive treatment of this topic is BRUCE W. WINICK, *THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT* (1997) (evaluating the standard in light of the Supreme Court remands and cases, as well as elaborating on why it is a good standard, does add to this literature).

This article first reviews the primary, relevant Supreme Court cases and then look at subsequent cases and statutes. The article then argues—on whatever doctrinal basis—that the competency/emergency standard is the best.

In *Youngberg v. Romeo*, the Court held that a person with mental retardation can be mechanically restrained so long as the restraint decision does not depart significantly from the judgment a professional would use.⁶ Importantly, in *Rennie v. Klein*, the Supreme Court remanded the right to refuse medication in light of *Youngberg*.⁷ Additionally, the Court remanded a case that required incompetence or an emergency and reasoned that the state standard may be higher than what the federal constitution requires.⁸

Washington v. Harper considered a prisoner's right to refuse medication.⁹ There, the Court held that states can involuntarily medicate a prisoner if he is mentally ill; dangerous to self or others or gravely disabled; and the medication is in his medical interests.¹⁰ The Court uses a "rational relation" test and adverts to security issues that are especially prominent in jails and prisons.¹¹ The Court does not require that the prisoner lack capacity to make his own decision.¹² That is, his competent decision may be overridden if the conditions above are met.

On its face, *Youngberg*, if taken literally, is broader than *Washington*. Based on *Youngberg*, it could conceivably be a practice among hospital doctors to medicate someone to enforce discipline; to serve goals of convenience; or to incentivize patients to accept medication in the future.¹³ In a narrow sense, these practices would not be in the patient's medical interests. In the same way, doctors might even forcibly medicate patients who are not currently dangerous to themselves or others or gravely disabled, as *Washington* requires.

In fact, subsequent case law does not give physicians *carte blanche* on decisions to medicate. For instance, the *Rennie v. Klein* court, whose case had been remanded by the Supreme Court in

6. *Youngberg v. Romeo*, 457 U.S. 307 (1982).

7. *Rennie v. Klein*, 458 U.S. 1119 (1982).

8. *Id.*

9. *Washington v. Harper*, 494 U.S. 210 (1990).

10. *Id.*

11. *Id.*

12. *Id.*

13. *Youngberg v. Romeo*, 457 U.S. 307 (1982).

light of *Youngberg*, requires the professional judgment that a patient is dangerous before imposing medication (see *Rennie v. Klein*, *infra* note 6).¹⁴ Other cases specify factors that must be part of the professional judgment.¹⁵ For example, the risks and side effects should be considered and the medication cannot be for convenience or economic reasons. Finally, some courts say more generally that the professional judgment must balance state and individual interests.

Indeed, if the *Rennie* remand allowed the court to specify findings that doctors must make in the exercise of professional judgment—i.e. there is some guidance on the substantive standard—then a progressive reading of the standard could require incompetency or an emergency. The inquiry becomes whether it comports with professional judgment to find this patient incompetent and in need of medication.

Even if the broadest version of the holding is correct, it may not govern in all medication contexts. That is, even though the Court remanded *Rennie* in light of *Youngberg*, it doesn't follow that the *Youngberg* standard must govern in all cases. There are at least two ways the contexts are importantly different. First, soft restraints are generally less risky than medication (though also often more painful and degrading). More important, Romeo was profoundly retarded and had the mental age of an 18-month old child with an IQ between eight and ten.¹⁶

What this means is that the *Youngberg* standard should arguably be limited to not-so-risky medication of people who totally lack capacity to make their own decisions. Losing the right to decide is not as grave an insult to dignity if the person doesn't have capacity to decide. In short, the *Youngberg* remand will lead to the use of a *Youngberg* standard in these limited conditions; but what standard to apply when a person doesn't grossly lack capacity is an open question.

Another way to think of this is that the exercise of professional judgment is really about procedure: a professional's determination, e.g. that a patient is sufficiently dangerous to be

14. *Rennie v. Klein*, 458 U.S. 1119 (1982).

15. *See, e.g., Rennie*, 458 U.S. 1119; *Brandt v. Monte*, 626 F. Supp. 2d 469 (D. N.J. 2009); and *Stensvad v. Reivitz*, 601 F.Supp. 128 (W.D. Wisconsin 1985).

16. *Youngberg*, 457 U.S. at 309.

medicated, gives the patient a right to a reasonably arrived at decision. The courts have affirmed that other procedures are adequate, but that doesn't mean that this approach wouldn't also be accepted. Or perhaps it is a first procedural step in a more extensive process.

Another thought—I suggest in the context of restraints—is that the Court is basically saying that if professionals are not effectively grossly negligent in using their judgment, patients' rights are adequately protected. Their liberty is sufficiently protected as a constitutional matter if doctors don't practice medicine in a grossly substandard way—furthering their medical interests is protection enough of patient liberty.

This is likely to mean that if medicine is credibly in a patient's medical interests, doctors can impose it on patients. That is, the professional judgment standard collapses into the *Washington v. Harper* standard.

There are, however, complications in how to read *Washington*. In particular, it is a little unclear in *Washington* whether the “dangerousness” criterion is met simply by virtue of the prisoner's crime (when it involved danger) or requires active dangerousness in the prison.¹⁷ If the former is true, the *Washington* standard would mean that many patients civilly committed as dangerous to self or others would, by virtue of their very commitment, meet the *Washington* standard. The same is true with “grave disability.”¹⁸ If inability to take care of oneself on the outside equals grave disability, then civil committees confined as gravely disabled would ipso facto meet the medication standard. In other words, there would effectively be no right to refuse for an involuntary patient.

On the other hand, if we require active dangerousness inside to justify medication, that seems overly narrow. What about the patient who is not dangerous but lacks capacity to refuse treatment? Shouldn't we be able to medicate him or her if it is in his or her interests? Perhaps, however, grave disability is meant to cover people who lack capacity—i.e. lacking capacity to take care of yourself can cover incompetency to make self-care medical decisions.

17. *Washington v. Harper*, 494 U.S. 210, 219 (1990).

18. *Id.*

But should *Washington v. Harper* govern? Taken most narrowly—that doctors can medicate anyone who has met civil commitment standards if it is in their medical interests—I believe it grants doctors overly broad discretion and should not govern. While *Washington* does refer to medication, and not just restraints (as in *Youngberg*), the context is also one in which the population is likely more dangerous than any other population and security is a major issue.¹⁹ Moreover, prisoners sacrifice some of their liberty when convicted, and arguably don't have as strong an entitlement to exercise choice as do non-criminals.

I believe the differences in these two contexts calls for not adopting, in the civil context, the “in best medical interests standard” used in jails and prisons. The Court repeatedly says that civil patients are entitled to better, more humane, treatment than prisoners, so limiting their liberty in a way that is analogous to limitations of prisoners’ interests flies in the face of the Court’s reasoning.

So, in short, the more liberal reading of *Washington* requires active dangerousness or grave disability and medical interests,²⁰ while the more conservative reading allows medication in one’s interests provided that one has met the involuntary commitment standard.

Finally, note that the Supreme Court requires a “least restrictive alternative” analysis in the context of competency to stand trial.²¹ It also allows the state to force medication even if it is not in the patient’s medical interest, if there is a compelling enough reason.²² But while the lower *Rennie* court struggles with whether such a “least restrictive alternative” analysis should govern in the civil context,²³ it is arguable that it might be imported here. That said, medication, when it is indicated, usually will be the least restrictive alternative. In emergencies, one could find seclusion less restrictive, but essentially no other modality than medication effectively treats serious mental illness.

The case law is divided on the right to refuse; whether based on the Federal Constitution, the state constitution, state

19. *Harper*, 494 U.S. 210.

20. This includes incompetency to decide on treatment.

21. *Sell v. United States*, 539 U.S. 166 (2003).

22. *Id.*

23. *Rennie v. Klein*, 458 U.S. 1119 (1982).

common law, or state statute.²⁴ Some cases and statutes use the most progressive standard—that you can medicate someone

24. A sampling of the cases shows that they range from those that allow a person, absent an emergency, to be forcibly treated only if he or she is incompetent to refuse treatment to those that allow medication if it is the doctor's professional judgment to impose it because, e.g., it is "medically appropriate." The cases base their holdings on the federal constitution, the state constitution, state common law, or state statute. For cases that allow competent patients to refuse absent an emergency, *see, e.g.*, *Rogers v. Commissioner of Dept. of Mental Health*, 390 Mass. 489 (1983); *Riese v. St. Mary's Hospital and Medical Center*, 209 Cal.App.3d 1303 (1987); *People v. Medina*, 705 P.2d 961 (Colo. 1985); *Rivers v. Katz*, 67 N.Y.2d 485 (1986). For more detail on one of these cases, *see, e.g.*, *Steele v. Hamilton Cnty. Cmty. Mental Health Bd.*, 90 Ohio St. 3d 176 (2000) (in a nonemergency context, a court may issue an order for involuntary medication if the patient lacks capacity to consent or refuse; it is in the patient's best interests to take the meds, i.e. the benefits outweigh the side effects; and no less intrusive treatment will be as effective. Accepts a specific vs. general incapacity and doesn't require a judicial finding of incompetence; and holds that incompetency is a uniquely judicial determination). Other jurisdictions use a "professional judgment standard," following the Supreme Court's remand of *Rennie v. Klein* in light of *Youngberg v. Romeo*. *See, e.g.*, *Rennie v. Klein*, 720 F.2d 266 (1983) (indicating that state may medicate only if in exercise of professional judgment such an action is deemed necessary to prevent the patient from endangering himself or others. Professional judgment must also be exercised in the resulting decision to medicate someone. The court also notes that part of professional judgment involves considering harmful side effects); *Brandt v. Monte*, 626 F. Supp. 2d 469 (D. N.J. 2009) (application of New Jersey regulations. May medicate patient if he constitutes a danger to self or others but only as necessary "to prevent the patient from endangering himself or others," and the exercise of professional judgment may require doctor to consider available alternatives in the context of such factors as harmful side effects. Interpretation of *Rennie* as permitting any forcible medication as long as the treater has exercised professional judgment doesn't stand. Following *Sell* and *Riggins*, less restrictive alternatives must be considered. In terms of dangerousness required, a "reasonably foreseeable" danger standard would fail to offer any meaningful protection. Court allows medication only "in an imminent or reasonably impending emergency." May also medicate on a non-emergency basis if the medication is "a necessary part of the treatment plan." Particular findings are required, e.g. patient can't otherwise participate in any treatment plan available at the hospital that will give him/her a realistic opportunity of improving his/her condition, or one is available but medication will improve condition in a significantly shorter time or he might harm himself or others before improvement of his condition); *R.A.J. v. Miller*, 590 F.Supp. 1319 (1984) (Commissioner's Rule proposed by defendants is accepted. May medicate if "medically appropriate," i.e. if based on a professional judgment that

against his will only if he lacks capacity to refuse and it is not an emergency.²⁵ Some states seem to allow medication if it is in the patient's medical interests.²⁶ Others take an intermediate view—you can medicate someone forcibly if, e.g., without medication the patient's condition cannot be expected to improve in a reasonable time, or deterioration can't be prevented, or the person's condition will not be stabilized in time to prevent injury to self or others.²⁷ (Some jurisdictions take the latter to give content to the "best medical interests" standard.) The statutes are similarly divided.²⁸

without such medication the patient's condition cannot be expected to improve within a reasonable period of time, or deterioration of patient's condition cannot be prevented, or there is a significant possibility that the patient's mental condition will not be stabilized in time to prevent injury to himself or other persons." In addition, there is a two-tiered system; for a patient who has the ability to understand the consequences of his decision to object, there will be further review by an independent consultant psychiatrist); *Stensvad v. Reivitz*, 601 F.Supp. 128 (W.D. Wisconsin 1985) (statutory scheme in Wisconsin didn't violate due process because civil commitment is a finding of incompetency with respect to treatment decisions. "Nonconsensual treatment is what involuntary commitment is all about." Professional judgment standard determines whether medication may then be applied. Professional judgment standard also imposes limits, like no unnecessary or excessive medication).

25. See *supra* note 24.

26. See *supra* note 24.

27. Some jurisdictions interpret the latter to give content to the "best medical interests" standard. See *supra* note 24.

28. Based on a sampling of the statutes, the statutes fall into at least three categories. First are those that allow competent patients to refuse medication except in an emergency. See, e.g., FLA. STAT. ANN. § xxix Chapter 394 (3)(a)(1)(2) (2005); ME. REV. STAT. ANN. tit. 34 § 3864 (1-4) (2009); and TEX. HEALTH & SAFETY CODE ANN. Title 7, Subtitle C, Chapter 574, Subchapter G § 574.106 (West 2009). The second category of statutes allows involuntary medication only if certain conditions are met, e.g. without medication the person will come to serious harm or will substantially deteriorate or will suffer a substantial prolongation of treatment. See, e.g., WASH. REV. CODE ANN. § 71-05-1 (West 2008); West's MD. CODE ANN. Title 10, Subtitle 7.10-708 (g) 1-3 (2010) (requiring exercise of "professional judgment" as well). Other statutes that seem to allow forcible medication simply if it is medically needed include N.J. STAT. ANN. § 30:4-24.2 (West 1981) (indicating no unnecessary or excessive medication and that voluntary patients have the right to refuse, suggesting that involuntary patients don't. Query how *Rennie v. Klein* impacts this statute); and ARK. CODE ANN. § 20-47-218 (West 2012) (in need of treatment standard but may be referring to hospitalization and not medication).

I endorse the most progressive standard: one has a right to refuse unless one is incompetent or an emergency is present. The fact that the Supreme Court remanded a case like this in Massachusetts on the ground that state law might be more protective of patients does not adequately refute this. The Court may not wish to expend resources for something that could be decided on state law grounds. The Court's hunch that state law would be more progressive is not a clear finding and should not be presumed.

The principal reason to treat involuntary patients in this way is that we want to destigmatize mental illness—and provide people with mental illness as much dignity and respect as we provide non-ill people. People who don't have mental illness are allowed to make foolish, even self-destructive, medical decisions so long as they are competent and there is no emergency. People, can forego chemotherapy that will greatly increase their life-expectancy because they don't like the side-effects. They can refuse a simple, safe, and life-saving blood transfusion because it violates their religious beliefs. Indeed, except in the context of life-saving treatment, competent parents are also entitled to make questionable decisions for their children. Generally, courts will uphold "bad" parental decisions on treatment for their children unless the treatment is life-saving.²⁹ In one case, for example, if a teenager did not have surgery before his 18th birthday, he would be confined to a bed the rest of his life. The court allowed the parents and the child to make this decision, even though their choice was hard to understand and their reasoning was also highly irrational.

The move to destigmatize mental illness has been changing the presumption around competence and incompetence of involuntary patients. It is now the law in virtually every state that involuntary commitment does not raise a presumption of incompetence. By contrast, there is a presumption of competence. If we are presuming patients can make all sorts of decisions, why not the right to refuse? Again, the presumption can be rebutted, but our first take should be to assume competence and honor the patient's choice.

There are counterarguments to presumed competence to honor a patient's decisions. It seems anomalous to hospitalize

29. See, e.g., ROBERT H. MNOOKIN AND D. KELLY WEISBERG, *CHILD, FAMILY, AND STATE* (1995).

someone who needs treatment and then not provide the treatment. Refusing medication can also be quite costly. For example, it takes a few weeks to treat depression with medication; it can take up to a year for people to recover without meds. Should the state be required to pay for extended hospitalization if the patient refuses medication and doesn't have private resources? What if the patient is the sole parent of a minor child who will have to go into foster care if she doesn't get treated quickly? Will hospitals turn into snake pits if we cannot medicate patients? Also, most patient decisions to refuse are overturned when they go to court. Why not save the expense and just allow their refusal to be overridden if meds are in the patient's best medical interests?

These arguments do not carry the day. The locking-the-patient-up-then-not-providing-treatment is the patient's choice. Cost is never used to justify serious deprivations of liberty. Parents are allowed to elect to have their kids put in foster care. Hospitals have not remotely turned into snake pits. Most who refuse are episodic and not persistent. That most patients lose in court may simply mean that doctors are honoring other choices to refuse when they are not incompetent.

I appreciate a right to refuse not because I think refusal is good—on the contrary, I believe medication is the overwhelmingly optimal treatment for serious mental illness—but I think it is too grave an insult to the dignity of competent patients to deprive them of the right to refuse. It further marginalizes and “others” patients. I also like a right to refuse because it gives patients a chip with which to bargain with their doctors about meds. For example, if the patient can say no to drugs altogether, then his preference for one drug over another may be more readily heeded by the doctor.

There are intermediate standards between a right to competently refuse versus a standard that allow one to be medicated if it is in one's interests.³⁰ For example, one may be medicated if one is grossly deteriorating, liable to end up imminently dangerous, or unable to take care of oneself; and there are no other interventions that will work.

The question to consider is why we should we treat people with mental illness differently from other people whose competence is no better than the patient's. We could say that the patient has already lost his liberty. But what about a hypothetical

30. See *supra* notes 24 and 28.

patient with physical ailments who needs to be in the hospital but doesn't want further treatment? We could move this person to a nursing home, but we can do the same with the psychiatric patient? The person's confinement might be as long lasting and costly as the refusing psychiatric patient's. It might take her away from her minor child for as long a period. And we could use an intermediate standard for medicating the physically ill patient too—she is declining and will soon be unable to care for herself or become threatening to others.

One may respond that there are at least two important features of patients refusing medications that do not apply in the case of physical illnesses. First, even if competent, the patient may be mentally impaired.³¹ Second, the mentally ill person's personality may be distorted by the illness, and the distortion might dissipate if he is restored to himself. In this case, I posit that we should strive to protect the real, "authentic" choice of the patient.

The impairment point should lead us either to use an impairment standard, and some non-mentally ill patients will be impaired while others will not; or it is not a compelling enough reason to override a person's choice. The "authentic person" standard applies whenever someone's decision making is impaired by another condition—the person has a severe headache that impairs him during the decision making process. We don't override such choices typically.

There is perhaps another reason to medicate patients with psychiatric illness and not those with physical illness who are refusing care: the psychiatric patient may be dangerous to others in a way that physically ill patients are typically not. So keeping them in a nursing home, for example, will require even more resources than a person with physical illness.

My response is twofold. First, there could be a physically ill patient—e.g. a person with active tuberculosis, or another communicable disease, who refuses to take steps to protect others—who needs to be restrained from exposure to other people. Second, in the case of danger, there could be an emergency exception to the right to refuse. One might have more emergencies in the nursing home in the case of psychiatric patients, but again cost is not sufficient to dictate most forcible treatment.

31. In other words, while he may be technically competent, he is less competent than non mentally-ill patients.

The bottom line is that we should endeavor to honor competent patients' choices to refuse medication. This does not mean we should refrain from encouraging them not to refuse, nor that we must always honor their choices. But the goal of integrating people with mental illness into our communities means that we should treat them with dignity and respect. We should recognize their autonomous choices even if we think them wrong.

Success of Influence and Coercion: A Function of How Psychotropic Medication Impacts the Goals of Adult Psychiatric Patients

JENNIFER TALEVICH *

Empirical research was conducted for this article.

The use of force, coercion, and leverage to compel use of psychotropic medication is extensive and growing. Moral and logical debates rage but without relevance because they rely on a false premise that forced medication accomplishes what is intended. The efficacy of coercion is sparsely researched in proportion to its implementation and findings contradict one another. This article presents a new study with empirical data. The study shows that pressure to take psychotropic medication fails to predict adherence in the real world and offers a way to predict adherence and a direction for effective intervention. Goal Impact, the impact that taking psychotropic medication has upon a patient's life goals, significantly predicts and explains 19% of the variance in adherence. The myth of refusal-to-take-medication as a symptom of psychopathology is overturned in the face of highly successful participants with mental illness who refuse or only partially adhere to their medical prescriptions and whose decisions are predicted by their goals. The study results suggest that an intervention that examines a patient's goals and how he or she is affected by medication may actually increase adherence. Trends in our data suggest that when individuals' goals are congruent with medicating, a little pressure may increase adherence, but when their goals are incongruent with medicating, pressure may dangerously decrease adherence. Further research on this is necessary to draw definitive conclusions. The legal

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implication of the study recommends procedural justice and caretaker benevolence: a one-time-only forced-intervention to restore enough cognitive function to set up a life-goal patient plan. This plan should include the patient's decision as to whether he or she will be exposed to future coercive medical treatment, by whom, and under what circumstances.

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REVIEWING THE ARGUMENTS

TABLE 1: Arguments about Forced Medication ¹(reprinted from Lavelle & Tusaie, 2011).

Arguments AGAINST Forced Medication	Arguments SUPPORTING Forced Medication
1. Forcing someone to do something against their will is inherently wrong	1. Society has a paternal obligation to care for citizens who cannot care for themselves and provide for the safety of others affected by those who cannot see the harm they may cause.
2. People often refuse medications because of side effects or other bona fide reasons.	2. Lack of awareness of mental illness is a persistent symptom for many patients.
3. Coercion drives people away from the mental health system and builds distrust.	3. Offering services is often not enough when patients lack insight, compelling them to take medication may be necessary.
Arguments AGAINST Forced Medication	Arguments SUPPORTING Forced Medication
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ARGUMENTS AGAINST FORCED MEDICATION

Force is inherently wrong

A review of Table 1 will show that the arguments are largely concerned with weighing the *ethics* of force against the *practicalities* of the treatment process and outcome.² However, the practicalities of force should be demonstrated first, and in the event of good outcomes for patients and society, the moral implications of the treatment must also be considered. But in fact, reviewers of the psychological literature conclude there is so little research on the efficacy of coerced medication that it cannot be considered an evidence-based practice.³ Despite the fact that a number of countries require the explicit recording of any coercive measure, an extensive international literature search yielded just fourteen articles on forced medication.⁴ If this reporting requirement is being met, then there should be a large amount of data available for examination—but it appears the data is being ignored. So, the research remains in conflict. Only voluntary adherence will assure

1. Sandra Lavelle & Kathleen R. Tusaie, *Reflecting on Forced Medication*, 32(5) ISSUES IN MENTAL HEALTH NURSING 274, 274–278 (2011).

2. *Id.*

3. Manuela Jarrett, et al., *Coerced Medication in Psychiatric Inpatient Care: Literature Review*, 64 J. ADVANCED NURSING, 2008 538, 538–548 (2008).

4. *Id.*

long-term success.⁵ Nonetheless, the relationship between practitioner force and his or her patients' future voluntary adherence to treatment remains unknown.⁶ Despite this lack of empirical evidence, the use of coercive treatments increased over the last decade.⁷

Bona Fide Refusal

The most commonly noted reasons for a patient's non-adherence to a medication regime are due to legitimate problems with the drugs themselves.⁸ Sometimes the issue is the drug prescribed, the dosage amount, the timing of dosages, or the drug's side-effects.⁹ Note that side effects, though they vary by individual, are no figment of the patient's imagination but well-established and published by the drug manufacturers.¹⁰ Other reasons for medication refusal have to do with education of the patient. For example, a patient may not understand the need for long-term, continuous treatment.¹¹ Additionally, a patient's finances or issues with his or her insurance may also interfere with filling prescriptions.¹²

A patient may not see the benefit of remission, or the benefit he or she does perceive is outweighed by the drawbacks of medication.¹³ And sometimes, while remission would be desirable to the patient, the medication fails to bring the expected improvement in areas that are most important to the patient.¹⁴ These problems with the drugs themselves reasonably reduce perceived value of staying for many.

5. Paula K. Vuckovich, *Compliance Versus Adherence in Serious and Persistent Mental Illness*, 17 NURSING ETHICS 77, 77–85 (2010).

6. Jarrett et al., *supra* note 3.

7. Patricia A. Galon & N. Margaret Wineman, *Coercion and Procedural Justice in Psychiatric Care: State of the Science and Implications for Nursing*, 24 ARCHIVES PSYCHIATRIC NURSING, 307, 307–316 (2010).

8. Vuckovich, *supra* note 5, at 77–85.

9. *See id.*

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

14. *Id.*

Coercion drives people away: Psychological Reactance

While the effect of coercion in bringing about positive outcomes for patients remains uncertain, the effect of coercion in general is well-established.¹⁵ Research suggests that both mandatory and informal pressure to adhere to treatment serve as barriers to doing so.¹⁶ For instance, one study of fifty adolescents found that the majority (62%) would discontinue treatment if the decision were entirely up to them.¹⁷ One of the key factors among the minority that would voluntarily continue treatment was a lack of perceived coercion to take the medication: only 9% of those who perceived coercion were more committed to adherence while 91% were less committed.¹⁸

Coercion to medicate is not confined to institutionalization. It also occurs in outpatient treatment. Though outpatient treatment provides relative freedom compared to inpatient commitment, outpatient treatment is a continuation of the state's control. State-required outpatient treatment is increasingly perceived as coercive by patients and could contribute to factors in treatment avoidance.¹⁹

The experimental literature on psychological mechanisms underlying responses to coercion renders these findings unsurprising. The data found in clinical reports and studies on coerced medication, for or against, are correlational. A correlation is merely the observation that two things happened at the same time.²⁰ We cannot conclude that one causes the other merely

15. (Swartz, Swanson, & Hannon, 2003).

16. *Id.*

17. T. Moses, *Adolescents' Commitment to Continuing Psychotropic Medication: A Preliminary Investigation of Considerations, Contradictions, and Correlates*, 42 CHILD PSYCHIATRY & HUMAN DEV. 93 (2010).

18. *Id.* Commitment to medication was significantly related to lack of perceived coercion to take the medication and greater perceived family support. *Id.* at 101. The type of medication, if it was an antipsychotic, was the only clinical (as opposed to social) factor that was significant, and no demographic factors were significantly related to medication commitment. *Id.* at 100.

19. M. Allen & V.F. Smith, *Opening Pandora's Box: The Practical and Legal Dangers of Involuntary Outpatient Commitment*, 52 PSYCHIATRIC SERVICES 342 (2001); Galon & Wineman, *supra* note 7, at 307–316.

20. T. Höfer et al., *New Evidence for the Theory of the Stork*, 18 PEDIATRIC AND PERINATAL EPIDEMIOLOGY 88 (2004); J. Pearl, *Causality: Models, Reasoning, and Inference*, 34 IIE TRANSACTIONS 583 (2002). A

because they occur at the same time; something else, not observed, may be causing both. The beauty of experiments with random assignment, on the other hand, is that they allow the researcher to create the cause. The search for evidence to confirm or deny the relationship between coercion and treatment avoidance has been neglected by clinicians who view the avoidance of treatment as being itself a symptom of psychosis. However, avoidance in response to coercion has been well researched by experimental psychologists. It is important to understand the difference between a correlational study, such as a clinical report, and an experiment. As an experimenter, when looking for a cause, I find correlational studies are an excellent source for hypothesis generation but not hypothesis testing. Only experiments with random assignment of participants to different conditions allow the researcher to manipulate the cause (e.g. pressure) and measure the resulting effects (e.g. lack of cooperation).

Clinical reports, incident forms, interviews, questionnaires, and retrospective analyses of any kind are correlational by nature and, therefore, cannot identify cause and effect; logically, individuals with mental illness who are either successfully receiving treatment, or who are coping adequately without, would not come to the attention of authorities. Thus, it is reasonable to assume that state-mandated outpatient program reports will not have data from these individuals. Those patients who do receive treatment from these programs must be given treatment that is appropriate to their ailment. Obviously, it would be unethical to randomly assign a patient to a treatment condition unless they are taking part in an officially sanctioned clinical trial such as to compare the effectiveness of a new medication. A review of the clinical literature has revealed no experimental designs utilizing random assignment to coercive versus non-coercive treatment plans²¹. There is, however, ample work with such qualifications to consider from the experimental psychology literature.

correlational study simply shows that two events occur together and the assumption that they have a cause-and-effect relationship is a common logical fallacy known as *cum hoc ergo propter hoc* (Latin for “with this, therefore because of this”) and *false cause*. While it may seem, intuitively, that one event causes another event it is very often the case that both events are caused by a third, possibly unexpected and unmeasured, event.

21. Jarrett et al., *supra* note 3.

Starting in the 1960s, J.W. Brehm experimentally manipulated the freedom to choose everyday opinions and behaviors. He and his colleagues measured psychological resistance to the restriction of freedom by light pressure or force. By removing a choice between an array of objects, Brehm found participants would rate the removed object as preferable to those that remained.²² In another study, when only one side of a two-sided issue was presented, participants found the argument less convincing than when it was presented alongside its opposing argument.²³ Brehm interpreted the withholding of one side of the argument as pressure to adopt the proffered position and participants responded by moving against it.²⁴

Brehm explains that people constantly gauge their internal states to consider their wants and needs against the dangers and benefits that surround them.²⁵ This is an evolutionarily adaptive process that allows a person to maximize success through immediate and fluid adaptation to environmental constraints.²⁶ An internal examination exists within a stream of decisions about what to do and when to do it in the service of accomplishing activated goals.²⁷ Through a process of surveilling the situation, aspects of that situation will trigger goals automatically, both inside and outside of conscious awareness.²⁸ The implication of this is that individuals will frequently do some things without quite knowing why.²⁹ Even so, if a person's own will has been re-routed, he or she may have a sense of having done one thing as a result of being unable to do the other.³⁰

22. Thomas Hammock & Jack W. Brehm, *The Attractiveness of Choice Alternatives When Freedom to Choose Is Eliminated by a Social Agent*, 34 J. PERSONALITY 546, 546–554 (1966).

23. *Id.*

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.*

28. John A. Bargh et al., *The Automated Will: Nonconscious Activation and Pursuit of Behavioral*, 81 J. PERSONALITY AND SOC. PSYCHOLOGY 1014, 1015 (2001).

29. JACK W. BREHM, *ORG. CHANGE: A COMPREHENSIVE READER* 377 (W.W. Burke, D.G. Lake & J.W. Paine eds. 2008).

30. *Id.*

To recap, if a patient's behavioral freedom is reduced (or threatened) he or she will be motivated not only to reestablish what freedom was lost but to prevent any further reduction in the power to act. This motivational state is what Brehm refers to as "psychological reactance".³¹ If an individual's knowledge about themselves or the situation is not valid (e.g. skewed by mental illness) poor choices may be made.³² But this will not alter the motivational processes of situation assessment, automatic goal activation, and the will to act in accordance with goals.

Even without being aware that they are reacting against coercion, an individual may experience an increased amount of self-direction, "he will feel he can do what he wants, that he does not have to do what he doesn't want".³³ If this freedom of choice is of great importance, then the magnitude of psychological reactance will increase in proportion to that importance. Such elevated reactance may induce feelings of hostility and aggression. These would be acted upon or denied, to others and even to one's self, depending on the individual and the consequences of doing so in any particular situation.³⁴ The logical consequence of this is that cooperation under coercion may falsely resemble voluntary adherence that will disappear when the coercive force is removed. Conversely, active (even aggressive) resistance may turn to genuine voluntary adherence should the coercive force be removed.

It is surprising how little pressure is needed to induce psychological reactance. Even one's own sense of obligation to reciprocate a small favor can trigger psychological reactance if it is felt to reduce one's own freedom to act. In a two by two factorial experimental design, participants were randomly assigned to either receive a favor from another (confederate) participant, or not.³⁵ The favor was performed by a confederate (posing as another participant) who went to get a soda for himself and brought a second back for the participant, as well.³⁶ All participants were

31. *Id.* at 378.

32. *Id.* at 378.

33. *Id.* at 384.

34. *Id.* at 384.

35. Brehm, Jack W., & A.H. Cole, (1966). *Effect of a favor which reduces freedom*, 3 J. OF PERSONALITY AND SOC. PSYCHOLOGY 420, 423 (1966).

36. *Id.* at 422.

then assigned a task that was described, through random assignment, as either being important or unimportant.³⁷ At the end of the study, the participants were given the opportunity to reciprocate the confederate's earlier favor.³⁸ And, when the task had been described as unimportant participants did so.³⁹ But when it had been described as important, practically none of the participants reciprocated the confederate's favor.⁴⁰ The soda favor had been a kindness, without any ostensible intention to compel the participant, yet nearly every participant was strongly motivated to resist the influence of obligation when matters seemed important.⁴¹

In the decades since Brehm's introduction of reactance theory to psychology, researchers have manipulated it in a wide variety of contexts. In these experiments people read arguments that attempt to convince them to do beneficial things such as floss "As any sensible person can see, there is really no choice when it comes to flossing: You simply have to do it. In fact, the scientific evidence showing..."⁴² and so on. Participants are told to comply with drinking less alcohol such as, "There is a problem and you must be part of the solution. So if you drink, drink responsibly"⁴³ or less soda and more water "Stop the denial... you need to drink

37. *Id.* at 421. The experimenter entered and gave the participant and confederate a task, to be done independently, and told the participants that the task was either important or unimportant to the research team, depending upon the condition. Note, the task was a mere filler unrelated to the favor and not personally relevant to the participant or confederate. After the task was completed, the experimenter gave an additional assignment to the confederate only: to sort a stack of papers into separate piles. Participants could return the soda favor by helping the confederate with his new sorting task.

38. *Id.*

39. *Id.* at 424. Nearly all of the participants (14 of 15) in the favor x unimportant task returned the favor and helped the confederate.

40. *Id.* Two of the 15 participants in the favor x important task would later return the confederate's favor.

41. *Id.*

42. J.P. Dillard & L. Shen, *On the nature of reactance and its role in persuasive health communication*, 72 COMM'C'N MONOGRAPHS, 144, 152 (2005). See Study 1.

43. J.P. Dillard & L. Shen, *On the nature of reactance and its role in persuasive health communication*, 72 COMM'C'N MONOGRAPHS, 144, 153 (2005). See Study 2.

water, seltzer or low-fat milk instead.”⁴⁴ Others have been pressured to exercise more “Therefore, you really must exercise...because doing so will help you stay happy while increasing your overall feelings of well-being”⁴⁵ To reiterate, these are experimental manipulations—the only method that allows researchers to draw conclusions about cause and effect. A recent meta-analysis statistically pools the effects from these studies and many more.⁴⁶ It shows these attempts to pressure people into making better decisions are instead perceived as threats to their freedom to decide for themselves.⁴⁷ This elicits the angry counter-arguments of psychological reactance which, in turn, influences attitudes in undesirable ways.⁴⁸ Note, the outcome variable is not agreement or disagreement with the message but participants attitude toward the target of the message (e.g. flossing or exercising).⁴⁹ For, though participants may agree with the content of the message (e.g. one should exercise) their *attitude* toward exercise may become negative.⁵⁰

Extrinsic and Intrinsic Motivation: Compliance is not adherence

The words “force” and “coercion” imply strong influence under notable circumstances. However, ordinary circumstances and insignificant influences can easily trigger psychological reactance. Another word used in the clinical literature, “compliance,” is the use of pressure and persuasion as opposed to physical force. However, this “lighter touch” does not change the motivational character of the act to compel a patient to do something outside of their own will, nor does compliance change

44. Yoav Magid, *The following message might make you mad: Forewarning and inoculation against reactance*, DIGITAL REPOSITORY UNIV. MD. 47 (2011) (unpublished manuscript), available at <http://hdl.handle.net/1903/11739>.

45. C.H. Miller et al., *Psychological reactance and promotional health messages: The effects of controlling language, lexical concreteness, and the restoration of freedom*, 33 HUMAN COMMUN RESEARCH 219, 239 (2007).

46. S.A. Rains, *The Nature of Psychological Reactance Revisited: A Meta-Analytic Review*, 39 HUMAN COMMUN RESEARCH 47 (2013).

47. *Id.*

48. *Id.*

49. *Id.* at 59.

50. *Id.*

the motivational character of the reaction that wells from within the patient to resist.

There is a basic distinction in psychology between intrinsic and extrinsic motivation.⁵¹ This is important to understand when distinguishing between compliance with external motivation and adherence to internal motivation. The source of extrinsic motivation is external to the individual.⁵² Intrinsic motivation is internal; it comes from within the individual.⁵³ Rewards, money, and social pressure are certainly preferred to force, but they are all sources of extrinsic motivation. To give an example a child may clean her room spontaneously because she enjoys a well-kept area or even the process of organizing and arranging. If her parents reward her with money because they are pleased with this occurrence, a peculiar thing occurs. The child will no longer clean her room unless she is paid to do so. Her motivation has changed from being intrinsically motivated, when she enjoyed the activity and creating a nice space for herself, to being extrinsically motivated because she now wishes to be rewarded for her efforts. This may be unintuitive, that being doubly-motivated to do something should reduce motivation. But what occurs is that the external motivation *replaces* the internal motivation.⁵⁴ And then, when the external reward or pressure ceases, so does the desirable behavior it compelled.⁵⁵ One way has been found to protect intrinsic motivation from being usurped by extrinsic motivation: choice.⁵⁶ When people feel in control of their own behavior and circumstances, they attribute their own behavior to their own motivations. When people do not feel in control, they attribute the motivation for their behavior to reasons outside themselves.⁵⁷

Unlike compliance, adherence is the internally-motivated choice to voluntarily take medication. Researcher and practicing clinician Vuckovich calls for greater acknowledgement of the

51. DENNIS COON & JOHN O. MITTERER. INTRODUCTION TO PSYCHOLOGY: GATEWAYS TO MIND AND BEHAVIOR 339 (2006).

52. *Id.*

53. *Id.*

54. J.Y. SHAH & W.L. GARDNER, HANDBOOK OF MOTIVATION SCIENCE 52 (2008).

55. *Id.*

56. *Id.* at 53.

57. *Id.*

difference between compliance and adherence.⁵⁸ This is considered the only long-term solution. She is concerned about the popular tendency to interpret coercion as adherence.⁵⁹ In Vuckovich's opinion, both are necessary tools at different phases of treatment.⁶⁰ She finds that compliance is effective during acute psychosis, but thereafter the practice is useless, because only adherence is effective for long-term or chronic psychosis.⁶¹ Thus, if compliance remains the goal during remission, a time when voluntary adherence can come about, a great opportunity is lost.⁶² Vuckovich states that it is the nurse's duty to investigate the reasons for non-adherence with the same vigor nurses use to coerce.⁶³

ARGUMENTS SUPPORTING FORCED MEDICATION

Society has a paternal obligation

Some feel that society has an obligation to help those who do not help themselves. However, if coercion is not effective care then the matter is moot, as discussed above. Another social obligation argument is that, in some cases, forcing medication is necessary to protect the citizenry.⁶⁴ For instance, after a young woman, Kendra Webdale, was pushed in front of a train by an untreated mentally ill person, 42 states adopted versions of "Kendra's Law."⁶⁵ For those with severe mental illness and a history of violence or re-hospitalization, Kendra's Law allows the court to "monitor treatment compliance", through "assisted outpatient treatment" (AOT).⁶⁶ Patients on AOT have excellent outcomes, including dramatic decreases in arrests and incarceration, psychiatric hospitalizations, homelessness, and harmful behaviors.⁶⁷ Studies demonstrate most of these effects can be obtained after 6 months and show that "sustained

58. Vuckovich, *supra* note 5, at 82.

59. *Id.*

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.*

65. N.Y. MENTAL HYG. § 9.60 (McKinney 2010).

66. *Id.*

67. *Id.*

improvements” continue through to the termination of AOT.⁶⁸ These results are listed under the heading “Longer Term Findings: Outcomes for AOT Recipients Beyond the Initial Six Months.”⁶⁹ This title is misleading in two ways. Both the short term and “longer term” are measured while treatment remains coerced. But if the mental illness does not end when AOT comes to an end then the study cannot speak to how a patient will fare after AOT is terminated. Severe mental illness is a chronic condition: “long-term” means “life-long” management.⁷⁰

The Kendra Law studies suggest two things: individuals compelled to take medication will do so, and those with severe mental illness see good outcomes if they are medicated. Ergo, those who are compelled to take medication will have better outcomes, as long as they are so compelled. That is the crux of the matter; pressure is only effective as long as it is applied. But if the state, and its taxpaying citizens, are not willing to finance the life-long monitoring and provision of treatment compliance, then voluntary adherence is the only viable solution. This has further consequences for two other situations in which the state is known to use treatment coercion: medication to render a defendant fit to stand trial, and the chemical castration of pedophiles.

No societal obligation is felt as strongly as the need to protect children. Pharmaceutical castration is one approach to dealing with the danger that pedophiles pose to children.⁷¹ The concept is that by requiring a pedophile to take a pill, such as anti-androgens or women’s birth control hormones, he will no longer be a danger.⁷² However, the “feminizing” side effects such as the development of “man boobs”, can cause humiliation and gender-identity issues. If the state is not monitoring and coercing, the patient’s motivation to take the medication must be stronger and more consistent than the internal drive of the patient to feel healthy, look socially acceptable, and feel familiar to his own self.

68. *Id.*

69. *Id.*

70. Helen Lester et al., *Patients’ and health professionals’ views on primary care for people with serious mental illness: focus group study*, 330 BRIT. MED. J. 1122 (2005).

71. Scott Thompson, *Court: Jared Loughner can refuse anti-psychotic medication*, CNN.COM (2011, July 13), available at <http://www.cnn.com/2011/CRIME/07/13/loughner.forced.medication/index.html>.

72. *Id.*

Forced medication in criminal courts has a different illogic to it than the previous examples. In such cases, mentally ill defendants are required to take medication in order to obtain sufficient competence to stand trial.⁷³ Logically, if a guilty defendant wishes to refuse medication in order to avoid punishment: the defendant will be in the prison of his or her own mind and save the state considerable expense. For the innocents who would be freed, or at least serve a more limited term than indefinite mental illness, the same issues apply as to all others: only voluntary adherence will free them from their prison in the long term.

Refusal as a symptom-of-illness and coercion as necessity

The remaining points in favor of forced medication are two parts of the same argument: lack of awareness is a symptom, so offering is not enough and, therefore, compulsion may be necessary. This is in direct opposition to the argument that patients refuse medication for bona fide reasons, previously discussed in this article. Now, we will evaluate this matter from a goal systems perspective.

I. Goal Systems Perspective

Motivation as a Force

Humans are driven by motivation at every moment in waking life.⁷⁴ These forces determine behavior.⁷⁵ Motives, or goals, provide both the direction of movement (towards or away from some object) and the strength or intensity of the force behind the movement.⁷⁶ In physical terms, goals can be represented as a vector graph that represents both the direction of the force and the intensity or strength of that force. For example, in Lewin's Force Field Theory of Motivation he viewed some factors as helping

73. *Id.*

74. John A. Bargh, *Auto-motives: Preconscious determinants of thought and behavior*, 2 HANDBOOK OF MOTIVATION AND COGNITION 93(1990); KURT LEWIN, A DYNAMIC THEORY OF PERSONALITY (1935).

75. Kurt Lewin, *Field theory and experiment in social psychology: Concepts and methods*, 44 AM. J. OF SOCIOLOGY, 868 (1939).

76. JOHN W. ATKINSON ET AL., AN INTRODUCTION TO MOTIVATION (1978).

forces, driving movement toward a goal. Other factors were hindering forces, driving movement away from a goal. Each force had a strength or intensity. Finally, the vectors could be aggregated in order to determine the resultant direction and strength of an agent's movement through life.

Important life decisions, such as whether or not to leave one's job, maintain a healthy weight, or "keep an eye out" for a new relationship are strongly influenced by "Goal Impact"—the perceived impact that these decisions would have on one's important life goals.⁷⁷ Here, we examine this question in the context of deciding whether or not to take psychotropic medication. We propose that important life decisions can be understood as the result of a process in which life-congruent and incongruent goals, and the means accompanying those goals, determine the direction of a driving force toward or away from particular outcomes in such a way as to optimize goal pursuit. To predict decisions, we use the judged importance of life-motive clusters, derived from a comprehensive Hierarchical Taxonomy of Human Goals.⁷⁸ This importance rating is the "strength" of the internal force. To determine the direction of the force we measure the helping and hindering forces driving movement towards a goal. This combined measure of strength and direction we call Goal Impact.

Goal Impact

Goal Impact measures the forces for individual goals and then aggregates those forces in order to provide a resultant vector that can predict important life choices. To derive Goal Impact, participants indicate the importance of each goal in the taxonomy of life goals and then rate the extent to which an important life choice, such as quitting a job, facilitates or inhibits the attainment of each of those goals. For each goal, the importance is multiplied by the facilitation/inhibition ratings to get an impact score. This

77. Jennifer R. Talevich, D.A. Walsh, & S.J. Read, *Goal Impact: Context-Free Prediction Tool Applied to Voluntary Job Turnover*, PERSONALITY AND SOC. PSYCHOLOGY REV. (forthcoming 2013).

78. Jennifer R. Talevich, S.J. Read, D.A. Walsh, R. Iyer, R., & G. Chopra, *Toward a Comprehensive, Empirically-based Taxonomy of Human Goals*, J BASIC AND APPLIED PSYCHOLOGY (forthcoming 2013).

measure of Goal Impact is a simple, but surprisingly powerful predictor of important life choices.

Our previous work with Goal Impact strongly suggests that true adherence will only be adopted in the long-term if a patient perceives medication as being goal-congruent. Patients must perceive medication as something that will help them get what they want in life and avoid what they don't want. The following study tests this hypothesis, specifically, that the Goal Impact of taking psychotropic medication will predict adherence.

The Goal Impact of Psychotropic Medication: An Empirical Study

This study represents the first look, to the authors' knowledge, at psychotropic medication adherence and refusal from outside clinical psychology. Our participants are not recruited from a patient population. They are students at a top-ranking university who have been recommended to take psychotropic medication and, in some cases, are currently treating mental illness with these medications. This non-clinical perspective allows us to investigate the reasons for refusal and adherence that are not considered in situations where a clinician is dealing with an individual patient in distress.

Our hypotheses are as follows:

- 1) The impact of taking psychotropic medication upon one's life goals (Goal Impact) will predict whether or not they adhere to medication.
 - a. Participants will report greater adherence to medication when medicating positively impacts, and not medicating negatively impacts, their most important life goals.
 - b. Participants will report less adherence to medication when medicating negatively impacts, and not medicating positively impacts, their most important life goals.
- 2) Pressure to take psychotropic medication will decrease adherence.

- 3) There will be an interaction between Goal Impact and Pressure such that more pressure reduces Goal Impact and, together, they predict decreased adherence.

Procedure

Students were eligible for participation if they had, at some point, been recommended to take psychotropic medication by a medical professional. Participants may or may not have actually taken the medication—having done so was not a requirement of participation. This allowed us to measure total refusal of medication. Thirty undergraduates met this requirement and completed the questionnaire. First, I asked what medications had been recommended to them.⁷⁹ Then, I asked them to rate all 46 life-goals for importance,⁸⁰ the goal congruence of taking medication,⁸¹ and complete a Treatment Satisfaction Questionnaire

79. Medications were recommended, with multiple selections possible, as follows: Stimulants (23); SSRIs, Mood Stabilizers, and Anti-depressants (41); Anti-Panic or Anti-Anxiety (29); Antipsychotics (3); Other (3). A more specific breakdown can be seen in Table 1.

80. Q-sort: a forced sort of the goals into a quasi-normal seven-point distribution. Requiring participants to sort the goals into this quasi-normal distribution, based on importance, forced them to make distinctions among the different goals, and especially among their most important ones. Participants were presented with one of two randomly chosen orders (either alphabetical or reverse alphabetical order) of the forty-six goals in a list on the left side of the page, and two boxes, arranged vertically, on the right. They went through a series of rounds to indicate goal importance. Each round was on a separate page. First, in Round 1, participants were asked to drag their two most-important goals into the top box and their two least-important goals into the bottom box. Round 2 presented participants with the remaining forty-two goals and asked them to drag the six most-important goals into the top box and six least-important goals into the bottom box. This was repeated in Round 3 by asking them to drag the nine most-important goals into the top box and the nine least-important goals into the bottom box. At the end of the task twelve goals remained unsorted and were assigned to the middle point of the quasi-normal Q-sort. The result was to force the importance ratings by each individual into a quasi-normal distribution of 2, 6, 9, 12, 9, 6, and 2 goals ranging from most important to least important.

81. Goal Congruence Measure: On an 11-point scale, participants were asked how much harder (-5) to easier (+5), with zero (neither harder nor easier) as the middle point, did taking psychotropic medication make each of the 46 goals. Then, using the same scale, they were asked how much harder or easier did NOT taking the medication make each goal.

for Medication (TSQM).⁸² I also asked about how much pressure they felt to take the medication. Participants were asked about adherence, specifically: “How often did you take your medication as compared to what was prescribed? If you were never prescribed or never actually took the medication then select 0% for never”

Results with Discussion

Why patients think they might be alright without medication

The subjects in this study are individuals among the top undergraduates in the nation. Intellectual functioning and diligence are required to attain this level of success. If refusal to take medication is a symptom of psychosis, then we can expect these high functioning, nationally-competitive individuals, to be strictly adhering to medication. However, this is not what we find. Our results show a near-even split between adherence and non-adherence. In fact, twice as many are totally, or strongly, refusing medication than are strongly adhering. No one reported 100% adherence (See Table 1: Adherence). Clearly, some people can refuse to take medically recommended psychotropic medication and do very well. One may argue the type of mental illnesses with which our participants are dealing are not of the severest forms, e.g. depression rather than schizophrenia, with which the courts and mental institutions must contend. This may indeed be the case. But the proliferation of non-adherence combined with successful living that we find in our data suggests that labeling refusal as psychosis is something that many patients will know from their experience to be a falsehood. This can only undermine their trust and future adherence. Also interesting, among our nationally competitive students, a few *have* been recommended to take antipsychotics and their adherence rates are only 40% to 70% (See Table 1: Adherence). The reason patients think good outcomes can happen without medication is because, for many, it is true.

82. Murtuza Bharmal et al., *Validation of an abbreviated Treatment Satisfaction Questionnaire for Medication (TSQM-9) among patients on antihypertensive medications*, 7 HEALTH AND QUALITY LIFE OUTCOMES, 36 (2009).

Bona fide situational reasons for refusal (and adherence)

There are two types of congruence that would increase adherence: when taking medication makes achievement of a goal easier, and when *not* taking medication makes achievement of a goal harder. The congruencies that would decrease taking medication are: when taking medication makes achievement of a goal harder, and when *not* taking medication helps make a goal easier. Each score, when multiplied by the importance of the goal, will contribute to a negative Goal Impact. Each score, when multiplied by the importance of the goal, will contribute to a positive Goal Impact.

What goals are most important and how their achievement is aided or hindered by the environment is an entirely personal matter and the results of this particular group shouldn't be generalized to other individuals.⁸³ But, as an example, this particular group found the goals most congruent with medicating as follows: Self-Regulation, being Organized & Efficient, Occupational Success, Mastery & Perseverance, Happiness, Enjoying Life, and Avoiding Stress & Anxiety. The goals that are most incongruent with medicating are Sexual and Emotional Intimacy, Being Physically Capable/Healthy, Avoiding Socializing, Knowing One's Self, & Interpersonal Caretaking (Figure 1).

Personal Goals vs Pressure in the prediction of adherence

It does not matter if a situation makes it harder or easier to achieve a goal unless that goal is important. Therefore, for each goal we multiplied the congruence/incongruence measure by how important that goal was to the participant. We did this for every goal and then added them together to create one Goal Impact score for Medicating and another for Not Medicating. Finally, we

83. We have no evidence to suggest there is a consistent pattern upon which one can rely to say "this is most important to people" and "that is made harder by X situation". Thus, as we report what goals and congruence emerged for this particular sample of thirty people it should not serve as a guide to what is important or congruent but, instead, as illustrative examples that we should expect to change if we were to sample any other set of thirty people. Data collection would need to number in the several hundreds at least to draw any such conclusion.

subtracted the Goal Impact of Not Medicating from the Goal Impact of Medicating to form one total Goal Impact score.

Three regression models were tested. In the first model, we entered Goal Impact as a predictor of adherence. As expected, and in line with our previous work in many decision making domains, Goal Impact was a strong predictor of adherence ($p=.01$).⁸⁴ In psychological research, it is considered good to account for 5% the variance of a predictor.⁸⁵ Goal Impact accounted for 18.5% of the variance in predicting adherence to psychotropic medication.

For the next model, we added how pressured participants felt to take psychotropic medication on the second step of Model 1. Pressure to take psychotropic medication failed ($p=.95$) to predict adherence or account for any of the variance at all.⁸⁶ This finding adds to the clinical literature that fails to find evidence that coercion is an effective practice.⁸⁷ We may begin to understand why the results for pressure are often mixed in the third model we present.

When is it “helping” and when is it “coercion”?

For our third model, we computed an interaction term by multiplying Goal Impact and pressure together in order to see what the combined effect yields. The model, as a whole, is significant ($p=.05$) but does suggest that Goal Impact is the source of prediction ($p=.008$).⁸⁸ Again, there was no main effect for pressure, which failed to predict adherence.⁸⁹

84. In Model 1, Goal Impact predicts adherence, explaining 50% of its variance ($b = 1.52, p<0.01, sr^2=0.5$).

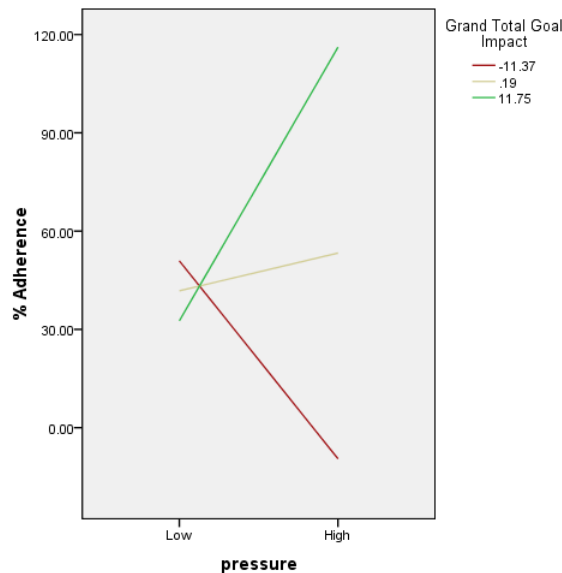
85. We computed effect size estimates (squared semipartial correlations, sr^2) for all primary hypothesis tests. Values of squared semipartial correlations represent the percentage of variance in the dependent variable uniquely explained by each predictor variable (controlling for all other predictors in the equation). This effect size estimate is equivalent to eta squared in analysis of variance models.

86. In Model 2, pressure failed to predict adherence, explaining -1% of its variance ($b = -0.24, p<0.946, sr^2=-0.01$).

87. Jarrett et al., *supra* note 3.

88. Model 3 as a whole: ($R^2_{adj}=0.19, F(3,23)=3.04, p<0.05$). In Model 3, Goal Impact significantly predicts adherence, explaining 51% of its variance ($b = 1.8, p<.008, sr^2=.51$).

89. In Model 3, pressure failed to predict adherence ($b = -.64, p<.85, sr^2=-.03$).



Though the interaction term between power and Goal Impact was not significant, that is not statistically surprising with a sample size of 30.⁹⁰ However, the trends we see when this interaction is plotted are surprising and may lend insight as to why the clinical literature reports discrepant findings.

As pressure to take medication increases, adherence decreases, but only when medicating has a poor or negative impact upon a person's life goals (Low Goal Impact). Yet, adherence increases as pressure increases if medicating has a highly positive impact on the participants' most important life goals (High Goal Impact).

Consider those whose total goal impact is high and positive. As pressure to take medication increases, these people show increased adherence. That is, when adhering obviously benefits their goals, helping them to adhere, works. Perhaps this is caused by the social support aspect, attempts to encourage or reminding them to take their medication is interpreted as showing support for them, their life, and their goals. Perhaps a timely reminder helps the patient overcome absent-mindedness, and

90. In Model 3, pressure multiplied by Goal did not significantly predict adherence ($b = 0.59$, $p < 0.15$, $sr^2 = 0.26$). More power (aka more subjects) are generally necessary to obtain an interaction so even a marginal interaction was a bit of a surprise given our modest sample size.

encouragement helps them to deal with negative side effects that might otherwise have resulted in a skipped pill here or there.

However, our trend suggests the effects of pressure are grim for those whom the total goal impact of medicating is low or even negative. These individuals see a lot of conflict between taking psychotropic medication and achieving what is important to them in life. When they feel pressured to take medication, they seem to experience psychological reactance. For them, pressure is coercive and dangerous and the result is that they refuse the medication more than if they had been left alone.

This is in keeping with results from an experimental manipulation in which participants read speeches that were either for or against the participants' own opinion. In one condition, participants' freedom to decide for themselves was manipulated. Most participants, moved their position toward the advocated position, including those whose freedom to decide was threatened and they originally held the opposing opinion. However, those who were initially in agreement with the advocated position tended to move away from it when their freedom to decide for themselves on the issue was threatened. These results suggest that attempting to persuade a patient to take medication, without a clear indication that they are free to decide for themselves may move patients to resist when, unpressured, they would have chosen to adhere.⁹¹

Pressure may change a person's goals

What can we learn about the content of this psychological reactance to the pressure to medicate? Are the goals different for those who see coercion and those who see helping? Are these persistent goals of the individual or triggered by the situation?

If pressure is evoking goals that work against adherence, likely culprits are autonomy and personal power.⁹² We began our investigation by correlating each of the 46 goals with Pressure. The importance of Autonomy was negatively and insignificantly correlated with being pressured ($r = -.17$ $p = .39$). However, the goal

91. S. Worchel & J.W. Brehm, *Effect of Threats to Attitudinal Freedom as a Function of Agreement with the Communicator*, 14 J. PERSONALITY AND SOC. PSYCHOLOGY 18, 18–22 (1970).

92. Additional to these caveats, note that at a significance level of .05 it is probable that about two correlations will be significant entirely by chance. On the other hand, there may be many correlations that do not reach significance due to our small sample size ($N=27$).

cluster Control Others was significantly and positively correlated with being pressured ($r=.42$, $p=.03$).⁹³ We followed up with regressions for each and found that, indeed, pressure did not predict Autonomy goals but did significantly predict goals to Control Others.⁹⁴

The goals in the cluster Autonomy, to which pressure was unrelated, are “being self-sufficient, independent” and “setting and following my own guidelines.” People were not more or less likely to be pressured when having these goals. However, could a power-monger personality lead to a refusal to take medication and ultimately a pressure to do so? Our taxonomy includes several other power-related goal clusters including To be Better than Others, Leadership, and being Respected. None of these power or control-related goals are significantly related to being pressured. Control of Others is the only power-related cluster that is predicted by pressure, which may suggest this is not a power-monger personality type eliciting pressure but, perhaps, pressure eliciting a specific power-related goal cluster which includes rather notably the goal to “To get revenge (get even).”⁹⁵

Control Others, however, is just one of 46 goals presented to participants from our hierarchy and its impact alone does not predict adherence.⁹⁶ As with past studies, it is the aggregate Goal

93. Also positively and significantly correlated with being pressured were the goals to be Interpersonally Effective ($r=.42$, $p=.03$), to Knowing One’s Self ($r=.43$, $p=.03$), as well as Religion & Spirituality Goals ($r=.41$, $p=.03$). Religion and Spirituality goals seem peculiar, however, as religious families and communities may be more involved in caretaking and thus more likely to pressure members. Inversely and significantly correlated with pressure were goals for Money and Wealth ($r=-.39$, $p=.04$) as well as to Financial Freedom ($r=-.45$, $p=.02$). It seems unlikely that both these goal clusters would reach significance due to chance. So one must wonder at the direction of this relationship: are those with the goal to be better off financially less likely to be pressured (due to some success at obtaining wealth) or less likely to need to be pressured to take their medication (due to the self-regulation necessary to achieve such ambitions)?

94. Pressure fails to explain a significant portion of variance in Autonomy ($R^2_{adj}=0.03$, $F(1,25)=0.77$, $p<.38$). Pressure can explain a significant portion of variance in Control Others ($R^2_{adj}=0.17$, $F(1,25)=5.23$, $p<.03$).

95. Control of Others also includes “Making decisions for others,” “To have others give me what I want,” etc.

96. In Model 2, Control of Others failed to predict adherence ($b = -1.22$, $t = -0.2$, $p < 0.78$).

Impact of a participant's most important goals that carries the predictive power.⁹⁷

The most bona fide reasons for refusal are overlooked

In order to address the matters typically considered as bona fide reasons, we used the *Treatment Satisfaction Questionnaire for Medication* (TSQM). The TSQM asks patients how satisfied or dissatisfied they are with several aspects of taking medication. It asks first about the medication's effectiveness in treating the condition and relieving symptoms. It asks about side effects, in general, and specifically, one's ability to function mentally, emotionally, and physically when on the medication. It asks about practical matters like how easy the medication is to use and the planning and timing of doses. To our surprise, the TSQM failed to predict adherence ($b = 25$, $p < .15$) and added only an additional 4% of the variance above the 18.5% contributed by Goal Impact alone.

It is understandable that a clinician's focus is on fighting an illness and administering medication. Our findings suggest that, for the patients, decisions about medication have nothing to do with medications or mental illness—they have to do with everything in life that lies outside them.

Practical Implementation in Policy

Logically, it is simply not possible to compel long-term behaviors unless the compelling force can be indefinitely maintained. For, without that compelling force then other forces, from within the person and from without, will direct behavior.⁹⁸ With regard to society's paternal obligation to protect, coerced outpatient treatment is doomed to eventually break down. For instance, if convicted pedophiles who have fulfilled their sentences are allowed back into society the pedophiles must be people who recognize their illness and they must have a personal determination to never harm another child. Such a person will adhere to their medication without the pressure of coercion. If coercion is inappropriately applied to such a person, it could undermine their own internal motivation to take the medication and, thereby, undermine their voluntary adherence.⁹⁹ Conversely, if a pedophile

97. Talevich, *supra* notes 77 and 78.

98. Bargh, et al. *supra* note 28.

99. M. Allen & V. F. Smith, *supra* note 19.

will not adhere and coercion is truly deemed necessary, this individual should not be released into society as they will likely escape the force requiring them to medicate and a child will be in danger.

Galon & Wineman find evidence that procedural justice and caretaker benevolence can diminish these perceptions.¹⁰⁰ In essence, a patient's sense of procedural fairness can help mitigate the unfairness of force.¹⁰¹ The sense of being cared for as an individual can help diminish the sense of being treated as a "thing" without will.¹⁰²

Retrospective interviews have been conducted with patients and nurses involved in forced medication incidents.¹⁰³ Every patient mentioned at least one alternative to coerced medication.¹⁰⁴ Not one nurse mentioned an alternative.¹⁰⁵ This is unfortunate because reports indicate that offering a range of treatment options and negotiating these choices lead to agreement and can avoid force altogether.¹⁰⁶

For instance, patients in acute psychiatric emergency wards have clear preferences between seclusion and medication: men were more likely to choose seclusion (43% vs 27%) whereas women were more likely to choose medication (60% vs. 23%).¹⁰⁷ Furthermore, being given a choice helped preserve trust between patient and practitioner. Patients appreciated receiving explanations of the reasons for the use of a restrictive measures and discussing their preferences with staff.¹⁰⁸

As Vuckovich noted, sometimes the perceived benefit of remission is not great, particularly in comparison to the difficulties presented by the medication.¹⁰⁹ Sometimes, though medicated remission would be desirable, remission is not significant in the

100. Galon & Wineman, *supra* note 7, at 307–316.

101. *Id.*

102. *Id.*

103. K. Haglund, L. von Knorring, & L. von Essen, *Forced Medication in Psychiatric Care: Patient Experiences and Nurse Perceptions*, 10 J. PSYCHIATRIC AND MENTAL HEALTH NURSING. 65, 65–72 (2003).

104. *Id.*

105. *Id.*

106. Lavelle & Tusaie, *supra* note 1.

107. *Id.*

108. *Id.*

109. Vuckovich, *supra* note 5.

areas most important to the patient.¹¹⁰ These factors would reasonably reduce the perceived value of staying medicated to any person. Human beings are deeply goal-driven, mentally ill or not. This motivation and our results suggest that an intervention that examines a patient's goals and how the goals are affected by medication may actually increase adherence.

With the knowledge of which goals medicating helps and hinders most frequently, agencies can design information campaigns that cast treatment in a positive, goal-congruent light. On an individual level, this procedure could be implemented to more accurately individualize interventions with this same aim. These efforts would likely be far more effective than forced drug treatments and may well be the only path to long-term adherence.

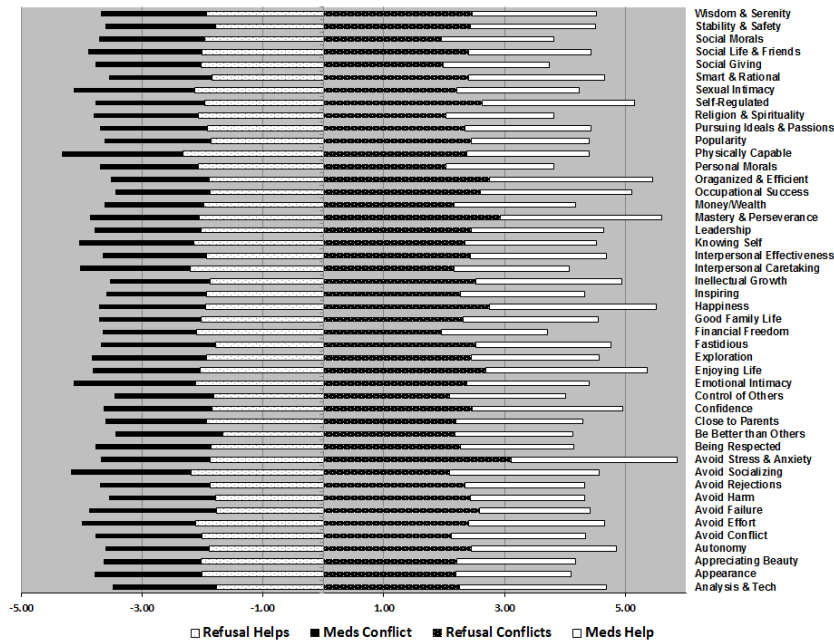
110. *Id.*

Table 1: Adherence

How often do you take your meds as often as prescribed?

	Reported Frequencies		Category % of		Subtotal
	Adherence	N	N	N	N
Total Refusers	0.00	5	5	17%	14
Strong Refusers	0.10	2	5	17%	
	0.30	1			
	0.70	1			
	0.10	1			
More-often Refusers	0.27	1	4	13%	
	0.28	1			
	0.45	1			
	0.49	1			
More-often Adherers	0.53	1	8	27%	16
	0.55	1			
	0.60	2			
	0.62	1			
	0.68	1			
	0.70	2			
Fair Adherer	0.75	1	5	17%	
	0.78	1			
	0.79	1			
	0.86	1			
	0.86	1			
Strong Adherers	0.91	1	3	10%	
	0.96	2			
Total	1.00	30	30	100%	30

Figure 1: Goal Congruence with Taking Medication and Not Stacked Means



The Ethics of Cognitive Enhancement: ADHD Medications and Beyond

DOUG LAWSON

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WHAT IS ADHD?

Attention deficit hyperactivity disorder (ADHD) is a condition characterized at its core by “inattention, hyperactivity and impulsiveness.”¹ According to the Diagnostic and Statistical

1. Ilina Singh, *Beyond Polemics: Science and Ethics of ADHD*, 9 NATURE REVIEWS: NEUROSCIENCE 957, 957 (Dec. 2008).

Manual of Mental Disorders (DSM-IV), the behavioral symptoms of ADHD are divided into two main categories: inattention and impulsivity-hyperactivity.² In order for an individual to meet the criteria for being diagnosed with the disorder, a certain number of the listed symptoms must have “persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level.”³ Depending on the degree to which the symptoms listed in each category accurately describe an individual’s behavior, she will receive an ADHD diagnosis that is further specified into one of three subtypes: (1) ADHD, Combined Type; (2) ADHD, Predominantly Inattentive Type; and (3) ADHD, Predominantly Hyperactive-Impulsive Type.⁴

According to the symptoms identified in the DSM-IV, the inattention that accompanies ADHD manifests itself in forgetfulness, distractibility, a tendency to lose things and make careless mistakes, organizational difficulties, and trouble following through on instructions to complete assigned tasks.⁵ In addition, the individual may appear to not be listening when spoken to directly, may fail to pay attention to details, and may avoid “activities that demand sustained self-application and mental effort or that require organizational demands or close concentration (e.g., homework or paperwork).”⁶ On the other hand, the hyperactivity component of an ADHD diagnosis involves fidgeting, squirming, getting up from one’s seat, excessive running and climbing, and excessive talking.⁷ The DSM-IV describes the hyperactive individual as frequently “on the go” and behaving as if “driven by a motor.”⁸ Lastly, the impulsivity component of ADHD may be demonstrated by an individual’s tendency to blurt out an answer before the question is finished, to interrupt and intrude on others, and to have difficulty waiting his or her turn.⁹

Despite the DSM-IV’s status as the “go-to” guide for diagnosing ADHD in the United States, the disorder may in fact be

2. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 80 (4th ed. 1994) [hereinafter DSM-IV].

3. *Id.* at 84.

4. *Id.* at 80.

5. *Id.* at 78–79.

6. *Id.* at 78.

7. *Id.* at 79.

8. DSM-IV, *supra* note 2, at 79.

9. *Id.*

more complex than the manual suggests. In an article that focuses on the science and ethics of ADHD diagnosis and treatment, Ilina Singh highlights a major issue with the way in which ADHD is currently diagnosed.¹⁰ Singh notes that the DSM-IV criteria “fail to capture the phenotypic heterogeneity that is seen in clinical contexts where ADHD is diagnosed” because the manual uses “a categorical, rather than a dimensional system of classifying symptoms and making a diagnosis.”¹¹ In other words, while individuals with ADHD tend to present symptoms that fall along a continuum from mild to severe, the diagnostic criteria employ a black and white structure that classifies individuals as either normal or pathological with no room for gradations of severity. Another article on the subject supports Singh’s view of the disorder: “Although diagnosed as a categorical disorder, ADHD may actually represent the extreme end of a normal continuum for the traits of attention, inhibition and the regulation of motor activity.”¹²

A further complexity not addressed in the DSM-IV is the fact that “ADHD symptoms, especially hyperactive-impulsive symptoms, tend to decline through adolescence into adulthood, so that the adult presentation of ADHD differs somewhat from the childhood presentation.”¹³ While this may bode well for aging individuals struggling with ADHD symptoms, the fact that the diagnostic manual does not account for the changing presentation of ADHD over time indicates that its categorization technique is incomplete. If childhood and adult presentations of ADHD differ significantly, it follows that it is inappropriate to use the same criteria in diagnosing individuals from both age groups. Additional research and revision of the DSM-IV text to distinguish between child and adult cases would create a more accurate system of diagnosis and will likely lead to a better public understanding of the disorder.

10. Singh, *supra* note 1, at 958.

11. *Id.*

12. Kevin M. Antshel et al., *Advances in Understanding and Treating ADHD*, 9:72 BMC MED. 1, 1 (2011), available at <http://www.biomedcentral.com/content/pdf/1741-7015-9-72.pdf>.

13. *Id.*

ADHD: PAST AND PRESENT

Although ADHD was not officially recognized as a clinical disorder until the 20th century (and the disorder did not acquire the name “ADHD” until 1987),¹⁴ author Thom Hartmann theorizes that it has been with us since prehistoric hunter-gatherer times.¹⁵ According to Hartmann’s “Hunter vs. Farmer” theory, the same ADHD characteristics that tend to cause problems in modern society—inattention, hyperactivity, and impulsiveness—may have been advantageous during a period in human history when societal roles were quite different than they are today.¹⁶ Instead of acting as a hindrance to success, ADHD traits may have provided an evolutionary advantage for early human beings in that those who had the “disorder” were actually better equipped for active roles in society: particularly hunting, but also performing mating rituals and engaging in various types of risky behavior.¹⁷ On the other hand, early humans without ADHD—those who lacked their counterparts’ impulsiveness, short attention span and affinity for being constantly in motion—were better suited for roles as farmers, gatherers, basket-weavers, and community organizers and planners.¹⁸ Both ADHD and non-ADHD personality types were advantageous for early human societies in different ways, and, as a result, both personalities passed on to succeeding generations as advantageous traits have a tendency to do.¹⁹

Today, however, those bearing the traits of the ADHD personality may find themselves worse off than their ancient predecessors in terms of holding an evolutionary advantage over their peers.²⁰ Over the course of human history, we have shed our

14. See generally Conn. ADHD Task Force, REPORT OF THE CONN. TASK FORCE ON ADHD 8 (3d ed. 2005), available at http://www.ctserc.org/initiatives/teachandlearn/ADHD_report_5-2-05.pdf.

15. See Thom Hartmann, ATTENTION DEFICIT DISORDER: A DIFFERENT PERCEPTION (2d ed. 1997).

16. *Id.*

17. *Id.*

18. *Id.*

19. *Id.*

20. See *id.* at 67, 87. Referring to ADHD people as natural Hunters and non-ADHD people as natural Farmers, Hartmann writes that there are “very bright Hunter children” whose grades in the “‘normal’ Farmer classroom system, generally aren’t good.” Hartmann emphasizes that this concept applies

hunter-gatherer roots in exchange for a farm-based existence, allowing for the emergence of small towns, cities, and finally modern industrialized urban settlements with extraordinarily dense populations.²¹ As human beings managed to remain in one geographical area for longer and longer, the prehistoric balance between active and sedentary societal roles subsided and was replaced by a job structure heavily based in office jobs, an educational system in which students are required to sit at desks for long periods of time, and other sedentary, non-active societal responsibilities.²² A study of US citizens in 2003–2004 revealed that subjects spent an average of 54.9% of their waking hours engaged in sedentary behaviors.²³ Today, “80 percent of jobs...are sedentary or require only light activity.”²⁴

So, where does the shifting societal climate leave those with ADHD? In both school and in the workplace, individuals with ADHD are likely to find themselves at a severe disadvantage.²⁵ Although people with ADHD are wired to flourish in unstructured situations where they can remain active,²⁶ they are ill-equipped to succeed in modern educational and professional environments that

outside of school: Hunters run into problems in jobs designed for people with a Farmers’ ability to be patient, proceed methodically and maintain concentration for an entire day at “one desk and on one task.”

21. See Neolithic Period, ENCYC. BRITANNICA ONLINE (Mar. 31, 2011, 11:40 PM), <http://www.britannica.com/EBchecked/topic/408894/Neolithic-Period>; Industrial Revolution, Subsection of History of Europe, ENCYC. BRITANNICA ONLINE (Mar. 31, 2011, 11:40 PM), <http://www.britannica.com/EBchecked/topic/195896/history-of-Europe/58404/The-Industrial-Revolution?anchor=toc58404>.

22. Hartmann writes that “today we are not a society of hunters, raiders, and warriors. We are farmers, office- and factory-workers. Therefore, we punish and discourage hunter and warrior behavior in our children and adults.” Hartmann, *supra* note 15, at 35.

23. Charles E. Matthews et al., *Amount of Time Spent in Sedentary Behaviors in the United States, 2003–2004*, 167 AM. J. EPIDEMIOLOGY. 875, 875 (2008), available at <http://aje.oxfordjournals.org/content/167/7/875.full.pdf+html>.

24. Tara Parker-Rope, *Less Active at Work, Americans Have Packed on Pounds*, N.Y. TIMES, May 25, 2011, at A1.

25. V. A. Harpin, *The Effect of ADHD on the Life of an Individual, Their Family, and Community from Preschool to Adult Life*, 90 (Issue Suppl. 1) ARCHIVES OF DISEASE IN CHILDHOOD i2, i4 (2005), available at http://adc.bmj.com/content/90/suppl_1/i2.full.pdf+html.

26. See DSM-IV, *supra* note 2, at 78–85.

often require individuals to sit still, sustain attention for long periods of time, and be patient in asking questions or giving answers.²⁷ It is apparent that such situations are anathema to someone plagued by hyperactivity, inattention, and impulsiveness. As a result, people with ADHD often have a hard time succeeding in structured academic and professional environments, no matter their level of intelligence or desire to succeed.²⁸ Even worse, because the public at large generally lacks an adequate understanding of ADHD—seeing it as a fictional condition or merely an excuse for poor behavior—those who suffer from its symptoms are unlikely to find others to sympathize with their plight.²⁹ Instead, peers who do not understand the reality of the disorder’s symptoms are likely to view individuals with ADHD as lazy, careless, unprofessional, and irresponsible when they miss a detail, fail to follow instructions, or lose focus during an important meeting.³⁰

Additionally, individuals with ADHD face obstacles outside of school and the workplace.³¹ Poor impulse control may lead to speeding tickets, unplanned pregnancies, fistfights, or worse.³² “Relationship difficulties and break-ups are more common” for people with ADHD.³³ People with ADHD may turn to street drugs and alcohol in a misguided attempt to counteract their hyperactive state so that they can finally calm down and feel “normal.”³⁴ The conclusion of a worldwide ADHD study illustrates this point:

27. *Id.*

28. *Id.*

29. Kristen L. Aggeler, *Is ADHD a “Handy Excuse”? Remedying Judicial Bias Against ADHD*, 68 UMKC L. REV. 459, 464, 466, 473, 481 (2000).

30. *Id.*; DSM-IV, *supra* note 2, at 80 (noting that “inadequate self-application to tasks that require sustained effort is often interpreted by others as indicating laziness, a poor sense of responsibility, and oppositional behavior”); see Patricia Quinn, *10 Problems That Could Mean Adult ADHD* (Feb 12, 2012), <http://www.webmd.com/add-adhd/10-symptoms-adult-adhd?page=2>.

31. Harpin, *supra* note 25, at i4.

32. *Id.*

33. *Id.*

34. *Id.* (“The risk of drug and substance abuse is significantly increased in adults with persisting ADHD symptoms who have not been receiving medication”), see Quinn, *supra* note 30 (noting that “adults with ADHD are more likely to exhibit restlessness or find they can’t relax”).

The effects of ADHD significantly impact on the individual throughout childhood and well into adult life, especially if not managed optimally; people with ADHD tend to have a lower occupational status, poor social relationships, and are more likely to commit motoring offences and develop substance abuse. Parents and siblings also suffer as a result of the behavioral problems associated with ADHD; increased levels of stress are common as are depression and marital discord.³⁵

Individuals with ADHD, unlike their evolutionarily-advantaged predecessors from the distant past, often find themselves at a disadvantage in the modern age.³⁶ Left to their own devices, they are unlikely to understand the nature of their disorder, and they are likely to fall short of their potential in both personal and professional endeavors.³⁷ There is little doubt that these individuals could greatly benefit from some form of help, support, and guidance.

Thanks to widespread efforts to understand and treat the disorder over the course of the past few decades, this type of assistance is currently available in a variety of forms.³⁸ However, literature from the 18th and 19th centuries indicates that the disorder was alive and well for a long time before any real understanding or treatment methods were developed.³⁹ The mystification embodied in descriptions of ADHD symptoms from this time period illustrates this lack of understanding.⁴⁰ For example, in 1798, Sir

35. Stephen V. Faraone et al., *The Worldwide Prevalence of ADHD: Is It an American Condition?* 2 WORLD PSYCHIATRY 104, 104 (June 2003).

36. *See id.*; *see also* Hartmann, *supra* note 15.

37. *See* Faraone et al., *supra* note 35, at 104.

38. *See* Antshel et al., *supra* note 12, at 1.

39. *See* SIR ALEXANDER CRICHTON, AN INQUIRY INTO THE NATURE AND ORIGIN OF MENTAL DERANGEMENT: COMPREHENDING A CONCISE SYSTEM OF THE PHYSIOLOGY AND PATHOLOGY OF THE HUMAN MIND AND A HISTORY OF THE PASSIONS AND THEIR EFFECTS 272 (1798); *see also* Sir George Frederic Still, *Some Abnormal Psychical Conditions in Children: The Goulstonian Lectures* 159 THE LANCET 1163, 1166 (1902).

40. *See id.*

Alexander Crichton described what appears to be ADHD in a book chapter entitled “Attention”:

In this disease of attention, if it can with propriety be called so, every impression seems to agitate the person, and gives him or her an unnatural degree of mental restlessness. People walking up and down the room, a slight noise in the same, the moving of a table, the shutting a door suddenly, a slight excess of heat or of cold, too much light, or too little light, all destroy constant attention in such patients, inasmuch as it is easily excited by every impression.⁴¹

In addition to the attentional difficulties associated with the disorder, Crichton was also aware of the hyperactivity component of ADHD, noting that those afflicted with this disease “have a particular name for the state of their nerves, which is expressive enough of their feelings.”⁴² They say they have the fidgets.”⁴³ More than a century later in 1902, Sir George Frederick Still lectured about young people with attentional difficulties, describing ADHD symptoms in a similarly primitive manner:

Another boy, aged 6 years, with marked moral defect was unable to keep his attention even to a game for more than a very short time, and as might be expected, the failure of attention was very noticeable at school, with the result that in some cases the child was backward in school attainments, although in manner and ordinary conversation he appeared as bright and intelligent as any child could be.⁴⁴

Although Still’s belief that the symptoms he described derived from a “moral defect” may seem absurd from a fully-informed modern perspective, this is a misconception continues to haunt people with ADHD in modern times. As noted earlier, peers who

41. CHRICHTON, *supra* note 39, at 272.

42. *Id.*

43. *Id.*

44. Still, *supra* note 39, at 1166.

observe the behavior and tendencies of an individual with ADHD are more likely to attribute that person's shortcomings to morally-culpable deficiencies that they can understand—such as irresponsibility and laziness—than they are to attribute them to a clinical disability of which they are blissfully unaware.⁴⁵

Because health science professionals in the past did not fully understand ADHD, it would have been quite difficult for them to provide tailored treatment to individuals struggling with its symptoms. Fortunately, knowledge about ADHD steadily increased throughout the 20th century, and a new and more complete understanding of the disorder has allowed for targeted behavioral therapy and medication to be successfully utilized in helping individuals cope with ADHD in the modern world.⁴⁶

A BRAVE NEW WORLD: INCREASING PREVALENCE OF ADHD AND MEDICATION USE

Since the turn of the 21st century, “rates of [ADHD] diagnosis have increased sharply in most countries around the world.”⁴⁷ It is unclear whether such increases are the result of over-diagnosis, or whether ADHD prevalence has remained proportionally static in the human population and increasing rates are instead attributable to a global growth in awareness which has allowed more people to recognize its symptoms and seek a formal diagnosis⁴⁸. A third theory suggests that growing numbers of ADHD diagnosis can be explained by “an actual increase in ADHD prevalence” across the globe.⁴⁹

Coinciding with the worldwide increase in ADHD diagnoses, there has been a “parallel growth in the consumption of stimulant medications.”⁵⁰ Although cognitive-behavioral therapy has proven effective to some extent, individuals with ADHD often find that drugs which target the neurotransmitter dopamine—implicated as part of the biological cause of ADHD—and the prefrontal cortex—implicated as part of the neurological cause of

45. See Aggeler, *supra* note 29, at 459, 464, 466, 473, 481.

46. See Singh, *supra* note 1, at 960–61.

47. *Id.* at 958.

48. See *id.*

49. Singh, *supra* note 1, at 958.

50. *Id.*

the disorder—can be very helpful.⁵¹ And, although non-stimulant medication is available for treatment of the disorder, “stimulant medication is often the first choice for medication management of ADHD [because] research has shown that stimulant medication is an effective treatment for many of the symptoms associated with ADHD.”⁵²

At first blush, it may seem that the decreasing availability of active societal roles from prehistoric to modern times caused problems for people with ADHD, and that the recent growth in understanding and ability to treat the disorder with medication simply solved these issues. Upon further investigation, however, it quickly becomes apparent that the subject of ADHD medication is much more complicated. While it is true that these medications have gone a long way toward helping people with ADHD manage their symptoms, the introduction of ADHD medications into the market has raised several ethical questions that have yet to be adequately addressed: Who should have access to ADHD medications? Should healthy individuals who do not have ADHD be permitted to “performance enhance” using these drugs?

Answering these questions will create a line of reasoning which can be used to aid lawmakers in designing rules to regulate ADHD medication. However, the importance of this ethical discussion is not limited to the ADHD medication context, nor is it confined to the present. Rather, as time goes on and new methods of cognitive performance enhancement are developed, the answers to these ethics-based questions will become increasingly relevant. It is essential that we address these unresolved issues now in the context of ADHD medication so that an ethical framework can be established and later applied through the law to future innovation in a meaningful, rather than haphazard, way.

A QUESTION OF ACCESS: REMOVING BARRIERS TO TREATMENT FOR INDIVIDUALS WITH ADHD

It almost goes without saying: people who need ADHD medication to cope with ADHD symptoms should have access to it. In the United States, however, the reality is that a number of significant barriers prevent individuals with ADHD from seeking

51. Antshel et al., *supra* note 12, at 1.

52. *Id.*

and receiving the help they need. The most significant barriers are the stigma associated with mental illness and the public's misunderstanding of the legitimacy and characteristics of the disorder.⁵³

One study, which focused on barriers to ADHD diagnosis and treatment, involved a "district-wide stratified random sample of 1615 elementary school students" who were pre-screened "for ADHD risk" before being selected for analysis.⁵⁴ Although 88% of the schoolchildren who took part in the study were found to indeed have a problem,⁵⁵ only 39% had been previously evaluated, 32% had received an ADHD diagnosis and 23% were currently receiving treatment.⁵⁶ The results of this study indicate that the rate of diagnosis and treatment for schoolchildren with ADHD may be below 50%.⁵⁷ This could mean that half of young people with ADHD may not even be aware they have a recognized disability, which is an obvious prerequisite for receiving treatment. Even more alarming is the fact that female students, minority students, and students from low-income families are disproportionately likely to belong to the undiagnosed and untreated half of the student population with ADHD.⁵⁸ In order to accomplish the goal of allowing widespread access for all who truly need medication, the barriers that stand in the way of ADHD diagnosis and treatment must be broken down and eliminated to the furthest extent possible.

The most significant set of barriers to access may be curable through education. One significant barrier preventing those who need ADHD drugs from accessing them is the stigma attached

53. See Aggeler, *supra* note 29, at 459, 464, 466, 473, 481; see also Abraham Mukolo et. al, *The stigma of childhood mental disorders: A conceptual framework*, 49 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 92, 93 (2010).

54. Regina Bussing et al., *Barriers to Detection, Help-seeking, and Service Use for Children with ADHD Symptoms*, 30 J.OF BEHAV. HEALTH SCI. & RES. 176, 176 (2003).

55. *Id.* Note that the children were pre-screened for ADHD symptoms before being selected for the study; this percentage does not reflect the prevalence of ADHD in a normal, randomly-selected population.

56. Bussing et al., *supra* note 54, at 176.

57. *Id.*

58. *Id.*

to seeking help for a cognitive disorder.⁵⁹ Too many young people resist treatment because of social pressure to project an unblemished image, to hide signs of weakness from peers, and to avoid admitting to themselves or others that they are anything other than “normal.”⁶⁰ There may be no surer way to become an outcast in a high school population than to gain a reputation as someone afflicted by mental problems.

Another barrier is the fact that many young people—and oftentimes their teachers—are undereducated about the significance and identifying characteristics of ADHD.⁶¹ Young people often fail to seek treatment because they fall victim to the misconception that disorders of the mind are fundamentally different from disorders of the body in that they can be cured through persistence and sufficient effort.⁶² In many cases, both students and their teachers believe that a lack of effort is the sole cause of a student’s inability to maintain focus in the classroom,⁶³ but consider the second grader who constantly asks to go to the bathroom just so she can walk in circles to alleviate a restlessness she does not understand. Teachers who are undereducated about

59. See *Mental Health Course, Module 7: Cultural Perspectives on Mental Health*, Unite for Sight, Inc., (Feb. 27, 2013, 3:50 PM), <http://www.uniteforsight.org/mental-health/module7>.

60. See *id.* The National Institute for Health reports, “An estimated two-thirds of all young people with mental health problems are not receiving the help they need.” Information about Mental Illness and the Brain. Biological Sciences Curriculum Study, (Feb. 27 2013, 3:34 PM), <http://science.education.nih.gov/supplements/nih5/mental/guide/info-mental-a.htm>.

61. Vickie E. Snider et al., *Teacher Knowledge of Stimulant Medication and ADHD*, 24 J. REMEDIAL AND SPECIAL EDUC. 46, 46 (2003). (“A random sample of 200 general educators and 200 special educators from Wisconsin were surveyed. Results revealed that teachers had limited knowledge about ADHD and the use of psychostimulant medication”).

62. Although ADHD is no longer classified outright as symptoms of a “moral defect” as it was by Still in the early twentieth century, people unfamiliar with research regarding the disorder in the last few decades may still understand it from a similarly primitive perspective and believe that if ADHD people were more committed to being “good” they could overcome their attention problems. See Still, *supra* note 39, at 1166. Hartmann writes, “Prior to the 1970s, when ADD was first characterized as a specific disorder, ADD children and adults were largely treated simply as ‘bad people.’” Hartmann, *supra* note 15, at 21.

63. See Aggelar, *supra* note 29, at 459, 464, 466, 473, 481 (discussing the common public perception that ADHD is merely an excuse for lack of effort).

cognitive disorders are likely to become frustrated with ADHD students, who often appear lazy, disruptive, and careless to the untrained eye.⁶⁴ Frustration can lead to exasperation for the teacher and punishment for the student.⁶⁵ Seldom does such a scenario lead to the much-needed diagnosis and treatment that could help the troubled student to understand her condition and find ways to cope, compensate and survive in the classroom and beyond.⁶⁶

First and foremost, we are in dire need of an educational campaign aimed at eroding the stigma of consulting with a therapist or psychiatrist, being diagnosed with a cognitive disorder, and taking medication on a regular basis to combat symptoms of a cognitive disorder. The onus is on educators to convey to young people that there truly is no such thing as “normal”; all individuals have their own strengths and weaknesses and the best way to lead a happy and successful life is to find ways to minimize one’s personal weaknesses and emphasize one’s personal strengths.

Perhaps one way to begin such an educational campaign is to institute mandatory therapy for all school-aged children at least once a year. Just as children must undergo a yearly physical examination before they participate in physical activities at school, a new policy could be put in place that requires students to go through a psychological examination on a yearly basis. Because disorders of the mind can be just as threatening, if not more threatening, to a child’s well-being as physical ailments, it makes no logical sense that physical problems are screened for early and often while mental issues are, in stark contrast, left unacknowledged until serious problems arise.

64. *See id.*

65. Hartmann notes that “today we are not a society of hunters, raiders, and warriors. We are farmers, office- and factory-workers. Therefore, we punish and discourage hunter and warrior behavior in our children and adults.” Hartmann, *supra* note 15, at 35.

66. Perri Klass, *Attention Deficit Hyperactivity Disorder (ADHD)*, N.Y. TIMES HEALTH GUIDE, (Jan. 31, 2012, 6:00 AM), <http://health.nytimes.com/health/guides/disease/attention-deficit-hyperactivity-disorder-adhd/diagnosis.html>. The rising popularity of Ritalin has caused some parents and teachers to actually *over-diagnose* ADHD in students, seeing it as a simple solution for poor grades or aggressive behavior. However, since this section deals with barriers to ADHD diagnosis and treatment for individuals who have ADHD, I will not address the problem of over-diagnosis here.

The benefits of a mandatory therapy program are two-fold. First, students with ADHD of every gender, race and socio-economic background will be much more likely to receive diagnosis and treatment for their disability. No longer will half of the student population with ADHD slip between the cracks of the ADHD screening process. Second, by subjecting every student to counseling sessions, the stigma associated with seeking help for psychological conditions will be greatly reduced. If everyone does it, social pressures may no longer keep children from seeking this type of support on their own outside of the mandatory program.

Of course, an attempt to establish a mandatory therapy program will likely be met with resistance from parents and school boards alike. As is the case with the institution of any new program, people accustomed to the old way of doing things will likely resist the change. Parents, especially those who are undereducated about cognitive disorders, may decry the use of school funds to provide psychological counseling, seeing it perhaps as a backhanded way of criticizing their parenting. Parents may have stigmas of their own which could cause them to view psychotherapy in a negative light and therefore be critical of a mandatory therapy program. It is not difficult to imagine parents who lack a full understanding of the value of psychological counseling protesting against this program with impassioned vocal pronouncements: "My kid is not crazy; why does he need therapy?" School boards, dependent on community funding, may be forced to bend to the will of the myopic majority even if their members understand the value of counseling and assessment of schoolchildren at an early stage.

School boards and parents are also likely to question the use of funds for this program because it may not produce immediately tangible results. Many students do not have a cognitive disorder and would therefore undergo therapy, receive no diagnosis or treatment, and carry on as they had before going through counseling. Further, even students who benefit from a mandatory therapy program by receiving appropriately-tailored treatment may not go on to immediately produce tangible results to illustrate the success of the program. Although these students may earn better grades once they have adapted to changes brought on by their respective treatment arrangements, academic improvement may take some time to manifest itself. Moreover, the true value of identifying and treating a child's disability lies in a series of

intangible improvements: her new ability to enjoy school, to shed feelings of hopelessness in the classroom, to develop and utilize coping mechanisms, and to finally understand why she experiences learning differently than her classmates do. These kinds of personal benefits may be difficult to reduce to concrete terms, but the fact that they are intangible in no way detracts from their value and potential for making a real impact on students' young lives.

Despite criticisms and concerns about funding, early intervention therapy remains a laudable goal for our country's education system. Students with ADHD who go through the school system undiagnosed and untreated are likely to become jaded with the learning process, upset at the way they were handled by teachers frustrated by their behavior, and, importantly, unaware that they have a recognized condition which could be ameliorated through legitimate means. This impulsive, restless, and undereducated population is likely to drop out of school, to experiment with street drugs as a form of self-medication for their ADHD symptoms,⁶⁷ and to continually cause problems not only for themselves but for society at large. An early intervention program could help these young people avoid such an undesirable fate, steering them instead toward a future where they are more likely to feel personally fulfilled and more likely to have a positive impact on society.

Another step in the educational campaign to remove barriers to ADHD treatment is to "educate the educators" by putting a program in place to give teachers at least an introductory level education in cognitive disorders like ADHD. This program could be structured in a way that requires new teachers to take a course that provides them with a general understanding of cognitive disorders and the way in which they may be manifested in the classroom. In order to reduce costs, minimize inconvenience, and standardize the program for a national audience, this program could be administered online. Teachers all over the country could

67. Beverly R. Horner & Karl E. Scheibe, *Prevalence and Implications of Attention Deficit Hyperactivity Disorder Among Adolescents in Treatment for Substance Abuse*, 36:1 J.A.M. ACAD.CHILD & ADOLESCENT PSYCHIATRY 1, 30 (1997). ("ADHD subjects began drug use at an earlier age, had more severe substance abuse, and had a more negative self-image prior to drug use and improved self-image with drug use. They experienced more negative affective responses related to substance use and more drug craving and attentional difficulties in treatment than control subjects").

participate from the comfort of their own homes or anywhere else they like, provided they can connect to the internet. Through this educational initiative, teachers could learn how to identify symptoms of various disorders, including ADHD, as well as to follow certain steps in dealing with a student who may have a disability.⁶⁸ Optimally, teachers of all grade levels would be required to take this course and pass a comprehension exam before classes begin every year to ensure that the material is fresh in their minds each time they prepare to interact with a new group of students.

An “educate the educators” campaign could create an understanding and compassionate teacher workforce more inclined to help students with cognitive disabilities and less likely to become frustrated and punish these students for behavior that they have difficulty controlling. In turn, this effect could increase the chances that a student with ADHD is diagnosed and receives treatment. In this way, students and teachers could work together as a cohesive unit with common goals instead of becoming antagonists in the classroom.

In light of the risks faced by young people with ADHD, it is very important to clear a path for early intervention and treatment so they can avoid the worst of these pitfalls. Since ignorance forms the foundation of many barriers that prevent these individuals from receiving the help they need, a comprehensive education initiative could be the answer.

IS IT ETHICAL FOR HEALTHY INDIVIDUALS TO UTILIZE COGNITIVE ENHANCEMENT METHODS?

Although medications to enhance the duration and intensity of an individual’s attention span were originally developed for the benefit of those who need medication to counteract the symptoms of a recognized disability, the very existence of these cognitive-

68. See Julie Mickel & Jayne Griffin, *Inclusion and Disability Awareness Training for Educators*, BEYOND THE JOURNAL: CHILDREN AND THE WEB (July 2007), <http://www.naeyc.org/files/yc/file/200707/Mickel.pdf>, (describing a disability education and awareness program called “Kids Like You, Kids Like Me” aimed at teachers who work with young children; linking to other resources helpful in implementing a similar program; noting that educators reported “that the workshop provided them with a more balanced awareness of the world of disabilities and a sense of self-assuredness”).

enhancing medications begs an interesting question: is it ethical for healthy individuals who do not have a cognitive disorder to “performance enhance” through the use of these drugs?

In a way, this ethical issue has been rendered moot by the fact that use of these drugs for such a purpose is already occurring on a mass scale across the United States. Prevalence estimates for “prescription stimulant misuse” among college students in North America “range from 6.9% to 35.3%,”⁶⁹ and 3.2% to 11% of this North American college student population reportedly misuse stimulant medication for the express purpose of “improving concentration, alertness and academic performance.”⁷⁰ And college students are not the only ones who have hopped on the cognitive performance enhancement bandwagon: “Sales of nutritional supplements that promise improved memory in the middle age and beyond have reached a billion dollars annually in the United States alone.”⁷¹

The medications “most commonly used for cognitive enhancement at present are stimulants, namely Ritalin (methylphenidate) and Adderall (mixed amphetamine salts).”⁷² These drugs are prescribed mostly to treat ADHD, but “with rates of ADHD in the range of 4–7% among US college students using DSM criteria, and stimulant medication the standard therapy, there are plenty of these drugs on campus to divert to enhancement use.”⁷³ As one college professor puts it, “in my classes, everyone knows someone who is using or selling the stuff.”⁷⁴ This statement indicates another reason to believe this discussion may ultimately be moot: no matter what determination is reached on this subject, it is very likely that market forces will operate to supply the drugs to demanding consumers regardless of official policies in favor or

69. Cynthia Forlini & Eric Racine, *Disagreements with Implications: Diverging Discourses on the Ethics of Non-Medical Use of Methylphenidate for Performance Enhancement*, 10:9 BMC MEDICAL ETHICS 2, 2 (2009).

70. *Id.*

71. Martha J. Farah et al., *Neurocognitive Enhancement: What Can We Do and What Should We Do?* 5 NATURE REVIEWS: NEUROSCIENCE 421, 421 (2004).

72. Henry Greely et al., *Towards Responsible Use of Cognitive-Enhancing Drugs by the Healthy.*, 456 NATURE 702, 702 (2008).

73. *Id.*

74. James Butcher, *Cognitive Enhancement Raises Ethical Concerns*, 362 THE LANCET 132, 132 (2003).

against such distribution. The failure of both alcohol prohibition in the 1920's and the more recent "War on Drugs" demonstrate the validity of this concern.⁷⁵

The already-widespread use of medication-based cognitive performance enhancement does not necessarily indicate that it is too late to control the phenomenon. A conversation regarding the ethical implications of this growing trend would not be moot; rather, the prevalence of ADHD medication use without a prescription makes this a timely issue, primed for debate. Even though government action is unlikely to cleanse the country of all medication-propelled cognitive performance enhancement, there may be ways to slow its ever-widening grasp on the American education system and society as a whole. But before we decide how we might put an end to this variety of performance enhancement we must first decide whether it is wise to do so, taking into account society's best interests and considering the most relevant ethical issues.

HOW CAN WE DRAW THE LINE BETWEEN LEGITIMATE AND ILLEGITIMATE USE OF ENHANCERS?

The idea that people with disorders should have unfettered access to medication that can help alleviate the symptoms of their disorders is rooted in the following principle:

Each kind of living thing has some *prima facie* right to grow, to express itself, to live, as the kind of thing that it is. For example, an acorn to grow and flourish as a fully functioning oak, a kitten as a fully

75. Eric L. Jensen, et. al, *Social Consequences of the War on Drugs: The Legacy of Failed Policy*, CRIMINAL JUSTICE POLICY REVIEW 15(1) 100–121 (March 2004); NAT'L COMMISSION ON LAW OBSERVANCE AND ENFORCEMENT, REPORT ON THE ENFORCEMENT OF THE PROHIBITION LAWS OF THE UNITED STATES (Jan. 7, 1931), *available at* <http://www.druglibrary.org/schaffer/library/studies/wick/wick3.html>; See Steven Wisotsky, BEYOND THE WAR ON DRUGS: OVERCOMING A FAILED PUBLIC POLICY (1990).

functioning cat, a human fetus as a fully functioning person.⁷⁶

However, this principle is problematic in that there are no universally-accepted parameters to precisely define the qualities of a “fully functioning person.” In fact, the process of becoming a fully-formed organism necessarily involves a spectral shift from less-developed to more-developed to even-more-developed and so on, as opposed to a simple step progression from completely-undeveloped to fully-developed. People continually grow and evolve as time goes on; therefore, “changing in some ways is thus remaining the same in another way: we continue the process of realizing one’s potential—and perhaps even raising it.”⁷⁷

Taking this reality into account, it is hard to justify strict adherence to a “disorder model” for permitting the use of performance enhancement.⁷⁸ Since individual ability exists on a spectrum, disability only exists in comparison to those who are better-equipped with valuable societal skills. In a manner of speaking, every human of average intellect is cognitively “disabled” in comparison to the likes of Stephen Hawking, Bill Gates, and other great thinkers of our time. One major problem with the disorder model is that it will always be difficult to accurately draw the line between individuals who are “disabled” and those who are not.

Because of the difficulty involved in objectively defining the terms “fully functioning” and “disabled,” it will likely be hard to distinguish between individuals who “need” cognitive performance enhancement and those who simply “want” such enhancement. Even assuming we could design a perfect system to accurately distinguish between these two groups, a policy that restricts non-disabled citizens from accessing enhancers is not necessarily consistent with fundamental American ideals. After all, the so-called “American Dream” calls for citizens to constantly strive to improve themselves and their positions in society, and the preamble to the Declaration of Independence protects individuals’

76. Michael H. Shapiro, *The Technology of Perfection: Performance Enhancement and the Control of Attributes*, 65 S. CAL. L. REV. 11, 110–11 (1991).

77. *Id.* at 35.

78. *Id.* at 49.

“inalienable rights,” which include “life, liberty and the pursuit of happiness.”⁷⁹ If a citizen’s pursuit of happiness involves self-improvement via cognitive performance enhancers, is it right for the government to stand in his or her path? USC Law Professor Michael H. Shapiro thinks the answer is “not necessarily”:

To dismiss ‘wanting’ as a negligible rationale for self-transformation makes little sense, at least in a liberal regime. The major justification for athletic [performance enhancement] is often couched as a praiseworthy—though perhaps somewhat perverse—personal desire for excellence Failure to establish a need does not clearly show that there is no case for some transformative action.⁸⁰

Human beings are born with certain talents and abilities, and these natural gifts are not evenly distributed amongst the population. Thus, each person who is not the best at something is arguably “disabled” in that realm of performance, and she therefore has a case to seek performance enhancers to improve and compete more effectively. Furthermore, even people who are the best in a certain realm of performance should not necessarily be denied access to performance enhancers because they are in a unique position to push the limits of human progress. Do we really want to hold back those whose innovation may reveal an unending source of renewable energy or the cure for cancer?

COGNITIVE-ENHANCING DRUGS COULD REVOLUTIONIZE THE WORLD

Undoubtedly, opening the door to unchecked cognitive enhancement would result in both positive and negative consequences for society as we know it. In the past, debate over “performance enhancement” has largely taken place regarding its use in athletics, an arena in which the practice has been condemned as undesirable. Primed by the term’s use in the sports context, many are likely to enter any debate involving “performance

79. THE DECLARATION OF INDEPENDENCE pmbl. (U.S. 1776).

80. Shapiro, *supra* note 76, at 49.

enhancement” with a residual sour taste in their mouths. However, “unlike athletic competitions, in many cases cognitive enhancements are not zero-sum games. Cognitive enhancement, unlike enhancement for sports competitions, could lead to substantive improvements in the world.”⁸¹ In light of this distinction, it is important to enter this debate with an open mind.

Cognitive performance enhancement could allow for a population better adapted for an environment in which information is exchanged faster than ever and innovation is occurring at ever-increasing speeds. Moore’s Law dictates that the speed of computer processor chip doubles every 18 months.⁸² Wouldn’t it be nice if human cognition could match this exponential pace of improvement?

Widespread cognitive enhancement could lead to advancements that benefit all of humankind. Our next Einstein may be a cognitive enhancing drug or two away from solving an important mystery of the universe through theoretical physics. Perhaps the cure for cancer could be found if only an innovator had the extensive memory, focus, and endurance that could be gained through use of cognitive enhancing drugs. Innovations that would have happened in a century could happen in ten years. Innovations which never would have otherwise been developed at all could finally be within the grasp of our species once our best and brightest use cognitive enhancement to become better and brighter.

In addition to advancing the state of our species as a whole, a more self-centered analysis of the issue reveals that use of cognitive enhancement could greatly benefit our nation. If the United States were the first country to pour money into research aimed at developing better performance-enhancing drugs and to advocate for their unbridled use by its citizens, it could pave the way for a new level of efficiency in all spheres of society, from education to business to science. Schoolchildren could learn at a superhuman pace, eagerly studying for more hours than ever before without losing focus. Employees could produce at superhuman speed, getting more done in an eight-hour shift than could previously be accomplished in a full workweek. Importantly,

81. Greely et al., *supra* note 72, at 704.

82. John Markoff, *Physicists Createa Working Transistor From a Single Atom*, N.Y. TIMES, Feb. 19, 2012, <http://www.nytimes.com/2012/02/20/science/physicists-create-a-working-transistor-from-a-single-atom.html?pagewanted=all>.

innovators could design and develop new products more quickly than ever before. These changes could cause the United States' GDP to skyrocket, cementing the nation's place as an economic superpower for years to come. On the other hand, if the United States does not embrace a liberal policy toward cognitive enhancement, other countries with more permissive stances might garner these benefits in its stead.

Furthermore, it makes sense that our nation would allow cognitive enhancement because doing so corresponds with US policy embodied in several existing legal regimes. Individual freedom, a value that has been emphasized in US policy since its inception as a sovereign nation, applies in this context to mean that citizens should have the right to choose whether or not to consume medication to enhance cognition. If nothing else, decisions affecting one's own brain chemistry belong to the class of private choices protected by the "penumbra" of privacy rights extrapolated from the meaning of the 14th Amendment.⁸³ As such, these types of decisions are inherently the province of individual freedom and are therefore beyond the reach of government control.

Although it may seem that this libertarian argument is called into question by the fact that a number of drugs are currently outlawed for general use in the United States, the logic supporting these drug laws may actually favor a liberal policy toward cognitive enhancing drugs:

Both medicinal and recreational drugs are regulated because of possible harms to the individual and society. But drugs are regulated on a scale that subjectively judges the potential for harm from the very dangerous (heroin) to the relatively harmless (caffeine).⁸⁴

Based on this system of regulation, harmful drugs with no known medical use are the most strictly controlled; they are outlawed absolutely with no exceptions. Harmful drugs with known medical uses are generally outlawed but are allowed in certain strictly defined circumstances. Other harmful drugs are considered acceptable for general use in American society, subject to a

83. See *Griswold v. Connecticut*, 381 U.S. 479 (1965).

84. Greely et al., *supra* note 72, at 703.

minimum age requirement that keeps them away from young children (e.g., nicotine and alcohol). At the far end of this harm-benefit spectrum, relatively harmless drugs—like caffeine—are hardly restricted at all. Based on the logic that informs these regulations, a theoretical drug that causes no harm and indeed produces benefits both for the individual user and for society would fall somewhere below caffeine on the harm-benefit regulation scale, and a harm-benefit analysis would certainly not require restriction of such a drug. Arguably, this analysis could even support a policy that encourages use of such a drug by consumers. Practically, this result makes sense: the worst drugs are currently outlawed to protect citizens from underachieving and contributing nothing to society while they waste their days getting high or perhaps harming society if they resort to crime to support their drug addiction. Conversely, allowing use of cognitive enhancing drugs could help individuals to reach their full potential, to become more productive in their personal lives, and to contribute more to society than they otherwise could have.

Like constitutional law and drug regulations, intellectual property is a body of American law that contains principles that support the use of cognitive enhancing drugs. A close look at the laws governing patents, trade secrets, and copyrights reveals that encouraging innovation is a central goal of US legal policy.⁸⁵ In order to encourage individuals to invest resources in developing new ideas, intellectual property law gives innovators a property right in their creations, but this right is limited so that it does not block the spread of essential knowledge that is required for further innovations.⁸⁶ Thus, intellectual property law involves a delicate balance between putting in place an incentive to innovate and simultaneously ensuring that this incentive does not function in a way that blocks innovation in the future.⁸⁷ Reading between the lines, this body of law communicates that it is an implicit goal of

85. See Mark A. Lemley, *Beyond Preemption: The Law and Policy of Intellectual Property Licensing*, 87 CALIF. L. REV. 111, 124 (1999). (“Intellectual property law is designed to provide creators with a limited set of rights over ideas and inventions in order to serve the instrumental purpose of encouraging more creation”).

86. See *id.* at 124–125.

87. See *id.* at 125 (calling intellectual property law a “balanced incentive structure”).

our legal system to encourage human progress through innovation.⁸⁸

In patent law, the innovator gives his science to the government in exchange for a temporally-limited monopoly to use the patented technology in the marketplace.⁸⁹ The government protects trade secrets from use by competitors so that an individual can be assured the use of his discoveries in the marketplace as long as reasonable care is taken to keep the underlying information private.⁹⁰ Copyright law protects creations, even those that have little or no value in the marketplace, from being used by others for decades, often even after the creator's death.⁹¹ Each subset of intellectual property law provides incentives for innovation in a different way.

The same innovation-maximizing policy that forms the basis of intellectual property law could also be applied to support the use of cognitive enhancing drugs. As mentioned above, widespread use of these drugs could allow innovators to function at an accelerated pace. After shedding the hindrance imposed by limits on attention span, mental fatigue, and memory, innovators could not only learn more and remember more in order to conceive a greater number of new ideas, they could also stay focused and active for longer stretches, allowing their ideas to become realities faster than ever before. Even if US citizens use cognitive enhancing drugs to augment their ability to produce in a way that has no economic value, the policy precedent demonstrated through copyright law suggests that even this kind of extra-market productive activity is to be encouraged. Considering the effect that cognitive enhancement could have on innovation, a liberal stance

88. See Lawrence Lessig, *Intellectual Property and Code*, 11 ST. JOHN'S J. LEGAL COMMENT 635, 638 (1996) (noting that "we protect intellectual property to provide the owner sufficient incentive to produce such property").

89. 35 U.S.C. § 154(a)(1) ("Every patent shall contain . . . a grant to the patentee . . . of the right to exclude others from making, using, offering for sale, or selling the invention throughout the United States. . . ."); see CRAVATH, SWAINE & MOORE LTD. LIAB. P'SHIP, *INTELLECTUAL PROPERTY LAW ANSWER BOOK* 2011–12 at 3, 4, 9–11 (2011) (explaining the duration of patent rights).

90. UNIF. TRADE SECRETS ACT § 1(4) (1985); see CRAVATH, SWAINE & MOORE LTD. LIAB. P'SHIP, *supra* note 89, at 196–97.

91. See 17 U.S.C. § 106; see also CRAVATH, SWAINE & MOORE LTD. LIAB. P'SHIP, *supra* note 89, at 420–21.

toward the use of cognitive enhancing drugs in America would likely support the pro-innovation policy expressed through US intellectual property law.

CONCERNS ABOUT “MORALITY” AND SOCIAL NORMS ARE NOT
PERSUASIVE

Although taking a pill to improve one’s concentration, memory and endurance may feel unnatural because it works by spurring a change in brain function, any activity that enhances cognition alters the way the brain works. In fact, “recent research has identified beneficial neural changes engendered by exercise, nutrition and sleep as well as instruction and reading.”⁹² Besides, human beings have been behaving “unnaturally” for millennia, from wearing clothes to living in homes to writing and using computers. Reflecting on this issue, Michael H. Shapiro writes:

What is most natural to humans includes the unnatural – the construction and the use of artifacts, perhaps with ourselves as the chief artifact. *It is natural for us to pursue the artificial.* Although I do not think the natural/artificial distinction is vacuous, the best way to work with this conflation seems to be to try to find independent reasons to accept or reject different sorts of transformation.⁹³

In other words, concerns about whether behavior is “natural” will not help us reach a conclusion regarding the ethics of cognitive performance enhancement use by healthy individuals. At this stage in human evolution, a new practice only seems unnatural until it has become so commonplace that we cease to question it. But why should identical behavior be considered more ethical after it has become culturally accepted than before it has received society’s normative blessing? Simply put, it should not. We cannot allow moral inhibitions to trump logic-based decision-making, especially when a delay for this reason could cost humankind a century or more of enhanced innovation and discovery.

92. *Id.*

93. Shapiro, *supra* note 76, at 35–36 (emphasis added).

Another moral argument that fails to be persuasive in the context of an ethical debate is the idea that cognitive performance enhancement is “cheating.” Objectively, there is no such thing as cheating. Cheating requires the imposition of subjective rules and the subsequent violation of these rules. The field of cognitive performance enhancement is so new that few rules have yet to be established in many contexts. The rules that do exist are inherently subject to amendment because we know so little about the current versions of performance-enhancing drugs and we know even less about future drugs of this variety that are sure to come down the pipeline. It is therefore premature to label all cognitive enhancement by the healthy as “cheating” because we have yet to consider the varying contexts in which such enhancement could play a role. After all, an ethical debate revolves around deciding what the rules should be rather than whether or not an existing set of rules has been violated.

A third moral argument, that cognitive enhancement by the healthy amounts to “drug abuse,” is similarly impotent. The words “abuse” and “misuse” are subjective terms used to refer to use that falls outside the bounds of socially accepted conduct. Like “cheating,” these terms are meaningless in the context of a debate about what the rules should be. Until the appropriate level of regulation is determined, “the mere fact that cognitive enhancers are drugs is no reason to outlaw them.”⁹⁴

OTHER ARGUMENTS AGAINST WIDESPREAD COGNITIVE ENHANCEMENT ARE MORE PERSUASIVE

Although the preceding moral-based arguments are not persuasive, a more interesting moral argument against allowing cognitive performance enhancement for the healthy is that it would result in unfairness. At its core, the concept of unfairness involves an imbalance between two or more groups. Already, the world we live in is unfair; the great wealth disparity that exists between the rich and the poor among nations and within nations is evidence enough of this truth. However, the coming age of cognitive enhancement is likely to exacerbate this imbalance. Just as private higher education today could be considered a “cognitive enhancer” accessible only to those who can afford to pay for it, cognitive

94. *Id.*

enhancing drugs are likely to be available primarily to the wealthy, a class which arguably needs them the least. In other words, if they were effective and available but “not everyone had equal access to intellect-enhancing drugs . . . the social gaps would be widened, perhaps irreversibly, because many of the attributes involved are highly wealth-attractive.”⁹⁵ There are essentially two ways to mitigate this concern: we could place an absolute ban on use of cognitive enhancing drugs or, alternatively, we could provide them free of charge to anyone who wants them.

Another strong argument against allowing cognitive enhancement for the healthy is that such a policy is likely to introduce an element of coercion, either directly or indirectly. Direct coercion by those in control is possible in myriad settings. Because cognitive enhancing drugs allow for increased productiveness and effectiveness in the workplace, it is not hard to imagine a future in which employers put direct pressure on their subordinates to utilize these drugs to work longer hours and perform better. Further, individuals with jobs that involve managing the health of others could eventually face a mandate to use these drugs as a safety measure. For instance, pilots might be required to pop a pill that assures their alertness for the duration of a flight. Military personnel may be ordered to take drugs to remember complex codes for use in covert missions or to stay awake in dangerous situations. The fact that this practice is already occurring in the armed forces demonstrates the reality of the concern about direct coercion: “Soldiers in the United States and elsewhere have long been offered stimulant medications including amphetamine and modafinil to enhance alertness, and in the United States are legally required to take medications if ordered for the sake of their military performance.”⁹⁶

Indirect coercion could arise in any competitive setting if an individual’s peers are using cognitive enhancing drugs and realizing a substantial advantage as a result. While people in these settings are not directly *required* to take cognitive enhancing drugs, they are constructively coerced to do so because refusing may cost them their job or their place at the top of the class. This “arms race” of enhancement is one reason why the use of performance enhancers is often prohibited in sports: athletes

95. Shapiro, *supra* note 76, at 104.

96. Greely et al., *supra* note 72, at 703.

should not feel like they have to chemically alter their bodies in order to compete. This principle is especially true given the competitive nature of childhood sporting events. If performance enhancement were permitted at the professional level it could inspire an epidemic of chemical experimentation among our country's youngsters. The result of a "poll of athletes at the 1984 Los Angeles Olympics" revealed that "fifty-five percent... 'would take a drug that could kill [them] five years later if it enabled them to win a gold medal.'"⁹⁷ This shocking statistic illustrates the extent of the potential threat posed by indirect coercion: If athletes were permitted to use such a drug, the enhanced abilities of those taking the drug would essentially force the remaining competitors to assume the extreme health risk of using the drug themselves or else lose the ability to compete with the best.

The concern regarding coercion responds to the argument that individuals in the United States should be given the personal freedom to decide what goes into their bodies, especially when it comes to brain altering chemicals. Because of the potential for individuals to be directly and indirectly coerced into taking cognitive enhancers, allowing citizens the unrestricted freedom to make decisions regarding cognitive enhancement could ironically result in restricting their freedom to abstain from doing so.

Another major concern is that the cognitive enhancing drugs currently on the market are not completely devoid of both short- and long-term negative side effects. Alas, the theoretical drug discussed earlier that causes no harm to the consumer but produces benefits both for the individual and for society does not yet exist. This fact makes more alarming the concerns just addressed regarding coercion: individuals pressured into using these drugs may be doing so at the cost of their physical health or mental well-being. While it is possible that the benefits of these drugs outweigh any harm they may cause, this certainly seems like a cost-benefit determination that is the distinct province of the individual. The idea that employers, the government or indirect pressure from peers can effectively take this decision away from the individual is quite unnerving.

An additional worry is the potential for abuse and addiction that comes with the use of performance enhancing drugs. While

97. Shapiro, *supra* note 76, at 85–86 (citing REUTERS, THE REUTERS LIBRARY REPORT 1 (1988)).

drugs may be safe in limited doses and spaced out over sufficient time periods, individuals who misunderstand the implications of violating these safety parameters or those who feel pressured to do so are likely to disregard such safeguards. Additionally, there may be potential for addiction with the use of stimulant medications. Although “new stimulant formulations have made it possible to tailor treatment to the duration of efficacy required by patients and to help mitigate the potential for abuse, misuse and diversion,”⁹⁸ these fears are unlikely to ever be completely assuaged. Although we may indeed want our next Einstein to be able to focus long enough to write down a new ground-breaking theory, we certainly do not want him to fall victim to addiction or harmful side effects which divert him from his work before it is finished.

BEYOND ADHD DRUGS: THE FUTURE OF PERFORMANCE ENHANCEMENT

Although the cognitive enhancement discussion mostly revolves around drugs prescribed for the treatment of ADHD that increase mental endurance and attention span, these are not the only cognitive enhancing drugs on the market. For example, a number of drugs used to promote memory improvement in Alzheimer’s patients have proven effective in augmenting the memory of healthy subjects.⁹⁹ There is little doubt that new drugs of this caliber, if not already in production, will soon be developed. Truly, the field of cognitive enhancing drugs is a dynamic and expanding one. Furthermore, new techniques of cognitive enhancement are likely to include methods beyond drugs. Future cognitive enhancement may involve the use of “newer technologies such as brain stimulation and prosthetic brain chips.”¹⁰⁰

It is important that we address the ethical issues surrounding cognitive enhancement before these technologies become a reality. Once they are available, powerful market forces will act to bring supply to the public’s constant demand for personal improvement, academic advantage, and professional

98. Antshel et al., *supra* note 12, at 1.

99. Louis M. Solomon et al., *Cognitive Enhancements in Human Beings*, 6 GENDER MED. 338, 339 (2009).

100. Greely et al., *supra* note 72, at 702.

advancement. A delay in deciding these essential ethical questions could mean a century in which humankind is deprived of these drugs to our great collective harm or, alternatively, a century where these drugs are used to our great regret.

WHAT CAN BE DONE?

If we ultimately decide that cognitive enhancement is a bad thing, how can we control it? Realistically, it may be impossible for the government and the school system to completely eradicate unsanctioned cognitive enhancement without serious violations of privacy and other important personal freedoms. However, there are some measures that could be helpful in controlling cognitive enhancement.

The government could, of course, list new cognitive enhancing drugs on its controlled substance list as soon as they are developed. This would make it a criminal offense to possess or distribute these drugs without a prescription or other proper authority. In this way, the government would at least have the power to prosecute individuals partaking in this undesirable behavior because they will have then committed an actionable offense under the law. However, this tactic is likely to be ineffective in the face of market forces that will act powerfully to supply these drugs to those who demand them, whether or not there is an official policy against such distribution. This market effect is illustrated by the posture of the ADHD drugs Adderall and Ritalin in our society today; though they are both currently on the government's controlled substance list, they continue to be readily available on the black market. The problem of the black market will likely persist even if the government increases its efforts to enforce the law with widespread, intense monitoring and severe penalties for violations. But chances are that the American public would rather have Ritalin and Adderall used illegitimately on college campuses than to have, for example, police invading their homes and counting their pills.

One way academic institutions could attempt to control cognitive enhancing drugs on campus would be to list the illicit use or possession of such drugs as grounds for expulsion in the school's official code of conduct. In fact, several American colleges, including Duke University, have already embraced this

tactic.¹⁰¹ Because private schools are non-governmental entities unconstrained by Constitutional prohibitions against search and seizure, they may invade students' privacy in ways that would be unallowable by government actors (e.g., random searches of students' bags and dormitory rooms). One school, Linn State Technical College, has already instituted a policy that requires individuals to submit urine for drug testing, which includes screening for cognitive enhancing drugs, before they can be admitted as students.¹⁰²

On the other hand, we may decide that cognitive enhancement will be good for society and therefore should be encouraged. Under this theory, the relevant question will become how to structure its introduction into society in a fair way that causes little harm and produces the greatest possible good. As Henry Greely and his colleagues suggest, the introduction of cognitive enhancing drugs to society should be accompanied by policies that "support fairness, protect individuals from coercion and minimize enhancement-related socioeconomic disparities."¹⁰³ Unfortunately, even if we start with these focused objectives in mind, it will be extremely hard to craft regulations that are capable of bringing about such optimal results in an effective and enforceable way.

WHAT SHOULD BE DONE?

Whatever our current stance toward cognitive enhancement, this view is likely to require revision as new drugs and techniques are developed. Although it may be too early to definitively decide whether cognitive enhancement is desirable for our species, it is certainly not too early to advocate for research into the long-term effects that current drugs in this category could have on our brains and bodies. Additionally, it is never too soon to push for an educational campaign to increase awareness of the issues concerning the use of performance enhancing drugs so that when the time comes to make decisions regarding their place in

101. *Academic Dishonesty*, Duke University Student Affairs Website (Jan. 31, 2012, 6:36AM), <http://www.studentaffairs.duke.edu/conduct/resources/academicdishonesty>.

102. *Drug Screening*, Linn State Technical College Website (Jan. 31, 2012, 6:25 AM) https://mylstc.linnstate.edu/ICS/Drug_Screening.jnz.

103. Greely et al., *supra* note 72, at 704.

society the public will be ready to do so from an informed perspective.

Ultimately, the question of whether we want a world where constant productivity allows for superhuman advances as opposed to a world where basic human fatigue mandates lunch breaks, weekends, and vacations is a philosophical one. Finding the answer may in fact depend on each individual's personal understanding of the meaning of life. If an individual believes that the most important result of human existence is to push the human species forward and make life better for the next generation, she may elect to live in a world where constant productivity reigns over competing considerations. On the other hand, if she believes that the true value of life lies in the joy one can potentially bring to oneself and others, that person may instead choose a world where play can be emphasized at least as much as work.

In any event, this choice is not one that should be made for us. The onus is on us as citizens to investigate and think critically about these issues, to reach personal conclusions and to advocate passionately for our views. Purposeful debate and action are key steps in exercising our power as individuals over decisions regarding the role of cognitive performance enhancement in our society in the future. Therefore, if we wish to retain this individual power, inaction is not an option. Failure to act in this context is effectively an act of acquiescence to the market forces that will undoubtedly make cognitive enhancements widely available, perhaps creating a dystopic world we would have never chosen for our species.

Treatment for Punishment: The Problem with Forced Medication for Execution under California Law

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In *Ford v. Wainwright*, the United States Supreme Court prohibited any state from executing an incompetent prisoner as “cruel and unusual” punishment under the Eighth Amendment.¹ The ‘medicate-to-execute controversy’ concerns whether a state can forcibly medicate an inmate to induce the requisite level of competency for execution.² Medication for execution raises distinct questions separate from debates surrounding the legality (or wisdom) of the death penalty alone.

One problem concerns “mixed motives,” the problem of disentangling whether forced medication is in fact used to treat the inmate or is rather just another step in the execution process. For example, if the state offers several reasons to justify forced

1. *Ford v. Wainwright*, 477 U.S. 399 (1986).

2. Barry Latzer, *Between Madness and Death: The Medicate-to-Execute Controversy*, 22 CRIM JUSTICE ETHICS 4 (2003) (coining the phrase “medicate-to-execute controversy”).

medication, the inmate's competency for execution may be regarded as a mere 'side effect' of a legitimate state policy. Assuming the state has at least one legitimate interest in forced medication, should adding the *additional* state interest of punishment lessen the state's power? Medication for execution blurs the distinction between punishment and treatment. Analyzing these mixed motives is crucial to framing the relevant legal questions.

Medication for execution also raises distinct legal questions about how states define and assess competency because the definition of competency determines what the medication must achieve. The United States Supreme Court has not yet addressed the constitutionality of medication for execution. In those states that have retained the death penalty, only the Supreme Court of Louisiana has expressly ruled that medication for execution is unlawful under state law.³ Seventeen states, most recently Connecticut, have abolished the death penalty altogether, making medication-for-execution a moot issue.⁴ While much attention has rightfully been given to the minimum federal standards surrounding executions, relatively few inmates currently serve on federal death row. Of the nation's total death row population of 3,146 inmates, fewer than 2% (60) are housed in federal institutions.⁵ The remaining 98% are in state institutions where their primary protections are governed by state law.⁶ At present, approximately one-fifth (724 inmates) of the nation's death row population resides in California.⁷ After analyzing the federal standards applicable to medication for execution, this note focuses on ways these standards may be different or similar to execution under California law.

Part one introduces the current principles governing medication for execution under federal law. These principles are based on a patchwork of standards involving the definition of

3. State v. Perry, 610 So.2d 746 (1992).

4. DEATH PENALTY INFORMATION CENTER, <http://www.deathpenaltyinfo.org/> (last visited January 28, 2013).

5. DEATH PENALTY INFORMATION CENTER, <http://www.deathpenaltyinfo.org/> (last visited January 28, 2013).

6. DEATH PENALTY INFORMATION CENTER, <http://www.deathpenaltyinfo.org/> (last visited January 28, 2013).

7. DEATH PENALTY INFORMATION CENTER, <http://www.deathpenaltyinfo.org/> (last visited January 28, 2013).

competency, the minimum due process standards for assessing competency, and the constitutional standards for forcibly medicating prisoners. Part two turns to California law and identifies ways in which California state law may provide greater protection against forced medication for execution than that provided by federal law. Part three sketches a public policy proposal recommending that California enact legislation to identify and suspend death penalty litigation for inmates who would ultimately require forced medication for execution.

I. FEDERAL PROTECTIONS AGAINST MEDICATION FOR EXECUTION

As the Supreme Court has yet to rule on medication for execution and the matter has never been expressly addressed by Congress, the protections are best understood by aggregating three related strands of federal law: the definition of competency for execution, the federal standards for assessing competency, and the constitutional protection against forcibly medicating prisoners. In addition, this section analyzes the decision in *Singleton v. Norris*, in which the Eighth Circuit Court of Appeals held that it was constitutional to forcibly medicate an inmate for treatment, even if the treatment had the side effect of rendering an inmate competent for execution.⁸

A. Competency for execution

Although *Ford v. Wainwright* is often cited for holding that executing an insane prisoner would violate the Eighth Amendment's ban on 'cruel and unusual' punishment,⁹ the "real battle" in *Ford*, as Justice Rehnquist noted in dissent, was over process, not punishment.¹⁰ Both the dissent and majority agreed that a long history of common law jurisprudence already precluded executing the insane, a point which the dissent found so "uniform" among the states as to make it simply "unnecessary to

8. *Singleton v. Norris*, 319 F.3d 1018 (8th Cir. 2003).

9. In terms of defining "insanity," Justice Powell's concurrence established a two-part test, in which mental fitness for execution requires understanding (1) the fact that one is about to be executed and (2) the reason for the execution. *Ford v. Wainwright*, 477 U.S. 399, 422 (1986).

10. *Id.* at 435.

constitutionalize”.¹¹ The State of Florida, the respondent in *Ford*, did not argue that it had constitutional authority to execute an insane prisoner, but rather, defended the constitutionality of its procedures for determining competency. In *Ford*’s case, three state psychologists had determined that, while he suffered from severe symptoms of mental disorder, he was competent to understand his execution and the reason for it, meeting the same test for sanity ultimately established in *Ford* by Justice Powell’s concurrence.¹²

The majority found three defects in Florida’s procedures. First, other than a psychological evaluation with a panel of state psychologists (lasting just 30 minutes in *Ford*’s case), the prisoner was provided no opportunity to be heard and argue his case, the “fundamental requisite of due process of law.”¹³ The majority held that “any procedure that precludes the prisoner or his counsel from presenting material relevant to his sanity or bars consideration of that material by the factfinder is necessarily inadequate.”¹⁴ A second defect, also related to *Ford*’s right to be heard, was that Florida offered prisoners no effective means to “challenge or impeach” the opinions offered by the state-appointed psychiatrists.¹⁵ *Ford* clarified that an adequate hearing includes both the opportunity to be heard and the opportunity to rebut. The third and “most striking defect” in Florida’s procedures was in leaving the entire competency evaluation with the executive branch.¹⁶ The same Governor whose subordinates had initiated “every stage of the prosecution . . . from arrest through sentencing” also appointed the experts with final authority in evaluating prisoners for execution.¹⁷ The Governor, as “commander of the State’s corps of prosecutors,” could not be a neutral arbiter of the inmate’s competency for execution.¹⁸

11. *Id.* at 434.

12. The relevant Florida statute, both then and now, defines competency for execution as “understand[ing] the nature of the death penalty and the reasons why it was imposed upon him or her.” Fla. Stat. § 922.07; *see Ford*, 477 U.S. at 403–04.

13. *Ford*, 477 U.S. at 413 (quoting *Grannis v. Ordean*, 234 U.S. 385, 394 (1914)).

14. *Id.* at 414.

15. *Id.* at 415.

16. *Id.* at 416.

17. *Id.*

18. *Id.*

The defects in Florida's scheme offer a blueprint for the minimum due process standards applicable to competency determinations. The process must (1) give the prisoner an opportunity to be heard; (2) provide the prisoner an opportunity to rebut the state's experts; and (3) have final decisions made by a neutral arbiter, such as a judge, rather than by an extension of the executive branch. While *Ford* addressed standards for assessing competency for execution, the act of forcibly medicating an inmate, for execution or any other purpose, brings additional federal standards.

B. Forced medication for treatment and safety

In *Washington v. Harper*, the Supreme Court upheld a Washington State prison policy of forcibly medicating inmates determined to be both (1) mentally ill and (2) gravely disabled or dangerous.¹⁹ Although the inmate had a constitutionally protected liberty interest against forcible medication, the State's penological interest in safety trumped that interest.²⁰ In order to pass constitutional scrutiny, the state's medication policy had to reasonably relate to prison safety.²¹ The Court reiterated that "the proper standard for determining the validity of a prison regulation claimed to infringe on an inmate's constitutional rights is to ask whether the regulation is *reasonably related* to legitimate penological interests," and that this standard was appropriate "even when the constitutional right claimed to have been infringed is *fundamental*."²²

Although *Harper* did not concern competency for execution, the procedures for determining whether the inmate was (1) mentally ill and (2) gravely disabled or dangerous also satisfied the procedural requirements in *Ford*. The inmate had the opportunity to be heard at a hearing in which the inmate was free to present evidence and witnesses. The inmate had the opportunity

19. *Washington v. Harper*, 494 U.S. 210, 215 (1990) ("the inmate may be subjected to involuntary treatment with the drugs only if he (1) suffers from a 'mental disorder' and (2) is 'gravely disabled' or poses a 'likelihood of serious harm' to himself, others, or their property").

20. *Id.*

21. *Id.* at 224–25 (quoting *Block v. Rutherford*, 468 U.S. 576, 586 (1984) (emphasis added)).

22. *Harper*, 494 U.S. at 223 (citing *Turner v. Safley*, 482 U.S. 78, 89 (1987)).

to rebut the state's experts and was entitled, before the hearing, to "receive notice of the tentative diagnosis, the factual basis for the diagnosis, and why the staff believe[d] medication is necessary."²³ Finally, the decision to forcibly medicate was ultimately made by a special committee consisting of a psychiatrist, a psychologist, and the associate superintendent of the facility, none of whom could be involved in the inmate's treatment or diagnosis.²⁴ The state could forcibly medicate an inmate by a majority vote of the committee only if the psychiatrist was in that majority.²⁵ The inmate had a right to appeal the committee's decision to the superintendent within twenty-four hours and even that appeal was subject to judicial review in state court.²⁶ Moreover, continued treatment required periodic review consisting of re-approval by the committee and written reports to the medical director of the Department of Corrections every fourteen days.²⁷

Arguably, the procedures in *Harper* still failed to meet *Ford*'s "neutral arbiter" requirement because the committee is ultimately an extension of the executive branch, controlled by the governor. One distinction, however, is that in *Ford* the "commander of the state's corps of prosecutors" made a decision regarding punishment,²⁸ whereas in *Harper* the committee's decision related only to treatment and prison safety.²⁹ The executive's control may be less of a concern for decisions of treatment and safety than for punishment, in which case, *Harper* cannot apply, as is, to medication-for-execution.

Moreover, *Harper*'s sweeping language that prison regulations may infringe on even the most "fundamental" constitutional rights if "reasonably related to legitimate penological interests," would, if left unchecked by some distinction between punishment and treatment, overturn *Ford*. Florida's procedures in *Ford* were "reasonably related" to a legitimate penological interest in punishment. Justice Powell's concurrence, which established the competency test in *Ford*, noted that "the

23. *Id.* at 216.

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.*

28. *See generally* *Ford v. Wainwright*, 477 U.S. 399.

29. *See generally* *Harper*, 494 U.S. 210.

State has a substantial and legitimate interest in taking petitioner's life as punishment for his crime" but the reasonably related standard is notably absent from the discussion, not only from Justice Powell's concurrence but from any part of the Court's opinion.³⁰ The omission is not easily explained by the fact that *Ford* raised an Eighth Amendment claim of cruel and unusual punishment, given that the decision—and "real battle" in *Ford*—was based on Due Process grounds; the decision as to Ford's competency was remanded to the District Court.³¹

A more pragmatic reading of *Harper* is that the state may infringe upon the fundamental rights of prisoners only to the extent it satisfies principles of "basic fairness," which, as Justice Powell emphasized in *Ford*, is necessarily a "flexible concept, requiring only such procedural protections as the particular situation demands."³² The reasonable relation standard would likely meet Justice Powell's "basic fairness" test when applied to day-to-day prison policies affecting fundamental rights such as privacy or speech. However, an inmate's fundamental interest in life is not trumped by any state policy reasonably related to safety or treatment. The same point is crystalized in *Ford*'s pronouncement that "death is different."³³ Day-to-day prison policies adjust with experience; the death penalty leaves no room for correction. When the inmate's life is at stake, *Ford* limits *Harper* by protecting against policies that may "reasonably relate" to a penological interest but which are "basically unfair" to the protection of an inmate's fundamental rights.

C. *Competency for execution as a side effect of Harper treatment (Singleton)*

The Eighth Circuit Court of Appeals is the highest federal court to address the constitutionality of forced medication for execution, finding in *Singleton v. Norris* no violation of the Eighth

30. *Ford*, 477 U.S. at 425.

31. *Id.* at 424. As Justice Powell noted, the question in this case is whether Florida's procedures for determining petitioner's sanity comport with the requirements of due process.

32. *Id.* at 427 (quoting Powell, J., "As long as basic fairness is observed, I would find due process satisfied ...").

33. *Id.* at 411 (citing *Woodson v. North Carolina*, 428 U.S. 280, 305 (1976) (noting "death is a punishment different from all other sanctions in kind rather than degree").

Amendment or due process as applied to Mr. Singleton.³⁴ Importantly, *Singleton* was not a case in which the state sought to medicate Mr. Singleton for the *sole* purpose of execution.³⁵ The district court below found “no evidence . . . that the actions and decisions of the medical personnel involved were in *any* degree motivated by the desire, purpose or intent to make Mr. Singleton competent so that he could be executed.”³⁶ Independently of Mr. Singleton’s status on death row, the state was already medicating him for treatment under *Harper*.³⁷ In this sense, *Singleton* was not a case about medication for execution or even medication for the dual purpose of execution and treatment. Rather, at least as framed by the Eighth Circuit Court of Appeals, *Singleton* concerned only medication for treatment with a resulting (unintended) side effect of competency for execution.³⁸

Singleton argued that once his execution date was set, forced medication was no longer constitutional, even under *Harper*, because it was “obviously . . . not in the prisoner’s ultimate best medical interest.”³⁹ The court disagreed that Singleton’s interest in life was relevant, given that his “due process interests in life and liberty . . . have been foreclosed by the lawfully imposed sentence of execution and the *Harper* procedure.”⁴⁰ In other words, under the Eighth Circuit’s analysis, the inmate’s medical interests cannot preclude the imposition of the death penalty. Moreover, the court used the fact that Singleton contested his medication only after the execution date had been set as an implicit concession that the medication was in Singleton’s best medical interest, aside from the execution itself.

As to Singleton’s Eighth Amendment claim, the court not only declined to find that Singleton’s medication was cruel and unusual, but even reiterated the state’s “obligat[ion] to provide

34. *Singleton v. Norris*, 319 F.3d 1018 (8th Cir. 2003).

35. *Id.*

36. *Id.* at 1022.

37. *Id.* at 1020.

38. *Id.* at 1023. (framing the question before it as “whether the State may execute a prisoner who has been involuntarily medicated under a Harper procedure”).

39. *Id.* at 1026.

40. *Id.*

medical care for those whom it is punishing by incarceration.”⁴¹ By removing the death penalty as a valid consideration in assessing Singleton’s medical interests, the court not only foreclosed Singleton’s Eighth Amendment claim but also hinted that it might be cruel and unusual *not* to forcibly medicate Singleton.

Singleton should not be read as justifying forced medication for execution; rather, the decision skirted the issue entirely by starting from the premise that the medication involved was not to further motivate the state’s interest in punishment. By removing the death sentence as a valid medical interest, the Court essentially carved medication-for-execution out of its legal analysis. The result may have been different had the State expressly offered execution as a purpose for the medication. This sort of ‘mixed motive’ case was precisely the issue before the Supreme Court of Louisiana in *Perry v. State*, where the court found medication-for-execution unlawful under both federal and state law.⁴²

In *Perry*, the State argued it was constitutionally *obligated* to medicate Perry, forcibly if necessary, because the Eighth Amendment barred “cruel and unusual” punishment, including the “deliberate indifference to serious medical needs of prisoners.”⁴³ This argument was also viewed favorably by *Singleton* which carefully separated treatment from execution.⁴⁴ But unlike in *Singleton*, the *Perry* court characterized the State as having a “dual objective of forcible medication.”

The *Perry* court acknowledged the state’s legitimate interest in both prison safety and treatment. Just two years prior, *Harper* announced that even “fundamental” constitutional interests could be infringed by regulations “*reasonably related* to legitimate penological interests.”⁴⁵ Given the state’s valid interest in prison safety and treatment, it’s natural to ask why an additional legitimate state interest in punishment would render the combined objectives unconstitutional. Under a balancing test, multiple

41. *Singleton*, 319 F.3d at 1027 (quoting *Estelle v. Gamble*, 429 U.S. 97, 103 (1976)).

42. *State v. Perry*, 610 So. 2d 746, 749 (La. 1992).

43. *Estelle*, 429 U.S. at 97 (emphasis added).

44. *Singleton*, 319 F.3d 1018.

45. *Washington v. Harper*, 494 U.S. 210, 223 (1990) (citing *Turner v. Safley*, 482 U.S. 78, at 89).

interests appear to give the state more reason to forcibly medicate. However, balancing fails to acknowledge the interference these interests impose on each other. The interests in punishment and treatment—particularly in the context of the death penalty—are mutually exclusive. When the state imposes the death penalty, it destroys not only the inmate, but also the state’s asserted interest in treatment. The “dual objective” of medication for treatment and execution becomes merely medication for execution.

Moreover, in *Perry*’s case, the Court was not persuaded that execution would further the state’s interest in prison safety and, of course, it would not advance *Perry*’s medical interest, thereby removing each of the only two justifications expressly permitting forcible medication under *Harper*.⁴⁶ Just as the Eighth Circuit Court of Appeals, in *Singleton*, had carved out the medication-for-execution issue entirely and focused solely on the legitimate state interests, the Louisiana Supreme Court in the *Perry* carved out the legitimate interests and found only medication-for-execution.

Another important analytical difference between *Perry* and *Harper* is that, relying primarily on state law grounds, *Perry* adopted a “compelling interest” standard against forcible medication, which differs significantly from *Harper*’s rational basis test.⁴⁷ The difference between the two standards is more significant than one requiring a *compelling* state interest and the other a mere “valid” or “legitimate” one. The compelling interest test requires state action “be *narrowly* confined so as to further *only* that compelling interest.”⁴⁸ Under rational basis, as used in *Harper*, the state has no obligation to seek out “alternative method[s] of accommodating the claimant’s constitutional complaint.”⁴⁹ If the state establishes a “rational connection between the prison regulation and the legitimate governmental interest,” the inquiry ends.⁵⁰ Under the compelling interest test, the state must consider whether a given policy is overly broad in its intrusions. Even if forced medication was, in fact, the most effective way of achieving prison safety, the “narrowly tailored” requirement might still force the state to adopt a less intrusive

46. *Perry*, 610 So. 2d at 751–52.

47. *Id.* at 760.

48. *Id.* (emphasis added).

49. *Harper*, 494 U.S. at 225.

50. *Id.* at 224.

alternative. Moreover, the state would bear the burden of showing it had adopted a policy “narrowly confined” to meet the compelling interest.⁵¹ Though the state may have a compelling interest in prison safety, the decision to forcibly medicate Perry swept “unnecessarily broadly” in pursuing safety at the expense of individual liberty.⁵²

The United States Supreme Court declined to adopt a compelling interest standard in *Harper*, and adoption of the “wrong” standard below was the very basis for reversing the Washington Supreme Court decision, which had decided that the state could forcibly medicate an inmate only with “clear, cogent, and convincing” proof that psychotropic medication was “both necessary and effective for furthering a *compelling* state interest.”⁵³ The Court found such a standard was “neither required nor helpful” in light of the “government interest involved.”⁵⁴ *Perry* avoided this problem precisely because it found *Harper* “inherently inapposite” in the context of medication for execution, given the mutually exclusive nature of treatment and punishment.⁵⁵

A second argument, accepted by the Court in *Perry* but rejected by *Singleton*, involved the question of “artificial competence.” The notion of “artificial competence” asserts that there is a fundamental difference between “natural” competency and competency brought about through medication.⁵⁶ According to this argument, the inmate’s un-medicated state represents his “authentic” self. Medication temporarily “masks” the symptoms of incompetency without curing the underlying causes of those symptoms.⁵⁷ Until those causes are addressed, the authentic version of the inmate remains incompetent.⁵⁸

51. *Id.* (emphasis added).

52. *State v. Perry*, 610 So. 2d 746, 761 (La. 1992).

53. *Harper*, 494 U.S. at 218 (emphasis added).

54. *Id.*

55. *Perry*, 610 So. 2d at 754.

56. *Id.*

57. *Id.*

58. Lisa N. Jones, *Singleton v. Norris: The Eighth Circuit Maneuvered Around The Constitution By Forcibly Medicating Insane Prisoners To Create An Artificial Competence For Purposes of Execution*, 37 CREIGHTON L. REV. 431 (2004); Kathy Swedlow, *Forced Medication of Legally Incompetent Prisoners: A Primer*, 30 HUM. RTS. Q. 3, 4 (Spring 2003).

Judge Heaney's dissenting opinion in *Singleton v. Norris*, joined by two justices on the Eighth Circuit Court of Appeals, argued that artificial competency was not the same as natural competency, calling it a "medically-coerced cousin" of "true sanity."⁵⁹ Judge Heaney emphasized the temporary and unpredictable effects of psychotropic medications.⁶⁰ Mr. Singleton's medical history showed that while receiving treatments from the state, his medication had "often been changed, either in dose or in type," and his treatment plan had failed to keep him "consistently free of symptoms."⁶¹ As a result, the competence Mr. Singleton could temporarily obtain by medication was artificial. Behind whatever "mask of stability" Mr. Singleton achieved with medication, the authentic Singleton remained insane.⁶²

Similar to the argument that natural and artificial competencies are fundamentally different versions of the inmate is the argument that one version is more stable, given the monitoring and adjustments that accompany prescription medication. These adjustments imply that the state cannot be sure that the inmate remains competent at the moment of execution, particularly when the inmate's medical history shows that medications have "often been changed, either in dose or in type."⁶³ In short, inmates rendered competent by medication may be at a significantly higher risk of incompetence during execution than inmates who have a long history of maintaining competence without medication. While the authenticity argument opposes forced medication on grounds that it somehow masks the inmate's natural self, the reliability argument faults it for not changing him consistently or permanently enough.

II. CALIFORNIA STANDARDS

In addition to the federal standards, California state law provides additional protection against forced medication for execution. For example, to the extent California law defines "sanity" for execution more stringently than Justice Powell's two-

59. *Singleton v. Norris*, 319 F.3d 1018, 1034 (8th Cir. 2003).

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.*

part test in *Ford*, the state definition would provide further the protection against medication for execution by defining more precisely the level of competency that the medication must induce. Similarly, California inmates are entitled to California's procedures for assessing competence, which may go beyond the minimum requirements in *Ford*. Thirdly, the inmate is protected by California's standards surrounding forcible medication generally, which are stronger than the federal protections in *Harper*.

A. Defining sanity

California's definition of "sanity" is the first line of protection against forced medication for execution. Even if medication for execution is lawful, the definition of sanity determines what the medication must do—the level of competence the medication must induce under state law for its use to be relevant. The higher the standard of competency, such as the ability to rationally assist counsel in one's own defense, the more the medication must accomplish to justify its use. Justice Powell's two-part test in *Ford*, for example, requires mere awareness of the fact of execution and an understanding of the state's rationale for inflicting the punishment.⁶⁴ However, California courts have recognized that the concept of sanity includes the inmate's ability to participate in the relationships necessary to protect his rights. As the California Court of Appeal noted in *Riese*:

Competence is not a clinical, medical, or psychiatric concept. It does not derive from our understanding of health, sickness, treatment, or persons as patients. Rather, it relates to the world of law, to society's interest in deciding whether an individual should have certain rights (and obligations) relating to person, property and relationships.⁶⁵

Any additional nuances or layers a state adds to its definition of competency become potential safeguards for inmates challenging

64. *Ford v. Wainwright*, 477 U.S. 399, 422.

65. *Riese v. St. Mary's Hosp. & Med. Ctr.*, 209 Cal.App.3d 1303, 1321 (1987) (quoting Michels, *Competence to Refuse Treatment in Doudera & Swazey, Refusing Treatment in Mental Health Institutions—Values in Conflict*, at 115; *accord*, PAUL S. APPLEBAUM & THOMAS A. GUTHEIL, *CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW* 215 (1982)).

forced medication for execution. In California, the illegality of punishing an insane person is a common law rule, codified as early as 1850 by the first session of the California Congress. Chapter 119, Section 502 stated:

If, after judgment of death, there be good reason to suppose that the defendant has become insane, the sheriff of the county, with the concurrence of the judge of the Court by which the judgment was rendered, may summon a jury of twelve persons to inquire into the supposed insanity

While this original code prohibited punishing the insane, it did not define “insanity,” effectively leaving the definition open to the jury. When the California Penal Code was adopted in 1872, Section 1367 stated that “[a] person cannot be tried, adjudged to punishment, or punished for a public offense, while he is insane.” This section was amended in 1974. The word “insane” was changed to “mentally incompetent” and incompetence was defined. The current version, Section 1367 of the California Penal Code, reads:

A person cannot be tried or adjudged to punishment while that person is mentally incompetent. A defendant is mentally incompetent for purposes of this chapter if, as a result of mental disorder or developmental disability, the defendant is unable to understand the nature of the criminal proceedings or to assist counsel in the conduct of a defense in a rational manner.⁶⁶

While other sections of the Penal Code refer to sanity, Section 1367 stands alone as the only part of California’s Penal Code to provide a definition. This standard is notably higher than Justice Powell’s two-part test in *Ford*, which requires only that the inmate understand the fact of his execution and the state’s rationale for it. In particular, Justice Powell’s two-part test would not require the mental ability to assist counsel.⁶⁷ The California Supreme Court

66. CAL. PENAL CODE § 1367 (West 2011).

67. *Ford v. Wainwright*, 477 U.S. 399, 422 (1986).

has never addressed whether California's standard of competence is higher than the federal standard. While California has the largest death row population in the country (724 inmates),⁶⁸ the lack of resolution on this question is not surprising. Claims involving competency for execution arise only after an inmate has been scheduled for execution and has effectively exhausted all other avenues for relief. Since the 1986 decision in *Ford*, California has executed thirteen individuals, none of whom raised serious claims of incompetency for execution.⁶⁹

Requiring that an inmate be not only competent under the two-part test in *Ford* but also competent to assist counsel is consistent with William Blackstone's Commentaries on the Laws of England. Blackstone states, "[i]f, after judgment, he [the prisoner] becomes of nonsane memory, execution shall be stayed: for peradventure, says the humanity of the English law, had the prison been of sound memory, he might have alleged something in stay of judgment or execution."⁷⁰

In effect, California's definition of sanity in Penal Code section 1367 protects against the possibility that a condemned prisoner might be able to offer a defense right up until the moment of execution. Given that a right to counsel is now recognized as fundamental to a constitutionally adequate defense, a prisoner must be sane enough to rationally assist counsel to maintain the protections provided by the common law rule. Conversely, if a state defines sanity without requiring competence to assist counsel, it would effectively eliminate one of the common law rationales for staying the execution of insane prisoners.

A second reason why sanity for execution must include the ability to assist counsel is to validate the determination of sanity itself. Section 1368 of the California Penal Code provides that a defendant has a right to counsel during competency hearings.⁷¹ If the prisoner were deemed "sane" under Justice Powell's two-part test, but "insane" to his ability to assist counsel, the validity of the

68. DEATH PENALTY INFORMATION CENTER, <http://www.deathpenaltyinfo.org/> (last visited January 28, 2013).

69. DEATH PENALTY INFORMATION CENTER, <http://www.deathpenaltyinfo.org/> (last visited January 28, 2013).

70. 4 WILLIAM BLACKSTONE, COMMENTARIES at 24; *People v. Riley*, 235 P.2d 381, 388 (Cal. 1951).

71. CAL. PENAL CODE § 1368 (West 2011).

sanity determination is brought into question. Just as Blackstone recognized that sanity formed part of a prisoner's ability to assist in his defense, the sanity hearing (for purposes of execution) may be a prisoner's final defense. To find him unable to assist counsel but sane for execution would violate the common law rule.

Of course, the sanity hearing does not require protections equal to that of a criminal trial, and it has appropriately been called a "special proceeding of a civil nature."⁷² California law presumes sanity, so the prisoner bears the burden of proof, which is met by a preponderance of the evidence.⁷³ Moreover, the verdict on sanity need not be unanimous; nine to three is sufficient.⁷⁴ While these distinctions are significant, they arguably heighten the prisoner's need for counsel, as acknowledged by the decision of the California legislature to include the appointment of counsel expressly in the statute. In addition to California's definition of sanity, inmates are protected by California's procedures for assessing sanity. The next section reviews these procedures against the requisites in *Ford*.

B. Assessing sanity

California Penal Code § 3700.5 governs the "investigation of sanity of persons sentenced to death."⁷⁵ Once a court places an inmate on calendar for execution, the Director of Corrections selects three psychiatrists to evaluate the inmate's sanity and report their opinions in writing at least 20 days before the execution.⁷⁶ The statute mandates that all three psychiatrists selected "must be from the medical staffs of the Department of Corrections."⁷⁷ The department sends the report to the governor and warden, and the defendant has a right to receive a copy upon request.

Under California law, the warden makes the initial decision as to whether "there is good reason to believe that a defendant, under judgment of death, has become insane."⁷⁸ The legislature has further clarified that "[n]o judge, court, or officer, other than the

72. *Riley*, 235 P.2d at 385 (citing *People v. Lawson*, 172 P. 885, 888–89 (Cal. 1918)).

73. *Id.*

74. *Id.* at 385.

75. CAL. PENAL CODE § 3700.5 (West 2011).

76. *Id.*

77. *Id.*

78. *Id.* at § 3701 (West 2011).

governor, can suspend the execution of a judgment of death, except the warden”⁷⁹ Assuming the warden finds “good reason,” he or she notifies the district attorney who has the duty of petitioning the court for a competency hearing.⁸⁰ The court impanels a twelve-member jury to decide the question based on a preponderance of the evidence, with nine votes being sufficient (consistent with a civil proceeding) to find the defendant sane for execution.⁸¹ California’s evidence code expressly provides that the “party claiming that any person, including himself, is or was insane has the burden of proof on that issue.”⁸² The “presumption may be rebutted . . . by a preponderance of evidence,” leaving it for the inmate to convince the jury at the sanity trial that it is more likely than not that he is insane for execution.⁸³

As the real battle in *Ford* was over process, it is worth briefly reviewing California’s process in the context of *Ford*. Clearly, once the warden finds “good reason” to believe the inmate is insane, all three *Ford* requirements are met at the sanity trial: the inmate (with counsel) has the opportunity to be heard, the inmate can rebut the state’s psychiatrists, and the question of sanity is ultimately resolved by a neutral arbiter of fact—the jury. However, by placing the prerequisite for a sanity trial—“good reason” to believe the inmate is insane—exclusively in the warden’s control, California has placed an executive gatekeeper in front of *Ford*’s provisions.

The scope of the remedy available under state law, if any, for a warden who fails to find “good reason” for insanity without meaningful review is unclear. In *Caritativo v. Teets*, the California Supreme Court decided, and the United States Supreme Court affirmed, that it was “settled that ‘due process’ does not prevent delegation of the duty of determining the sanity of a person awaiting execution of the death penalty to an administrative official, and judicial review of that officer’s determination is *not* required.”⁸⁴ In *Caritativo*, all three state psychologists to evaluate

79. *Id.*

80. *Id.*

81. *Id.*

82. CAL. EVID. CODE § 522 (West 2012).

83. *People v. Daugherty*, 256 P.2d 911, 925 (Cal. 1953).

84. *Caritativo v. Teets*, 303 P.2d 339, 341 (Cal. 1956) *aff’d sub nom. Caritativo v. People of State of California*, 357 U.S. 549 (1958) (emphasis added).

Caritativo found him sane, and the warden followed these reports in finding no good reason to believe Caritativo was insane.⁸⁵ Caritativo challenged the warden's determination as violating due process because his opportunity to be heard was conditioned on the warden finding "good reason" for a sanity trial.⁸⁶ Justice Harlan concurred in the Court's decision, calling it "entirely proper for the State to condition a prisoner's right to a sanity trial upon a preliminary determination by a responsible official," all the more so "in the hands of the warden, the official who beyond all others has had the most intimate relations with, and best opportunity to observe, the prisoner"⁸⁷ In his dissent, Justice Frankfurter accused the majority of leaving "no remedy whatsoever under California law if the warden fails to perform" the initial review satisfactorily, potentially allowing him to forgo "any inquiry whatsoever into the prisoner's sanity."⁸⁸

Ford did not expressly overrule *Caritativo*, and the warden's "good reason" determination remains intact as the primary gateway to a sanity trial under state law. As the United States Supreme Court has never squarely addressed the warden's authority after *Ford*, the possibility remains that a renewed challenge could render Section 3701 unconstitutional in failing to meet *Ford*'s procedural requirements. State law provides no right to be heard at the warden's initial "good reason" determination and no right to rebut the initial positions of the psychiatrists on which the warden relies; the warden decides the matter as an officer of the executive branch.⁸⁹ As Justice Frankfurter noted in dissent, when the warden fails to find "good reason" for a sanity trial, the warden's "determination on this issue is not a 'preliminary determination,' but both an initial and final determination."⁹⁰

Assuming the warden's gate-keeping authority under Section 3701 remains constitutional, California courts may be powerless to provide a remedy even if all three psychiatrists provide the warden with opinions that the inmate was insane. Indeed, this was the conclusion of the California Supreme Court in

85. *Id.*

86. *Id.*

87. *Id.* at 551.

88. *Id.* at 555.

89. *Id.*

90. *Id.*

Ex parte Phyle, holding that because Section 3701 prohibits anyone other than the governor or warden from suspending an execution, the courts have “no inherent power” to review sanity decisions, and the inmate has “no right to a judicial determination” on the matter.⁹¹ The inmate could still seek clemency from the governor or seek relief in federal court with a claim directly under the Constitution. But if Section 3701 is constitutional, i.e. the state process for determining competency was adequate, the federal court would have no reason to find a due process violation, even if it disagreed with the result.

While *Phyle*’s holding as to the constitutionality of the warden’s authority has never been revisited by the California Supreme Court, there are reasons to doubt the continued validity of the decision. At the time of *Phyle* (1947), the California Supreme Court did not consider post-conviction sanity as a valid constitutional claim. The court saw no “constitutional or inherent right” to have an execution suspended on the basis of post-conviction insanity.⁹² Rather, the Court viewed the matter as exclusively governed by the legislature (specifically referring to Section 1367) and, alternatively, as “discretionary with the court or the executive power in the exercise of clemency, as a merciful dispensation, an act of grace.”⁹³ Given that the *Phyle* court did not recognize constitutional protections against executing the incompetent, it is not surprising that it saw no problem with the warden acting as the gatekeeper to a competency hearing.⁹⁴

C. *California’s standard for forcibly medicating inmates*

Recall that under *Harper* an inmate could be forcibly medicated if he was (1) mentally ill and (2) gravely disabled or dangerous.⁹⁵ The Supreme Court held that the Constitution required only that the infringement of a basic right be “reasonably related to legitimate penological interests.”⁹⁶ Section 2600(a) of

91. *Ex parte Phyle*, 186 P.2d 134, 139 (Cal. 1947).

92. *People v. Riley*, 235 P.2d 381, 384 (Cal. 1951).

93. *Id.*

94. *Ex parte Phyle*, 186 P.2d at 139.

95. *Washington v. Harper*, 494 U.S. 210, 215 (1990) (“[T]he inmate may be subjected to involuntary treatment with the drugs only if he (1) suffers from a ‘mental disorder’ and (2) is ‘gravely disabled’ or poses a ‘likelihood of serious harm’ to himself, others, or their property.”).

96. *Id.* at 223 (citing *Turner v. Safley*, 482 U.S., 78, 89) (emphasis added).

the California Penal Code similarly provides that the rights of prisoners may be infringed, so long as the infringement is “reasonably related to legitimate penological interests.”⁹⁷ As amended in 2011, Section 2600(b) adds that “[n]othing in this section shall be construed to overturn the [California Supreme Court] decision in *Thor v. Superior Court*, 5 Cal. 4th 725.”⁹⁸ *Thor* held that the common law right to refuse medical treatment negated any affirmative duty by the State to continue providing (or imposing) life-preserving treatment against the inmate’s wishes.⁹⁹ *Thor* remains significant in the medicate-to-execute context because it both acknowledged the right of bodily integrity as “fundamentally compelling” and enumerated four “countervailing state interests, that would generally justify violating patient autonomy: (1) preserving life; (2) preventing suicide; (3) maintaining the integrity of the medical profession; and (4) protecting innocent third parties.”¹⁰⁰ In the medication for execution context, it is notable that none of these considerations include punishment as a valid consideration for adjusting treatment. The first, second, and third considerations are clearly inconsistent with medication for execution. Even in the context of treatment, the preservation of life is not necessarily furthered by the state merely trying to induce a particular level of competency (such as competency to assist counsel) as opposed to inducing a safe level of mental stability.

The second consideration, preventing suicide, is also inconsistent with medication for execution. In the execution context, the prisoner not only tries to preserve his life, but may be willing to forgo the medication offering a higher quality of life in order to continue surviving with less stability. The inmate essentially chooses madness over death.

The third consideration, integrity of the medical profession, is also violated by medication for execution, which runs counter to the historic Hippocratic Oath to do no harm. The American Medical Association’s (AMA’s) Code of Medical Ethics codifies this ethic, which expressly prohibits medical professionals from facilitating in state executions, reading: “A physician, as a member

97. CAL. PENAL CODE § 2600 (West, Westlaw through 2012 Reg. Sess.).

98. *Id.*

99. *Thor v. Super. Ct.*, 855 P.2d 375 (Cal. 1993) (en banc).

100. *Id.* at 383.

of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution.”¹⁰¹ In a 2007 article published in the *Journal of the American Medical Association*, the Association confirmed that it had revoked a physician’s membership “for participation in execution by lethal injection.”¹⁰² In response, some states, such as Georgia, have changed their laws to explicitly indicate that participating in an execution is not the practice of medicine, thereby protecting the physician from receiving discipline by the State Board of Medical Examiners.¹⁰³ Irrespective of whether one would support disciplinary action for physicians participating in executions, medication for execution can do nothing to further the integrity of the profession. As might be expected, medication-for-execution schemes demand even more from the medical profession than ‘standard’ executions. In a state like California, where the competency standard may include the ability to assist counsel, the physician’s decision as to the appropriate medication involves a more complicated assessment only partially relevant to the health of the inmate. While such assessments may be reasonably related to penological state interests, they are inconsistent with the integrity principles in *Thor*, codified by the amended 2600(b).¹⁰⁴

Proponents of forced medication for execution may rely on the final consideration of protecting innocent third parties. Proponents will argue that execution is the only definitive way to ensure that the prisoner on death row will not kill again. According to this argument, some inmates are so dangerous that medication alone does not adequately provide the same level of safety as the punishment by death. Therefore, forced medication for execution is justified whenever it provides a greater level of safety than either no medication or medication for treatment alone. Under this rationale, inmates could be forcibly medicated under both *Thor* and *Harper* in the interest of prison safety.

101. *Opinion 2.06 – Capital Punishment*, AMERICAN MEDICAL ASSOCIATION, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion206.page> (last visited January 28, 2013).

102. Lee Black and Robert M. Sade, *Lethal Injection and Physicians: State Law vs Medical Ethics*, <http://www.deathpenaltyinfo.org/node/2264> (last visited January 28, 2013).

103. Black and Sade, *supra* note 102.

104. CAL. PENAL CODE § 2600 (West, Westlaw through 2012 Reg. Sess.).

The argument is virtually identical to the one adopted by the Eighth Circuit Court of Appeals in *Singleton v. Norris*, holding that execution was only a side effect of lawful treatment.¹⁰⁵ California could similarly justify forced medication under *Thor* by claiming it created a safer environment than no medication at all and that the execution was a mere side effect of lawful medical treatment in the interest of safety. But prisoners in California could also respond to this argument in much the same way *Perry* did under Louisiana law.¹⁰⁶ The response has three parts. First, as in Louisiana, the California Supreme Court would have to acknowledge that forced medication for execution represents a “dual objective” of treatment and execution, irrespective of the state’s stated objective.¹⁰⁷ Second, the court would have to agree that these dual objectives are mutually exclusive.¹⁰⁸ This analytical step is critical, as it recasts the dual objective issue as one of medication-for-execution alone, rendering the justifications in *Harper* inapplicable. Similarly, the step rejects the unintended “side effect” argument adopted by the Eighth Circuit Court of Appeals in *Singleton*, as such a side effect must first be derived from a legitimate state interest, which is precisely what the mutually exclusive argument negates.

Thirdly, as in *Perry*, the court would have to apply a compelling interest standard to justify forced medication.¹⁰⁹ Although Section 2600 of the California Penal Code justifies most prison regulations based on a mere reasonable relation to a legitimate penological interest, this section must be read in light of 2600(b)’s reference to *Thor*, which describes “the right to be free from nonconsensual invasions of bodily integrity” as a “fundamentally compelling” human right.¹¹⁰ Moreover, the California Supreme Court has affirmed that the California Constitution protects prisoners against forced psychotropic medication.¹¹¹ The state can force competency medication for extended periods only if a judge first finds the inmate incompetent

105. *Singleton v. Norris*, 319 F.3d 1018 (8th Cir. 2003).

106. *State v. Perry*, 610 So.2d 746 (La. 1992).

107. *Id.* at 749.

108. *Id.*

109. *Id.* at 760.

110. *Thor v. Super. Ct.*, 855 P.2d 375, 383 (Cal.1993) (en banc).

111. *In re. Qawi*, 81 P.3d 224, 231 (Cal. 2004).

to make a decision to refuse medication.¹¹² This requisite is, in itself, a significant curbing of the mere “reasonable relation” standard articulated in *Harper*. In the same case cited with approval by the California Supreme Court, the California Court of Appeal remarked that “[f]orced drugging is one of the earmarks of the gulag,” which could be implemented “only after adherence to stringent substantive and procedural safeguards.”¹¹³ It is safe to say that California inmates enjoy as much or more protection against forcible medication as that provided by the State of Louisiana’s compelling interest test in *Perry*.

III. POLICY: A MODEST PROPOSAL

While in principle the California Supreme Court could, like the Supreme Court of Louisiana, outlaw medication for execution under state law, such an outcome is far from certain. If these issues are left solely to the courts, the cost of a death penalty system already deemed broken, even by some of its most ardent supporters, will continue to increase.¹¹⁴ Moreover, because competency for execution claims generally become ripe only after all other viable claims have been exhausted, litigation over forced medication is especially costly. The inmate who succeeded on an eleventh hour claim against forced medication would have already exhausted all of the remaining habeas claims in his case in both federal and state court (otherwise he would not have been scheduled for execution). Public policy could, if nothing else, save significant costs of litigation by flipping this inquiry on its head. The goal of such a policy would be to identify and suspend litigation in cases in which the inmate would be ineligible for execution without forced medication. The policy would save the cost of reaching this inquiry only after all other claims have been exhausted.

A policy of identifying and suspending cases involving incompetent petitioners would, in addition to saving costs, also

112. *Keyhea v. Rushen*, 223 Cal. Rptr. 746, 755–56 (Cal. Dist. Ct. App. 1986).

113. *Id.* at 756.

114. Adam Nagourney, *Seeking an End to an Execution Law They Once Championed*, N.Y. TIMES, April 6, 2012, http://www.nytimes.com/2012/04/07/us/fighting-to-repeal-california-execution-law-they-championed.html?page_wanted=all&_r=0.

preserve the dignity of the medical profession in California. Critics may counter that such a policy only adds delay to a system already rife with delays. More accurately, the policy neither increases nor reduces delays for death row inmates in California, but merely reduces the cost of that delay, based on the conclusion that forced medication for execution is likely unconstitutional under California law. Critics may rightly view it as a step toward abolishing the death penalty, but it is a relatively modest step, affecting only those inmates with serious and well-documented mental health issues. To date, it's unlikely that any one of the thirteen inmates California scheduled for execution after *Ford* could have benefited from the policy. Yet, the suspension policy could benefit the public by reducing the ongoing costs of litigation for inmates who, even if they were to lose their habeas petitions, will not be deemed competent for execution absent forced medication. For these inmates, California would be wise to show leniency sooner rather than later.