

**OVERRIDING MENTAL HEALTH TREATMENT REFUSALS:  
HOW MUCH PROCESS IS “DUE”?**

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### **Abstract**

Getting mental health treatment to patients who need it is today a much beleaguered enterprise. This is in part because law makers have a skewed view of the enterprise, in particular the treatment of patients with antipsychotic medications. The properties and uses of these medications are misunderstood by many in the legal community, while the drugs' undesirable side-effects are typically overstated and the remedial effects undersold when not outright ignored. One specific legal effect has been to accord to mental patients a substantively outsized right to refuse treatment that comes with a correspondingly action-stifling dose of procedural safeguards, this despite the patients' frequent lack of capacity to exercise the right wisely and the bad personal and systemic consequences that flow from that. The purpose of this article is to provide better balanced and accurate evidence of the properties of antipsychotic drugs so as to convince law makers and advocates for the mentally disabled that it is safe to roll back some of the more counterproductive legal strictures on the effort to provide mental health treatment. An analysis of selected cases and statutes is intended to illustrate that such a roll back can and should be applied to a variety of legal and institutional contexts.

# Overriding Mental Health Treatment Refusals: How Much Process Is “Due”?

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## Overriding Mental Health Treatment Refusals: How Much Process Is “Due”?

### I. Introduction

In 1991 the above listed authors published an article in the *Indiana Law Review* titled “Taking Harms Seriously: Involuntary Mental Patients and the Right to Refuse Treatment.”<sup>1</sup> In it we argued that the extension to involuntarily committed mental health patients of a legal right to refuse mental health treatment (at least in the sense of its being protected by potentially multiple judicial hearings), was a legal/logical anomaly and one that had bad consequences for those patients who exercised the right, not to mention their fellow patients, the hospital doctors and the institutions in which the patients were (ware)housed. We felt, somewhat naively perhaps, that the reason the law was askew stemmed from the lack of good medical information on the part of lawyers, judges and legislators and that rectifying the situation required the presentation in an appropriate legal forum of such information. Everyone’s eyes would be opened and the law would change in the direction warranted by our confidence in the medical facts—*i.e.*, that the antipsychotic drugs predominantly used in treatment were highly efficacious and without anywhere near the negative side-effects profiles portrayed by antipsychiatric alarmists.

There has been some success in the realization of this hope, though pinning much or any of it on the publication/dissemination of a legal academic article would be presumptuous.<sup>2</sup> There has been progress in the law in the sense that the cases and statutes today are somewhat more likely than a decade or so ago to reflect an appropriate appreciation of what the medications can do (and what they won’t do), in multiple contexts. Whether the issue is civil commitment and treatment (inpatient or outpatient), or treatment in the criminal justice-mandated context of competency commitments (whether pre-trial or pre-sentence) or post-conviction treatment in the prison setting, medical authority to medicate unwilling patients has in the overall expanded while judicial review has been relegated to a lesser and later (“post-deprivation”) role—a realignment of power that one would surmise has much to do with better knowledge of the (large) benefits vs. (relatively small) costs in potential negative consequences of the medications.

At the same time, however, there has been some jurisprudential backsliding as well, including at the U.S. Supreme Court level (ironically there, in that throughout the previous decade or two that Court acted as a much-needed brake on the lower federal and

state courts' penchant for belegalizing medical decision making with all sorts of procedural strictures in all kinds of institutional settings), where a small number of decisions has been handed down and some language articulated that seems to give new life to what one had hoped was the moribund view of psychotropic drugs as predominantly harmful and the accompanying disbelief in the competence and integrity of doctors to appropriately prescribe them.

Given the thus still uneven, not to say precarious, lay of the legal landscape on treatment refusals, we feel it is timely to do a reprise of sorts of our 1991 article and to present once again what we believe is a true picture of the risks and benefits of antipsychotic medications. It is a picture that in many respects is and can be more optimistic than before, consistent with another set of major advances over the last 10-15 years in psychiatric medicine (in particular, the development of the so-called atypicals, a new line of antipsychotic drugs with higher benefit potential and fewer risks than the "old" medications, and continuing improvement in their usage).

Unlike last time when we avoided engaging the medication skeptics on their terms, we will this time around get into the legal/constitutional arguments these skeptics are prone to advance. After all, most of the skeptics are lawyers and this is their game. And it is the law that rules what doctors can do, not their medical axioms, ethics or habits. Also, whether an optimist by inclination or more of a realist, one can hardly hope to persuade the unpersuaded with "inconvenient" facts alone. The facts do matter, both qualitative/anecdotal and quantitative, but only in conjunction with a challenge to theoretical positions staked out and with an overt (*i.e.*, compensated for) appreciation of how readily the facts can be disregarded or manipulated by the theoretically pre-positioned and pre-disposed.<sup>3</sup>

Also unlike last time, when we limited our observations and conclusions to the civil commitment context, leaving to implication the wider message that we knew was there, this time we are more willing to spell out the implications for other legal contexts. It comes with the territory of engaging the skeptics on their wider legal/constitutional terms. The legal context may vary from institution to institution as may the patients' legal status whether in or outside an institution; legitimately (if one will permit some small word-play), the legal/institutional context will have much bearing on what is "right", proper and practicable when it comes to the matter of who makes and reviews treatment decisions; who has the first and final decision-making authority.

We will proceed as follows:

We will begin by presenting the new medical data because (1) it is the most significant (new) element in the debate on the matter of treatment rights, including the right to refuse it and (2) it immediately makes more intelligible what that debate is about as well as what our preferences/biases as authors are and from where these derive. We will present the research and anecdotal results documenting the heightened efficacy and the reduced possibility of untoward effects of the new antipsychotic drugs. This section of the paper will include information, new information to the extent it has been developed, on the

harms, both personal and institutional, that result from withholding for legal reasons treatment that is medically indicated—in short we will present some indication at least of the costs of an inefficient legal treatment refusal regime, one that makes any conscientious and medically justified attempt to override the patient’s resistance to treatment cumbersome to the point of impractical, if not impossible.

After the medical discussion we will, as before, try to pinpoint what we believe is the real issue in the debate over mental patients’ rights to refuse treatment (implicit, even explicit, in the new article’s title) from both a legal and pragmatic standpoint, what ultimately the controversy is about, to the extent there is such. Without such a focal delineation the whole debate is or soon becomes unrewarding, if not incomprehensible.

This is followed by a recapitulation of where things stood legally in 1991 at the time we were writing the first article—the promise we saw in some contemporary judicial decisions and pronouncements but also the persisting levels of entrenchment of antipsychiatric bias that we felt could easily dash hopes for further progress.

After that, we will list and analyze the more significant new cases and statutes, both those that appear to endorse the legal implications of the new medical advances and those that seem (still) to go counter and continue to trade on the medical misinformation and myths that used to dominate the right-to-refuse jurisprudence.

In the course of the above we will try to touch once again on what we believe is the contextual reality in which treatment refusals and the decisions to override them are made, this time a wider reality in that we characterize not only patients and institutions subject to the dictates of civil commitment but also civil outpatients as well as individuals on the criminal side of the ledger. Though dealt with to an extent in the medical data section, this discussion will make reference to new data on the prevalence among the severely mentally ill of anosognosia (inability to recognize one’s illness) and the implications of the data on the law’s approach to treatment refusals.

Finally, we conclude with a section on such (further) legal reforms as we feel are needed. This will be brief in that we will suggest principles rather than call for the emulation or adoption of specific salutary (in our view) case decisions, statutory provisions or agency regulations. Much less will we engage in the drafting of model laws on involuntary (or “assisted”)<sup>4</sup> mental health treatment or urge the adoption of such existing models as are out there. Of course any attempts to put on the books or into practice such “principled” reform as we advocate will of necessity involve detailed analysis of the precedents (non-legal meaning) and ultimately much borrowing from them, but we feel that job is best left to the reformers.

## **II. Of Typical and Atypical: the Old and New Medical Data**

We begin this section on the new medical data by summarizing what we said in the old article. Under the heading “Separating Myth from Reality” we first reported on a review we conducted of the legal literature on the use of psychotropic drugs—law journals as

well as judicial opinions—concluding that the vast bulk of it was woefully, even willfully, misinformed about the both the drugs’ risks and benefits.<sup>5</sup> The prevalence and severity of negative (side-)effects were almost uniformly overstated, alleged misuse of “drugging” by state physicians was played up as rampant if not the norm (embellishments/inventions ranging from the charge that drugs were administered mostly for administrative convenience or punishment to the suggestion by analogy that it might be or at least risked being done to suppress political dissent), while the huge health benefits of proper drug usage for people with serious mental illness got no play at all (the whole helping rationale behind psychiatric treatment being simply ignored).<sup>6</sup> We wrote of the characteristic internal referencing aspect of this legal literature where reliance for authority was not on original medical publications but almost exclusively on a few biased analyses written by non-physicians or one or two radical anti-psychiatry doctors, leading to an inevitable repetition of false information and myth or even, as in the legal cases ruled by common law precedent, the outright transformation of medical myth into legal fact.<sup>7</sup>

Not much has changed in the law journal commentary of the decade and a half since. As for judicial pronouncements they have shown sporadic, marginal improvement (but with some backsliding as well), as we will sketch out in text sections to come. The reasons for this lack of progress may be more profound than we initially thought. It is more than a difference in priorities between the two professions, medicine and law, and the presumed pursuit of a patient’s medical best interests by the one side versus the preservation of his or her legal rights by the other. Nor is it a matter of mere information lag as sometimes occurs when law has difficulty (or deliberate reasons for not) keeping up with science. It is not even a matter of different world views. Rather, it is that the world view which has animated law and continues to hold sway over the profession is just plain wrong, a fact for which psychiatry bears some responsibility.

An analogy might help clarify our point. Had there been a well developed legal system at the time everyone believed the world was flat, one could imagine the existence of an intricate body of maritime and trade law reflecting that assumption. The individual parts or provisions of that body of law would, ideally, partake of an inherent logic and consistency that would regulate the domains at issue with maximum efficiency. And the system might have worked, or seemed to work. But it would have worked only up to a point because the whole legal edifice was built on a flawed premise whose fault lines would eventually be exposed and bring it crashing down. Such is the case with the law of psychiatry, as we might put it: while in some respects appealing in its patient protective logic and workable for achieving these limited ends, it too is built on a false premise and it is crashing all around us in a cascade of ruined lives that are the product of treatment needs frustrated through misdirected law and treatment opportunities foregone.

In the last 40-50 years there has been an almost revolutionary shift in theories about schizophrenia, the classic form of mental illness. Absent a Magellan of psychiatric medicine, it has taken time for that revolution to fully spread its tenets and inferences even within the psychiatric profession. In law, however, it appears that even rumors of this revolution have yet to penetrate as the advocacy bar persists in making sure patients

do not fall off the precipice of law-protected self-determination into a psychiatric netherworld of custodial neglect and punishment, even as safe and effective treatments are becoming increasingly if not globally available. The premise underlying the revolutionary transformation of psychiatry is this: schizophrenia (and other major mental disorders no less)<sup>8</sup> is biologically based and so is the treatment of it. The implications of this reality once recognized are enormous.

Half a century ago, it could be argued (and was) that schizophrenia did not exist and that mental illness was a myth propagated to permit the incarceration of dissidents and misfits or others with “problems in living.”<sup>9</sup> This was not the dominant view and counter arguments were certainly made, but the theories on which they were based proved not easy to substantiate. Results of early investigations of biological or genetic factors were inconclusive or subject to criticisms that were fatal to credibility.<sup>10</sup> Unlike physical disease where pathology could be demonstrated on post-mortem examination, no similar proof of abnormalities was available for schizophrenia and it could be maintained that none existed. The very “reality” of the illness could thus be drawn into question.

Today by contrast there is an overwhelming body of data showing that schizophrenic patients have physical abnormalities.<sup>11</sup> Post-mortem examination of the brains from schizophrenic patients show these abnormalities, some of which are at the cellular level, others subcellular. The pathology can be seen in living patients as well via imaging technology.<sup>12</sup> There is today no doubt that schizophrenic patients have less grey matter than normals as well as enlarged ventricles, fluid-filled space in the brain. These findings have been replicated in hundreds of studies and can be considered established. There are also encephalographic (EEG) changes which can be detected when patients have electrodes placed on their head and electrical events are recorded and analyzed. The studies finding such abnormalities, too, have been replicated many times and validated using multiple indicators of EEG function.<sup>13</sup> In addition, schizophrenic patients have an eye movement disorder, detectable electrophysiologically (EES) or neuropsychologically (psychological tests), which is characterized by difficulty in trying to follow a target.<sup>14</sup> The common denominator in these physical changes/abnormalities is the presence of cognitive and information processing deficits in patients with schizophrenia resulting in impaired thinking and deficiencies in other higher mental processes.<sup>15</sup>

There are now also multiple of studies conducted in various countries showing a well-replicated genetic association of schizophrenia.<sup>16</sup> There are a number of leads pointing to abnormalities in certain genes or regions of the genome (at a given location on a given chromosome).<sup>17</sup> Furthermore, there is an active exploration in schizophrenia research of epigenetic events, changes in DNA after conception. During life many genes can be silenced and remain dormant; whereas others can be activated at certain times in embryonic or adult life. Post-mortem examination of brains from schizophrenic patients for example shows major protein decreases of the “reelin” gene,<sup>18</sup> suggesting potentially major negative effects for brain development or the formation of normal (synaptic) connections between neurons that occurs throughout adult life, and the negative cognitive and information processing consequences that in turn flow from that.

Not all of these pathologies and pathophysiological events are as yet well understood. There remains much we do not know as research on schizophrenia continues with increased intensity and sophistication. But the notion that the disease schizophrenia does not exist and that it is caused simply by psychodynamic events (bad mothering) or sociologically (by a sick society) (and therefore is not a disease) has been abandoned by any serious medical investigator or practitioner. It is time the law acknowledged the consequences of our new understanding as well.

One area where the law needs to adjust is the treatment of patients with antipsychotic drugs. When these drugs were first discovered in the early 1950's they were referred to as tranquilizers. The first antipsychotic drug, chlorpromazine, did have considerable sedative properties. Thence came the charge that the drugs "dulled the senses" or that they were a convenient chemical straightjacket. But even the early drugs did not act by sedation. Like the newer drugs their action is to counteract psychosis by blocking excessive dopamine in the brain, a hormone-like substance whose release in abnormal quantities is associated with "positive" psychiatric symptoms such as hallucinations and delusions.<sup>19</sup> While the drugs may quiet a highly agitated and excited patient, they also help restore apathetic, affect-less patients.<sup>20</sup> The restoration is in the nature of a regaining of cognitive skills, ideally as close as possible to normal pre-morbid thinking and functioning.

The old drugs risked producing parkinsonism in an area of the brain concerned with modulating movements and could cause stiffness, involuntary jerking and other parkinsonian-like symptoms.<sup>21</sup> The newer drugs have only weak activity in this area of the brain and as a result a much-reduced profile for this type of extrapyramidal side-effect. Normal treatment practice would be for the doctor to choose a drug for the patient that he or she thinks does not have or has the least chance of producing side-effects the patient is concerned about. If side-effects do develop, the option almost always exists today to switch the patient to a drug that does not cause these effects.<sup>22</sup> Particularly in cases that engender dispute or litigation today where the issue is short-term hospitalization or otherwise mandated treatment, the potential for extrapyramidal symptom development would rarely be of concern, if ever.

There is no correlation between sedative properties of the antipsychotic drugs and their benefit to psychotic patients.<sup>23</sup> There are the so-called minor tranquilizers (benzodiazepines, Librium, valium and so forth) which do produce sedation at higher doses, but this is an altogether different process and they are used for conditions that are unrelated to schizophrenia and other psychotic manifestations.<sup>24</sup>

Treatment with antipsychotic drugs is the hallmark of psychiatric treatment of patients suffering from schizophrenia and other major mental disorders. In no institution today, whether the remaining state facilities, private general hospitals or specialized facilities, the medical schools, or for that matter in the doctor's office, is psychological or psychosocial treatment alone provided. Treatment is always given with drugs. It is not true that wealthy patients get verbal psychotherapy while poor patients are drugged. The

wealthy get drugs *plus* psychotherapy. Medication dispensation and management have become primary aspects of psychiatric treatment for mentally ill patients of all classes and cultures. What is seen by unknowing critics as an orgy of pill pushing is no more than a reflection of the reality that without drugs as the base treatment for schizophrenia and other psychotic disorders there is no hope for improvement. Talk and behavior therapy are still provided, but such therapy builds on the substantial degree of cognitive and emotional restoration that can be achieved with medication. Often its focus is on developing the patient's and even the family's coping skills, to sharpen recognition of the onset of an episode, of the conditions, stresses that signal vulnerability, and what to do in the face of them. The family has become an ally in this, whereas before it was often the scapegoat. Psychotherapy in the form of assertive case management can also be quite useful in helping the patient with the residual "negative symptoms" of apathy and poor motivation.<sup>25</sup> By themselves however these treatment methods are useless for schizophrenia, potentially harmful even, particularly if used to the exclusion of needed pharmacology.<sup>26</sup>

Prior to the early 1950's most schizophrenic patients spent much of their life in state insane asylums. Since schizophrenia's onset is typically in adolescence, the illness took away most of the patients' normal lives. In the early 1950's 50% of the hospital beds in the country were in massive state mental facilities located in rural areas.<sup>27</sup> Up to half a million mental patients filled these beds.<sup>28</sup> When chlorpromazine was discovered in 1953 its use spread quickly throughout the world in two or three years. Violence in state hospitals in the United States dropped by 90% almost overnight.<sup>29</sup> The number of patients in hospitals began to drop year by year with comparable alacrity. Today the total of patients in state mental hospitals throughout the United States is less than 10% of what it was in the mid-1950's and the facilities themselves have almost completely disappeared, restructured for new use or torn down.<sup>30</sup>

When good care is available and patients take their medication the majority of them can return to work or school and be productive members of society. Unfortunately, many schizophrenic patients do not have access to high quality care. The emptying of the state hospitals was accompanied by the realization that much of the treatment burden would now fall on community, mostly outpatient, programs. But the will or wherewithal to create a community treatment system equal to the task never materialized. The result is that the hope of full social rehabilitation, a theoretical possibility for many schizophrenic patients, is realized in all too few cases. For other patients it is worse than that. They may get brief treatment in a hospital or, more likely today, in a jail but they will stop taking their medication once released. Their lives will spiral downward to where episodes of active schizophrenia grow more frequent and worse and recovery is less complete with each episode. Eventually the disease process may flatten out but by then too often alcoholism, drug abuse and homelessness will have become dominant if not permanent features of the patient's existence.<sup>31</sup> What used to be the back wards of hospitals for these patients have today become the back streets and jails. As presently structured, the law and the courts provide little in the way of relief from this pattern.

Schizophrenia is not normally thought of as a fatal illness. The average life expectancy of schizophrenic patients is lower than that of the normal population, but many live into old age. Much of the shorter life span is attributable to a high suicide rate among people suffering from schizophrenia, as well as accidental death and the negative life-style effects of those who are not well cared for. In that respect, it is relevant to note that schizophrenic patients not receiving drugs die at a rate ten times higher than patients on medication.<sup>32</sup>

We also wrote about what we called the “reality of the patient’s setting.”<sup>33</sup> By this we meant to convey the fact that when dealing with the issue of the right to refuse treatment—*i.e.*, of asserted and contested refusals—one would be dealing typically with involuntarily hospitalized patients, the sickest of patients, as distinct from voluntary admittees or community facility residents or outpatients who tended to be less ill and for whom refusing was not an issue because they could.<sup>34</sup> In other words, the matter of how the law should deal with refusals had to be approached in the context not of people with mild, first-time episodes or marginal conditions (let alone the mere worries of the well) but of patients with major mental illnesses (schizophrenia, mania or psychotic depression, often with suicidal tendencies, not to mention a history of revolving-door psychiatric admissions and scrapes with the law due to violent or threatening behavior).<sup>35</sup> Today with mandated outpatient treatment on the rise, as will be discussed, the landscape of psychiatric treatment refusers and refusals has changed somewhat, though the laws as written still intend that nonconsensual treatment be reserved for the most ill. As for patients in correctional facilities or forensic units within the mental health system, we will in this paper address the right-to-refuse implications of their particular legal status, but in recognition that they, like the civilly committed (which many of them once were or would have been in earlier times), tend equally to come from the ranks of the seriously ill.<sup>36</sup> Finally, it bears emphasizing on the matter of context reality that though not unknown at the time we wrote the first paper, there is today a great deal more documented evidence of the concept of anosognosia.<sup>37</sup> More than just an assertion that mentally ill people sometimes lack full awareness of or adequate insight into their illness and distinct from denial as a psychologically-based defense tactic, the term is meant to describe a “biologically-based” or even “neurological” inability on the part of the sick person to appreciate that he/she is sick and needs treatment, which is a characteristic of the illness itself. It is said to afflict some 47%-57% of schizophrenic patients<sup>38</sup> with implications not just for health and behavior (as mentioned, untreated mental illness is strongly related to psychiatric deterioration and violence) but of course also the law’s assessment of a treatment refuser’s “competence” and the desirability/wisdom of honoring his or her wishes.

A general description of the “state of the medical art and research” followed, the state of the art at that time.<sup>39</sup> In it we wrote, as above, of the history of mental health treatment and the relatively recent (1950’s) discovery of antipsychotic drugs, including the resultant, gradual transformation of mental hospitals from places where basic physical care and custody was about all that could be delivered, to institutions where effective treatment of the patient population was a distinct possibility if not always the immediate reality. We explained the role of the federal Food and Drug Administration (FDA) in the

evaluation and approval of drugs, the insistence on blind trials and other study controls, and how antipsychotic drugs had become the treatment of choice world-wide for the major mental illnesses, relegating psychoanalytic and other talk therapies that used to be the hallmarks of psychiatry to at best complementary roles in treating the seriously mentally ill.<sup>40</sup> We presented some “hard” results from an early (1966) National Institute of Mental Health (NIMH) study on the clinical benefits of drug treatment not only to document these benefits but to give a feel for/ flavor of the research methods and the drug approval process.<sup>41</sup> We also wrote of the costs of treatment delayed or denied because of the law’s overprotections: individual clinical costs such as mental deterioration and the inability to recapture such psychiatric loss; institutional costs and harms on the order of increased violence in hospitals on the part of untreated patients and its effect on compliant patients and care givers; and the direct financial costs of warehousing patients before they can be treated, as well as legal process expenditures in judicially or administratively resolving treatment refusal disputes.<sup>42</sup>

Finally, we wrote of the “true risks of side effects” of the antipsychotic drugs (the first-generation drugs of that time), noting that on the one hand all drugs have side effects, and on the other, that as measured by both their efficacy (high but underappreciated) and their asserted bad effects (grossly overstated as to seriousness, general prevalence and particular risk to the patient or patient class) the antipsychotics predominantly used were relatively benign.<sup>43</sup> We pointed out that muscle reactions such as dystonia and akathisia, while alarming and painful, were rarely dangerous and could be readily and effectively treated with antiparkinsonian medication (dystonia in particular), while simply going away when the antipsychotic dose was reduced or the medication changed.<sup>44</sup> With respect to neuroleptic malignant syndrome, a potentially fatal reaction, we wrote that while its seriousness could obviously not be gainsaid, it beared noting that its occurrence was very rare and its causal attribution to the taking of antipsychotics not conclusively established.<sup>45</sup> Besides, the risk of death from untreated psychosis, drawn from hospital studies documenting large numbers of deaths from lethal catatonia, suicide, accidents, infection and other harms that used to befall chronically psychotic patients in pre-drug days, was infinitely larger than from the antipsychotic drugs, a situation we analogized to the benefits of penicillin which exponentially increased medical survival rates in homes, hospitals and on the battle fields despite the fact that an allergic reaction to the drug can on occasion be fatal.<sup>46</sup> As for tardive dyskinesia (TD), the most notable/visible of the adverse reactions to medication with antipsychotics, we pointed out in the face of outsized claims that half of all hospitalized mental patients suffered from the condition that the true figure was more on the order of twenty percent and that only after prolonged, continued treatment with the drugs in excess of six to seven years. Even then, many of the cases would be mild to moderate in severity and typically reversible. It would be exceedingly rare for TD to develop in the first six months of treatment; thereafter the risk of contracting the disorder rises about three percent per year assuming continued administration of the drug at high dosage.<sup>47</sup> Most mental patients even then spent only a few weeks in the hospital when the risk of developing TD is essentially nil if they have not had antipsychotics before and would be increased by only a small fraction of a percent if they had. To anticipate arguments about autonomy or (even) free speech, we emphasized, as we do today, the restorative properties of the drugs; that the evidence of

cognitive/perceptual restoration to pre-morbid “normal” mental processing was substantial for many patients treated with the drugs; and the bearing this in turn should have on which of the patient’s choices in what mental state to honor.<sup>48</sup>

This was the state of the medication treatment art in regard to what have since been called the “typicals” (*i.a.*, haloperidol, chlorpromazine, thioridazine, fluphenazine, perphenazine), the “old”, “conventional” antipsychotic drugs that in the early 1990’s began to be replaced by a newer line of pharmaceuticals called (of course) the “atypicals” (the forerunner clozapine and later olanzapine, quetiapine, risperidone, ziprasidone, and aripiprazole). Trials and other research on the atypicals tended to show substantial efficacy gains as well as a marked reduction in the prevalence and seriousness of undesirable side effects. Moreover, the higher costs of the new drugs, clozapine in particular, were shown (or projected) to be easily offset by reduced relapse and rehospitalization rates and all other associated alleviations of personal and social misery presumably brought about by improved treatment.<sup>49</sup> It would have been simple for us to summarize and cite this literature and be done with the medical data section, moving on to the legal policy analysis from the firm base of major medical advances that would allow us to reinforce the argument for abandoning the stricter, medically counterproductive legal process controls and advocate for a (return to) a treatment-decision making model that paid greater heed and deference to the medical perspective and to physician authority.

However, the burden of persuasion has been somewhat altered by the appearance of a recent study funded by the National Institute of Mental Health (NIMH)<sup>50</sup> suggesting, or at least so reported in the popular press, that the medical advances are a mirage and that the new generation of psychiatric drugs is no better or not appreciably better than the old drugs. We do not want to overstate the medical significance of the so-called “CATIE” study, but do need to acknowledge its potential political impact. The study results have been seized upon by some to suggest, as one commentator *within* the profession put it, that a drug market equivalent of the “irrational exuberance” that infected the financial markets in the 1990’s may have blinded researchers, doctors, manufacturers and investors alike to a more sobering reality that could and should have been perceived.<sup>51</sup> If this is the view of a medical insider (albeit an iconoclastic one), it requires no great imagination to speculate how legal outsiders unsympathetic to the “drugging” of patients, if not to the whole psychiatric enterprise, might want to interpret the information.

We can begin by agreeing to the proposition that a Greenspanian word of caution is indeed in order as a corrective against overenthusiasm in this context (as in any context). That does not mean, however, and we think it is important to stress, that we must now reject all good news and submit to an equally irrational backlash of pessimism. Some substantial exuberance remains justified, as we shall see.

First, the CATIE study itself. What *can* be made of the results? Not a great deal we feel, at least not such as has legal policy implications. The study has too many built-in limitations for that. We will describe some of these in the extended footnote below (and include two charts in an appendix to give an overview of the finer medical details).<sup>52</sup> We

use a footnote for this purpose not only because we are hesitant to interrupt the narrative too much, but also because we feel the study does not *deserve* more play in this narrative. In some ways, as the medical author of this paper put it when first weighing what sort of response would be appropriate, the less said about CATIE the better. And this is not because we want to hide the “bad news” but rather because it is too much “no news.” The limitations of the CATIE study severely restrict its capacity to verify *or* negate the claimed advantages of the new, second-generation atypicals; much less do its results speak to the drug “debate” as it is waged in the legal cases and commentaries of today or yesterday.<sup>53</sup>

The lack of a clearer picture emerging from the CATIE study on neurological side-effects such as tardive dyskinesia (TD) is especially unfortunate given the condition’s prominence in the legal mythology on treatment refusals. As a result, FDA labeling that no antipsychotic has been shown to have a lower risk for TD than any other will probably remain in effect for the time being.<sup>54</sup> The evidence continues to accumulate however that the risk of TD is very low with the new drugs, in effect non-existent for some. New evidence also affirms that it was overstated for the older drugs, and even that some of that which was thought to be TD is spontaneously occurring dyskinesia that is part of the symptomatology of schizophrenia. As one of the leading researchers on schizophrenia puts it, “A wide variety of neurological abnormalities have been reported in individuals with schizophrenia who have never been treated with antipsychotic medications”<sup>55</sup>—have *long* been reported, for two centuries in fact, long before there were antipsychotics.

The evidence also continues to accumulate and solidify that all drugs, old or new, produce major gains and help safeguard against psychiatric loss which occurs in the absence of treatment and cannot be recouped even after treatment is initiated. Recent studies document disturbingly high percentages of untreated mental illness or treatment that is interrupted against medical advice (this, in a context where the law’s preoccupation continues, anachronistically, to be with alleged unneeded and unwanted treatment). A 2001 report of a National Comorbidity Survey conducted between 1990 and 1992 found that fewer than 40% of a cohort of seriously mentally ill patients received stable treatment, with the primary reason for failure to seek treatment or failing to continue being the subjects’ unwillingness or inability to see the need.<sup>56</sup> The prognosis for these patients is a diminishing chance of amelioration or recovery as relapses mount and symptoms increase in acuity, severity (negative symptoms in particular) and resistance to remediation.<sup>57</sup> At the same time, studies on adherence to drug treatment, many conducted in the context of attempts to evaluate the merits of so-called outpatient commitment (OPC),<sup>58</sup> show the benefits of treatment and especially *continued* treatment (even for the minimally symptomatic) on virtually all important personal and social measures: *i.a.*, reduced hospital recidivism and reduced criminal recidivism/violent behavior,<sup>59</sup> as well as reduced victimization,<sup>60</sup> quality of life improvements such as measured by reduced psychiatric symptomatology and better functioning,<sup>61</sup> and systemic gains in terms of less discordant and more appropriate use of the mental health and correctional systems, respectively, for mentally ill people who come into contact with the law as well as appreciable gains in housing situations (reductions in homelessness).<sup>62</sup>

Finally, as mentioned, new findings and confirmation of older study results on anosognosia, which document the relationship between schizophrenia and lack of insight as one of the latter being a neurological function/symptom of the former,<sup>63</sup> provide strengthening support for a best-medical-interests decision making model in mental health matters. The implications of the concept of anosognosia for treatment adherence/compliance are self-evident. A person who believes he is not sick will resist treatment at all stages and levels. To the extent the implications for the person's mental health (negative, as they would be for most any untreated somatic illness) are not equally self-evident, they have been described and documented in studies such as those cited in the preceding paragraph. Last, while the details may ultimately bedevil some or many, we believe no spelling out is required of anosognosia's implication *in principle* regarding the need for and propriety of the option of (legal) coercion in mental health treatment. Much as we might want, desirable as it may seem, we cannot afford to limit mental health treatment to its entirely voluntary provision and acceptance.

These then are the contemporary medical facts against whose backdrop we proceed with the analysis in the remainder of the paper.

### **III. Once Again: What is the Legal Debate About?**

The overwhelming jurisprudential consensus today is that mental patients have, like all other citizens, a right to refuse unwanted medical treatment, or at least a right and an opportunity to articulate their objection(s).<sup>64</sup> Virtually every court that has ruled on the matter—irrespective of whether the patients were civil or “criminal”, voluntary or involuntary—has recognized that the patients have what is called a due process-protected liberty interest in not being medicated against their will.<sup>65</sup> There are also state tort laws against unauthorized touching (battery), natural law concepts averring to the rights and entitlements of personhood, Bill of Rights claims stemming from the first amendment's protection of “free speech”, the eighth amendment's prohibition against cruel and unusual punishment, “penumbral” privacy rights that emanate from the overall constitutional firmament, and any number of other legal theories that can and have been invoked to protect patients from unwanted treatment.<sup>66</sup> But when it comes to establishing a generally recognized and (federal as well as state) enforceable protective shield for patients, most lawyer advocates and the judges who hear them prefer to construct it on the due process concept (when they don't just fold these other theories into the concept).<sup>67</sup>

To doctors, this language of due process-protectable liberty interests will be unfamiliar and the reasoning on what is embedded in, implied by, or derived from it perhaps arcane (it certainly won't resonate with them as it does with the legally initiated). Even so, there is every reason for doctors to support this particular application of the theory and the language that seeks to advance it. For one, to agree to the accord (via the due process theory or otherwise) of a general human right to a specific population disadvantaged by past withholding of the right and/or vulnerable to continued disempowerment if not discrimination is a humane position to take—liberal in the classic sense of the term. Second and more directly pertinent to our discussion, it is a position every doctor can live

with, so to speak, because the extension as per the due process clause of a right to refuse treatment to mental patients need not and does not, in and of itself, interfere with the doctor's ability to treat the patients when and as well as necessary. The reason is that the obstructions erected by the patient's opposing will and wishes can be overcome when and where medically needed by virtue of the fact that, as the courts never tire of saying, due process rights are not absolute substantively and wholly flexible procedurally.<sup>68</sup>

That the patient's right to refuse treatment is not absolute substantively means it may at some point have to give way to other important interests (classically, more "compelling" state interests when these are weighed, as by constitutional precedent they must be, against the individual's interests).<sup>69</sup> In most instances that concern us, it is the doctor who stands in the state's authoritative "shoes", so it is the interests of the doctor or the medical/correctional institution where he or she works, if not the State itself (the first two are typically listed as respondents in right-to-refuse litigation) which are pitted against the patient's and which in the proper circumstances may trump the patient's right to refuse. The only question is what circumstances (as indicated by what legal criteria, provable by what proof)?

More important yet than its substantive relativity is the procedural flexibility of due process. This is because the theoretical possibility of the state's right trumping the patient's right in some situations can be vitiated for all practical purposes by the requirement of costly, cumbersome and time-consuming procedures that must be followed in the deciding. The legal precedents on what constitutes "procedural due process" show a wide range, from very quick and informal "proceedings" (the word suggests too much already) to full-fledged, even multiple, court adjudications.<sup>70</sup> Any and all of it *may* satisfy due process. How much procedural process is due in any given situation depends precisely on that situation, on the interests involved, the stakes, the costs, the benefits, the feasibility of more or the economy of less of it, and so forth.

Properly understood thus, due process suggests an ordering of the substantive interests to reflect their relative weight or importance, and a tailoring of procedure to whatever the situation mandates, or tolerates.

This then is what it comes down to, what our paper on the right to refuse, *any* paper on the subject, must begin with acknowledging: All patients have a legally, even constitutionally, protected right to refuse treatment. There is no disagreement on this and need not be. Nor, despite its constitutionally protected status, is there any doubt that this right of a patient (who in most cases will have been formally declared incompetent, but even when not)<sup>71</sup> in some situations must yield to superior interests, in particular the interests of treating doctors and/or those they represent. The "issue" is how much/what kind of process must be observed to override the patient's refusal, should that be considered medically necessary. This is where opinions, both legal and lay, diverge. And the legal/medical context in which the refusal is asserted will have everything to do with what the answer is or, better, as there is no consensus here, what we think the answer ought to be. This is the crux of the matter and it is from this vantage point that we will

proceed to examine the pertinent cases and statutes and how we will come to our own conclusions about what sort of legal right-to-refuse regimen makes most sense.

#### **IV. Where Were We in 1991?**

There is no one, agreed upon, “short list” of cases that dominated the right-to-refuse jurisprudence of the 1980’s when the concept first gained full recognition, but *any* such list likely would include the following: *Rennie v. Klein*<sup>72</sup>, *Rogers v. Okin (Mills, Commissioner)*<sup>73</sup>, *Davis v. Hubbard*<sup>74</sup> and *Bee v. Greaves*<sup>75</sup>. We would add to this list *United States v. Charters*<sup>76</sup>, for reasons to be spelled out. The first three of these cases, *Rennie*, *Rogers* and *Davis*, each took many years to complete<sup>77</sup>, winding their way from first initiation of the action to final decision via a route that took them not only through one or several appeals (some interim or interlocutory, as opposed to from a final order), including side-trips to U.S. Supreme Court in the cases of *Rennie* and *Rogers*, but also, as in the latter, a switch for its final denouement from the federal forum to the state’s and a change in the name of the defendant party--not once, but twice.<sup>78</sup> The other two had a shorter, somewhat less tortuous, legal life-span. Merely to order these cases chronologically presents hazards, as it is difficult to find agreement on precisely when each of these cases began or ended<sup>79</sup> (much depends on the bendable fact of what one considers the first and last *significant* action in each case).<sup>80</sup> The lack of a clear, straight-line chronology ensures that there is no straight-line doctrinal development that can be discerned from the cases either. Instead, one finds a multi-directional reliance by any one of the courts on early and interim decisions of the others, as well as the later results, in what is perhaps best, or at least most sympathetically, characterized as a process of abundant legal cross-fertilization.

The cases also come from different legal contexts and their outcomes are, for that reason as well as others to be explained, hardly identical. What they all have in common though (except for *Charters*)<sup>81</sup> is that they are cited again and again not only during their progress to finality but in the years after the final outcomes were handed down. And they are cited as much for the verbiage and the rhetoric they employ as for their outcomes, if not more so. In fact, the way the cases are used by advocates and academic commentators alike suggests a heavy-on-the-process/need-to-police-the-psychiatrists solidarity that fails to reflect the substantial differences in the diagnoses of the issue and the consequent remedies proposed or imposed by the various courts.

##### **A. The Bad News in the Civil Commitment Context**

Take for example *Rennie v. Klein*.<sup>82</sup> To the extent it is cited in the *Rogers* case (generally recognized as the other of the two classic right-to-refuse cases from the civil commitment context) as the case announcing the right, *Rennie* is considered the source of the right. Yet *Rennie* is a case that at each and all points along its meandering route to final disposition is in fact reasonably deferential to medical decision-making authority.

The plaintiff/petitioner John Rennie was a man with longstanding mental disorder who had been hospitalized on numerous occasions, in fact twelve times in the six years leading up to the litigation.<sup>83</sup> It was during his last institutionalization, involuntary this time, to Ancora Psychiatric Hospital, a public facility in New Jersey, that he asserted his right to refuse with the persistence and legal backing that turned it into the sort of dispute that generates landmark rulings for whole classes of individuals (in this case all adult patients involuntarily committed to any of New Jersey's five state mental health facilities, who were formally joined).<sup>84</sup>

New Jersey doctors had been medicating unwilling patients pursuant to a state administrative regulation [N.J. Adm. Bulletin 78-3 § II(B)].<sup>85</sup> That regulation provides a fairly elaborate, but manageable, set of both substantive and procedural standards. It required the treating physician to base his decision to administer the drugs to the patient on one of three *alternative* findings: (1) that the patient will harm himself or others if not medicated; (2) the patient will not improve without taking the medication; or (3) he can improve without taking the drugs, but only at a significantly slower rate.

Procedurally, the regulation mandated that the physician meet with the patient to explain his/her assessment of the patient's condition, the reasons for prescribing the medication, and the benefits and risks of taking the medication as well as those of alternative courses of action. If the patient protests, the doctor must encourage the patient to discuss the matter with relatives or friends while the physician him/herself is required to consult with the patient's treatment team. If the patient persists in his refusal, the doctor must submit the case to the facility's medical director who must approve the recommended course of action before any medication may be administered.<sup>86</sup>

The District Court took several passes at the case because of the shifting situation of the petitioner, Rennie, who for a period had no issue with his treatment regimen until he deteriorated and was (again) prescribed a drug, thiorazine, which he did not want.<sup>87</sup> The Court's ultimate holding consisted of two essential findings; (1) that the petitioner and members of the similarly situated class of involuntary patients in New Jersey's mental hospitals had a constitution-based right (privacy) to refuse treatment, a result that went beyond New Jersey law which accorded such a right to voluntary patients only; (2) though acknowledging, even stressing, that this right was not unqualified, the Court found the New Jersey administrative procedure for overriding a patient's treatment refusal encoded in Bulletin 78-3 to be inadequately protective of the right.<sup>88</sup> The Court wound up prescribing an alternate procedure for overriding patients' refusals, but it remained relatively uncumbersome.

What due process required, according to the District Court, was that the treating doctor's recommendation be reviewed and approved not just by fellow physicians and the medical director but by an independent decision maker (*i.e.*, presumably someone from outside the facility). That decider need not be a judge or even an administrative hearing officer--in fact the Court suggested a psychiatrist was preferable<sup>89</sup>—while the patient at this limited hearing was entitled to representation, but by a public advocate of sorts and not necessarily by a lawyer.<sup>90</sup>

Two considerations by the Circuit Court of Appeals followed,<sup>91</sup> sandwiching a brief detour to the U.S. Supreme Court,<sup>92</sup> which vacated and remanded the case based on its then recent decision in *Youngberg v. Romeo*<sup>93</sup> and the professional judgment rule therein espoused. This remand prompted the Court of Appeals to drop as inconsistent with *Romeo* one requirement previously imposed below on the institutional physicians and reviewers—that the determination to medicate be made in (legally explicit) accordance with the least restrictive/least intrusive principle.<sup>94</sup> The overall result was that the New Jersey procedure in the Administrative Bulletin now met the protective mandate(s) generated by even a constitution-based right.<sup>95</sup> The medical decision could be arrived at and implemented so long as the deciders followed the procedure outlined in the administrative regulation; and it would be sustained upon any court review (*after* initiation of treatment, post-deprivation) so long as it was made “professionally”—*i.e.*, by individuals trained and authorized to make them--and not arbitrarily. Among other things it freed the defendants, unlike many defendants facing directives issued by later courts adjudicating this type of dispute, from having to contend with such medically baseless claims as that restraints or seclusions or the use of tranquilizers on schizophrenic patients furnished reasonable, less intrusive, options to treatment with antipsychotics.<sup>96</sup>

From a medical perspective (or that of a legal advocate representing that perspective) the only downside of the final *Rennie* outcome was that the Court of Appeals in its last review interpreted the New Jersey administrative procedure to require (as a matter of substantive due process) a finding of dangerousness to self or others before involuntary medication could ensue. The regulation by contrast merely listed that as one of three alternatives, two of which (see above) were straightforward medical standards. Treating doctors of course favor medical standards for medical decisions, not least in the case of patients involuntarily committed to their charges by the judiciary based on the patients’ inability to make that initial hospitalization decision and per force already found dangerous. If not plain anomalous, having to (re)prove such a fact would appear to be unnecessary and counterproductive to the objective of maximally effective and efficient care of the patient population.<sup>97</sup> But in the context of what was to follow in terms of litigation and legislative outcomes subsequent to *Rennie*, this could be seen as only a minor drawback.

In addition to thus yielding an outcome doctors could live with, *Rennie* also incorporated judicial reasoning and rhetoric that from a medical perspective was mostly benign, if not better. The District Court for example variously at one or the other of the two junctures it had the case before it (1) made a generous acknowledgement of the efficacy of drug treatment (citing studies documenting success rates as high as 95% for first admission schizophrenic patients<sup>98</sup> as well as the marked improvement of the original plaintiff/patient himself, while on prolixin)<sup>99</sup>; (2) did not overemphasize the misuse and/or negative effects of the drugs, despite hearing expert testimony that tended in that direction;<sup>100</sup> (3) appropriately rejected the First and Eighth Amendments as apposite theories for the plaintiffs’ claim or the relief requested;<sup>101</sup> and (4) opined that, while some objections to medication are well-grounded (including at least one instance involving the named plaintiff), in “many” of the substantial number of treatment refusals in mental

hospitals the patient's opposition stems from the "irrational components of his illness"<sup>102</sup> (in marked contrast to claims accepted as fact by the courts in other cases regarding the intact reasoning capacity of the large majority of institutionalized mental patients). There were some low points, too, in that the institutional administration and treatment staff also came in for heavy criticism of some of their specific decisions as well as their larger modus operandi (in the form of testimony accepted as fact by the District Court),<sup>103</sup> but again in context this was (or would prove to be) a relatively small price paid.<sup>104</sup>

*Rogers v. Okin*<sup>105</sup> (later, in its appearance before the U.S. Supreme Court, *Rogers v. Mills*, and *Rogers v. Commissioner*, when decided with finality by the Massachusetts Supreme Court)<sup>106</sup> is a different matter. Far less sympathetic to the medical perspective and less balanced on the medical facts, the various courts that considered the case on the merits (*i.e.*, excluding the Supreme Court) prescribed a legal override regime that ranged from cumbersome to effectively obstructionist to the provision of unassented-to medical treatment.

In their initial action, the patients in the litigant class in *Rogers*—seven individuals at two Units of Boston State Hospital for the mentally ill (later expanded to all present and future patients on these Units)—asked the U.S. District Court to issue a permanent injunction against their being involuntarily medicated as well as an award of money damages, both compensatory and punitive, for what they had "suffered" at the hands of the hospital staff. The Court granted the injunction,<sup>107</sup> henceforth allowing the hospital to forcibly medicate patients in emergencies only (as tightly redefined by the Court from the concept used by the medical staff) and to require competency hearings in all other situations; treatment without personal consent would be permitted only for those found incompetent and then only through a laborious guardianship process.<sup>108</sup> The Court declined to award any damages, but that part of the decision along with its supporting arguments is not significant other than for the fact that logically it undercut the justifications for the injunctive relief prescribed.<sup>109</sup>

The defendants' appeal to the Circuit Court resulted in some cutting back of the farther reaches of the District Court's decree. To the extent the hospital had so interpreted the District Court's holding, the Court of Appeals corrected that "full-blown probate proceedings" to override medication refusals were not required.<sup>110</sup> Nor would all medication decisions have to go through a guardian when the patient had been found incompetent.<sup>111</sup> In addition the appeals court vacated the "limited definition" of emergencies imposed by the court below and suggested a new formula be worked out on remand that would include consideration of a patient's "significant deterioration" (a medically-oriented criterion that avoids the police/emergency aspects of "dangerousness").<sup>112</sup> However, the Court of Appeals did sustain the substance of the competency hurdle and also perpetuated the requirement of engaging in a least restrictive alternative analysis, suggesting—quite erroneously for a population of the severely mentally ill—that "in most situations less restrictive means [than forced medication] will be available."<sup>113</sup>

The case then was appealed to the U.S. Supreme Court on the theory that an intervening state court decision involving the right to refuse of an incompetent *non*-institutionalized patient (*Guardianship of Roe*)<sup>114</sup> suggested Massachusetts law recognized “more extensive” liberty interests than those protected by the Federal Constitution’s due process clause.<sup>115</sup> The High Court took the case and agreed, stating in passing that it “assume[d] for the purposes of . . . discussion” that involuntary patients retained liberty interests protected by the Constitution,<sup>116</sup> and remanded the case for ultimate resolution to the state’s judiciary. In *Rogers v. Commissioner*,<sup>117</sup> the Massachusetts Supreme Court seized the opportunity to deliver an opinion that fully endorsed the civil libertarian premise (and anti-medication bias, in our view) underlying the dispute and the need to value a process protective of legal rights over any asserted institutional, medical or even personal (best) interests.

In terms more certain than contained in any of the federal court decisions, the Massachusetts Court reaffirmed the surviving competency of involuntarily committed patients to make treatment decisions. The commitment criteria had in the Court’s view “nothing” to do with the patients’ “judgmental capacity”, which was a wholly independent issue<sup>118</sup> impliedly requiring the kind of “full-blown”, *de novo* examination the federal appeals court had shied (shoed the litigants) away from. If found competent at this trial, the refusing patient’s refusal would stand, period. And even if *incompetent*, every effort would be made to honor the patient’s presumed wishes via a substituted judgment inquiry. Not even guardians could consent for the patient in the absence of such an inquiry. The patient has and should be given every right to make the decision, even the wrong decision, the Court emphasized (“however unwise”).<sup>119</sup> Whether or not to drug a patient was after all not a medical determination in the first place, but a social one over which the patient (and the court through its oversight responsibility) had as much control as anyone.<sup>120</sup> Drug treatment was dangerous, “intrusive” business, analogous to other “extraordinary” medical interventions such as electroconvulsive therapy and psychosurgery.<sup>121</sup> Moreover, and here the more radical judicial statements from other cases were invoked along with cites to the antipsychiatric socio-legal literature, doctors could not be trusted with the drugs, given their “conflict of interests” and habit of using them as “chemical restraints” (for “convenience” and “expediency”—*i.e.*, to save time, money and hassle) or to instill in patients the proper measure of “passivity”, “obedience” and “submission”) when not outright medicating them for “punishment.”<sup>122</sup> This could have been a brief written by the anti-psychiatry lobby; instead it became the mainstream model for the right-to-refuse law as it would henceforth be conceived.

If *Rennie* and *Rogers* are the so-called seminal cases on the right to refuse in the civil mental hospital context (with *Rogers* representing the “problem” precedent), then *Davis v. Hubbard*<sup>123</sup> is the bastard child. *Davis* was an all-inclusive class action against doctors, administrators and other officials at Ohio’s Lima State Hospital for the mentally ill, in which the need to obtain prior consent from the (involuntary) patients before they could be medicated was just one of many contested issues, though it turned out to be by far the most conspicuous and significant one.<sup>124</sup> The case contains some of the more incendiary language used in the line of cases on this subject, and it has received more than its share

of judicial and lawyerly attention because of that, though the decision's final procedural prescriptions are fairly modest and moderate.

"Prescriptions" is the wrong word even for what the *Davis* Court came up with at the end. Citing that the parties had not addressed the matter of what procedural protections the application of due process in this context required, it declined to do so on its own ("this Court is simply in no position to decide the question").<sup>125</sup> Rather, it emphasized the "flexibility" of the concept and said it could offer no more than "certain general observations."<sup>126</sup> These included that the State should give the patient "some kind of hearing"<sup>127</sup> before compelling the administration of drugs. Such a hearing should be presided over by an "impartial decision-maker"<sup>128</sup> but by no means need this be a judge or even a lawyer, according to the Court.<sup>129</sup> In fact, based on its reading of *Parham v. J.R.*<sup>130</sup>, the Court did not think someone from outside the institution was necessarily required. It also noted "full-scale" competency proceedings are not in the patient's interests in that they could lead to a deprivation of rights broader than treatment decision making and would in any event be "unnecessarily expensive and burdensome."<sup>131</sup>

The legacy of *Davis v. Hubbard*, however—why it has come to be cited so often in later briefs and opinions—lies in the Court's rhetoric and its use of facts for which the word "questionable" is a generous description. For example, the Court noted that patients at Lima State Hospital were generally not given an opportunity to refuse medications even though "roughly 85% of the patients are capable of rationally deciding whether to consent to their use."<sup>132</sup> Instead of providing support for this estimate--out-of-line with even the most generous competency conceptualizations (not to mention empirical data)--the footnote accompanying it merely goes on to make the further assertion that "[o]f the 15% incapable of making such decisions, few have been found 'incapable' by some neutral party or tribunal."<sup>133</sup> The Court had strong things to say as well—for lack of a better characterization--about the costs and benefits of the medications. On the benefits, it asserted in a footnote that "recent studies indicate that in cases in which psychotropic drugs are usually given, the patient can improve just as effectively without as with the drug."<sup>134</sup> A note immediately prior to this claim concluded that "the drug[s] may even exacerbate the symptoms for which they are given."<sup>135</sup> On costs, the Court devoted a full page to the alleged harmful side-effects, citing many of the most resolutely antipsychiatric and polemical "studies" from the socio-legal literature along with a small and very select smattering of medical journal pieces. It gave as fact the distinctly high-end finding cited also in the first *Rogers* decision of a 50% to 56% incidence of tardive dyskinesia among hospitalized schizophrenics and added an estimate from the same study that as many as 41% of outpatients "are affected."<sup>136</sup>

The Court's rhetoric was, if anything, even more over the top. The section of the opinion addressing "Issue 12", the need for "prior consent", began by noting psychotropic drugs were the most popular form of "treatment" at LSH.<sup>137</sup> As if the word popular (not in quotes in the original) were not dismissive enough the Court did put the word "treatment" in quotes. This was followed by the Court's conclusion from what it said was the testimony at trial that the drugs were used in a "countertherapeutic" fashion and only for "the convenience of the staff and for punishment."<sup>138</sup> It then wrongly depicted the effect

of the drugs as primarily “mood-altering” and tranquilizing.<sup>139</sup> And it went on to such excesses as comparing the forcible use of drugs to the practice of “mind control” and other politically-motivated tactics that are the “hallmark of those totalitarian ideologies we profess to hate.”<sup>140</sup> Footnotes to a study on criminal justice in the Peoples Republic of China, to Anthony Burgess’ *Clockwork Orange*, and a law review article by Peter Breggin, one of a small number of radically antipsychiatric psychiatrists, on *Psychosurgery for Political Purposes* rounded out the Court’s picture<sup>141</sup> that would then presumably inform the “interest balancing” required to reach the appropriate due process solution.

In the aggregate then, with *Rennie* liberally cited but its more moderate approach essentially rejected and the outcomes and especially the rhetoric of *Rogers* and *Davis* paramount, the civil commitment precedents of the 1980’s left the right-to-refuse field in the following posture: (1) a mandate for overblown procedure plus the effects of that (obstruction of timely treatment even for those ultimately found treatable), generated in large part by (2) bad medical facts and bad rhetoric with their self-perpetuating force in law, (3) a requirement for competency inquiries that would exempt resisting “competent” patients from treatment (4) a mandate to prove dangerousness, the substantive standard, before even the incompetent could be administered unassented-to treatment, resulting in (5) the potential anomaly of a class of “nondangerous” incompetent treatment refusers or even dangerous “competent” ones locked up under court order (on grounds of dangerousness) in treatment institutions.

## **B. Troublesome Criminal Competency Cases**

*Bee v. Greaves*<sup>142</sup> and *United States v. Charters*<sup>143</sup> are two problematic judicial decisions with a different legal twist. Distinct from the civil “committees” in *Rennie*, *Rogers* and *Davis*, the plaintiff in *Bee v. Greaves* was a detainee in Salt Lake City’s County Jail whose medication (refusal) rights were at issue in the context of his competency to stand trial. The same was the case in *Charters*, except that the petitioner there was confined specifically for treatment in Butner (North Carolina), a federal correctional facility with a dominant “forensic” mission. A brief review of these two cases will reveal the potential impact of that legal complication on what the deciding court views as the appropriately tailored right to refuse for the patients. We say “potential impact” because the effect is not discernible in the two decisions with we begin (*Bee* and *Charters*), though we believe that it should be.

*Bee* involved a detainee who actually begged for medication shortly after being booked because he was emotionally unhinged and hallucinating.<sup>144</sup> He started refusing only months later after he had been found competent to stand trial while medicated (it is not clear whether his refusal was a legal tactic, the Court attributing it, cryptically, to his complaints of “having problems with the drug”).<sup>145</sup> He began “decompensating” within a matter of days, however, at which point he was forcibly medicated by injection administered by a jail medic accompanied by several guards who were sufficiently rough physically and verbally to intimidate him into taking the medication orally henceforth (*i.e.*, he did not retake it voluntarily in any meaningful sense of that term). He

subsequently filed for damages under Section 1983 of the Civil Rights Act naming as defendants just about everybody who had any connection to the Salt Lake County Jail, including several county commissioners. The District Court rendered summary judgment for the defendants on the ground that the County had interests in medicating the complainant that superseded any rights the complainant had to not be medicated. The Court of Appeals reversed and remanded to the trial court for further action.

The appellate outcome in *Bee* was in the light of the civil commitment precedents not especially remarkable or revolutionary, the Court limiting its holding to a determination that forcibly medicating a detainee was justified only in an emergency.<sup>146</sup> The remand thus instructed the District Court to decide whether an emergency had in fact existed<sup>147</sup> and whether the seemingly indefinite period during which the less than voluntary medication continued was justified or constituted the sort of “exaggerated [government] response” that the Constitution and the courts do not condone.<sup>148</sup> As with *Rogers, Davis et al.*, however, it is the rhetoric and reasoning that make the case the oft-cited precedent it is. In arriving at its decision the Court of Appeals indulged in the tactic of focusing almost exclusively on the bad side effects of medication while at the same time grossly overstating them (the 50%-56% estimate of the incidence of TD featured prominently here as did several of the “studies” where this claim and others similarly excessive were made).<sup>149</sup> Concern was expressed about the government mind control and the like.<sup>150</sup> And various other by now familiar but unconvincing, not to say false, lines of persuasion were thrown into the Court’s decision-justification mix. But on the issue of significance—the one that differentiated *Bee* from *Rennie* and *Rogers* and other alleged precedents, the status of the complainant as a criminally accused whose competency was at stake—all the Court had to offer was the conclusion that “where the use of antipsychotic drugs is concerned...the needs of the individual, not the requirements of the prosecutor, must be paramount.”<sup>151</sup> Certainly that is a simple way to dispose of the case, but not necessarily satisfying. After all, the interests of the government here, whether ultimately judged as overridingly compelling or not, are different than in the civil commitment context. Moreover, even the mentally ill accused has treatment “needs” that at the very least ought to be weighed against his strategic legal interests, to the extent his refusal is motivated by such.

*Bee*, however, is legal pabulum compared to the disposition and language of the first *Charters* case.<sup>152</sup> The accused in *Charters* was a presidential threatener (as the Secret Service tends to put it) who was found incompetent to stand trial for that offense and sent to Butner for restoration. To seek to accomplish that, his restoration, medical staff based on the sole opinion of the treating doctor obtained an order from the federal District Court to medicate the accused despite his objections. He appealed to the Circuit Court. The case was heard by a three-judge panel which sustained his (*i.e.*, his lawyers’) every argument and then some.

The Court’s opinion began inauspiciously with the usual citations to Plotkin’s *Therapeutic Orgy* article<sup>153</sup> and similarly oriented commentary plus a recital of the familiar negative attributes of antipsychotic medication and its misuses and abuses. The

list of negatives reads like an endless litany: the drugs “dull the senses”<sup>154</sup>; the “threat of permanent injury is substantial,”<sup>155</sup> “there is no principled distinction between the chemical invasion of drug therapy and the mechanical invasion of surgery”<sup>156</sup>; indeed, the medications are “potentially mind-altering [and] the threat to individual rights goes beyond a threat of physical intrusion and threatens an intrusion into the mind”<sup>157</sup>; the drugs have the “potential to infringe upon an individual’s freedom of thought” and to “allow the government to alter or control thinking and thereby to destroy the independence of thought and speech so crucial to a free society.”<sup>158</sup> This did not augur well for those hoping for any amount or kind of judicial deference to medical authority.

It was only down-hill from there on. First, the Court dismissed any notion that the accused’s designation as incompetent to stand trial (his “legal incompetency”) had anything to do with or say about his treatment decision-making capacity (his “medical competency”)<sup>159</sup>—a position one could compare to the refusal of the majority of courts to equate civil commitment with any loss of capacity/right to consent to or reject treatment once institutionalized. *Rogers v. Commissioner* thus becomes the model here. The accused’s competency for the latter purpose, not having been assessed, still needs to be assessed if the government is to have the authority to ignore his wishes on this score. And pursuit of the *Rogers* model continues: if the accused is found competent his wishes must be respected and he may not be medicated, regardless of the medical, personal and/or institutional downside to this. If he is incompetent, then there must be a second judicial hearing, now on whether or not he should be medicated. Even then the medical interests do not necessarily prevail—the patient’s *or* his doctors—as the first requirement is to follow the substituted judgment rule and to try to divine what the accused might have wanted *if* competent and only in the absence of being able to unearth this, a determination of his best medical interests. Clearly this medicating business was not going to be made easy.

And why should it? In the Court’s view, the results of medicating the patient were iffy at best. Restoration to competence was by no means guaranteed.<sup>160</sup> And even if restored, it was to some “synthetic” competence<sup>161</sup> that could easily lead to what the Court termed “misimpressions”<sup>162</sup> about the accused’s “true” mental state and his sanity at the time of the crime, which would presumably be at issue in the trial (as if a defendant has a right to present as floridly psychotic at trial, assuming the relevance of that).<sup>163</sup> Moreover, whatever interest the government might have in an adjudication of the charges, it paled in the light of “such a draconian invasion of the individual’s freedom and the risk of permanent physical injury”<sup>164</sup> as posed by drugging him.

Together with *Rogers* and *Davis* in the civil commitment context and *Bee* in the criminal detention/corrections sphere, the first *Charters* decision seemed to consolidate an antipsychiatric legal mode and mood that virtually precluded treatment to which the patient did not explicitly consent.

### **C. Some Good News: Revised Judgments on Medicating the Restorable Accused and the Convicted**

A radically different view of psychiatric medications than the decidedly jaundiced one that prevailed in legal circles and that drove the preoccupation with legal due process for refusers was not wholly lacking. The subsequent overruling of the panel decision in the *Charters* case<sup>165</sup> by the full Court of Appeals furnished an early opportunity for those among the judiciary so informed to articulate a much more benign (and by all measures an historically/medically more accurate) view of psychiatric medications and their uses. The view moved the Court to empower physicians to dispense the medications on their own accord in the context of a “legally” incompetent institutionalized patient who refused to be “helped” (as the government doctor put it and the Court implicitly seconded). Two years later in *Washington v. Harper*<sup>166</sup> the U.S. Supreme Court followed suit with a similarly tenored ruling in a prison case.

In both cases the preceding rulings—that of the Fourth Circuit Court of Appeals’ three-judge panel in *Charters* and that of the Washington Supreme Court in *Harper*--had prescribed the maximum possible process: judicial competency-to-make-medical-decisions hearings for every refuser whom the doctors wanted to medicate over his/her resistance, and a second trial on whether in fact to medicate for *incompetent* refusers (while the “competent” refuser would remain unmedicated until he/she had a change of mind or decompensated to such a state that the need for a new competency trial was evident to everyone). The overruling courts saw no need for anything like that amount of legal protection.

The full Circuit Court in *Charters* admitted that, given the individual liberty interest at stake in treatment refusals, there might be “instinctive appeal to the notion that only a panoply of . . . complex and multilayered . . . procedural protections is adequate to protect it.”<sup>167</sup> But it ultimately rejected the “two-stage plenary judicial” process prescribed below as needlessly “complicated.”<sup>168</sup> Its reasons were several.

First, the full Court disagreed with the panel’s assessment of the costs and benefits of the medications at issue, alluding to the fact that a “much less drastic appraisal of the risk-potential” than the excessively “vivid” and “pessimistic” description given by the panel was possible and appropriate.<sup>169</sup> Second, the full Court felt the panel had ignored the professional judgment principles of *Parham v. J.R.*<sup>170</sup> and *Youngberg v. Romeo*<sup>171</sup> under which “base-line”<sup>172</sup> medical decisions are made by medical personnel, subject to judicial review for whether they are indeed professional (made by appropriately credentialed persons and non-arbitrary). Instead, the panel decision had made the judiciary the base-line decisionmakers—creating a regime which, as the Court said, “collaps[es] their normal review functions into this threshold function . . . [and relegates the role of institutional treating doctors to that of] expert witnesses defending their decisions in judicial proceedings.”<sup>173</sup> To put it in the language of Fourteenth Amendment litigation, the holding of the panel essentially granted pre-deprivation judicial review in a context where post-deprivation relief is the norm or, as the full Court must implicitly have judged, a context where the post-deprivation mode is the only *realistic* mode given the costs in use of court resources and the diversion of medical resources of the alternative, not to mention the costs of treatment delayed/denied for those who medically need it.

Finally, the full Court in *Charters* rejected the notion that the patient's competency to refuse to be treated--his so-called medical competence--was an open issue in the context of an accused institutionalized because incompetent to stand trial (legally incompetent). The idea that these two competencies could/should be materially different the Court found implausible both practically and theoretically. It presumed, the Court said, a differentiation between the two mental states "of such subtlety and complexity as to tax perception by the most skilled medical or psychiatric professionals."<sup>174</sup> Treating the two competencies as separate issues further posed the "threat" of producing "wholly inconsistent or highly anomalous adjudications"<sup>175</sup> of the same controversy, in turn casting doubt on the "integrity and trustworthiness of the courts' already perilous involvement... in the adjudication of complex states of mental pathology."<sup>176</sup> Like consideration of the possible side-effects of medication prescribed, the patient's competence to make an informed judgment was to be treated "as simply another factor in the ultimate medical decision" on whether to go forward and treat over the patient's objection.

In sum, the decision in *Charters II* could not be more different in tone and outcome than *Charters I* or its "progenitors."

In *Washington v. Harper*<sup>177</sup> the U.S. Supreme Court took up the distinct issue of whether mentally ill individuals incarcerated *in prisons* had a right to refuse the medication treatments prison doctors wished to have them take. The majority had no trouble deciding that such a right existed (or survived) for inmates in the prison setting,<sup>178</sup> yet it was decidedly conservative in the procedural protections it felt to be required to safeguard the right. Squarely against the two-hearing plenary judicial model prescribed by Washington's highest court, it approved the administrative review mechanism used at Washington's Special Offender Center, the state's correctional treatment facility. While not without substantial protections for the inmate, that review process had the virtue of being capable of finalization within a day or two of the original treatment recommendation—*i.e.*, essentially without delay and the bad medical and institutional effects of that.

Going by the designation of "Policy 600.30",<sup>179</sup> the Washington process permitted involuntary medication of a prisoner upon approval of the treating psychiatrist's decision to do so by a special committee consisting of another psychiatrist, a psychologist and the facility's Associate Superintendent<sup>180</sup> in a hearing where the inmate could fully and openly contest the issue (given provisions for appropriate notice, the right to be present at the hearing, to cross-examine staff, to present his own witnesses, and to the assistance of at least an independent, knowledgeable lay advisor).<sup>181</sup> In finding the process constitutionally adequate, the Court thus held that independent<sup>182</sup> pre-deprivation medical/administrative review was all that due process in this context required. There was no need for this cumbersome first-instance, two-stage judicial vetting with its opening focus on the prisoner's ("medical") competency—in fact, the issue of treatment decision-making competency was summarily dismissed by the Court as "in no way responsive to the government's legitimate interest" in this situation.<sup>183</sup> As to substantive

criteria, the Policy required a finding that the prisoner suffer from a mental disorder (*i.e.*, medical need), and that he be either gravely disabled or pose a threat of serious harm to self, others or property (the dangerousness component common to the vast majority of commitment statutes)—standards the Court also essentially approved.<sup>184</sup>

The reasoning of the Court's majority in *Harper*—the type of arguments, facts, and precedents invoked to support the result—is telling (and furnishes as nice an example as any on the other side of the philosophical divide that the selection of these supports is driven by the outcome as much as the supports drive it). Unlike the classic right to refuse cases and their strings of self-referential citations to one another on that issue, the *Harper* precedents are drawn mostly from classic prison law, in particular cases that champion the principle of deference to expert decision making and the judicial review strictures this principle implies.<sup>185</sup> These precedents moreover show a federal deference to state control over its own housekeeping (or how it houses the kept, if you will) and fealty to the notion, made explicit here, that ordinarily the Due Process Clause confers no greater rights on prison inmates than those recognized under state law.

As to the specifics of the business of dispensing drugs in prison, the Court's posture toward this "medical matter" (including the fact that it so classified it, as it did) could not differ more from the suspicious to hostile mode that dominates so much of the earlier legal cases and commentary. Are the antipsychotics mind-altering? Yes, the Court said, but in the positive sense that they "alter the chemical balance in a patient's brain" with the intended result of producing "beneficial" changes.<sup>186</sup> Are there risks? Yes, but instead of citing a 50%-plus incidence of Tardive Dyskinesia the Court maintained that a "fair reading of the evidence" suggests its occurrence is more in the 10%-20% range, with 60% of that percentage being "mild" cases having "minimal effect."<sup>187</sup> Finally, if protections are needed for prisoner patients, the idea that (in these medical matters) they are best furnished through adversary judicial proceedings is "more illusory than real."<sup>188</sup>

When it comes to the uses of the drugs by prison doctors, the Court makes clear that "[u]nlike the dissent" (and the legal tradition the dissent draws on) it "will not assume that physicians will prescribe these drugs for reasons unrelated to the medical needs of the patients."<sup>189</sup> The posture is one of belief in medical good faith. Doctors don't abuse the dispensation of drugs because, as the Court puts it simply and directly, "the ethics of the medical profession are to the contrary."<sup>190</sup> Their institutional "purpose is not to warehouse the mentally-ill, but to diagnose and treat."<sup>191</sup> The operating mind-set here is distinctly of the sanguine kind, diametrically opposite to the judicial attitude on display in, say, *Davis v. Hubbard* or *Rogers v. Commissioner*. And this despite the reality that in the prison context (as the dissent by Justice Stevens tries to suggest in behalf of its prescription of an exponentially stronger dose of process)<sup>192</sup> the temptation to deviate from the patient population's medical interests in favor of, or to mix them with, management, security or punitive considerations would seem to be inherently stronger than in the civil hospital.

Important commonalities notwithstanding, there is at the same time significant contrast to be found between the Fourth Circuit Court of Appeals' holding in *Charters II* and the

U.S. Supreme Court's decision in *Harper*. *Harper* prescribes (sustains) a fair amount of procedural process (*i.e.*, mandatory pre-deprivation review, even if of the administrative/medical kind rather than judicial) and of course substantive constraints (proof of medical need *plus* dangerousness);<sup>193</sup> *Charters* II prescribes none of either (the treating doctor has final authority and medical propriety inferentially is the only standard). The explanation appears to lie in the parenthetical "sustains" we used above to characterize the *Harper* holding; not in the differences between the types of institutions housing the petitioners (prison vs. "forensic" hospital) or the differences in legal status between them (convicted offender vs. accused detainee), though there is an argument to be made—and we will make it later—that these differences matter as well, and should tend in the same direction, process-wise.

By happenstance (we know of no deliberate planning) the U.S. Supreme Court in *Harper* was operating in the context of an elaborate state-created review mechanism, which it saw fit to approve as constitutionally sufficient. The *Harper* mechanism thereupon came to be seen as a safe and sound model for correctional departments around the country, many of which in short order adopted its features either intact or with some local variations. The *Charters* Court by contrast was given a barren record, the doctors at Butner having no internal paper procedure to follow but apparently in practice, it being both safe and easy, going for approval of their decisions to the federal district court, where the review was by a professional judgment standard that avoided complications of patient competency, substituted (patient) judgment or least restrictive alternative inquiries. The Court of Appeals displayed no urge to create the internal review machinery out of whole cloth. Nor for that matter did it mandate the judicial application process followed by the Butner doctors. To the contrary, it rejected this approach because, as it made clear, it did not think it appropriate to have judges play such a base-line decision-making role.

That happenstance ultimately limited the utility and shelf-life of *Charters* (as even many doctors will support oversight mechanisms that are medically controlled and efficient and that give the resisting patient some recourse), while *Harper*, which provided both, became the next great precedent.

#### **V. *Zinerman*<sup>194</sup>, *Riggins*<sup>195</sup> and *Sell*<sup>196</sup>: The Supreme Court Retreats?**

In our 1991 article we wrote that the *Harper* decision notwithstanding, "it can hardly be concluded that the medical side has won the battle of what process best serves the treatment interests of mental patients."<sup>197</sup> This assessment has proved accurate. While there have been both legislative and judicially-fostered gains since *Harper*, a certain amount of backsliding to the anti-drug posture and rhetoric of earlier years, including imposition of accompanying legal restrictions on the authority of (state) physicians, has simultaneously occurred. Surprisingly, given its relatively pro-government/pro-doctor record on matters involving medical authority (exemplified by the *Harper* judgment as well as any), the U.S. Supreme Court has aided and abetted this latter development via a short series of decisions on treatment refusal rights in varying legal contexts. Examining

these decisions leaves a sense that the Court was not purposefully steering this reversal of direction, but that it drifted there in response to dominant alternate issues raised in the litigation before it, which threw off the Court's jurisprudential compass.

The *Zinermon* case<sup>198</sup>, decided virtually simultaneous with *Harper* in 1990, had been (foot)noted in our article with an assessment that it threatened the very "capacity of the states to provide treatment for mentally ill persons."<sup>199</sup> Based on an action brought by a disgruntled Florida patient who had been rescued from the streets and successfully treated as a voluntary patient (but who argued that he was wronged because he did not have the legal capacity to admit himself, as he had),<sup>200</sup> the Court's decision essentially prescribed pre-admission competency hearings for all future patients willing to sign themselves into a mental facility for treatment.<sup>201</sup> A competency to *assent* case then, as opposed to refuse, *Zinermon* had the ironic potential of putting *doctors* in the position of having to be treatment refusers for needing and willing patients or, alternatively, requiring them to act as the less than willing initiators of involuntary treatment proceedings, whose cumbersomeness and costs were compounded by the stark reality that in many situations they would not "work" because the patient did not meet statutory involuntary treatment criteria.

In the months following the *Zinermon* decision state mental health systems around the country, aided by professional organizations such as the American Psychiatric Association, worked to mute the case's impact by devising quick and easy screening procedures (medically controlled; low competency standard) that would respond to the Court's mandate at minimum cost. These efforts were successful and ultimately proved wrong the direr assessments regarding the case's potential to destroy mental health services as we then knew it.<sup>202</sup> Thanks to a unique combination concerted mobilization and timely reaction, the predicted admission disaster did not materialize. But the experience showed that the High Court, preoccupied with the competency and pre- and post-deprivation issues in which the *Zinermon* case came framed, and with scant attention to the larger need-for-treatment issues and systemic implications, could be diverted from the salutary course it had historically chosen to navigate.

*Riggins v. Nevada*,<sup>203</sup> decided two years after *Harper* and *Zinermon*, is a case that is more difficult to interpret than its 1990 predecessors in that it seems to give out signals for which the word "mixed" is underdescriptive at best. It has in fact been interpreted in widely varying ways,<sup>204</sup> but in the overall it is from the medical perspective a step back rather than forward.

The case involved a capital defendant charged with robbery-murder who, while detained in jail prior to trial, initially asked for medication to overcome his sleeping difficulties and to quiet the voices he said he was hearing in his head. He was given Mellaril (thioridazine) because, as he told the psychiatrist contracted to treat the jail's detainees, he had been successfully treated with that drug before.<sup>205</sup> Three months into his detention his attorney moved for a determination of his competence to stand trial.<sup>206</sup> He was found competent while taking the medication and preparations for his trial went forward.<sup>207</sup> Six months later, however, as the trial date approached, the defense moved for a court order

to suspend administration of the medications until the end of the trial.<sup>208</sup> The county court denied this motion and the defendant continued to be medicated on what was at least technically an “involuntary” basis throughout the trial, proceedings in which he presented an insanity defense and personally testified. He was found guilty and sentenced to death by the jury that convicted him.<sup>209</sup>

On (direct) appeal of his conviction and sentence to the Nevada Supreme Court, the defendant claimed, *i.a.*, that the forced administration of medication had “prejudicially affected his attitude, appearance, and demeanor at trial”,<sup>210</sup> thereby inhibiting him in his ability to assist in his own defense and denying him a fair trial. The Nevada Supreme Court did not buy his arguments and affirmed his conviction and sentence,<sup>211</sup> which led to a request to the U.S. Supreme Court to review the matter. The Court granted the petition and, in a decision whose majority opinion was written by Justice O’Connor, reversed the Nevada Supreme Court’s judgment (and thus the conviction and sentence) because “the Nevada courts failed to make sufficient findings to support [the defendant’s forcible medication].”<sup>212</sup> The decision contains several key subsidiary points/speculations elaborating on the reversal, but where they lead or were meant to lead is difficult to tell.

Though *Riggins* involved a jailed detainee and not a convicted prisoner as in *Harper*, the Court applied the *Harper* analysis<sup>213</sup> (inappropriately, according to the dissent)<sup>214</sup> and began by reiterating that a due process clause-protected liberty interest was at stake here, citing well-settled precedent that unconvicted jail detainees “retain at least those constitutional rights...enjoyed by convicted prisoners.”<sup>215</sup> Due process being flexible, however, this did not answer what should be or should have been done to lawfully medicate someone in *Riggins*’ position. The primary problem with the way Nevada had operated was, as the Court saw it, that all along the way the judgments made were essentially unsupported—no adequate justifications were established (or even offered) for why the defendant’s wishes could or should be overridden. Having made that point in the opinion’s second sentence (“failed to make findings sufficient to support...;”<sup>216</sup> allowed continued medication “without *any* determination of the need...or *any* findings about reasonable alternatives”),<sup>217</sup> the Court went on to set out two distinct standards that *would* have satisfied due process had the state actors chosen to try to meet them.

The first standard is emphatic: “Nevada certainly would have satisfied due process if the prosecution had demonstrated and the District Court had found that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for *Riggins*’ own safety or the safety of others.”<sup>218</sup> Not only does the *Harper* analysis apply; this is the *Harper* standard. The question is, is it an appropriate standard? Our answer would be: possibly appropriate, but incomplete. Jails and prisons are institutions that share many, if not all, security concerns implicated in housing criminal offender populations. It is why the courts have permitted detainee rights’ curtailments in jails essentially duplicative of those allowed/necessitated for convicted felons in prisons.<sup>219</sup> But when we are dealing with a pre-trial detainee whose competency to be tried is at issue, additional interests present themselves; interests that would presumably be invoked especially where the dangerousness standard is not met.

Evidently aware of this, Justice O'Connor presented a second option, though in slightly less certain terms ("the State *might* [also] have been able to justify..."),<sup>220</sup> requiring that the prosecution establish medical propriety plus a criterion directly related to the reason *Riggins*-style defendants are where they are and to what purpose they are kept: "that it could not obtain an adjudication of *Riggins*' guilt or innocence" any other way. As she had in articulating the first standard, Justice O'Connor employed formal least restrictive alternative language as a qualifier ("could not obtain an adjudication...by using less intrusive means").<sup>221</sup> However, the significance of that is unclear given that the Court ultimately resisted the doctrinal implications of that language (such as the application of a "strict scrutiny" review standard), a fact Justice Thomas took unfavorable note of in his dissent.<sup>222</sup> What is significant is that this was clearly a different standard than *Harper*'s: one that had no bearing on convicted prisoners or for that matter prison doctors but was specifically tailored to a pre-trial population.

How difficult would it have been for Nevada to meet either of these standards? Or how much trouble would *Riggins*' either-or formula cause physicians in any other county jail or special forensic facility housing offenders before trial, whether run by corrections or mental health? An initial on-the-face-of-it assessment would suggest: not very much.

Establishing medical propriety should be easy-to-automatic given the courts' deference to this quintessential medical judgment, uncontaminated as it is in isolation, separated from judgments that have arguable social components, such as whether the treatment should be forced upon the patient *given* medical need. That is when other factors and values might come into play; when context becomes relevant. But second-guessing professional, medical judgments is not the courts' business and, as before, in those cases where such judgment is reviewed it is limited to evaluating assertions that it was *unprofessional*.<sup>223</sup>

The second criterion in both standards veers away from pure medical propriety, though by no means totally. In *Riggins*' *Harper*-style formulation the second criterion is dangerousness which is assessed by a mix of medical and security considerations. It should not be difficult to establish in prisons, as the courts also defer substantially to correctional expertise, particularly on security issues. They do also, and as much as, to jail administration expertise, for the same reasons. So the *Riggins* context should not change anything in this respect. One could speculate about the number or percentages of mentally ill pre-trial detainees who would meet the second criterion. Arguably, it would be comparable to the numbers or percentages in prisons given the comparability in populations. On the other hand, those in special forensic units might be there more for treatment needs than security risk, so fewer would be dangerous. The answer is not important. The point is that *some* detainees who need treatment, whatever their numbers, will fail the *Harper* standard but should, at least from the State's perspective, be treated.

This is where *Riggins*' new standard comes into play: the alternate standard of medicating the detainee because that is the only way to achieve a recovery of (or to maintain) trial competence. How hard will it be for the State to prove this? We would submit that it, too, should be easy—easier perhaps even than *Harper*-style dangerousness. The reason is that medicating for competency is both theoretically and pragmatically

speaking essentially indistinguishable from doing it on medical need/propriety. Pursuing the objective of achieving/maintaining trial competence is and should be no different than that of regaining or maintaining mental health. Those who have argued otherwise, whether in the pre-trial context or at the post-conviction sentencing or execution-of-sentence phase (capital cases in particular, where there is talk of treating to relieve suffering but stopping short of restoring to competence),<sup>224</sup> are pursuing a different agenda, have a different social-legal bone to pick. The fact is that we send incompetent defendants to mental health treatment facilities, rather than to schools where the rudiments of the trial process are taught. We send them to the jail psychiatrist for the same reason—to be treated, not to be instructed in the law. They are sent because they are sick. The institutions and professionals who staff these institutions are trained and in the business of treating sick people, not of affecting legal restoration.<sup>225</sup>

To put it another way, the idea that there is a right to be crazy in free society is precarious enough, subject to curbs by the State based on its *parens patriae* and police powers. That such a tenuous right survives for incompetent persons in institutions of detention with compelling security concerns and the treatment obligations of total institutions (*Estelle v. Gamble*)<sup>226</sup>, and with the added, specific responsibility of readying or keeping their charges ready for trial, is an even longer stretch. Or, if one is inclined to make the stretch—and assert that there is a (nominal) right to refuse in this context—it should be with the acknowledgement that the right cannot come protected by a heavy, in effect treatment-stifling, dose of (procedural or substantive) due process.

In sum, *Riggins* should not complicate matters much for physicians in special forensic detention facilities or in jails where some reasonable semblance of mental health treatment is provided. Other than to give incompetent defendants a new, just-before-trial, opportunity to challenge their treatment regimen, the interests/stakes are (and outcomes, in cases of formal contest, should be) the same as before. This prognosis, however, appears to be off the mark. Whether because courts and lawyer advocates have not appreciated the above analysis, or do not agree with it, or for some other reason, the fact is that the post-*Riggins* jurisprudence has become contaminated by issues such as the relative importance of the need to *try* the defendant rather than the need to treat, as we shall see. First, however, we turn to some other ways in which *Riggins* has proved regressive.

At least some of the problem with *Riggins* lies in the subtext, which has provided ammunition to those who wish to adhere to the old and inaccurate view that medicating a person with antipsychotics produces in him or her a “synthetic” sanity (or competency). The resulting state, it is said, is not “real.” In fact it may be worse than that in that it comes at the price of obscuring the person as he or she “normally” is, behaves, reacts, interacts and so on. The charge is that it dehumanizes the person and in the case of criminal offenders robs them of such defense-friendly assets as the capacity to show empathy or, where an insanity defense is on the line, the opportunity to exhibit craziness. Perhaps in part because the defendant in *Riggins* was overmedicated (in response to his continuing symptom complaints), the case is full of language that nurtures this sort of old-school speculation.

In reversing the verdict against Riggins—not a small step in a capital murder case fully reviewed by the state’s judicial machinery--the U.S. Supreme Court assumed there was a substantial probability that his trial was adversely prejudiced by his being on medication.<sup>227</sup> Having set the bar high, the Court then had to clear it, which it did by reciting a litany of possible effects of the drug on Riggins’ demeanor and appearance. In the space of a page, three paragraphs, Justice O’Connor lists a whole range of negative possibilities (some of which were speculated about at the trial, others not): “could make him ‘uptight’”; “might suffer from drowsiness or confusion”; “clearly possible that such side effects impacted not just [his] outward appearance, but also the content of his testimony . . ., his ability to follow the proceedings, or the substance of his communication with counsel”; “[expert testimony about the potential effects of the medication] did nothing to cure the possibility that the substance of his own testimony, his interaction with counsel, or his comprehension at trial were compromised”; and so on.<sup>228</sup> All of which, the Court added, likely “impaired [Riggins’] constitutionally protected trial rights.” The impact of this language was nothing less than to give renewed credence to the notion that the drugs are, if not hazardous *per se*, typically productive of serious side-effects that often overwhelm the primary effect, which as a chemical artifice is more likely negative for legal competency than restorative in any case. That over against these speculative risks stands the proven fact that, untreated, the defendant is incompetent the Court seems to have lost sight of.

A concurring opinion by Justice Kennedy was even more damaging. Emphasizing the dangerous side-effects of the drugs, Justice Kennedy wrote to express his conclusion that “absent an extraordinary showing by the State, the Due Process Clause prohibits prosecuting officials from administering involuntary doses of antipsychotic medicines for purposes of rendering the accused competent for trial in most cases, given our present understanding of the properties of these drugs.”<sup>229</sup> It is language that not only resurrects the negative view of antipsychotics in all its force, but suggests in addition a need to weigh the State’s interest—and apparently only an “extraordinary” interest will do--in prosecuting a case against the presumably competing private interests of the patient, a difficult and diversionary inquiry into a false dichotomy that has spelled all kinds of trouble in later cases (see discussion below). The whole thing smacks of old-fashioned psychiatry bashing, a fact reinforced by Justice Kennedy’s reference to “prosecuting officials”<sup>230</sup> as the ones who need to be prohibited from administering the medications, as if the doctors who work in government facilities are mere stand-ins for the prosecutors who to all intents and purposes are calling the “shots” (recall the similarly inappropriate implication in *Bee v. Greaves*).<sup>231</sup>

That *Riggins* thus caused some backsliding in the form of subsequent court decisions insufficiently deferential to medical judgment in a variety of legal contexts is not surprising. As for the specific authority to treat/restore the incompetent-to-stand-trial defendant, the denouement of that issue came only recently in the case of *Sell v. United States*<sup>232</sup> decided by the U.S. Supreme Court in 2003. It is a decision that shows the Court’s thinking continues to be freighted with *Riggins*’ heavy anti-medication baggage.

The accused in *Sell* was a once practicing dentist with a “long and unfortunate history of mental illness”<sup>233</sup> which, whatever its relevance to the criminal behavior at issue (insurance, mail and Medicaid fraud),<sup>234</sup> clearly affected the accused’s capacity to deal with the aftermath of being caught and charged. He went on a retaliatory bender which included trying to intimidate one witness in the case against him as well as attempts to murder two other witnesses—a former employee who had relevant knowledge and the FBI agent who had arrested him.<sup>235</sup> During various pre-trial proceedings moreover Sell was “totally out of control”, as he engaged in “screaming and shouting”, throwing out “personal insults and racial epithets”, and in at least one instance spitting in the arraiging judge’s face.<sup>236</sup> Based on the evident doubts this behavior raised about his competency to proceed, a formal inquiry was held and Sell was found incompetent. He was sent to the United States Medical Center for Federal Prisoners in Springfield, Missouri, where the staff recommended that he be put on antipsychotic medication. But he refused, which landed the case in the courts.

In fact, the question of whether Sell could be medicated against his will went through five “hierarchically ordered lower court and Medical Center determinations,”<sup>237</sup> the initial treatment staff recommendation followed by two medical/administrative intra-institutional reviews and three judicial hearings from the Federal Magistrate to the District Court and Circuit Court of Appeals, before the U.S. Supreme Court took the sixth (and still not final—given that the case was remanded) pass at the issue. Each of the decisions below was that the medication could be administered over Sell’s objections, but each posted somewhat differing rationales from the others based on different factual assumptions (mostly about the accused’s dangerousness and dependent less on which of his particular charges were emphasized than on whether dangerousness went to his behavior within the institutional environment or outside).<sup>238</sup> At one point even new factual evidence came into play (of the accused’s not-so-innocent “boundary violations” with a female nurse at the Medical Center).<sup>239</sup> The machinations in the case were so strange that the Supreme Court had the case before it on the stipulation (based on the last reviewing court’s conclusion) that Sell was not dangerous to others, a conclusion the Court itself saw the need to brand as “contrary” to the record.<sup>240</sup> However, the Court also added to this mischaracterization (or at least to the confusion) when Justice Breyer opened the majority opinion with the statement that the question was about the accused’s restoration to competency to stand trial for “serious, but nonviolent crimes.”<sup>241</sup> Attempted murder, two attempts in fact, may be nonviolent in the sense that ultimately the violence did not materialize, but not in any other sense, including common. There is no question the High Court was forced to *assume* Sell’s non-dangerousness in the face of a contrary record; it is less clear whether or not the depiction of the offenses as nonviolent is hypothetically-based as well--forced by the limits of the lower courts’ focus on the fraud charges--as opposed to the Court’s own assessment.

In any event, the rule that came out of the Supreme Court’s decision in *Sell* was a conscious and explicit combination of the *Harper* and *Riggins* standards. It held that involuntary medication of a “mentally ill defendant facing serious criminal charges” is permitted

“but only if the treatment is medically appropriate, substantially

unlikely to have side effects that may undermine the fairness of the trial, [and] taking account of less intrusive alternatives, necessary significantly to further important governmental trial-related interests.”<sup>242</sup>

The *Riggins* legacy is pronounced here, particularly in the reference to bad side effects and the need to take into account less restrictive or intrusive alternatives (whatever these may be in the real world, as distinct from the world of doctrinal make-believe). It is not a message that comports well with the properties of the modern drugs or the alternatives for that matter.

As for the importance of the governmental interests in obtaining an adjudication, the “trial-related interests,” one would think, in fact there is no question but that, they are weighed earlier in the process and are what put the defendant in his current situation, in the institution, in the first place. The fact that he is there means that (1) the court and the parties have deemed the case important enough to lead to a formal inquiry into competency and (2) the government (the court and prosecution), once the (in)competency decision was rendered, saw the case as significant enough to commit the accused for restoration (few if any minor felons or misdemeanants are hospitalized in the hope that they will be restored so that they can then be prosecuted). Why the matter must be litigated again is difficult to comprehend. The prerequisite in the formula, the preamble to it, that the defendant face “serious charges” only adds to the redundancy; it means that the already duplicative assessment of trial-related interests called for in the formula’s body is ultimately a triplicate rendering of the same.

Finally, the opinion eviscerates its own mandate by suggesting its standards are likely to be rarely met<sup>243</sup> and that institutional physicians should as much as possible use other, more traditional, standards for doing what they want to do<sup>244</sup>—which are characterized as “more objective and manageable”<sup>245</sup> than determining whether the defendant ought to and/or will be rendered competent. The court here is referring to alternative *legal* rationales such as premising the recommendation to medicate on the defendant’s dangerousness to others and the prognosis that he will thus be rendered nondangerous (*Harper*) or on dangerousness to self (one of the traditional civil commitment justifications). The Court even suggests the possibility of using a best-(medical)-interests-of-the-patient standard as applied in guardianships to justify administering unwanted medication,<sup>246</sup> but how that is different from how physicians decide and what they do when treating to restore is not clear. It *isn’t* different of course, except from that twisted perspective articulated by Justice Kennedy in *Riggins* that sees institutional physicians acting as mere stand-ins for the prosecutor who is the real needle-wielder, unknowing and uncaring of the medical needs/interests of the patient.

It is hard to think of instructions less edifying to doctors in treatment institutions than that they should substitute for their clinical judgment a decision-making process based on a professionally foreign, not to say unprofessional, quasi-legal calculus. This is not progress in any sense of the word—legal or medical—and in the end one can trace the roots of *Sell*’s misdirectedness to the old misgivings dug up in *Riggins* about whether drugs can “really” make people better, saner and more competent.

One of the mysteries of *Sell* is why there is no reference in the majority opinion to the administrative regulation in place, and in fact used by the Center, for deciding when medications can be administered to a federal prisoner or detainee. The Federal Bureau of Prisons (“BOP”) in 1992 put forth Rule 57 Fed. Reg. 53,829, Administrative Safeguards for Psychiatric Treatment and Medication<sup>247</sup>, precisely to deal with defendants in the position of *Sell* and other inmates in federal treatment facilities. The regulation sets out both substantive criteria and procedural requirements for the lawful, forcible medication of federal prisoners or detainees who refuse to comply voluntarily with the treatment prescribed for them.

The BOP rule’s procedural mandates are closely modeled on the *Harper* administrative/medical review mechanism that originated at the state level (Washington) but was in effect “constitutionalized”/nationalized when the U.S. Supreme Court approved it as at least minimally sufficient, in the case in which it was challenged.<sup>248</sup> The BOP rule posits that in cases where an inmate cannot or will not voluntarily consent to the treatment prescribed for him, he is entitled on 24-hour notice to a hearing before a psychiatrist “not involved in the diagnosis or treatment of the inmate.”<sup>249</sup> If the reviewing psychiatrist’s decision supports the treatment staff, the inmate can appeal within 24 hours to the “institution mental health division administrator” who in turn has 24 hours to render his decision.<sup>250</sup> Unless emergency circumstances dictate the contrary, no medication shall be administered prior to that final administrative decision. As the *Harper* Court intimated (and we have registered our agreement earlier), such administrative/medical decision making and review are adequately protective of the inmates’ interests while at the same time not unduly burdensome to institutional treating staff nor ultimately self-defeating for inmates who, despite their resistance, could in fact use psychiatric help.

Also arresting is that the majority in *Sell* addressed its legal prescriptions to “a court.”<sup>251</sup> The problem with that is in the routine run of things there is no, need be no, court to make a binding treatment decision. In fact, the BOP rule as written specifically addresses the substantive criteria to be used in deciding (see paragraph below) to the *reviewing psychiatrist* as the relevant decision maker<sup>252</sup> and perforce implies that the inmate’s medication can lawfully begin on administrative authority alone. Justice Scalia’s dissent picks up on this point noting the majority’s tangentiality, so to speak, to the rule’s procedural schema. But it is only to make the technical point that the Supreme Court has no jurisdiction because there is no appealable final order or grounds for an interlocutory appeal and that the petitioner *Sell* has chosen a “mistaken litigation strategy.”<sup>253</sup> Beyond that, *Sell*’s procedural misdirectedness remains essentially unnoticed.

Of at least equal if not greater interest are the substantive standards prescribed by the BOP rule: *who* may be forcibly medicated in federal detention/corrections facilities *under what circumstances?* Here the regulators drew upon *Harper* as well, but also heeded *Charters* and *Riggins* because of the competency angle, while adding a novel factor that seems to derive from a mix of institutional security and (civil) treatment concerns. The rule states that forcible medication is authorized when it

“is necessary in order to make the inmate competent for trial or ...  
because the inmate is dangerous to self or others, is gravely  
disabled, or is unable to function in the open population.”<sup>254</sup>

Note that the regulation’s first-stated rationale, the competency restoration rationale, for medicating the inmate is succeeded by the *alternatives* (“or”) of doing it for the inmate’s dangerousness or inability to function in the facility. It suggests that the regulators continued to consider *Charters* a viable precedent in terms of substantive due process: assuming medical propriety (as *Charters* does), restoring a defendant is an independently sufficient reason for medicating him and requires no further proof of things such as dangerousness or grave disability (functional or otherwise), much less gauging the government’s interest in prosecuting the case or requiring the deliberate “shooting down” of every conceivable less restrictive alternative to administering medication (including unreasonable ones). The alternative grounds of risk to self or others, in or apart from the general inmate population, are there in case the matter presents itself primarily as such, but they need not be invoked to obtain the requisite medical authority to treat. Had the attention of the Supreme Court’s majority been focused on the BOP regulators’ judgment, presumably entitled to some substantial deference, who knows how *Sell* would have been decided? And who knows how much more of a *medically rational* regime would have been constructed for dealing with mentally ill incompetent patients committed for treatment/restoration?

Not only was *Sell* decided in a regulatory vacuum despite the existence of pertinent regulation, apart from invocations of *Harper* and *Riggins* there was, despite the existence of several post-*Harper/Riggins* decisions of note, no reference to case-law precedent either. The Court’s consideration of these cases would likely have been illuminating as well and perhaps, as with the neglected regulation, might have materially affected the outcome.

*United States v. Brandon*<sup>255</sup> is a 1998 decision by the 6<sup>th</sup> Circuit Court of Appeals that has relevance, even if from our perspective it sets a bad precedent. The case concerned a *non-dangerous*<sup>256</sup> federal detainee whom institutional personnel sought to medicate over his objections under the BOP procedures. Overruling the judgment of the trial court that the administrative review process prescribed in the BOP regulation was adequately protective of the inmate’s interests, the Circuit Court held that what was required in the absence of either proof of dangerousness or a medical emergency was a *judicial* hearing on the evidence.<sup>257</sup> At this hearing the government would, in the *Brandon* Court’s holding, have the burden of proving (by a clear and convincing standard) that the proposed treatment “is the least restrictive and least harmful means of satisfying the government’s goal...of rendering [the accused] competent to stand trial.”<sup>258</sup>

The *Brandon* opinion detailing the rationale for the decision is a throw-back to old-school judicial thinking about anti-psychotic medications. It identifies the inmate’s (private) interests as, *i.a.*, the First Amendment’s right to be free from government interference with one’s ability to communicate ideas (citing *Bee v. Greaves*) and the Sixth Amendment’s right to a fair trial and even to effective assistance of counsel<sup>259</sup> (as if these

interests are safeguarded by allowing a defendant to remain or be rendered incompetent). Much is made of Justice Kennedy's jaundiced *Riggins* view regarding the questionable remedial properties of the medications and their potential to prejudice the accused's trial rights<sup>260</sup>—perceptions that drove the *Brandon* Court to its prescription of a strict scrutiny standard of judicial review as well as its requirement that the government prove its case by a clear and convincing standard (see language in above paragraph). After all, the decision to medicate in cases where imminent danger is absent was in the Court's view a legal rather than medical one<sup>261</sup> (how it is so transformed is a mystery, the patient being no less sick or incompetent when "nondangerous" and the facility where he is housed no less of a hospital), while an extra margin of protection was felt to be in order where the risk of error was substantial, given the prospects of harm to both trial rights (the *Riggins* legacy) and to medical well-being (the old bad side-effects bugaboo).

Finally, by having the decision mandating all this *extra* process (over and above the BOP regulation's prescriptions) hinge on the patient's non-dangerousness, the *Brandon* Court impliedly held that dangerousness *was* a necessary element of proof before the government could medicate in accordance with the BOP regulations, the facial sufficiency of the restoration goal by itself notwithstanding. As late as 1998 then, at least in the 6<sup>th</sup> federal Circuit, we were back to a regime of judicial dominance over medical/administrative discretion every bit as total as that which was first arrogated by judges in the civil commitment cases of twenty-some years ago. As for the government's (the public) interest in prosecuting crime or in the patient's being treated, that would simply have to take a back-seat to the ostensibly "private" interest of the patient to remain or render himself incompetent. The empirical fact that restoration can be safely and readily achieved in a substantial majority of incompetency cases,<sup>262</sup> or that restoration serves substantial private interests as well (the patient's not inconsequential medical well-being), can/must apparently be ignored.

The *Brandon* case came in the midst of a confusion of precedents perseverating about strict scrutiny versus reasonable interest balancing, whose outcomes ironically were not determined by the choice made between the two. Its most noteworthy exemplar, decided before the BOP regulation was promulgated, and cited in *Brandon*, is an impassioned but equally anachronistic (as *Brandon*) dissent to a District of Columbia Court of Appeals majority decision not to rehear a case in which the government's doctors had been given the go-ahead to medicate based on a *Charters/Harper* procedure (*Khiem v. United States*).<sup>263</sup> None of this gave confidence that institutional doctors would soon be allowed to make medical decisions made on medical criteria.

A year after *Brandon*, however, in the 4<sup>th</sup> Appellate Circuit—where *Charters* was decided—*United States v. Morgan*<sup>264</sup> yielded a very different line of reasoning in a case where the incompetent patient *was* dangerous (though his attorney intimated that the designation was a sham perpetrated by doctors who wanted to medicate and avoid laborious process).<sup>265</sup> Operating from the perspective that *Charters* was still viable,<sup>266</sup> the *Morgan* Court held that the BOP regulation's protections were more than adequate in this context. Indeed, the Court seemed to doubt that *Harper* had changed anything since *Charters* either procedurally or substantively when it came to treating an incompetent

patient, whose legal status (*i.e.*, reason for being institutionalized) was materially different from that of a prisoner.<sup>267</sup> As for the impact of *Riggins* on the adequacy of the BOP process and in particular the regulation's sufficiency for addressing the potential impact of the medication on the accused's demeanor, the *Morgan* Court brushed off this concern. The matter, it intimated, might be something for the trial judge to look into immediately preceding trial<sup>268</sup> but it should not influence the basic treatment regimen doctors wanted to use to make the patient medically better and per force enhance his legal competence.

In the 4<sup>th</sup> Circuit then, medical reason and legal sanity continued to prevail. Had the legal precedents been invoked in *Sell*, Justice Breyer might have been moved to borrow a page or two from *Morgan*. If so, we would have had a very different opinion and a very different standard for dealing with trial-incompetent treatment refusers—one much more in tune with the remedial properties of the medications and much better aligned with the forensic mental health system's goal/responsibility of treating and restoring the patients committed to its charges.

A random but intimate example of what is wrong with today's standard comes from the forensic practice of the first-listed author. It involves a deliberately failed bank robber (he wanted to get caught and be "safely" jailed so he would escape the CIA operatives who he thought were after him on the street). After a false start or two occasioned by the defense attorney's misunderstanding of the mental health facts and their implications (shared by the trial judge until the evidence became overwhelming), he was found incompetent to stand trial and sent to the Butner institution from where so many of the federal case law precedents come. As of the moment, he refuses to be medicated, but for irrational reasons (he thinks he is not sick and that his delusions are reality). And the Butner staff will not force him or try to obtain the administrative approval or court order that might allow them to, no doubt because they feel they cannot under the *Sell* standard (his crime is comparatively non-serious, he is non-aggressive in the institution and he has already done substantial time there). Without medication, however, the patient's legal restoration is a long shot and his personal well-being, not to mention his peace of mind, precarious given persisting delusions about government persecution mixed in with sexual paranoia involving cell-mates and family members. Of the so-called better and more manageable forcible treatment alternatives contemplated by *Sell*, civil commitment with the government dropping the charges may in theory be the most apt. But the process will take a long time and likely involve substantial legal maneuvering to get there, assuming we get there at all with a client/patient who shows few overt signs of dangerousness (risk of imminent violence to others or self). In short, the idea that the civil route for criminal trial-incompetent patients is preferable to what could be done directly, simply and quickly under a *Charters*-style standard or for that matter a *Morgan*-style interpretation of the BOP regulation fades rapidly in light of the clinical and legal "realities."

The most recent reported legal cases, in particular two from the 10<sup>th</sup> Circuit, bear out the same. *Sell* is all but unworkable. In *United States v. Morrison*<sup>269</sup> the Court of Appeals vacated a trial court order to medicate on grounds that it had failed to do Justice Breyer's preferred *Harper*/dangerousness analysis before reaching its conclusion. *United States v.*

*Bradley*<sup>270</sup> came next. While upholding the district court's order to medicate in that case, the Court got bogged down in standard of proof issues and the need to divide *Sell*'s tripartite standard between factual and legal issues. It wound up classifying the government's interest in trying the case as legal, the likelihood of restoration and medical necessity of the treatment as factual matters.<sup>271</sup> But how this will help the reviewing psychiatrist who under the BOP rule is to approve or disapprove the treating doctor's recommendation is anyone's guess.

There is also the case of Susan Lindauer, the former Congressional aide and journalist, accused of working with Iraqi intelligence prior to the start of the Iraq war. By most accounts she is a seriously ill person, mentally. A federal trial judge in Manhattan released her on bail however when he found she could not be medicated under the *Sell* standard on the ground that the government's interest in prosecuting her was not compelling and because he believed that even when medicated she might not be competent.<sup>272</sup>

Finally, there is the unedifying saga from Utah of the kidnapper defendants in the case of Elizabeth Smart, Wanda Barzee and Brian David. Both are institutionalized as mentally ill and incompetent to stand trial though the behavior of David suggests he may be faking. Attempts to medicate them are undergoing the sort of intense and diverting legal scrutiny that can be expected in the wake of *Sell*, with Barzee's case already argued to the Utah Supreme Court but nowhere near resolution.<sup>273</sup>

## VI. Legislative Process and Progress

Our discussion of *Sell v. United States* ends the case law description/analysis and per force the focus on the constitutional dimensions of the right to refuse treatment for patients and any corresponding authority on the part of doctors to override medically ill-advised patient resistance to treatment. Indeed, in our analysis of *Sell* we suggested that deference to existing non-judicially made rules—in this case an administrative (BOP) regulation—might have produced a “better” outcome than the one Justice Breyer devised based on constitutional case-law precedent. Progress in the legislative arena, unlike in regulatory law, is impossible for the courts to ignore and important for that reason as well as for what it says about the legislators' (the public's) grasp of the medical needs and realities.

We will report primarily on legislative developments in civil commitment, which cover, especially if one incorporates the somewhat incongruously-named but salutary concept of “outpatient commitment”, what is both theoretically and practically most important in the civil arena. Reports by groups favoring psychiatric intervention when needed such as the Treatment Advocacy Center (TAC)<sup>274</sup> suggest that in regard to inpatient commitment observable strides have been made nationally—*i.e.*, jurisdiction by jurisdiction—to impart a more medically-oriented/*parens patriae* perspective and, if not replace, to at least supplement the danger-to-others/police power focus of the earlier statutes. This has been accomplished via a revival of the need for treatment standard to suffice for commitment and an accompanying refocus of the legal lens on indicators such as

psychiatric treatment history, recent decompensation, deterioration or destabilization, or even mere risk of such—all of which avoid, conceptually, the implicit emergency/police power strictures that dominate the dangerousness formulation, and should help us move away in practice from the consequent futile pattern of repetitive one-at-a-time, typically post-crisis, interventions.

As for outpatient commitment statutes, the concept underlying them is not new, but they have over the past few years swept the country in terms of increased visibility and use.<sup>275</sup> The objective of these laws, at least partly met according to early studies,<sup>276</sup> is to ensure treatment for those who otherwise resist, avoid, stop, slip-through-the-cracks-of, and “recycle” through the mental health and criminal justice systems, to their own as well as their fellow citizens’ detriment. More, and especially earlier, treatment for more people who need it is the aspiration here, as is the continuation of treatment already begun given the proven benefits of adherence/compliance and the well-documented negatives associated with the interruption or cessation of the treatment regimen. The concept’s ancillary virtue, ignoring some unhappy commentary by uncompromising civil libertarians that it has “widened the net” and subjected more people to the coercive power of the State,<sup>277</sup> is that it is and has been correctly perceived by many as a lesser infringement on patients’ liberty than having the treatment need met by inpatient hospitalization (or the “police need” for segregation met by incarceration). In other words, it is a concept on which people of differing political/philosophical persuasion and orientation—*i.e.*, those on opposite sides of the traditional advocacy divide—should be able to agree.<sup>278</sup>

Finally, we will look at a key Americans With Disabilities Act (ADA) provision and its relevance to the provision of outpatient treatment services, as interpreted in the recent United States Supreme Court decision of *Olmstead v. L.C. ex rel. Zimring*.<sup>279</sup> The case is at best a side-light, but nevertheless of interest and perhaps importance in that it may signal a new appreciation of the medical realities on the part of several Justices not known to be so oriented previously.

#### **A. Increased Treatment Focus in Commitment Statutes**

Literature disseminated by the TAC group reports<sup>280</sup> that since 1990 the civil commitment statutes of at least 13 states have undergone revision in a way that advances the possibility of getting timely psychiatric treatment to an individual who needs it but resists for medically unsound and incompetent reasons (by incompetent we mean not necessarily that states’ legal definitions, but more the commonsense meaning of incompetence as irrationality).<sup>281</sup> While this certainly presents cause for optimism, we are at the same time concerned that the picture drawn is a bit too optimistic. The reason is that the count of states having made changes in the right direction comprises changes of different orders, some more significant than others.

#### **1. Persistence of Dangerousness as the Sole Commitment Criterion (and Four Deviations)**

The dominant characteristic of the “old” laws is the dominance of dangerousness as the standard for hospitalizing someone involuntarily. In fact, that was seen as the laws’ “beauty.”<sup>282</sup> There was danger to self as well as to others, with the emphasis on the latter, provable by threats or actions (preferably the latter) of varying degrees of overtness.<sup>283</sup> If danger to self was invoked it would have to be shown by evidence similarly drastic or explicit in terms of imminence and seriousness. Some states translated the danger-to-self requirement into a “gravely disabled” or similarly-worded standard or else posed it as an alternative ground for commitment.<sup>284</sup> But neither in intent nor in practice did these “alternate” standards deviate much from the preoccupation of having commitment be essentially a police operation—to intervene/commit only to squelch serious, imminent harm or to prevent additional harm where it had already been done.

This continues to be the pattern notwithstanding the reports of meaningful progress. When it comes to inpatient commitment (to be redundant for clarity’s sake) only four states have moved away from “dangerousness” according to our search: Wisconsin, Oklahoma, Iowa and Oregon.<sup>285</sup> The legislatures in these states have enacted a more medically-oriented need-for-treatment-style standard as a *sufficient alternate* ground for commitment. Legal change in all other states has been in the form of enacting medical standards for *involuntary outpatient treatment* only, or to permit *medically-focused evidence* as proof of dangerousness or of grave disability for purposes of inpatient commitment, but not as independent grounds. This is not to understate the significance of these latter changes in the absolute, but to point out that the kind of statutory change we would see as the biggest measure of progress is at this point far from universally endorsed.

Wisconsin’s civil commitment law today has what is locally called a “fifth standard”, enacted in 1995 after a long and contentious legislative battle.<sup>286</sup> The fifth standard designation stems from the fact that Wisconsin already had four other standards<sup>287</sup> for determining “committability” under the law, each one reflective of the traditional emergency-suggestive conceptualizations that ruled the civil-libertarian era during which they were enacted: “The individual is [mentally ill and] dangerous because he or she evidences”: (a) “substantial probability of physical harm to himself or herself as manifested by ... recent threats of or attempts at suicide or serious bodily harm”; (b) “substantial probability of physical harm to other individuals as manifested by evidence of recent homicidal or other violent behavior [etc.]”; (c) “impaired judgment, manifested by evidence of a pattern of recent acts or omissions, that there is a substantial probability of physical impairment or injury to himself or herself”; and (d) “behavior manifested by recent acts or omissions that ... he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety ... so that substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensue.”

The fifth standard, standard (e),<sup>288</sup> by contrast is not tied to the threshold dangerousness criterion. It provides that commitment may ensue if the individual proposed for it lacks capacity to understand his or her illness and to make rational treatment decisions, but “needs care or treatment to prevent further disability or deterioration.” The quoted phrase

is the key; unlike with the previous four standards, it stands independently of the dangerousness predicate. It is followed by a long qualifier describing further medical and social risks if the individual remains untreated, and even employs verbiage about “loss of cognitive and volitional control”<sup>289</sup> that seems to hearken somewhat unfortunately to criminal insanity, but none of this undermines the essential decoupling of committability from evidence of what we might call policeable harms. This is a medically-focused *parens patriae* standard, as opposed to emergency/police power standard.

Oklahoma, one of the three states besides Wisconsin which appears to have decoupled a medical commitment standard from dangerousness, has done it more simply and directly. It has today three independently sufficient criteria for civil commitment.<sup>290</sup> The first is the traditional identifier of a committable person as one “who because of mental illness ... represents a risk of harm to self or others.” The second speaks of “drug- or alcohol-dependent person[s] ... who as a result of dependency represent[ ] a risk of harm to self or others.” But Oklahoma’s “third standard” for effectuating involuntary treatment is as simple as it is classical in its medical essence: “a person who requires inpatient treatment for [either] a previously diagnosed history of schizophrenia, bipolar disorder, or major depression with suicidal intent, or [who] due to the appearance of symptoms of schizophrenia, bipolar disorder, or major depression with suicidal intent ... [and] for whom such treatment is reasonably believed will prevent progressively more debilitating mental impairment.” There is no language here of imminent physical harm or dangerousness, but instead of mental regression as such and only in cases where the diagnosis or history suggests the presence of one of the three major, DSM Axis I, mental disorders. It is the view, correct in our opinion, that for determining the need for psychiatric intervention it is both apposite and sufficient to use psychiatric standards and terms, and not those of law enforcement. The law is not asking a secondary question here such as it does in the context of, say, the insanity defense, where the psychiatric input is meant to address cognitive or volitional capacity so as to help resolve the ultimate legal issue of accountability/culpability, or any of a number of issues where the law seeks psychiatric consultation as it were via testimony on so-called penultimate issues.<sup>291</sup> This is direct and ultimate: it is about treatment and treatability. The question can both be posed and answered directly, in medical terms.<sup>292</sup>

Iowa today still operates with the two traditional standards of danger to self or others and inability to provide for basic/essential needs, but it also has a new commitment criterion focusing on the likelihood that the person proposed for hospitalization will “inflict serious emotional injury on members of [his or her] family or others who lack reasonable opportunity to avoid contact with the [mentally ill person].”<sup>293</sup> The reference to family members and others close to the person as well as the concern not only for their physical but also emotional well-being can be considered break-throughs in this area of law.

Finally, Oregon today provides for the commitment of the “chronically mentally ill” as a separate class. The class is defined as comprising those who “Within the previous three years [have at least] twice been placed in a hospital [and are] exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the hospitalizations.”<sup>294</sup> The law further specifies that it must also be found that, unless

treated, the members this group “will continue, to a reasonable medical probability, to physically or mentally deteriorate so that [they] *will* become [dangerous to self or others or unable to provide for basic needs] [emphasis added].”<sup>295</sup> The prospective reference, as it were, to the traditional commitment criteria could give one pause on whether Oregon has fully decoupled commitment of the chronically mentally ill from these criteria, but it seems acceptable to determine that the difference between that and the traditional law’s insistence on current to retrospective-but-recent dangerousness does indeed “make the difference.”

## 2. Secondary Psychiatry-focused Reforms

Of the lesser reforms--those not undoing the dangerousness standard, but allowing proof of it via more medically-oriented testimony--the state of Washington took the lead in 1979. In that year the state’s legislature redefined “gravely disabled” (both in spirit and practice a danger-to-self standard, “danger of serious physical injury” in fact) as alternatively provable by “severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her and actions and ... not receiving such care as is essential for his or her health and safety.”<sup>296</sup> The alleged practical results of this change were promptly panned in a near-hysterical article by researchers Durham and LaFond,<sup>297</sup> who exclaimed that it would among other things permit hospitalization on the basis of “virtually any ‘decompensation’ or significant worsening of an individual’s psychological condition,” but this did not stop other states from gradually taking a similar approach. Today one can count about a dozen jurisdictions where like changes have been made by the legislature. A few examples follow (some of the “victories” identified by proponents of this sort of legal change are small indeed, though even small victories are prized; others are more significant):

We begin with one of the smaller, which occurred in Idaho where the legislature in 2002 decided that “grave disability,” formerly defined as “inability to provide for his *essential* needs,” could henceforth be found if the subject for commitment could not meet his or her “*basic* needs” [emphasis added].<sup>298</sup> Though dutifully noted on TAC’s “legislative successes” list,<sup>299</sup> one could be inclined to doubt that the change from essential to basic would have much operational consequence. However, a more significant change was missed in the TAC summary which was that the new basic needs formulation came with the complementary words “for nourishment, essential medical care, shelter or safety.” As classic deficiencies in so many mentally ill people’s lives, the addition of these terms to the assisted treatment law *is* likely to have significant impact on the ability to get mental health care to those in Idaho who need it. Proof of lack of essential/basic medical care indeed should *equate* to it.<sup>300</sup>

What one hopes is also a significant reform, one that not only could but should have practical consequences, was enacted in Wyoming where in 1999 the legislature added “[mental] destabilization from lack of or refusal to take prescribed psychotropic medications” to the traditional kinds of evidence that could prove danger to self.<sup>301</sup> This is important. Not only does “mental destabilization” signal an appropriately lower and more psychiatrically-focused standard for treatment intervention than the traditional

inability to provide for essential nourishment requirement, let alone likely “death or serious physical injury”, the provision also gains from alluding to one of the major causes of such destabilization, lack of medication or refusal to take it even though prescribed. In other words, it joins the matter of proof to basic medical realities.

Between the low-end and high-end spectrum of reforms, there have been, tautologically, many statutory-language changes tending more toward the middle. A general, and in our view salutary, focus on treatment history characterizes a fair number of such changes. A couple of examples are: Illinois, where the commitment statute was amended in 2003 to say that “In determining whether the person meets the [danger to self or others] criteria, the court may consider evidence of the person’s repeated past pattern of specific behavior and actions related to the person’s illness”,<sup>302</sup> and South Dakota, where today the danger to self or others standard is provable by recent statutory language (enacted in 2000) that makes three discrete references to the individual’s “treatment history.”<sup>303</sup>

Finally, a growing number of states are passing statutory provisions that premise involuntary hospitalization on a finding by the committing court that the individual proposed therefore lacks capacity to make treatment decisions.<sup>304</sup> In our 1990 article we counted six states (though one of these may have been misclassified) whose statutes required such a finding and we lauded these statutes as making explicit what we felt was logically implicit in the finding that the individual was committable.<sup>305</sup> More important than any perceived logical consistency is the fact that such laws collapse the inquiry into need for hospitalization with the (to us, self-evident) need to be treated once hospitalized and thereby avoid the anomaly of legally sustainable treatment refusals by whatever number of patients chooses to assert this “right” and thereby winds up languishing on the wards-untreated-until-a-formal-legal-disposition-of-their-case-is-made-and-possibly-never-be-treated-in-the-event-they-are-found-competent-to-refuse-or-that-there-is-credible-evidence-they-would-refuse-if-competent-or-that-treatment-is-not-in-their-best-medical-interest. (We string all these unlikely eventualities together stream-of-consciousness-style to emphasize the near-absurdity and ultimately the futility of individual/institutional scenario created by laws which continue to separate hospitalization and treatment determinations).<sup>306</sup>

One problem with arriving at a fair count of how many states have enacted such reforms is that the statutory language in some, including Connecticut, Delaware, Florida and New York,<sup>307</sup> refers to the individual’s incapacity to make the decision regarding *hospitalization*. That of course is self-evident. When a court decides to commit a resisting or non-assenting person it not merely implies but per force *determines* that he or she is incapable of making that decision. To require the court to specifically find such incapacity is redundant. It is only when the statute speaks of the broader issue of capacity to decide on *treatment* that anything new is added, with (or without) attendant implications for the patient’s right to assent to or refuse treatment *once committed*. The states we identified previously as having such broader language were Delaware, Iowa, Kansas, Michigan, South Carolina and Utah,<sup>308</sup> but Delaware’s law clearly speaks to ability to make “responsible decisions with respect to ... hospitalization.” Iowa’s law refers to deciding on “hospitalization *or* treatment”, with the remainder speaking of

treatment only. Two new states, Texas<sup>309</sup> and Wisconsin, can be added to the latter list with the Wisconsin statute (in the course of articulating its fifth standard) referring to “either [the individual’s] incapability of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives, or substantial incapability of applying an understanding of the advantages, disadvantages and alternatives to his or her *mental illness*” [emphasis added].<sup>310</sup>

## **B. Outpatient “Commitment” Laws**

The judicial power to order treatment outside the institutional context has today been formalized in the laws of all but eight states in the U.S. with the passages of what are generally, if oxymoronic, known as outpatient commitment statutes. Actually, the courts have long if not always had such power via a variety of less formal or less explicit routes but due to lack of knowledge of the existence, or weak confidence in the solidity, of this authority on the part of the judiciary it was rarely used. These routes included (1) an outpatient treatment option under the “least restrictive” application of general civil commitment statutes, (2) mandated outpatient treatment as a condition of discharge following inpatient commitment, and (3) in cases involving criminal charges (and thus under the jurisdiction of the criminal court rather than a probate court or the like), the possibility of a diversionary disposition whereby the offender (typically charged with a minor offense) could (a) “choose” to go for outpatient mental health treatment as part of a pre-trial agreement that would end the criminal case or (b) where the case *is* processed criminally, as a condition of probation, following a guilty plea or even a guilty verdict, if the judge is so inclined.<sup>311</sup>

Even after enactment of the first series of explicit outpatient commitment laws during the early 1970’s<sup>312</sup> the concept was slow to take hold in practice. This has changed, however, with the recent passage of this type of legislation in several key states—New York (1999), California (2002), and Florida and Michigan in 2004—a development that both signals and responds to the reality that the concept “has arrived.” Mandated outpatient treatment was identified in a 2005 scholarly article<sup>313</sup> as “one of the most contested [read “significant” or “contentious”] human rights issues in mental health law in the United States at the beginning of the 21<sup>st</sup> century.” Kendra’s Law, New York’s outpatient treatment law, is today as much part of the popular or at least popular legal lexicon as is Megan’s Law, New Jersey’s sex offender registration statute, and for reasons beyond that the victims after whom the statutes were named suffered brutal death. That last allusion of course also says something about the motivation behind this legislation or at least its most recent push.<sup>314</sup>

Though almost half the states operate with a unitary standard for both in- and outpatient involuntary treatment, conceptually the defining characteristic of the outpatient commitment laws is that they permit mandated treatment based on criteria that are “looser” than those that authorize involuntary inpatient treatment—typically more medically-oriented criteria under which dangerousness or grave disability is at best (at worst?) a *predicted* outcome if the individual is *not* treated.<sup>315</sup> In that sense the treatment mandate differs from one that could eventuate under the least restrictive application of

the traditional inpatient commitment statutes, which premise that the subject meets the criteria for hospitalization but the judge in his wisdom or generosity decides that the risk of not hospitalizing can be taken.<sup>316</sup> It is that difference that is of course also the focus of the mandated outpatient treatment laws' critics, the civil libertarians, who by virtue of their fealty to liberty in its most obvious/conspicuous sense(s) only, deplore any widening of the so-called coerced-treatment net.<sup>317</sup>

Recently have come more subtle challenges than the libertarian broadside to the concept of outpatient commitment, or *leveraged outpatient treatment* as the modern lingo has it. These include the general detraction that the concept, whether good or bad, is less significant than both its proponents and opponents suggest by the vehemence of their (pr)opposition. Apart from whatever diminution in significance is conveyed by the change in terminology (leveraging treatment certainly sounds less onerous than mandating commitment or coercing care), the point is bolstered by research findings indicating that other forms of "leverage"—such as those the State may invoke in providing housing or abstaining from criminal punishment—may play as large if not larger a role in encouraging/enforcing treatment compliance than that brought to bear by direct judicial order.<sup>318</sup> And, as mentioned, there is the reformulation of the outpatient commitment issue as one essentially of contract rather than forcible imposition.<sup>319</sup> Neither of these perceptions, these "new takes," however should in fact diminish the salience of the outpatient commitment idea. Maximizing treatment initiation and adherence for the mentally ill is critical no matter how or in how many ways it can be achieved. And while the language of contract may be appropriate to some situations and certainly implies a softer message in all, it does not apply where the patient lacks legal competence or, by virtue of his legal status, choice.<sup>320</sup>

Even though it is among the more recent statutes of this type, New York's Kendra's law<sup>321</sup> may serve as an example because of its prominence in the public scheme of things: "A patient may be ordered to obtain assisted outpatient treatment if the court finds that:

- (1) The patient is eighteen years of age or older; and
- (2) The patient is suffering from a mental illness; and
- (3) The patient is unlikely to survive safely in the community without supervision, based on a clinical determination; and
- (4) The patient has a history of lack of compliance with treatment for mental illness that has:
  - (I) At least twice within the last thirty-six months been a significant factor in necessitating hospitalization . . . , or receipt of services in a forensic or other mental health unit of a correctional facility, . . . or
  - (II) Resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months . . . .
- (5) The patient is, as a result of his or her mental illness, unlikely to voluntarily participate in [treatment]; and
- (6) In view of the patient's treatment history and current behavior, the patient is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would likely result in serious harm to [self or others]; and

- (7) It is likely that the patient will benefit from assisted outpatient treatment; and
- (8) If the patient has executed a health care proxy, [the court shall take its directives into account].”

Note first that the New York statute uses the up-to-date “assisted treatment” in somewhat incongruous conjunction with “ordered.” That is merely a linguistic quibble, however. A more important point is that there are several provisions that hearken back to the dangerousness matter. This feature is not unique as the language appears in (was borrowed from) state statutes passed prior to New York’s enactment and can be found as well in laws passed subsequently.<sup>322</sup> It gives a libertarian cast to the law. Whether that is desirable, whether it comports with the ultimate goal of delivering treatment in timely fashion to individuals who need it is a matter of opinion (empirical data at this point are wanting but even if developed would be subject to varying interpretations). Our sense is that it is too restrictive and excessively conscious of the legal concerns that still dominate inpatient commitment. Without 4 (II) and the last sentence part in (6) that speak of serious harm, the remaining provisions would seem more than adequately protective of the patient’s overall interests. Certainly for assisted outpatient treatment--a lesser infringement on “liberty” than hospitalization--the dominance of medical criteria is easily justified.

A few states in fact appear to have recognized that. Georgia’s statute<sup>323</sup> for example is much shorter and simpler. The patient must be (a) in need of involuntary treatment and (b) unable to voluntarily seek it or comply with it, based on his/her mental status and history. The third component is that he/she requires outpatient treatment “in order to avoid predictably and imminently becoming an inpatient.” That last standard, if interpreted narrowly, could be seen as equivalent to requiring imminent dangerousness; but it may also leave room for an order based on medical harms. Texas appears to have moved away from any dangerousness references or implications altogether. The patient in order to be required to undergo *temporary* outpatient treatment must have a mental illness that is “severe and persistent” who if not treated will “continue to suffer ... severe and abnormal mental, emotional, or physical distress ... experience deterioration of the ability to function independently ... [and] ... safely in the community and ... [have demonstrated] ... an inability to participate in outpatient treatment effectively and voluntarily.”<sup>324</sup> *Extended* outpatient treatment may be ordered if one additional criterion is met: “the proposed patient has received court-ordered inpatient mental health services ... for at least 60 consecutive days during the preceding 12 months.”<sup>325</sup> That last proviso still speaks to medical history, even if in practice it may in most or all cases equate with the reality of dangerousness.

## VII. The ADA, *Olmstead* and the “Conversion” of Justice Kennedy

In 1990 Congress passed the Americans with Disabilities Act (ADA)<sup>326</sup> in order to help combat discrimination against disabled persons, which it found to be pervasive in many public and private spheres of socio-economic life throughout the United States. *Olmstead v. L.C. ex rel. Zimring*<sup>327</sup> is a case in which the United States Supreme Court took the

opportunity to construe, in the face of conflicting assertions about its proper reach, the anti-discrimination mandate in the public services portion (Title II) of the Act. The suit was brought on behalf of two women patients in Georgia Regional Hospital in Atlanta who, based on the judgment of the state's own treating doctors, were well enough to be discharged and enrolled in community-based treatment programs, but who were not because there were no openings.<sup>328</sup> The two patients were mentally retarded but one was diagnosed as also suffering from schizophrenia, while the other was found to have a co-existing personality disorder; both however were treated on the hospital's psychiatric unit. In an opinion written by Justice Ginsburg the Court upheld the patients' claim that they had been discriminated against by the state of Georgia in violation of Title II of the Act.

While we feel the concept of discrimination was misused by the majority of the Court in this case (our view being more in line with the dissenters and Justice Kennedy in concurrence that the patients suffered no discrimination *on account of* ("by reason of") their disability and were not treated worse than any identified comparable class of individuals),<sup>329</sup> the possible ill-effects of the holding were much muted by the provisos written into the majority opinion by Justice Ginsburg. In fact, those provisos turned the case into at least a partial victory for the psychiatric treatment-interest side. Despite its conclusion that the plaintiffs in the case had suffered discrimination under the law by their continued confinement in an inpatient facility when the uncontroverted evidence was that they could be cared for in the community, the *Olmstead* Court made clear its decision was not a call for precipitous, massive deinstitutionalization.<sup>330</sup> Rather, the ADA's "reasonable accommodations" (or "reasonable modifications"/"no fundamental alterations") standard for gauging the state's obligation meant that any move toward greater than current reliance on community-based treatment could proceed at a "reasonable pace."<sup>331</sup> Even budgetary considerations—often dismissed a defense to failure to fully and immediately respond to legal imperatives<sup>332</sup>—were held by the Court to be relevant to how and how fast to implement the remedy. The Court further went on to note that any transfers to community facilities be of "qualified" individuals only and that there was no mandate to move those who did not desire it, much less move people to undesirable settings (such as shelters for the homeless, as the state at one point proposed).<sup>333</sup> Finally, the Court gave full recognition to the fact that a complete phasing out of inpatient institutions was neither realistic nor desirable, as there would always be mentally ill patients who need institution-based care "to stabilize acute psychiatric symptoms" and others, mentally ill or retarded, who are simply "not prepared at particular times—perhaps in the short run, perhaps in the long run—for the risks and exposure of the less protective environment of community settings."<sup>334</sup>

Perhaps most gratifying of all, however, was the verbiage used by Justice Kennedy in his concurrence in *Olmstead*. Justice Kennedy began by quoting Dr. Fuller Torrey of the Treatment Advocacy Center for the proposition that "For a substantial minority [of patients] ... deinstitutionalization has been a psychiatric Titanic. Their lives are virtually devoid of 'dignity' or 'integrity of body, mind and spirit.' 'Self-determination' often means merely that the person has a choice of soup kitchens. The 'least restrictive setting' frequently turns out to be a card-board box, a jail cell, or a terror-filled existence plagued

by both real and imaginary enemies.”<sup>335</sup> Having thus exposed the cynical aspects of the civil liberties/rights “talk” as applied to the lot of the mentally ill, Justice Kennedy added in his own words his understanding of mental illness and its amelioration through medication: “It must be remembered that for the person with severe mental illness who has no treatment, the most dreaded of confinements can be the imprisonment inflicted by his own mind, which shuts reality out and subjects him to the torment of voices and images beyond our powers to describe....It is a common phenomenon that a patient functions well with medication, yet, because of the mental illness itself, lacks discipline or capacity to follow the regime the medication requires.”<sup>336</sup>

This is a far cry from the language penned by Justice Kennedy in *Riggins* seven years earlier. While that case presented a legal/strategic context unlike civil commitment or discharge, in- or outpatient, one is tempted to believe that perhaps the radical change in tone stems from new insight into the medical reality. As such, just as the damaging *Riggins* language was capitalized on by the anti-medication forces, Justice Kennedy’s new words can be used in years to come to mobilize those who through the medium of either legislation or litigation seek to return mental health-treatment decision making to a form and forum that more adequately accounts for the interests of patients, doctors and the State—the last to extent it designates and manages the locus of treatment, where treatment will take place, and delegates control over whom, how and when to treat.

## Conclusions

Because we feel it is more appropriate to offer guiding principles in our conclusion than detailed legal reforms, we can and will be brief, very brief in fact.

We believe that for civil commitment (including those found not guilty by reason of insanity, NGRI, a population not specifically touched on in this paper) and commitment for restoration to trial competence both the substantive standards and procedures can and should be medical. As we said at the outset, every patient or proposed patient has a right to refuse treatment if he/she does not want it. That is to say, patients as other citizens should be able to articulate their objection to prescribed treatment and that objection, if made, should be heard. Moreover, the physician who is responsible for treating the patient should try to convince the patient that the course prescribed is best for him/her or propose another course or courses that the patient finds more palatable but that, despite perhaps being suboptimal, still work(s). In short, we support the kind of therapist/patient dialogue about therapy that we will presume takes place in any hospital, community treatment center or doctor’s office to the extent the patient’s mental condition permits.<sup>337</sup>

However, if the patient cannot be convinced to accept the prescribed treatment, rejecting it and any plausible alternative courses (including trial and error), the physician should be allowed to initiate treatment over the patient’s objection with minimal legal interference. That is, the only substantive criterion that need or should inform the physician’s decision to proceed to treat is medical need/propriety. Inquiries into the patient’s dangerousness, the government’s (compelling) interest in prosecuting or any similarly diversionary issues should not be required. Procedurally, in-house medical review of the initial treatment

decision should suffice to allow the primary physician to go ahead. The purpose after all of each of these commitments, simply stated even if not always simple to achieve, is to restore mental health and functioning as much and as quickly as possible, whether defined/understood in the civil discharge terms of “no longer mentally ill” (and dangerous or gravely disabled), recovery of “sanity” (same as civil commitment but with dangerousness only), or in the language of restoration to “legal” competency. The (medical) objectives being the same for each of these classes of patients, whatever the institutional (or non-institutional) setting, so is and should be the medical treatment and the grounds on which it can be delivered.

The only group of patients for which the standards may or perhaps should be different is for correctional detainees and prisoners. Even for them, if ill, the treatment is the same as and its purpose identical to that for the foregoing groups. However, because detainees and prisoners are not incarcerated for treatment of their mental illness and being so treated is not an expected part of their detention or punishment,<sup>338</sup> the law appropriately may require proof of facts beyond medical need/propriety. That is, for this class of patients dangerousness *is* a legitimate second substantive standard to be met before unwanted treatment may ensue. In fact, the standard not only may but should incorporate impact on institutional security as the appropriate measure of dangerousness, as per *Harper*.<sup>339</sup> *Harper* provides the procedural standard as well. That is to say, in-house medical review of the treating doctor’s recommendation suffices (by an interdisciplinary committee, if one wishes).

There need be and should be no judicial involvement in processing the stated treatment refusals for *any* of these classes of patients. Judges cannot be and should not be the baseline decision makers in any of these institutional (or non-institutional), post-legal judgment phases of the treatment process. Forced treatment can begin once the medical reviewer has approved the treating physician’s recommendation. Post-deprivation judicial review, after treatment has been initiated and limited by the professional judgment rule, is all the law should call for at this juncture.<sup>340</sup>

## Footnotes

1. Samuel J. Brakel & John M. Davis, *Taking Harms Seriously: Involuntary Mental Patients and the Right to Refuse Treatment*, 25 IND. L. REV. 429 (1991).

2. Indeed, it would be demonstrably wrong. (1) What success there is has been slow in coming and uneven. (2) The article has not been cited with great frequency, its appeal apparently being limited mostly to the already converted. And (3) the achievement of significant legal change tends to require a combination of many factors and forces, among which academic writings may play a role but not usually a prominent one.

3. For example, on a different issue—the need for tort reform—lawyers who oppose such reform (most of them) have demonstrated substantial agility when it comes to dealing with unpleasant facts. The large number of reported instances of the abuse of law they dismiss as “mere anecdotes”, despite the fact that the common law is quintessentially and fundamentally anecdotal (as per the quip “one grievance is an anecdote; two are a class action”). But when anecdotes make a point they want or like, the anti-anecdotalists are as ready to invoke them as anyone. And when the ostensibly “hard” quantitative facts suggest an unwanted message, the tactic is to “contextualize”, distort or simply ignore them. See Samuel J. Brakel, *Using What We Know About Our Civil Litigation System: A Critique of “Base-Rate” Analysis and Other Apologist Diversions*, 31 GA. L. REV. 77 (1996).

4. The word “assisted”, introduced by pro-treatment activists with the Treatment Advocacy Center (TAC), a group with roots in the National Alliance for the Mentally Ill (NAMI) but corporately separate today, is more than a euphemism, as it is meant to reflect the fact that many of the mentally ill who resist hospitalization do so only half-heartedly, inconsistently or temporarily, while many others do so for delusional reasons, including paranoia about the motives of relatives who want to get them the help they need or a false belief that they are not ill and don’t need help.

5. Brakel & Davis, *supra*, note 1, at 437-438 and notes.

6. *Ibid.*

7. *Id.* at 438-440, especially note 33, citing *In re the Mental Commitment of M.P.*, 510 N.E. 2d 645 (IN 1987) and *In re Orr*, 531 N.E. 2d 64 (IL 1988) as textbook examples. The earlier Indiana case had made reference to a “virtually undisputed allegation that a person medicated with antipsychotic drugs has a 50% risk of contracting tardive dyskinesia.” This in fact highly disputable, if not plain erroneous (the much less alarming facts were not widely known at the time), allegation was then cited by the Illinois court in a subsequent decision as a “fact” “found” by the Indiana Supreme Court.

8. We will use schizophrenia as our prototypic severe mental illness. Most patients in mental facilities, where the issue of assent to or refusal of treatment comes primarily into play, have been diagnosed with schizophrenia. Other psychotic diseases such as manic manifestations of bi-polar disorder and psychotic depression and occasionally severe suicidal non-psychotic depression may also lead to institutionalization. Mostly we will describe the major advances in our understanding and treatment of schizophrenia over the

last 15 to 20 years but the implications if not always the facts apply as well to these other illnesses. Occasional comments about factual differences will be made.

9. Thomas Szasz, *The Myth of Mental Illness*, 15 AMERICAN PSYCHOLOGIST 113 (1960); THOMAS SCHEFF, BEING MENTALLY ILL (1966).

10. S.S. Kety, *From Rationalization to Reason*, 141 AM. J. OF PSYCHIATRY 967 (1974).

11. Even a partial perusal of the psychiatric literature would yield many thousands of writings documenting this fundamental fact, from materials in textbooks such as the American Psychiatric Association's Comprehensive Textbook of Psychiatry to individually published research monographs to articles in sub-specialty journals such as Molecular Psychiatry, Psychiatric Genetics, Journal of Psychiatric Research, Schizophrenia Bulletin, Schizophrenia Research, and Biological Psychiatry to pieces in general psychiatric journals such as Journal of the American Psychiatric Association or the Archives of General Psychiatry published by the American Medical Association, not to mention research meetings such as the International Congress on Schizophrenia where numerous papers are presented on any number of subjects, but all equally supportive of the biological basis of schizophrenia. For the sake of space (and sanity) we only present a few of the more significant writings, supporting different aspects of the basic point (as reflected in the titles), e.g.: S.L. Eastwood & P.J. Harrison, *Cellular Basis of Reduced Cortical Reelin Expression in Schizophrenia*, 163 AM. J. OF PSYCHIATRY 540 (2006); D.A. Lewis & J.A. Lieberman, *Catching Up on Schizophrenia: Natural History and Neurobiology*, 28 NEURON 325 (2000); L.D. Selemon, G. Rajkowska & P.S. Goldman-Rakic, *Abnormally High Neuronal Density in the Schizophrenic Cortex: A Morphometric Analysis of Prefrontal Area 9 and Occipital area 17*, 52 ARCH. GEN. PSYCHIATRY 805 (1995); L. A. Glantz & D.A. Lewis, *Dendritic Spine Density in Schizophrenia and Depression*, 58 ARCH. GEN. PSYCHIATRY 203 (2001); A. Guidotti, J. Auta, J.M. Davis *et al.*, *Gabaergic Dysfunction in Schizophrenia: New Treatment Strategies on the Horizon*, 180 PSYCHOPHARMACOLOGY 191 (2005).

12. E.g., M.E. Shenton, C.C. Dickey, M. Frumin & R.W. McCarley, *A Review of MRI Findings in Schizophrenia*, 49 SCHIZOPHRENIA RESEARCH 1 (2001).

13. J. Ahveninen, L.P. Jaaskelainen, D. Osipova *et al.*, *Inherited Auditory-Cortical Dysfunction in Twin Pairs Discordant for Schizophrenia*, BIOLOGICAL PSYCHIATRY (in press, 2006). L.F. Martin, W.R. Kem & R. Freedman, *Alpha-7 Nicotinic Receptor Agonists: Potential New Candidates for the Treatment of Schizophrenia*, 174 PSYCHOPHARMACOLOGY 54 (2004).

14. P. Holzman, *Behavioral Markers of Schizophrenia Useful for Genetic Studies*, 26 J. OF PSYCHIATRIC RESEARCH 427 (1992).

15. See L. F. Martin, W.R. Kem & R. Freedman, *supra*, note 13; S.R. McGurk & H.Y. Meltzer, *Changes in Cognitive Functioning with Risperidone and Olanzapine Treatment:*

*A Large-Scale, Double-Blind, Randomized Study*, 169 PSYCHOPHARMACOLOGY 404 (2003).

16. P.F. Sullivan, *The Genetics of Schizophrenia*, 7 PLOS MEDICINE 212 (2005); I. GOTTESMAN, SCHIZOPHRENIA GENESIS: THE ORIGIN OF MADMEN (1991).

17. E.g., R.E. Straub & D.R. Weinberger, *Schizophrenia Genes: Famine to Feast*, 60 BIOLOGICAL PSYCHIATRY 81 (2006).

18. E. Costa, Y. Chen, J.M. Davis *et al.*, *Reelin and Schizophrenia: A Disease at the Interface of the Genome and the Epigenome*, 2 MOLECULAR INTERVENTIONS 47 (2002); S.H. Fatemi, J.A. Earle & T. McMenomy, *Reduction in Reelin Immunoreactivity in Hippocampus of Subjects with Schizophrenia, Bipolar Disorder and Major Depression*, 5 MOLECULAR PSYCHIATRY 654 (2000).

19. There are imaging data today from living schizophrenic patients that show excessive dopamine release in the brain when the patient is having hallucinations and delusions, as well as of the blocking effect on dopamine receptors when antipsychotics are administered. See A. Abi-Dargam, R. Gil, J. Krystal *et al.*, *Increased Striatal Dopamine Transmission In Schizophrenia: Confirmation in a Second Cohort*, 155 AM. J. PSYCHIATRY 761 (1998); A. Bartolomeis, D.R. Weinberger, N. Weisenfeld *et al.*, *Schizophrenia is Associated with Elevated Amphetamine-Induced Synaptic Dopamine Concentrations: Evidence from a Novel Positron Emission Tomography Method*, 94 PROC. NAT'L ACAD. SCI. U.S.A. 2569 (1997).

20. The amotivational, apathetic, poor social skills aspects of schizophrenia are its so-called negative symptoms. Combined with cognitive/executive defects, these deficits contribute greatly to poor social and vocational functioning among people with the illness. But today's drugs can go a long way toward remedying these deficits and we have an understanding, albeit imperfect, of how they work. S. R. Marder, J.M. Davis & G. Chouinard, *The Effects of Risperidone on the Five Dimensions of Schizophrenia Derived by Factor Analysis: Combined Results of the North American Trial*, 58 J. CLIN. PSYCHIATRY 538 (1997); J.M. Davis & N. Chen, *Clinical Profile of an Atypical Antipsychotic: Risperidone*, 28 SCHIZOPHRENIA BULLETIN 43 (2002).

21. See R. BALDESSARINI, J. COLE, J. DAVIS, G. SIMPSON & D. TARSY, TASK FORCE REPORT 18: TARDIVE DYSKINESIA (1980); J. M. KANE, DYSKINESIA: A TASK FORCE REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION (1991).

22. E.g., G. Chouinard, T.T. Kolivakis, L. Beauclair *et al.*, *Tardive Dyskinesia in the Era of the Typical and Atypical Antipsychotics. Part 2: Incidence and Management Strategies in Patients with Schizophrenia*, 50 CANADIAN J. OF PSYCHIATRY/REVUE CANADIENNE DE PSYCHIATRIE 703 (2005).

23. There are many drugs given to patients by psychiatrists and neurologists which have considerable sedative properties: barbiturates, non-barbiturate sedatives and hypnotics,

anti-anxiety agents in the benzodiazepine class of drugs such as Librium and Valium and drugs like Ambien. Some anticonvulsants have substantial sedative aspects. Certain antidepressants such as amitriptyline (Elavil), mirtazapine (Remeron) and trazodone do as well, as do certain antihistamines that pass the blood brain barrier and can produce considerable sedation. None of these drugs help schizophrenia. While some antipsychotics, particularly chlorpromazine and clozapine, have sedative properties, most of the newer antipsychotics either have no sedative effects above placebo or only a very low incidence of such effects. Stimulants do not help schizophrenia either. The amount of sedation produced by an antipsychotic is irrelevant to its antipsychotic action. It should be noted that sometimes a sedative agent might be useful in the first few hours of treatment of a highly agitated patient. However, beyond this transitory effect sedatives have no antipsychotic utility. See LAURENCE L. BRUNTON, JOHN S. LAZO & KEITH L. PARKER (EDS.) GOODMAN & GILMAN'S THE PHARMACOLOGICAL BASIS OF THERAPEUTICS, 11<sup>th</sup> ed. 2006 at 317-341, 401-428, 426-460, 461-500 and 501-526.

24. *Ibid.*

25. See S.M. Essock & N. Kontos, *Implementing Assertive Community Treatment Teams*, 46 PSYCHIATRIC SERVICES 679 (1995); K.T. Mueser, G.R. Bond, R.E. Drake & S.G. Resnick, *Models of Community Care for Severe Mental Illness: A Review of Research on Case Management*, 24 SCHIZOPHRENIA BULLETIN 37 (1998).

26. It is less a matter of psycho-social treatments having no place or a lesser place in the treatment of severe mental illness today than that the treatments are entirely different. They *capitalize* today on the gains in thinking and functioning that can be achieved by the medications, as distinct from trying the impossible, which is to achieve these gains directly through verbal or behavioral therapy. See *Osherhoff v. Chestnut Lodge, Inc.* 62 Md. App. 519, 490 A.2d 720 (1985) for an early case—the reported court case merely affirms an arbitration award for allegedly negligent treatment that took place in 1979--involving the recognition that verbal therapy as such is ineffective in treating mental illness with substantial biological components, in this instance a psychotic depressive reaction, and that the failure on the part of the defendant to initiate psychopharmacologic treatments may constitute negligence. The defendant institution, Chestnut Lodge, was a facility famous for furthering psychoanalytic theory and practice, having trained a number of prominent American psychiatrists of this school, a fact which seems to have influenced the diagnosis its staff made of the plaintiff's mental health problems as much as the treatment course that was pursued in the face of unmistakable evidence that the patient was getting worse rather than better.

27. E. FULLER TORREY, *OUT OF THE SHADOWS* (1997).

28. *Ibid.* See also, H. Brill & R.E. Patton, *Population Fall in New York State Mental Hospitals in First Year of a Large-Scale Use of Tranquilizing Drugs*, 114 AM. J. OF PSYCHIATRY 509 (1957).

29. See Brill & Patton, *supra*, note 28.

30. See *OUT OF THE SHADOWS*, *supra*, note 27. The lawyer author of this paper conducted social/legal research in the early 1970's at Kankakee State Hospital 30 miles south of Chicago at a time when it housed some 4,000 patients. Within a few years the hospital was a relic, empty of mentally ill patients and in the process of being converted, to the extent possible, to other uses.

31. The neuropsychological deficits and the loss of grey matter seem to get worse after the patient's first psychotic episode and there is strong evidence that failure to treat the first episode with antipsychotic drugs leads to substantially worse outcome, in terms of repeat episodes and recovery therefrom, in the following five years. There is beginning evidence that at least some of the second-generation drugs in particular are effective in blocking the progression of these deficits and losses. K. Kasai, M.E. Shenton *et al.*, *Progressive Decrease of Left Superior Temporal Gyrus Grey Matter Volume in Patients with First-Episode Schizophrenia*, 160 *AM. J. OF PSYCHIATRY* 156 (2003); W. Cahn, H.E. Hulshoff Poll *et al.*, *Brain Volume Changes in First Episode Schizophrenia: A One-Year Follow-Up Study*, 59 *ARCH. OF GENERAL PSYCHIATRY* 1002 (2002). Moreover, a large study carried out in Finland, based on that country's central register, found that the risk of untreated schizophrenic patients dying was 10 times higher than that of patients on medication. J. Tiihonen, K. Wahlbeck *et al.*, *Effectiveness of Antipsychotic Treatments in a Nationwide Cohort of Patients in Community Care after First Hospitalization Due to Schizophrenia and Schizoaffective Disorder: Observational Follow-Up Study*, 333 *BRITISH MED. J.* 224 (2006).

32. *Ibid.*

33. Brakel & Davis, *supra*, note 1, at 441.

34. *Id.* at 441-443.

35. *Ibid.*

36. The emptying of the large state mental hospitals in the 1970's was part of a conscious deinstitutionalization movement whose promise was that most of the mentally ill would and could henceforth be treated "in the community." Implicit if not inherent in this promise was a secondary promise that enough quality community mental health treatment facilities would be built and staffed to accommodate the numbers coming out of the hospitals. For any number of reasons that second promise was not fulfilled [for a provocative account of the whole deinstitutionalization movement, its promises, failures and the various motivations of the variously connected actors, commentators and spectators, see RAELEEN ISAAC & VIRGINIA C. ARMAT, *MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL* (1990)] with the result that the post-institutionalization age came to be marked by abundant homelessness and the phenomenon of transinstitutionalization, the latter meaning to convey the large numbers and percentages of mentally ill people coming to attention to criminal justice officials and

winding up in correctional rather than mental health facilities. To the extent this “hydraulic” or systemic “balloon” phenomenon reflects an irreducible constant of psychiatrically and socially impaired people, it stands to reason that their treatment needs are equally constant, irrespective of where they happen to be housed (or not housed).

37. Researchers most prominently identified with the concept of anosognosia, through studies conducted in the early 1990’s, are psychologist Xavier Amador at Columbia University in New York and psychiatrist Anthony David at the Institute of Psychiatry in London (UK). Psychiatrist Joseph McEvoy of the University of Pittsburgh however first explicitly linked the characteristic to the illness in the 1980’s. Joseph P. McEvoy *et al.*, *Why Must Some Schizophrenic Patients Be Involuntarily Committed? The Role of Insight*, 30 *COMPR. PSYCHIATRY* 13 (1989); Joseph P. McEvoy *et al.*, *Measuring Chronic Schizophrenic Patients’ Attitudes Toward Their Illness and Treatment*, 32 *HOSP. COMMUNITY PSYCHIATRY* 856 (1981).

38. Xavier Amador *et al.*, *Awareness of Illness in Schizophrenia and Schizoaffective and Mood Disorders*, 51 *ARCHIVES GEN. PSYCHIATRY* 826 (1994); Xavier Amador *et al.*, *Awareness Deficits in Neurological Disorders and Schizophrenia* (abstract), 24 *SCHIZOPHRENIA RES.* 96 (1997).

39. Brakel & Davis, *supra*, note 1 at 444-451.

40. *Ibid.*

41. *Id.* at 451-453, under “Clinical Benefits of Drug Treatment.”

42. *Id.* at 453-461, under “Research Findings on the Harms Resulting from Delayed Treatment.”

43. *Id.* at 461-467.

44. *Id.* at 462.

45. *Id.* at 462-463.

46. *Ibid.*

47. *Id.* at 463-464.

48. *Id.* at 465.

49. R.J. Wyatt & I. de Saint Chislain, [Letter], *Economic Savings and Clozapine*, 152 *AM. J. PSYCHIATRY* 650 (1995). The first large, pivotal trial was conducted as early as 1988 and involved the drug clozapine, the first atypical, as measured against a dominantly used typical, chlorpromazine. J. Kane, G. Honigfeld, J. Singer & H. Meltzer, *Clozapine for the Treatment-resistant Schizophrenic. A Double-Blind Comparison with*

*Chlorpromazine*, 45 ARCHIVES OF GEN. PSYCHIATRY 789 (1988). See also K. Wahlbeck, M. Cheine, A. Essali & C. Adams, *Evidence of Clozapine's Effectiveness in Schizophrenia: A Systemic Review and Meta-Analysis of Randomized Trials*, 156 AM. J. PSYCHIATRY 990 (1999).

50. See Jeffrey A. Lieberman, T. Scott Stroup, Joseph P. McEvoy *et al.*, *Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia*, 353 NEW ENG. J. OF MEDICINE 1209 (2005). The study was reported in the Chicago Tribune under the headline "New Schizophrenia drugs no better than the old" (Ronald Kotulak, CHI. TRIB. 9/20/05). Among the initiated, the study is known (affectionately?) as "CATIE" after the study's Clinical Antipsychotic Trials of Intervention Effectiveness subtitle. Prior to the CATIE study there had been other studies whose results questioned the larger claims of the new drugs' superiority, but these studies did not have much traction. Some of this research was done abroad. *E.g.* Stephan Leucht, G. Pitschel-Walz, D. Abraham & Werner Kissling (Munich, Germany), *Efficacy and Extrapyramidal Side-Effects of the New Antipsychotics: A Meta-Analysis of Randomized Controlled Trials*, 35 SCHIZOPHRENIA RESEARCH 51 (1999), concluding that while all the new anti-psychotics were more effective than placebo, so "contrary to wide-spread opinion" were the conventional drugs and that the new drugs were on many measures only "slightly" superior to the old drugs; John Geddes, Nick Freemantle, Paul Harrison & Paul Babbington, in *Atypical Antipsychotics in the Treatment of Schizophrenia: A Systematic Overview and Meta-Regression Analysis*, 321 BRITISH MEDICAL J. 1371 (2000), found that "atypical antipsychotics had no benefits in terms of efficacy or overall tolerability, [though] they still caused fewer extrapyramidal side effects" and concluded that the cheaper conventional drugs should be used "unless the patient has previously not responded to these drugs or has unacceptable extrapyramidal side effects."

51. Robert Rosenheck, *The Growth of Psychopharmacology in the 1990's: Evidence-Based Practice or Irrational Exuberance*, 28 INT. J. OF LAW AND PSYCHIATRY 467 (2005). Rosenheck is well known as a ferocious critic of the drug industry and his article should be read with that in mind. One reason for the scarcity of data comparing the first-generation drugs with the later drugs is that much of the research has been on the order of comparing new drugs against placebo, or comparisons between and among new drugs. The latter, aided and abetted by the fact that the drug companies sponsor much of the research and control the published results, does not always produce the most usable or for that matter credible information. For an analysis of atypical drug trials that is more scientifically-oriented than the Rosenheck piece, see Stephan Heres, John Davis, Katja Maino *et al.*, *Why Olanzapine Beats Risperidone, Risperidone Beats Quetiapine, and Quetiapine Beats Olanzapine: An Exploratory Analysis of Head-to-Head Comparison Studies of Second-Generation Antipsychotics*, 163 AM. J. OF PSYCHIATRY 185 (2006).

52. The CATIE study's method was to randomly assign a total of 1,493 schizophrenic patients recruited for this purpose from sites throughout the U.S. to receive a flexible (determined by the treating doctor) but conservative dosage of one of the four new-generation drugs or of one "midpotency" first-generation antipsychotic for up to 18 months. Lieberman *et al.*, *supra*, note 26, at 1209, 1211. The primary measure of relative

efficacy was “time to discontinuation of treatment for any cause,” with the cause (inefficacy, intolerable side-effects or “any other reasons”) recorded as a matter of high secondary, explanatory interest. While imminently defensible to the extent that, as the researchers put it, time to discontinuation is a discrete outcome selected because discontinuation *or changing* of medication is a frequent occurrence in the treatment of schizophrenia and because it “integrates patients’ and clinicians’ judgments of efficacy, safety and tolerability into a global measure of effectiveness that reflects their evaluation of therapeutic benefits in relation to undesirable side-effects” (*Id.* at 1211), it by definition emphasizes the negative at the expense of a more textured look at what is gained. In addition, the study’s method in effect encouraged discontinuation from treatment with the assigned drug. Given randomization, it is inevitable that a large number of patients were “randomized” to a to-them less effective/desirable drug than the one they were on before the study started. Many would recognize this sooner rather than later and discontinue/switch their medication in short order. For other patients and their doctors mere curiosity would be enough of a motivator to switch medications in a study of this type, given the ever-present hope to do better and to do better with fewer untoward effects. By measuring discontinuation from the first-assigned drug the research thus creates a perversely negative image of the sort of trial-and-error treatment that is in fact the hallmark of effective psychopharmacology in the real world where the ultimate goal is to *continue* treatment and to *promote adherence via selection* of a drug for which the patient’s tolerance is optimum. Finally, the administration in the study of low, possibly sub-therapeutic, dosages of medication may have depressed efficacy results just as they reduced, per the study’s intent, the risk of bad side-effects. Even at that, the results preserve significant advantages for (selected) atypicals though this is all but hidden by the report’s preoccupation with the global cost/benefit equation. One of the second-generation drugs in particular, olanzapine, seems to have come out as appreciably more effective on critical measures than the first-generation drug used as well as compared to the other atypicals. It had the lowest rate of discontinuations (though the rate was high for all, for reasons speculated about above, not disconfirmed by the finding that by far the most prevalent reason for stopping was an undifferentiated, unexplained “patient’s decision”) as well as superior efficacy as measured by reduction in psychopathology, duration of successful treatment and rate (low) rate of hospitalization or rehospitalization for exacerbation of symptoms. This was purchased at the cost of greater weight gain among patients taking olanzapine and related undesirable metabolic effects. Against this one disadvantage, however, stands the substantial evidence developed in earlier studies and acknowledged by the CATIE researchers in their report (*Id.* at 1210, plus cites) that olanzapine as well as the other atypicals produce far fewer neurological or extrapyramidal effects than the old typicals and are appreciably more efficacious than the old drugs in reducing the negative symptoms of schizophrenia such as lack of emotion, interest and expression. See J. M. Davis, N. Chen & I. D. Glick, *A Meta-Analysis of the Efficacy of Second-Generation Antipsychotics*, 60 ARCH. GEN. PSYCHIATRY 553 (2003). In the service of full disclosure and out of concern that the actual results might get lost in the advocacy, we summarize this research in two tables appended at the end of this paper at --, one comparing side-effects among and between typical and atypical drugs, the other on comparative efficacy.

53. As the foregoing material in both the text and footnotes indicates, there is genuine controversy in psychiatry about the efficacy gains of the new drugs over the old ones, especially in light of the formers' higher costs. But this is largely irrelevant to the central aspect of the legal debate which is whether to drug or not to. The fact of the matter is there is no alternative, less restrictive or otherwise, to drug treatment for patients with major mental disorders be it with typicals or atypical. As to the side-effects, the other half of the legal controversy, it is today pretty much a non-issue given contemporary treatment realities. This includes the relatively short periods of mandated treatment to which patients might be exposed, the options to choose from among various drugs with varying side-effects, the availability of medications that counter-act undesirable effects and, last, when it comes to the side-effects of greatest concern, the so-called extrapyramidal effects, it can be concluded that, some hesitancies stemming from the CATIE study notwithstanding, the profile of the new generation of drugs is that they are largely risk-free in this regard.

54. See Rosenheck, *supra*, note 51, at 475.

55. E. Fuller Torrey, *Studies of Individuals with Schizophrenia Never Treated with Antipsychotic Medications: A Review*, 58 SCHIZOPHRENIA RESEARCH 101 (2002).

56. Ronald C. Kessler, Patricia A. Berglund, Martha L. Bruce *et al.*, *The Prevalence and Correlates of Untreated Serious Mental Illness*, 36 HEALTH SERVICES RESEARCH 978 (2001).

57. *E.g.*, Diana O. Perkins, Hongbin Gu, Kalina Boteva & Jeffrey A. Lieberman, *Relationships Between Duration of Untreated Psychosis and Outcome in First-Episode Schizophrenia: A Critical Review and Meta Analysis*, 162 AM J. OF PSYCHIATRY 1785 (2005); D.A.W. Johnson, G. Pasterski, L. Ludlow *et al.*, *The Discontinuance of Maintenance Neuroleptic Therapy in Chronic Schizophrenic Patients: Drug and Social Consequences*, 67 ACTA PSYCHIATR. SCAND. 339 (1983); Charles M. Beasley, Jr., Virginia K. Sutton, Cindy C. Taylor *et al.*, *Is Quality of Life Among Minimally Symptomatic Patients with Schizophrenia Better Following Withdrawal or Continuation of Antipsychotic Treatment?* 26 J. OF CLINICAL PSYCHOPHARMACOLOGY 40 (2006).

58. See section on this topic *infra* at pp.—of this paper.

59. Jeffrey W. Swanson, Randy Borum, Marvin S. Swartz, Virginia A. Hiday *et al.*, *Can Involuntary Outpatient Commitment Reduce Arrests Among Persons with Severe Mental Illness?* 28 CRIM. JUSTICE AND BEHAVIOR 156 (2001); Jeffrey W. Swanson, Marvin S. Swartz, Randy Borum, Virginia A. Hiday *et al.*, *Involuntary Outpatient Commitment and Reduction of Violent Behaviour in Persons with Severe Mental Illness*, 176 BRITISH J. OF PSYCHIATRY 324 (2000); Marvin S. Swartz, Jeffrey W. Swanson, H. Ryan Wagner, Barbara J. Burns *et al.*, *Can Involuntary Outpatient Commitment Reduce Hospital Recidivism?: Findings from a Randomized Trial with Severely Mentally Ill Individuals*, 156 AM. J. OF PSYCHIATRY 1968 (1999).

60. Virginia A. Hiday, Marvin S. Swartz, Jeffrey W. Swanson, Randy Borum & H. Ryan Wagner, *Impact of Outpatient Commitment on Victimization of People with Severe Mental Illness*, 159 AM. J. OF PSYCHIATRY 1403 (2002).

61. Jeffrey W. Swanson, Marvin S. Swartz, Eric B. Elbogen *et al.*, *Effects of Involuntary Outpatient Commitment on Subjective Quality of Life in Persons with Severe Mental Illness*, 21 BEHAV. SCIENCES AND THE LAW 473 (2003).

62. Haya Ascher-Svanum, Douglas E. Faries, Baojin Zhu *et al.*, *Medication Adherence and Long-Term Functional Outcomes in the Treatment of Schizophrenia in Usual Care*, 67 J. OF CLINICAL PSYCHIATRY 453 (2006).

63. See Amador and McEvoy articles, *supra*, notes 37 and 38. Also, Joseph P. McEvoy, Paul S. Appelbaum, L. Joy Apperson *et al.*, *Why Must Some Schizophrenic Patients Be Involuntarily Committed? The Role of Insight*, 30 COMPR. PSYCHIATRY 13 (1989); Anthony S. David, *Insight and Psychosis*, 156 BRITISH J. OF PSYCHIATRY 798 (1990); Xavier F. Amador, David H. Strauss, Scott A. Yale & Jack M. Gorman, *Awareness of Illness in Schizophrenia*, 17 SCHIZOPHRENIA BULLETIN 113 (1991); Faith B. Dickerson, John J. Boronow, Norman Ringel & Frederick Parente, *Lack of Insight Among Outpatients with Schizophrenia*, 48 PSYCHIATRIC SERVICES 195 (1997); Xavier F. Amador & Regina A. Seckinger, *The Assessment of Insight: A Methodological Review*, 27 PSYCHIATRIC ANNALS 798 (1997); Graig Goodman, Gabriella Knoll, Victoria Isakov & Henry Silver, *Insight into Illness in Schizophrenia*, 46 COMPR. PSYCHIATRY 284 (2005).

64. A classic supporting citation here is to *Schloendorff v. Society of New York Hospitals*, 211 N.Y. 125, 105 N.E. 92 (1914). In this venerable case, later U.S. Supreme Court Justice Cardozo wrote: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body.” Of course the qualification “sound mind” draws into question the rights of mentally ill individuals, just as “adult years” renders equivocal the right of minors to make their own health decisions. *Parham v. J. R.*, 442 U.S. 584 (1979) shows the extent to which the rights of minors may be qualified when it comes to making mental health decisions. The *Parham* case is ultimately about procedure, which we will show to be the crux of the matter for the adult mentally ill as well.

65. Classic cites here are to *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978), 476 F. Supp. 1294 (D.N.J. 1979), *modified*, 653 F.2d 836 (3<sup>rd</sup> Cir. 1981), *vacated*, 458 U.S. 1119 (1982), 720 F.2d 266 (1983) and *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650 (1<sup>st</sup> Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291 (1982); *Rogers v. Commissioner*, 390 Mass. 489, 458 N.E.2d 308 (1983), which are seen to have “established” this proposition in the civil commitment context. But there are dozens of other cases, in a variety of legal contexts (a number of which will be explicitly reviewed later in this paper) that make the same point in the same terminology. This includes several cases that provide only scant procedural protection to patients who seek to exercise the right. *See, e.g., United States v. Charters*, 863 F.2d 302

(4<sup>th</sup> Cir. 1988) (*en banc*) (*Charters II*); *Washington v. Harper*, 494 U.S. 210 (1990). In *Mills v. Rogers* (1982) the U.S. Supreme Court assumed without deciding the existence of a right to refuse treatment for mentally ill persons (457 U.S. 291, 299); by the time it decided *Harper* ten years later the Court “had no doubt” about it (494 U.S. 210, 221-22).

66. See note 67, *infra*, for examples of cases and theories in this regard.

67. For example, the court in *Davis v. Hubbard*, 506 F. Supp. 915 (N.D. Ohio, 1980), after listing most of the competing theories for finding a right to refuse, said its source “can be best understood as substantive due process, or...as an aspect of ‘liberty’ guaranteed by the due process clause of the Fourteenth Amendment.” Judge Coffin in *Rogers v. Okin*, 634 F.2d 650, 653, equally thought this to be the source for the right, “most likely *as part of* the penumbral right to privacy, bodily integrity, or personal security [emphasis added].” Yet another way to conceptualize it is to see the Fourteenth Amendment as “incorporating” and applying to the states, who may not by the Amendment’s mandate deprive its citizens of liberty without due process, the four or five federal Bill of Rights Amendments thought to be the source of the patient’s right to refuse (*Rogers v. Okin*, 478 F. Supp. 1342, 1361). Whether the conceptualizations of the right/interest as an aspect of the thing itself or a part of something else or an incorporation *via* something else are reconcilable or, for that matter, intelligible, is the sort of issue few lawyers, let alone lay folks, worry much about. In any event, following the federal constitutional “genesis” of the right to refuse treatment, state law (or interpretations thereof)—both statutory and constitutional—has become available as a complementary source for the right; indeed, a source even of an expanded, procedurally better protected, version of the right. See, e.g., *Rogers v. Commissioner*, 390 Mass. 489, 458 N.E. 2d 308 (1983) for the State of Massachusetts Supreme Court’s articulation/elaboration of the right based, ostensibly, on state law.

68. One could cite in support of this proposition the major mental health law cases that are the subject of this paper. However, prison law cases provide the more dramatic example. As recently as a century and a quarter ago prisoners were considered slaves of the state, dead men, for legal purposes, having no rights or claims to right whatsoever. *Ruffin v. The Commonwealth*, 62 Va. 790 (Ct. of App. Va. 1871). But gradually during the 20<sup>th</sup> century and not-so-gradually during its latter part and the civil rights revolution of the 1960’s and ‘70’s, this position gave way to a consensus that prisoners retained many of their legal and constitutional rights, subject to curtailment by the State primarily if not only in the face of legitimate penological counter-interests. These penological counter-interests defined the substantive due process limits for prisoners. As for procedure, prisoners’ rights came to be protected by a due process mandate that varied from a “modicum” of formality in contexts such as disciplinary cases, including major infractions where loss of good-time was a potential outcome [in effect lengthening confinement: *Wolff v. McDonnell*, 418 U.S. 539 (1974); *Superintendent, Mass. Correctional Institution at Walpole*, 472 U.S. 445 (1985)] to hearings with substantial trial-like trappings, required for example when the State contemplated the transfer of a prisoner to a mental hospital [with associated stigmatization and potentially invasive treatment: *Vitek v. Jones*, 445 U.S. 480 (1980)]. Among the mystifications of

constitutional analysis to lay readers, the distinction between substantive due process and procedural due process, or even the very identification of these concepts, probably ranks well up there. Process to the ordinary mind is just that: process, procedure. Even some judges, especially those of conservative bent, have expressed bafflement. Judge Posner of the seventh Circuit Court of Appeals for example has labeled substantive due process an “oxymoron”, in the same sense that its procedural counterpart would be a redundancy. A more politically charged assessment, one made by jurists who subscribe to a philosophy of “judicial restraint” against their more activist brethren, is that substantive due process is a convenient myth that empowers judges to do as they please on the bench—*i.e.*, to strike down as unconstitutional whatever displeases them. Having raised these questions about the nature and meaning of due process, we will in this article for pragmatic reasons proceed as if they had not been broached and as if they have no bearing on the analysis.

69. The point is made explicitly in almost all of the right to refuse decisions, no matter what their outcome. Even the least compromising advocates for patient-plaintiffs will concede that the state can override the patient’s right in *some* situations. *See, e.g.*, *Rogers v. Okin*, 478 F. Supp. 1342, 1351 and 634 F.2d 650 at 654. Emergencies are pretty much universally conceded to be a circumstance, for plaintiffs often the only one, under which the patient’s right must give way (to the interventions of those appointed to deal with the alleged dangers of the moment, whose true scope and reality there is no time to assess). Of course there can be disagreements over what constitutes an emergency, as there was in *Rogers* where the defendants gave a psychiatric definition that to the plaintiff’s side seemed like *any psychiatric reason* (*Rogers v. Okin*, 478 F.Supp. 1342, 1364), but all the real battles, legal and otherwise, are over medical authority in non-emergency situations. *Mathews v. Eldridge*, 424 U.S. 319 (1976) is the leading precedent for the procedural aspects of this non-absolutist proposition. The case requires courts to weigh or balance the private (individual’s) interests against the state’s interests in determining whether a given procedure that regulates a particular practice is constitutional (it goes so far as to not only require inquiry into the effect of existing procedures on these respective interests, but also an assessment of the costs and benefits of additional or substitute procedures proposed by one party or the other). That this can get pretty intricate goes without saying. For one of the earliest, oft-cited expressions of the general proposition that fundamental rights are not absolute, but subject to regulation by the State for reasons of health and safety, *see Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

70. To preview a bit, the maximum dose of due process prescribed is in cases such as *Rogers v. Commissioner*, 390 Mass. 489, 458 N.E.2d 308 (1983), while the minimum is exemplified by the *United States v. Charters*, 863 F.2d 302 (4<sup>th</sup> Cir. 1988) (*Charters II*) decision. In recognition of the reality that the procedural protections for refusers may be minimal indeed, we phrased the right to refuse three paragraphs earlier in the text as a right to *articulate* objections. In some situations it is no more than that (and perhaps this is really all human decency—or to be more academic, the respect-for-persons principle—requires). The *Charters II* minimalism came in the context of and was influenced by the patient’s incompetence to stand trial. But we feel, against the state of the prevailing law, that patients who are involuntarily committed to civil hospitals should have no more elaborate a right to refuse treatment in terms of ascertainable time to be “bought” or

protective procedure to be invoked to sustain their refusal once they have made their objection known. We do not mean to suggest involuntarily committed patients have no right to refuse at all (as some thought our earlier article intimated). Our point then was and remains now only that the issue of the patient's decisionmaking capacity (and thus his or her very competence to refuse) should be disposed of either as part of, or as close to simultaneous as feasible with, the decision to commit. As we said then and repeat now, there is no point in, logic to, committing patients for treatment (thus taking away their liberty in the largest, most conspicuous sense) only to allow them to litigate at length in another court whether or not once they walk through the hospital door they will in fact be treated. Or, take even the right to refuse of the involuntary patient's legal opposite, the voluntary patient. Though it is labeled absolute, as opposed to the involuntary patient's qualified right, it is hardly more substantial. An exercise of the right to refuse on the voluntary patient's part beyond mere articulation will typically result in a discharge against medical advice (this in fact happened to the patient in *Rennie* at one point). But in being discharged the voluntary patient pays a distinctly untherapeutic price for the assertion of this unqualified right. The alternate, "therapeutic", possibility is that the doctor will initiate civil commitment proceedings against the patient, which involves a loss of rights and liberty greater than being coerced to take an antipsychotic drug.

71. The incompetency may relate to the patient's capacity to decide to be hospitalized, or treated as an outpatient, or even his or her capacity to stand trial or be sentenced, competencies that can and have been distinguished from the competency to make "actual" treatment decisions, but that is not material. The State in pursuit of its wide-ranging *parens patriae* and police powers may override the will of even a competent person given sufficiently compelling reasons, such as the patient's dangerousness (within or without the institution) or even contagiousness (a form of dangerousness) or simply because the integrity of the legal process mandates it. Again, previewing some of the involuntary treatment cases, see *Jacobson v Massachusetts*, 197 U.S.11 (1905) (vaccination/quarantine for contagious medical disease); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972) (civil mental health commitment); *Washington v. Harper*, 494 U.S. 210 (1990) (forcible treatment of "dangerous" convict); *Jones v. United States*, 463 U.S. 354 (1983) (treatment/restoration of "morally innocent" criminal offender); *Kansas v. Hendricks*, 521 U.S. 346 (1997) (civil commitment of recidivism-prone compulsive sex offender); *United States v. Charters*, 863 F.2d 302 (4<sup>th</sup> Cir. 1988) and *Sell v. United States* 539 U.S. 166 (2003) (forcible treatment of criminally accused to restore for trial). It is also worth noting that the best or better (medical) interests of the patient, whether competent or not, may conflict with his/her legal interests or assertions not to be treated. It is not always the State that stands in opposition to the individual, who in a sense may be at war with him/herself.

72. 462 F.Supp.1131 (D.N.J. 1978), *et seq.* (see note 65 for full cite).

73. 478 F. Supp. 1342 (D. Mass. 1979), *et seq.* (see note 65).

74. 506 F.Supp. 915 (N.D. Ohio, 1980).

75. 744 F.2d 1387 (10<sup>th</sup> Cir. 1984).

76. *United States v. Charters*, 829 F.2d 479 (4<sup>th</sup> Cir. 1987) (*Charters I*) and *United States v. Charters*, 863 F.2d 302 *en banc* (4<sup>th</sup> Cir. 1988), (*Charters II*).

77. The six to eight years or so that it took to litigate these cases in various forums (fora?) (*Rennie*, complaint first filed in 1977; *Rogers*, plaintiff/patient class first certified in 1975; *Davis*, first single-judge U.S. District Court order issued in 1974) is nowhere near long in the context of institutional litigation. A major prison case, *Ruiz v. Estelle*, 503 F. Supp. 1265 (S.D. Tex. 1980), for example, was actively open for 20-plus years, and only then did it wind down to less than active status with most of the major issues resolved and the Court having formally relinquished jurisdiction over them. The 1980 date cited for the *Ruiz* case is when the District Court entered its decision on the merits and issued its first decree in the case, which had been originally filed in 1974. Some matters were still under the Court's jurisdiction in the early 1990s.

78. Again, for a case of even moderate length this feature of a change in the named defendant is routine (directors of major, frequently sued, bureaucracies or institutions tend not to last that long). The *Ruiz* case cited above became *Ruiz v. McKaskle* in 1983 when Texas Department of Corrections (TDC) Director W. J. Estelle, Jr., had had enough and resigned. After that it was *Ruiz v. Procnier*, followed by *Ruiz v. McCotter* and perhaps other, later designations (one loses track once personal involvement in the case ceases). There are a half dozen or so landmark cases in which the named defendant is *Estelle* owing to the fact that "Jim" Estelle directed TDC during many of its legally more contentious years, the lesson being that if one wants to achieve a measure of legal fame or infamy one should become head of Corrections in a large, preferably southern, state. TDC Director Procnier had a number of major California cases to his name as a result of directing that state's correctional department before he came to run the Texas prisons and garnered a few more. Florida's DOC director has given us several major *Wainwright* decisions spanning a period from the late 1960s to the mid 1980s!

79. *See* note 77, *supra*, in regard to the matter of selecting the starting date of a case or any series of cases. The date of a case's completion tends to be no easier to determine consistently. *See, e.g.*, *Davis v. Hubbard*, 506 F.Supp. 915 (N.D. Ohio, 1980) whose formal citation suggests a final decision at the end of the decade of the 1970s when in fact several issues were still open at the time. This, too, is characteristic of big institutional litigation. *See* note 78, *supra*.

80. Dating a case can even depend on which issue one chooses as most significant. For example, the *Charters* litigation, *supra*, note 76, could be said to have begun in 1974 with judicial inquiry into the competency matter or not until 1976 if one decides the forcible medication of the patient marks the relevant beginning of the treatment dispute.

81. *Charters I*, the panel decision, is not cited because it was overruled by the full court in *Charters II* (*supra*, note 76). The latter decision is not usable to plaintiff advocates because of the minimal process it prescribes. Even defense advocates may be prone to

avoid it for the reason that the clients they represent can accommodate, and would not necessarily object to, more process and because the case's procedural minimalism makes it vulnerable to being rejected as a precedent.

82. 476 F. Supp. 1294 (D.N.J. 1979), *supra*, note 65.

83. The case's history is usefully summarized in the Circuit Court of Appeals' second review of the dispute, *Rennie v. Klein*, 720 F.2d 266 (3<sup>rd</sup> Cir. 1983).

84. There are only four state hospitals today in New Jersey. The fifth and largest facility, Marlboro Psychiatric Hospital, was shut down in 1998. The remaining four facilities have had populations exceeding their planned capacities (undoubtedly lower than in the heyday of state institutionalizations) ever since, according to Mary Zdanowicz, J.D., executive director of the Treatment Advocacy Center (TAC), who used to work at the Marlboro facility and attended its closing ceremony.

85. *See* especially Chief Judge Seitz' concurring opinion, *Id.* at 274.

86. *Ibid.*

87. *Rennie v. Klein*, 476 F.Supp. 1294, 1297 (D.N.J. 1979).

88. *Id.* at 1296.

89. *Id.* at 1312.

90. *Id.* at 1311.

91. *Rennie v. Klein*, 653 F.2d 863 (3<sup>rd</sup> Cir. 1981); 620 F.2d 266 (3<sup>rd</sup> Cir. 1983).

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

93. 457 U.S. 307 (1982).

94. *Rennie v. Klein*, 462 F. Supp. 1131 (D. N.J. 1978); 653 F. 2d 836 (3<sup>rd</sup> Cir. 1981). We say "legally explicit" in that doctors can ordinarily be presumed to make their medical intervention decisions based on the least intrusive principle and cannot/should not ordinarily be challenged on this. The earlier *Rennie* decisions in effect did away with that presumption, holding that the medical deciders had to explicitly consider and justify their course of action as being least intrusive and that they could be challenged on this on the merits. The post-*Romeo* holding by contrast says any challenge to the medical judgment cannot come until after the course of action has been implemented and it cannot be on the merits, is not a *de novo* reconsideration, but an inquiry limited to the matter of whether the judgment exercised was indeed professional.

95. *Rennie v. Klein*, 720 F.2d 266, 269 (3<sup>rd</sup> Cir. 1983).

96. See the medical data section of this paper, “Of Typical and Atypical,” *supra*, at pp. —, for the proven proposition that restraints and seclusion or the administration of tranquilizers are not feasible alternatives for treating schizophrenics or other patients with severe mental disorders.

97. See Brakel & Davis, *supra*, note 1 regarding the costs of the need to relitigate the treatment issue after the patient has been committed. The literature cited there, at notes 70, 71 and 74 documents these costs and includes, *i.a.*, such studies as Steven K. Hoge, Thomas G. Gutheil & -- Kaplan, *The Right to Refuse Treatment under Rogers v. Commissioner: Preliminary Empirical Findings and Comparisons*, 15 BULL. AM. ACAD. PSYCHIATRY & LAW 163 (1987); Veliz & James, *Medicine Court: Rogers in Practice*, 144 AM. J. PSYCHIATRY 62 (1987); R. Schouten & T. Gutheil, *Aftermath of the Rogers Decision: Assessing the Costs*, 147 AM. J. PSYCHIATRY 1384 (1990).

98. *Rennie v. Klein*, 462 F. Supp. 1131, 1137 (D.N.J. 1978).

99. *Id.* at 1153.

100. *Id.* at 1136-38.

101. *Id.* at 1143-44. To put it in unvarnished terms, use of the First and Eighth Amendments in right-to-refuse litigation is patently wrong-headed and demonstrates the users’ misapprehension (deliberate distortion?) of the nature of antipsychotic drugs and why they are administered. Antipsychotics are given to psychotic patients in order to restore the brain’s chemical balance and thereby to restore normal, pre-morbid thinking and functioning to the extent possible. They do not infringe on the patient’s right of free speech or association in any sensible interpretation of that right. Contrary to what the antipsychiatric advocates wish to allege, there is no constitutional, due process protected right to be crazy. And medicating an institutionalized patient or for that matter a mentally ill outpatient over his objections does not mean the “government” is engaging in (political) mind control or that it is pursuing some other bizarre, sinister scheme for dealing with or disposing of its “undesirable” citizens. Nor does it constitute punishment in any commonsense or constitutionally accepted meaning of that term when doctors in public or private treatment settings medicate resisting patients. Yet these are the kinds of scenarios on which legal advocates proceed when they invoke these amendments in support of their clients, many of whom are unknowing of or manipulated into buying this literally outlandish worldview.

102. *Rennie v. Klein*, 476 F.Supp. 1294, 1305 (D.N.J. 1979).

103. *Id.* generally and *Rennie v. Klein*, 462 F.Supp. 1131 (D.N.J. 1978).

104. *Cf.* the description of the relief prescribed in *Rogers v. Commissioner*, 390 Mass. 489, 458 N.E.2d 308 (1983), or the facts and theories adopted by the Court in *Davis v.*

Hubbard, 506 F. Supp. 915 (N.D. Ohio 1980) as guiding its judgment, as described in the text below.

105. 478 F. Supp. 1342 (D. Mass. 1979).

106. See full cites at *supra*, note 65.

107. *Rogers v. Okin*, 478 F. Supp. 1342, 1371 (D. Mass. 1979).

108. 478 F. Supp. 1342. The prescription of so much process in this first go-around of the *Rogers* case was, as one surmises to be true for all cases with similar outcomes, undoubtedly influenced by the Court's "pessimistic" view (the adjective is taken from the *Charters II en banc* opinion, see note 76, *supra*, describing the panel decision's treatment of the drug issue) of the risks and benefits of drug treatment. Not only did the Court grossly overstate the potential for bad side-effects—for example, it quoted studies estimating the prevalence of tardive dyskinesia at 50%-56% (for institutionalized schizophrenics) at a time when the average length of stay for patients at the Boston Hospital Units was 14 days (meaning the risk of contracting TD was in fact nil for first admissions and a fraction of one percent in incremental risk for readmissions and other patients previously treated with antipsychotics)—it seemed to misperceive the nature and purpose of drug treatment altogether. While antipsychotic drugs may have "mind-altering" properties in some positive, restorative sense, the Court appeared stuck on the (inapposite) negative connotations of the term (*cf.* Douglas Mossman in *Denouement of an Execution Competency Case: Is Perry Pyrrhic?*, 23 BULL. AM. ACAD. PSYCHIAT. LAW 269, -- (1995): "Neuroleptics are to psychosis what eye glasses are to myopia: both interventions remove impediments to perception"). It saw the medications as endangering the First Amendment's "right to produce a thought" and the "communication of ideas", indeed the very "capacity to think." It spoke of "mind control" and speciously counterposed Justice Brandeis' famous dissenting remarks in *Olmstead v. United States*, 277 U.S. 438 (1928), about "man's spiritual nature" and the Constitution's implicit acknowledgement of that fact in the protections accorded to speech and thought (which "secure conditions favorable to the pursuit of happiness"), against the presumed threat to these fundamental values posed by the unwanted administration of drugs in a hospital designed to treat the most severely mentally ill.

109. *Id.* at 1383. The court ruled against damages because it could find no intent to inflict harm on the part of the defendants or even the harm itself that might entitle the plaintiffs to such recovery. Nor could it find any violations of state law on the order of assault and battery, false imprisonment or plain (negligent) malpractice. Instead, the Court made appeals to common sense in favor of the defendants, the difficult context, resource- and otherwise, in which the state physicians operated, and their presumed good faith. This is curious given all the verbiage about the infringement of fundamental rights and liberties that drove the injunction, language that presumes some intentionally culpable or at least reckless state of mind.

110. *Rogers v. Okin*, 634 F. 2d 650, 659 (1<sup>st</sup> Cir. 1980). The appeal also generated a new take on the right to refuse treatment for voluntary patients, the Court saying essentially that it made no sense to equivocate their right to that of involuntary patients. If a voluntary patient disagrees with the treatment regimen proposed, he or she can be asked to “leave”, the Court intimated, and there is nothing unconstitutional about that request or command.

111. *Id.* at 660-61.

112. *Id.* at 660.

113. *Id.* at 656-57. *See* note 96, *supra*.

114. 383 Mass. 415; 421 N.E.2d 40 (1981).

115. *Mills v. Rogers*, 457 U.S. 291, 303 (1982).

116. *Id.* at 299, note 16.

117. 390 Mass. 489, 458 N.E. 2d 308 (1983).

118. 458 N.E. 2d 308, 313.

119. *Id.* at 314.

120. *Id.* at 317.

121. *Id.* at 316.

122. *Id.* at 320.

123. 506 F. Supp. 915 (N.D. Ohio 1980).

124. *Ibid.* The U.S. District Court in its final published holding identified 23 “Issues” as requiring resolution, among which the matter of consent to medication was Issue 12, which the Court in its opinion disposed of together with Issue 13 on the need for/right to prior consent to *any* treatment modality or modalities used at the hospital.

125. *Id.* at 938.

126. *Ibid.*

127. *Ibid.*

128. *Id.* at 939.

129. *Ibid.*
130. 442 U.S. 584 (1979).
131. *Davis v. Hubbard*, 506 F. Supp. 915, 939 (N.D. Ohio 1980).
132. *Id.* at 927.
133. *Id.* at 927, note 8.
134. *Id.* at 928, note 14.
135. *Id.* at 928, note 13.
136. *Id.* at 929.
137. *Id.* at 926.
138. *Ibid.*
139. *Id.* at 927.
140. *Id.* at 933.
141. *Id.* at 933, note 22.
142. 744 F.2d 1387 (10<sup>th</sup> Cir. 1984).
143. 829 F.2d 479 (4<sup>th</sup> Cir. 1987) (*Charters I*). We confine ourselves to discussing in this section the first, panel, decision and opinion; *Charters II*, the *en banc* decision, we reserve for review in the section following on what (we think) is right with the law.
144. *Bee v. Greaves*, 744 F.2d 1387, 1389 (10<sup>th</sup> Cir. 1984).
145. *Ibid.*
146. *Id.* at 1395.
147. *Id.* at 1396.
148. *Id.* at 1397. Some of this is classic prison law analysis and no more. *See Bell v. Wolfish*, 441 U.S. 520 (1979).
149. *Id.* at 1390-91 and note 3.
150. *Id.* at 1394.

151. *Id.* at 1395.

152. 829 F.2d 479 (4<sup>th</sup> Cir. 1987).

153. *Id.* at 483, note 2. Robert Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW.U.L.REV. 461 (1977). Other favorite "authorities" cited include Lawrence D. Gaughan & Lewis H. LaRue, *The Right of a Mental Patient to Refuse Antipsychotic Drugs in an Institution*, 4 LAW & PSYCH. REV. 43 (1978); Zander, *Proloxin Decanoate: A Review of the Research*, 2 MENTAL DISABILITY L. REP. 37 (1977); and Crane, *Clinical Psychopharmacology in its 20<sup>th</sup> Year*, 181 SCIENCE 124 (1973).

154. *Id.* at 489.

155. *Ibid.*

156. *Ibid.*

157. *Id.* at 492.

158. *Ibid.*

159. *Id.* at 495.

160. *Id.* at 494.

161. *Ibid.*

162. *Ibid.*

163. *Ibid.* See Linda C. Fentiman, *Whose Right is it Anyway?: Rethinking Competency to Stand Trial in Light of the Synthetically Sane Insanity Defendant*, 40 U. MIAMI L. REV. 1109 (1986), which the Court cites in the text of its opinion.

164. *Ibid.*

165. United States v. Charters, 863 F.2d 302 (4<sup>th</sup> Cir. 1988), *Charters II*.

166. 494 U.S. 210 (1990).

167. *Charters II*, 863 F.2d 302, 307.

168. *Id.* at 309.

169. *Id.* at 307, note 3. The quoted sentences refer specifically to the side-effect of Tardive Dyskinesia, but the language is clearly generalizable to the costs and benefits of antipsychotic drugs at large.

170. 442 U.S. 584 (1979).

171. 457 U.S. 307 (1982).

172. *Charters II*, 863 F.2d 302, 309.

173. *Ibid.*

174. *Id.* at 310.

175. *Ibid.*

176. *Ibid.*

177. 494 U.S. 210 (1990).

178. *Id.* at 221-22.

179. *Id.* at 214.

180. *Id.* at 215.

181. *Id.* at 216.

182. The independence in fact of the review mechanism was challenged in no uncertain terms by the dissenters per Justice Stevens who, writing for himself and Justices Brennan and Marshall, referred to the process approved by the majority as “a mock trial before an institutionally biased tribunal.” *Id.* at 237. That is strong stuff, but perhaps not entirely out of line given shared institutional/penological interests among the tribunal members that could trump strict medical considerations. Less defensible is the dissent’s heavy emphasis, in line with the Washington Supreme Court, on all the negative properties of psychotropic medications, including their equation with psychosurgery, and so on (at 239-241).

183. *Id.* at 226.

184. *Ibid.*

185. *Id.* at 223-25. E.g., *Turner v. Safley*, 482 U.S. 78 (1987); *O’Lone v. Estate of Shabazz*, 482 U.S. 342 (1987); *Block v. Rutherford*, 468 U.S. 576 (1984) and *Hudson v. Palmer*, 468 U.S. 517 (1984).

186. *Id.* at 229.

187. *Id.* at 230.

188. *Id.* at 232, quoting *Parham v. J.R.*, 442 U.S. 584 (1979).

189. *Id.* at 222, note 8.

190. *Ibid.*

191. *Ibid.*

192. *Id.* at 244-45.

193. The “grave disability” criterion which was part of the Washington Policy seems to have been conflated by the Court, as is often done, with dangerousness (to self) as it is not alluded to in the key parts of the Court’s opinion regarding the substantive adequacy of the Policy.

194. 494 U.S. 113 (1990).

195. 504 U.S. 127 (1992).

196. 539 U.S. 166 (2003).

197. Brakel & Davis, *supra*, note 1 at 435.

198. *Zinermon v. Burch*, 494 U.S. 113 (1990).

199. Brakel & Davis, *supra*, note 1 at 432, note 12.

200. *Zinermon*, 494 U.S. 113, 115.

201. *Id.* at 138.

202. See, e.g., Rael Jean Isaac & Samuel J. Brakel, *Subverting Good Intentions: A Brief History of Mental Health Law “Reform”*, 2 CORNELL J. LAW AND PUBLIC POLICY 89 (1992). Even some traditional “reform” advocates saw *Zinermon* as a potential threat to appropriate voluntary mental health care. Bruce J. Winick, *Competency to Consent to Treatment: The Distinction between Assent and Objection*, 28 HOUSTON L. REV. 15 (1991).

203. 504 U.S. 127 (1992).

204. *E.g.*, a reporter for the Chicago Tribune, who apparently had no access to reasonably sophisticated and impartial legal informants, interpreted *Riggins* as “Upholding the rights

of mentally ill criminal defendants [via its ruling] that they cannot be given mind-altering drugs to make them appear sane at trial.” Elsasser, *Rights of Mentally Ill Defendants Upheld*, CHI. TRIB. May 19, 1992, at 3 (sec. 1).

205. *Riggins*, 504 U.S. 127, 129.

206. *Ibid.*

207. *Id.* at 130.

208. *Ibid.*

209. *Id.* at 131.

210. *Ibid.*

211. *Id.* at 132.

212. *Id.* at 129.

213. *Id.* at 133.

214. *Id.* at 151. Justice Thomas in dissent notes that the defendant in *Riggins* was not a *Harper*-style refuser. *Riggins* did not contest the medical propriety of his medication regimen and his objections were based on considerations of legal strategy rather than personal well-being (or personal delusion for that matter). Also, he was not seeking an injunction against being forcibly medicated or damages for improper treatment or violation of his civil rights. Instead he wanted a reversal of his conviction on the theory that the effects of the medication precluded a fair trial. *Harper*'s relevance to this context and these objectives is limited at best.

215. *Id.* at 135. *Bell v. Wolfish*, 441 U.S. 520 (1979).

216. *Id.* at 129.

217. *Id.* at 136.

218. *Id.* at 135.

219. *Bell v. Wolfish*, 441 U.S. 520 (1979).

220. *Riggins* at 135. Some commentators have made something of this “might” and perhaps it is behind the equivocations in applying the standard demonstrated by the Court in the *Sell* case, *infra*, though there is no overt reference to this in *Sell*.

221. *Ibid.*

222. *Id.* at 156.

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

224. Much of this is driven by opposition to the death penalty *per se* and/or by the ethical quandaries many physicians feel are posed by the axiom not to do harm to patients (an axiom that, like it or not, cannot be pertinent to physicians who are willing to assume the forensic role). The most serious dilemma the physician confronts is the quasi-forensic one when psychiatric treatment is medically needed and legally mandated over the resistance of a death row prisoner, in particular a prisoner nearing the execution date. This is primarily because of the *proximity* between medical restoration and the State's facility to carry out the capital sentence, as treatment--whether for somatic or psychiatric illness--should not raise ethical concerns when the date is distant (surely, physicians could not justifiably withhold their services, and would not, from death row inmates as such). For those burdened by the proximity problem, a way out in addition to the treat-only-to-alleviate-suffering response is to have the State commute the death sentence of a prisoner who is rendered incompetent before execution, thereby eliminating the dilemma of "participation" in the death process, as it is seen by some (including organized psychiatry which prohibits its members from treating to restore in this context). Such solutions can be and have been arrived at case-by-case but it is also possible to write the law that way, as at least one state, Maryland, has done (MD. CODE ANN., CORRECTIONAL SERVICES § 3-904 (c) (h) (2). *See, e.g.*, Richard J. Bonnie, *Symposium: The Death Penalty and Mental Illness: Unsolved Puzzles for Courts and Legislatures*, 54 CATH. U. L. REV. 1169 (2005). Bonnie prefers this solution because in his view forced treatment in this context is "unethical...[and therefore] not 'medically appropriate' and...constitutionally impermissible." If this sounds like a conclusion masquerading as argument, it is not atypical of the debate in this area. *See, generally, Analysis and Commentary, Organized Psychiatry and the Death Penalty*, articles by Michael A. Norko *et al.*, 32 J. AM. ACAD. PSYCHIATRY LAW 178 (2004).

225. Actually, more than a few "forensic" institutions today do engage in limited attempts at *legal* restoration. But absent medical improvement (via medication) this would be futile. It is analogous to, as is typically done, "educating" someone who is being evaluated for competency so as to differentiate between lack of knowledge and lack of understanding of or distorted perceptions about the legal process. This overriding medical reality is reflected, *i.a.*, in the fact that mentally retarded defendants have been found to be restorable at 50% of the rate that mentally ill accuseds are (40%-45% vs. 80%-90%) and that goes only for those at the margin of developmental deficiency. Studies show that administering medication is the *sine qua non* for restoring the mentally ill to legal competence and that on average three to four months of such treatment suffices for the 80% to 90% who are restored. Studies also show (*see* Brian Ladds *et al.*, *The Disposition of Criminal Charges After Involuntary Medication to Restore Competency to Stand Trial*, 38 J. FORENSIC SCI. 1442 (1993) that an accused's forcible medication does not adversely affect ability/opportunity to arrive at a mutually acceptable plea bargain nor inhibit success (from the defense's perspective) in cases where the

insanity defense is asserted. There is evidence that specific legal education-oriented restoration efforts, when combined with treatment of the medical symptoms, speed up the restoration process (though this may also be due to the halo effect, the extra staff attention given to the patients). That finding may argue for legal restoration efforts as one facet of treatment, though concerns have been expressed about over-involving clinicians in the patients' legal matters from both an ethical and pragmatic stand-point. It may, ironically, yield a competency that is in both appearance and fact superficial and synthetic—the very charges that have been leveled, with much less if any justification, against medication-restored patients. See Debra A. Pinals, *Symposium: New Law, Policy, and Medicine of Involuntary Treatment: A Comprehensive Case Problem Approach to Criminal and Civil Aspects*, 31 N.E. J. ON CRIM. & CIV. CON. 81 (2005), relying in particular on Linda Pendleton, *Treatment of Persons Found Incompetent to Stand Trial*, 137 AM. J. OF PSYCHIATRY 1098 (1980); Daniel L. Davis, *Treatment Planning for the Patient Who is Incompetent to Stand Trial*, 36 HOSP. & COMMUNITY PSYCHIATRY 268 (1985); Stephen G. Noffsinger, *Restoration to Competency Practice Guidelines*, 45 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 356 (2001); and Robert D. Miller, *Hospitalization of Criminal Defendants for Evaluation of Competence to Stand Trial or Restoration to Competence; Clinical and Legal Issues*, 21 BEHAV. SCI. & L. 369 (2003).

226. 429 U.S. 97 (1976). The State may not be deliberately indifferent to an inmate's serious medical needs.

227. *Riggins*, at 137. Later in the opinion the Court speaks of the “unacceptable risk” and the “strong possibility” of prejudice (at 137 and 138, respectively). Justice Thomas in dissent makes the point, among several other technical but critical ones, that to justify a reversal of one's conviction, one must *prove* actual prejudice, not merely allege its possibility.

228. *Id.* at 137-38.

229. *Id.* at 139.

230. *Id.* at 143.

231. 744 F.2d 1387 (10<sup>th</sup> Cir. 1984).

232. 539 U.S. 166 (2003).

233. *Id.* at 169.

234. *Id.* at 170.

235. *Ibid.*

236. *Ibid.*

237. *Ibid.*
238. *Id.* at 171-75.
239. *Id.* at 172-73.
240. *Id.* at 184.
241. *Id.* at 169.
242. *Id.* at 179.
243. *Id.* at 180.
244. *Id.* at 181.
245. *Id.* at 182, quoting from Justice Kennedy's concurrence in *Riggins*.
246. *Ibid.*
247. Codified at 28 C.F.R. § 549.40-549.43.
248. *Washington v. Harper*, 494 U.S. 210 (1990).
249. 28 C.F.R. § 549.43.
250. *Ibid.*
251. *Sell v. United States*, 538 U.S. 166 (2003).
252. 28 C.F.R. § 549.43.
253. *Sell*, at 178.
254. 28 C.F.R. § 549.43.
255. 158 F.3d 947 (6<sup>th</sup> Cir. 1998).
256. *Id.* at 950.
257. *Id.* at 955-56.
258. *Id.* at 960.
259. *Id.* at 953-54.

260. *Id.* at 960-61.
261. *Id.* at 955.
262. See Ladds *et al.*, *supra*, note 225.
263. 612 A.2d 160 (D.C. App. 1992).
264. 193 F.3d 252 (4<sup>th</sup> Cir. 1999).
265. *Id.* at 257.
266. *Id.* at 260.
267. *Id.* at 262.
268. *Id.* at 264.
269. United States v. Morrison, 415 F.3d 1180 (10<sup>th</sup> Cir. 2005).
270. United States v. Bradley, 417 F.3d 1107 (10<sup>th</sup> Cir. 2005).
271. *Ibid.*
272. A. Hartocollis, *Ex-Congress Aide Accused in Spy Case is Free on Bail*, NEW YORK TIMES, Sept. 9 2006.
273. Pat Reavy, *Barzee Ruling Argued*, DESERET MORNING NEWS, Dec. 7, 2006; Pat Reaves, *Highly Agitated Mitchell Still Incompetent for Trial*, DESERET MORNING NEWS, Dec. 19, 2006.
274. See the CATALYST (Newsletter of the Treatment Advocacy Center) Spring/Summer 2004. TAC also maintains a website, [www.psychlaws.org](http://www.psychlaws.org), on which it provides, *i.a.*, updates on the latest legislative reforms. TAC advocates refer to the process as “assisted outpatient treatment” (AOT) which apart from deemphasizing the nonconsensual aspects of “outpatient commitment” also has the advantage of avoiding its oxymoronic quality, the term commitment being associated with confinement in an institution, *i.e.*, being an *inpatient*.
275. *Ibid.*
276. CATALYST, Spring/Summer 2005 at 7 and 15. The latter page presents “real-world results” on New York’s Kendra’s law under the title “Kendra’s Law families and participants laud program: Report shows sharp reductions in hospitalizations, incarcerations, homelessness.” The TAC group points to a number of other studies supporting the notion that the outpatient commitment laws have achieved their intended

effects: Guido Zanni & Leslie deVeau, *Inpatient Stays Before and After Outpatient Commitment*, 37 HOSP. & CMTY PSYCHIATRY 941 (1986); M.R. Munetz *et al.*, *The Effectiveness of Outpatient Civil Commitment*, 47 Psychiatric Services 1251 (1996); B.M. Rohland, *The Role of Outpatient Commitment in the Management of Persons with Schizophrenia*, IOWA CONSORTIUM FOR MENTAL HEALTH SERVICES, TRAINING, AND RESEARCH (1998); and Gustavo A. Fernandez & Sylvia Nygard, *Impact of Involuntary Outpatient Commitment on the Revolving-Door Syndrome in North Carolina*, 41 HOSP. & CMTY PSYCHIATRY 1001 (1990). Later studies in North Carolina have been especially persuasive in documenting positive effects of mandated outpatient treatment in various respects. See (the titles are indicative) Marvin S. Swartz, Jeffrey W. Swanson, H. Ryan Wagner *et al.*, *Can Involuntary Outpatient Commitment Reduce Hospital Recidivism?* 156 AM. J. PSYCHIAT. 1986 (1999); Jeffrey W. Swanson, Marvin S. Swartz, R. Borum *et al.*, *Involuntary Outpatient Commitment and Reduction in Violent Behaviour in Persons with Severe Mental Illness*, 176 BRIT. J. PSYCHIAT. 224 (2000); Jeffrey W. Swanson, R. Borum, Marvin S. Swartz *et al.*, *Can Involuntary Outpatient Commitment Reduce Arrests among Persons with Severe Mental Illness?* 28 CRIM. JUSTICE & BEHAVIOR 156 (2001); Virginia A. Hiday, Marvin S. Swartz, Jeffrey W. Swanson *et al.*, *Impact of Outpatient Commitment on Victimization of People with Severe Mental Illness*, 159 AM. J. PSYCHIAT. 1403 (2002).

277. Once seemingly a minority perspective, this reflexive civil libertarian complaint is now the dominant perspective, if the law journal literature is any guide (that literature is of course selective). See, *e.g.*, Bruce J. Winick & -- Kress, *Special Theme: Preventive Outpatient Commitment for Persons with Serious Mental Illness: Forword: A Symposium on Outpatient Commitment Dedicated to Bruce Ennis, Alexander Brooks, and Stanley Herr*, 9 PSYCH. PUB. POL. AND LAW 3 (2003). One need only read the Forword, invoking the views of past mental health law luminaries, to know where the surviving generation of those who presume to be patients' advocates is going. Further evidence that the civil libertarians have organized themselves is that both old and new "research" findings are (mis)used to make the case against outpatient commitment: *e.g.*, Jennifer Honig & Susan Stefan, *Outpatient Commitment Debate: New Research Continues to Challenge the Need for Outpatient Commitment*, 31 N.E. J. CRIM. & CIV. CON. 109 (2005). (Honig is Staff Attorney to the Mental Health Legal Advisors Committee of the Supreme Judicial Court of Massachusetts in Boston; Stefan is an attorney with the Center for Public Representation in Newton, MA). How something new can "continue" to make a case for or against anything is one small mystery. The substance of what is presented is no more edifying. Much of it has the imprint of the Therapeutic Jurisprudence school of thought which, its benign if not disingenuous name notwithstanding, but in line with its civil libertarian roots and continued backing from these quarters, is against therapy in its straightforward sense (*i.e.*, as sought to be provided via the laws of civil commitment, both in- and outpatient). Among other things, the argument is made, with conspicuous irrelevancy, that recent studies (*e.g.*, by the "prestigious" MacArthur Network on Mental Health, the authors' words) presumably documenting an absence of relationship between mental illness and violent behavior robs the outpatient treatment concept of its primary rationale (or "pretext" as the over-the-top lingo of this school would have it). An Australian study is cited for the proposition that outpatient commitment *alone* does not

reduce hospitalizations *in the first year after the introduction of community treatment orders* (some measure!). The distinctly uncontroversial idea that outpatient commitment improves compliance with medication is dismissed on the ground that “few studies have directly addressed it.” The few that have, purportedly are inconclusive because (1) they do not appear to show discernible improvement in the short term but only in the longer run and even that is a mirage because, in a sequitur that is as dubious logically as it is empirically, the drugs complied with “have serious side-effects and [are of] questionable efficacy.” Studies on the so-called “subjective quality of life experiences” of the severely mentally ill are invoked to show that the subjects perceived outpatient commitment as “coercive” (is that not the point?) and that they would be inclined to participate voluntarily in all sorts of alternative “consumer-operated and –oriented” remedial programs whose lack of availability is matched only by absence of any proof of efficacy (a true mirage!). And so on. Personally, over against this sort of lawyerly special pleading, we are quite willing to take the word of the Treatment Advocacy Center’s reporters and the studies they rely on, see note 276, *supra*, that the outpatient treatment laws have had many of their desired effects.

278. In theory at least. A recent article by Richard J. Bonnie and John Monahan, *From Coercion to Contract: Reframing the Debate on Mandated Community Treatment for People with Mental Disorders*, 29 LAW AND HUMAN BEHAVIOR 485 (2005), confirms (by the title alone) that there is much less agreement on the value of the concept than its proponents once optimistically believed. See also note 277, *supra*.

279. 527 U.S. 581 (1999).

280. See note 274, *supra*.

281. See, e.g., the studies on anosognosia, *supra*, at notes 37 and 38, for the notion that the resistance to treatment on the part of a high percentage of the mentally ill is founded on bad reasons, including the failure to recognize their illness which is a feature of the illness.

282. The American Bar Foundation in the 1970’s and ‘80’s published two editions of a major study tracing these developments in civil commitment law, including commentary on the rationales (*i.e.*, their “beauty”): SAMUEL J. BRAKEL & RONALD S. ROCK, *THE MENTALLY DISABLED AND THE LAW* (1971) and SAMUEL J. BRAKEL, JOHN PARRY & BARBARA A. WEINER, *THE MENTALLY DISABLED AND THE LAW* (1985).

283. See generally the 1985 ABF study, *supra*, note 282.

284. *Ibid.*

285. The Oregon law contains a feature, discussed below, that could cause one to hedge a bit on whether the state has fully decoupled commitment from proof of dangerousness, but on balance the conclusion that it has seems not merely tenable but appropriate.

286. Personal contact with advocates in Wisconsin and others outside the state, including Rael Jean Isaac, an influential New York-based supporter of this assisted treatment standard, confirms the fight over this standard was major. Isaac of course is the first author of *MADNESS IN THE STREETS*, *supra*, note 36.

287. WIS. STAT. ANN. § 51.20(1)(a)1 and 2. *See* text below.

288. *Id.* at § 51.20(1)(a)2(e).

289. This language is taken from the “gravely disabled” statute of Washington, which was reformed to encompass more medically-oriented criteria back in 1979. *See* text, *infra*.

290. OKLA. STAT. ANN. § 43A-1-103(13)(a).

291. The law has gone back and forth on whether it is appropriate for mental health experts to offer testimony on ultimate legal issues, with the post-Hinckley reforms following the acquittal by reason of insanity of President Reagan’s would-be assassin, enacted in 1984 for the federal courts, leading the way toward the currently dominant position of disallowing it.

292. It has been pointed out innumerable times by both judges and legal commentators that commitment is a social/legal decision rather than a medical one, but this does not alter the fact that medical criteria and medical facts are what that social/legal decision should be heavily based on.

293. IOWA CODE § 229.1(15).

294. OR. REV. STAT. § 426.005(1)(d)(C)(i),(ii),(iii) and(iv).

295. *Ibid.*

296. WASH. REV. CODE ANN. § 71.05.020(14)(a).

297. A version of this piece can be found in DAVID B. WEXLER, *THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT* (1990), ch. 6, at 121, Mary L. Durham and John Q. LaFond, *The Impact of Expanding a State’s Therapeutic Commitment Authority*.

298. IDAHO CODE § 66-317(m).

299. *See* note 276, *supra*.

300. Mary Zdanowicz of TAC, *see supra*, note 84, brought the incompleteness of the earlier analysis to the authors’ attention.

301. WYO. STAT. ANN. § 25-10-101(a)(ii)(C).

302. 405 ILL. COMP. STAT. § 5/1-119.

303. S. D. CODIFIED LAWS § 27A-1-1(4) and (5)(a) and (b).

304. *See, e.g.*, reports on this trend reported by the Treatment Advocacy Center, *supra*, notes 274 and 276.

305. *See* Brakel & Davis, *supra*, note 1, at 469-72.

306. The process is futile in that ultimately, after all the delay and its bad consequences, the override of the patient's refusal is sustained by the courts in over 95% of the cases. *See, e.g.*, R. Schouten & T. Gutheil, *Aftermath of the Rogers Decision: Assessing the Costs*, 147 AM. J. PSYCHIATRY 1348 (1990) (96.6% of 1,514 Massachusetts cases studied).

307. CONN. GEN. STAT. ANN. § 17a-495(a); DEL. CODE ANN. Tit. 16, § 5001(6)(i); FLA. STAT. ANN. § 394.467(1)(b); N.Y. MENTAL HYG. Law § 9.01.

308. DEL. CODE ANN. Tit. 16, § 5001(6); IOWA CODE ANN. § 229.1(15); KAN. STAT. ANN. § 59-2946(f)(1); MICH. COMP. LAWS ANN. § 330.1401(c); S.C. CODE ANN. § 44-17-580(1).

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309. TEX. HEALTH & SAFETY CODE ANN. § 574.034(a)(2)(C)(iii).

310. WIS. STAT. ANN. § 51.2091(a)2(e).

311. *See* Joel M. Silberberg, Terri L. Vital & S. Jan Brakel, *Breaking Down Barriers to Mandated Outpatient Treatment for Mentally Ill Offenders*, 341 PSYCHIAT. ANNALS 433 (2001). Also: Bonnie & Monahan, *supra*, note 278. The latter makes the point that all of these choices are coerced from the patient's standpoint, but also that the level of coercion varies and that any evaluation of the relative merits or wisdom of making these choices available would profit from being viewed from a contract-law perspective as distinct from an autonomy infringement/coercion stand point. If taken literally, this advice may suffer from the drawback that many patients may not be competent to contract.

312. *See* G. Zanni & L. deVeau, *Inpatient Stays Before and After Outpatient Commitment*, 37 HOSP. AND COMM. PSYCHIATRY 941 (1986).

313. *See* Bonnie & Monahan, *supra*, notes 278 and 311.

314. While it would be inappropriate, even unfair, to discount the rehabilitative motives driving the mandated outpatient treatment movement, it is also a fact that—as with similar legal developments (*e.g.*, recent sex offender commitment legislation)—the catalyst is often a criminal event that inspires public horror, suggesting that the objectives

of punishment and incapacitation are also operative. Advocates from groups such as TAC and others who favor expanding the availability of “assisted “ treatment, contrary to earlier activists for mental patients, make no bones about the association between mental illness and violent behavior or about using this association to motivate legislators to support their agenda.

315. It could be argued that states with a unitary standard for inpatient and outpatient commitment do not “really” have discrete outpatient commitment laws, as the least restrictive principle as applied in commitment requires a finding that outpatient treatment be considered first and that (inpatient) commitment is permissible only on proof that outpatient treatment is not the answer.

316. It could also be argued that applying the least restrictive alternative principle is mandatory, in which case the judge is merely following the law instead of exercising benevolent discretion.

317. Mary Zdanowicz, Executive Director of TAC, points out that the opponents of outpatient commitment argue that the “home invasion” that could occur in the course of the effort to medicate an uncooperative outpatient is every bit as demeaning of liberty as involuntary hospitalization. We would disagree: (1) such unwanted home entries, if they occur, would be exceptional whereas (2) hospitalization and its total loss of residential freedom is the rule in commitment.

318. Bonnie *et al.*, *supra*, note 278.

319. *Ibid.*

320. For purposes of their paper, Bonnie *et al.*, *supra*, note 278, at 489, simply assume the competency of the patients involved in the bargaining process. This may be theoretically permissible but it does not do away with the practical problem.

321. N.Y. MENTAL HYG. LAW § 9.60(C).

322. *See, e.g.*, HAW. REV. STAT. § 334.60.2; CAL. WELF. & INST. CODE § 5346(a).

323. GA. CODE ANN. § 37-3-1(12.1).

324. TEX. HEALTH & SAFETY CODE ANN. § 574.034.

325. *Id.* at § 574.035.

326. 104 STAT. 337, 42 U.S.C. § 12132. The specific section refers to Title II of the Act, at issue in the *Olmstead* case, *infra*.

327. 527 U.S. 581 (1999).

328. Actually, the patient/petitioners had already obtained community placement by the time the Supreme Court took the case, but the Court ruled the matter was not moot because of the patients' history of multiple institutional placements which presumably suggested similar controversies could arise in the future.

329. 527 U.S. 581, 611, 615-616 (1999).

330. *Id.* at 604-605.

331. *Id.* at 606.

332. *Id.* at 603-604. It is possible the Court allowed the budgetary "defense" because it was interpreting statutory imperatives rather than Constitutional ones, but that is doubtful given Justice Ginsburg's opinion made no such distinction.

333. *Id.* at 605.

334. *Ibid.*

335. *Id.* at 609.

336. *Id.* at 609-610.

337. The law is allowed to, should in fact, assume basic medical/institutional realities including such that there ordinarily is communication about treatment prospects and plans between therapist and patient. As distinct from case law drawn from litigation where worst-case evidence is introduced, the statutory or regulatory law ordinarily need not and should not be written based on worst-case scenarios. *Cf.* the discussion of *Rennie v. Klein* in the text, *supra*, at pp.-- where we reproduce the administrative regulation—presumptively a codification of practices--guiding doctors in New Jersey on how to approach patients who resist prescribed treatment. Substantively, the regulation in fact incorporates the least intrusive/least restrictive principle and its procedural mandates suggest abundant deference to the patient's preferences via the physician's stated obligation to discuss alternatives with the patient, to try make the patient understand and to encourage voluntary acceptance (with the help of relatives and friends if so indicated) before seeking approval from the hospital medical director to proceed over the patient's objections.

338. *Vitek v. Jones*, 445 U.S. 480 (1980).

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

340. Post-deprivation judicial review should suffice because (1) judges have no expertise in medical matters and therefore should not be baseline (first-instance) decision makers and (2) the costs in time and treatment foregone, deflection of resources, and institutional

bad effects of the judiciary's failing to show proper deference to medical professionals are large.