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Is It More than Dodging Lions and Wastin' Time: Adequacy of Counsel, Questions of Competence, and the Judicial Process in Individual Right to Refuse Treatment Cases

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IS IT MORE THAN "DODGING LIONS AND WASTIN' TIME"? Adequacy of Counsel, Questions of Competence, and the Judicial Process in Individual Right to Refuse Treatment Cases

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This article argues that, if the MacArthur Treatment Study is to be meaningfully operationalized, it is necessary to consider the ways that counsel is provided in individual cases to institutionalized individuals wishing to assert the right to refuse antipsychotic drug treatment. It looks at the role of counsel in individual right to refuse cases, examines the ways that counsel is assigned in 3 states, and considers the underlying questions through the filters of "sanism" and "pretextuality." It concludes that the issues of the availability of and competence of counsel must be addressed by policy makers if the goals of the MacArthur study are to be met.

I. Introduction

No aspect of mental disability law is more contentious than the right of institutionalized mental patients to refuse antipsychotic medication. For nearly two decades a rancorous debate has focused on two overarching questions: the degree of autonomy that presumptively mentally ill persons can exercise in treatment decision making and the extent to which treatment decision making is justiciable. This debate has dominated both the relationship between law and psychiatry and the emerging jurisprudence of mental disability law.[1]

Medical journals, law reviews, forensic psychiatry publications, and "crossover" interdisciplinary volumes have published a steady stream of "right to refuse" literature from every imaginable perspective—that of the institutional psychiatrist, the expert witness, the political scientist, the philosopher, the sociologist, the academic, the patient advocate, the family member, and the patients themselves. And this stream continues unabated.[2]

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[1] *See generally* Michael L. Perlin, *Decoding Right to Refuse Treatment Law,* 16 INT'L J.L. & PSYCHIATRY 151 (1993).

[2] *See generally* 2 MICHAEL L. PERLIN, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL (1989), §§ 5.01–5.02, at 29–33 (1995 Supp.) (citing sources).

Since the trial decisions in *Rennie v. Klein*[3] and *Rogers v. Okin*[4] first articulated a limited constitutional right to refuse, a flood of court decisions from state and federal courts in practically every jurisdiction in the nation have tinkered with the contours of the right.[5] Although the Supreme Court has issued substantive decisions in two right to refuse cases emanating from the criminal trial process—*Washington v. Harper*[6] and *Riggins v. Nevada*[7]—it has not returned to the question in a civil case[8] since it initially sidestepped a merits decision on the issue in 1982 in *Mills v. Rogers.*[9]

The combination of the flood of decisions and the Supreme Court's failure to articulate bright line standards in civil right to refuse cases has contributed to the volatility of this area of the law and has understandably left many clinicians and administrators in a state of confusion regarding the appropriate legal standards in any individual case.[10] The MacArthur Treatment Competence Study was designed, at least in part, to provide a better data base to such providers by developing "reliable and valid information with which to address clinical and policy questions" about one of the key "swing factors" in this area of the law: "the abilities of persons with mental illness to make decisions about psychiatric treatment."[11]

The MacArthur study[12] recognizes appropriately that any research done about questions of competence and consent must take into account the broad range of court decisions that have constitutionalized the right of institutionalized psychiatric patients to impose objections to involuntary medical treatment.[13] The study clearly recognizes the significance of this body of case law and the extent of the degree of contentiousness involved in (a) its approach to the questions of causation and competence in the institutional administration of antipsychotic medication[14] and (b) its rationale for the need to develop mechanisms to measure patients' competence to

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[3]476 F. Supp. 1294 (D.N.J. 1979), *stay denied in part, granted in part,* 481 F. Supp. 552 (D.N.J. 1979), *modified and remanded,* 653 F. 2d 836 (3d Cir. 1981) (en banc), *vacated and remanded,* 458 U.S. 1119 (1982). *See generally* 2 PERLIN, *supra* note 2, §§ 5.10–5.21.

[4]478 F. Supp. 1342 (D. Mass. 1979), *modified,* 634 F. 2d 650 (1st Cir. 1980) (en banc), *vacated sub nom* Mills v. Rogers, 457 U.S. 291 (1982); *see generally* 2 PERLIN, *supra* note 2, §§ 5.22–5.26.

[5]*See* 2 PERLIN, *supra* note 2, §§ 5.41–5.46.

[6]494 U.S. 210 (1990); *see generally* 2 PERLIN, *supra* note 2, § 5.64A (1995 Supp.).

[7]504 U.S. 127 (1992); *see generally* 2 PERLIN, *supra* note 2, § 5.65A (1995 Supp.).

[8]The Court had also granted *certiorari* to resolve the question of whether the Eighth Amendment prohibits states from forcibly medicating death row inmates to make them competent to be executed but eventually remanded that case in light of its decision in *Harper. See* Perry v. Louisiana, 498 U.S. 38 (1990); *see generally* 3 PERLIN, *supra* note 2, § 17.06B (1995 Supp.).

[9]457 U.S. 291 (1982); *see generally* 2 PERLIN, *supra* note 2, § 5.33 at 310–11. In remanding *Mills* (for further consideration in light of an intervening state court decision), the Court specified that a state was free to create liberty or other due process interests broader than those mandated by the federal Constitution. 457 U.S. at 300–03.

[10]*See* Perlin, *supra* note 1, at 177.

[11]Paul Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study. I: Mental Illness and Competence to Consent to Treatment,* 19 LAW & HUM. BEHAV. 105, 118 (1995).

[12]*E.g.*, Appelbaum & Grisso, *supra* note 11; Thomas Grisso et al., *The MacArthur Treatment Competence Study. II: Measures of Abilities Related to Competence to Consent to Treatment,* 19 LAW & HUM. BEHAV. 127 (1995); Thomas Grisso & Paul Appelbaum, *The MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments,* 19 LAW & HUM. BEHAV. 149 (1995) (hereinafter Grisso & Appelbaum, *Abilities*); Thomas Grisso & Paul Appelbaum, *A Comparison of Standards for Assessing Patients' Capacities to Make Treatment Decisions,* 152 AM. J. PSYCHIATRY 1033 (1995) (hereinafter Grisso & Appelbaum, *Comparison*).

[13] *See, e.g.,* Appelbaum & Grisso, *supra* note 11, at 107 (citing cases). *See generally* MICHAEL L. PERLIN, LAW AND MENTAL DISABILITY §§ 2.08–2.31 (1994).

[14]Appelbaum & Grisso, *supra* note 11, at 107–08.

consent to such treatment.[15] It also recognizes that court decisions must be looked at as a source for any attempt to understand the various standards of assessing decision-making competence that governs the administration of medication to nonconsenting patients.[16] Furthermore, the study's analysis of the data developed through the use of testing instruments designed to assess competence to refuse also suggests an understanding of the significance of the developing case law.[17] Finally, it notes the relationship between competency determinations and legal standards and discusses what should be done—clinically and legally—in the cases of patients with severely reduced decision-making abilities.[18]

The study, however, does *not* consider a critical issue that must be considered if the full textures of the network's findings are to be appreciated (and, optimally, operationalized): the ways that counsel (or other advocacy assistance)[19] is provided in individual cases to the persons at risk. Although it cites decisions such as *Rogers v. Commissioner of Mental Health*[20] and *Riese v. St. Mary's Hospital & Medical Center*[21] that set out a constitutional framework for analyzing the underlying issues,[22] these cases (perhaps with the exception of *Rivers v. Katz*)[23] do not focus on the critical issue of implementation: How are these rights to be effectuated on a case-by-case basis?[24]

We are aware that our focus here is on a problem that is at least 2° removed from the core questions considered by the MacArthur group. We have chosen to write about it, however, because of our belief that, if serious attention is not paid to the case-by-case implementation issue, any ameliorative changes in the law based on the MacArthur study[25] will be little more than "paper victories."[26]

All too often, we assume (with little evidentiary basis) that adequate legal counsel is provided globally to institutionalized mentally ill persons (despite an extensive data base that belies this assumption).[27] It is critical that the study be read in light of what actually happens in such cases. Is counsel available?[28] Is counsel adequate?[29] Are courts competent to make determinations as to competency of counsel in this area?[30]

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[15]Grisso et al., *supra* note 12, at 127–28.

[16]Appelbaum & Grisso, *supra* note 11, at 108–11.

[17]Grisso & Appelbaum, *Abilities, supra* note 12, at 170–72.

[18]*Id.* at 168–73.

[19]In California, e.g., it is not necessary that the advocate be an attorney. *See infra* text accompanying note 101.

[20] 458 N.E. 2d 308 (Mass. 1983); *see generally* 2 PERLIN, *supra* note 2, § 5.35.

[21] 243 Cal. Rptr. 241 (Ct. App. 1987), *republished at* 271 Cal. Rptr. 1991 (Ct. App. 1987), *review granted & superseded by* 751 P. 2d 893 (Cal. 1988) *cause dismissed & order published,* 774 P. 2d 698 (1989); *see generally* 2 PERLIN, *supra* note 2, § 5.43A.

[22] *See generally* Perlin, *supra* note 1.

[23]495 N.E. 2d 337 (N.Y. 1986); *see generally* 2 PERLIN, *supra* note 2, § 5.43.

[24]*See, e.g.,* 2 PERLIN, *supra* note 2, at §§ 5.43–5.44 (1995 Supp.).

[25]*See, e.g.,* Bruce Winick, *The MacArthur Treatment Competence Study: Legal and Therapeutic Implications,* 2 PSYCHOL., PUB. POL'Y, & L. 137–166 (1996) (this issue).

[26]*See* Michael L. Perlin, *The ADA and Persons with Mental Disabilities: Can Sanist Attitudes Be Undone?* 8 J.L. & HEALTH 15, 23 (1993–94).

[27]*See generally* Michael L. Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases,* 16 LAW & HUM. BEHAV. 37 (1992).

[28]*See id.* at 43–45.

[29]*See id.* at 49–52.

[30]*See* Michael L. Perlin, *Are Courts Competent to Decide Competency Questions? Stripping the Facade from* United States v. Charters, 38 U. KAN. L. REV. 957 (1990).

Are they even interested in the issue?[31] What are the implications of these findings for the "real life" future of the study's conclusions and recommendations?[32] Do right to refuse treatment hearings advance dignity values,[33] or are they, in the words of Bob Dylan, simply an exercise in "dodging lions and wastin' time?"[34]

We address these questions through a variety of filters: through the case law that has developed in this area in *individual* actions that have followed the entry of broad class-based relief in such cases as *Rivers, Rogers,* or *Riese*;[35] through a study of the way representation is actually provided programmatically in several states;[36] through the filter of *sanism* (an irrational prejudice of the same quality and character of other irrational prejudices that cause, and are reflected in, prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry);[37] and through the filter of *pretextuality* (the ways in which courts often accept [either implicitly or explicitly] testimonial dishonesty and engage similarly in dishonest [frequently meretricious] decision making, specifically where witnesses, especially *expert* witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends").[38] We conclude that it is only through these filters that the posed questions can be answered and that the issues raised in the MacArthur study can be fully aired and addressed.[39]

II. Adequacy of Counsel

The assumption that individuals facing involuntary civil commitment are globally represented by adequate counsel is an assumption of a fact not in evidence.[40] The data suggest that, in many jurisdictions, such counsel is woefully inadequate—disinterested, uninformed, roleless, and often hostile.[41] A model of "paternalism/best interests" is substituted for a traditional legal advocacy position, and this substitution is rarely questioned.[42] Few courts have ever grappled with adequacy of

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[32]*See* Perlin, *supra* note 27, at 58–59.

[33]Michael L. Perlin, *"Dignity Was the First to Leave"*: Godinez v. Moran, *Colin Ferguson, and the Trial of Mentally Disabled Criminal Defendants,* 14 BEHAV. SCI. & L. 61 (1996).

[34]Bob Dylan, *When I Paint My Masterpiece* (1970). *Compare* Parham v. J.R., 442 U.S. 584, 605–06 (1979) (Chief Justice Burger's characterization of involuntary civil commitment hearings as "time-consuming procedural minuets").

[35]*See, e.g.,* 2 PERLIN, *supra* note 2, § 5.43, at 40–41 n. 844; § 5.43A at 41–42 n. 846.2 (1995 Supp.) (citing cases).

[36]This article does *not* profess to be a national survey; it reports here only on the contrasting experiences in the three states where author Deborah A. Dorfman has represented individuals at medication refusal hearings.

[37]Michael L. Perlin, *On "Sanism,"* 46 SMU L. REV. 373 (1992); Perlin & Dorfman, *supra* note 31.

[38]Michael L. Perlin, *Morality and Pretextuality, Psychiatry and Law: Of "Ordinary Common Sense," Heuristic Reasoning, and Cognitive Dissonance,* 19 BULL. AM. ACAD. PSYCHIATRY & L. 131, 133 (1991); *see generally* Michael L. Perlin, *Pretexts and Mental Disability Law: The Case of Competency,* 47 U. MIAMI L. REV. 625 (1993) [hereinafter, Perlin, *Pretexts*]; Deborah A. Dorfman, *Through a Therapeutic Jurisprudence Filter: Fear and Pretextuality in Mental Disability Law,* 10 N.Y.L. SCH. J. HUM. RTS. 805 (1993).

[39]For a similar inquiry, *see, e.g.,* Michael L. Perlin, *Therapeutic Jurisprudence: Understanding the Sanist and Pretextual Bases of Mental Disability Law,* 20 N. ENG. J. CRIM. & CIV. CONFINEMENT 369 (1994).

[40]Perlin, *supra* note 27, at 39.

[41]*Id.* at 43.

[42]*Id.* at 43–44.

counsel questions in this context; fewer yet have found assigned involuntary civil commitment to be inadequate.[43]

The question of adequacy of counsel in this context has at least been subject to some scholarly attention.[44] There is scant literature that addresses the question of the availability and adequacy of counsel in right to refuse medication hearings.[45] This near-total lack of attention is even more striking when juxtaposed with the extensive scholarship that has developed discussing the law reform–test case litigation that led directly to the judicial articulation of a right to refuse treatment.[46]

Like other legal rights, the right to refuse treatment is not self-executing.[47] A statement by a state supreme court or a federal court of appeals that a patient has a "qualified right to refuse treatment" does not, in and of itself, automatically translate into a coherent structure through which hearings are scheduled, counsel appointed, and hearing procedures established. Of the important right to refuse cases only *Rivers v. Katz* establishes any mechanism for the appointment of counsel in individual right to refuse cases;[48] *Rennie v. Klein,*[49] one of the first federal cases finding a substantive constitutional right to refuse, originally mandated the appointment of counsel[50] but later receded from this position and required only the presence of "patient advocates" (employees of the state Division of Mental Health and Hospitals) to serve as "informal counsel to patients who wish to refuse [antipsychotic medication]." [51]

A handful of statutes mandate the application of counsel in right to refuse treatment hearings;[52] on the other hand, at least one court has held that failure to

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[43] *Id.* at 50–52; *see generally* 2 PERLIN, *supra* note 2, § 8.30, at 844–49, and *id.*, at 216–17 (1995 Supp.). In Strickland v. Washington, 466 U.S. 668 (1984), the Supreme Court established as the standard for evaluating adequacy of counsel claims in criminal cases as "whether counsel's conduct so undermined the proper function of the adversarial process that the trial court cannot be relied on as having produced a just result"; *see* Perlin, *supra* note 27 at 53 (characterizing standard as "sterile and perfunctory").

[44] *See, e.g.,* Perlin, *supra* note 27, at 43–45 nn. 21–34 (citing sources).

[45] *See* Melvin Shaw, *Professional Responsibility of Attorneys Representing Institutionalized Mental Patients in Relation to Psychotropic Medications,* 22 J. HEALTH & HOSP. L. 186 (1989) (characterizing lawyers' arguments seeking to vindicate a right to refuse medication as an "injustice").

[46] For recent literature, see, e.g., 2 PERLIN, *supra* note 2, § 5.01 at 29 n. 0.1 (1995 Supp.) and *id.* § 5.02 at 29–30 n.1 (1995 Supp.) (citing sources).

[47] *See, e.g.,* Bruce Winick, *Restructuring Competency to Stand Trial,* 32 U.C.L.A. L. REV. 921, 941 (1985); Perlin, *supra* note 27, at 47; *see also* Alan H. Macurdy, *The Americans With Disabilities Act: Time For Celebration, or Time for Caution?,* 1 PUB. INT.'L L.J. 21, 29 (1991); John Parry, *Rights Aplenty But Not Enough Money: A Paradox in Federal Disability Policies,* 12 MENTAL & PHYSICAL DISABILITY L. REP. 486 (1988) (pointing out that although there has been legislation to enhance the civil rights of persons with disabilities, the laws are not always fully implemented due to the lack of funding and other resources).

[48] *Rivers,* 495 N.E. 2d 337, 344 (N.Y. 1986). Representation in *Rivers* hearings is provided by the state-funded Mental Hygiene Legal Services office. Application of St. Luke's-Roosevelt Hosp. Center, 607 N.Y.S. 2d 574, 580 n. 11 (Sup. 1993), *reversed and vacated in part on other grounds,* 627 N. Y. S. 2d 357 (App. Div. 1995).

[49] 462 F. Supp. 1131 (D.N.J. 1978), *suppl.,* 476 F. Supp. 1294 (D.N.J. 1979), *mod.,* 653 F. 2d 836 (3d Cir. 1981), *vacated and remanded,* 458 U.S. 119 (1982), *on remand,* 720 F. 2d 266 (3d Cir. 1983); *see generally* 2 PERLIN, *supra* note 2, §§ 5.10–5.21.

[50] *Rennie,* 462 F. Supp. at 1147.

[51] *Rennie,* 476 F. Supp. at 1311. *See also id.* at 1313 (Patient advocates may be attorneys, psychologists, social workers, registered nurses, or paralegals, "or have equivalent experience"). This recession followed the Supreme Court's decision in Parham v. J.R., 442 U.S. 584 (1979), allowing for relaxed procedures in the cases of the involuntary civil commitment of juveniles.

[52] *See, e.g.,* OKLA. STAT. ANN. § 5-212(B)(1); WIS. STAT. ANN. § 880.33(1); N.M. STAT. ANN. §§ 43-1-4, 43-1-15; 405 ILL. COMP. STAT. ANN. 5/2-107.1.

appoint counsel is not reversible error.[53] And only a few cases have spoken to the role or scope of counsel at medication hearings.[54] Although more courts are beginning to articulate the criteria to be considered at a medication refusal hearing,[55] this level of specificity is simply not present in the assessment of the role and responsibilities of counsel.[56]

Without such an articulation of specificity, the authentic meaning of a "right to refuse" remains murky. A right without a remedy[57] is no right at all; worse, a right without a remedy is meretricious and pretextual—it gives the illusion of a right without any legitimate expectation that the right will be honored.[58] This is especially significant in light of the research in procedural justice done by Tom Tyler that individuals subject to involuntary civil commitment hearings, like all other citizens, are affected by such process values as participation, dignity, and trust, and that experiencing arbitrariness in procedure leads to "social malaise and decreases people's willingness to be integrated into the polity, accepting its authorities, and following its rules."[59] Recent research by Hoge and Feucht-Haviar provides further empirical support for Tyler's insights. Their study of long-term psychiatric patients found, in an informed consent context, that "capable patient involvement is an important check on a physician's judgment."[60]

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[53]*In re* Steen, 437 N.W.2d 101, 105 (Minn. Ct. App. 1989). *Compare* Cornett v. Donovan, 51 F.3d 894 (9th Cir. 1995) (right to legal assistance extended only through pleading stage of habeas or civil rights action).

[54]*See, e.g.,* Rennie, 476 F. Supp. at 1313 (patient advocates "must be given training in the effects of psychotropic medication and the principles of legal advocacy"); *In re* Jarvis, 433 N.W.2d 120, 123–24 (Minn. Ct. App. 1988) (criticizing failure to give counsel adequate time to explore basis for treating psychiatrist's choice of medications); Williams v. Wilzack, 573 A.2d 809, 821 (Md. 1990) (criticizing failure to give counsel opportunity to present evidence or cross-examine witnesses).

[55]*See, e.g.,* Virgil D. v. Rock County, 524 N.W.2d 894, 899–900 (Wis. 1994), *reconsideration denied* (Wis. 1995):

> Factors which the court should take into account in reaching its decision include:
> (a) Whether the patient is able to identify the type of recommended medication or treatment;
> (b) whether the patient has previously received the type of medication or treatment at issue;
> (c) if the patient has received similar treatment in the past, whether he or she can describe what happened as a result and how the effects were beneficial or harmful;
> (d) if the patient has not been similarly treated in the past, whether he or she can identify the risks and benefits associated with the recommended medication or treatment; and
> (e) whether the patient holds any patently false beliefs about the recommended medication or treatment which would prevent an understanding of legitimate risks and benefits.

[56]*See* Perlin, *supra* note 27, at 56 n.101 (as mental disability law becomes more complex, it is essential that counsel for patients understand differing right to refuse treatment doctrines and their rationales).

[57]Donald Zeigler, *Rights Require Remedies: A New Approach to the Enforcement of Rights in the Federal Courts,* 38 HASTINGS L.J. 665, 678–79 (1987).

[58]This is not to suggest that the existence of a constitutional right is somehow illegitimate if it is not honored in each individual case seeking to vindicate it. Rather, *honored* here refers to the presence of a legally legitimate hearing at which a decision as to whether to honor the right is fairly assessed.

[59]Tom Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings,* 46 SMU L. REV. 433, 443 (1992).

[60]Steven K. Hoge & Thomas C. Feucht-Haviar, *Long-Term, Assenting Psychiatric Patients: Decisional Capacity and the Quality of Care,* 23 BULL. AM. ACAD. PSYCHIATRY & L. 343, 349 (1995); *see id.* ("our findings seem to undermine physicians' arguments that informed consent is an unnecessary intrusion into the doctor–patient relationship, which interferes with the provision of effective treatment"); *see also* Bruce Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection,* 28 HOUS. L. REV. 15, 46–47 (1991); Julie Zito et al., *One Year Under* Rivers: *Drug Refusal in a New York State Facility,* 12 INT'L J.L. & PSYCHIATRY 295, 357 (1989) (on therapeutic benefits of right-to-refuse hearing).

Empirical surveys consistently demonstrate that the quality of counsel "remains the single most important factor in the disposition of involuntary civil commitment cases."[61] Certainly, the presence of adequate counsel is of critical importance in the disposition of right to refuse treatment cases as well.

These findings take on even more importance when considered in the context of the MacArthur study's findings that mental patients are not always incompetent to make rational decisions and are not inherently more incompetent than nonmentally ill medical patients.[62] Contemporaneous constitutional case law and some statutory law generally reject the idea that mental illness and incompetency can be equated and often specifically endorse a presumption of competency.[63] Yet, what Winick refers to as "19th-century notions" (equating mental illness with incompetence) still, in practice, "persist and continue to influence legal rules and practices in this area."[64]

What, then, are we to make of the future "real world impact" of the MacArthur study's recommendations if effective counsel is lacking? We can try to answer this from a therapeutic jurisprudence perspective.[65] If judges uncritically conflate institutionalization with incompetency, lack of meaningful counsel—to structure statutory, case law-based, and empirical arguments—may be fatal to the patient's case.[66] The mere *existence* of counsel on behalf of institutionalized mental patients is often invisible to trial courts;[67] certainly, there is no reason for optimism about

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[61]Perlin, *supra* note 27, at 49, citing 2 PERLIN, *supra* note 2, § 8.02 at 744.

[62]*See generally* Grisso & Appelbaum, *Abilities, supra* note 12.

[63]*See* Winick, *supra* note 25, at 151 n.80 (citing sources).

[64]*Id.* at 151–52 (for an explanation of these "19th-century notions," see *id.* at 145).

[65] One of the most important theoretical and conceptual developments in mental disability law of the past decade has been the growth of "therapeutic jurisprudence" as a model through which to assess the ultimate impact of case law and legislation that affects mentally disabled individuals. *See, e.g.,* David Wexler, *Justice, Mental Health, and Therapeutic Jurisprudence,* 40 CLEVE. ST. L. REV. 517 (1992); 1 PERLIN, *supra* note 2, § 1.05A at 6 (1995 Supp.); Dorfman, *supra* note 38, at 819. Therapeutic jurisprudence studies the role of law as a therapeutic agent and self-consciously asks the question: Does the law have a therapeutic (or antitherapeutic) effect on the individuals it seeks to regulate? *See, e.g.,* THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT (David Wexler ed., 1990); David Wexler & Bruce Winick, *Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research,* 45 U. MIAMI L. REV. 97 (1991); David Wexler, *Health Law Compliance Principles and the Insanity Acquittee Conditional Release Process,* 27 CRIM. L. BULL. 18 (1991); Michael L. Perlin & Keri K. Gould, *Rashomon and the Criminal Law: Mental Disability and the Federal Sentencing Guidelines,* 22 AM. J. CRIM. L. 431, 455 (1995).

Therapeutic jurisprudence scholars have turned their attention to right to refuse treatment questions and have begun to weigh values such as "consent" and "autonomy" using a therapeutic jurisprudence filter. *See, e.g.,* Dorfman, *supra* note 38; Bruce Winick, *On Autonomy: Legal and Psychological Perspectives,* 37 VILL. L. REV. 1705 (1992); Bruce Winick, *The Right to Refuse Treatment: A Therapeutic Jurisprudence Analysis,* 17 INT'L J.L. & PSYCHIATRY 99 (1994); Winick, *supra* note 60; Michael L. Perlin, et al., *Therapeutic Jurisprudence and the Civil Rights of Institutionalized Mentally Disabled Persons: Hopeless Oxymoron or Path to Redemption?* 1 PSYCHOL., PUB. POL'Y & L. 80 (1995). As Winick has noted, "according patients a right to refuse or accept treatment can have the effect of restructuring the therapist–patient relationship in ways that maximize its potential effectiveness as a therapeutic agent in its own right." Bruce Winick, *Psychotropic Medication in the Criminal Trial Process: The Constitutional and Therapeutic Implications of* Riggins v. Nevada, 10 N.Y.L. SCH. J. HUM. RTS. 637, 704–05 (1993).

[66] On counsel's *educative* role, *see* 2 PERLIN, *supra* note 2, § 8.23 at 210 (1995 Supp.); Michael L. Perlin & Robert L. Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process,* 45 LAW & CONTEMP. PROBS. 161, 168–73 (Summer 1982).

[67]*See, e.g., In re* C.P.K., 516 So. 2d 1323, 1325 (La. Ct. App. 1987) (reversing commitment order where trial court did not comply with statute expressing explicit preference for representation by state Mental Health Advocacy Service, rejecting as "untenable" the argument that trial court should be excused "since it did not know . . . whether the Service really existed").

judicial knowledge or interest in this area of the law, absent aggressive, advocacy-focused counsel.

If ward psychiatrists demonstrate a propensity to equate *incompetent* with *makes bad decisions* and to assume, in face of statutory and case law, that incompetence in decision making can be presumed from the fact of institutionalization,[68] then lack of counsel—to inquire into the bases of these views on cross-examination and to demonstrate to the court that they are dissonant with established case and statutory law—may similarly make the legal process an illusory safeguard.

Despite the impressive body of case law outlined above, the existence of a right to refuse treatment remains enigmatic at best for many clinicians.[69] Some are resistant, arguing (unsuccessfully in court, but, perhaps, more successfully in clinical practice) that the existence of the right is destructive; certainly, the provocative titles of early articles written about the right to refuse treatment suggest a basic tension that may not be resolved without sensitive articulation of the underlying legal concepts.[70]

The study's inquiry into the plight of the patient with severely reduced decision-making capacities offers thoughtful clinical and legal recommendations.[71] Without the presence of effective counsel, the promise of these recommendations may turn into an empty shell.

Another therapeutic jurisprudence issue that requires further attention here is one of time. Few jurisdictions currently have in place a statewide system of independent, vigorous effective counsel whose job is to provide across-the-board representation for institutionalized patients in individual cases.[72] Even if such counsel is to be provided—a leap that requires belief in the dubious proposition that state legislative finance committee staffs will read and be persuaded by the arguments in this article—there will inevitably be a delay (of years, likely) before such counsel systems are in place. Until that happens, should policy makers act on the MacArthur study's recommendations anyway, or should such actions be deferred until this problem is comprehensively addressed? Perhaps here, the baton should be passed back to the study's authors and their measurement mechanisms subtly recalibrated[73] to reflect the current inadequacies in counsel provision.

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[68]*See, e.g.,* Brian Ladds et al., *The Disposition of Criminal Charges After Involuntary Medication to Restore Competency to Stand Trial,* 38 J. FORENS. SCI. 1442 (1993); Brian Ladds et al., *Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Descriptive Study of the New York Experience with Judicial Review,* 21 BULL. AM. ACAD. PSYCHIATRY & L. 529 (1993).

[69]One of the authors (Michael L. Perlin) has been presenting papers on this topic to mental health professionals for the better part of 20 years. Audiences frequently express surprise that there *is* such a right and often express the opinion that such a right is clinically unwarranted.

[70] *See, e.g.,* Paul Appelbaum & Thomas Gutheil, *Rotting With Their Rights On: Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients,* 7 BULL. AM. ACAD. PSYCHIATRY & L. 306 (1979); Steven Rachlin, *One Right Too Many?* 3 BULL. AM. ACAD. PSYCHIATRY & L. 99 (1975); Darryl Treffert, *Dying With Their Rights On,* 130 AM. J. PSYCHIATRY 1041 (1973). *But compare* Hoge & Feucht-Haviar, *supra* note 60, at 349 (discussed *supra* note 60).

[71]*See* Grisso & Appelbaum, *Abilities, supra* note 12, at 168–73.

[72]*See generally* 2 PERLIN, *supra* note 2, § 8.11, and *see* 2 *id.,* § 8.23, at 208–09 (1995 Supp.).

[73]*See, e.g.,* Grisso et al., *supra* note 12, at 127–28; Grisso & Appelbaum, *Abilities, supra* note 12, at 170–172.

III. Implementation

A. Introduction

It is impossible to truly grasp the real meaning of the right of institutionalized mentally disabled persons to refuse antipsychotic medications without considering the actual implementation of court decisions that purportedly mandate this right. Implementation must be considered when analyzing the impact of such laws on mental health patients, particularly with regard to the way representation is provided. The mere fact that due process protections are statutorily or judicially required prior to the imposition of involuntary medication in a nonemergency does not guarantee that these protections are actually present in any individual case.[74] It is no surprise that jurisdictions are wildly inconsistent in the implementation of the right to refuse laws in general,[75] especially with regard to the specific issue of the provision of counsel.

In this section, we examine the differences regarding the implementation of right to refuse laws, focusing on the right to counsel or other representation in involuntary medication hearings. First, we compare right to refuse laws of several jurisdictions. We also briefly discuss the U.S. Supreme Court's influence on the provision of counsel in right to refuse cases in different jurisdictions as a result of its decisions in *Washington v. Harper*[76] and *Riggins v. Nevada.*[77] In addition, we analyze this difference within individual jurisdictions. Specifically we look at how state laws actually anticipate and allow for inconsistency, examining data in three states (California, Washington, and Utah) that illustrate the disparities regarding the provision of counsel in right to refuse cases within jurisdictions.[78] Finally, we discuss the significance of these differences in relationship to the conclusions of the MacArthur study.

B. Differences Between Jurisdictions in the Right to Counsel in Right to Refuse Laws

The laws regarding civilly committed mental health patients' rights to refuse medication are not the same in every state. This is largely because the Supreme Court, while finding a constitutional right to due process in involuntary psychiatric medication cases in *Mills v. Rogers,*[79] has never specifically articulated the extent of due process that is required for civilly committed mental health patients who wish to refuse medications.[80] Indeed, in *Rogers,* the Court restated the basic proposition that a state is always free, either under its own state constitution or under the common law, to create substantive or procedural liberty or other due process interests broader than those minimally mandated by the federal Constitution.[81]

After the Court's decision in *Rogers,* two basic due process models have evolved in right to refuse cases: the "expanded due process model" and the "limited due

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[74]*See supra* note 47 (citing sources).
[75]*See infra* Part III B.
[76]494 U.S. 210 (1990).
[77]504 U.S. 127 (1992).
[78]*See supra* note 36.
[79]457 U.S. 291 (1982).
[80]2 PERLIN, *supra* note 2, § 5.33 at 309.
[81]*Id.* at 300. *See generally* PERLIN, *supra* note 13, § 2.10 at 241.

process model."[82] The expanded due process approach has resulted primarily from state court decisions based either on a state statute[83] or on state constitutional rights.[84] Under this model, mental health patients are often provided with procedural due process protections such as notice, counsel, the right to cross-examine witnesses, the right to present evidence (including expert testimony), and the right to appeal.[85] The limited due process model has evolved from federal court decisions based on the U.S. Constitution.[86] Under this model, mental health patients are provided with only minimal due process protections. Narrower administrative review is provided, and broad readings of the Fourteenth Amendment's Due Process Clause are rejected.[87]

Adoptions of the limited due process model increased following the Court's decision in *Washington v. Harper,* which held in the case of a convicted prisoner that minimal due process protections were constitutionally sufficient.[88] Following *Harper,* some state courts limited the range of due process protections for civilly committed patients, even though *Harper* was specifically decided in the prison context.[89] For example, in Washington, the jurisdiction where *Harper* originated, the state right to refuse statute was changed from an expanded due process model for all mental health patients to a limited due process model for some mental health patients while maintaining an expanded due process approach for others.[90]

Harper appeared to augur a future in which the federal courts would be overtly unsympathetic to right to refuse claims,[91] but the jurisprudence became somewhat more muddled after the U.S. Supreme Court decided *Riggins v. Nevada*.[92] There, the Court reversed the death sentence of a competent mentally disabled defendant pleading insanity who had been involuntarily medicated with antipsychotic medication during his trial finding that the defendant's right to a fair trial had been violated as a result of the administration of involuntary antipsychotic medication during his trial.[93] Although the court in *Riggins* did not set out a bright line test for determining the state's burden in involuntarily medicating a pretrial detainee at trial, it did find that the burden would be met if the state proved medical appropriateness and considering less intrusive alternatives, either (a) that such medication was "essential for the sake of Riggins' own safety or safety of others," or (b) that there was a lack of

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[82]Perlin et al., *supra* note 65, at 112: *see generally* Perlin, *supra* note 1.

[83]*See* Riese v. St. Mary's Hospital & Medical Center, 243 Cal. Rptr. (Ct. App. 1987), *republished at* 271 Cal. Rptr. 199 (Ct. App. 1987), *review granted & superseded by* 751 P.2d 893 (Cal. 1988), *cause dismissed & order published,* 774 P.2d 698 (Cal. 1989).

[84]*See* Rivers v. Katz, 495 N.E.2d 337 (N.Y. 1986).

[85]*See* Perlin et al., *supra* note 65.

[86]*See* Project Release v. Prevost, 722 F.2d 960 (2d Cir. 1983).

[87]Perlin et al., *supra* note 65, at 112.

[88]494 U.S. at 225–29. The Supreme Court's decision approved a state regulation (*State Offender Center Policy* 600.30) that had provided for a hearing before a committee composed of a psychiatrist, psychologist, and a correctional associate superintendent, at which representation by counsel was not allowed. *See* Harper v. State, 759 P.2d 358, 362 (Wash. 1988), *rev'd,* 494 U.S. 210 (1990), discussed in this context in 2 PERLIN, *supra* note 2, § 5.64A, at 76 n.1074A.7 (1995 Supp.).

[89]*Harper,* 494 U.S. at 222 ("The extent of a prisoner's right under the [Due Process] Clause to avoid the unwanted administration of antipsychotic drugs must be defined in the context of the inmate's confinement.").

[90]*See infra* notes 122–28 and accompanying text.

[91]*See* 2 PERLIN, *supra* note 2, § 5.64A, at 86 (1995 Supp.).

[92]504 U.S. 127 (1992).

[93]*See* Perlin, *supra* note 13, § 2.18 at 258–64; *see generally* Perlin & Dorfman, *supra* note 31.

less intrusive means by which to obtain an adjudication of the defendant's guilt or innocence.[94] It is still unclear how *Riggins* affects the due process rights of civilly committed individuals seeking to refuse involuntary medication and just as unclear how courts will reconcile *Riggins* with *Harper.*[95]

This lack of clarity—confusing to constitutional law scholars and (no doubt) equally perplexing to hospital administrators and ward psychiatrists—suggests another reason why counseled hearings have practical importance. Individual cases litigated post-*Harper* and post-*Riggins* so far offer no coherent framework for determining how individual right to refuse hearings are to be conducted. Surely, the presence of adequate counsel at such hearings makes it more likely that the sorts of questions addressed in the MacArthur study are actually considered in an appropriate and regularized way.[96]

C. Disparity in Implementing Right to Refuse Laws Within Jurisdictions

This *inter*state inconsistency in implementing right to refuse medication laws is confounded further by *intra*state disparities within individual jurisdictions. In the following section, we analyze such inconsistency in three jurisdictions, each representing a different due process model. Specifically we look at the involuntary medication laws of each of these jurisdictions and discuss how these laws actually anticipate and often allow for inconsistency of implementation of these laws. We also look at some of the actual data that illustrate the differences in the right to counsel in right to refuse cases within each state.

1. California. Under California law, institutionalized mentally disabled persons are afforded expanded due process protections in right to refuse cases, known as *capacity hearings* or Riese *hearings.*[97] Nonetheless, there is a significant difference in the manner in which these hearings are conducted in different California counties, including whether or not attorneys are provided by the State to represent mental health patients in the hearings.[98] The most obvious evidence of this inconsistency is language in the section of the California Welfare and Institutions Code codifying the *Riese* decision.[99] The statute allows for the "capacity hearings" to be conducted either by a superior court judge, a superior court commissioner or referee, or a court-appointed hearing officer.[100] In addition, whereas it mandates representation at such hearings, it allows for representation to be provided by the public defender, patients' rights advocate, or other representative, who may be a nonattorney.[101] Finally, the California statute requires that each county develop its own policies and

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[94]*Riggins,* 504 U.S. at 135.

[95]Cases construing *Riggins* are discussed in 2 PERLIN, *supra* note 2, § 5.65A, at 99–100 n. 1088.60 (1995 Supp.).

[96]*Compare* Trudi Kirk & Donald N. Bersoff, *How Many Procedural Safeguards Does It Take to Leave the Lightbulb Unchanged?: A Due Process Analysis of the MacArthur Treatment Competence Study,* 2 PSYCHOL. PUB. POL'Y, & L. 45–72 (this issue).

[97]*See* Riese v. St. Mary's Hospital & Medical Center, 243 Cal.Rptr. 241, 254 (App. 1987), *app'l. dismissed,* 774 P.2d 698 (1989); *see generally* 2 PERLIN, *supra* note 2, § 5.43A.

[98]*See California Office of Patients' Rights Report on Informed Consent/Capacity Hearing Services* [hereinafter *Report*] (November 6, 1995) (on file with authors).

[99]CAL. WELF. & INST. CODE §§ 5332 *et seq.*

[100]*Id.* § 5334(c).

[101]*Id.* § 5333(a). It should be noted that some of the patients' rights advocates in at least one county (Santa Clara) are also attorneys.

procedures for implementing the hearings.[102] Thus, the implementation of *Riese*—the test case decided by the California Supreme Court articulating a right to refuse treatment—varies from one county to the next on the important variable of the type of representation provided to the patient.

A study conducted by the California Office of Patients Rights[103] in 1994 on Informed Consent and Capacity Hearing Services illustrates these variations. The study involved data reported from 30 out of a total of 37 counties in California with involuntary psychiatric facilities.[104] Of the 30 counties[105] reporting data, 13 counties reported using public defenders to represent patients in capacity hearings, 15 counties reported use patients' right advocates, and 2 counties reported using other individuals as representatives.[106]

The California study also examined the amount of time spent by counsel, advocates, and other representatives on the capacity hearings.[107] These data were broken down into three categories: time spent preparing for hearings, time spent conducting the hearings, and time spent in follow-up activities related to the hearings.[108] The data showed a substantial range. The average length of time spent in preparation for the hearing on behalf of the patient was 43.83 minutes,[109] ranging from 5 minutes to 240 minutes.[110]

The average length of time spent conducting the hearings was 26 minutes[111] (ranging from 10 to 60 minutes).[112] The average length of time spent on follow-up activities related to the hearings was 11.67 minutes (ranging from 5 minutes to 60 minutes).[113]

The length of time spent on hearings is significant for several reasons. First, it is important from the point of view of actual effectiveness of the representation provided to the patient. Advocates and attorneys who spend only a short time preparing for and representing the patient in the hearing may compromise the quality of their representation.[114] To effectively prepare for a hearing, advocates or

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[102]*Id.* § 5334.

[103]The California Patients' Rights Office is created and mandated pursuant to state statute. *See* CALIF. WELF. & INST. CODE § 5510. Its purpose is to ensure "that mental health laws, regulations and policies on the rights of recipients of mental health services are observed in State hospitals and in licensed health and community care facilities." *Id.*

[104]*Report, supra* note 98, at 3.

[105]The reporting counties include Alameda, Butte (includes Colusa), Contra Costa, El Dorado, Fresno, Glenn, Humbolt (includes Del Norte), Inyo, Kern, Los Angeles, Marin, Mendocino (including Lake), Merced, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Sonoma, Stanislaus, Ventura, and Yolo (includes Colusa Plumes). *Id.* at 4.

[106]*Report, supra* note 98, at 4.

[107]*Id.* at 6.

[108]*Id.*

[109]*Id.* at 3.

[110]*Id.*

[111]*Id.* The mean time for involuntary civil commitment hearings studied in the 1970s ranged from 3.8 to 9.2 minutes. *See* Parham v. J.R., 442 U.S. 584, 609 n.17 (1979). This finding has been the topic of astonishingly little academic commentary. *See,* however, Perlin, *Pretexts,* note 36, at 625 n.115; Robert Burt, *Withholding Nutrition and Mistrusting Nurturance: The Vocabulary of In re* Conroy, 2 ISSUES L. & MED. 317, 330 n.21 (1987).

[112]*Report, supra* note 98, at 3.

[113]*Id.*

[114]*See, e.g.,* Perlin, *supra* note 27, at 43–44; *see generally* Perlin & Sadoff, *supra* note 66.

attorneys should meet with patients to advise them of their legal rights at the hearing, conduct a full interview, and review the patients' medical charts.[115] If advocates or attorneys spend only 5 minutes preparing for the hearing, it is unlikely that either they or their patients will be adequately prepared, and the effectiveness of representation is likely to be compromised.[116]

Also, the time spent in pretrial preparation is significant in terms of the impact it has on the patients' *perception* of its meaningfulness.[117] If attorneys and advocates do not spend a reasonable amount of time preparing for (and providing representation at) such hearings, patients may see the entire hearing as a sham.[118] It can also undermine the trust that patients might have in their attorneys or advocates as patients may—often, correctly—view this lack of zealous advocacy as reflecting either apathy or constructive complicity with the agency or facility seeking the involuntary imposition of medication. Again, given the MacArthur study's findings undermining the "ordinary common sense"[119] notion that mentally ill persons are *per se* incompetent [120] (a notion that is reflected on a daily basis in individual right to refuse hearings nationwide[121]), the need for zealous counsel is especially critical.

Finally, the data suggest that, that despite legislation that appears to provide expanded due process procedures, there is no guarantee that patients receive adequate representation at medication hearings.

2. Washington. Washington's right to refuse law, on the other hand, reflects a hybrid of expanded and limited due process protections, a hybrid that has created disparity in the implementation of the right to refuse medication in Washington state. Prior to the Supreme Court's decision in *Washington v. Harper*[122] (a prison case), Washington state cases had required a judicial hearing consonant with the expanded due process model.[123] After *Harper,* however, the state legislature modified existing law so that the extent of the due process afforded a civilly committed mental health patient became dependent on the length of commitment.[124] In the case of a patient committed for 0–30 days who is to be involuntarily medicated in a

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[115]*See, e.g.,* ABA Commission on the Mentally Disabled, *How To Prepare for an Involuntary Civil Commitment Hearing,* 37 PRAC. LAW. 39 (Jan. 1991) (attorneys should, inter alia, review all medication orders; check possible side-effects of each medication; check any pre-hearing changes in medication and/or behavior; be prepared to introduce evidence as to medication's effects). *See generally Medication Capacity Hearings: Policies and Procedures from Los Angeles County* 6 (1994) (spelling out duties); Superior Court of Santa Clara, *Capacity Hearings: Policies and Procedures* 7–8 (July 1993).

[116]On the multiple roles of counsel in the representation of institutionalized mentally disabled persons in general, *see* 2 PERLIN, *supra* note 2, § 8.21, at 807–17.

[117]*See* Perlin et al., *supra* note 65, at 113–16.

[118]*Id.* at 116–17. *See also,* Tyler, *supra* note 59.

[119]*See* Michael L. Perlin, *Psychodynamics and the Insanity Defense: "Ordinary Common Sense" and Heuristic Reasoning,* 69 NEB. L. REV. 3 (1990) (explaining significance of this concept to mental disability law).

[120]*See generally* Winick, *supra* note 25.

[121]*See supra* note 36. Author Michael L. Perlin represented patients in similar hearings in New Jersey and has supervised students conducting such hearings in New York.

[122]494 U.S. 210 (1990); *see supra* text accompanying notes 88–90.

[123]*See, e.g., In re* Schouler, 723 P.2d 1103 (Wash. 1986); *In re* Ingram, 689 P.2d 1363 (1984); *In re* Colyer, 660 P.2d 738 (Wash. 1983).

[124]In Washington, mental health patients committed for involuntary mental health treatment are statutorily committed for different lengths of time, depending on treatment needs and restrictivity decisions. *See* REV. CODE WASH. §§ 71.05.150 et seq. Each patient begins the commitment process on a "72 hour hold" and is then subsequently placed on a "14 day hold," then a "30–180 day hold," and, if further treatment is necessary, a "180 day hold" that is subject both to review and renewal. *Id.*

nonemergency circumstance, the medication order must only be reviewed by another psychiatrist.[125] Patients committed for 30–180 days are afforded a review by the facility medical director or their designee, of the order for involuntary medication.[126] However, patients committed for 180 days or longer are given expanded due process protections including a court hearing, counsel, the right to present evidence and cross-examine witnesses, and appeal.[127] In other words, the amount of due process protection available to institutionalized patients in Washington is directly related to their legal status.[128]

We must reflect on the therapeutic jurisprudence implications of this conclusion. One of the central issues of right to refuse treatment law is the existence of (often irreversible) neurological side-effects that may result from the administration of antipsychotic drug medication.[129] Indeed, much of the class action and test case litigation in this area has focused specifically on these side-effects in the structuring of a constitutional remedy.[130] There is, intuitively, no inevitable difference in the level of neurological side effects to which a person committed under one section of the Washington state laws may be subjected to, as opposed to a person committed pursuant to a different section of the same laws.[131]

Yet, the fact is that one set of patients (those committed pursuant to §71.05.215(2)(c)) receives *no* counsel, whereas another set (those committed pursuant to §71.05.370(7)) *does* receive counsel. The first set receives a nonjudicial review; the second is statutorily entitled to a court hearing. Assuming that the lawyers assigned to represent the second set of patients actually do provide the type of independent advocacy services urged in Part II of this article, and assuming that the MacArthur study's recommendations are accepted by Washington state lawmakers, there will still be a gross disparity in the ways that individuals in the Washington state system—those whose clinical conditions may be alike but whose legal statuses differ—are dealt with if they seek to assert their right to refuse treatment. This disparity makes neither clinical nor conceptual sense.

3. Utah. Utah follows a limited due process model in implementing medication hearings. As in California and Washington, there is a great deal of inconsistency regarding the implementation of right to refuse laws in Utah. However, whereas California and Washington have elaborate involuntary medication statutes and regulations, Utah has neither. In 1994, the previous Utah involuntary medication statute—which had provided for medication hearings at which the treatment order would be reviewed by a committee of mental health professionals[132]—was re-

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[125]REV. CODE WASH. § 71.05.215; WASH. ADMIN. CODE § 275-55-241(1)(c)(ii). REV. CODE WASH. § 71.05.215(2) gives the Washington Department of Social and Health Services the authority to promulgate regulations and rule regarding the right of mental health patients to refuse antipsychotic medications.

[126]*See* REV. CODE WASH. § 71.05.215(2)(c); WASH. ADMIN. CODE § 275-55-241(c)(iii)(B).

[127]*See* REV. CODE WASH. § 71.05370(7); WASH. ADMIN. CODE § 275-55-241(c)(iii)(B).

[128]On the significance of such status generally in right to refuse cases, *see, e.g.,* Perlin, *supra* note 1, at 177.

[129]*See generally* PERLIN, *supra* note 13, § 2.08, at 214–18.

[130]*See, e.g.,* Rivers v. Katz, 495 N.E. 2d 337, 343–44 (N.Y. 1984); Riggins v. Nevada, 504 U.S. 127, 136–37 (1992), and *see id.* at 138–144 (Kennedy, J., concurring).

[131]*See supra* text accompanying notes 125–28.

[132]UTAH CODE ANN. § 62A-12-234.1 (1992) (repealed). Committee members could not be directly involved in the individual patient's treatment. *Id.*

pealed.[133] The intent of the Utah legislature in repealing the statute was to allow each mental health facility establish its own policies and procedures to deal with the involuntary medication of mental health patients "since this area of the law is a rapidly evolving area."[134] This repeal followed the decision of *Woodland v. Angus,*[135] declaring the statute unconstitutional as violative of the Due Process Clause.

As a result of this repealer, the extent of due process afforded mental health patients in Utah, including the right to counsel, differs by facility. For instance, the Utah State Hospital involuntary medication policies and procedures mirror the due process standards set out in *Harper.*[136] Patients having medication hearings at the Utah State Hospital are not provided counsel at the hearings and are in fact prohibited from having an attorney represent them in the hearing, even if they pay for it.[137] Instead, patients are provided only with a lay patient advocate who is an employee of the hospital.[138] However, at the Utah State Prison, prisoners are provided with attorneys to represent them at the medication hearings.[139]

Utah's "solution" to the provision of counsel problem is even more strikingly off-kilter. The only mentally ill institutionalized individuals with a right to assigned counsel are those in the Utah State Prison; those in the Utah State Hospital—even those who are independently wealthy and can afford to retain counsel—are prohibited from being represented.[140]

As we discussed earlier, some courts have begun to more carefully articulate criteria to be considered at a judicial right to refuse hearing. For example, in *Virgil D. v. Rock County,* the Wisconsin Supreme Court set out five relevant factors:

> (a) whether the patient is able to identify the type of recommended medication or treatment;
>
> (b) whether the patient has previously received the type of medication or treatment at issue;
>
> (c) if the patient has received similar treatment in the past, whether he or she can describe what happened as a result and how the effects were beneficial or harmful;
>
> (d) if the patient has not been similarly treated in the past, whether he or she can

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[133]*See* UTAH CO. ANN., Compiler's Notes, 62A-12-234.1, 62A-12-234.2 (repealed) (1994).

[134]*See id.*

[135]820 F. Supp. 1497 (D. Utah 1993).

[136]*See Utah State Hospital Operational Policy and Procedure, Section 13: Involuntary Medication of Civilly Committed Patients* 3–6 (1994).

[137]*See id* at 4. The specific language of the relevant part of the policy states the following:

> The patient has the right to attend the hearing, present evidence, including witnesses; and cross-examine staff witnesses. Because the issue before the committee is purely a medical one, it is not necessary or advisable for attorneys to be present to represent either the patient or the physician. For that reason the patient is allowed representation only by a lay advisor who understands the psychiatric issues involved however, the lay advisor need not be provided at government expense. The patient and his treating physician are not allowed representation by an attorney.

[138]*Id.*

[139]*See State of Utah Department of Corrections Institutional Operations Division Manual, Vol. Facilities Operation: Medical/Mental/Dental Health, Chapt. FI 15 Involuntary Treatment* § 2.04, E2 (1991), at 15: "At the hearing an opportunity to be represented by counsel shall be afforded to every inmate/parolee." It should be noted that this only applies to inmates in the custody of the Department of Corrections who are at the Utah State Prison. Those who are on the forensic unit of the Utah State Hospital are only afforded minimal due process protections. *See supra* text accompanying notes 136–38.

[140]An inquiry into the constitutionality of this regulation is beyond the scope of this article.

identify the risks and benefits associated with the recommended medication or treatment; and

(e) whether the patient holds any patently false beliefs about the recommended medication or treatment which would prevent an understanding of legitimate risks and benefits.[141]

It is almost a conceptual impossibility to conjure an image of *pro se* patients—presumptively seen as incompetent by the court—convincing fact finders in a Utah State Hospital case to conduct a probing and careful assessment of each of these factors in their individual cases. It is virtually as impossible to see the MacArthur study's recommendations having the authentic potential for social change in such a case. From a therapeutic jurisprudence perspective, the Utah system fails miserably.

D. Disparity and the MacArthur Study Findings

The MacArthur study concluded (a) that persons with mental illnesses did not perform as well as nonmentally ill persons in their ability to give informed consent to treatment; (b) that the results regarding ability to give such consent are consistent between groups of individuals with different diagnoses, as those with depression tended to do better than did those with schizophrenia; and (c) that among those with schizophrenia, the group that tended to do poorly in test results was found to have more severe symptoms of their mental illness.[142]

The study's authors recognized the limitations of these findings in relation to legal, policy, and clinical decision making. One of these limitations was the "conceptual difference between the ability measures and determination of legal competence."[143] Specifically, they acknowledged that legal standards are applied differently and that a judgment of incompetency is not consistent in every case and that variables such as the specific mental illness involved and the proposed medication and side effects affect the outcome.[144]

However, one variable that the authors did not address is the inconsistency in the implementation of right to refuse laws, particularly as it relates to whether counsel or other representation is available and the quality of that representation. The data presented here show that the implementation of these laws differs both between jurisdictions and even within jurisdictions. This factor is likely to have a significant impact on individual decisions made by fact finders in individual right to refuse treatment cases.

Again, if the findings of the MacArthur study are to be operationalized, it is essential that these differences be addressed and that serious thought be given to the structure and contours of the right to refuse hearing.[145] If there is no counsel (as per the Utah State Hospital system) or no judge (vide the Washington system for short-term commitments), this puts additional responsibilities on the reviewing psychiatrist (or on the review team) to integrate the study's guidelines into its decision-making process, to (somehow) try to compensate for the lack of counsel,

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[141]524 N.W. 2d 894, 899–900 (Wis. 1994), *reconsid. den.*, 531 N.W. 2d 331 (Wis. 1995).

[142]Grisso & Appelbaum, *Abilities, supra* note 12, at 169.

[143]*Id.* at 170.

[144]*Id.*

[145]*Compare* Kirk & Bersoff, *supra* note 96.

and to (somehow) throw off the mantles of what Winick refers to as "19th-century notions."[146]

If there is nonattorney representation before a hearing officer (as in some California counties), this responsibility may subtly shift to the hearing officer. The statistics on length of time spent preparing for hearings, on the actual hearings, and on follow-up, however, serve as a stark reminder that such hearings are often an empty shell (offering only an illusion of due process). Again, it is necessary for the folkways of these hearings to be radically altered.[147]

On the other hand, if there is authentic counsel, as appears to be present in some of the California counties studied, then the therapeutic jurisprudence prospects are brightest. Assuming that this counsel is truly adequate,[148] then these cases could serve as an exciting laboratory to determine the potential empirical impact of the MacArthur study's recommendations. This optimism, of course, must be tempered by the fact that there appear to be very few jurisdictions in the nation where such counsel is currently available.[149]

IV. Sanism and Pretextuality

A. Introduction

One of the most venerable underpinnings of American jurisprudence is the theory of "neutral principles," most closely associated with the writings of Herbert Wechsler.[150] According to Wechsler, legal reasoning had to be "genuinely principled, resting with respect to every step that is involved in reaching judgment on analysis and reasons quite transcending the immediate result that is achieved."[151] Judges, this theory suggested, "could impersonally decide cases through the process of 'reasoned elaboration,' i.e., the elaboration of 'principles and policies [that yielded] a reasoned, if not analytically determined result in particular cases.' "[152]

This approach, of course, assumes another "fact not in evidence":[153] that judges and fact finders are *able* to approach cases analytically with the sort of "reasoned elaboration" and "neutrality" urged by Wechsler and his adherents. An examination of the development of mental disability law jurisprudence suggests that "neutral principles" are simply *not* a factor in the case law in this area[154] and that, rather, the twin themes of sanism and pretextuality dominate the mental disability law landscape.[155]

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[146]Winick, *supra* note 25, at 151–52, discussed *supra* text accompanying note 64.

[147]On the folkways of involuntary civil commitment hearings, *see, e.g.,* JAMES A. HOLSTEIN, COURT-ORDERED INSANITY: INTERPRETIVE PRACTICE AND INVOLUNTARY COMMITMENT (1993); James A. Holstein, *Court Ordered Incompetence: Conversational Organization in Involuntary Commitment Hearings,* 35 SOCIAL PROBLEMS 459 (1988). On the folkways of the mental disability law process in general, *see* Michael L. Perlin, *The Legal Status of the Psychologist in the Courtroom,* 5 J. PSYCHIATRY & L. 41 (1977).

[148]*See generally* Perlin, *supra* note 27, at 49–52.

[149]*See generally* 2 PERLIN, *supra* note 2, § 8.23A at 208–12 (1995 Supp.).

[150]*Toward Neutral Principles of Constitutional Law,* 73 HARV. L. REV. 1 (1959).

[151]*Id.* at 15. *See,* for a helpful explanation, Anthony Sebok, *Misunderstanding Positivism,* 93 MICH. L. REV. 2054, 2114–15 (1995).

[152]John Hasnas, *Back to the Future: From Critical Legal Studies Forward to Legal Realism, or How Not to Miss the Point of the Indeterminacy Argument,* 45 DUKE L.J. 84, 93 (1995).

[153]*See supra* text accompanying note 40.

[154]*See, e.g.,* Perlin & Dorfman, *supra* note 31; Perlin, *supra* note 37; Dorfman, *supra* note 38; Perlin, *supra* note 39.

[155]*See generally,* Perlin, *supra* note 39.

B. Sanism[156]

1. Introduction. *Sanism* is an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry.[157] It infects both our jurisprudence and our lawyering practices.[158] Sanism is largely invisible and largely socially acceptable. It is based predominantly on stereotype, myth, superstition, and deindividualization and is sustained and perpetuated by our use of alleged "ordinary common sense" and heuristic reasoning in an unconscious response to events both in everyday life and in the legal process.[159]

Judges are not immune from sanism. "[E]mbedded in the cultural presuppositions that engulf us all,"[160] they express discomfort with social science[161] (or any other system that may appear to challenge law's hegemony over society) and skepticism about new thinking; this discomfort and skepticism allows them to take deeper refuge in heuristic thinking and flawed, nonreflective ordinary common sense, both of which continue the myths and stereotypes of sanism.[162]

2. Sanism and the court process in mental disability law cases. Judges reflect and project the conventional morality of the community, and judicial decisions in all areas of civil and criminal mental disability law continue to reflect and perpetuate sanist stereotypes.[163] Their language demonstrates bias against mentally disabled individuals[164] and contempt for the mental health professions.[165] Courts often appear

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[156]This section is largely adapted from Perlin, *supra* note 33.

[157]The classic treatise is GORDON ALLPORT, THE NATURE OF PREJUDICE (1955).

[158]The term *sanism* was, to the best of our knowledge, coined by Morton Birnbaum. *See* Morton Birnbaum, *The Right to Treatment: Some Comments on its Development,* in MEDICAL, MORAL AND LEGAL ISSUES IN HEALTH CARE 97, 106–07 (Frank Ayd ed., 1974); Koe v. Califano, 573 F.2d 761, 764 (2d. Cir. 1978); *see* Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization,* 28 HOUS. L. REV. 63, 92–93 (1991) (discussing Birnbaum's insights). Birnbaum is universally regarded as having first developed and articulated the constitutional basis of the right to treatment doctrine for institutionalized mental patients. *See* Morton Birnbaum, *The Right to Treatment,* 46 A.B.A.J. 499 (1960), discussed in 2 PERLIN, *supra* note 2, § 4.03, at 8–13.

[159]*See, e.g.,* MICHAEL L. PERLIN, THE JURISPRUDENCE OF THE INSANITY DEFENSE (1994).

[160]Anthony D'Amato, *Harmful Speech and the Culture of Indeterminacy,* 32 WM. & MARY L. REV. 329, 332 (1991).

[161]The discomfort that judges often feel in having to decide mental disability law cases is often palpable. *See, e.g.,* Perlin, *supra* note 30, at 991 (court's characterization in United States v. Charters, 863 F.2d 302, 310 (4th Cir 1988) (en banc), *cert. den.,* 494 U.S. 1016 (1990), of judicial involvement in right to refuse antipsychotic medication cases as "'already perilous' . . . reflects the court's almost palpable discomfort in having to confront the questions before it").

[162]Perlin, *supra* note 119; Michael L. Perlin, *Unpacking the Myths: The Symbolism Mythology of Insanity Defense Jurisprudence,* 40 CASE W. RES. L. REV. 599, 618–30 (1989–90).

[163]*See* Perlin, *supra* note 37, at 400–04.

[164]*See, e.g.,* Corn v. Zant, 708 F.2d 549, 569 (11th Cir. 1983), *reh'g den.,* 714 F.2d 159 (11th Cir. 1983), *cert. den.,* 467 U.S. 1220 (1984) (defendant referred to as a "lunatic"); Sinclair v. Wainwright, 814 F.2d 1516, 1522 (11th Cir. 1987) (quoting Shuler v. Wainwright, 491 F.2d 213 (5th Cir. 1974) (using "lunatic")); Brown v. People, 134 N.E. 2d 760, 762 (Ill. 1956) (judge asked defendant, "You are not crazy at this time, are you?"); Pyle v. Boles, 250 F. Supp. 285, 289 (N.D. W. Va. 1966) (trial judge accused habeas petitioner of "being crazy"). *But cf.* State v. Penner, 772 P.2d 819 (Kan. 1989) (unpublished disposition), at *3 (witnesses admonished *not* to refer to defendant as "crazy" or "nuts").

[165]*See, e.g.,* Commonwealth v. Musolino, 467 A.2d 605 (Pa. Super. Ct. 1983) (reversible error for trial judge to refer to expert witnesses as "headshrinkers"); *compare* State v. Percy, 507 A.2d 955, 956 (Vt. 1986), *app'l after remand,* 595 A.2d 248 (Vt. 1990), *cert. den.,* 502 U.S. 927 (1991) (conviction reversed where prosecutor, in closing argument, referred to expert testimony as "psycho-babble"), *to* Common-

impatient with mentally disabled litigants, ascribing their problems in the legal process to weak character or poor resolve. Thus, a popular sanist myth is that "[m]entally disabled individuals simply don't try hard enough. They give in too easily to their basest instincts, and do not exercise appropriate self-restraint."[166] We assume that "mentally ill individuals are presumptively incompetent to participate in 'normal' activities [and] to make autonomous decisions about their lives (especially in the area of medical care)."[167]

Sanist thinking allows judges to avoid difficult choices in mental disability law cases; their reliance on nonreflective, self-referential alleged "ordinary common sense" contributes further to the pretextuality that underlies much of this area of the law. Such reliance is likely to make it even less likely that judicial decisions[168] in right to refuse treatment cases reflect the sort of "dignity" values essential for a fair hearing.[169] Some judges simply rubber stamp hospital treatment recommendations in right to refuse cases.[170] Other judges are often punitive in cases involving mentally disabled litigants,[171] and their decisions frequently reflect textbook sanist attitudes.[172]

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wealth v. Cosme, 575 N.E. 2d 726, 731 (Mass. 1991) (not error where prosecutor referred to defendant's expert witnesses as "a little head specialist" and a "wizard").

[166]Perlin, *supra* note 37, at 396; *see, e.g.,* J.M. Balkin, *The Rhetoric of Responsibility,* 76 VA. L. REV. 197, 238 (1990) (Hinckley prosecutor suggested to jurors, "if Hinckley had emotional problems, they were largely his own fault"); *see also* State v. Duckworth, 496 So. 2d 624, 635 (La. Ct. App. 1986) (juror who felt defendant would be responsible for actions as long as he "wanted to do them" not excused for cause) (no error).

[167]Perlin, *supra* note 37, at 394.

[168]Where the fact finder is a nonjudicial officer, the problems discussed here are probably accentuated further. *See* Donald Bersoff, *Judicial Deference to Nonlegal Decisionmakers: Imposing Simplistic Solutions on Problems of Cognitive Complexity in Mental Disability Law,* 46 SMU L. REV. 329, 331–32 (1992) (psychiatrists as fact finders more likely to take paternalistic positions in right to refuse cases).

[169]*See generally* Perlin, *supra* note 33.

Courts and commentators have regularly discussed "dignity" in a fair trial context both in cases involving mentally disabled criminal defendants and in other settings. *See, e.g.,* Marquez v. Collins, 11 F.3d 1241, 1243 (5th Cir. 1994) ("Solemnity . . . and respect for individuals are components of a fair trial"); Heffernan v. Norris, 48 F.3d 331, 336 (8th Cir. 1995) (Bright, J., dissenting) ("the forced ingestion of mild-altering drugs not only jeopardizes an accused's rights to a fair trial, it also tears away another layer of individual dignity . . ."); Keith Nicholson, *Would You Like Some More Salt in That Wound? Post-Sentence Victim Allocution in Texas,* 26 ST. MARY'S L.J. 1103, 1128 (1995) (for trial to be fair, "it must be conducted in an atmosphere of respect, order, decorum and dignity befitting its importance both to the prosecution and the defense"); *see also* Tyler, *supra* note 59, at 444 (significance of dignity values in involuntary civil commitment hearings); Deborah A. Dorfman, *Effectively Implementing Title I of the Americans With Disabilities Act for Mentally Disabled Persons: A Therapeutic Jurisprudence Analysis,* 8 J. L. & HEALTH 105, 121 (1993–94) (same).

[170]*See* Winick, *supra* note 59, at 60, and *id.* n.148 (citing studies).

[171]*Compare* Perlin, *supra* note 37, at 407 n. 203:

> None is perhaps as chilling as the following story: Sometime after the trial court's decision in *Rennie* . . . I had occasion to speak to a state court trial judge about the *Rennie* case. He asked me, "Michael, do you know what I would have done had you brought Rennie before me?" (the *Rennie* case was litigated by counsel in the N.J. Division of Mental Health Advocacy; I was director of the Division at that time). I replied, "No," and he then answered, "I'd've taken the son-of-a-bitch behind the courthouse and had him shot."

[172]*See, e.g.,* Perlin, *supra* note 1, at 174 (discussing the sanist nature of Justice Thomas's dissent in Riggins v. Nevada, 504 U.S. 127 (1992); Perlin & Dorfman, *supra* note 31, at 58–61 (same).

C. Pretextuality[173]

The entire relationship between the legal process and mentally disabled litigants is often pretextual. By this, we mean simply that courts accept (either implicitly or explicitly) testimonial dishonesty and engage similarly in dishonest (frequently meretricious) decision making, specifically where witnesses, especially *expert* witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends."[174] This pretextuality is poisonous; it infects all participants in the judicial system, breeds cynicism and disrespect for the law, demeans participants, and reinforces shoddy lawyering, blasé judging, and, at times, perjurious or corrupt testifying. The reality is well known to frequent consumers of judicial services in this area: to mental health advocates and other public defender–legal aid–legal service lawyers assigned to represent patients and mentally disabled criminal defendants, to prosecutors and state attorneys assigned to represent hospitals, to judges who regularly hear such cases, to expert and lay witnesses, and, most importantly, to the mentally disabled person involved in the litigation in question.

The pretexts of the forensic mental health system are reflected both in the testimony of forensic experts and in the decisions of legislators and fact finders.[175] Experts frequently testify in accordance with their own self-referential concepts of "morality"[176] and openly subvert statutory and case law criteria that impose rigorous behavioral standards as predicates for commitment[177] or that articulate functional standards as prerequisites for an incompetency to stand trial finding.[178] Often this testimony is further warped by a heuristic bias. Expert witnesses, like the rest of us, succumb to the seductive allure of simplifying cognitive devices in their thinking and use such heuristic gambits as the vividness effect or attribution theory in their testimony.

This testimony is then weighed and evaluated by frequently sanist fact finders.[179] Judges and jurors, both consciously and unconsciously, frequently rely on reductionist, prejudice-driven stereotypes in their decision making, thus subordinating statutory and case law standards as well as the legitimate interests of the mentally disabled persons who are the subject of the litigation. Judges' predispositions to use the same sorts of heuristics as do expert witnesses further contaminate the process.[180]

This is especially critical in this context. Judges regularly decide involuntary civil commitment cases *not* under the terms of the underlying statutes, but rather on the

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[173]This section is largely adapted from Perlin, *supra* note 33.

[174]Perlin, *supra* note 38, at 133; Charles Sevilla, *The Exclusionary Rule and Police Perjury,* 11 SAN DIEGO L. REV. 839, 840 (1974).

[175]*See, e.g.,* Streicher v. Prescott, 663 F. Supp. 335, 343 (D.D.C. 1987) (although District of Columbia Code contained provision that patient could invoke to seek periodic review of commitment or independent psychiatric evaluation, in 22 years since passage of relevant statute, not a single patient exercised rights to statutory review). The significance of *Streicher* is discussed in Arlene Kanter, *Abandoned but Not Forgotten: The Illegal Confinement of Elderly People in State Psychiatric Institutions,* 19 N.Y.U. REV. L. & SOC. CHANGE 273, 304–06 (1991–92).

[176]*See, e.g.,* Cassia Spohn & Julia Horney, *"The Law's the Law, But Fair Is Fair": Rape Shield Laws and Officials' Assessments of Sexual History Evidence,* 29 CRIMINOLOGY 137, 139 (1991) (a legal reform that contradicts deeply held beliefs may result either in open defiance of the law or in a surreptitious attempt to modify the law).

[177]*See, e.g.,* Perlin, *Pretexts, supra* note 38, at 135–36.

[178]*See, e.g.,* People v. Doan, 366 N.W.2d 593, 598 (Mich. Ct. App. 1985).

[179]*See generally* Perlin, *supra* note 37; Perlin & Dorfman, *supra* note 33.

[180]*See generally* Perlin, *Pretexts, supra* note 38.

basis of their perceptions of whether patients will self-medicate in the community.[181] The paradox should thus be apparent: If patients seek to vindicate their constitutional right to refuse treatment, it may be seen as presumptive evidence that they require involuntary hospitalization. Counsel's potential role—in exposing this pretext—should be clear.

V. Sanism, Pretextuality, and the MacArthur Study

The MacArthur study sets out its goal as "an effort to develop standardized means of assessing decision-making abilities in the context of the consent to treatment."[182] For these assessment studies to be truly meaningful, it is necessary that decision makers consider (through the sanism and pretextuality filters[183]) the following issues:

- the attitudes of trial judges toward patients;
- the attitudes of counsel toward patients;
- the implication of courts' articulating expansive remedies in right to refuse class action litigation, without making provision of counsel to represent patients in individualized cases;
- the assignment of nonspecialized counsel and uneducated judges to represent patients in right to refuse cases;
- the failure of appellate courts to take seriously the *pro forma* quality and nature of hearings in many instances;
- the propensity of decision makers to equate "incompetent" with "makes bad decisions" and to assume, in face of statutory and case law, that incompetence in decision making can be presumed from the fact of institutionalization;[184]
- the perception of a positive relationship between implementation of the right to refuse and failed deinstitutionalization policies;[185] and
- the perception of drugs as the only "cure" for dangerousness.[186]

Each of these issues raises therapeutic jurisprudence concerns. If sanist trial judges assume that patients are incompetent (and thus discredit their testimony), the entire enterprise may be doomed to failure, and hearings become little more than empty shells. What difference will the study's recommendations make—as to the ability of these patients to engage in autonomous medication-choice decision making—if trial judges simply ignore patients' testimony? If sanist counsel similarly disparage their clients' stories (or, just as inappropriately, present them to the court

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[181]Perlin, *supra* note 37, at 395, reporting on cases discussed in 1 PERLIN, *supra* note 2, § 3.45 nn. 726.1–726.3 at 46–47 (1991 Supp.) (subsequently updated in *id.* at 102–04 (1995 Supp.)); Michael L. Perlin, *Reading the Supreme Court's Tea Leaves: Predicting Judicial Behavior in Civil and Criminal Right to Refuse Treatment Cases*, 12 AM. J. FORENSIC PSYCHIATRY 37, 52–59 (1991); Theresa Scheid-Cook, *Commitment of the Mentally Ill to Outpatient Treatment*, 23 COMMUNITY MENTAL HEALTH J. 173, 180–81 (1987).

[182]Appelbaum & Grisso, *supra* note 11, at 106.

[183]*See generally* Perlin, *supra* note 39.

[184]*See, e.g.*, Brian Ladds et al., *The Disposition of Criminal Charges After Involuntary Medication to Restore Competency to Stand Trial*, 38 J. FORENS. SCI. 1442 (1993); Brian Ladds et al., *Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Descriptive Study of the New York Experience with Judicial Review*, 21 BULL. AM. ACAD. PSYCHIATRY & L. 529 (1993).

[185]Perlin, *supra* note 1, at 159–63.

[186]Perlin, *supra* note 37, at 395; *see* cases cited in 1 PERLIN, *supra* note 2, § 3.45 nn. 726.1–726.3, at 102–04 (1995 Supp.).

with an overt or covert "wink" that asks the judge to share in a complicitous sham, suggesting that the lawyers are simply participating in what they see as a charade),[187] then, again, the potential impact of the study's findings is seriously compromised.[188]

If appellate courts enter broad orders in right to refuse cases without thinking about the operationalization of these orders in subsequent individual cases (or if only perfunctory assignment of disinterested counsel is made),[189] the initial order becomes little more than a pretext. If other appellate courts close their eyes to the level of inadequacy of counsel, this "willful blindness" simply adds one extra layer of pretextuality to the process.

Finally, although outside the scope of this article, the underlying social issues must be addressed. The common wisdom is clear here. Drugs serve two major purposes of social control: They "cure" dangerousness, and they are the only assurance that deinstitutionalized patients can remain free in community settings.[190] Both of these assumptions are reflected in the case law that has developed in individual involuntary civil commitment cases (in which a judge's perception of the likelihood that an individual self-medicates becomes the critical variable in case dispositions);[191] they are also reflected in the public discourse that is heard in classrooms, hospital corridors, and courtrooms.

Neither of these assumptions has any basis in science or in law. Yet, without counsel to serve as a brake—to ask questions, to challenge assumptions, to identify false ordinary common sense, to point out the dangerous pitfalls of heuristic thinking—these assumptions will continue to dominate and control the disposition of individual right to refuse treatment cases, notwithstanding the MacArthur study's recommendations.

Again, counsel's significance increases even more drastically here in the context of the improper "presumption of incompetency" discussed earlier. Winick suggests in his article in this issue, "Unless a *parens patriae* commitment statute requires an individualized determination of incompetence to engage in hospital admission decisionmaking, it would seem deficient as a matter of substantive due process."[192] Without vigorous, independent counsel, it is doubtful that such challenges would ever be launched. This is especially problematic in light of the fact that the equation of incompetency to mental illness *does* appear consonant with "ordinary common sense."[193] Counsel's role is especially important in areas of the law where common

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[187]On the problems raised when a lawyer feels "foolish" or "awkward" in the representation of an individual at an involuntary civil commitment hearing, *see* Perlin & Sadoff, *supra* note 66, at 167.

[188]*See id.* at 166 (on how a lawyer's perceptions that his client is not credible can have a "devastating" impact on the presentation of the client's case). For a recent thoughtful and comprehensive therapeutic jurisprudence analysis of the role of lawyers in the representation of mentally disabled individuals, *see* Jan Costello, *"Why Would I Need a Lawyer?": Legal Counsel and Advocacy for Persons with Mental Disabilities, in* LAW, MENTAL HEALTH, AND MENTAL DISORDER 15 (Bruce Sales & Daniel Shuman eds., 1996).

[189]On a startling variation between jurisdictions, *see* 2 PERLIN, *supra* note 2, § 8.23A at 210 (1995 Supp.) (contrasting experiences in Minnesota and Virginia).

[190]*See, e.g.,* Dorfman, *supra* note 38; Perlin, *supra* note 1; Perlin, *supra* note 158; Frances Cournos, *Involuntary Medication and the Case of Joyce Brown,* 40 HOSP. & COMMUN. PSYCHIATRY 736 (1989).

[191]*See supra* text accompanying note 181; *see also,* 1 PERLIN, *supra* note 2, § 3.45 at 104 (1995 Supp.), and *id.* at 105–06 n. 741 (citing cases).

[192]Winick, *supra* note 25, at 139.

[193]*See* Perlin, *supra* note 119; *see also,* Winick, *supra* note 25, at 145 ("Although the assumption that all mentally ill people are incompetent may not be irrational, the MacArthur study strongly suggests its incorrectness").

sense is so dissonant with empirical fact.[194]

If there is any expectation that the issues listed immediately above will be considered critically and thoughtfully in the context of individual right to refuse treatment determinations, it is essential that the issue of presence and adequacy of counsel be moved to center stage. Only then can the MacArthur study's important goals be met, and only then will there be any reasonable hope that right to refuse hearings cease to be little more than "dodging lions and wastin' time."

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[194]*See, e.g.*, PERLIN, *supra* note 159.