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How many procedural safeguards does it take to get a psychiatrist to leave the lightbulb unchanged?

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HOW MANY PROCEDURAL SAFEGUARDS DOES IT TAKE TO GET A PSYCHIATRIST TO LEAVE THE LIGHTBULB UNCHANGED?
A Due Process Analysis of the MacArthur Treatment Competence Study

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The MacArthur Treatment Competence Study developed measures of treatment decision-making competency in accordance with current legal standards for competency determinations. The current legal standards are more stringent than necessary and may not comply with the 14th Amendment's requirements of substantive and procedural due process. If policy makers and legal decision makers rely on the MacArthur instruments when making competency determinations, standards for treatment competency may become even more stringent, threatening the autonomy of mental health treatment refusers.

Everyone is familiar with the joke, "How many psychiatrists does it take to change a lightbulb?" Answer: "Only one; but the lightbulb really has to want to change." A golden oldie, perhaps, but pretty much outdated. The modern day punchline would go like this: "Only one; but the psychiatrist must believe the change is in the lightbulb's best interest." Not nearly as funny, but just as true.

The wholesale abandonment of a model of treating people who want to change to treating people who are compelled to change (and may not want to) has come about for several reasons. First, drugs are now available that eliminate the need for motivation. Whereas disorders like schizophrenia and bipolar affective disorder

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1 Actually, society has always tolerated the involuntary detention of persons believed to be suffering from mental disorders. See Thomas S. Szasz, The Manufacturer of Madness: A Comparative Study of the Inquisition and the Mental Health Movement, 147 (1970) ("Until the middle of the nineteenth century, the American physician had uncontested power to compel the medical detention of any individual whom he considered in need of care for mental disease."). Throughout the nineteenth century, all forms of mental health "treatment," including psychosurgery, shock therapies, and sterilization, were routinely performed on the mental health profession's detainees, without any pretenses of informed consent. See e.g., Paul S. Appelbaum & Thomas Grisso, The MacArthur Treatment Competence Study: I. Mental Illness and Competence to Consent to Treatment, 19 LAW & HUM. BEHAV. 107 (1995) ("Whether patients were committed involuntarily or admitted themselves voluntarily, the question of consent to treatment once hospitalized seems not to have been raised."). However, the modern-day concern with involuntary intervention and competency determinations, at least in the mental health system, focuses primarily on involuntary administration of psychotropic medication. AMERICAN BAR ASSOCIATION, MENTAL DISABILITY LAW: A PRIMER (5th ed. 1995) ("Perhaps no treatment issue has been more controversial—or more litigated—in mental disability law than that of whether involuntarily committed patients have the right to refuse treatment, particularly antipsychotic medication.").


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were previously believed to be causally related to highly disturbed parenting or other environmental events, they are now understood to be largely biological in nature with symptoms that remit with proper medication.³

Second, the push for deinstitutionalization has contributed to the widespread belief that psychotropic medications are an agent of liberty and freedom for patients who previously required indefinite, sometimes lifelong, hospitalization.⁴ Third, some of those who populate the mental health professions have become what contracts professors call "officious intermeddlers," dedicated to diminishing, if not eliminating, all significant anomalies in thinking and affect, regardless of the wishes of the holder of those thoughts and feelings.⁵ It is obvious to those who have worked with mental patients that not all of them desire professional intervention; some consumers would rather keep their symptoms, particularly if the alternative involves taking psychotropic medication.⁶

Before the days of mental health reform, refusers of mental health care were routinely treated despite their objections.⁷ There was no inquiry into their reasons. Rather, it was widely accepted by mental health professionals that if refusers could actually comprehend how crazy they were, they would gladly accept the intervenors' help. In any event, when they got better they would be grateful for the treatment's help (i.e., "the thank you theory")⁸. As reformers gathered number, things changed and the law began looking into the reasons for refusal. Procedures for judicial hearings and Internal Review Committees were established, and the question of competency to refuse treatment took hold as a cottage industry.⁹

behavior. For a description of these medications, see Michael J. Gitlin, The Psychotherapist's Guide to Psychopharmacology 240 (lithium), 287 (thorazine and other antipsychotic drugs) (1990).

³Schizophrenia and bipolar disorder are thought to be largely biologically determined. John P. Houston et al., Invitation to Psychology (3d ed.) 648–57 (1989).

⁴"With the[] discovery of thorazine, the road to transforming what had been a hospital based disorder into an outpatient disorder with only intermittent hospitalizations was opened." Gitlin, supra note 2, at 287.

⁵See, e.g., Samuel Jan Brakel & John M. Davis, Taking Harms Seriously: Involuntary Mental Patients and the Right to Refuse Treatment, 25 Ind. L. Rev. 429, 434 (1991) ("Once a person becomes a client of the mental 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"); "We argue that a lawyer in possession of the medical facts cannot maintain the fiction that liberty is best protected by a legal philosophy . . . that holds the right to refuse treatment as the patient's paramount right.").

⁶The case of Amy, a 47-year-old quadriplegic suffering from paranoia, was described by Santo W. Bentivegna & Kathleen Garvey, Applications of Hartman's Competency to Consent and Right to Refuse Treatment Concepts, 8 Am. J. Forensic Psychology 25, 26–27 (1990). Amy (who was found competent by the Supreme Court of New York, despite doctor's testimony that she was a danger to herself) wanted to remain free of psychotropic medication because the side effects could decrease her ability to perceive, think, and feel, the only things left to her control after becoming a quadriplegic. Id. at 29.

For a review of cases pointing out the devastating consequences to the recipients of unwanted mental health treatment, see Bruce J. Ennis, Prisoners of Psychiatry (1972). For a philosophical analysis of the same issues, see Thomas Szasz, Psychiatric Slavery (1977).


⁸The term thank you theory is credited to Alan Stone, a psychiatrist who promotes the argument that incompetent persons should be treated against their wills because if they were competent, they would choose treatment, and because when they regain competency, they will appreciate the intervention. See Alan Stone, Mental Health & Law: A System in Transition 18–19 (1976). The problem with this, of course, is that it is impossible to know before treatment begins which treatment recipients will appreciate the intervention and which ones will not. See Bruce J. Ennis & Robert Emery, The Rights of Mental Patients 42–43 (1978).

Tom Grisso, a psychologist, and Paul Appelbaum, a psychiatrist, have taken the reform one step further. With the development of the MacArthur Treatment Competency instruments, judges and mental health professionals have statistically reliable and potentially valid instruments designed specifically for the measurement of the elusive concept of competency to make treatment decisions.

Standardization of the way in which we determine competency or the lack thereof appears to be a profound step forward in securing the fair treatment of mental health treatment refusers. Appearances may be deceiving, however. The bulk of mental health and judicial energies in the area of treatment decision-making is directed toward treatment refusers. Furthermore, the MacArthur instruments are attempts to operationalize the law as it currently is, a body of law that has developed around treatment refusal, not acceptance. However, the available data regarding who accepts and who refuses mental health treatment show unequivocally that the great majority of mental health consumers accept treatment, even when involuntarily committed to hospitals.

Three of the four Supreme Court decisions that considered competency to make treatment decisions arose in a treatment refusal situation: Riggins v. Nevada, 504 U.S. 127 (1992) (criminal defendant sought reversal of conviction obtained while he was involuntarily medicated; the Court reversed the conviction); Washington v. Harper, 494 U.S. 210 (1990) (prisoner challenged state's authority to administer involuntary medication; the Court found the state interest in prison safety outweighed the prisoner's interest in refusing medication); Mills v. Rogers, 457 U.S. 291 (1982) (mental hospital patients brought a class action suit after being involuntarily medicated; the Court remanded for a decision under state law); but see Zinermon v. Burch, 494 U.S. 113 (1990) (hospital that admitted a clearly incompetent person on a voluntary basis was liable for violating the individual's Fourteenth Amendment right to due process).

Alan Meisel, Loren Roth, and Charles Lidz, pioneers in informed consent theory and research, noted that the concept of "informed consent" should properly be thought of as "patient decision making" because genuine "informed consent" does not necessarily result in treatment acceptance. Alan Meisel et al., Toward a Model of the Legal Doctrine of Informed Consent, 134 AM J. PSYCHIATRY 135 n. 1 (1977). See also Bruce J. Winick, Competency to Consent to Treatment: The Distinction Between Assent and Objection, 28 Hous. L. Rev. 15, 21 (1991) (arguing that persons who accept mental health treatment should be considered competent and that laws and policies should use different standards for scrutiny of assenters' treatment decisions).

The MacArthur instruments were developed to represent the legal standards for competency determinations used in the United States today. MacArthur I, supra note 10, at 108–11. It is the States' standards that have arisen in response to treatment refusals, rather than the MacArthur instruments themselves.

In a very large study of psychiatric treatment refusers, only 7.2% of all psychiatric patients studied refused treatment with psychotropic medication and only about 2% of all patients studied refused long enough to reach the review stage. Steven K. Hoge et al., A Prospective, Multicenter Study of Patients' Refusal of Antipsychotic Medication, 47 ARCHIVES OF GEN. PSYCHIATRY 949, 950 (1990). Other studies report rates of refusals between 1% and 15% that result in reviews. Id. at 949. The average appears to be around 10%. Paul S. Appelbaum & Steven K. Hoge, The Right to Refuse Treatment: What the Research Reveals, 4 BEHAV. SCI. & L. 279, 281 (1986). However, the average may be skewed to the higher end by the atypical high rates reported in certain settings. Appelbaum and Hoge reported the following percentages for refusals that lasted longer than 24 hours: 5% in a California state hospital, less than 1% in a New York community mental health center, 2% in a Massachusetts state hospital, 2.4% for St. Elizabeth's Hospital in Washington, D.C., 5% at Napa State Hospital in California, 4% in an Oregon state hospital, 8% in a maximum security forensic hospital in Ohio, 10.5% in a later study of the same Ohio hospital, 13% from a forensic unit in Oregon, and 15% from a state hospital in Minnesota. Id. at 281. The modal
Only a minority of patients refuse treatment, and an even smaller minority persistently refuse treatment.\(^{14}\)

Moreover, the whole idea of competency determination presupposes that if patients are determined to be "incompetent," the medically right and morally justifiable thing to do is to give them treatment, despite their refusal. This article makes no such philosophical leap of faith. We believe that the following questions should be asked: Is it constitutionally permissible to medicate a person, even if the person is "incompetent"? If so, to whom does the Constitution delegate the power of competency determinations? That settled, what procedural safeguards are required to protect against erroneous determinations of incompetency (i.e., false positives)?\(^{15}\)

We answer each of these questions in turn, using a procedural due process analysis and incorporating the currently available empirical data to increase both the accuracy and the force of our argument. In the end, we conclude that (a) mental health treatment refusers are held to a higher competency standard than mental health treatment acceptors or medical health treatment refusers; (b) the state's interest in providing mental health treatment to persons diagnosed with mental illness rarely outweighs an individual's liberty interest in being free from unwanted medications; and (c) the proper use of the MacArthur Treatment Competency instruments is in the clinical setting, for the facilitation of truly competent assent to mental health treatment.\(^{16}\)

I. Competency and the Right to Refuse: The Law's Current Status

In *Washington v. Harper*, the Supreme Court held that individuals have a constitutionally protected liberty interest in freedom from unwanted psychotropic medication.\(^{17}\) According to the Court, the Fourteenth Amendment prohibits involuntary medication, except when the State's interest outweighs the individual's

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\(^{14}\)In the Hoge et al. study, *supra* note 13, at 951, where only 7.2% of the patients refused medication at any time, the majority of refusers (53%) accepted treatment within 1 week or less; of the 7.2% that refused medication, only 29% refused for longer than 15 days. In other words, only 2% of the sample refused medication for longer than 2 weeks (.072 \(\times .29 = .00209\)). Most patients refused for only 2 days, and the average length of refusal was only 13 days. *Id.*

\(^{15}\)See infra note 34 for specific studies that found a low rate of treatment refusal. For a thorough review of treatment refusal studies, see Appelbaum & Hoge, *supra* note 13.

\(^{16}\)The term *false positive* refers to the situation in which one believes the data or evidence support the hypothesis, but they *actually do not* support the hypothesis. Statisticians refer to false positives as *Type I error*. The opposite of the false positive is the *false negative*, the situation in which one believes the data or evidence do not support the hypothesis, but they *actually do*. Statisticians refer to false negatives as *Type II error*. See Barbara G. Tabachnick & Linda S. Fidell, *Using Multivariate Statistics* 34–35 (1989).

\(^{17}\)Although the MacArthur instruments were not developed for clinical use, the clinical setting may well be the most appropriate setting for their use. Policy and law makers wishing to implement the MacArthur instruments should proceed with caution. It is our position that the current legal standards for competency determinations are too high. As the MacArthur instruments were designed to assess an individual's competency, *as defined by state law*, the MacArthur instruments have the potential danger of reifying standards that are already too high and do not respect individual autonomy.

\(^{18}\)494 U.S. 210, 221 (1990) ("We have no doubt that, in addition to the liberty interest created by the State's Policy, respondent possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment.").

interest in refusing unwanted medication. In Harper, the state's interest in prison safety outweighed the individual prisoner's interest in refusing Mellaril. Although the prisoner argued that his liberty should not be deprived unless he was adjudicated incompetent to make treatment decisions, the Court disagreed. Given the State's weighty interest in prison safety, a finding by an internal review committee that the treatment was medically appropriate could override a prisoner's refusal.

In Riggins v. Nevada, the Supreme Court reversed the petitioner's murder conviction because he had been involuntarily medicated during his trial. The Court held that involuntary medication of a criminal defendant violated the Fourteenth Amendment, because absent a finding that treatment was medically appropriate and that the involuntary medication was the least restrictive means of ensuring the accused could remain competent to stand trial, the State's interest in resolution of the criminal trial did not outweigh the individual's interest in freedom from unwanted medication.

The remaining question is whether the State's interest could outweigh the liberty interest of a person committed to a mental health treatment facility. The Court was presented with this precise question in Mills v. Rogers but declined to provide an answer, remanding the case for resolution under state law. Ultimately, the Supreme Judicial Court of Massachusetts held that the individual liberty interest in freedom from unwanted medication outweighs the State's interest in providing treatment, unless the individual has been adjudicated incompetent to make treatment decisions. In the case of an incompetent person, the court must make a

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18Id. at 227 ("[G]iven the requirements of the prison environment, the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest.").

19Id. at 225–26 ("Where an inmate's mental disability is the root cause of the threat he poses to the inmate population, the State's interest in decreasing the danger to others necessarily encompasses an interest in providing him with medical treatment for his illness.").

20Id. at 228–29.

21Id. at 231 ("Notwithstanding the risks that are involved, we conclude that an inmate's interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge. The Due Process Clause 'has never been thought to require that the neutral and detached trier of fact be law trained or a judicial or administrative officer.' Parham v. J.R., 442 U.S. at 607 (1979). "). But see Donald N. Bersoff, Judicial Deference to Nonlegal Decisionmakers: Imposing Simplistic Solutions on Problems of Cognitive Complexity in Mental Disability Law, 46 SMU L. REV. 329, 371 (1992) ("The fact that mental health professionals are universally admitted as experts on issues within their areas of competence does not ineluctably lead to the conclusion that they make accurate professional judgments or are preferred decisionmakers... They may be expert enough to offer their professional observations, data, and judgments, but they lack knowledge of the legal, moral, and social values to balance all the interests at stake. Society has placed that role in the hands of the judges."). Bersoff also pointed out the Supreme Court's inconsistency in this area. Whereas the Court embraced mental health professionals as decision makers in the area of involuntary medication, in Washington v. Harper, 494 U.S. 210 (1990), it ridiculed and rejected the accuracy of mental health professionals' diagnostic abilities in O'Connor v. Donaldson, 422 U.S. 563 (1975). Id. at 334–35 ("[I]t is incongruous that the Court's serious concern about the indeterminacy, inexactitude, and instability of judgments by mental health professionals coexists with their elevation by the Court to the position of ultimate decision-maker.").

22Id. at 135 ("[U]nder Harper, forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of overriding justification and a determination of medical appropriateness. The Fourteenth Amendment affords at least as much protection to persons the State detains for trial.").

23Id. at 139 (1992).


25Rogers v. Commissioner, 458 N.E.2d 308, 314–15 (Mass. 1983) ("In Massachusetts there is 'a general right in all persons to refuse medical treatment in appropriate circumstances. The recognition of
substituted judgment, on the basis of what the “incompetent” person would have decided had he or she been competent to make a decision.\textsuperscript{26}

There is no shortage of similar decisions. The courts of Arizona, California, Connecticut, Illinois, Massachusetts, New York, South Dakota, and Wisconsin have all agreed that individuals cannot be involuntarily medicated unless they have been adjudicated incompetent to make treatment decisions.\textsuperscript{27} The legislatures in many states, including Alaska, California, Connecticut, the District of Columbia, Florida, Hawaii, Idaho, Illinois, Kansas, Kentucky, Massachusetts, Minnesota, New Mexico, New York, Texas, Vermont, Washington, and Wisconsin, have passed laws to the same effect.\textsuperscript{28}

\textsuperscript{26}Id. at 316. “Even if the patient’s choice will not achieve the restoration of the patient’s health, or will result in longer hospitalization, that choice must be respected.” Id. at n. 15.


\textsuperscript{28}ALASKA STAT. § 47.30.825(c) (1995) (“A patient who is capable of giving informed consent has the right to give and withhold consent to medication and treatment in all situations that do not involve a crisis or impending crisis. . . . A facility shall follow the procedures [for competency determinations] before administering psychotropic medication.”); CAL. WELF. & INST. CODE § 5325.2 (1984) (“Any person who is subject to detention pursuant to [any section but the section providing for commitment of dangerous individuals] shall have the right to refuse treatment with antipsychotic medication . . . .”); CONN. GEN. STAT. § 17a–543(e) (Supp. 1995) (“If it is determined by the head of the hospital and two qualified physicians that a patient is incapable of giving informed consent to medication . . . and such medication is deemed necessary for the treatment of such patient’s, a facility . . . may apply to the court of probate for appointment of a conservator . . . .”); D.C. CODE ANN. § 21–2203 (Supp. 1995) (“An individual shall be presumed capable of making health-care decisions unless certified otherwise [in competency hearing]”); FLA. STAT. Ch. 394.459(3)(a) (Supp. 1996) (“If any patient refuses to consent to treatment or revokes consent previously provided and the treatment not consented to is essential to appropriate care for the patient, then the administrator shall immediately petition the court for a hearing to determine the competency of the patient to consent to treatment.”); HAW. REV. STAT. § 327F–1 (1993) (“The legislature finds that all competent persons have the fundamental right to control decisions relating to their own medical care, including the decision to accept or refuse medical treatment, including the administration of psychotropic drugs . . . .”); IDAHO CODE § 66–346(c) (1989) (“Only in cases of emergency or when a court has determined that a patient lacks capacity to make informed decisions about treatment, may the director of a facility deny a patient’s rights [to refuse specific modes of treatment]”; III. Rev. Stat. ch. 405, para. 5/2–107 (1993) (“[p]sychotropic medication may be administered to a recipient of services against his will . . . if the recipient lacks the capacity to make a reasoned decision about the medication”); KAN. STAT. ANN. § 59–2927(a)(b) (1994) (psychotropic medication may be administered involuntarily to committed persons, but commitment requires a finding of “mental illness” which requires a finding that the individual lacks the capacity to make an informed decision concerning treatment, KAN. STAT. ANN. § 59–2902(b)(2)) (1994); KY. REV. STAT. ANN. § 202A–196(3) (1991) (“If the patient . . . refuses to participate in any or all aspects of his individual treatment plan, the hospital may petition the district court for a de novo determination of the appropriateness of the proposed treatment . . . the court shall conduct a hearing . . . and shall utilize the following factors in reaching its determination: . . . (b) whether the patient is incapable of giving informed consent to the proposed treatment”); MASS. GEN. L. ch. 123,
At this time it is difficult to predict how the Court would rule if faced once again with the question of whether the Fourteenth Amendment requires a competency determination, absent a genuine emergency, before a civilly committed mental patient can be forcibly medicated. Some commentators have interpreted the Riggins decision as a broadening of the right to refuse treatment that was so narrowly defined in Harper. 29 Given its penchant for "state counting," 30 the Court may be reluctant to go against the tide. 31 On the other hand, the present conservative Court has not been particularly supportive of individual rights when they conflict with state prerogatives.

§ 8B(a) (Supp. 1995) ("the superintendent of a facility . . . may further petition the district court . . . (i) to adjudicate the patient incapable of making informed decisions about proposed medical treatment, (ii) to authorize, by an adjudication of substituted judgment, treatment with antipsychotic medications . . . "); MINN. STAT. § 253B.03(6e) (1994) ("(a) Neuroleptic medications may be administered to persons only if . . . the patient has given written, informed consent to administration of the neuroleptic medication, or . . . (b) A medical director or patient may petition the committing court . . . for a hearing concerning administration of neuroleptic medication"); N.M. STAT. ANN. § 43–1–15 (1993) ("A. No psychosurgery, convulsive therapy, experimental treatment or behavior modification program involving aversive stimuli or substantial deprivations shall be administered to any client without proper consent . . . B. If the mental health . . . professional . . . who is proposing this or any other course of treatment or any other interested person believes that the client is incapable of informed consent, he may petition the court for the appointment of a treatment guardian to make a substitute decision for the client."). (Arguably, since the New Mexico statute does not expressly provide for consent to psychotropic medication, the question of involuntary treatment with psychotropic medication could be determined under some other law); N.Y. MENTAL HYG. LAW § 80.01 (Supp. 1996) ("The legislature hereby finds . . . that the public interest will be served by the establishment of a statewide quasi-judicial surrogate decision-making process, which would determine patient capacity to consent to or refuse medical treatment and assess whether the proposed treatment promotes the patient's best interests, consistent with the patient's values and preferences."); TEX. HEALTH & SAFETY CODE § 574.106 (Supp. 1994) ("The court may issue an order authorizing the administration of one or more classes of psychoactive medication only if the court finds by clear and convincing evidence after the hearing that: (1) the patient lacks the capacity to make a decision regarding the administration of the proposed medication; and (2) treatment with the proposed medication is in the best interest of the patient"); WASH. REV. CODE § 275–55–241(1)(c)(iii)(B) (Supp. 1996) ("Persons committed for one hundred eighty days who refuse or lack the capacity to consent to antipsychotic medications have the right to a court hearing . . . prior to the involuntary administration of antipsychotic medications."); WISC. STAT. § 51.61(1)(g)(2) (Supp. 1995) ("At or after the hearing to determine probable cause for commitment but prior to the final commitment order, the court shall, upon the motion of any interested person, and may, upon its own motion, hold a hearing to determine whether there is probable cause to believe that the individual is not competent to refuse medication or treatment and whether the medication or treatment will have therapeutic value and will not unreasonably impair the ability of the individual to prepare for or participate in subsequent legal proceedings."); WISC. STAT. § 51.61(1)(g)(3) (Supp. 1995) ("Following a final commitment order, [patients] have the right to exercise informed consent with regard to all medication and treatment unless the committing court . . . makes a determination, following a hearing, that the individual is not competent to refuse medication or treatment or unless a situation exists in which the medication or treatment is necessary to prevent serious physical harm to the individual or others.").

29 Bruce J. Winick, New Directions in the Right to Refuse Mental Health Treatment: The Implications of Riggins v. Nevada, 2 WM. & MARY BILL RTS. J. 205, 233 (1993) ("Riggins thus breathes new life into the right to refuse treatment. Whereas Harper suggested a narrow scope for the right to refuse mental health treatment, Riggins moves in the opposite direction. The language in Justice O'Connor's opinion suggests that the Court will construe the right to refuse treatment much more broadly in contexts outside of the prison.").

30 See, e.g., Thompson v. Oklahoma, 487 U.S. 815, 824 (1988) (death penalty not permitted for juveniles because of agreement among the fifty states that juveniles are "not prepared to assume the full responsibilities of an adult."); Tison v. Arizona, 481 U.S. 137, 147 (1987) (death penalty not permitted for robbery–felony–murder, in part, because only eight jurisdictions allowed it); Addington v. Texas, 441 U.S. 418, 431 (1979) (adopting "clear and convincing" standard of evidence for civil commitment, in part, because 20 of the 50 states agreed); Coker v. Georgia, 433 U.S. 584, 593 (1977) (death penalty not permitted for defendants who rape adult women, in part because Georgia was the only state permitting it).

31 Of 22 states that require a determination of incompetency prior to the involuntary administration of psychotropic medication, 18 rely on legislation, 8 rely on case law, and 4 rely on both. See supra notes 27–28.
II. Defining Competency

Assuming the Court would follow the States' lead, the critical issue is to define competency. The States provide no clear guidance. Whereas some States allow for complete judicial discretion in defining competency, others have attempted to define it through legislation, and others have attempted to define it through case law. The MacArthur Treatment Competency research group has surveyed the various standards and developed the MacArthur Treatment Competency instruments in accordance with the States' definitions of competency. Table 1 shows the States that have formally defined competency and the elements of competency that are included in each State's definition.

An admirable and undoubtedly valuable achievement, the MacArthur project accepts the law as it found it and did not ask the fundamental due process question. Are the States' definitions of competency valid? We know from the rigorous standardization procedures used by the MacArthur group that the instruments are reliable, that is, the instruments yield the same results, time and time again. We also know from the same methodological scrutiny that the instruments are valid measures of the a priori competency standards as defined by the States. What we do not know is whether the States' definitions of competency are valid methods of defining the true state of competency.

To some extent, this begs the question, because the States developed their definitions in accord with what they believed to be the true state of competency, and if that was the sole criterion, their definitions of competency would be valid per se. However, it is not as simple as that. The States developed their definitions of competency on the basis of what they assumed to be the decision-making behavior exhibited by "competent" decision makers, that is, those who have not been adjudicated incompetent. Likewise, their definitions of incompetency were developed from years of observed behavior by persons ultimately held "incompetent" in the courts and by administrative tribunals.

Thus, the States used truly circular logic and defined competency tautologically. As a result, standardizing measurement instruments according to State definitions of competency, the MacArthur group has potentially elevated the State definitions to the "gold standard" for competency determinations. By relying on this method, there is a real danger that their work will limit, rather than expand, the autonomy and due process rights of mental health treatment recipients. This is because the States' definitions (now the MacArthur definitions) of competency are too high, in our view. If all mental health treatment refusers are held to these standards, the law will effectively demand higher levels of competency for mental health treatment refusal than it does for medical health treatment refusal. Thus, very few mental health treatment refusers will have their decisions upheld in competency hearings.

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33Id.
34In fact, this is the case under the law as it now stands. In the Hoge et al. study, supra note 13, at 952, 19 of the 98 treatment refusers (2% of the hospital's census) went to court and none of the refusals were upheld. In an earlier study of the right to refuse treatment in Oregon, where approximately 5% of the admissions resulted in treatment refusal override procedures, 95% of treatment refusals were overridden (by an outside physician, not a judge). Sally L. Godard et al., The Right to Refuse Treatment in Oregon: A Two Year Statewide Experience, 4 BEHAV. SCI. & L. 293, 301 (1986). In a study of treatment refusals in a facility for the criminally insane, researchers found that only 98 of over 1,000 admissions (less than 1%)
III. Due Process Interests at Stake

When analyzing a law for compliance with the Fourteenth Amendment's procedural due process guarantee, courts use a three-part balancing test developed in *Mathews v. Eldridge*. First, the court looks at the individual liberty interest at stake and the risk of an erroneous deprivation. In treatment decision making, the liberty interest is freedom from unwanted treatment, and the risk of an erroneous deprivation occurs in the competency determination. If a court erroneously finds a person incompetent to make treatment decisions, the person will be medicated involuntarily.

Second, the court looks to the risk of an erroneous deprivation under the currently available procedural safeguards and the probable value of additional safeguards. In treatment competency, the currently available and potential additional procedural safeguards include the manner in which competency is defined, the traditional elements of a fair adversarial hearing, and adherence to a substituted judgment standard rather than simply using a surrogate decision maker. The risk of an erroneous deprivation is discussed below.

Third, the court looks to the state interest involved and the cost in time and resources of additional safeguards in relation to their potential for avoiding an erroneous deprivation. In treatment competency, as in any other due process analysis, the costs are the ones associated with human and social resources as well as the costs in not satisfying the state interest.

Although much has been made of the expense and delay involved in providing for judicial review of treatment refusals, the data relied on by those who make this argument do not provide much support for this position. After reviewing the

resulted in a court hearing for treatment refusal; of these, 90% of treatment refusals were overridden. Jorge Veliz & William S. James, *Medicine Court: Rogers in Practice*, 144 AM. J. PSYCHIATRY 62, 64 (1987).

In a similar study of treatment refusals in a New York forensic psychiatric hospital, only 18 petitions were submitted (.02% of the hospital's admissions) and only 15 actually went to court; 100% of the treatment refusals were overridden. Frank H. DeLand & Neal M. Borenstein, *Medicine Court, II: Rivers in Practice*, 147 AM. J. PSYCHIATRY 38, 41 (1990). In another study of a New York forensic facility, 87% of treatment refusals were overridden. Julie Magno Zito et al., *One Year Under Rivers: Drug Refusal in a New York State Psychiatric Facility*, 12 INT'L J.L. & PSYCHIATRY 295, 305–06 (1989).

For a review of even more empirical studies on the low percentage of patients who refuse treatment and the high percentage of treatment override decisions, see Appelbaum & Hoge, supra note 13, at 279. 35424 U.S. 319 (1976). *Mathews* involved the termination of social security benefits. The Supreme Court held that the Due Process Clause of the Fifth Amendment did not require a pretermination hearing. Id. at 349.

36Id. at 335.

37In *Harper*, the Supreme Court found that the individual liberty “interest in avoiding the unwarranted administration of antipsychotic drugs is not insubstantial. The forcible injection of medication into a nonconsenting person's body represents substantial interference with that person's liberty.” 494 U.S. at 229.

38424 U.S. at 335.

39Id.

40Godard et al., supra note 34, at 303 (average time for completed review was 13 days); DeLand & Borenstein, supra note 34, at 40 (time for completed review ranged from 8 to 53 days, with an average of 24 days); Zito et al., supra note 34, at 300 (median length of time for review was 35 days, range was 5 to 109 days); Hoge et al., supra note 34, at 952 (average length of time for completed review was 36.7 days); Veliz & James, supra note 34, at 63 (time for complete review ranged from 2 to 7 months, with an average of 4.5 months); Hoge et al., supra note 13, at 168 (cost could range from $30,000 per year to $1 million per year,
<table>
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<tr>
<th>Understand relevant facts</th>
<th>Appreciate one's illness or nature of the decision</th>
<th>Use rational thought process</th>
<th>Can make rational decision</th>
<th>Make willful or voluntary, knowing and intelligent decision</th>
<th>Communicate decision</th>
<th>Understand or weigh risks and benefits of treatment and any alternatives</th>
<th>Able to articulate reasonable objections</th>
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| Alaska 41               | Alaska                                           | Alaska                      |                           |                                                             |                     |                                                            | Alaska                           |
| California 43           | California                                       | California                  |                           |                                                             |                     |                                                            | Arizona 42                       |
| District of Columbia 46 | Florida                                          | Hawaii                      |                           |                                                             |                     |                                                            | Idaho                            |
| Hawaii 48               | Idaho                                            | Kansas                      |                           |                                                             |                     |                                                            | New York                         |
| Idaho 49                | Kansas                                           | South Dakota 53             |                           |                                                             |                     |                                                            | Texas 44                         |
| New York 51             | Maine                                            | Texas                       |                           |                                                             |                     |                                                            | Texas Wisconsin 55              |

41Alaska Stat. § 47.30.837 (d) (1) (1995) “(Competent” means that the patient (A) has the capacity to assimilate relevant facts and to appreciate and understand the patient’s situation with regard to those facts, including the information described in [the informed consent provisions] of this subsection; (B) appreciates that the patient has a mental disorder or impairment, if the evidence so indicates; denial of a significantly disabling disorder or impairment, when faced with substantial evidence of its existence, constitutes evidence of its existence, constitutes evidence that the patient lacks the capability to make mental health treatment decisions; (C) has the capacity to participate in treatment decisions by means of a rational thought process; and (D) is able to articulate reasonable objections to using the offered medication.”

42In re Application for the Commitment of an Alleged Mentally Disordered Person, 854 P.2d 1207 (Ct. App. Ariz. 1993). “The determination of whether a person is incapable of making an informed decision turns on the question of whether such person is incapable of understanding and expressing an understanding of the advantages and disadvantages of the treatment and the alternatives to the treatment after such matters are explained to the patient.”

43CAL. WELFARE & INSTITUTIONS CODE § 5326.5 (c) (1984). “A person confined shall be deemed incapable of written informed consent if such person cannot understand, or knowingly and intelligently act upon, the information specified in [the informed consent] section.”

44Under California law, a court should assume that a patient is using rational modes of thought unless there is a “clear link between the patient’s delusional or hallucinatory perceptions and his ultimate decision to consent or refuse treatment.” Reise v. St. Mary’s Hosp. & Med. Ctr., 271 Cal. Rptr. 199 (1987).
People v. Medina, 705 P.2d 961 (Colo. 1985). “A patient’s incompetency to make treatment decisions is not established by fact of involuntary certification, but is established only by evidence that patient’s mental illness has so impaired his judgment as to render him incapable of participating in decisions affecting his health.”

D. C. CODE § 21–2202 (5) (Supp. 1995) “Incapacitated individual’ means an adult individual who lacks sufficient mental capacity to appreciate the nature and implications of a health-care decision, make a choice regarding the alternatives presented or communicate that choice in an unambiguous manner.”

FLA. STAT. ch. 394.459(3)(A) (Supp. 1995) “A patient is incompetent to consent to treatment if his judgment is so affected by his mental illness that he lacks the capacity to make a well-reasoned, willful, and knowing decision concerning treatment.”

HAW. REV. STAT. § 327F-2 (Supp. 1995) “Incompetent person’ means any person suffering from a psychotic condition who is temporarily impaired by reason of having lapsed back into that psychotic condition to the extent that while temporarily impaired, the person lacks sufficient understanding or capacity to make or communicate responsible decisions concerning the person’s health care.”

IDAHO CODE § 66–317(I) (Supp. 1995) “Lacks capacity to make informed decisions about treatment’ shall mean the inability, by reason of mental illness, to achieve a rudimentary understanding after conscientious efforts at explanation of the purpose, nature, and possible significant risks and benefits of treatment.”

KAN. STAT. ANN. § 59–2902(e) (1992) “Lacks capacity to make an informed decision concerning treatment’ means that the person, by reason of the person’s mental disorder or condition, is unable, despite conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment or is unable to engage in a rational decision making process regarding hospitalization or treatment, as evidenced by inability to weigh the possible risks and benefits.”

N.Y. MENTAL HYG. LAW § 80.03(c) (1988) “Lack of ability to consent to or refuse major medical treatment’ means the patient cannot adequately understand and appreciate the nature and consequences of a proposed major medical treatment, including the benefits and risks of and alternatives to such treatment, and cannot thereby reach an informed decision to consent to or to refuse such treatment in a knowing and voluntary manner that promotes the patient’s well being.”

MAINE REV. STAT. ANN. § 11001 (1992) “Incompetent person’ means a person who suffers from a psychotic condition who is temporarily impaired by reason of having lapsed into that psychotic condition to the extent that while temporarily impaired, the person lacks sufficient understanding or capacity to make or communicate responsible decisions concerning the person’s health care.”

S.D. CODIFIED LAWS ANN. § 27A–12-3.15 (1992) “If the court finds by clear and convincing evidence that the person is incapable of consenting to treatment with psychotropic medication because his judgment is so affected by his mental illness that he lacks the capacity to make a competent, voluntary and knowing decision concerning the medication and the administration of the recommended psychotropic medication is essential . . . the court may exercise a substituted judgment on the administration of psychotropic medication.”

TEX. HEALTH & SAFETY CODE § 574.101(1) (Supp. 1995) “Capacity means a patient’s ability to: (A) understand the nature and consequences of a proposed treatment, including the benefits, risks, and alternatives to the proposed treatment; and (B) make a decision whether to undergo the proposed treatment.”

WISC. STAT. § 51.61(g)(4) (Supp. 1995) “[A]n individual is not competent to refuse medication or treatment if, because of mental illness, developmental disability, alcoholism or drug dependence, the individual is incapable of expressing an understanding of the advantages and disadvantages of accepting medication or treatment, and the alternatives to accepting the particular medication or treatment offered, after the advantages, disadvantages and alternatives have explained to the individual.”
treatment refusal literature, Appelbaum and Hoge concluded that “[t]he feared epidemics of clinically significant treatment refusal . . . have not materialized.”56 Another research group concluded that “[r]efusing patients at Anoka State Hospital have not been ‘rotting with their rights on,’ as Appelbaum and Gutheil feared.”57

Expense and delay are part and parcel of due process. It takes longer and costs more to provide criminal defendants with the services of public defenders; it takes longer and costs more to consider habeas corpus petitions of prisoners; and it takes longer and costs more to provide judicial hearings prior to civil commitment. In each case, however, we take the time and bear the expense because our society has decided that the time and the expense are far outweighed by the risk of erroneous deprivations.58

Of course, there are costs in time and money when a judicial review is compared to no review or cursory review by a second physician. This is only logical. However, considering that only about 5% of refusers do so for longer than 24 hours and only about 2% of all mental health consumers refuse long enough to reach the review stage, the costs associated with judicial review are not outrageous or intolerable.59 Moreover, the data reveal that the actual incidence of judicial proceedings goes down when procedural safeguards are enacted.60 Furthermore, lowering the standards for competency eliminates the need for the few hearings that are currently the subject of complaints.

Critics of heightened due process complain that the most intolerable cost of increased procedural safeguards is that more persons diagnosed with mental illness will go untreated.61 There is some evidence that patients who refuse treatment will be refused admission or discharged without treatment62 and that patients who remain in the hospital without treatment have longer hospitalizations and experience more

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56 Appelbaum & Hoge, supra note 13, at 281.
57 Zito et al., supra note 34, at 357.
58 See Mathews v. Eldridge, 424 U.S. 319, 348 (1976) (“Financial cost alone is not a controlling weight in determining whether due process requires a particular procedural safeguard prior to some administrative decision.”)
59 See supra note 34.
60 “The [] threshold of tolerance for refusals . . . could conceivably have been raised as a result of the Rivers decision. Anecdotal evidence at one hospital suggests that now only the most meritorious cases proceed—those in which the staff is relatively certain that they can convince the judge.” Stephen Rachlin, Rethinking the Right to Refuse Treatment, 19 PSYCHIATRIC ANNALS 213, 216 (reporting on two New York hospitals that experienced a decrease in treatment refusals and a third hospital that experienced no change, following the Rivers decision that required a competency determination prior to involuntary treatment with psychotropic medication); Zito et al., supra note 34, at 302 (“There are additional factors that may explain the low prevalence of court applications, such as the convenience of the review process, the prescriber’s attitude toward court resolution of drug refusal, and patients who change their minds. Thus, it is not surprising that the court hearing which is likely to be the least treatment-oriented and most bureaucratic response to patient refusal will produce the lowest prevalence of refusal . . .”).
61 Given the fact that approximately 300,000 involuntary commitments take place each year, however, even an incidence of 10% of patients consistently refusing treatment implies considerable interference with the care of more than 30,000 patients per year.” Appelbaum & Hoge, supra note 13, at 281.
seclusion, restraint, and emergency doses of forced medication. However, these same researchers also find that most people who refuse medication have more severe symptoms than nonrefusers. The overwhelming evidence is that most persons who refuse treatment ultimately receive treatment, either because they change their minds about it or because their decisions are overridden through the state's hearing procedure.

Thus, remembering that correlation does not equal causation, it is far from clear that the longer hospitalizations and higher incidence of violent or other emergency situations are caused by treatment refusal. These more severe behavioral problems are equally likely to be simply a manifestation of a more severe mental disturbance. Although some studies have attempted to discern the overall increase in these incidents, comparing preright to refuse incidents to postright to refuse incidents, none have done so in a controlled way. These studies have simply looked at the frequency of incidents at Time 1 and compared that number to frequency of incidents at Time 2.

Such an analysis is interesting but not necessarily valid unless the two groups of patients were homogenous on a number of demographic and diagnostic variables. The potential confounds in a simple comparison like this are endless.

Some would argue that given the high rate of decisions overriding patient refusals, the refusal process is nothing more than a waste of time and resources. There is no shortage of subjective anecdotal reports by psychiatrists who believe the override procedures lead to animosity in the doctor-patient relationship. However, there are compelling arguments and evidence to the contrary. That is, even when the override procedure results in a decision in favor of involuntary medication, the procedure itself may produce therapeutic benefits to the treatment refuser.

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63 See Appelbaum & Hoge, supra note 13, at 286–87.
64 Id. at 282–84.
65 Appelbaum & Hoge, supra note 13, at 290 (“[P]atients' refusals are usually not upheld, with the vast majority of refusing patients being treated, at least initially, over their objections.”); Hoge et al., supra note 13, at 956 (100% of refusals from the study were overridden, and 98.6% of refusals are overridden across the state of Massachusetts).
66 For examples of these studies, see Veliz & James, supra note 34; Zito et al., supra note 34; and DeLand & Borenstein, supra note 34.
67 Even if the groups were diagnostically the same, were they the same age? Were they from similar socioeconomic backgrounds? Was the average symptom severity the same for each group? Did they have the same number of prior hospitalizations? Were the medical and nursing staffs the same for both groups?
68 See e.g., Veliz & James, supra note 34, at 65 (“it was the subjective impression of several of the psychiatrists involved in the hearings that the process of the hearing adversely affected the relationship between the patient and the treating psychiatrist.”); DeLand & Borenstein, supra note 34, at 41 (“Each of the psychiatrists interviewed expressed reservations about the interposition of court influence in treatment decision making and indicated that their physician-patient relationships were adversely affected by the interdiction of the court.”). It is interesting that the researchers did not consider the possibility that forced treatment might also lead to more strained doctor-patient relationships.
69 Zito et al., supra note 34, at 357 commented that “[f]or some [treatment refusers], the process is undoubtedly beneficial, considering the long-standing belief that an active role in the therapeutic alliance between patient and therapist will be worthwhile. Social and cognitive psychology provide a theoretical explanation as to why permitting individual choice enhances the potential for success. People directed to perform tasks do not feel personally committed to the goal or personally responsible for its fulfillment.” Winick, supra note 11, at 46–47. See also Bersoff, supra note 20, at 364–65 (discussing Thibaut & Walker's theory of procedural justice and the importance of perceived fairness in a person's ability to accept an unfavorable outcome).
Furthermore, studies on the effects of coercion on mental health treatment reveal that mental health treatment consumers are particularly sensitive to the presence of coercion and react particularly negatively to the persons and systems that exercise the coercion.\textsuperscript{70} Moreover, most criminal trials and appeals are won by the state. Does this mean that as the state is almost always found to be right, we should no longer provide accused and convicted criminals with the basic elements of procedural due process?

A. The State Interest in Providing Treatment Rarely Outweighs the Individual Liberty Interest in Freedom From Unwanted Psychotropic Medication

Under the doctrine of \textit{parens patriae}, States have the authority to care for individuals who are not capable of caring for themselves. Additionally, through the \textit{police power}, States have the authority to make laws that protect and further public health, safety, and welfare. Thus, from a constitutional standpoint it is virtually beyond argument that States have a legitimate interest in providing mental health treatment to persons who cannot obtain it for themselves.

States’ power and authority, however, are not unlimited. Under the constraints of substantive due process, laws designed to further a state interest at the expense of individual liberty interests must bear at least a reasonable relationship to the state’s interest.\textsuperscript{71} For example, the law cannot quarantine persons who are HIV positive to serve a state purpose of preventing the spread of AIDS. Such a law would go too far because HIV is not easily communicable. Likewise, the law cannot permit involuntary treatment with psychotropic medication for individuals simply because they have been involuntarily committed to psychiatric hospitals. This law also would go too far because many people who are involuntarily committed to psychiatric hospitals are competent to make their own treatment decisions. Moreover, not every person who is involuntarily committed to a psychiatric hospital would benefit from treatment with psychotropic medication.

When the Supreme Court has considered the issue of involuntary treatment with psychotropic medication, it has been very clear in its characterizations of the liberty interest that is at stake.\textsuperscript{72} According to the Court in \textit{Harper}, the right to be free from unwanted psychotropic medication involves a “substantial interference with [a]
person's liberty.\textsuperscript{73} In its later decision in \textit{Riggins}, the Court strengthened this position, characterizing involuntary treatment with psychotropic medications as a "particularly severe" interference with an individual's liberty.\textsuperscript{74}

Thus, the individual liberty interest in being free from unwanted psychotropic medications is significant and must be jealously guarded. A law designed to provide mental health treatment to those who cannot obtain it for themselves must not be so broad that it also provides mental health treatment to those who are capable of obtaining it for themselves but choose \textit{not} to. Moreover, with regard to providing treatment to those who are not capable of obtaining it for themselves, the law must provide only for treatment that is actually effective in ameliorating the person's condition.\textsuperscript{75}

\textbf{B. Psychotropic Medication Is Not a Cure for Mental Illness}

One of the most common misperceptions, or misrepresentations perhaps, in the debate over involuntary treatment with psychotropic medications is that psychotropic medications are the only viable treatment alternative for certain types of mental illness.\textsuperscript{76} This is patently false. As with any physical or mental disturbance, there are always alternatives, including no treatment. Psychotropic medications are known to relieve certain symptoms of some mental illnesses in some people diagnosed with those illnesses.\textsuperscript{77}

Psychotropic medications are preferred by the medical profession, a group with a unidimensional goal—the elimination of symptoms. However, psychotropic medications are no more a cure for mental illness than aspirin is a cure for headaches. There are multiple causes for headaches, including psychological causes. Aspirin relieves the symptoms of a headache, but it is by no means a cure and cannot prevent the next headache from coming. Likewise, psychotropic medications relieve certain symptoms of mental illness, but those symptoms return when the medication is discontinued, and often the symptoms return even when the medication is continued.\textsuperscript{78}

Certain side effects are associated with the use of psychotropic medications. Unlike the side effects associated with aspirin, however, the side effects associated with psychotropic medications are quite severe, ranging from episodic and reversible involuntary muscle movements to chronic irreversible neurological impairment to death.\textsuperscript{79} Proponents of the wonders of psychotropic medication argue that there are other medications that can be used to control the side effects of the primary

\textsuperscript{73}\textit{Harper}, 494 U.S. at 229.
\textsuperscript{74}\textit{Riggins}, 504 U.S. at 134.
\textsuperscript{75}\textit{Id.} at 226 (involuntary medication was reasonably related to a legitimate government interest of controlling violence caused by symptoms of mental illness because it was applied exclusively to inmates who were mentally ill and gravely disabled or dangerous to others).
\textsuperscript{76}See e.g., Brakel & Davis, supra note 5, at 450 ("It should . . . be noted that for patients suffering from one of the major mental illnesses, there is no alternate 'less restrictive' treatment to drugs or E.C.T."). Brakel & Davis go so far as to say that "[s]ome patients will have residual symptoms, but many will be 'cured' or almost cured." \textit{Id.}
\textsuperscript{77}For a recent review of the benefits and hazards of neuroleptic medications, see Gilbert et al., \textit{Neuroleptic Withdrawal in Schizophrenic Patients}, 52 ARCHIVES GEN. PSYCHIATRY 173 (1995).
\textsuperscript{78}\textit{Id.}
\textsuperscript{79}\textit{Id.}
medication.\textsuperscript{80} These professionals rarely mention that the medications for side effects also produce side effects of their own.\textsuperscript{81}

No right-minded person would support a law that required all headache sufferers to take aspirin. Even if the headaches were so severe that the sufferers lost their jobs and spouses and became entirely dependent on the public welfare system, few would argue that they must be forced to ingest aspirin or another common analgesic. This is perhaps especially true if the headache sufferers had a history of unsuccessful treatment with aspirin and other analgesics or permanent gastrointestinal disorders as a side effect of having taken aspirin over an extended period of time.

Yet many otherwise right-minded people support laws that require persons who experience symptoms of mental illness to take psychotropic medications. Amazingly, the proponents of this position rarely back down, even when faced with a person with a history of unsuccessful treatment and side effects.\textsuperscript{82} For some reason, people who lose their jobs and families because of mental illness are viewed differently than people who lose their jobs and families because of headaches. Whereas headache sufferers are afforded the opportunity to accept the responsibility, even blame, for their condition, the mentally ill are taken under the paternalistic wing of the State. Evidence suggests that this is due more to psychiatrists' tendency to view symptoms of mental illness as a greater threat to society than side effects are to individuals.\textsuperscript{83}

\textbf{C. Mental Health Treatment Refusers Are Held to a Higher Standard Than Medical Health Treatment Refusers}

The common argument used to respond to the analogy we have just posed is that the headache sufferer makes a rational decision to reject treatment but that the very symptoms of severe mental illness make the hospitalized mental patient too irrational to make a reasoned choice. The empirical literature on informed consent lends little support to this argument.

To the contrary, the literature reveals that most medical health treatment consents are not based on a rational weighing of the risks and benefits of the proposed treatment, the treatment alternatives, and the possibility of foregoing treatment altogether.\textsuperscript{84} Rather, medical treatment decisions frequently may be made before the patient ever hears or reads the informed consent disclosure.\textsuperscript{85} Often, the decision is based on facts entirely distinct from the risks and benefits of treatment.\textsuperscript{86} Furthermore, many medical treatment patients who have given \textit{pro forma} "informed consent" did not understand or cannot remember the contents of the treatment disclosure.\textsuperscript{87}

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\textsuperscript{80}Antiparkinsonian agents, such as Cogentin, are used to control some of the side effects caused by neuroleptic medications. Gitlin, \textit{supra} note 2, at 303–05.

\textsuperscript{81}Antiparkinsonian agents produce anticholinergic side effects such as dry mouth, constipation, urinary hesitation, blurred vision, and decreased memory. \textit{Id.} at 310.

\textsuperscript{82}In a summary of all the cases brought before a mental health hearing officer, Morris described 40 examples (60% of the hearings) of physicians seeking to override a patient's refusal, despite a history of side effects. Morris, \textit{supra} note 16, at 403.


\textsuperscript{84}For a review of this literature, see Alan Meisel & Loren H. Roth, \textit{What We Do and Do Not Know About Informed Consent}, 246 JAMA 2473 (1981).


\textsuperscript{86}\textit{Id.}

\textsuperscript{87}Meisel & Roth, \textit{supra} note 83, at 2474–75.
Many voluntary mental health treatment acceptors do not understand or remember informed consent disclosures.88 In a study of voluntary psychiatric patients, Loren Roth and colleagues found that about 25 percent of the patients studied showed "very poor understanding" of the content of informed consent disclosures.89 A recent Canadian study found that almost half of the voluntary psychiatric patients studied would have been found incompetent if required to undergo a judicial determination of competency.90 Given these data, it is questionable whether a law requiring mental patients who refuse psychotropic medication to meet a higher, more sophisticated decision-making test than can be met by medical patients or voluntary psychiatric patients could withstand equal protection scrutiny, even under the heightened rationality standard developed in City of Cleburne v. Cleburne Living Center.91

D. Coerced Treatment Is Probably Less Effective Than Voluntary Treatment

The scant research that has looked at the effect of coercion in mental health treatment reveals that coerced treatment may actually harm treatment recipients.92 At the very least, it probably reduces the efficacy of mental health treatment. At worst, from a state-interest perspective, it may lead to more treatment refusal in the future. One self-described opponent of the right to refuse admitted that treatment refusers frequently discontinue medication after discharge, leading to a "new revolving door," the door of the courthouse.93 A widely cited study of the reaction of treatment refusers after involuntary medication concluded that treatment refusers generally responded poorly to treatment in the end.94

In addition to the problems of side effects and denial of symptoms, one of the more common reasons for refusing treatment is distrust of, or anger toward, the doctor.95 In fact, one of the more common sequelae of coerced mental health treatment is distrust for the person who implements the coercive treatment.96 This is not a surprising result. Nevertheless, supporters of involuntary psychotropic medication continue to insist that the medication does more good than the coercion does.

88Paul S. Appelbaum et al., Empirical Assessment of Competency to Consent to Psychiatric Hospitalization, 138 AM. J. PSYCHIATRY 1170, 1175 (1981) ("Perhaps a majority of psychiatric patients may not be competent to sign themselves into the hospital.").
89Roth et al., Competency to Decide About Treatment or Research, 5 INT'L J. L. & PSYCHIATRY 29, 45 (1982).
90B.F. Hoffman & J. Srinivasan, A Study of Competence to Consent to Treatment in a Psychiatric Hospital, 37 CAN. J. PSYCHIATRY 179, 181 (1992) (44% of voluntary admissions to a Canadian psychiatric hospital would not satisfy the legal standard for competency to consent to treatment).
91473 U.S. 432 (1985) (a heightened level of scrutiny is applied to laws that discriminate on the basis of mental retardation).
92See supra note 69 and accompanying text.
93Rachlin, supra note 59, at 221.
95Over 30% of the treatment refusers that came to one hearing officer's attention testified that they were refusing treatment because they were angry with or did not trust their doctors. See Morris, supra note 16, at 403. It is interesting that in the same sample of hearings, doctors reported that the patient was refusing due to denial of symptoms in 93.9% of the cases, but they did not report the patient's distrust or animosity toward the doctor in any of the cases. Id. at 400.
harm. It is clear, at least from a constitutional perspective, that if coercion leads to a condition that leads to more treatment refusal, the State interest of providing treatment to those who are unable to obtain it for themselves is hardly being served.

IV. Substantive Standards for Competency

Current standards for determining competency do not serve the State interest in providing treatment for those unable to obtain it for themselves. These standards lead to treatment for those who would be capable of obtaining treatment for themselves but who choose not to. There will be no move to change these restrictive standards if they are reified by the MacArthur instruments. However, we argue that a mental health treatment refuser should be adjudicated incompetent only if the individual cannot communicate a choice at all, cannot comprehend the risks and benefits of treatment, or makes a decision as a clear result of delusional thinking or extreme confusion.

A. Understanding

The MacArthur group defined understanding as "ability to demonstrate comprehension of [informed consent disclosure] by paraphrasing or recognizing items of information (related to one's own mental disorder) after they are presented in an informed consent disclosure." The MacArthur Treatment Competence Study III found that individuals diagnosed with schizophrenia or depression performed less well than medically ill individuals. Furthermore, those with schizophrenia tended to perform less well as the severity of their symptoms increased. For people with depression, performance on the understanding instrument was strongly related to verbal cognitive functioning.

What does this signify? It simply means that when persons are experiencing symptoms of mental illness, such as schizophrenia or depression, they are less able to recognize and paraphrase elements of the informed consent disclosure than are persons who are medically ill but who are not diagnosed with any mental disorder. It does not indicate that recognition and paraphrasing are essential to making treatment decisions.

Consider the following example. Z., an 83-year-old man who is in and out of a delusional state brought on by natural processes of aging, is approached by his physician and told that he must decide whether he consents to amputation of his right leg. Z. has lived with a leg injury for more than 60 years. During his life as a farmer, he did not properly care for his leg and ended up more than once in the hospital, unable to work, in danger of death by infection. More than once, doctors insisted that the only treatment alternative was amputation. Each time, Z. refused the amputation, preferring to live with the leg as long as he could, willing to take responsibility for the consequences of his decision. Now, in a state of confusion, frequently disoriented regarding time and place, suffering from a potentially fatal

98 MacArthur III, supra note 10, at 159–62.
99 Id.
100 Id.
case of gangrene poisoning, Z. is approached once again for consent to amputate the leg.

Why would a physician give Z. such a choice? Why honor Z.'s autonomy and liberty when he was so clearly confused? Had Z. been required to demonstrate recognition and paraphrase of the informed consent disclosure regarding amputation and gangrene, he would have failed miserably. Notwithstanding that, he was permitted to make his own decision, even though it probably meant earlier death, even though the cost of his health care would have increased, even though he could not at that time recognize members of his own family, and even though he would tell visitors that he had been working on the farm just yesterday, when in fact he had been in the hospital for the last few days.

Why? Because it was Z.'s leg and only he knew whether he would rather die with one leg or two. The doctor, young and healthy, with a still-living spouse and children that he needed to see grow up and go to college, would have preferred one leg to death. Z.'s adult children, albeit sensitive to their father's lifelong struggle to preserve the leg, believed that the trade of a leg for a longer life was worth it. However, only Z. could decide the relative values of life and limb for himself.

B. Appreciation

The MacArthur group defined appreciation as "acknowledgment of illness and the potential value of treatment, or acknowledgment of these things after illogical premises underlying initial nonacknowledgment were challenged." As Slobogin discusses in his article for this special issue, this standard is too high for a determination of competency to make mental health treatment decisions. There are many reasons a mental health consumer might not acknowledge diagnosis or potential for treatment that are not necessarily delusional or the product of mental illness. A person might not want to think of himself or herself as mentally ill because he or she does not believe in the concept of mental illness, does not want the stigma that comes with a diagnosis of mental illness, or does not feel ill. Moreover, like Z., the person may simply prefer the symptoms over the cure.

The MacArthur instruments also adopt too high a standard for competency with regard to appreciation of the potential benefits of treatment. Of all the standards for competency determinations, this may be the most arbitrary as well as the most offensive to individual liberty. As discussed by Slobogin, there are numerous reasons why a competent person might not agree with the physician regarding the potential benefits of treatment.

The more important inquiry, the due process question, is "why are you even asking?" The MacArthur Treatment Competence Study III found that persons diagnosed with schizophrenia were more likely to deny that they were ill. Persons diagnosed with schizophrenia or depression were less likely to acknowledge the

102 Christopher Slobogin, "Appreciation" as a Measure of Competency: Some Thoughts About the MacArthur Group's Approach, 2 PSYCHOL., PUB. POL’Y & L., 18–30.
103 Id.
104 Id.
105 Id.
106 MacArthur III, supra note 10, at 162–64.
potential benefits of treatment than were medically ill persons who were not diagnosed with mental illness.\textsuperscript{107} Neither of these findings is surprising. Denial is a symptom of schizophrenia, and hopelessness is a symptom of depression.

The participants in the MacArthur study behaved as would have been expected by their diagnoses. What we do not know is whether they are actually incapable of making treatment decisions, to the extent that the State’s interest in providing them with treatment outweighs the individual liberty interest of making one’s own treatment decisions.

Consider the person diagnosed with mental illness who is permitted to refuse unwanted treatment on religious grounds. To strengthen the argument, assume the person is a life-long practicing Christian Scientist. Because the Christian Scientist rejects the diagnostic label of mental illness and refuses to acknowledge the potential benefits of medication therapy, \textit{on recognized religious grounds}, the patient’s refusal is usually honored. Does the fact that the refusal was based on religious beliefs endow the decision with competency? Is it any closer to medical reality? Is it supported by empirical data? \textit{Of course not.} It is recognized and honored because the individual liberty interest in free exercise of religion is believed to outweigh the State’s interest in providing mental health treatment to those unable to obtain it for themselves.

How is this really any different than the person who \textit{truly believes} psychotropic medications are not helpful, that the side effects outweigh any potential benefit? Is this viewpoint true from a medical or scientific perspective? No. However, neither is the viewpoint of the Christian Scientist. The only difference is that our society tolerates interference with the liberty of persons with mental illness whereas it does not tolerate interference with religious beliefs, \textit{even when the religious beliefs are entirely without objective support.}

This is simply a distinction without a difference. To permit some individuals potentially to hurt themselves on religious grounds while preventing others from hurting themselves in the same manner because we lack respect for their reasons the way we do religious ones is an excellent example of “sanism.”\textsuperscript{108} Would it make a difference if the Christian Scientist had just converted to this faith 5 years ago? Would it make a difference if the Christian Scientist had only converted 1 year ago? Would it matter that the person diagnosed with mental illness had numerous experiences with psychotropic medications? What about only one really bad experience?

The hypothetical questions could go on forever. The point is that if the autonomy of some but not others is to be respected, the distinctions must be drawn rationally, along lines of true differences. If a person is unequivocally delusional or believes that medications are poison or will give supernatural powers, then these would be classified as irrational and, hence, incompetent beliefs. Few would argue that such a person is incompetent to make treatment decisions. Contrast that to a failure to acknowledge the “benefits” of treatment. This only shows a disagreement with the science of medicine and a disagreement regarding the relative values of medication and symptoms.

\textbf{C. Rational Manipulation or Reasoning}

The MacArthur group defined \textit{rational manipulation or reasoning} as demonstration of certain “problem-solving abilities when faced with a decision about treatment

\textsuperscript{107}Id.

for a disorder."\textsuperscript{109} The problem-solving abilities included information seeking, consequential thinking, comparative thinking, complex thinking, generating consequences, weighting consequences, transitive thinking, and probabilistic thinking.\textsuperscript{110} Like their performances on the measures of "appreciation," the performances of individuals diagnosed with mental illness were poorer than the performances of persons who were medically ill but who were not diagnosed with mental illness.\textsuperscript{111}

Although there can be little doubt that the subtests on this portion of the MacArthur instruments do reflect problem solving and, therefore, "reasoning," there is a good deal of doubt that a deficit in these skills would justify the State imposition of involuntary psychotropic medication. The State interest in providing treatment to those who cannot obtain it for themselves need not reach this far into individual problem-solving abilities.

A deficit in problem-solving abilities is a feature common to many emotional disturbances. In fact, some clinicians and researchers would argue that almost every person who seeks outpatient psychotherapy has a deficit in problem-solving skills. This does not mean that the psychotherapy outpatient is incompetent to make treatment decisions. It simply means that training in problem-solving skills probably increases the person's ability to make better decisions and successfully live an independent and autonomous life.

It is true that the study participants with diagnoses of mental illness did not perform as well as those who were not diagnosed with mental illness. This is not a surprise. The important question is whether these skills are really necessary for treatment decision making. We do not believe that individuals must demonstrate average or better than average problem-solving skills in order for the State to accept that they do not want to tolerate the side effects of psychotropic medication. This decision is far simpler than one requiring such sophisticated skills as transitory reasoning or probabilistic reasoning. All that is necessary is for people to be able to make a decision for or against medication and for that decision to be based on something other than a delusion.

V. Due Process for Mental Health Treatment Refusers

Given that mental health treatment refusers are held to a higher standard for competency than either mental health treatment acceptors or medical health treatment decision makers, the likelihood of an erroneous determination of incompetency is impermissibly high. Furthermore, given that psychotropic medications are not a cure; may not be effective for some people; and have definite, predictable, and serious side effects, the risk of harm from an erroneous competency determination is also very high. Finally, considering the possibility that coerced treatment may actually lead to future treatment refusal, the State interest of providing treatment may be undermined rather than served.

Therefore, in light of the serious consequences of an erroneous competency determination, the State should erect substantial procedural safeguards to protect mental health treatment refusers from an erroneous competency determination. Thus far, states have developed a variety of procedural safeguards to protect mental health treatment refusers. Some are more protective than others.

\textsuperscript{109}MacArthur II, supra note 10, at 134–36.
\textsuperscript{110}Id.
\textsuperscript{111}MacArthur III, supra note 10, at 164–67.
The more critically essential safeguards include providing for judicial, rather than clinical or administrative, determination of competency; providing the full panoply of due process rights, including the right to be present, the right to present evidence, the right to cross-examine witnesses, the right to have a recording of the hearing, a right to a reasoned decision, and the right to appeal an unfavorable outcome; the use of a substituted judgment standard, rather than a best interests standard; a conservative time limit on any involuntary medication order; and frequent monitoring by a treatment guardian. Each of these procedural safeguards is discussed in turn.

A. Judicial Decision Makers

Social scientists and the Supreme Court have agreed that the diagnostic and treatment decisions made by mental health professionals are far from infallible.\textsuperscript{112} However, in a recent string of cases involving individual liberty in mental health treatment settings, the Supreme Court has consistently endorsed mental health professionals, rather than judges, as the preferred decision makers.\textsuperscript{113} On the surface, the Court's preference for mental health professionals over judges seems logical, perhaps even intelligent. After all, mental health professionals have more expertise in the area of mental illness than do judges.\textsuperscript{114}

However, familiarity and expertise in the area of mental illness do not contribute to fair or accurate legal decisions. If they did, judges would be trained in specialty areas, rather than the law. A judge need not understand chemistry to know whether a chemical company has liability to its ultimate consumers. The question of liability is strictly a legal question. Similarly, a judge need not understand mental illness to know whether an individual is competent to make treatment decisions. Like the question of liability, the question of competency is strictly a legal question.

Despite the generally accepted importance and value of adversarial proceedings for fair and accurate determination of legal decisions, not all states provide for a judicial hearing prior to involuntary medication.\textsuperscript{115} Maryland and Minnesota, for example, use an internal review committee rather than a judicial hearing.\textsuperscript{116} New York has instituted a surrogate decision committee/panel system, consisting of 12

\textsuperscript{112}"There can be little responsible debate regarding the 'uncertainty of diagnosis in this field and the tentativeness of professional judgment.'" O'Connor v. Donaldson, 422 U.S. 563, 584. "Critical literature and the new generation of social science evidence clearly support the Court's apprehension [about the ability of psychiatrists and psychologists to make sound clinical judgments]." Bersoff, \textit{supra} note 21, at 329.

\textsuperscript{113}See Bersoff, \textit{supra} note 21, at 329–33. Bersoff analyzed the Court's decisions in Parham v. J.R., 442 U.S. 584 (1979), Youngberg v. Romeo, 457 U.S. 307 (1982), and Washington v. Harper, 494 U.S. 210 (1990). In all three cases, the Court held that mental health professionals, rather than judges, were the appropriate decision makers, even though each case raised legal issues of individual liberty, rather than clinical decisions of diagnosis or preferred treatment.

\textsuperscript{114}In a review of general and clinical decision-making literature, Bersoff concluded that despite their expertise in the area of mental illness, mental health professionals are far from accurate in their clinical decisions. \textit{Id.} at 351–62.

\textsuperscript{115}Clinical judgment, as opposed to judicial decision making, is subject to biases in favor of treatment. \textit{See} Bersoff, \textit{supra} note 21, at 336–51.

\textsuperscript{116}Md. Code Ann., Health–Gen. \textsection 10–708 (panel consists of the clinical director of the psychiatric unit, a psychiatrist, and a nonphysician mental health professional—none of whom can be directly involved in the patient's treatment); Minn. Stat. \textsection 253.03(6c) (providing for a "multi disciplinary treatment review panel," but not specifying the membership criteria; also providing for judicial review).
committee members, appointed by the Commission on Quality of Care for the Mentally Disabled, four of whom serve on a panel at any one time. The panel is entitled to provide surrogate "consent" for the involuntary treatment if the panel finds that the treatment refuser is incompetent to make the decision and that the treatment is in the treatment refuser's best interest.

Although these administrative decision-making models provide for some elements of the adversarial process, they do not provide for law-trained, judicial decision makers. Research comparing law-trained decision makers to medical model decision makers reveals dramatic biases. The law-trained decision makers tend to estimate the frequency and severity of side effects from psychotropic medications at a much higher level than the medical model decision makers. It is interesting that research comparing psychiatrists to their patients reveals that, like the law-trained decision makers, mental health consumers estimate the likelihood and severity of side effects from psychotropic medications at higher levels than do psychiatrists. We can speculate as to the plausible explanations for these differences. Psychiatrists are trained and ethically bound to heal. Presumably, they are highly motivated to provide treatment and eliminate symptoms of disease and illness. Lawyers and other law-trained persons are trained and ethically bound to defend individuals against foreseeable harm and governmental deprivation of constitutionally protected rights. On the other hand, mental health consumers are motivated by neither of these noble callings; they are interested only in their own self-determined best interests.

Mental health consumers, the parties in interest and possibly least biased group in this analysis, estimate the side effects of psychotropic medication to be likely and severe. Lawyers, and law-trained decision makers, the potential agents of mental health consumers, tend to adopt the mental health consumers' perspective and set to work defending and protecting them from unwanted and unnecessary intrusions. In contrast, medical model decision makers are compelled to provide treatment and therefore may not make a reasoned decision as to the value of treatment to an individual. To the medical model decision maker, treatment is always best, and the medically determined "best" treatment is always desired over the less effective one. A subjective judgment by the mental health consumer that the side effects are worse than the symptoms is perceived as unreasonable per se if the "best" outcome is always "treatment" of the symptoms.

117 N.Y. Mental Hyg. Law § 80.05 (committees are composed of physicians, nurses, psychologists, or other health care professionals; former patients or parents, spouses, adult children, siblings or advocates of mentally disabled persons; attorneys; and other persons with recognized expertise or demonstrated interest in care and treatment of mentally disabled persons).

118 N.Y. Mental Hyg. Law § 80.01.

119 Harold Bursztajn et al., Medical and Judicial Perceptions of the Risks Associated with Use of Antipsychotic Medication, 19 BULL. AM. ACAD. PSYCHIATRY & L. 271, 273 (1991) (judges estimated a 62.5% probability of tardive dyskinesia, psychiatrists estimated 25%).

120 Finn et al., supra note 81, at 846–47. Patients and psychiatrists were asked to rate the discomfort associated with side effects of neuroleptic treatment and the discomfort associated with the symptoms of psychosis. On 24% of the side effects questions and on 20% of the symptoms of psychosis questions, psychiatric patients gave significantly higher ratings of discomfort than did psychiatrists. Id.

121 Lawyers must "act in a manner reasonably calculated to advance a client's lawful objectives, as defined by the client. . . ." RESTATEMENT OF LAW, 3D, LAW GOVERNING LAWYERS § 28(1) (1992).
This is not to say that a non-law-trained decision maker cannot be made to use a rights-oriented approach to competency determinations. However, without a strong commitment to individual rights, such as the one that develops through law training and judicial experience, a non-law-trained decision maker is susceptible to the biased recommendations of the psychiatrist who is seeking an order for involuntary treatment. Even the most vigilant defender of individual rights is influenced at some level by the prospect of doing what is in the "best interest" of the person who refuses treatment. The rights-oriented decision maker may consider the protection of individual liberty to be as much in the individual's best interests as is receipt of treatment.

B. Substituted Judgment Rather Than a Best Interests Test

Once a competency determination is made, the next issue becomes how to decide whether to refuse or consent to the treatment. In some states, a finding of incompetency is equivalent to a court order for the proposed treatment. The rationale seems to be that since the mental health consumer is incompetent, the mental health professional is permitted to make all the decisions for the incompetent person. Other states make a determination of the person's best interests along with the person's competency to make treatment decisions. In these states, the involuntary medication is only permitted if the person is incompetent and if the proposed treatment is in the patient's best interests.

In states more protective of individual autonomy, like Massachusetts, a substituted judgment standard is applied. Under the substituted judgment standard, the involuntary treatment is ordered by the court only if evidence exists that the person would have chosen to accept the treatment if he or she had been competent.

The substituted judgment standard is "subjective in nature . . . the goal is to determine with as much accuracy as possible the wants and needs of the individual involved." The court must consider the incompetent person's "actual interests and

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123 E.g., New Mexico and New York. N.M. Stat. § 43-1-15(B); N.Y. Mental Hyg. Law § 80.01.
Saikewicz involved a decision regarding whether chemotherapy should be administered to a profoundly retarded man who, the lower court found, was unable to understand the purpose of the treatment and would experience significant confusion and discomfort if it was administered and an earlier, but relatively peaceful, death if it was withheld. Id. at 432.

In Saikewicz, the Supreme Judicial Court of Massachusetts provided the following philosophical rationale for a substituted judgment standard:

Professor Robertson of the University of Wisconsin Law School argued that "maintaining the integrity of the person means that we act toward him 'as we have reason to believe [he] would choose for [himself] if [he] were [capable] of reason and deciding rationally.' It does not provide a license to impute to him preferences he never had or to ignore previous preferences . . . If preferences are unknown, we must act with respect to the preferences a reasonable, competent person in the incompetent's situation would have.' John A. Robertson, Organ Donations by Incompetents and the Substituted Judgment Doctrine, 76 COLUM. L. REV. 48, 63 (1976) (quoting JOHN RAWLRS, A THEORY OF JUSTICE 209 (1971)).

Id. at 431. Note, however, that this rationale, as well as the Saikewicz court's ultimate decision to withhold consent for chemotherapy, rests not on the individual's "actual interests and preferences," id. at 432, but rather on the objective standard of a reasonable person.
preferences” and arrive at the treatment decision “which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person.”

“This may or may not conform to what is thought wise or prudent by most people.”

In the absence of such evidence, some states revert to the best interests standard or the reasonable person standard. Like any surrogate decision-making process, each of these methods is offensive to individual autonomy and involves a degree of paternalism. However, the substituted judgment standard is, in theory, the least offensive.

In a philosophical analysis of coerced mental health treatment, Alan Wertheimer discussed the potential justifications for coercion, including “soft paternalism,” that is, paternalism justified by the assumption that the individual mental health treatment refuser is not making an autonomous or voluntary treatment refusal. The argument in favor of this “soft paternalism” is that the surrogate decision maker does not further an individual’s liberty by giving effect to decisions that do not reflect the individual’s underlying “true” preference.

True substituted judgment is not to be confused with retroactive approval, what Stone called “the thank you theory.” Rather, it is a variant of what Elyn Saks called the “different person theory.” Basically, the rationale is that one person may act like a different person because of psychological or emotional stresses.

C. Time Limitations

In addition to the requirements of a judicial decision maker and a substituted judgment standard for surrogate decision making, mental health treatment refusers must be protected from erroneous deprivation of their rights by implementation of conservative time limitations on involuntary medication orders. The State interest of providing treatment to those unable to obtain it for themselves does not outweigh the individual liberty interest in refusing medication if the order for involuntary treatment continues beyond the time at which competency is regained.

If psychotropic medication is going to effectively relieve symptoms of mental

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127. Id. at 431. In Saikewicz, the Supreme Judicial Court of Massachusetts ultimately found that Saikewicz would have refused the treatment, even though Saikewicz had never before been competent to make such a decision. The court considered six factors: Saikewicz’s age (he was elderly), probable side effects of treatment, a low probability of remission, the certainty that treatment would cause immediate suffering, Saikewicz’s inability to cooperate with the treatment (which would likely lead to his being physically restrained for administration of the chemotherapy), and the quality of life he would experience if the treatment was administered. Id.

128. Id. at 432 (emphasis added).

129. E.g., Illinois. In re Schapp, 654 N.E.2d 1084, 1087 ("When the patient's wishes have not been clearly proven, however, the court should be guided by an objective standard of reasonableness . . .").


131. Wertheimer gives the example of a person ignorantly walking across a bridge that is sure to collapse under his weight. Id. at 252.

132. Stone, supra note 8.


134. See Wertheimer, supra note 130, at 253.
illness that impair decision-making capacity, specifically delusions and confusion, it
does so in a relatively short time.135 Persons treated with antipsychotic medication
typically reach a therapeutic drug level within a few weeks, as do persons diagnosed
with bipolar disorder who are treated with lithium.136 Some persons who are
"treatment resistant" in the physical rather than intellectual sense may take longer.
However, rarely does it take longer than 6 weeks for a person who is going to respond
to medication to receive a therapeutic effect.137

Once lucidity is regained, competency should be restored. Most states have
placed time limits on involuntary medication orders, but only a minority of states
have made the time limit less than the date on which the involuntary commitment
order expires. Connecticut uses a 30-day limit if the involuntary treatment decision is
made by a physician without benefit of judicial review.138 If the involuntary treatment
decision is ordered by a court, it does not expire for 4 months.139 Idaho is the only
state that has instituted a time limit for involuntary medication that approaches a
standard of reasonableness. In Idaho an involuntary medication order expires at the
end of 7 weeks.140

Considering that most patients receive therapeutic benefit within 3 to 4 weeks,
the judicial order for involuntary medication should not last more than 4 weeks. At
the end of 4 weeks, the mental health consumer should reappear before the court. If
the individual is lucid, legal competency should be restored and the treatment
decision to continue or discontinue psychotropic medication should be made by the
individual. If the individual continues to be incompetent, the order for involuntary
treatment should be continued or discontinued in accordance with the substituted
judgment standard.

D. Frequent Monitoring

Any person subject to such an order for involuntary medication should be
monitored frequently for signs of serious side effects and for signs of therapeutic
effects of the medication. This monitoring should consist of weekly face-to-face
meetings between the person subject to the involuntary medication and a treatment
guardian. The treatment guardian should be someone who is entirely disinterested in
the continuation or discontinuation of medication (i.e., not a relative or loved one of
the patient and not an employee or member of the hospital’s professional staff).
Treatment guardians should keep records of their observations and interactions with
those subjected to the involuntary medication order, and these records should be
given to the court at the expiration of the order.

VI. Conclusion

Although the MacArthur instruments adopted the law as it exists, which we
believe is inconsistent with the Fourteenth Amendment, the instruments can have
significant value in the clinical setting. They have a vital role to play in enhancing

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135 See Brakel & Davis, supra note 5, at 450 ("It takes about three to four weeks to achieve substantial
improvement and approximately six weeks more to get optimal improvement.").

136 Id.

137 Id.


139 Conn. Gen. Stat. § 17a-543(g).

140 Idaho Code § 66-322(j).
self-determination rights. They can be used to identify and remedy decision-making deficits in mental health treatment refusers and acceptors.

If more mental health treatment providers and facilities had policies designed to identify and ameliorate decision-making deficits in mental health consumers, there would be far less to fear by way of coercive and potentially dangerous forms of mental health treatment. The consumer would be better informed and better able to make the understanding, appreciative, rational decision anticipated by the doctrine of informed consent. It is reasonable to predict that this could lead to stronger treatment alliances between doctors and mental health consumers. If that occurred, it is reasonable to expect more positive outcomes from mental health treatment.

Mental health laws should be designed to provide maximum benefits, including treatment, that increase the individual’s ability to function independently, without the need for extended future involvement with the mental health system. Unfortunately, many states adhere to unreasonably high standards for treatment decision-making competency and consequently undermine their potential abilities to increase autonomy and independence in persons diagnosed with mental illness.

If a state is concerned with providing treatment to those who cannot obtain it for themselves while respecting the right to self-determination of those who could obtain treatment but choose not to, the standards for competency must be lowered. The standards must reflect the actual deficits that cause persons diagnosed with mental illness to make decisions that they would not make if the symptoms of mental illness were less severe. Rather than testing persons diagnosed with mental illness for abilities and only respecting the independence of those who prove competency by passing a test based on tautological definitions of competency, the law should look for disabilities.

The only disabilities that justify the state’s imposition of involuntary medication are decisions clearly based on delusions, failure to comprehend information, and failure to evidence any choice (unconscious, catatonic, or rapidly changing decisions). To require standards any higher imposes a requirement of supercompetency that is not required of any other group of health care decision makers.

To protect mental health consumers against erroneous competency determinations, the law must provide for judicial hearings with the full panoply of procedural rights. To place this kind of decision in the hands of an individual unduly impressed with the beneficence of the medical model is to place the fox in charge of the henhouse. The fox simply cannot appreciate the hens’ point of view or right to be left alone. Orders for involuntary medication must be time limited, and this time limit must be set in accordance with what is known about the time needed for therapeutic effect. When a therapeutic effect is achieved, legal competency should be restored, and the individual must be given a new opportunity to make a “competent” decision to continue or discontinue medication. During any period of involuntary medication, an impartial treatment guardian must monitor the individual subjected to the order with weekly face-to-face meetings. A report of the guardian’s observations must be provided to the court before any hearing for renewal of the order.

To be sure, this is a tall order. It takes much autonomy from physicians and other mental health care providers and gives much autonomy to mental health consumers. However, ours is a country founded on the right to be left alone.141 Ours is a country in which we are permitted to make unlimited bad decisions as long as we do not hurt

141 “Experience should teach us to be most on our guard to protect liberty when the Government’s purposes are beneficent.” Olmstead v. United States, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting).
anyone but ourselves. Ours is a country in which we are permitted to be as crazy as we
want to be—at least until diagnosed by a mental health professional. Ours is a
country that should not tolerate state-mandated treatment without a showing of a
truly compelling government interest that cannot be served by any less restrictive
means.

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