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## MENTAL HEALTH LAW: THREE SCHOLARLY TRADITIONS

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For the last quarter-century there has been considerable court activity in the arena of mental health law, much of it based on federal and state constitutions.<sup>1</sup> As in other areas of law, advocates for the civil rights of patients made more strides earlier in this period than later.<sup>2</sup> On the other hand, antidiscrimination and provision-of-benefits-type actions have made

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1. On civil commitment, substantive and procedural, see, for example, *Addington v. Texas*, 441 U.S. 418, 419 (1979); *O'Connor v. Donaldson*, 422 U.S. 563, 565 (1975). On criminal commitment, see, for example, *Foucha v. Louisiana*, 504 U.S. 71, 73 (1992); *United States v. Jones*, 463 U.S. 354, 356 (1983). On sexual predator commitment, see *Kansas v. Hendricks*, 521 U.S. 346 (1997). On right to refuse medication, there are two U.S. Supreme Court cases in the criminal area. See *Riggins v. Nevada*, 504 U.S. 127, 129 (1992); *Washington v. Harper*, 494 U.S. 210, 213 (1990). In the civil arena, the Court has remanded these cases. See, e.g., *Rennie v. Klein*, 458 U.S. 1119 (1982); *Mills v. Rogers*, 457 U.S. 291, 293 (1982). There are a considerable number of state law cases granting competent patients the right to refuse medication. See, e.g., *Mills*, 457 U.S. at 293; *Riese v. St. Mary's Hosp. & Med. Ctr.*, 271 Cal. Rptr. 199, 201 (1987); *Rivers v. Katz*, 495 N.E.2d 337, 339 (N.Y. 1986). Right-to-treatment cases did not get too far, see *Youngberg v. Romeo*, 457 U.S. 307, 309 (1982), although there may now be impetus under the Americans with Disabilities Act (ADA) to provide care in the community. See, e.g., *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 583 (1999). There have also been civil cases about restraints and seclusion. See, e.g., *Youngberg*, 457 U.S. at 309. On confidentiality, see *Speaker v. County of San Bernardino*, 82 F. Supp. 2d 1105, 1106 (C.D. Cal. 2000). On duty to warn, see, for example, *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334, 339 (Cal. 1976). And there have been criminal cases on the guilty-but-mentally-ill plea, e.g., *People v. Crews*, 522 N.E.2d 1167, 1169 (Ill. 1988), on the right to an expert in an insanity case, e.g., *Ake v. Oklahoma*, 470 U.S. 68, 70 (1985), and on competency to be executed, e.g., *Ford v. Wainwright*, 477 U.S. 399, 401 (1986).

2. Compare, e.g., *O'Connor*, 422 U.S. at 576 (adopting autonomy-protective standard for civil commitment in 1975), with *Washington*, 494 U.S. at 236 (adopting paternalistic standard for prisoners refusing medication in 1990).

more headway, largely as a result of federal legislation interpreted liberally by the courts.<sup>3</sup>

This article will not trace the development of the case and statutory law in this arena, but rather three traditions of mental health law scholarship. These are doctrinal treatments, therapeutic jurisprudence treatments, and philosophical treatments of mental health law issues. After discussing these three traditions, I will locate myself within the third, discussing both some of my work to date and future work I propose in the area of competency and responsibility.

## I. THREE TRADITIONS OF MENTAL HEALTH LAW SCHOLARSHIP

As I noted, there are three central traditions of scholarship in mental health law: doctrinal constitutional scholarship focusing on rights, therapeutic jurisprudence scholarship focusing on the therapeutic implications of different laws, and theoretical scholarship focusing on philosophical issues underpinning mental health law.

### A. DOCTRINAL CONSTITUTIONAL SCHOLARSHIP

The first tradition, doctrinal constitutional law scholarship, was quite prominent at the beginning of the mental health rights movement,<sup>4</sup> although this is not to say that many do not continue to work in this tradition.<sup>5</sup> Arguments tended to be framed in doctrinal terms. A right to refuse treatment, for example, was based in a Fourteenth Amendment privacy

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3. For litigation under the ADA, see, for example, *Olmstead*, 527 U.S. at 583; Kathleen S. v. Dep't of Pub. Welfare, 10 F. Supp. 2d 460, 462 (E.D. Pa. 1998); *Doe v. Stincer*, 990 F. Supp. 1427, 1428 (S.D. Fla. 1997). For litigation under the Individual Disabilities Education Act (formerly the Education for All Handicapped Children Act), see, for example, *J.B. v. Killingly Bd. of Educ.*, 990 F. Supp. 57, 61 (D. Conn. 1997); *Unified Sch. Dist. No. 1 v. Dep't of Educ.*, 1999 WL 74531 (Conn. Super. Ct. 1999).

4. See, e.g., Alexander D. Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 179, 190-91 (1980); Alexander D. Brooks, *The Right to Refuse Antipsychotic Medications: Law and Policy*, 39 RUTGERS L. REV. 339 (1987); George E. Dix, *Major Current Issues Concerning Civil Commitment Criteria*, 45 LAW & CONTEMP. PROBS. 137 (1982); George E. Dix, *The 1983 Revision of the Texas Mental Health Code*, 16 ST. MARY'S L.J. 41 (1984); Robert Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U. L. REV. 461 (1978); Bruce J. Winick, *Legal Limitations on Correctional Therapy and Research*, 65 MINN. L. REV. 331 (1981); Bruce J. Winick, *Restructuring Competency to Stand Trial*, 32 UCLA L. REV. 921 (1985); Bruce J. Winick, *The Right to Refuse Mental Health Treatment: A First Amendment Perspective*, 44 U. MIAMI L. REV. 1 (1989) [hereinafter *Right to Refuse*].

5. E.g., BRUCE J. WINICK, *THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT* (1997).

claim,<sup>6</sup> a First Amendment right to mentation claim,<sup>7</sup> or an Eighth Amendment cruel and unusual punishment claim.<sup>8</sup> The various constitutional bases for different rights were explored, and courts indeed closely followed the scholarship in this area.<sup>9</sup>

Of course, the Court (and courts) changed, and advocates became much more ambivalent about articulating federal constitutional bases to support the civil liberties of psychiatric patients. Simply put, the Federal Constitution was interpreted in such a way that it was not too protective of patients' rights.<sup>10</sup>

Nevertheless, some legal scholars continued to write in this doctrinal tradition, framing their arguments on state constitutional, common law, or statutory grounds.<sup>11</sup> Or perhaps they were hoping for a change in the courts again, such that the federal constitutional arguments they were advancing would be better received. Some doctrinal scholars tried to put the most favorable spin on the Supreme Court's mental health law jurisprudence, hoping to influence further cases on doctrinal grounds.<sup>12</sup> In addition, new laws, such as the American with Disabilities Act (ADA), created new opportunities for doctrinal scholars to frame legal arguments in order to achieve the results they thought best.<sup>13</sup>

In sketching this history, I do not mean to imply that mental health law scholars were primarily advocates and, therefore, not scholars. Many had a law reform agenda, but were likely putting forward the interpretation of the Constitution they thought to be correct and best justified normatively. But the fact that these scholars framed their arguments in

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6. E.g., WINICK, *supra* note 5, at 193–94; Fakre Gibson, *A Bright Thread for California's Legal Crazy-Quilt: A Proposed Right to Refuse Antipsychotic Drugs*, 22 U.S.F. L. REV. 341, 370–73, 379 (1988); Plotkin, *supra* note 4, at 491.

7. E.g., Michael H. Shapiro, *Legislating Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 S. CAL. L. REV. 237 (1973); Winick, *Right to Refuse*, *supra* note 4, at 132–51.

8. E.g., Plotkin, *supra* note 4, at 491–92.

9. See, e.g., Lessard v. Schmidt, 413 F. Supp. 1318, 1319 (E.D. Wis. 1976).

10. Consider, for example, the Supreme Court's jurisprudence on the right to refuse medication compared with state law claims. See cases cited *supra* note 1.

11. E.g., Jessica Litman, Note, *Common Law Remedy for Forcible Medication of the Institutionalized Mentally Ill*, 82 COLUM. L. REV. 1720, 1738–43 (1982).

12. E.g., 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 (1993); Bruce J. Winick, *The Side Effects of Incompetency Labeling and the Implications for Mental Health Law*, 1 PSYCHOL. PUB. POL'Y & L. 6 (1995).

13. E.g., SUSAN STEFAN, *UNEQUAL RIGHTS: DISCRIMINATION AGAINST PEOPLE WITH MENTAL DISABILITIES AND THE AMERICANS WITH DISABILITIES ACT* (2001).

terms of doctrine meant that the arguments could be used practically by advocates in actual cases.

Thus, the first tradition of mental health law scholarship was doctrinal—in particular, constitutional. For the most part, the arguments advanced were civil libertarian and, thus, quite focused on rights. While some continue to write in this tradition, most of the doctrinal arguments have been well rehearsed, and appear, at least with the current Court, not to have carried the day.

### B. THERAPEUTIC JURISPRUDENCE SCHOLARSHIP

The second tradition of mental health law scholarship is quite different from the first. Unlike the constitutional scholarship, this tradition is of recent vintage. Dubbed “therapeutic jurisprudence,” its agenda is to explore the therapeutic dimensions of various laws.<sup>14</sup> At the inception of the therapeutic jurisprudence movement, traditional mental health law issues were looked at through this lens,<sup>15</sup> but over time all manner of issues came to be scrutinized in this way.<sup>16</sup>

One might have thought that practitioners of therapeutic jurisprudence would tend to be paternalists, because they seemed to care so much about the therapeutic implications of a law; but that is not how this school played out. Often writers in this tradition argued that what would be therapeutic was also most protective of autonomy. For example, a right to refuse treatment serves patients’ therapeutic interests, because it is mostly willing patients who benefit from treatment anyway.<sup>17</sup> Further, incompetency findings should be made sparingly, because they are stigmatizing and,

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14. *E.g.*, DAVID B. WEXLER & BRUCE J. WINICK, LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE 1 (1996); Dennis P. Stolle, David B. Wexler, Bruce J. Winick & Edward A. Dauer, *Integrating Preventive Law and Therapeutic Jurisprudence: A Law and Psychology Based Approach to Lawyering*, 34 CAL. W. L. REV. 15 (1997); David B. Wexler, *The Development of Therapeutic Jurisprudence: From Theory to Practice*, 68 REV. JUR. U.P.R. 691 (1999) [hereinafter *Theory to Practice*]; David B. Wexler, *Redefining the Insanity Problem*, 53 GEO. WASH. L. REV. 528 (1985); David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence and Criminal Justice Mental Health Issues*, 16 MENTAL & PHYSICAL DISABILITY L. REP. 225 (1992); Bruce J. Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 J. CONTEMP. LEGAL ISSUES 37 (1999).

15. *See, e.g.*, DAVID B. WEXLER & BRUCE J. WINICK, ESSAYS IN THERAPEUTIC JURISPRUDENCE 3–38 (1991); Wexler, *Theory to Practice*, *supra* note 14, at 691.

16. *See, e.g.*, Ellen Waldman, *The Evaluative-Facilitative Debate in Mediation: Applying the Lens of Therapeutic Jurisprudence*, 82 MARQ. L. REV. 155 (1998); Patricia Monroe Winsom, Note, *Probate Law and Mediation: A Therapeutic Perspective*, 37 ARIZ. L. REV. 1345 (1995).

17. *See, e.g.*, WINICK, *supra* note 5, at 328–38.

therefore, do not contribute to a patient's therapeutic interests.<sup>18</sup> Indeed, many who came to the therapeutic jurisprudence school were originally in the constitutional scholarship camp and shared the agenda of that camp.<sup>19</sup>

Therapeutic jurisprudence explicitly fashioned itself as having a law-reform agenda.<sup>20</sup> All other things being equal, we should strive to make law as therapeutic as possible. Therapeutic proponents would also make the other side see, so to speak, that what the rights theorists wanted would also serve the interests central to the paternalists: patients' therapeutic interests.<sup>21</sup> Indeed, some saw proponents of therapeutic jurisprudence as advocates, rather than scholars—at least as much as some saw the constitutional scholars as advocates.

In certain hands, therapeutic jurisprudence could also lead to the opposite outcome: letting us do what is therapeutically best for the patient notwithstanding his autonomy interests. For instance, if you care most about therapeutic benefits, it is arguable that you make people take medication even though that trenches on their autonomy and makes them feel bad, because forced medication works well enough that the pain of not being listened to is outweighed by the treatment benefits. A paternalist slant is certainly a danger of the therapeutic jurisprudence lens.

This brings me to my last point about therapeutic jurisprudence: It is utterly nonnormative.<sup>22</sup> Above I said that all other things being equal, we should strive to make laws as therapeutic as possible. But all other things are rarely equal. And when a patient's treatment interests conflict with his autonomy interests, how do we decide which to prefer? Therapeutic jurisprudence offers no answer to this question.

Not all scholarly traditions need to be normative to be valuable, and therapeutic jurisprudence has had and continues to have some useful things to say. But it remains somewhat disappointing that the tradition gives no guidance as to the degree of importance of therapeutic interests. And without the normative orientation, one wonders what is jurisprudential

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18. See Bruce J. Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection*, 28 HOUS. L. REV. 15, 46–53 (1991).

19. Compare WINICK, *supra* note 5 (doctrinal account of right to refuse treatment), with Winick, *supra* note 14 (therapeutic jurisprudence account of civil commitment), and Winick, *supra* note 18 (therapeutic jurisprudence account of assent to treatment).

20. See, e.g., Stolle, *supra* note 14, at 36–37; Bruce J. Winick, *The Jurisprudence of Therapeutic Jurisprudence*, 3 PSYCHOL. PUB. POL'Y & L. 184, 192 (1997).

21. See Winick, *supra* note 20, at 191–92.

22. See Stephen H. Behnke & Elyn R. Saks, *Therapeutic Jurisprudence: Informed Consent as a Clinical Indication for the Chronically Suicidal Patient with Borderline Personality Disorder*, 31 LOY. L.A. L. REV. 945, 980–81 (1998).

about therapeutic jurisprudence.<sup>23</sup> Perhaps it is even a school of scholarship best practiced by clinicians.

### C. THEORETICAL SCHOLARSHIP

The third tradition of mental health law is more theoretical than the other two. It has tended to focus more on philosophical issues raised by mental health such as autonomy versus paternalism, the nature of mental illness, what it is to be a person, and responsibility and competency.<sup>24</sup> For instance, Stephen Morse has discussed responsibility,<sup>25</sup> including volitional tests of insanity.<sup>26</sup> And Michael Moore has discussed the nature of mental illness, responsibility, and the unity of the self.<sup>27</sup>

At its best, this tradition has laid the normative groundwork for the first two traditions. A due process analysis of a right to refuse medication is, or should be, founded on some notion of when autonomy should prevail over the patient's interests in well-being. While the constitutional scholars framed the argument in doctrinal terms, the philosophical scholars talked about the important values that underlay such a focus. In the same way, proponents of therapeutic jurisprudence may tell us when a particular procedure is therapeutic, while the philosophical theorists should help us see how to adjudicate the dispute when therapeutic interests conflict with justice.

Indeed, scholars in the third tradition have focused on those issues which should help us decide when a rights-based civil libertarian focus is appropriate (the first tradition) and when we should be concerned primarily with the patient's treatment interests (in some hands, the second tradition). For this genre of scholarship has a considerable amount to say about not only autonomy and paternalism, but also personhood, responsibility, and competency, as well as their relationship to each other. Indeed, it is arguable that when the patient is a "person," a full moral agent, and therefore competent to make choices, then, and only then, should we support her autonomy.

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23. *See id.*

24. *See, e.g.,* MICHAEL S. MOORE, LAW AND PSYCHIATRY: RETHINKING THE RELATIONSHIP (1984); Stephen J. Morse, *Crazy Reasons*, 10 J. CONTEMP. LEGAL ISSUES 189 (1999); Elyn R. Saks, *Competency to Refuse Psychotropic Medication: Three Alternatives to the Law's Cognitive Standard*, 47 U. MIAMI L. REV. 689 (1993) [hereinafter *Refuse Psychotropic Medication*]; Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945 (1991) [hereinafter *Refuse Treatment*].

25. Morse, *supra* note 24, at 190–204.

26. Stephen J. Morse, *Culpability and Control*, 142 U. PA. L. REV. 1587 (1994).

27. MOORE, *supra* note 24, at 155–216, 249–383, 387–415 (respectively).

These then are three important traditions in mental health law scholarship, and each has contributed in some way to doctrinal developments in the law. Additionally, each has contributed to our theoretical understanding quite apart from its practical implications for the law, which has been of utmost importance as well.<sup>28</sup>

## II. A PROPOSAL FOR FUTURE WORK IN THE THIRD TRADITION

My own work is located mostly in the third tradition.<sup>29</sup> I will elaborate briefly on two contributions I have made to this tradition: on competency to make treatment decisions<sup>30</sup> and on the criminal

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28. Of course I do not mean to imply that these are the only mental health law traditions of scholarship. For instance, some scholars (often in the hermeneutic tradition) have focused on the contribution of psychoanalysis, and different versions of psychoanalysis, to the law. *E.g.*, David S. Caudill, *Freud and Critical Legal Studies: Contours of a Radical Socio-Legal Psychoanalysis*, 66 IND. L.J. 651 (1991). Some critical legal realists have written in the area attempting to deconstruct certain concepts and focus our attention more on relationships. *E.g.*, Caudill, *supra*, at 651; Duncan Kennedy, *Distributive and Paternalist Motives in Contract and Tort Law, with Special Reference to Compulsory Terms and Unequal Bargaining Power*, 41 MD. L. REV. 563 (1982). And some psychologists have made important contributions to our understanding of eyewitness testimony and juries through purely empirical research. *E.g.*, ELIZABETH F. LOFTUS & GARY L. WELLS, *EYEWITNESS TESTIMONY: PSYCHOLOGICAL PERSPECTIVES* (1984); Phoebe C. Ellsworth, *Are Twelve Heads Better Than One?*, 52 LAW & CONTEMP. PROBS. 205 (1989). Also in the empirical vein are those scholars who work on child testimonial capacity and childhood abuse and neglect. *E.g.*, Thomas D. Lyon & Jonathan J. Koehler, *The Relevance Ratio: Evaluating the Probative Value of Expert Testimony in Child Sexual Abuse Cases*, 82 CORNELL L. REV. 43 (1996); John E.B. Myers, *The Child Witness: Techniques for Direct Examination, Cross-Examination, and Impeachment*, 18 PAC. L.J. 801 (1987). For an especially insightful look at abuse and neglect through a psychoanalytic lens, see JOSEPH GOLDSTEIN, ALBERT J. SOLNIT, SONJA GOLDSTEIN & ANNA FREUD, *THE BEST INTERESTS OF THE CHILD: THE LEAST DETRIMENTAL ALTERNATIVE* (1996). In addition, there are those studies bringing cognitive psychology to bear on the law. *E.g.*, Edward J. McCaffery, Daniel J. Kahneman & Mathew L. Spitzer, *Framing the Jury: Cognitive Perspectives on Pain and Suffering Awards*, 81 VA. L. REV. 1341 (1995); Richard E. Redding, *How Common-Sense Psychology Can Inform Law and Psychological Research*, 5 U. CHI. L. SCH. ROUNDTABLE 107 (1998); Dan Simon, *A Psychological Model of Judicial Decision Making*, 30 RUTGERS L.J. 1 (1998). Still, the three traditions I describe are important traditions in mental health law.

29. *See, e.g.*, ELYN R. SAKS WITH STEPHEN H. BEHNKE, *JEKYLL ON TRIAL: MULTIPLE PERSONALITY DISORDER AND CRIMINAL LAW* (1997); Saks, *Refuse Psychotropic Medication*, *supra* note 24; Saks, *Refuse Treatment*, *supra* note 24. I am also in the process of completing a book on the normative dimensions of forced treatments of a variety of kinds in the mental health context. ELYN R. SAKS, *LAW, ETHICS, AND SEVERE MENTAL ILLNESS: QUESTIONING OUR VALUES* (forthcoming 2001).

30. *See* Elyn R. Saks, *Competency to Decide on Treatment and Research: The MacArthur Capacity Instruments*, in 2 NAT'L BIOETHICS ADVISORY COMM'N, *RESEARCH INVOLVING PERSONS WITH MENTAL DISORDERS THAT MAY AFFECT DECISIONMAKING CAPACITY* 59 (1999) [hereinafter *MacArthur Capacity Instruments*]; Saks, *Refuse Psychotropic Medication*, *supra* note 24; Saks, *Refuse Treatment*, *supra* note 24; Elyn R. Saks & Stephen H. Behnke, *Competency to Decide on Treatment and Research: MacArthur and Beyond*, 10 J. CONTEMP. LEGAL ISSUES 103 (1999).

responsibility of people with multiple personality disorder (MPD).<sup>31</sup> I will then sketch a current project extending my research on treatment capacity and some ideas about the civil capacity (as opposed to the criminal responsibility) of people with MPD, which is something I would like to focus on in a more systematic way in my future work.

#### A. TREATMENT CAPACITY

I have long retained an interest in treatment capacity. In my first article after beginning to teach law, I discussed several standards of treatment capacity, and endorsed one that required an understanding of relevant information and the formation of no “patently false beliefs” (PFBs).<sup>32</sup> I controversially argued that denial of mental illness did not amount to a patently false belief. I then contributed to a symposium on treatment capacity, where I wrote about noncognitive standards and argued against adopting them.<sup>33</sup>

More recently, the field has been advanced considerably by the MacArthur Mental Health Law Network researchers, one of whose topics has been treatment capacity.<sup>34</sup> The MacArthur researchers identify four abilities arguably necessary for capacity and study them empirically. I have criticized the MacArthur research in two further articles, arguing that they need to address the important normative questions raised by a capacity instrument, that they indeed smuggle in normative judgments while denying doing so, and that their “appreciation” instrument is flawed.<sup>35</sup>

Their appreciation instrument (the Perceptions of Disorder Instrument or the POD) is flawed, I argue, because it essentially requires agreement with one’s doctor about one’s diagnosis and prognosis with and without treatment. Such an approach is misguided. For example, it ignores the possibility that the patient could believe an earlier doctor’s diagnosis. It is implausible to make an individual doctor the final authority on truth. What would become of second opinions if we were to do so?<sup>36</sup>

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31. See SAKS WITH BEHNKE, *supra* note 29; Elyn R. Saks, *The Criminal Responsibility of People with Multiple Personality Disorder*, 66 PSYCHIATRIC Q. 169 (1994); *Does Multiple Personality Disorder Exist? The Beliefs, the Data, and the Law*, 17 INT’L J.L. & PSYCHIATRY 43 (1994); *Integrating Multiple Personalities, Murder, and the Status of Alters as Persons*, 8 PUB. AFF. Q. 169 (1994); *Multiple Personality Disorder and Criminal Responsibility*, 25 U.C. DAVIS L. REV. 383 (1992).

32. See Saks, *Refuse Treatment*, *supra* note 24, at 455–56, 962–65, 984–92.

33. See Saks, *Refuse Psychotropic Medication*, *supra* note 24.

34. See Saks & Behnke, *supra* note 30, at 106–07 n.5.

35. See Saks, *MacArthur Capacity Instruments*, *supra* note 30; Saks & Behnke, *supra* note 30.

36. See Saks, *MacArthur Capacity Instruments*, *supra* note 30, at 69–71; Saks & Behnke, *supra* note 30, at 117–18.

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The MacArthur researchers' clinical instrument, the MacArthur Competence Assessment Tool for Treatment (MacCAT-T), is somewhat of an improvement, because it focuses on beliefs that grossly distort reality as opposed to simply disagreeing with one's doctor's beliefs. However, it makes no effort to operationalize that concept.<sup>37</sup> Thus, I suspect that reliability and validity will suffer as a result. I am also concerned that, even with this language, most denials of mental illness will unjustifiably be taken to vitiate capacity.

In response to the flaws of the MacArthur instrument and other instruments on appreciation, my collaborators at the University of California, San Diego School of Medicine<sup>38</sup> and I are developing a new instrument to measure appreciation that will redress some of these problems. In particular, our development of the concept of a PFB to measure the adequacy of the patient's beliefs goes a long way in addressing the problems posed by requiring true beliefs according to the individual doctor.

What does our instrument, which makes use of this concept of a PFB, look like? We are aiming our instrument in the first instance at decisions to participate in psychiatric research. There are two versions of our instrument: one relating to "direct benefit" psychiatric research and the other to "no direct benefit" psychiatric research. The instruments start with a very simple informed consent form, different parts of which are labeled and cover the standard items, including those items which are research-specific. A questionnaire with fourteen questions is then administered to the subject. At the end, there are five more open-ended questions that try to get at the same things in a different way.

To take a closer look at what our instrument asks, our "direct benefit" instrument has four questions that relate to the nature of the procedure, four to risks and benefits, one to the status of the researcher, four to the status of the subject, and one to voluntariness. For example, under the nature of the procedure, subjects are asked whether they understand they will be undergoing a randomized clinical trial. Under risks and benefits, subjects are asked if they understand that nothing terrible or supernatural will happen depending on their choice. Under the status of the subject, subjects are asked if they understand that they do not have special powers that will

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37. See Saks, *MacArthur Capacity Instruments*, *supra* note 30; Saks & Behnke, *supra* note 30, at 123-24.

38. Dilip Jeste, Laura Dunn, Laurie Lindamer, Barbara Marshall, and Larry Schneiderman are foremost among them.

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protect them from harm. Under voluntariness, they are asked if they realize they can say “no” to the procedure. Then there are the five more open-ended questions that get at the same things in a slightly different way.

Detailed scoring instructions say which beliefs should vitiate consent and make use of a residual category of any PFB. Unlike the MacCAT-T, we provide an operational definition of a PFB and a series of a couple dozen examples of delusional beliefs with a discussion of why they are or are not PFBs. Subjects who, in any of their answers, evidence one of the impermissible beliefs or any other PFB are deemed incapable. Of course, the PFB must relate to the research and must have an effect on the subject’s decision. And there are questions at the end of the instrument probing the relation of the suspect answers to the subjects’ decisions.

We have begun administering our instrument in a pilot study and intend to administer the instrument to fifty middle-aged and older inpatients with a psychotic disorder, fifty middle-aged and older outpatients with a psychotic disorder, and fifty matched normal controls. We will not now be studying subjects about to embark on a research protocol, but will ask subjects to act as if they were about to embark on the research protocol that we describe in our informed consent. Thus a “vignette” procedure will be used. The instrument will be administered twice within a few days of each other by two different evaluators to test for inter-rater and test-retest reliability.

We hope to learn a number of things from our pilot study. For one, we want to refine our instrument as a result of the study. Are all the items needed? Are any duplicative? Are any outliers? Do the closed-ended and open-ended questions get at the same things, or does one set do a better job than the other, or are they best when both are administered? Moreover, does the test achieve good inter-rater reliability and good test-retest reliability? Equally important are what are our preliminary findings on how patients with psychosis and matched controls fare on this capacity measure. Do any other demographic variables explain our results?

After we refine our instrument, we want to do a much larger study with a much larger subject group. In our larger study we want to compare patients with schizophrenia, other psychotic disorders, depression, and some chronic medical condition such as ischemic heart disease, as well as normal controls, to see how they fare on our measure. We want to study such patients at different stages of their illness, such as acute, decompensating, and in remission. Thus, we would study both inpatients

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and outpatients and hope to enroll some of the same patients in both conditions.

Once again, we will want to collect data on reliability—inter-rater and test-retest. We will also again want to see how different populations compare on the measure—different in terms of diagnosis, phase of illness, and other demographic variables. We will probably want to compare the results on our instrument with the results on the MacArthur instrument measuring appreciation and a clinical capacity exam. In this way, we will test for consistency among measures and, thus, move towards establishing the validity of our instrument.

Eventually, we will want to study subjects about to undergo research, and their appreciation of the issues involved in the research they are about to undergo. This will, of course, require adapting our instrument to the particular research about to be undertaken by the subjects. In the course of doing this, we hope to explore ways to help clinical evaluators to devise quickly an instrument modeled on ours and tailored to the specific information pertinent to their project.

Our final hope is to be able to construct a normatively justified, psychometrically sound, and easily administrable instrument to measure the appreciation component of capacity to decide on treatment or research. Capacity to consent to treatment and research is immensely important. I hope our project furthers thinking and greater public debate about this important issue.

#### B. CRIMINAL RESPONSIBILITY OF PEOPLE WITH MULTIPLE PERSONALITY DISORDER

Another contribution I have made to the third tradition of research in mental health law is on the criminal responsibility of people with MPD.<sup>39</sup> Like competency, responsibility is a crucial feature of moral agency. Indeed, responsibility can be thought of as competency to commit a crime.

Our standard accounts of criminal responsibility do not speak to MPD. Typically, insanity refers to a condition in which persons have a cognitive or volitional impairment which prevents them either from knowing or being able to control what they are doing.<sup>40</sup> But people with MPD are often cognitively and volitionally intact at any one given time. However,

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39. See sources cited *supra* note 31.

40. See DONALD H.J. HERMANN, MENTAL HEALTH AND DISABILITY LAW 262–65 (1997).

over time they are simply so divided that it may be wrong to see them as single, responsible agents.

To consider the criminal responsibility of people with MPD, I first evaluate three different ways of conceptualizing alter personalities: as people by the best criteria of personal identity, as personlike centers of consciousness, or as nonpersonlike parts of a deeply divided person. I conclude that the jury is still out on how best to conceptualize alter personalities.<sup>41</sup>

Still, when considering criminal responsibility of these people on each of the three accounts, I conclude that most people with MPD should be found nonresponsible. If alters are people, then it is unjust to punish any innocent alters. Recall the law's edict that it is better to let ten guilty people go free than to punish one innocent person. If alters are personlike centers of consciousness, then, since alters are as capable of guilt and of innocence and of suffering from punishment as persons are, we shouldn't punish innocent alters any more than we should punish innocent persons. If alters are nonpersonlike parts, multiples are often still nonresponsible. Just as in the case of sleepwalkers or those acting under posthypnotic suggestion, multiples are not sufficiently integrated to make it just to hold them responsible. Since much of the person cannot be brought to bear on whether the act occurs, it is not, in a sense, *the person's* act.<sup>42</sup>

I, therefore, conclude that unless all alters acquiesced in the crime—i.e., were complicit, or could have stopped the act but did not—the multiple should be nonresponsible. Interestingly, it is not all that uncommon for multiples to have all of their alters acquiescing in a crime.<sup>43</sup>

### C. CIVIL RESPONSIBILITY OF PERSONS WITH MULTIPLE PERSONALITY DISORDER

In my book on MPD and the criminal law, I also look at other criminal law issues, such as competency to stand trial and competency to be executed.<sup>44</sup> However, I in no way look at civil capacities. What is it for a multiple to be able to consent to treatment, enter a contract, write a will, or be parentally fit? Need all the alters agree to such a decision, as I claim they must in the criminal arena?

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41. SAKS WITH BEHNKE, *supra* note 29, at 39–66.

42. *Id.* at 67–105.

43. *Id.* at 106–40.

44. *Id.* at 141–71.

Although these are questions that I need to think about more, I nevertheless have a few thoughts to share for now. First, it does not seem to me that we must take the same position for criminal responsibility and civil competencies. These are different contexts with wholly different purposes, and there may be reasons for taking a different position in one context than in the other. The same is true for the different civil competencies. For example, given the need for the security of transactions, we may have a different competency standard for contracts than for wills.<sup>45</sup>

In the criminal law context, finding the person nonresponsible allows the justice system to accomplish most of the purposes of the criminal law without compromising the principle that only the guilty shall suffer punishment. We simply confine the person in a nonretributive institution. By contrast, finding a person generally incompetent means that he loses all decisional authority. The consequences are simply much greater, and it is not possible to satisfy most of the goals of the civil law while finding the person generally incompetent.

Indeed, even in the context of imposing punishment, we may have different rules for what the state may impose than for what individuals, like therapists, children, or parents, may impose. For example, parents can punish their young children, even though the law would never hold them criminally accountable for their actions. In the same way, it may be wrong for the state to imprison an innocent alter, but perfectly fine for a therapist to hold an alter accountable for what another alter does. Staff in psychiatric hospitals can seclude an acting-out multiple even if all of her alters are not acting out. Both the contexts and the principles governing acceptable actions are different.<sup>46</sup>

But then what should the rule for civil competency be in the case of MPD? Because, as noted above, different civil competencies may call for different rules, let us focus on one: capacity to decide on treatment. When a doctor decides a person with MPD needs antidepressants because the patient seems depressed across all alters, can the doctor simply take the

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45. See, e.g., *In re Estate of Dokken*, 604 N.W.2d 487, 491–95 (S.D. 2000).

46. See *SAKS WITH BEHNKE*, *supra* note 29, at 136–40.

If another example of the context-bound nature of most of our normative concepts is needed, consider, for example, the concept of a person. Depending on the context, we may have quite different views about whether an entity is a person. For instance, an alter should arguably be construed as a person for purposes of the criminal law, but not for purposes of getting unemployment benefits. And this could be justified because the multiple does the work of only one person notwithstanding her different alters. Or as another example, we should hold multiples to be only one person for purposes of voting, if for no other reason than that the possibilities of fraud are otherwise too great. Context is immensely important.

patient's assent at that moment to be valid consent? Or does the doctor need all of the alters to consent? What about an individual alter's refusing? In such cases should a guardian be appointed to make decisions like these?

The argument in favor of requiring all of the alters to decide is the same as that in the criminal law context: We should not burden "innocent," nonassenting alters with the consequences of what their "guilty" brethren have chosen. Suppose the alter who refuses treatment is opposed to the use of drugs, while all the other alters desperately want the medication or have other acceptable values that make them welcome pharmacological help for depression. Suppose that these others cannot come out for a time. Why should the assenting alters have to live with the consequences of what the nonassenting one has chosen?

On the other hand, the doctor on notice that the patient is a multiple may not be able to get the opinions of all or even most of the alters. What then? Do we want busy doctors trying to interact with what may be a great many alters? But if we don't expect the doctor to negotiate consent, should we appoint a guardian to make the decision?

A guardian making a decision for the multiple is an ironic solution at best. It seems to add just one more competent alter, so to speak, to the mix. The guardian is simply going to decide, more likely than not, as the guardian sees best. But why is that decision any better than the decision of any competent alter within the system of the multiple?

One response is that a guardian could be under a duty to try to negotiate consent among the alters. The guardian could be required to speak with as many of them as possible, and try to get them all to agree. If negotiating a settlement, so to speak, is not possible, the guardian could be under a duty to make the choice that best meets the needs and desires of most of the alters. By contrast, any competent alter may not have the interests of the brethren alters in mind in the same way.

On the other hand, it may be well-nigh impossible for such a solution to be reached. In that case, adding the guardian helps very little and, of course, has huge costs of its own in terms of time expended, stigma imposed, and all the discomforts of not having one's choice respected. Whether we think a guardian should be imposed depends on how likely we think the guardian able to negotiate a solution and how often the guardian will just impose what the guardian thinks best. Moreover, even if we think the former more likely, the decision depends on how much we think the costs of imposing a guardian outweigh the benefits of hearing out as many alters as possible on a decision.

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My tentative view is that imposing a guardian does not make sense because a guardian will generally be no better a decisionmaker than any competent alter. I have one reservation, though, about letting any competent alter decide. What if the alter is deciding something that's really unconscionable and totally against the interests of all of the other alters? This is the case, for example, of the suicidal alter, even if suicidal for a good reason.

Suppose, for instance, that a multiple shows up at an emergency room acknowledging that she is a multiple, and it turns out she needs an immediate blood transfusion in order to survive. Suppose further that, when consent is sought, the alter who is out says "no," because he is a Jehovah's Witness. None of the other alters is a Jehovah's Witness, and they are each desperate to say "yes" to the transfusion in order to survive. But the Jehovah's Witness alter stays in control of the body and won't let the others out. Should the doctor accept the refusal of the Jehovah's Witness alter and let the patient die?

Or take another, less extreme case in a different competency context that also makes the point. A very wealthy multiple with several children in dire need goes to make a will, announcing to his lawyer that he is a multiple. But the alter who comes out in the lawyer's office is one who identifies with his aggressors and his abusers and, thus, wants to leave his vast estate to a pedophile organization. Should he be able to bind his fellow alters to this course even though it's exactly what they would *not* have chosen? If the multiple is hit by a car on the way out of the lawyer's office, is this will valid?

Clearly, cases like this give pause about a view that would allow any competent alter to decide for the whole. But there is a possible solution to this problem that is less intrusive than simply giving all multiples guardians: Any competent alter's decision is valid so long as it is not unconscionable. Indeed, this position would make civil competency equivalent to criminal responsibility, for in the latter context the competent alter's choice is in fact unconscionable.

One may think this idea too favorable to multiples: We honor only their good choices and protect them from any bad ones. But this is, I think, not entirely a fair criticism of this view. For we do allow bad choices—just not unconscionable ones. Moreover, we prevent multiples from making "unconscionable" choices, which we allow other people to make; and one person's unconscionable choice may be in another person's best interest, at least as she sees it. So this view does take away some of multiples'

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decisional authority, with all its stigmatizing consequences and other possible detrimental effects. Multiples do not, so to speak, get all good things with no bad ones. And indeed, would it be so horrible to arrange institutions in such a way that one did get all good things?

If all of this is right, at least a first cut on competency to make treatment decisions for multiples would allow any competent alter's consent to be valid, unless the choice were unconscionable. A close second to this position would be to require a guardian to try to find the choice that best represents what most alters want (again so long as that is not unconscionable). Different civil competency contexts may require different rules. And indeed further thought might lead me later to take a different position even in this context.

### CONCLUSION

Mental health law is an interesting and exciting field in which to work. Great strides have been made in the law in the last twenty-five years. Scholars have made important contributions as well. I, myself, find issues around personhood, moral agency, responsibility, and competency the most intriguing, at least in part because they implicate many different areas of the law. I feel privileged that USC Law School has given me the opportunity to think about these issues in a sustained way.