

Taking Harms Seriously: Involuntary Mental Patients and the Right to Refuse Treatment

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INTRODUCTION

One of the more controversial, if not paradoxical, developments in the continually expanding field known as "mental health law"¹ has been the establishment in the mid-to-late 1960's of a patient's right to treatment,²

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1. In no field of law is the divisive, dualistic character of America's legal system more apparent than in the field known as mental disability law. There, legislatures, courts, and scholarly tradition have combined to produce an unwieldy amalgam of general principles and particularized provisions so riddled with internal conflict as to justify a diagnosis of florid legal schizophrenia. In this field of law, the state's *parens patriae* power competes with its police power; the patient's right to treatment coexists (all so uneasily) with the right to refuse it; the therapist's obligation to preserve client confidentiality militates against the duty to warn others; the psychiatrist's wish to treat is undercut by legal compulsion to deinstitutionalize or to refrain from institutionalization altogether; while the pressure on the provider/administrator toward early release increases the risk of legal liability; and the doctrine to deliver least restrictive treatment threatens the disabled with the reality of being subjected to a regimen that retains most of the coercion and restraints of the institutional setting, but without the treatment, or worse, of being left with the unfettered freedom to deteriorate and die in the streets.

Brakel, *Legal Schizophrenia and the Mental Health Lawyer: Recent Trends in Civil Commitment Litigation*, 6 BEHAV. SCI. & L. 3, 4 (1988).

2. *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966), is generally recognized as the first judicial articulation of the right to treatment. The concept was explicitly put forth as early as 1960 in an influential article by Birnbaum. Birnbaum, *The Right to Treatment*, 46 A.B.A. J. 499 (1960). The *Rouse* court based the availability of this right on closely related language in the District of Columbia's mental health code. However, subsequent court decisions in other jurisdictions had no trouble finding such a right in the absence of explicit or suggestive statutory language. The right was seen to be inherent in the "logic" of civil commitment and according to some courts, was even compelled by the state and federal constitutions. See, e.g., *Welsch v. Likins*, 550 F.2d 1122 (8th Cir. 1977); *Eckerhart v. Hensley*, 475 F. Supp. 908 (W.D. Mo. 1979); *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971). The United States Supreme Court has never found a patient's treatment right to be constitutionally compelled. See *Youngberg v. Romeo*, 457 U.S. 307 (1982); *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

followed a short decade later by the legal consolidation of its counter point — the right to refuse treatment.³ Although legal rights advocates⁴ may contend that there is no conflict between these two rights, the reality is that they often do conflict. The clash of interests is most pronounced in mental hospitals housing involuntarily committed patients,⁵ where the very concept of right to refuse treatment seems anomalous and its unchecked assertion would wholly vitiate the purpose of the enterprise. In this setting, many treating psychiatrists find themselves cornered into an ethical and legal no-win position as they must watch patients, committed to their charges by the state because the patients are incapable of recognizing their need for treatment, fall prisoner⁶ to this “liberty interest” they have chosen to exercise.⁷

3. The leading cases here are *Rennie v. Klein*, 476 F. Supp. 1294 (D.N.J. 1979), *modified*, 653 F.2d 836 (3rd Cir. 1981), *vacated*, 458 U.S. 1119 (1982), and *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291 (1982). The appeals and rehearings of these cases chipped away at the breadth and constitutional stature of this right, as compared to its initial articulations, though the general proposition that the right to refuse is available to mental patients remained intact. In some writings, the date of “discovery” of the right-to-refuse concept is pushed back to 1972 via a reference to *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). However, this case is about informed consent to treatment, a doctrine of far longer standing that at best *implies* a right to refuse, and it does not involve a mental patient.

4. These advocates are often called, or label themselves as, patients' advocates. In our view, this is a misnomer because the uncompromising assertion (or creation) of legal rights frequently clashes with the patient's personal and medical interests.

5. The conflict may, of course, also arise in the treatment of voluntary patients, except that hospital personnel in that situation can mitigate the dilemma by discharging or threatening to discharge the refuser. By the same token, the assertion of the right to refuse can also undercut medical objectives in the outpatient clinic or the psychiatrist's office. Legally, the institutional psychiatrist's dilemma is that he is potentially liable if he treats and also if he does not. *See also infra* notes 36-37.

6. The term “prisoner” is no mere figure of speech here. A patient who refuses treatment will often extend the length of his confinement, thereby acting counter to his “liberty interest.” Without treatment, he can only receive custodial care (*i.e.*, be “warehoused”), thus undercutting both his own and the institution's medical interests, not to mention society's interest in the efficient treatment of medical patients, particularly “public” patients. For the initial articulation of the view that to hospitalize a patient involuntarily, but not to permit treatment under the right to refuse, subjects the patient to preventive detention, see Stone, *The Right to Refuse Treatment: Why Psychiatrists Should and Can Make It Work*, 38 ARCHIVES GEN. PSYCHIATRY 358 (1981).

7. The “liberty interest” analysis is classic to right-to-refuse cases. It derives from the due process clause of the fourteenth amendment and was recently endorsed by the Supreme Court in *Washington v. Harper*, 494 U.S. 210 (1990), a case in which the institutional inmate's refusal was held to be properly overridden. Legal rights advocates may see this as an irony. In our view, the greater irony is how often the assertion of the liberty interest, in effect, decreases freedom.

In and of itself, the existence of a right to refuse unwanted medical treatment is not controversial and is clearly salutary. It is a right we presume to be accorded to all citizens—an indisputable element of the political and moral consensus in a society committed, such as ours, to democratic traditions limiting the power of the state and other external authorities. It is part of the premium we put on individual freedom, the liberty we possess to define and decide what is in our interests, our right to self-determination, personal autonomy, or even (and awkwardly) “personhood.” These core values find expression in our contemporary legal culture under the rubric of one’s “right to privacy”—a general, stretchable concept whose more particularized, and in our context, most relevant articulations include the “right to bodily integrity” or “freedom from bodily intrusions.”⁸

Although the principle of personal inviolability thus commands us to respect an individual’s medical treatment decisions in all “ordinary” situations,⁹ exceptions must sometimes be made in unusual circumstances. For example, when the treatment offered or requested is experimental or presents a high risk, appropriate limits are placed on the individual’s affirmative treatment choices. The same is true when the *refusal* to be

8. Liberty, freedom, privacy, and autonomy are interwoven concepts that, judging from their articulation in court cases, seem more to feed on one another than to submit to any logical progression from primary to secondary or general to specific. Is it the right to privacy that creates the liberty interest or the other way around? Does the concept of personal autonomy foster various freedoms or do the acknowledged freedoms generate autonomy? The constitutional invocations for these concepts are equally confounding and range from specific clauses in the fourteenth amendment to fuzzier constitutional “penumbrae” from which the rights (e.g., “privacy”) are seen to emanate. See *Griswold v. Connecticut*, 381 U.S. 479, 483 (1965). The specific right to bodily integrity or freedom from bodily intrusions derives from traditional tort law.

9. A favorite judicial quote here is from Justice Cardozo, who in *Schloendorff v. Society of New York Hospitals*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) wrote: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body.” The “sound mind” qualification is critical to our context. The qualification of adulthood is also relevant. Children are not competent under the law to make contractual or other decisions that have legal ramifications. In recent years, the law has vacillated between a hands-off and an interventionist approach as regards the *mental* treatment and commitment of minors, with the most recent trend favoring the former mode. See *Parham v. J.R.*, 442 U.S. 584 (1979). Legal interference is rare for the treatment of children’s *physical* illnesses. Parents, in consultation with their physicians, routinely make these decisions on behalf of their children, unencumbered by legal process or even the thought of it. It is in cases when parents, out of religious conviction, have attempted to *withhold* treatment that the law has recognized a need to intervene. See, e.g., *Walker v. Superior Ct.*, 194 Cal. App. 3d, 222 Cal. Rptr. 87 (1986), *superseded*, 47 Cal. 3d 112, 763 P.2d 852, 253 Cal. Rptr. 1, *cert. denied*, 491 U.S. 905 (1989) (rejecting a Christian Scientist’s defense that the “spiritual treatment” given to her four-year-old daughter who died of acute meningitis exonerated her from charges of involuntary manslaughter and child endangerment).

treated is life-endangering, amounting to a passive suicide decision. The possibility of serious, even fatal, harm to the patient is the unifying thread. The right to make one's own health choices is not absolute. One may (still) kill oneself slowly by smoking cigarettes or, as in some of our more freedom-loving states, live with the increased risk of instantaneous injury or death by not wearing a seatbelt while driving a car or protective head gear while riding a motorcycle. Yet, neither the law nor social morality presently condones the notion that people are free to kill themselves actively or to mutilate themselves severely.¹⁰ Once a person becomes a client of the health care system, the idea that treatment choices may be circumscribed is reinforced by the doctor's professional ethic that he shall not harm his patient.

The "extraordinary" situation most relevant to our topic tends to be less extreme than the death-defying scenarios invoked above and involves balancing different values.¹¹ It is the situation when the individual needs standard medical intervention, but is, for one reason or another, incapable of asking for it (or incapable of resisting it, in instances when the treatment provider is willing or obligated to intervene in the absence of the individual's request or consent). There is no treatment decision issuing from the individual on which the treatment provider can act. A person who is comatose or who is otherwise overwhelmed by physical trauma cannot request or consent to medical treatment. In the mental health setting, "incapacity" usually means "incompetency." There is no treatment decision because the individual is mentally incapable of making it.

Much has been written about the meaning of "mental incompetency":¹² (1) whether its essence is clinical or legal or some mix of the two; (2)

10. The so-called right-to-die cases, which are becoming increasingly prominent in law and in the public consciousness, turn on the assertion that the life of the individual who wishes to end it is (in the individual's view or that of a substitute decisionmaker) no longer worth living—an assertion that is debatable or litigable only in dire circumstances. *See, e.g., Cruzan v. Director of Mo. Dep't of Health*, 110 S. Ct. 2841 (1990); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976).

11. Some commentators and interested parties on either side of the issue nevertheless try to structure the debate in right-to-live/right-to-die terms. This misses the point and constitutes a gross exaggeration of the mental treatment issue. Even the more invasive interventions, such as psychosurgery (today virtually never performed) or ECT, are not of that order. For antipsychotic medication treatments, despite side effects that in isolated cases of misadministration have caused death, framing the issue as such is even less pertinent. *See Kaimowitz v. Department of Mental Health*, No. 73-19434-AW, slip op. (Cir. Ct. Wayne County Mich., July 10, 1973).

12. For an extensive treatment of the civil incompetency concept, see S. BRAKEL, J. PARRY, & B. WEINER, *THE MENTALLY DISABLED AND THE LAW* 369-433 (3d ed. 1985). Contemporary articulations of the incompetency concept threaten the capacity of the states to provide treatment for mentally ill persons. Given a rigid interpretation of the theory that

whether it stands for a general incapacity or one specific to the decisional situation at hand; (3) whether it is, or should be, presumed for all who certifiably suffer from a mental illness, for those institutionalized in mental hospitals, for those involuntarily hospitalized, or for none of the above; (4) if and when it is advisable to have a delegate for an incompetent person make substitute decisions for the latter; and (5) whether "incompetency" is merely a pragmatic concept for those who wish to exercise power over the alleged incompetent.

This Article does not attempt to resolve the preceding questions about the concept of competency. What is important for the purpose of our present analysis is that an individual's mental incompetency does not, except in isolated instances, wholly preclude him from articulating a treatment decision. In other words, in contrast to one who is silenced by physical incapacity, a mentally incompetent person can voice objection to treatment.¹³ Based on this generalized presumption of retained capacity to speak, we can postulate the following minimal principle on which general agreement should be possible: All mentally-ill persons, irrespective of adjudicated or presumed incompetency, retain an initial right to articulate their objection to or refusal of unwanted treatment which should be heard. Beyond this principle, interests begin to diverge and opinions may differ. The crux of the controversy regarding treatment refusals by mentally ill persons is whether, when, how, and by whom an articulated refusal can be overridden.

Having identified what we believe is the true issue, we can supply the answer. We state it in the form of three basic contentions whose direct application is intended to be limited to situations when patients are in mental hospitals via involuntary commitment and when the proposed treatment is antipsychotic medication. We contend that in this situation: (1) the decision to override a treatment refusal is best made by medical personnel rather than judges or other legal functionaries;¹⁴ (2) the override

"incompetent" persons cannot give valid consent to voluntary hospitalization and treatment, the viability of the states' entire voluntary admission schemes is undermined. Persons who may wish to be hospitalized or who willingly sign voluntary admission and treatment papers, will instead have to be involuntarily committed—hardly the preferred approach. Worse, some of these persons, though seriously ill, may not meet the restrictive criteria for involuntary commitment and thus, could be left without any way to obtain treatment. For the proposition that hospital officials may even be legally liable when they extend "voluntary" treatment to such persons, see *Zinerman v. Burch*, 494 U.S. 113 (1990).

13. The unconscious patient will not object to treatment, but the delirious adult and many children, particularly small children, may. They may fight, scream, and voice inarticulately their "objection" to treatment. Indeed, not infrequently, patients need to be restrained for treatment to proceed. This has never been deemed a problem requiring legal intervention, nor should it be.

14. The mandate for judicial review of treatment refusals produces an especially

decision can be made in all circumstances, not, as presently conceded by the law and most legal advocates, only in emergencies; and (3) it can and should be made with minimal loss of time (even no loss of time if the basic treatment decision is made simultaneous with the commitment decision, as we propose the law should provide).¹⁵ The objectives of and rationales for each of these contentions are interrelated. They defer to professional competency and perhaps more importantly, the need for timely treatment.¹⁶

Legal rights advocates are prone to dispute the above contentions on constitutional grounds. Rather than debate or litigate the straightforward question of what measure of patient autonomy is desirable and practicable in the mental hospital setting, the advocates' strategy has been to outflank the perceived "opposition" by redefining the issue in terms of "due process," "equal protection," or even "freedom of expression," often enveloping the analysis in the language of discriminatory treatment.¹⁷

This Article does not intend to join the debate on this level for the following reasons. We do not believe that the right to receive or to refuse treatment conundrum is likely to be solved by constitutional or other doctrinal analysis. Nor are treatment issues usefully conceptualized as problems in invidious discrimination. The heart of the problem, we believe, lies elsewhere. It is primarily factual. Its essence is in the law's apparent, and in some cases apparently willful, misunderstanding of the medical facts. As such, we believe its resolution will come principally through factual rectification.

I. THE PERSISTENCE OF MEDICAL MISINFORMATION AND MYTHS IN THE LAW

Although a recent Supreme Court decision concerning the involuntary medication of a state prison inmate endorses a medical/administrative pro-

anomalous result in cases in which the involuntary patient refuses medication upon admission. In that instance, a second trial must then be held which will be almost wholly duplicative of the commitment proceeding just completed.

15. This proposal will be elaborated in the final pages of this Article. For now, we want to point out that making the treatment decision simultaneous with commitment will not threaten the patient's opportunity to be heard, to object, or to refuse. To the contrary, the matter would be addressed explicitly and separately. In addition, the treatment decision would be subject to periodic administrative review, including at the patient's initiative.

16. These principles may have substantial applicability beyond the present context. See *supra* note 5. In addition, medical judgment deserves substantial deference with respect to treatment methods other than medication. *Youngberg v. Romeo*, 457 U.S. 307 (1982).

17. The first amendment freedom of expression link to the matter of forced medication may appear the most remote of the various constitutional strategies. For an extensive argument that it is the most appropriate link (a point, it should go without saying, we do not share), see Winnick, *The Right to Refuse Mental Health Treatment: A First Amendment Perspective*, 44 U. MIAMI L. REV. 1 (1989).

cedure for overriding decisions to refuse treatment,¹⁸ it can hardly be concluded that the medical side has won the battle of what process best serves the treatment interests of mental patients. The Supreme Court has long been a voice in the wilderness on mental health matters, diverging sharply from other courts on both the state and lower federal levels.¹⁹ State court holdings in particular continue to adhere to the orthodoxies of the legal decisionmaking model,²⁰ under which the provider's determination to override the patient's refusal will be subjected to judicial reassessment at any of a variety of junctures while little heed is paid to the individual and institutional harms that may result from the consequent delay.²¹ At the

18. *Washington v. Harper*, 494 U.S. 210 (1990). In this case, the Court approved the State of Washington's Special Offender Center policy that an inmate may be involuntarily medicated upon the order of a psychiatrist if he is found to suffer from a mental disorder and to be gravely disabled or dangerous. Rejecting the legal decision model urged by the inmate and found to be constitutionally required by the state supreme court, the Court held the Center's administrative review procedures to be constitutionally sufficient. The essence of these procedures was a timely hearing and subsequent periodic review by an in-house special committee composed of a psychiatrist, a psychologist, and a corrections official. The decision's import for the mental health care setting is not altogether clear. Prisoners, to the extent they retain "autonomy" rights, which they do up to a point, retain somewhat different ones than do involuntary mental patients. In terms of the state's interest, forced treatment on the ground of security considerations may be more compelling for prisoners. On the other hand, involuntary treatment of mental patients is logically supported by the rationale of commitment and the objectives of mental institutionalization. If the medical decision model is appropriate for corrections, can it be wrong for mental health?

19. *See, e.g., Youngberg v. Romeo*, 457 U.S. 307 (1982); *Parham v. J.R.*, 442 U.S. 584 (1979). *Parham* and *Romeo* had a great deal to do with the outcome in *Harper*. The fact that *Harper* itself was a reversal of a decision by Washington's highest court is also telling. Finally, the three dissenters in *Harper*, Justices Stevens, Brennan, and Marshall, would have sustained the Washington Supreme Court's requirement for a judicial hearing. Their opinion reflects an overestimation of the dangers and discomforts of drug treatment mixed with legitimate points about the lack of independence of the institution's review mechanism and the unhealthy "muddling" of therapeutic and security rationales in the forced medication of inmate Harper.

20. The federal district and circuit courts are by design more prone to follow the lead of the United States Supreme Court than are the state courts, especially on minimum standards which the states are free to exceed. Evidence of this is detectable in the appellate courts' response to the initial decisions in *Rennie v. Klein*, 653 F.2d 836 (3rd Cir. 1981), *vacated*, 458 U.S. 1119 (1982) and *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom. Mills v. Rogers*, 457 U.S. 291 (1982). However, the most significant implementation of the Supreme Court's stance was presented in *United States v. Charters*, 863 F.2d 302 (4th Cir. 1988), *cert. denied*, 110 S. Ct. 1317 (1990), which upheld the medical-administrative procedures for ordering the forced medication of an involuntarily committed psychiatric patient who was unfit to stand trial.

21. Describing and documenting these harms is a major aspect of the remainder of this Article. For a listing of state and federal court decisions on the right to refuse treatment and a discussion of the general tenor of the law, see Brooks, *The Right to Refuse Antipsychotic Medications: Law and Policy*, 39 RUTGERS L. REV. 339 (1987). For another discussion by

same time, the legal literature²² has continually shown a one-sided preoccupation with the "invasive" nature of mental treatment and medication and its potentially deleterious side effects,²³ while down-playing, if not outright ignoring, its documented benefits.²⁴

When one combines the traditional inertia of law with the fact that the recent Supreme Court holding in *Washington v. Harper*²⁵ does no more than sustain a minimum constitutional standard for making the override decision in the prison setting, it is apparent that no real conciliation has been achieved between medical and legal rights and that none can be assumed to be forthcoming. The prospect of entrenchment or re-trenchment is real. Free to impose far more onerous standards for overriding patients' refusals, state courts and legislatures, influenced as in the past by a steady stream of medical misinformation and myths, can be expected to follow their institutional inclination to continue to "belegal" the process.²⁶

The purpose of this Article is to show that a retreat from the Supreme Court's recently approved standard is neither necessary nor desirable. By relieving the legal community of the popular cant that institutional psychiatrists are gleefully engaged in a "therapeutic orgy"²⁷ that is over-

the same author, see Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 179 (1980).

22. The value of the Brooks contributions lies in part in their relatively even-handed handling of the issue as compared to the treatment accorded to the mental treatment/refusal topic in most legal journals. We suppose that legal rights activist lawyers will find equal bias, in the opposite direction, in most medical publications. See *supra* note 21.

23. For the proposition that the side effects are really just "effects" and that the label "side" is used to diminish their significance or seriousness, see Winnick, *supra*, note 17. To assess the probity of this point, the reader might consider that the same thing can be said of more familiar drugs.

24. As with harms, a major objective of this Article is to document the benefits.

25. 494 U.S. 210 (1990).

26. When the Supreme Court took away the federal constitutional rationale for requiring full legal due process in treatment decisionmaking, a number of state courts responded by grounding the judicial process mandate for overriding treatment refusals on state statutory and common law or on the state constitution. See *Rogers v. Commissioner of the Dep't of Mental Health*, 390 Mass. 489, 458 N.E.2d 308 (1983); *Rivers v. Katz*, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986); *State ex rel. Jones v. Gerhardstein*, 135 Wis. 2d 161, 400 N.W.2d 1 (1986), *aff'd*, 141 Wis. 2d 710, 416 N.W.2d 883 (1987). State judges and legislators will presumably feel equally free to circumvent the implications of *Washington v. Harper*. For general comments on lawmakers' inclination to solve social problems with law and legal process, see R. SLOVENKO, PSYCHIATRY AND LAW, 221 (1973); Brakel, *Response to James Ellis*, 23 L. & SOC. REV. 961 (1989); Brakel, *Pro Se*, 14 STUDENT LAW. 38 (1986).

27. See Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U.L. REV. 461 (1978). This is one of the most frequently cited writings in right-to-refuse cases and other legal commentary on the subject. The article starts off by speaking of mentally ill persons as being "arrested and confined for 'treatment.'" *Id.* It then

whelmingly harmful in effect, and showing that the benefits of medication treatment are immense, indisputable, and capable of being delivered in a way that is largely risk-free for most patients, we hope to persuade decisionmakers that the patients' treatment interests can be served without the maintenance of a cumbersome and counterproductive legal-safeguard machinery. Faith in the law's capacity to render appropriate treatment decisions is misplaced. The law can only curb medical abuse. Too often the legal mind equates this with the assumption that there is abuse. Although never justified, this see-only-evil, hear-only-evil attitude is particularly inappropriate and destructive in today's mental health services environment. More than any previous time in psychiatry's history (and with due credit to the legal rights side for its role in fostering a new vigilance),²⁸ we believe that the contemporary law can safely afford to give a measured deference to the good faith, professional ethics, and professional competence of treating doctors.

II. SEPARATING MYTH FROM REALITY: THE EMPIRICAL-MEDICAL PERSPECTIVE

Our purpose is to focus on the empirical aspect of the right-to-refuse question and to present medically accurate information on the benefits and risks of drug treatment and the harms resulting from no treatment. This information shapes the consensus medical perspective on the right to refuse treatment. It should also be the basis for any and all *legal* perspectives, but unfortunately, it is not.

We have reviewed the legal literature on the use of psychotropic drugs in detail, and we find that almost all of it is not merely biased, but also factually incorrect. Of the more than thirty law journal articles we examined, at least twenty would by any objective criterion be classified as vitriolically "antidrug."²⁹ The remainder are somewhat more tempered,

goes on to assert that "while *incarcerated*, they are subjected to a veritable orgy of 'therapeutic techniques' imposed upon them without their consent and often against their will by state-employed physicians." *Id.* (emphasis added). For a typical court case echoing this unmodulated antipsychiatric perspective, see *Davis v. Hubbard*, 506 F. Supp. 915 (N.D. Ohio 1980).

28. Notwithstanding our view that law at the so-called cutting edge of mental health is too often based on worst case scenarios, refuses to acknowledge that the general scenario is not nearly so bad or is much improved, and as a result, goes too far in legally inhibiting the mental health care provider, the aggressive advocacy of legal rights must nevertheless be credited with directly or indirectly fostering needed correctives in perspective, policy, and procedures. For a brief discussion of this dialectic quality of legal reform in the area of corrections, see Brakel, *Prison Reform Litigation: Has the Revolution Gone Too Far?*, 70 JUDICATURE 5 (1986).

29. Few put the bias as unabashedly in the title as Plotkin, but the content is no less slanted. See *supra* note 27. In addition, there is an equally voluminous law journal

but even these, with a few exceptions, are fundamentally slanted against the use of drugs in psychiatry. Factual inaccuracies abound and, as the writings rely almost exclusively on one another, they merely repeat spurious myths, piling misinformation on top of misinformation.³⁰ In addition, there is almost no consideration of the "helping" rationale behind psychiatric treatment or an acknowledgment of the obvious legal conundrum of how the state can justifiably hospitalize a patient against his will without providing effective treatment.

The judicial opinions are only marginally better balanced.³¹ Too often they share the internal-referencing flaws of the reviews, with judges relying

literature that is antipsychiatric in general, as opposed to antidrug. In *Dautremont v. Broadlawn Hospital*, 827 F.2d 291 (8th Cir. 1987), the phrase "mental restraint" is used in connection with drug treatment. In most articles, drugs are said to be "intrusive." The word intrusive suggests unwarranted entry into someone's mental life, presumably for punitive purposes or subjectively unpleasant effect. This is a pejorative term much like referring to surgery as butchery. The word "drugged," which is used frequently, has the connotation of heavy sedation.

30. Initially, several medically inaccurate law review articles were published based on snippets of data found in studies that came to diametrically opposite conclusions than the ones proffered by the legal writers. See, e.g., DuBose, *Of the Parens Patriae Power and Drug Treatment Schizophrenia: Do the Benefits to the Patient Justify Involuntary Commitment?*, 60 MINN. L. REV. 1149 (1976); Plotkin, *supra* note 27; Plotkin & Gill, *Invisible Manacles: Drugging Mentally Retarded People*, 31 STAN. L. REV. 637 (1979). These misreferences were then quoted by authors of subsequent law review articles or incorporated into court discussions. This resulted in the consideration of a succession of factually erroneous materials by both legal academics and legal practitioners. Virtually no one read and correctly summarized the original medical literature. The problem is that most legal libraries do not carry medical books and journals; therefore, the medical information about the risks and benefits of drugs and practical information about the context and consequence of their use is unavailable to most lawyers. There is also a "communications gap" compounding the availability problem. It is not so much (or not only) that the medical information is written in jargon, but that the implications of the information may not be readily understood by nonmedical readers. References to "mean improvement scores" and the like are not well-tailored to express the full human significance of the changes to the patients. The suggestion, implicit above, that the psychiatric profession shares some of the blame for the lack of information, that its complaint is in part a self-inflicted problem, is further strengthened by the fact that psychopharmacology was and remains a developing science in which many psychiatrists and psychologists are not well versed. The legal system may at times have had inadequate, perhaps even incorrect, input from the mental health community. Occasional commissions of both lawyers and psychiatrists have been appointed to review the psychopharmacological literature. Yet, with the persistence of elements in the psychiatric community unschooled in this specialty, or apathetic or even unsympathetic to its potential and achievements, it is quite possible that these reviews have served only to contribute to the information gap. See *infra* note 45.

31. Judges, particularly trial judges, are bound in theory by the facts presented in the case before them and not by the literature. However, judicial "facts" are not facts in the ordinary sense. They may include, in addition to the parties' allegations about specific events, practices, or procedures, a wide range of conclusions based on direct testimony by

not on original medical data, but on the self-perpetuating "interpretations" of the data in the legal literature.³² Unique to the common-law system

experts, the "facts found" in other legal cases, and personal or so-called common sense perspectives and assumptions of which judges may simply take "judicial notice." Thus, it is possible for a case to state the following: "Such widespread use of psychotropic drugs . . . is not, however, necessarily supported by any sound medical course of treatment. Put simply, the testimony at trial *established that the prevalent use of psychotropic drugs is countertherapeutic and can be justified only for reasons other than treatment—namely, for the convenience of the staff and for punishment.*" *Davis v. Hubbard*, 506 F. Supp. 915, 926 (1980) (emphasis added). This case also states that "the inmates' principal interest affected in the present case arises not from the state's attempt to punish thoughts but its attempt to use treatment *as a means of controlling thought, either by inhibiting an inmate's ability to think or by coercing acceptance of particular thoughts and beliefs.*" *Id.* at 933 (emphasis added). Mixed in with these "findings" are references to the most vociferous antipsychiatric legal literature, including Plotkin, and a cite to *Rennie v. Klein*, 476 F. Supp. 1294, 1299 (D.N.J. 1979) for the proposition that "drugs may cause cancer." *Davis*, 506 F. Supp. at 928. The Fourth Circuit's decision in *United States v. Charters*, 863 F.2d 302 (4th Cir. 1988), *cert. denied*, 110 S. Ct. 1317 (1990), was preceded by a decision of a panel of the same court which endorsed the traditional judicial review model and supported this result with a great deal of antidrug invective similar to the *Davis* opinion. *See United States v. Charters*, 829 F.2d 479 (4th Cir. 1987).

32. This produces statements such as the one in an *amicus curiae* brief in *Okin v. Rogers* that patients are "forcibly drugged into a physical stupor to prevent these activities. . . . [C]hlorpromazine . . . produced . . . a marked lack of interest in what was going on. . . . [I]t is difficult for patients so sedated that they can only sleep . . . to become members of the community again. . . . [P]henothiazines . . . decrease learning performance." Mental Health Association, Civil Liberties Union of Massachusetts Amicus Brief at 45-46, *Okin v. Rogers*, 134 F.2d 650 (1st Cir. 1977) (No. 77-1201). In addition, the court in *Rennie v. Klein*, 476 F. Supp. 1294, 1299 (1979), *modified*, 653 F.2d 836 (3d Cir. 1981), *vacated*, 458 U.S. 1119 (1982), noted that "drugs inhibit a patient's ability to learn social skills needed to fully recover from psychosis." A further extended quote gives one a flavor of the right-to-refuse treatment movement's thinking on antipsychotic medication:

[D]rugs are the most painful, distressing ordeal they have ever experienced — in a different class than prolonged solitary confinement or physical deprivation. . . .

The drugs can, however, cause a permanent psychotic condition. . . .

Physiologically, antipsychotic effects cannot be confidently distinguished from crude measures—such as bleeding, purging, and, in all probability, lobotomy—which render individuals too weak or preoccupied to attend to their psychotic urging. . . .

[M]ost acute psychotic episodes abate . . . without drugs. . . . Drugs are remarkably effective restraining devices

Drugs also ease the burden of the custodian's remaining tasks [In the past] staff accompanied every restrained or secluded patient to the bathroom; if patients could not leave their rooms, staff had to clean up after patients who soiled themselves. . . . By contrast, drugged patients are generally ambulatory They can walk to the dining room, en masse, feed themselves, return to their quarters and relieve themselves. . . .

This psychological state, induced in confinees, must be every overweening jailer's ideal. . . .

is the insidious possibility that the unsubstantiated allegation of today's case becomes tomorrow's generally established "legal fact." For example, in *In re the Mental Commitment of M.P.*,³³ a well-known case used in psychiatric circles, the Indiana Supreme Court opined that "[a]t the heart of this case is the virtually undisputed allegation that a person medicated with antipsychotic drugs has a 50% risk of contracting tardive dyskinesia."³⁴ No more than a year later, this assertion prompted an Illinois appellate court to bolster its decision invalidating a trial court-approved medication plan with the "fact" that "[t]he Indiana Supreme Court found that a person medicated with antipsychotic drugs has a 50% risk of contracting tardive dyskinesia in addition to other unpleasant side effects."³⁵

These errors of fact and reasoning are no mere abstract concern. We are not just dealing with a dissonance in interprofessional metaphysics. The errors have real consequences. They affect the content of legal

Private facilities that routinely bound, shackled, restrained, benumbed, or secluded the mentally ill would be intolerable today, because the state jealously guards its monopoly on physical force. Thus, shifting custody from public to private institutions, depended on the invention of a treatment form that made private management of mental illness consistent with evolving general norms about physical force and restraint. What private custodians cannot be allowed to accomplish with physical restraint, they can do even more efficiently by drugging

Clinical state psychiatry's "paradigm"—if that is the appropriate term—is "political," however, in a number of respects. . . . The apparent motivation is to maximize drugging because of the drugs' custody-enhancing effects—a political rather than a scientific objective. Its reduction of individuals to fungible entities without distinguishing characteristics, its tolerance for state-induced distress, and its apparent willingness to conceal the truth bespeaks political overreaching more than scientific or professional error. . . .

Doctors lying to patients, their infliction of serious drug harms, and their affronts to patient dignity can be checked by court decree.

Gelman, *Mental Hospital Drugs: Professionalism and the Constitution*, 72 GEO. L.J. 1725, 1744-64 (1984).

33. 510 N.E.2d 645 (Ind. 1987). At the time of this case, quantitative data on the development of tardive dyskinesia (TD) fell short of acceptable standards of precision and reliability. However, it is known with substantial certainty that there is almost no risk for short-term patients, a category that describes the overwhelming majority of patients. We also know that the risk goes up when high-dose medication is continued over the longer-term (generally defined as beyond six months). A reasonable estimate, based on preliminary research findings, is that the risk of developing TD increases about three percent per year. Thus, a patient who has received medications for an aggregate span of three years has a 9% risk and a 15% risk after six years. The 50% risk "found" by the Indiana and Illinois courts for mental patients, undifferentiated by the length of drug treatment, would in fact apply only to patients who are well into their second decade of continuous medication. See *infra* note 106 and accompanying text.

34. *M.P.*, 510 N.E.2d at 646.

35. *In re Orr*, 176 Ill. App. 3d 498, 513, 531 N.E.2d 64, 74 (1988).

representation provided to patients. They determine the practical outcomes to the patients who are covered by the courts' rulings, either as direct parties or far more broadly, as the indirect "beneficiaries" of the litigant class. They turn the right to refuse into a proverbial double-edged sword, one edge of which is capable of cutting deeply into the treatment rights and needs of patients, their families, and professional care providers. Both lawyers and psychiatrists can profit from trying to understand their differing professional philosophies and perspectives. These differences are real, perhaps profound, and are not easily reconciled. Yet, differences in values can never be bridged if the facts are ignored or misstated.

We will describe the risks and benefits of psychotropic drugs based on well-controlled, verified, and verifiable investigations. Factual information cannot tell us how the law should balance values in conflict, but wrong facts can result in bad law. The translation of the abstract right-to-refuse issue into real world treatment refusals has consequences which are vastly more serious and more complicated than the law and legal literature presume. We argue that a lawyer in possession of the medical facts cannot maintain the fiction that liberty is best protected by a legal philosophy—whether perceived as liberal or conservative—that holds the right to refuse treatment as the patient's paramount right.

A. Reality of the Patient's Setting

Apart from the mythology surrounding medical treatments for psychiatric patients, there is a second operating myth that determines the predominant legal stance toward right-to-refuse cases. This second myth concerns the type of mental patient for whom the right to refuse is at issue and how and why the patient finds himself in the setting. Both myths need to be undone before members of two diverse professions can come to a mutual understanding or agreement on what is best for patients. We deal briefly with the second myth first, before devoting the remainder of the Article to the issue of psychotropic drugs.

Most right-to-refuse cases arise among patients who have been involuntarily hospitalized. Voluntary patients who do not wish to cooperate with the prescribed treatment regimen can simply leave the hospital against medical advice or be discharged if they want to maintain the untenable position of wishing to stay while rejecting the course of treatment decided upon in the doctor's best medical judgment.³⁶ Outpatients can simply

36. More significant perhaps, is the empirical evidence that treatment refusals among voluntary patients are qualitatively different than the refusals of involuntary patients. A 1980 study by Applebaum & Gutheil found that voluntary patients may resist treatment for a variety of reasons, but that the disagreements are usually resolved easily and quickly. See Applebaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 AM. J. PSYCHIATRY

refuse to take their medication.³⁷

For involuntary patients, there should be no illusions about the true nature of their commitment (*i.e.*, how and why it took place).³⁸ A court ordered them to be admitted to a psychiatric hospital, based on legal standards, substantive and procedural, that today are quite exacting.³⁹ They were found to either be so disabled as to pose a grave risk to their own well-being or so dangerous as to present an imminent threat to others. No alternative disposition less restrictive than hospitalization was deemed safe or available, or if available and offered to the patient, was not accepted by him. In personal terms, the patient's relatives felt hospitalization to be the only recourse, a judgment in which the family physician or other treatment provider almost certainly concurred. By contrast, the patient was unable to recognize his illness and his need to be hospitalized. It would not be unusual for him to be distrustful of, or even overtly angry at, those concerned about his mental health. Clinically, the patient's picture would be as follows: the patient suffers from a major mental illness (schizophrenia, mania, or psychotic depression, often with suicidal tendencies), is delusional and clinically incompetent, and has a history of repeated hospitalizations with an institutional record of psychotic episodes including violence against himself or others frequently matched by a similar

340 (1980). Only a small minority of voluntary patients are persistent refusers. By contrast, the typical involuntary patient who rejects treatment does so out of persistent delusions about the treatment which are difficult to dispel. *See infra* note 41.

37. One of the drawbacks of outpatient care of mental patients is that many do not take their prescribed medication regularly or stop taking it altogether. As a result, both legal and medical practice have moved toward compelling previously hospitalized patients to continue with their medication via discharge that is conditioned on their doing so, with rehospitalization to occur if they violate the condition. For outpatients under such legal compulsion, the decision to refuse to comply begins to resemble in its legal and clinical consequences, the situation of the involuntarily committed treatment refuser. In addition, the concern about side effects such as TD is real for the outpatient who remains under such compulsion for the long term.

38. If flaws are perceived in the commitment of a particular individual or in the commitment process, there are legal avenues for a direct challenge. To use the right-to-refuse concept as the linchpin for such challenges is, if nothing else, strategically unsound in that it produces a range of undesirable effects for the psychiatric treatment system and for patients who are ordered to be treated by the system.

39. We permit ourselves an understatement here. The evidence is abundant that the commitment laws today are overexact and leave many individuals who desperately need treatment untreated because the law, as interpreted by judges and sometimes even by treatment providers, does not permit their commitment. The rise in the number of homeless people on our streets and in our parks, many of whom are overtly psychotic, is not unrelated. For some insights into this relationship, see Brooks, *Law and Ideology in the Case of Billie Boggs*, 26 J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERV. 22 (1988) (analyzing the case of Joyce Brown/Billie Boggs, particularly the trial judge's opinion ordering her release).

free world history.⁴⁰ This is the context in which we should view the pros and cons of the right to refuse.⁴¹

40. Involuntary patients tend to be much sicker than voluntary patients. The formers' illnesses progress to a point where they—and only they—fail to recognize their need for help. From time to time the assertion (and it is no more than an assertion, though a quite tenacious one), surfaces that mentally ill patients are no more dangerous than the general population. See, e.g., Note, *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190 (1974). Usually invoked in support of the assertion is a disparate set of studies on varying population groups (hospitalized and nonhospitalized, voluntary and involuntary, and even criminal offenders with mental disabilities) that use widely diverging definitions of dangerousness and unmatched methodologies for detecting or measuring it. Most studies capture only the most conspicuous expressions of dangerousness—those which come to the attention of enforcement authorities, as reflected in the number of arrests and convictions. They do not capture the bulk of dangerous conduct that leads to rehospitalization or that bypasses the criminal justice system and the violent, overtly threatening or self-destructive behavior that occurs in the “private” realm of family, friends, or fellow patients. Finally, the studies are old and would, irrespective of their relevance, credibility, or inclusiveness at the time the data were collected, have little to say about the characteristics of contemporary populations hospitalized under today's restrictive commitment laws. The results of more recent studies tend to belie the sanguine conclusions of the earlier research. See, e.g., Brakel, *Sampling The Mental Health Law Literature: Three Recent Books*, 1981 AM. BAR FOUND. RES. J. 535 (all assessments of dangerousness involve a heavy, but usually hidden, “political” judgment component); Lagos, Perlmutter, & Saexinger, *Fear of the Mentally Ill: Empirical Support for the Common Man's Response*, 134 AM. J. PSYCHIATRY 1134 (1977); Sosowsky, *Crime and Violence Among Mental Patients Reconsidered in View of the New Legal Relationship Between the State and the Mentally Ill*, 135 AM. J. PSYCHIATRY 33 (1978); Zitrin, Hardesty, Burdock, & Drossman, *Crime and Violence Among Mental Patients*, 133 AM. J. PSYCHIATRY 142 (1976). A recent study, open to a variety of interpretations, is Hiday, *Dangerousness of Civil Commitment Candidates: A Six-Month Follow-Up*, 14 L. & HUM. BEHAV. 551 (1990). Much of its value lies in its demonstration of the definitional problem and the many indicators bearing on dangerousness.

Among the involuntary committed populations today, there may occasionally be persons with diagnoses such as multiple personality, various brief reactive psychoses, or any number of other states of lesser severity in personality disorganization or acuteness. Consensually, medication treatment would not be appropriate in such cases, and the idea that it would be routinely prescribed either in private or public hospitals is simply false.

41. There is persuasive evidence that the treatment refusals among the involuntarily committed population are a direct and persistent consequence of major mental illness. See Ciccone, Tokli, Clements, & Gift, *Right to Refuse Treatment: Impact of Rivers v. Katz*, 18 BULL. AM. ACAD. PSYCHIATRY & L. 203 (1990) [hereinafter Ciccone, *Right to Refuse*] (concluding from an empirical study of two samples that “the reasons for refusing medication were rarely independent of an ongoing psychosis”). In general, most empirical studies find treatment refusers to be seriously ill patients who refuse because of denial of their illness or delusional thought about medication. See Bloom, Faulkner, Holm, & Rawlinson, *An Empirical View of Patients Exercising Their Right to Refuse Treatment*, 7 INTL. J.L. PSYCHIATRY 315 (1984) [hereinafter Bloom, *An Empirical View*]; Young, Bloom, Faulkner, Rogers, & Pati, *Treatment Refusal Among Forensic Inpatients*, 15 BULL. AM. ACAD. PSYCHIATRY & L. 5 (1987).

B. *Treatment and Drugs: A General Description of the State of Medical Art and Research Today*

What can be done for these patients? Formerly, not much. The better hospitals may have provided decent physical care and custody, but little effective treatment. That has changed dramatically, however, with the advent of the so-called psychopharmacological revolution—a revolution we feel it would be tragic to reverse because of some presumed legal “liberty interest” that would allow the patients most in need of its benefits (as so certified by the legal system itself) to refuse them.

Medicine has developed a methodology for the evaluation of drug treatment in general medicine, pediatrics, and surgery. The same methodology is used in drug evaluation for psychiatric treatment. Although psychiatric theory can be “speculative,” with different experts giving different theories, drug evaluation is markedly different in that it is objective, empirical, unbiased, and stringently regulated by the federal Food and Drug Administration (FDA).⁴² Current, well-controlled studies show the dramatic value of treatment with antipsychotic medication. In the note below, we give a selective sampling of the writings and reports of many studies that form the basis for the textual discussion.⁴³

42. The FDA requires that any new medical drug or device be proven safe and effective before it is marketed. This means that the producing company must provide data from controlled, objective studies. In the case of drug manufacturers, this means “double blind” studies often involving thousands of patients conclusively showing that the new drug is superior to placebo or comparison medication. These drug trials are conducted under the threat of inspection by FDA officials. In anticipation of FDA audits, representatives of the sponsoring drug companies monitor the trials to insure that they are done in compliance with the FDA’s exacting requirements. The FDA takes legal action against investigators who violate the prescribed procedures. Many other countries where modern psychotropic drugs are used have similar validation procedures. Given this multiple review process of trials involving large numbers of subjects, the safety and efficacy of the drugs can be said to be established beyond a reasonable doubt, a legal standard that by the law’s own measure can be fulfilled by a single credible witness testifying in open court.

Some have charged that the operational mechanics of antipsychotic drugs are not well understood, suggesting that the theory on how the drugs work is no more robust than psychotherapy theory. In fact, we do know how the drugs affect the biological processes of the brain, though our understanding of the biological causes of mental illness and why the drugs improve the functioning levels of schizophrenics or patients with other serious mental illnesses is limited. Nevertheless, the conclusion that the drugs work is beyond dispute.

43. See M. GREENBLATT, M. SOLOMON, A. EVANS, & G. BROOKS, *DRUG AND SOCIAL THERAPY IN CHRONIC SCHIZOPHRENIA* (1965) [hereinafter M. GREENBLATT]; L. GRINSPOON, J. EWALT, & R. SHADER, *SCHIZOPHRENIC PHARMACOTHERAPY AND PSYCHOTHERAPY* (1972) [hereinafter L. GRINSPOON]; D. KLEIN & J. DAVIS, *DIAGNOSIS AND DRUG TREATMENT OF PSYCHIATRIC DISORDERS* (1st ed. 1969); P. MAY, *TREATMENT OF SCHIZOPHRENICS: A COMPARATIVE STUDY OF FIVE TREATMENT METHODS* (1968); G. PAUL & R. LENTZ, *PSYCHOSOCIAL TREATMENT OF CHRONIC MENTAL PATIENTS* (1977); Cole, Goldberg, & Davis, *Drugs in the Treatment of*

The placebo trial is the research methodology of choice for controlled studies. It is generally considered unethical to continue placebo clinical trials of acutely ill patients for longer than six weeks, which limits the "hard" data on the benefits of drugs. However, we know on the basis of more naturalistic longitudinal studies, anecdotal information, and individual case histories, that drug-induced improvements continue for several weeks or even months. The best data on the efficacy of the drugs are, of course, from the controlled studies. There are other sources of usable information, however, including: (1) institutional treatment practices; (2) the reports of uncontrolled clinical trials; and (3) reports from individual psychiatrists on their day-to-day practices. We focus first on this "softer" information to help set the practical context, including the history of the drug revolution in psychiatry.

Today, antipsychotic drugs are used throughout the world as the preferred treatment for schizophrenic, manic, and psychotically depressed

Psychosis, in *PSYCHIATRIC DRUGS* 153 (P. Solomon ed. 1966) [hereinafter Cole, *Drugs*]; Davis, *Recent Advances in Pharmacologic Treatment of the Schizophrenia Disorders*, in *PSYCHIATRY* 1982 ANNUAL REVIEW 178 (1982); Davis, *Important Issues in the Drug Treatment of Schizophrenia*, 6 *SCHIZOPHRENIA BULL.* 70 (1980); Davis & Chang, *A Look at the Data*, in *CONTROVERSY IN PSYCHIATRY*, 595-660 (J. Brady & H. Brodie eds. 1978); Davis, Janicak, Chang, & Klerman, *Recent Developments in the Drug Treatment of Schizophrenia*, 133 *AM. J. PSYCHIATRY* 208 (1976); DuBose, *Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patient Justify Involuntary Treatment?*, 60 *MINN. L. REV.* 1149 (1976); Englehardt, Rosen, Freedman, & Margolis, *Phenothiazines in the Prevention of Psychiatric Hospitalization*, 16 *ARCHIVES GEN. PSYCHIATRY* 98 (1967); Hogarty & Goldberg, *Drug and Psychotherapy in the Aftercare of Schizophrenic Patients: One-Year Relapse Rates*, 28 *ARCHIVES GEN. PSYCHIATRY* 54 (1973); Hogarty, Goldberg, & Schooler, *Drug and Psychotherapy in the Aftercare of Schizophrenic Patients II Two-year Relapse Rates*, 31 *ARCHIVES GEN. PSYCHIATRY* 603 (1974); Hogarty, Goldberg, & Schooler, *Drug and Psychotherapy in the Aftercare of Schizophrenic Patients III. Adjustment of Non-relapsed Patients*, 31 *ARCHIVES GEN. PSYCHIATRY* 609 (1974); Klein, Rosen, & Oaks, *Premorbid Asozial Adjustment and Response to Phenothiazine Treatment Among Schizophrenic Inpatients*, 29 *ARCHIVES GEN. PSYCHIATRY* 480 (1973); Leff & Wing, *Trial of Maintenance Therapy in Schizophrenia*, 3 *BRIT. MED. J.* 599 (1971); May, *Psychotherapy Research in Schizophrenia—Another View of Present Reality*, 9 *SCHIZOPHRENIA BULL.* 126 (1974) [hereinafter May, *Psychotherapy Research*]; May, Tuma, & Dixon, *Schizophrenia: A Follow-up Study of the Results of Five Forms of Treatment*, 38 *ARCHIVES GEN. PSYCHIATRY* 776 (1981) [hereinafter May, *Schizophrenia*]; May, Tuma, Yale, Potepan, & Dixon, *Schizophrenia: A Follow-up Study of Treatment II. Hospital Stay Over Two to Five Years*, 33 *ARCHIVES GEN. PSYCHIATRY* 481 (1976) [hereinafter May, *Follow-Up*]; May, Van Putten, Yale, Potepan, Jender, Fairchild, Goldstein, & Dixon, *Predicting Individual Responses to Drug Treatment In Schizophrenia: A Test Dose Model*, 162 *J. NERVOUS & MENTAL DISEASE* 177 (1976) [hereinafter May, *Predicting*]; The National Institute of Mental Health Psychopharmacology Service Center Collaborative Study Group, *Phenothiazine Treatment in Acute Schizophrenia*, 10 *ARCHIVES GEN. PSYCHIATRY* 246 (1964) [hereinafter Collaborative Study Group]; Williams, Karon, & Vandenbos, *Consequences of Psychotherapy for Schizophrenic Patients*, 9 *PSYCHOTHERAPY: THEORY, RES. & PRACT.* 111 (1972).

patients—the sort of patient who, when decompensated, would be subject to involuntary commitment in this country.⁴⁴ When antipsychotic drugs were discovered in the early 1950's, psychiatry in the United States was predominantly psychoanalytic in orientation and there was considerable inertia to keep it that way. It was not organized psychiatry, but Congress, that mandated research on drug treatment efficacy. As a result of this research, we know the treatment is effective based on objective, scientific evidence. Yet, for many years, even after conclusive evidence was obtained, psychiatric training programs did not cover drug treatment in depth and indeed, a few still do not. Some members of the psychiatric profession remain inadequately trained or uninterested in drug use. A good percentage of them are nontreating physicians. For example, many forensic psychiatrists are not well informed about psychopharmacology and its applications. Psychologists and social workers are generally not trained in psychopharmacology, and they are prohibited by the profession's licensing requirements from prescribing drugs.⁴⁵ Not surprisingly, skepticism or opposition to drug use within the mental health professions tends to be confined to those groups. Among physicians who treat mental patients

44. The class of involuntarily committed psychotic patients is a small subset of mentally ill patients. The physician author of this Article has talked with many leaders of the World Psychiatric Association and the World Health Organization-funded international research centers, and they are in full agreement that psychotropic drug treatment or electroconvulsive therapy is the treatment of choice for these patients. With the exception of a few psychiatrists who work in private sanatoria, there is no dissenting opinion in psychiatry. We do not know of the existence of data which document the treatment of involuntarily committed patients around the world, but our experience in visiting hospitals in numerous countries in both the developed world (Western Europe and Japan) and the developing world (China, India, Thailand, Morocco, Peru, Columbia, Panama) and in talking to the leaders of international psychiatric associations, provides irrefutable support. In short, there is no alternative to drug treatment or ECT for major mental illness, and a ban on either, whether imposed by general law or regulation or at the behest of the patient himself, is a ban on effective treatment. Standard text books from various countries show that there is a world medical standard for the treatment of these psychiatric conditions. See L. HOLLISTER & J. CSERNANSKY, *CLINICAL PHARMACOLOGY OF PSYCHOTHERAPEUTIC DRUGS* (3d ed. 1990); R. KENDALL & A. ZEALLEY, *COMPANION TO PSYCHIATRIC STUDIES* (4th ed. 1988); L. KILOH, J. SMITH, & G. JOHNSON, *PHYSICAL TREATMENTS IN PSYCHIATRY* (1988); J. TUPIN, R. SHADER, & D. HARNETT, *HANDBOOK OF CLINICAL PSYCHOPHARMACOLOGY* (1990).

45. It is worth noting that the American Psychological Association gave the antidrug movement ammunition by filing an amicus brief with the United States Supreme Court in support of the petitioner inmate in *Washington v. Harper*. On the other hand, to give credit when credit is due, it has been the psychologists with methodological expertise who have been principally responsible for the scientific rigor of the controlled studies providing the data on the efficacy of drugs. There has been much recent pressure to allow psychologists to prescribe drugs. This idea is currently being implemented on a limited, experimental basis. It is doubtful that organized psychology will maintain its antidrug stance if and when psychologists are permitted to prescribe the medications.

in hospitals, there is virtually no controversy about either the need for or benefits of drugs.

There is substantial evidence that the major mental disorders are at least in part biologically based.⁴⁶ This has strong, if not irresistible, implications for the treatment of these disorders, though the implications have been and continue to be resisted by some. There are both behavioral therapists and psychoanalysts who write about the successes of psychological treatment of patients with major mental illnesses, but a great many of these patients also received psychotropic medication.⁴⁷ One cannot make valid inferences about the beneficial results of psychotherapy alone if the data include patients also treated with medication. It has been argued that these studies support the notion that psychotherapy or behavioral therapy given along with drugs produces a better result than drugs alone, but the truth is that drug treatment is a prerequisite for the beneficial effects of psychological treatment. In the psychological treatment cases described, the drugs were an uncontrolled variable of the treatment process, and one can make no inference about what would have happened if they had not been used.⁴⁸

46. An evaluation of current textbooks in psychiatry indicates that for hospitalized patients, psychiatry as a field is primarily considering biological or biosocial explanations. See, e.g., H. KAPLAN & B. SADOCK, *COMPREHENSIVE TEXTBOOK OF PSYCHIATRY* (5th ed. 1989). Modern psychiatry recognizes both psychosocial and biological antecedents to major mental disorders. It is rare to find a psychiatrist who is exclusively psychological in orientation with respect to committed patients. There is solid, irrefutable evidence that a strong genetic factor is present in their diseases so that those who consider mental illness a myth will have to concede that this "myth" is passed through the genes. It is beyond the scope of this Article to give a review of biological psychiatry, but we know that major mental illnesses have a strong hereditary component. Identical twins usually have the same disease and children (including twins) adopted into normal families have the disease of their biological parents, not their environmental parents. There are many biological abnormalities that have been consistently found in persons suffering from schizophrenia, mania, and psychotic depression.

47. Three of the most frequently quoted studies are: Karon & O'Grady, *Intellectual Test Changes in Schizophrenic Patients in the First Six Months of Treatment*, 6 *PSYCHOTHERAPY: THEORY, RES. & PRAC.* 88 (1969); Karon & Vandebos, *Experience, Medication and the Effectiveness of Psychotherapy with Schizophrenics*, 116 *BRIT. J. PSYCHIATRY* 427 (1970); and Karon & Vandebos, *The Consequences of Psychotherapy for Schizophrenic Patients*, 9 *PSYCHOTHERAPY: THEORY, RES. & PRAC.* 111 (1972). In these studies, many patients in the psychological treatment groups (psychoanalysis or behavior therapy) received drugs. These studies may support the effectiveness of psychological treatment, but they do not negate the effectiveness of drug treatment. Karon combined data from patients who received substantial doses of drugs with those who had only minimal drugs, and many of Paul's "behavior therapy" patients received drugs during the course of the study.

48. Rosen, *The Treatment of Schizophrenic Psychosis by Direct Analytic Therapy*, 21 *PSYCHIATRIC Q.* 117 (1947) (reporting on a series of patients who were said to have dramatic results with psychoanalysis alone). See also J. ROSEN, *DIRECT ANALYSIS* (1953). However, these results were later challenged because many of the patients were not schizophrenic.

Not all drugs used in psychiatry are alike, and they cannot be prescribed indiscriminately for different disorders.⁴⁹ Lithium as well as several anticonvulsant drugs may be used effectively in treating acutely manic patients, often in combination with antipsychotic drugs. The former drugs can be used alone, but the rate of response is substantially slower. Severely impaired judgment may persist and, at least potentially, any number of violent acts may take place before the full effect is achieved. For schizophrenia, the only effective drugs are antipsychotics. Electroconvulsive therapy (ECT) also has important uses in the treatment of mania and schizophrenia, especially in emergency cases (e.g., catatonia) or alternatively, when the patient does not respond to the drugs or does not tolerate their side effects. For psychotic depression, effective treatment is ECT or the combination of antipsychotic drugs and antidepressant drugs. Antidepressant drugs alone are not an effective treatment for psychotic depression.⁵⁰ There have been no controlled evaluations of psychotherapy alone for the severely manic or the psychotically depressed, involuntarily committed patient. Positive individual case histories of extremely disturbed psychotic patients treated with psychotherapy have been reported, but there are no reports documenting successful treatment without drugs for any large series of patients.⁵¹ It is difficult to believe that large successes occur in either public or private hospitals without the psychotherapists writing about the results.

For patients suffering from schizophrenia who receive psychotherapy alone, the results have been disastrous.⁵² There have been a few control studies and all of them report that psychotherapy by itself does not

Horwitz, Polantin, Kolb, & Hoch, *A Study of Cases of Schizophrenia Treated by "Direct Analysis,"* 114 AM. J. PSYCHIATRY 780 (1958). In addition, a substantial number of patients were rehospitalized at the time the author was claiming permanent cures. This follow-up by an independent psychiatrist destroyed the credibility of the original report. The claims for psychotherapy alone simply have not held up.

49. Important as this information is, it is lost in the legal context when right-to-refuse treatment decisions fail to differentiate among illnesses or drugs and psychotherapy is indiscriminately viewed as an alternative.

50. The treatment for schizophrenia, mania, and psychotic depression is similar worldwide. Like physics or chemistry, psychopharmacology is universal. Some standard U.S. textbooks are translated and used in developing countries, such as the physician author's textbook on psychopharmacology which has been translated in Chinese and used in the Peoples Republic of China. See W. APPLETON & J. DAVIS, PRACTICAL CLINICAL PSYCHOPHARMACOLOGY (2d ed. 1980). English has become an international medical language, and the texts are read by academic psychiatrists in English. Academics who write their own text in their native language draw upon the same sources of psychopharmacologic knowledge quoted here and summarized above.

51. See *supra* note 43.

52. The physician author has reviewed the data in detail elsewhere. See M. GREENBLATT, *supra* note 43; L. GRINSPOON, *supra* note 43; Davis, & Chang, *supra* note 43.

produce good results and is inferior to drug therapy.⁵³ When psychotherapy is used in addition to drug therapy in an inpatient setting, the outcome (as measured by the discharge rate) is not materially affected.⁵⁴ Some studies find a somewhat better outcome and others find little or no difference.⁵⁵ After patients are discharged from the hospital and are living at home, and when supportive family treatment is added to antipsychotic drugs, the combined therapies are substantially better than drug therapy alone. The key in post-discharge situations is to educate the patient about the nature of the schizophrenic illness and to help the patient and the family adapt to the illness.⁵⁶ For the hospitalized population, however, control studies demonstrate conclusively that drug-free patients fare poorly and that psychotherapy alone is useless.⁵⁷

With appropriate drug treatment, the vast majority of hospitalized patients improve to the point where they can return home rather quickly.⁵⁸

53. See M. GREENBLATT, *supra* note 43.

54. See May & Simpson, *Schizophrenia: Evaluation of Treatment Methods*, in COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1240-74 (H. Kaplan, A. Freedman, B. Sadock eds. 3rd ed. 1980); Schooler, *Antipsychotic Drugs and Psychological Treatment in Schizophrenia* in PSYCHOPHARMACOLOGY: A GENERATION OF PROGRESS 1155-68 (M. Lipton, A. DiMascio, & K. Killam eds. 1978).

55. The best of these studies are from the McLean Hospital at Harvard University. See Gunderson, Frank, Katz, Vannicelli, Frosch, & Knapp, *Effects of Psychotherapy on Schizophrenia II. Comparative Outcome of Two Forms of Treatment*, 10 SCHIZOPHRENIA BULL. 564 (1984) (finding some gains, but not substantial gains, when psychotherapy was added to drugs). One can argue about how great an advantage psychotherapy is, but we emphasize that this is psychotherapy-plus-drugs. Such data are not relevant to the right to refuse medication treatment.

56. There are several controlled studies supporting the efficacy of psychotherapy-plus-drugs. Psychotherapy in the outpatient setting has been proven to be effective, but we must emphasize again that it is given with drugs. Indeed the family effect found in these studies is equal to the drug effects in magnitude. As a practical matter, however, such intensive family therapy is generally not available except in a research setting at a few institutions, but its use is spreading. We enthusiastically recommend such psychotherapy and our above remarks against psychotherapy alone are to be placed in the context of our argument on the right to refuse drug treatment. We are not against psychotherapy.

57. See May & Tuma, *Community Follow-up of Treatment of Schizophrenia Issues and Problems*, 35 AM. J. ORTHOPSYCHIATRY 754 (1965); May & Tuma, *Treatment of Schizophrenia*, 3 BRIT. J. PSYCHIATRY 503 (1965).

58. Exact data pertinent to our context are difficult to find. For the specific purposes of this Article, we checked with physicians at random in both private hospitals and in the public sector state hospital system. Respondents in both settings indicated that it is rare for a patient to be hospitalized continuously for more than "a few weeks." Some private hospitals have long-term care sections, but even there, the length of stay is counted in months, not years. The 1980 National Data Book produced by the United States Department of Health and Human Services pegged the average length of stay for patients in public mental health facilities, undifferentiated by type of admission, at slightly longer than three weeks. More recent estimates speak of even shorter terms. By contrast, a 1990 publication uses 1983 NIMH

The time for improvement is important.⁵⁹ It takes about three to four weeks to achieve substantial improvement and approximately six weeks more to get optimal improvement. The majority of patients usually recover enough to be discharged in the first several weeks, but drug-induced improvement continues when the medication is taken at home. Some patients will have residual symptoms, but many will be "cured" or almost cured. The more accurate term which physicians use is "in remission," because many of these patients will relapse in the ensuing years. Some will never function well outside a hospital despite the improvement they showed in the hospital.

What is important for patients' rights is that, with medication, most patients recover enough to go home and have their liberty restored. Once free and competent (if we may use the word in its common sense meaning), they can then choose to refuse or to take medication. Paradoxically, if their right to refuse medication is protected as an absolute right, they will never make the decision in a "competent" state themselves. The legal process will make it for them.

It should also be noted that for patients suffering from one of the major mental illnesses, there is no alternate "less restrictive" treatment to drugs or ECT. The alternative is no treatment.⁶⁰ Some may say that drug treatment makes psychological treatment possible and is not in itself primary. Even if this were true, it would not affect our argument. The prominent antidrug psychiatrist Laing referred his very ill patients for

"utilization" survey data to arrive at substantially longer hospitalization terms. See Rosenheck & Astrachan, *Regional Variation in Patterns of Inpatient Psychiatric Care*, 147 AM. J. PSYCHIATRY 1180 (1990). Combining figures from all components of the inpatient mental health care system (general and psychiatric, private and public, federal as well as state and county), this study reports the average length of stay as 41 days; 92 days for patients in state and county mental facilities. To the extent the discrepancies are explainable at all, they may be traced to the fact that a small percentage of chronic, long-term patients drives up the average dramatically. The lower official reports and estimates for the average patient may remain accurate.

59. Patients who refuse medication also increase the length of hospitalization—their own as well as the general average.

60. We have noted above, both in the text and footnotes, that for involuntarily committed patients suffering from the major mental illnesses (schizophrenia, mania, psychotic depression), the world-wide standard treatment is psychotropic drugs or ECT, the former being in legal nomenclature a less restrictive alternative. We cannot find reference to less restrictive alternatives when patients with these diagnoses and this level of severity are managed without medication or ECT. Neither are less restrictive alternatives advocated in standard psychiatric textbooks in any country of this world or in reports published by official bodies such as the FDA, the American Medical Association, or the American Psychiatric Association. See, e.g., M. GREENBLATT, *supra* note 43; Davis, Janicak, Chang, & Klerman, *Recent Advances in Pharmacologic Treatment of the Schizophrenia Disorders*, PSYCHIATRY 1982 ANNUAL REVIEW 178 (1982). Psychiatric textbooks have chapters on a wide variety of psychosocial treatments, but these texts also recommend medication.

pharmacotherapy.⁶¹ It is extremely rare to find a psychiatrist who does not either prescribe or refer some of his patients to others for medications. We have no hard data, but we estimate that 99 out of 100 psychiatrists use medication in at least some of their cases. Intensive, long-term inpatient psychoanalysis is not even offered in most hospitals. Drugs are equally used in expensive private or academic hospitals and in state hospitals. It is not true that wealthy patients with major mental illnesses receive psychotherapy without drugs and that poor patients are drugged.⁶²

C. *Clinical Benefits of Drug Treatment*

We now turn to the "hard" data from controlled studies to show the benefits of antipsychotic drug treatment. As an example, we use the raw data from an early National Institute of Mental Health (NIMH) study comparing the efficacy of drugs (*i.e.*, chlorpromazine, thioridazine, and fluphenazine) against a placebo for schizophrenic patients.⁶³ The results were dramatic and today they would be even stronger, given the development of more effective drugs and a more sophisticated knowledge of when and how to use them.

In this study, some 350 patients were randomly assigned to receive the medications, which were then new, or the placebo. The trials, which ran for six weeks, were double blind in that neither the patient nor the physician knew which subjects were receiving the medication or the placebo, both of which were administered in identical capsules or tablets. The clinical changes were evaluated by unbiased blind raters using quantitative evaluation scales.

The outcome was reflected by two variables: one measured improvement over the course of the trial, and the other assessed the patient's

61. The physician author has personally discussed this question with Dr. Laing, who told the author that he referred the more disturbed patients to a biological psychiatrist as an addition to psychotherapy. Many of the "nonmedical" psychotherapists deal with outpatients who are selected to be good candidates for psychotherapy. These are substantially different patients than involuntarily committed patients. Even for such different populations, Laing and his coworkers explicitly state that the *majority* of patients also receive drugs. See Esterson, Cooper, & Laing, *Results of Family-Oriented Therapy with Hospitalized Schizophrenics*, 2 BRIT. MED. J. 1462 (1965).

62. There is a social movement of followers of Thomas Szasz and Peter Breggin, most of whom are nonmedical and whose "thesis" is rejected by the medical community. This movement is against all coercive psychiatry and posits the proposition that mental illness is a myth. The leaders of this movement, who themselves are practicing psychiatrists, know better, but their followers do not. The same phenomenon can be found in medicine and surgery. Christian Science, for example, rejects virtually all of contemporary medicine. There are advocates for laetrile and other miracle interventions. These are fringe positions or ideologies not to be confused with legitimately debatable schools of scientific or professional thought.

63. Cole, *Drugs*, *supra* note 43; Collaborative Study Group, *supra* note 43.

condition at the end. At the beginning of the study, most patients had severe psychotic symptoms and almost all were rated as either moderately ill or severely ill. The study hypothesized that at the end of six weeks, patients could be completely remitted, have only borderline symptoms, or retain more noticeable symptoms ranging from mild to moderate to severe. The progressive improvement scale used the ratings very much improved, substantially improved, improved, no change, or worse.

Changes During Trial	Condition After Trial	% of Patients on Drug	% of Patients on Placebo
Very much improved	Remitted	16	1
Substantially improved	Borderline symptoms	29	11
Improved	Mild symptoms remain	16	10
Improved	Moderately ill	31	31
Not changed	Moderately ill	6	15
Deteriorated	Severely ill	2	33

Note that at virtually every point on the scale patients receiving drugs did significantly better than those receiving the placebo. Forty-five percent (16% + 29%) of the drug patients were rated as very much or substantially improved, with either complete disappearance of symptoms or only a few minor symptoms remaining. Only twelve percent (1% + 11%) of the placebo patients showed comparable improvement. The great majority of placebo patients (31% + 15% + 33%) were rated as still having at least a moderate degree of schizophrenic illness, with one-third (the last category) showing marked deterioration to severe illness. Failure to treat in the first six weeks thus leads to serious clinical harm for many patients.

We have presented an original study to give the lawyer a feel for the raw data. This was a National Institute of Mental Health study performed by academic investigators from a university. It is consistent with approximately seventy other placebo-controlled studies.⁶⁴ There are

64. D. KLEIN & J. DAVIS, *supra* note 43; Davis, *Recent Developments in the Drug Treatment of Schizophrenia*, 133 AM. J. PSYCHIATRY 208 (1976); Davis, Janicak, Chang, & Klerman, *supra* note 43; Davis, Janicak, Linden, Molonoey, & Pavkovic, *Neuroleptics and Psychotic Disorders*, in NEUROLEPTICS: NEUROCHEMICAL, BEHAVIORIAL AND CLINICAL PERSPECTIVES (J. Coyle & S. Enna eds. 1983). Many of the legal critics of drug treatment cite standard psychiatric texts such as the author's book as reference for side effects, but do not mention the evidence for its efficacy. See, e.g., W. APPLETON & J. DAVIS, *supra* note 50; DuBose, *supra* note 43.

no contradictory data. Furthermore, dose-response studies confirm that there is a positive correlation between the amount of drug given and the beneficial effects.⁶⁵

Much of the legal literature refers to the principle of least restrictive treatment, as if there are effective treatments of major mental illness other than drug treatment and ECT. Many legal commentators assume that drugs are ineffective as treatment and are effective only as sedatives or as a form of punishment.⁶⁶ The sedative property makes the institution safer by tranquilizing the violent patients, and the punishment effect deters violence. This is false. Most antipsychotic drugs have minimal sedative properties, some have mild to moderate sedative effects, and a few are not sedative at all.⁶⁷ In addition, there is no evidence showing that they are effective negative reinforcers in animals or that their benefit in humans is due to punishment.

D. Research Findings on the Harms Resulting from Delayed Treatment

A patient's exercise of the right to refuse treatment means that there will be no treatment or, at least, that it will be delayed. The difference may not be material because there is substantial evidence that treatment delayed is treatment denied. The legal rights community is unaware or ignores the exorbitant costs of delayed or denied treatment. Substantial clinical harms can result to patients who are not treated in a timely fashion. In turn, clinically deteriorating patients can do much harm to their institutional surroundings and simultaneously increase the financial costs of their own care as well as the care of their fellow patients. These costs will in many cases be charged to the public health systems (*i.e.*, they will be "societal" in a direct sense as well as in subtler, more circuitous ways through insurance rates or other welfare taxes). Finally, time itself can be viewed as a cost when nothing of clinical or legal benefit is accomplished as a result of ill-advised assertions of the right to refuse treatment.

1. Time Costs of Refusals: Loss Without Gain.—When the law states that a patient's refusal can be overridden only by judicial process, critical treatment time is lost. Most patients wait for many weeks or even months with no effective treatment. There is then a judicial hearing in a so-called medication court, and almost always, the judge orders treatment. Thus,

65. See Davis, Barter, & Kane, *Antipsychotic Drugs*, in H. KAPLAN & B. SADOCK, *COMPREHENSIVE TEXTBOOK OF PSYCHIATRY* 1662 (5th ed. 1989).

66. See *supra* notes 31-32.

67. See Davis, Barter, & Kane, *supra* note 65, at 1662.

nothing is gained in the legal sense, but much may be lost in terms of the patient's clinical condition.

Massachusetts is one state which has had substantial experience with judicial review of medication, first under the temporary restraining order (TRO) issued in the *Rogers v. Okin*⁶⁸ case and again when the Massachusetts Supreme Court affirmed *Rogers* on remand.⁶⁹ Under the *Rogers* mandate, medication, except in strict emergency situations, cannot be administered over a patient's objection, unless the patient is first ruled incompetent by a court. Several studies examined the time from the patient's first refusal to the judicial decision. These studies found that these cases took an average of four and a half months to come to trial.⁷⁰ Moreover, the outcomes of these cases suggest that almost all refusals lacked reasonable bases. In one study of 1,514 Massachusetts cases, courts ultimately overrode the patient in all but twenty-one (3.4%) of the cases.⁷¹

A much smaller study at the Central New York Psychiatric Center, a treatment facility for convicted offenders and pretrial detainees, focused on the effects of *Rivers v. Katz*.⁷² This case, like *Rogers*, requires a judicial competency hearing to override a patient's refusal of treatment.⁷³ Of eighteen refusers, three complied with the medical recommendation prior to the hearing. In each of the remaining fifteen cases, the court found the patient incompetent and approved the proposed medication. The average time between the doctors' override petition to the court and the hearing was twenty-four days.

Though generally less time-consuming than the judicial process, a variety of clinical review procedures imposed by the courts have also proved more costly than beneficial to the patients they were intended to protect. A 1983 study at the forensic unit of Oregon State Hospital

68. 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated sub nom.* Mills v. Rogers, 457 U.S. 291 (1982).

69. *Rogers v. Commissioner of Dep't of Mental Health*, 390 Mass. 489, 458 N.E.2d 308 (1983).

70. See Hoge, Gutheil, & Kaplan, *The Right to Refuse Treatment under Rogers v. Commissioner: Preliminary Empirical Findings and Comparisons*, 15 BULL. AM. ACAD. PSYCHIATRY & L. 163 (1987) [hereinafter Hoge, *Right to Refuse*]; Veliz & James, *Medicine Court: Rogers in Practice*, 144 AM. J. PSYCHIATRY 62 (1987).

71. Schouten & Gutheil, *Aftermath of the Rogers Decision: Assessing the Costs*, 147 AM. J. PSYCHIATRY 1348 (1990). Earlier, we noted the finding that almost all involuntary patients refuse treatment for delusional reasons. See *infra* text accompanying note 115. Another empirical finding is that the courts, although ostensibly deciding the issue of the patient's competency, in fact focus on the appropriateness of the prescribed treatment. See Applebaum, *The Right to Refuse Treatment with Antipsychotic Medications: Retrospect and Prospects*, 145 AM. J. PSYCHIATRY 413, 416 (1988).

72. 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986).

73. Deland & Borenstein, *Medicine Court II: Rivers in Practice*, 147 AM. J. PSYCHIATRY 38 (1990).

reported on thirty-three insanity acquittee patients who refused medication.⁷⁴ The independent psychiatrists performing the initial clinical review recommended treatment overrides in all cases. The chief medical officer, with final authority in the disputes, agreed in thirty-two cases. The process took an average of nine days. During the nine days between the refusal and override decision, there were thirty-six psychiatric emergencies for the thirty-three unmedicated patients.

In another study, several of the same researchers focused on treatment refusals in one of Oregon's civil hospitals, including patients who objected to treatment upon admission, as well as those who complied initially but refused later.⁷⁵ The rate of override, by the same clinical review process as in the forensic setting, was ninety-five percent for all cases, with the length of time between the override petition and the decision being fifteen days on the average for the initial refusers and a full seventy-seven days for patients who were compliant, but later became uncooperative.

Under the *Jamison-Farabee*⁷⁶ consent decree in California, which mandated outside clinical review of all treatment plans involving psychoactive medications within three days, 2,700 cases received this second medical opinion over a period of three years.⁷⁷ The results were approval of medication in over ninety-eight percent of the cases and reversals in less than two percent. In these forty-seven instances, significant deterioration occurred in twenty-five, no deterioration was seen in eight, and the clinical outcome of the rest was unclear.⁷⁸ Although the California procedure results in minimal delay, it wastes clinical resources in performing the review and results in harm to many of the patients whose refusal of treatment is not overridden.

A 1982 study reported on a former clinical treatment review protocol at Minnesota's Anoka State Hospital, a 236-bed facility serving the Minneapolis-St. Paul metropolitan area.⁷⁹ Treatment refusals (classified as

74. Williams, Bloom, Faulkner, Rogers, & Godard, *Drug Treatment Refusal and Length of Hospitalization of Insanity Acquittes*, 16 BULL. AM. ACAD. PSYCHIATRY & L. 279 (1988). In the one remaining case, the patient deteriorated one month later, and a second examiner recommended treatment. Thus, the treatment overrides were sustained in 97% of the cases initially and 100% if the subsequent second opinion is counted. Oregon uses an administrative review mechanism developed originally in New Jersey. It responds to an existing statute specifying that involuntary patients have a right to be free from "unusual or hazardous treatment procedures including ECT unless they have given their express and informed consent."

75. Bloom, *An Empirical View*, *supra* note 41.

76. No. 78-0445 WHO, slip op. (N.D. Cal. Apr. 26, 1983).

77. See Hargraves, Shumway, Knutsen, Weinstein, & Swuter, *Effects of the Jamison-Farabee Consent Decree: Due Process Protection for Involuntary Psychiatric Patients Treated with Psychoactive Drugs*, 144 AM. J. PSYCHIATRY 188, 190 (1987).

78. *Id.*

79. Zito, Lentz, Routt, & Olson, *The Treatment Review Panel: A Solution to Treatment Refusal?*, 12 BULL. AM. ACAD. PSYCHIATRY & L. 349 (1984).

emergency or nonemergency) were reviewed by a treatment review panel (TRP), which approved administration of the medication in ninety-five percent (59/62) of the emergency cases and sixty-seven percent (127/191) of the nonemergencies during the twenty month study period. Under the protocol, the TRP's decision was required to be made within seven days. The rate of refusals was fifteen percent among admissions during this period, with a sizable number of patients refusing repeatedly, leading to multiple reviews of their cases.⁸⁰

In total, there have been approximately twelve studies of 5,000 cases of patient's refusals of treatment.⁸¹ Courts have sustained the refusal in only three percent of the cases, at an average time cost of forty-eight days. Clinical review has affirmed the patient's rejection of treatment in four percent of the cases⁸² and comes at a cost of three to fifteen days in treatment time lost (not counting the unusual seventy-seven day delay for post-admission refusers in Oregon's civil hospital). Several reports note that even in those rare cases when the formal judicial or clinical decision upholds the patient's right to refuse, clinical deterioration often results.⁸³ Finally, not one of the studies reports clinical benefit to the patient from a delay in treatment. Most studies did not specifically look for such results, but presumably would have noted them if found incidentally. The lack of such a finding is more significant yet for those that did.⁸⁴

2. *Clinical Costs: Long-Term Harms.*—Because reviews of patients' refusals take substantial time, it is important to ascertain whether and to what extent long-term treatment delay affects recovery. Although most controlled trials last only weeks, one longitudinal study of the effect of psychotherapy versus drug therapy by May and his co-workers is particularly relevant.⁸⁵ Patients were randomly assigned to receive either med-

80. The incidence of refusals varies greatly from institution to institution, ranging from one to twenty-five percent. Much depends on the type and timing of the review mandated because many patients refuse to cooperate initially, but then relent as they achieve a level of comfort and stability within the institution. A patient does not become an official refuser until the review machinery is activated. See Bloom, *An Empirical View*, *supra* note 41; Hoge, Appelbaum, Lawlor, Beck, Litman, Greer, Crutheil, & Kaplan, *A Prospective, Multicenter Study of Patients' Refusal of Antipsychotic Medication*, 47 ARCH. GEN. PSYCHIATRY 949 (1990); Hoge, *Right to Refuse*, *supra* note 70; Veliz & James, *supra* note 70.

81. See *supra* notes 70-80.

82. The results stemming from the studies of the *Jamison* decree and *Rogers v. Okin* stilt the override averages because of the large number of cases. If, in order to correct for this, the mean number is used, the proportion of cases in which the patient's refusal is upheld is still under 10%.

83. See, e.g., Veliz & James, *supra* note 70, at 64.

84. See Ciccone, *Right to Refuse*, *supra* note 41.

85. P. MAY, *supra* note 43; May, *Psychotherapy Research*, *supra* note 43; May, *Follow-up*, *supra* note 43; May, *Predicting*, *supra* note 43; May, *Schizophrenia*, *supra* note 43.

ication or no medication. After six months, the group which did not receive medication was then given medication. May found that those patients who did not initially receive drugs for the six month period did substantially worse during the following three to five years, spending almost twice as much time in the hospital as did the initially medicated patients.

The study documents the harmful consequences that may occur when patients do not receive initial medication and treatment is delayed for a substantial span of time. Not only do patients do much worse during the initial phase of treatment when they are not receiving drugs, but even after drugs are taken, there is a long-term negative carryover effect. Although the judicial review process falls well short of six months, it can nevertheless be quite lengthy (*e.g.*, four-plus months in the Massachusetts study), and it is quite possible that such protracted treatment delays produce negative long-term consequences. The data collected by May suggest that once deterioration occurs, it may be irreversible. May's results are reliable. Patients were randomly assigned to the different samples so the groups were strictly comparable. Evaluations of outcome were done "blind" and are thus objective and unbiased.

3. *Institutional Costs and Harms.*—As well as doing harm to individuals, prohibition or delay of treatment also has undesirable consequences for institutions. In an early review of the actual and potential effects of the right to refuse treatment, Stone considered the experience at Boston State Hospital, which, at the time, was under a temporary federal district court order prohibiting physicians from forcibly medicating patients except in extreme emergencies.⁸⁶ He quoted from the Massachusetts Psychiatric Society's amicus brief in this initial phase of the *Rogers v. Okin* litigation:

One wing has been destroyed by fire, set by a patient. One female patient attempted to burn a staff member, to choke a patient, and to strangle herself with a ripped dress. . . . A schizophrenic male patient who has refused medication since the grant of the temporary restraining order has had sexual intercourse with at least three different patients who are either retarded or are severely and chronically regressed . . . [and has] grabbed and threatened two female staff members.⁸⁷

A later article on the same phase of the Boston hospital case provided additional information regarding the two wards most directly affected by

86. Stone, *Recent Mental Health Litigation: A Critical Perspective*, 134 AM. J. PSYCHIATRY 273 (1977) (discussing the implicit analogies the legal system has made between psychiatrists and agents of the criminal justice system and their effects on mental health care).

87. *Id.* at 278.

the *Rogers* TRO, which by then had been transformed into a permanent injunction.⁸⁸ Hospital witnesses specifically identified 145 patients who had suffered adverse consequences from their decision to refuse medication treatment during the two-plus year period from May 1975 to August 1977: eighty-nine whose mental condition deteriorated and fifty-six whose hospitalization had to be prolonged. The time spans during which patients had to remain untreated were long, ranging from two to as much as eleven months. The number of patients transferred to other hospitals because they were too disturbed to be cared for at Boston State went up by 370%. In addition, patients known to be likely to refuse treatment were denied admission. Despite the transfers and denials of admission, the rate of seclusion was up dramatically—in some months up to three times the monthly rates prior to the order.⁸⁹ The level of violence also increased markedly. One patient with no history of violence deteriorated to such an extent that he attacked an attendant, fracturing one of the latter's facial bones, which required surgery. He later attacked another attendant, injuring the man's cervical spine. This attendant did not return to work. The patient suffered from severe guilt from these actions. Staff turnover doubled as residents quit their jobs in unprecedented numbers.

Another report on the Boston State Hospital situation noted that among patients refusing treatment, many deteriorated to a point where they became assaultive or self-destructive.⁹⁰ Nevertheless, physicians attempting to force treatment on a psychotic young woman for physical deterioration when she refused food on pseudo-religious grounds were found in contempt of court.⁹¹ Of the fourteen patients who were denied admission during this period because of indications they would not cooperate with treatment, one subsequently stole a truck and was shot to death by police pursuing him. Yet another article attributes a suicide to the refusal to be treated:

[T]he one suicide in our series of patients who refused medication occurred in a paranoid man from a high achieving family. . . . He spent an unconscionably long time in a severe and florid

88. See Schultz, *The Boston State Hospital Case: A Conflict of Civil Liberties and True Liberalism*, 139 AM. J. PSYCHIATRY 183 (1982).

89. Another study conducted at the Mendota Forensic Center, a maximum security facility in Madison, Wisconsin, reported a six-fold jump in the total number of seclusion hours following the introduction of a right-to-refuse protocol. Miller, Bernstein, Van Rybroek, & Maier, *The Impact of the Right to Refuse Treatment in a Forensic Patient Population: Six-Month Review*, 17 BULL. AM. ACAD. PSYCHIATRY & L. 107 (1989).

90. Gill, *Side Effects of a Right to Refuse Treatment Lawsuit: The Boston State Hospital Experience*, in REFUSING TREATMENT IN MENTAL HEALTH INSTITUTIONS—VALUES IN CONFLICT 81-87 (A. Doudera & J. Swazey eds. 1982).

91. *Id.* at 86.

regression because of delays in judicial and departmental procedures in obtaining guardianship. The clinicians involved believed that this prolonged the state of being . . . "really crazy," and . . . played a role in the patient's suicide.⁹²

Gutheil and Mills noted that when clinical and legal representatives met to redesign the Massachusetts Department of Mental Health's regulations on involuntary medication following *Rogers*, the lawyers insisted that each incident of violence and the attempt to control it constituted an independent legal event.⁹³ This "one-punch-one-shot" approach to treatment means that a violent patient must assault someone before he can be given an injection. The concept of continually monitored treatment and control via medications responsive to the patient's specific (and variable) condition was entirely foreign to these "patients' advocates."

The report by Bloom on refusals of treatment in Oregon's civil hospital recorded 147 episodes of seclusion and thirty-two instances of emergency medication for the twelve patients who refused treatment after admission.⁹⁴ The high numbers of seclusions and emergency medications are in part because patients were untreated for an average time span of seventy-seven days (while the override decision was being processed), but they remain disturbing.

There is now empirical evidence on what happens to patients when they do not receive proper medication in a timely fashion. The legal profession should take this evidence into account. Lawyers who advocate for the right to refuse treatment must recognize the real potential for psychosis-related harm to individual patients: suicide, accidental death, or other harm to the patient resulting from psychotic activity that could have been prevented. The patient was committed because of the danger to himself and others. Without treatment, this risk continues and even escalates. The psychiatric hospital can prevent some instances of self-harm, but not all. It is difficult to prevent suicide by a determined individual. Psychotic self-harm, due to the wide variety of bizarre ideas patients can have, is unpredictable. The same is true of harm to others. Even a well-run hospital can only reduce the chance that a patient attacks another patient or a staff member. The hospital cannot always prevent such attacks, and in attempting to reduce the threat to others, the treatment and liberty interests of all patients suffer. It is an empirical fact that without med-

92. Applebaum & Gutheil, *The Boston State Hospital Case: "Involuntary Mind Control," the Constitution, and the "Right to Rot,"* 137 AM. J. PSYCHIATRY 720, 723 (1980).

93. Gutheil & Mills, *Legal Conceptualizations, Legal Fictions, and the Manipulation of Reality: Conflict Between Models of Decision Making in Psychiatry and Law*, 10 BULL. AM. ACAD. PSYCHIATRY & L. 17, 19 (1982).

94. See Bloom, *An Empirical View*, *supra* note 41, at 323.

ication, the incidence of serious harm due to patients' violence goes up significantly. This might have been predicted from the observation that the incidence of violence decreased markedly when antipsychotic drugs first were used.⁹⁵

4. *Financial Costs.*—The financial cost implications of the right to refuse treatment are substantial. Hospitalization fees range from \$100 to \$800 per day. Assuming a hospital cost of about \$400 per day and four and one-half months of hospitalization, the cost is \$50,000. For a state hospital, the legislature sets the budget, and if the cost of caring for certain patients is significantly increased, the quality of care to other patients proportionately decreases. For insured patients, the cost is passed on to the insurance carrier and hence, is eventually borne by all those paying premiums. Additionally, the costs of the legal proceedings should be considered, though these are small on a per case basis compared to the cost of the unnecessary hospitalization. For a medication refuser, the cost of hospitalization will be many times the cost of treating the acute episode.

Perr did a cost-accounting for two private hospital patients who refused treatment.⁹⁶ One had to wait three weeks, the other more than two months, for the first judicial hearing. Excluding the court costs, the price of the patient's refusals in extra institutional care and legal fees was \$13,000 for the first and \$19,000 for the second patient.⁹⁷ None of this, of course, takes into account the "hidden" costs of managing a deteriorating patient and the attendant effects on the safety and quality of care within the institution generally.

In the aggregate, the financial costs of the review proceedings themselves are substantial. The judicial process is by far the more expensive of the two. One study estimated that the *Rogers* hearings in Massachusetts

95. Schultz reports that the seclusion rate at Boston State Hospital dropped by 90% in 1955 following the introduction of psychotropic medications. Schultz, *supra* note 88, at 185. The law allows the forcible use of psychotropic drugs in emergencies, but defines emergency strictly. In many institutions, medication can be given only after a serious assault has occurred. Antipsychotics require time to become effective. The rate of symptom improvement is about 50% in the first 10 days, but symptoms persist even at six weeks, and improvement usually continues during this time and for several weeks beyond. Psychiatrists cannot predict the exact minute that a violent action will take place. Even if they could, medications do not have the desired effect in time. More to the point, if psychiatrists could predict the exact minute a violent attack will take place, they would place the patient in seclusion or a restraint, rather than medicate him.

96. See Perr, *Effect of the Rennie Decision on Private Hospitalization in New Jersey: Two Case Reports*, 138 AM. J. PSYCHIATRY 774 (1981) [hereinafter Perr, *Rennie Decision*]. For further discussion, see Perr, *The Rennie Philosophy and Treatment in the Private Sector*, in REFUSING TREATMENT IN MENTAL HEALTH INSTITUTIONS—VALUES IN CONFLICT 81-87 (A. Doudera & J. Swazey, eds. 1982).

97. Perr, *Rennie Decision*, *supra* note 96, at 776-77.

cost the state upwards of one million dollars per year in payments to judges, lawyers, and medical witnesses—a figure supported by the fact that the Massachusetts legislature in 1986 designated a supplemental appropriation of \$826,000 for this purpose.⁹⁸ Clinical review procedures, though less costly, also take “real money.” The *Jamison-Farabee* automatic review procedures have been estimated to have cost the state of California \$300,000 per year during their implementation at Napa State Hospital.⁹⁹ Had the model been imposed on all of the state’s facilities, the costs would have been in excess of one million dollars. The Anoka State Hospital TRP procedures (depicted as less formal than the California clinical review) are estimated to have cost the state of Minnesota \$30,000 annually.¹⁰⁰ Contributing to the relative modesty of this sum is the fact that Anoka State is a relatively small (236-bed) facility.

E. The True Risk of Side Effects

Legal decisions and law review articles are filled with long lists of the side effects of antipsychotic drugs, as if all patients had all side effects to the most severe degree. It is difficult to detect or gauge the side effects of these drugs in the first weeks or months of treatment, but they are rarely serious or permanent. Almost all patients will experience mild side effects such as dry mouth or mild tremor. These effects are transitory and disappear completely when the medication is discontinued. On the average, the initial side effects of antipsychotic drugs are no worse than those of the medications patients receive for serious physical diseases. It is difficult to quantify discomfort, but the general medical judgment is that the side effects of antipsychotic drugs are on the level of those resulting from hypertension medication and are certainly far less severe than those attendant to the use of such medications as anticancer drugs or those administered in conjunction with transplant surgery.¹⁰¹

There is a risk in everything we do in life, but it is a scare tactic to suggest that because a serious event can occur, it is a typical outcome. For example, one of the most dangerous things almost all of us do is to drive or ride in an automobile. One can be killed or seriously injured in an automobile accident, yet that does not mean that every time we drive to work there is a high probability that we will be killed or seriously injured.

98. Hoge, *Right to Refuse*, *supra*, note 70, at 168.

99. *Id.* at 186.

100. *Id.*

101. Virtually all patients receiving psychotropic drugs will experience some side effects, but most are mild. Even for the stronger reactions, it is important to put them in a general medical perspective.

The right-to-refuse treatment movement has claimed that antipsychotic drugs cause cancer and heart attacks. They do not cause cancer, and it is distressing to note that even judicial opinions have repeated this wholly unfounded charge and thereby given it credibility.¹⁰² A controversy in the medical literature exists as to whether antipsychotic drugs are associated with sudden death (presumably due to heart failure). Every year, some 600,000 persons in the United States die suddenly; therefore, everyone is at risk for sudden death. The American Psychiatric Association has reviewed the case histories of patients on psychotropic drugs who have died suddenly and has concluded that this is probably coincidence. Currently, there is no evidence from epidemiologic studies that psychotropic drugs cause sudden death. Indeed, what evidence there is suggests that they do not.¹⁰³

There is no doubt that the dystonic reactions (a type of muscle spasm) that some patients experience are alarming and painful, but it would be extremely unusual for them to be medically dangerous,¹⁰⁴ and they can be effectively treated with antiparkinsonian medication. Another side effect is akathisia, which is a feeling of motor restlessness. In some cases it is just a mild sensation, but it may be moderate or pronounced. Nevertheless, to suggest that severe cases are typical and will invariably occur is pure demagoguery. There are now a number of medications which quickly and effectively treat dystonia and akathisia.¹⁰⁵ Moreover, both dystonic reactions and akathisia will simply go away when the drug is stopped.

Patients can also have a side effect known as neuroleptic malignant syndrome which is characterized by a sudden steep elevation in temperature

102. See *Davis v. Hubbard*, 506 F. Supp. 915, 928 (N.D. Ohio 1980); *Rennie v. Klein*, 476 F. Supp. 1294, 1298 (D.N.J. 1978), *modified*, 653 F.2d 836 (3rd Cir. 1987), *vacated*, 458 U.S. 1119 (1982).

103. The FDA states that sudden death occurs, but that no causal association has been established. The American Psychiatric Association Task Force on the matter reached a similar conclusion. See G. SIMPSON, J. DAVIS, J. JEFFERSON, & J. PEREZ-CRUET, *SUDDEN DEATH IN PSYCHIATRIC PATIENTS: THE ROLE OF NEUROLEPTIC DRUGS* (1988).

104. We do not argue that side effects such as dystonia and akathisia are trivial. Indeed, the physician author of this Article has done research on these reactions because it is important for psychiatrists to understand their mechanics and to develop better preventive and treatment methods. It is a scare tactic to suggest, however, that these reactions are medically dangerous. The legal literature is filled with dishonest assertions. In addition to overstating the seriousness and incidence of certain side effects, it also lists conditions that simply have no causal relation to antipsychotics whatsoever (*e.g.*, cancer) or others where the cause and effect are unknown (*e.g.*, sudden death). In their treatment of TD, the legal writings succumb to overstating: (1) its prevalence; (2) its seriousness (many cases are mild and reversible); and (3) its relevance to the typical refuser, a patient with an acute psychotic episode who needs to be medicated for a brief period during which the risk of contracting TD is virtually nil.

105. Adler, Angrist, Reiter, & Rotrosen. *Neuroleptic-Induced Akathisia: A Review*, 97 *PSYCHOPHARMACOLOGY* 1 (1989).

which can lead to death. This effect is rare and while alarming, is contextually not out of line. The public does not appreciate the risks of some widely used drugs in general medicine. For example, penicillin allergy can lead to death, and aspirin can lead to fatal gastrointestinal hemorrhage. Conversely, if antipsychotic drugs are not used, there is a risk of developing lethal catatonia. Rather than increase, the risk of death in acutely psychotic patients is substantially *reduced* by the use of antipsychotic drugs. Medical science has made the treatment of mentally ill patients *safer*. Before antipsychotic drugs, electroconvulsive shock treatment was used for many psychotic emergencies. Before electroconvulsive shock was discovered, there was an alarmingly high incidence of death in patients with psychosis from lethal catatonia, suicide, accidents, infection, or other harms which may occur in chronically psychotic patients who are unable to care for themselves.

It is an unfortunate fact that long-term use of antipsychotics can cause a serious and sometimes irreversible neurological condition called tardive dyskinesia. Approximately twenty percent of patients using these drugs for a period in excess of six to seven years develop these symptoms, but these symptoms are severe in a much smaller percentage.¹⁰⁶ The vast majority of patients who receive medication in a hospital are discharged in a few weeks. It is extremely unusual for tardive dyskinesia to develop in the first six months of treatment; so for the typical patient, medication does not raise an appreciable risk of tardive dyskinesia. In the patient who has not previously received neuroleptics, it would be practically impossible to develop true TD within a few weeks of treatment. For the patient who has taken neuroleptics for years, an extra few weeks of treatment would in theory increase the risk of TD, but the increase of risk would be a fraction of one percent.

Those who attack psychotropic medication attack psychiatry for not being sensitive to the problem of TD. This is a justified criticism to the extent that organized psychiatry, the National Institute of Mental Health, and other support agencies were slow to recognize the risk of TD and to fund research for preventive measures. A substantial amount of research

106. See R. BALDESSARINI, J. COLE, J. DAVIS, G. SIMPSON, & D. TARSY, TASK FORCE REPORT 18: TARDIVE DYSKINESIA (1980). The new American Psychiatric Association Task Force on Tardive Dyskinesia, of which the physician author is a member, will attempt to quantify this. At a recent Task Force meeting, it was the opinion of all the members that the great majority of tardive dyskinesia cases are mild, but there is no doubt that some cases are serious. Among patients with serious cases of TD there are some whose symptoms inexplicably disappear despite continued neuroleptic treatment. For others, the TD will persist even after the medication is discontinued. Although few, these permanent cases are the most alarming. See J.M. KANE, DYSKINESIA: A TASK FORCE REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION (1991).

is in progress now.¹⁰⁷ There is a minority of patients who remain continually hospitalized in the long-term wards of state hospitals and refuse any psychotic medication in fear of TD. On occasion, there is court ordered long-term maintenance drug treatment with antipsychotic medication for outpatients.¹⁰⁸ In such situations, the decision whether to override an asserted right to refuse treatment should consider the risk of TD and should balance that risk against the benefits of continuing maintenance medication. We emphasize, however, that almost all patients with an acute episode will be discharged within weeks. For these patients, the risk of TD is essentially absent. Consideration of the risk of TD is important for the few patients who are in long-term institutional treatment and for outpatients for whom the court orders long-term medication. The trouble with much of the legal literature is that it has overlooked the fact that the risk/benefit ratio for short-term drug treatment is altogether different from its long-term administration.¹⁰⁹

Insofar as failure to adequately treat an acute episode results in a poor outcome and more chronic medication is given, the risk of tardive dyskinesia goes up. Additionally, during the time patients remain untreated while their refusal is being considered by the court or clinical reviewer, many will markedly deteriorate. When an emergency develops, it may be necessary to give patients vigorous, high dosage medication to control the emergency. There is no doubt that neuroleptic malignant syndrome, the most serious of the possible side effects, is more likely to occur with the rapid escalation of dose.¹¹⁰

107. See Davis, *Treatment of Schizophrenia*, 4 CURRENT OPINION IN PSYCHIATRY 28 (1991); Davis & Janicak, *Psychoses*, 4 CURRENT OPINION IN PSYCHIATRY 1 (1991); Davis, *Psychosis: Editorial Overview*, 3 CURRENT OPINION IN PSYCHIATRY 1 (1990); Davis, *Drug Treatment of Schizophrenia*, 3 CURRENT OPINION IN PSYCHIATRY 19 (1990). See also Woerner, *The Prevalence of Tardive Dyskinesia*, 11 J. CLINICAL PHARMACOLOGY 34 (1991).

108. See Bonnie, *Mental Disability Law Crosses a New Frontier: A Review of Recent Developments*, 6 DEV. MENTAL HEALTH L. 22 (1986) (discussing legal basis for compulsory outpatient treatment).

109. The FDA recently approved a new antipsychotic drug, Clozapine, which is apparently risk free for TD and various other effects associated with currently used antipsychotics. However, it has a number of unique risks of its own. See Blackburn, *New Directions in Mental Health Advocacy? Clozapine and the Right of Medical Self-Determination*, 14 MENTAL & PHYSICAL DISABILITY L. REP. 453, 457 (1990).

110. In cases when the wrong medication is given, judicial review is still not the answer. The judge does not have the training to make the correct diagnosis or the proper medication decision. The notion that peer review must take place in the context of an adversarial trial, with the doctors functioning as "expert witnesses," makes little sense from either a theoretical or a practical perspective. For the assertion that Neuroleptic Malignant Syndrome is associated with a rapid increase in dose, see Koek, Pope, Cohen, McElroy, & Nierenberg, *Risk Factors for Neuroleptic Malignant Syndrome*, 46 ARCH. GEN. PSYCHIATRY 914 (1989).

F. Restoring The Mind

Some claim that the involuntary administration of treatment violates the patient's right of free speech. They advance two arguments: (1) antipsychotic drugs are so sedative or the side effects so severe that they impair mental functioning and (2) they are mind-altering, making the person "different" than he is. With the onset of an episode of illness, the patient's "normal" mental processes change into ones characterized by loose, rambling, illogical, circumstantial, incoherent, inappropriately concrete, and bizarre thought and speech patterns. Delusional ideas may dominate, such as that the government or its particular agencies or personnel are plotting against the patient, or the patient may have vivid visual hallucinations or hear voices that command him to perform certain acts. Evidence from controlled studies shows that antipsychotic drugs correct these aberrations and restore normal thought.¹¹¹ For most of a person's life, he develops an integrity of personality characterized by his values, loves and hates, political and philosophic beliefs, religion, interests and dislikes, interpersonal relationships, and vocations and avocations. With mental illness, a person develops delusions and hallucinations different from his normal self and becomes an altered being. It does not make sense to see drugs as the mind-altering agent.

There have been a number of studies which have measured cognitive performance before treatment (drug free) and after treatment in schizophrenics. Performance is significantly improved as a consequence of drug treatment.¹¹² It is true that some of the antipsychotic drugs have sedative properties, but most are moderately to minimally sedative, and some are not sedative at all. Additionally, the sedation tends to dissipate in a few days. Most importantly, psychosis is often associated with a marked decrement in mental performance. Although the sedative properties of some of these drugs may produce a mild and transient degree of drowsiness, this is more than counterbalanced by the fact that antipsychotic properties correct a serious disturbance of thought; thus, the net effect is that the patient's cognitive powers are much improved after drug treatment.

111. Hurt, Holzman, & Davis, *Thought Disorder: The Measurement of Its Changes*, 40 ARCH. GEN. PSYCHIATRY 1281 (1983).

112. See Schooler & Goldberg, *Performance Tests in a Study of Phenothiazines in Schizophrenia: Caveats and Conclusions*, 24 PSYCHOPHARMACOLOGIA 81 (1972); Shimkunas, Gynther, & Smith, *Abstracting Ability of Schizophrenics Before and During Phenothiazine Therapy*, 23 ARCH. GEN. PSYCHIATRY 79 (1966); Spohn, Lacoursiere, Thompson, & Coyne, *Phenothiazine Effects on Psychological and Psychophysiological Dysfunction in Chronic Schizophrenics*, 34 ARCH. GEN. PSYCHIATRY, 633 (1977); Wahba, Donlon, & Meadow, *Cognitive Changes in Acute Schizophrenia with Brief Neuroleptic Treatment*, 138 AM. J. PSYCHIATRY 1307 (1981).

G. *Normal Use vs. Abuse*

Many of the antidrug law review articles discuss at great length the alleged abuse of drug treatment by psychiatrists. What is the point being made? Would the legal community be convinced of the argument that because some lawyers abuse the law or the legal process, we should scrap the system? Of our many social institutions, are there any that operate with complete perfection without room for reform? Scrapping the use of drugs until a judicial hearing four months later is like scrapping the system. We must distinguish between the customary practice of medicine and bad medicine. The right-to-refuse "reform" for involuntary patients is aimed only at bad medicine and penalizes customary medicine and its patients and providers.

There are clear standards for the use of antipsychotic medication. It is unacceptable practice for psychiatrists: (1) to use medication as a punishment; (2) to use drugs to heavily sedate mental patients (although there are rare exceptions to this when temporary sedation is desirable); (3) to use excessively high doses of these medications; or (4) to allow nonmedical personnel to prescribe these medications. There is extensive literature on the proper use of antipsychotic drugs that can be found in various medical articles, as well as in standard medical and psychiatric textbooks, the Physician's Desk Reference, and the American Medical Association's Drug Evaluation monographs.¹¹³ Misuse of drugs is an anathema to the psychiatric profession.

A conceptionally distinct question is whether drugs are, in fact, abused in hospitals, particularly in the state hospitals which are underfunded, where there is a shortage of just about everything and where major resources are squandered in performing meaningless rituals to satisfy the multiple layers of red tape entangling the state hospital system. We doubt that the quality of medical practice in the state hospital system is as high as that in the private sector. Yet, the idea that abusive medicine is the norm is like saying that the public defender or the public prosecutorial system is routinely abusive. Litigation has brought to light individual instances of medical error and abuse in both public and private hospitals. Occasionally, in the past, major systemic shortcomings have also been demonstrated to exist. This is to the good. However, the inference made

113. *The Physician's Desk Reference* (PDR) is published yearly by the Medical Economy Press and consists of the "package inserts" of ethical medications. This document represents the evaluations of both medical and nonmedical professionals, the pharmaceutical industry, and the FDA; therefore, its exact content may reflect a variety of concerns other than medical science. Nevertheless, it is a consensus document, approved by the FDA. No one source of information (medical texts or the data from scientific studies which shape medical opinion, PDR, AMA Drug Evaluation Monographs, or their equivalents in other countries) represents a single standard, but they produce evidence of established medical practice norms.

by antipsychiatric legal advocates (and in some cases accepted by the courts) that such cases represent normal institutional psychiatry is supported only by the inherently biased artifice of adversarial thinking and pleading. It bears little relation to the contemporary institutional reality or to psychiatry as it is practiced today even under circumstances of resource scarcity and bureaucratic inefficiency.

Ironically, the right-to-refuse movement accuses psychiatry of using drugs as punishment, yet in its one-punch-one-injection approach it in essence favors punitive medicine over a consistent and effective effort to treat the patients. Alternatively, the right-to-refuse treatment movement accuses psychiatrists of using drugs as sedatives, but in restricting the use of antipsychotics to a far-belated point after judicial review, it leaves sedatives as the only medication of the moment for psychosis. Sedatives have no antipsychotic effects. This movement would have the law produce what it criticizes psychiatry for.¹¹⁴

III. THE CASE FOR AN APPROPRIATE PATERNALISM: THE MEDICAL MODEL

The patient's advocate argues that the patient should have as many rights as possible, perhaps even the right to make a rational suicide decision. Legal thought that is uninformed by psychiatric reality generally assumes that the patient's circumstances and the degree of mental illness are constant. This is not the case. The patient may agree to the medication for weeks, but one day suddenly refuse,¹¹⁵ or he may refuse initially and then cooperate. Rarely are these changes of heart based on rational reasons. Most refusals result from delusional ideas. The constant is that treatment will restore the patient's sanity. On which side should the patient's lawyer come down—the insane self or the sane self?

What if the patient who is delusional and depressed, despite a history of success, decides he has been a failure and it is time to end it all? What if the patient—nonpsychotic but profoundly depressed—who objectively has many things to live for, feels he is a failure and decides on suicide? What if the patient has had a change of personality due to mental illness and decides on some self-destructive course short of suicide, such as not agreeing to effective treatment, and the result is not suicide but life-long hospitalization? In each of these cases, had the patient not been mentally ill, he would have realized that he had really been quite successful in the things he previously did in his life and that the outlook was good. In a normal state, he would not want to commit suicide or remain in the hospital for the rest of his life. His present desires are based on his

114. See Gutheil & Mills, *supra* note 93, at 19.

115. See, e.g., *Washington v. Harper*, 494 U.S. 210 (1990).

mental illness and do not reflect any of the desires of his entire previous life, except for the two week episode of mental illness. Which side should the lawyer represent, the life-long self or the momentarily altered self?

Medicine has a history of being paternalistic. As the technical experts, doctors have historically done what they conceive is best for the patient, without worrying about the patient's consent or understanding. Patients are beginning to question doctors' paternalism and want to make major decisions about their own lives, based on an understanding of their options, and not to abrogate choice by default. We feel that this is clearly desirable and support it in all but a few exceptional circumstances. There are Good Samaritan or paramedic laws which make it possible for a passerby or paramedic to render first aid to the unconscious victim of a cardiac arrest or accident without fear of liability.¹¹⁶ Doctors can render emergency treatment to an unconscious patient brought to the emergency room. There are procedures to allow physicians to take care of young children without their parents' permission or to care for clinically obtunded adults or the aged with next-of-kin permission. We feel that the law's conceptualization of the right to mental health treatment and to refuse antipsychotic medication should be analogized to these situations.

Perhaps the best analogy is to the partially unconscious medical patient who, although not completely unconscious, is so obtunded as to lose essentially all rational powers of reasoning. Normally, the emergency room staff makes the determination that the patient is essentially unconscious and renders whatever acute medical treatment is needed to restore the patient's health. There is no judge in the emergency room who passes judgment on the competency of the patient or the decision of the emergency staff. By contrast, a mentally ill person is better protected. He is committed for treatment on a court order after a court hearing. Once that commitment decision is made, however, we should relinquish the fiction that the patient is "fully conscious" or that another "emergency" must develop before he can be treated. We should not turn the desire to protect into over-protection that is harmful. A law that obstructs the right of mentally ill patients to receive effective treatment is a form of discrimination. An indiscriminate upholding of the right to refuse treatment forces the psychiatrist to commit malpractice.¹¹⁷

116. See, e.g., ILL. REV. STAT. ch. 70, para. 61 (1989) (providing immunity from liability for acts of ordinary negligence to police officers and firemen giving emergency assistance to accident victims).

117. It has been suggested that a state physician's decision to honor a clearly incompetent, confined person's refusal to be treated could constitute the kind of "deliberate indifference to serious medical need" that the Constitution prohibits. See *Estelle v. Gamble*, 429 U.S. 97 (1976); *People v. Thomas*, 217 Cal. App. 3d 1034, 266 Cal. Rptr. 295 (1990).

IV. IMPLEMENTING AN APPROPRIATE PATERNALISM:
A PROPOSAL FOR LEGAL REFORM

Involuntarily committed patients, in most states, are presumed competent unless or until declared incompetent in a subsequent court proceeding separate from the commitment proceeding. This two-stage process requirement is based on a legal fiction because the patients must have been found to be sufficiently lacking in competence with respect to their treatment needs to be committed. Empirically, it has been found that hearings on the right-to-refuse issue (in "medical court") focus on the appropriateness of treatment, rather than the patients' competency.¹¹⁸ The empirical reality thus recognizes the direct connection between the commitment status and the right to treatment or the right to refuse treatment. The act of commitment to a hospital takes away freedom and can only be based on the fact that these patients suffer from mental illness to such an extent that they will not voluntarily seek appropriate treatment either as outpatients or in a hospital on a voluntary basis. The court in overriding the patient's right to freedom assumes, indeed decides, the patient's incompetence as to treatment decisions. If it were otherwise, the commitment statutes would be merely statutes for preventive detention.

Before there was an effective treatment for the severe mental illnesses, patients were hospitalized mainly for shelter and custody. The purpose was not punishment. Rather, it was recognized that mental illness was indeed an illness and that it was more humane to care for the mentally ill in an asylum than to put them in prison or leave them "free" to fend for themselves and suffer hunger, indignity, or even death. Now that there are effective treatments, psychiatrists view the purpose of hospitalization as treatment, not long-term custodial care. Lawyers, especially those most concerned about patients' interests, should do the same.

The legal analysis should not separate the purpose of involuntary commitment from the right to treatment or the right to refuse treatment. Although state statutes vary in the details, in almost all jurisdictions the *explicit* criteria for involuntary commitment include the following:

- (A) presence of a severe mental disease
- (B) which causes the patient to:
 - (1) be unable to care for himself
 - (2) be likely to do harm to himself
 - (3) be likely to do harm to others.

Implicit in all the statutes, in the commitment process itself, is that the individual proposed for commitment is *unwilling* to accept treatment

118. See Applebaum, *supra* note 71, at 416.

voluntarily, either on an inpatient or outpatient basis. Once the court finds the statutory criteria met and orders commitment, it in effect rules that the patient was not merely unwilling, but *unable* to decide for himself. He was incompetent to make the treatment decision and, therefore, the court exercised its authority to *override* his objection.

What is merely implicit in the statutes of most states has in the last ten years been made explicit in six jurisdictions. Utah has led the way. Its commitment statute includes among its criteria that the court must find that "the patient lacks the ability to engage in a rational decision-making process regarding the acceptance of mental treatment as demonstrated by evidence of inability to weigh the possible costs and benefits of treatment."¹¹⁹ The statutes of Delaware, Iowa, Kansas, Michigan, and South Carolina contain similar language.¹²⁰ The legislatures of these states have drawn the logical conclusion inherent in commitment: the individual's mental state must be such that he cannot make the decision for treatment. His incompetency is, and must be found, simultaneous with his "commitability." In addition, the incompetency finding is not undone by the patient's exit from the courtroom door; it extends to his entry into the hospital as a patient committed to the charges of the treating doctors. There is no logic, and should be no legal requirement, to engage in a second legal contest on the same point a few short hours or days after the commitment hearing.¹²¹

We believe this is the right approach. We do not offer a "model" statute here—only the general principle. The model is available in any of the state statutes listed above, and we urge individual states that presently do not have such provisions to enact them with whatever detail and refinement they see fit. The approach saves valuable time. It will save patients and institutions from potentially incalculable harm. And the patient remains fully protected from a legal standpoint. His treatment rights and needs are fully addressed in the judicial hearing. The approach can even augment protection, as the state may require the hospital to make explicit to the court its treatment and medication plans for the patient.¹²²

119. UTAH CODE ANN. § 62A-12-234(c) (1991).

120. DEL. CODE ANN. tit. 16, § 5001 (1990); IOWA CODE ANN. § 229.1(2) (West 1989); KAN. STAT. ANN. § 59-2917 (1989); MICH. COMP. LAWS § 330.1401(c) (1991); S.C. CODE ANN. § 44-17-580 (Law. Co-op. 1991).

121. See *A.E. & R.R. v. Mitchell*, 5 Mental Disability L. Rep. 154 (D. Utah, June 16, 1980). The statutes of almost all states permit involuntary commitment only for definite, relatively short periods, bounded by mandatory judicial review. This statutory pattern reduces even further the functional necessity of separate "treatment trials" based on the right to refuse. See generally S. BRAKEL, J. PARRY, & B. WEINER, *THE MENTALLY DISABLED AND THE LAW* 21-176 (1985).

122. See, e.g., ME. REV. STAT. ANN. tit. 34-B, § 3864(5)(F) (1989).

Thus protected at the point of entering the hospital, both as to his need for and right to treatment, how can the patient be safeguarded subsequently? Again, we will deal in broad strokes, leaving the details for the lawmakers of individual states. First, we propose that the patient's course of treatment be subject to periodic medical-administrative review initiated by the hospital. This proposal presents nothing new, as such review is already mandated by law or administrative regulation in the vast majority of states and state institutions. Additionally, we propose the formalization of a patient-initiated review mechanism so that the patient can articulate his questions and concerns about the course of treatment.¹²³ The medical-administrative model should apply to this review opportunity as well, and it should also be fixedly periodic, or at least limited in the number of requests permitted over a given span of time, to prevent its exploitation by the chronically complaining patient (we assume that his opposite, the reticent complier who, without a formally granted opportunity to state his case, might never do so, is adequately protected by the state-initiated procedure). Informally, of course, patients are always free to object, discuss, and air complaints about how they are treated at the institution, subject only to the availability and patience of the hospital staff for such discussions. By the same token, members of the treatment staff remain at liberty to explain, give assurances about, and involve patients in treatment decisions, all the way to obtaining *de facto* consent.

The basic principle animating these proposals is that the medical decision model shall apply throughout. The essence of the procedures recommended is that they are administrative and nonadversarial; quick if not necessarily easy. There will be no treatment interruptions or delays and hence no clinical costs (deteriorating patients) or institutional harms (deteriorating hospitals) such as are associated with the legal model. There shall be no judicial review of treatment decisions based on a legal right to refuse. For cases of psychiatric abuse, there are other legal doctrines available that do not carry the pervasive, negative weight of the right-to-refuse concept—malpractice being a prominent one. In the isolated case

123. We mean real "review" here, not the opportunity for a clinical second-guess of the commitment order that would prohibit treatment to even begin (as in the Oregon and California models). Treatment can be initiated upon hospitalization on the strength of the commitment order, based on whatever treatment decision protocol exists at the institution. The precise reviewing mechanisms and procedures can be modeled on available TRP's such as those prescribed by departmental or institutional regulation (or "policy") in effect in various jurisdictions. See, e.g., *Washington v. Harper*, 494 U.S. 210 (1990); *United States v. Charters*, 863 F.2d 302 (4th Cir. 1988). There are, of course, costs involved in implementing such clinical review, but they are worth bearing if the procedure is appropriately targeted and limited.

when the conscientious legal advocate sees a need to force a change in the course of treatment over the judgment of the medical services provider to legally compel more appropriate or less intrusive treatment, it can be done on the basis of available, more positive concepts than the right to refuse. The right-to-treatment doctrine and the least restrictive alternative concept—properly applied with concern for the patient's medical and personal interests, as opposed to just his technical legal rights—are mechanisms adequate for this purpose.

V. CONCLUSION: THE TRUE PATIENT'S ADVOCATE

Our rejection of the legal separation between involuntary commitment and competency and thus of the involuntary patient's right to refuse treatment may be viewed as an attempt to turn back the clock. There will be those who will charge that we advocate a regression in the law. So be it. Our comfort with this proposal lies in the conviction that not all that passes (or has passed) for progress is truly progress. Thus not all "regress" is bad. We believe that turning back the legal clock on this particular matter comports with both the patient's and society's best interest, not to mention common sense.¹²⁴

We feel the patient has a right to receive treatment in order to regain both health and "competency" and that this right needs to be balanced against any right to refuse treatment. One cannot separate involuntary hospitalization from involuntary treatment. It is like having one court decide to take a patient to the operating room and give anesthesia, and then having another court decide whether to operate.

Consideration by legal practitioners of the consequences of the patient's right to refuse treatment is essential for truly adequate representation of the client. The total picture—the patient's total interests, not just his legal entitlements—must be seen. Routine judicial review of treatment decisions is both conceptually inappropriate and practically wasteful of precious time. Patients who receive treatment early on usually recover in a few weeks and can be discharged with freedom fully restored. Those who do not receive treatment may have the dubious satisfaction of seeing their right to refuse treatment held intact, but it comes at a cost of the loss of all other liberties as they stagnate or deteriorate as inpatients, indefinitely or in some cases, permanently. Given no prospect or requirement for speedy judicial review, the treated patient will be recovered and home before the refuser even has his day in court. The untreated patient remains

124. One may be tempted to say "communitarian" sense, in deference to the newly coined term for the hardly new idea that excessive libertarianism and excessive deference to special interests, particularly as pleaded by the self-designated representatives of these interests, often poorly serve the common good or even the true holders of these interests.

committed to the institution. The State protects his right to refuse treatment but takes away everything else.

The constitutional and other legal justifications for a right to refuse treatment with antipsychotic medications must be viewed in the context of the medical consequences to the patient which demonstrably result from the exercise of that right. Really to do "justice" to the client, the legal advocate must consider the pertinent medical facts before advising the client or client's family. To preserve the client's right to refuse medication, only to have that client permanently deprived of all other liberties, cannot be in the client's interest and cannot be what he wants. When the medical professional moves to temporarily abridge a singular right, so that health and freedom (and all other rights) may be restored quickly, he is assuredly promoting the patient's welfare. No attorney whose goal is to represent mentally ill clients to the limit of his professional ability and ethic can afford to ignore this point.¹²⁵

125. For a harshly judgmental account, written by nonlawyers, of the mental health bar's prevailing conception of what constitutes competent and ethical service of its clientele, and the results attributed to the implementation of this view, see R. ISAAC & V. ARMAT, *MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL* (1990). See also Brakel, 1981 *Legal Aid in Mental Hospitals*, AM. BAR FOUND. RES. J. 21 (1981); Brakel, *The Role of the Lawyer in the Mental Health Field*, 1977 AM. BAR FOUND. RES. J. 467 (1977); Galie, *An Essay on the Civil Commitment Lawyer: Or How I Learned to Hate the Adversary System*, 6 J. LAW & PSYCHIATRY 71 (1978).

