

My Journey Through Madness: the Experience of Mental Illness and Its Impact on the Law

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Competency to Decide on Treatment and Research: MacArthur and Beyond

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Every competent adult has the right to informed consent. These words carry with them the weight of a rich, yet troubled, history. They state a maxim of late 20th century bioethics, a maxim that was borne, in part, of horrific abuses during a holocaust without parallel in human history. While today the concept of a right to informed consent is firmly enconced in the culture of United States medicine, much work remains to be done to pour content into key elements of this right: How can it be determined when an adult's consent is "competent"? When is consent truly "informed"? And what exactly constitutes "consent"?

This article will discuss the competency of psychiatric patients in the contexts of treatment and research. Our hope is to identify areas where further normative discussion about instruments designed to assess competence—the MacArthur instruments being the premier example—will be fruitful. We first argue that any instrument designed to aid in assessing competency to consent to treatment necessarily implicates normative considerations, that is, entails identifying and balancing values. We then review the MacArthur instruments to explore their normative underpinnings. Next, we examine how the MacArthur investigators have balanced three values—autonomy, paternalism, and

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nondiscrimination against the mentally ill—and suggest different ways of balancing these values against one another when doing so seems appropriate. Finally, we ask what additional normative considerations arise in the context of psychiatric research.

I. NORMATIVE JUDGMENTS IN CREATING INSTRUMENTS DESIGNED TO AID IN ASSESSING COMPETENCY

Adopting an instrument to aid in assessing competency requires careful normative analysis.¹ A critical issue is how to strike the balance between autonomy and paternalism. While bioethicists have moved beyond this dichotomy in many areas, the tension between autonomy and paternalism remains central to the assessment of competency. Indeed, standards for competency are the lines drawn between those who may exercise autonomous choices and those on behalf of whom—*over* whom—decisions will be made.

Striking the balance between autonomy and paternalism by holding that competent patients alone have the right to exercise autonomous choices is of little help. Such a tautological statement merely restates the problem: competent patients are free to make choices, while incompetent patients are not and must allow others to make choices on their behalf. One challenge in defining competency is therefore to show *where* autonomy ends and paternalism begins. Perhaps the most subtle and even important part of defining competency requires that we decide how much latitude to give the decision maker in selecting a method of decision making. Are intuitive methods adequate? Must all alternatives be compared and contrasted? How much scope will the decision maker have to select a particular version of the truth, even if that version is idiosyncratic and unpopular?

To begin our search for a definition of competency, we attempt to identify all the values at play. First, we want to protect the vulnerable who are unable to make decisions for themselves. We call this value

1. Since the writing of this article, the MacArthur researchers, Thomas Grisso and Paul Appelbaum, have published a book that bears on this critique. THOMAS GRISSE & PAUL S. APPELBAUM, *ASSESSING COMPETENCE TO CONSENT TO TREATMENT* (1998) [hereinafter *ASSESSING COMPETENCE*]. In this book, the researchers lay out the kind of normative analysis that an individual must undertake in using the instrument they have designed to assess competency in a treatment setting. See *infra* note 5. Grisso and Appelbaum point out that a competency judgment must balance autonomy and paternalism, and that the balance may change depending upon the consequences of deciding one way or the other. This paper attempts to contribute to the discussion over the values at stake in assessing competency.

“paternalism.” Paternalism requires that we ask what abilities are essential for making decisions, so that we can determine when those abilities are lacking. Second, we want to protect the right to make choices, even when those choices are unconventional and stray from commonly held beliefs, views, and desires. We call this value “autonomy.” Finally, we must be mindful what mental health professionals—particularly psychoanalysts, have discovered—namely, that irrationality permeates decision making. As examples, people commonly misunderstand statistics, overvalue vivid memories, and form distorted beliefs about their doctors.² Our knowledge of the pervasive irrationality that governs decision making—indeed, that governs all human activities—serves as reason for extreme caution. We must be careful not to label as incompetent individuals with a mental illness who suffer no more irrationality in the relevant regard than many, if not most, other people. Not to heed this caution is to risk stigmatizing the mentally ill. Here is our third value, “nondiscrimination.”

Our definition of competency must be founded upon a clear conception of how autonomy, paternalism, and nondiscrimination work together and are weighed against one another. Clarity about what values are at play and how those values work together is the watch word. Concretely, we must first justify *which* abilities competency requires and what *level* of these abilities must be present. Thus, the researcher must ask: are *these* abilities, with *this* level of performance, really necessary, and if so, why? Conversely, might an ability be desirable, but inessential, much as speaking a foreign language with a good accent is not essential to basic communication? Deeming a particular skill helpful is also not necessarily definitive to making a decision. Other questions arise: Will requiring this skill for competency tread too greatly on autonomy? And if the absence or impairment of a skill is widespread, do we risk discrimination by requiring this skill only of the mentally ill? In short, defining competency is a thoroughly normative endeavor.³

2. See, e.g., SIGMUND FREUD, *PSYCHOPATHOLOGY OF EVERYDAY LIFE* (1901); JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984); Daniel Kahneman, *New Challenges to the Rationality Assumption*, 150 *J. INSTITUTIONAL & THEORETICAL ECON.* 18 (1994); Donald A. Redelmeier et al., *Understanding Patients' Decisions: Cognitive and Emotional Perspectives*, 270 *JAMA* 72 (1993); Amos Tversky & Daniel Kahneman, *Rational Choice and the Framing of Decisions*, 59 *J. BUS.* S251 (1986).

3. We do not mean to suggest that choosing a competency standard is *completely* normative, just that it is *in large part* normative. Choosing such a standard also depends on empirical findings—such as what impairments lead to substandard decisions, what

II. THE MACARTHUR INSTRUMENTS

The premier work on competency to make treatment and research decisions has been produced by the MacArthur network on law and mental health.⁴ The work of the MacArthur researchers, in particular Paul Appelbaum and Thomas Grisso, has been impressive indeed. The MacArthur researchers have developed three research instruments and one instrument designed for use in direct care settings. The instruments have achieved high reliability, can be administered with relative ease, and have been studied in interesting and informative ways.⁵ The

abilities people actually use when they are deciding, and how psychiatric impairments can affect the ability to make a decision.

4. The literature contains studies of only a few other treatment capacity/competency instruments. See, e.g., C. Dennis Barton, Jr. et al., *Clinicians' Judgment of Capacity of Nursing Home Patients to Give Informed Consent*, 47 PSYCHIATRIC SERVICES 956 (1996) (using Hopkins Competency Assessment Test [HCAT]); Jeffrey S. Janofsky et al., *The Hopkins Competency Assessment Test: A Brief Method for Evaluating Patients' Capacity to Give Informed Consent*, 43 HOSP. & COMMUNITY PSYCHIATRY 132 (1992) (utilizing the HCAT); Gary N. Sales, *Assessing Competency*, 43 HOSP. & COMMUNITY PSYCHIATRY 646 (1992) (discussing article on HCAT); Michael Lavin, *Assessing Competency*, 43 HOSP. & COMMUNITY PSYCHIATRY 646-47 (1992) (discussing same); Jay Englehart, *Assessing Competency*, 43 HOSP. & COMMUNITY PSYCHIATRY 647 (1992) (discussing same); Graham Bean et al., *The Assessment of Competence to Make a Treatment Decision: An Empirical Approach*, 41 CAN. J. PSYCHIATRY 85 (1996) (evaluating the Competency Interview Schedule [CIS]); Graham Bean et al., *The Psychometric Properties of the Competency Interview Schedule*, 39 CAN. J. PSYCHIATRY 368 (1994) (evaluating CIS); Daniel C. Marson et al., *Cognitive Models That Predict Physician Judgments of Capacity to Consent in Mild Alzheimer's Disease*, 45 J. AM. GERIATRICS SOC'Y 458 (1997) (testing of Alzheimer patients based on vignette procedure intended to identify incompetency based on Roth, Meisel, and Lidz' discussion of different standards in *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279 (1977)); Daniel C. Marson et al., *Neuropsychologic Predictors of Competency in Alzheimer's Disease Using a Rational Reasons Legal Standard*, 52 ARCHIVES OF NEUROLOGY 955 (1995) (using same instrument); Daniel C. Marson et al., *Toward a Neurologic Model of Competency: Cognitive Predictors of Capacity to Consent in Alzheimer's Disease Using Three Different Legal Standards*, 46 NEUROLOGY 666 (1996) (using same instrument); Daniel C. Marson et al., *Determining the Competency of Alzheimer Patients to Consent to Treatment and Research*, 8 ALZHEIMER DISEASE & ASSOCIATED DISORDERS 5 (Supp. 1994) (discussing the same instrument); Atsuko Tomoda et al., *Validity and Reliability of Structured Interview for Competency Incompetency Assessment Testing and Ranking Inventory*, 53 J. CLINICAL PSYCHOL. 443 (1997) (evaluating Structured Interview for Competency and Incompetency Assessment Testing and Ranking Inventory [SICIATRI]). The MacArthur instruments appear to be the most carefully constructed, best studied, and most discussed instruments in the literature.

5. The MacArthur researchers have written a number of articles describing the development of the three MacArthur research instruments and the treatment competence instrument (the MacCAT-T), as well as their application to patient populations and

MacArthur instruments will undoubtedly be the “gold-standard” for assessing competency for many years to come.

The three MacArthur research instruments are: (1) the Understanding Treatment Disclosures instrument (UTD), which measures understanding;⁶ (2) the Perceptions of Disorder instrument (POD),

matched controls. 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. 105 (1995); Thomas Grisso et al., *The MacArthur Treatment Competence Study. II: Measures of Abilities Related to Competence to Consent to Treatment*, 19 LAW & HUM. BEHAV. 127 (1995) [hereinafter *MacArthur I*]; Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 LAW AND HUM. BEHAV. 149 (1995); Thomas Grisso & Paul S. Appelbaum, *Comparison of Standards for Assessing Patients' Capacities to Make Treatment Decisions*, 152 AM. J. PSYCHIATRY 1033 (1995); Jessica Wilen Berg et al., *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 RUTGERS L. REV. 345 (1996) [hereinafter *Constructing Competence*]; Paul S. Appelbaum & Thomas Grisso, *Capacities of Hospitalized, Medically Ill Patients to Consent to Treatment*, 38 PSYCHOSOMATICS 119 (1997) [hereinafter *Hospitalized*]. They have also recently published a book on the MacCAT-T. See ASSESSING COMPETENCE, *supra* note 1. They have an article in press on the application of their instruments to the research context. See Jessica Wilen Berg & Paul S. Appelbaum, *Subjects' Capacity to Consent to Neurobiological Research*, in ETHICAL ISSUES IN PSYCHIATRIC RESEARCH: A RESEARCH MANUAL ON HUMAN SUBJECTS PROTECTION (Harold Alan Pincus et al. eds., forthcoming 2000) [hereinafter *Subjects' Capacity*]. Finally, considerable literature discusses the MacArthur instruments, most notably the articles in volume 2 of PSYCHOLOGY, PUBLIC POLICY, AND LAW EXPLORING A SPECIAL THEME: A CRITICAL EXAMINATION OF THE MACARTHUR TREATMENT COMPETENCE STUDY: METHODOLOGICAL ISSUES, LEGAL IMPLICATIONS, AND FUTURE DIRECTIONS. See 2 PSYCHOL. PUB. POL'Y & L. (1996).

6. The best way to understand the MacArthur instruments is to look at their manuals. For the UTD, see THOMAS GRISSO & PAUL S. APPELBAUM, MANUAL FOR UNDERSTANDING TREATMENT DISCLOSURES (1992) (unpublished manual available from authors). The UTD measures the subject's understanding of treatment disclosures about the illness he or she suffers from and its treatment. Form disclosures were devised for schizophrenia, depression, and ischemic heart disease (angina). Each disclosure, using language understandable at the junior high level, consists of five simple paragraphs briefly describing the illness and its treatment.

The first paragraph focuses on the illness itself, as well as on two common symptoms of the illness (“Schizophrenia is a mental disorder. People with schizophrenia often have unpleasant experiences, called symptoms. For example, they . . . may hear voices talking about what they are doing, even when there are no other people around.”). *Id.* at 24. The second paragraph discusses treatment, how it is administered, and what is required of the patient for treatment to be effective (“Fortunately, schizophrenia can be treated with medicine. . . . But if patients stop taking this medicine, their symptoms may come back.”). *Id.* The third examines the potential benefits of the treatment (“The medicines used to treat schizophrenia help many patients to think more clearly. They often stop the

which measures one's appreciation of disclosures about illness and treatment as they apply to one's own situation;⁷ and (3) the Thinking

frightening voices that some patients with schizophrenia hear.”). *Id.* The fourth paragraph notes the potential side-effects of the treatment (“[T]he medicine might make patients restless or cause their muscles to tighten up.”). *Id.* The fifth paragraph considers alternatives, benefits of the alternatives, and potential problems with the alternatives (“There is also psychotherapy [to help treat schizophrenia]. . . . This talking therapy may help patients better understand themselves and their feelings. But psychotherapy alone does not usually help with schizophrenia by itself. . . . [it] is most helpful when the patient is also taking medicine.”). *Id.*

The UTD is administered in three forms. First, the patient is read the entire disclosure and asked to paraphrase what has been said (with questions prompting him if need be). Second, the patient is then read each element of the disclosure format again and asked, after each element, whether a statement read is “the same as or different from” what has been said.

Patients receive points depending on how much they have remembered and (presumably) understood. For example, if two symptoms of schizophrenia have been disclosed, a patient will receive a full score on that issue if he or she repeats or paraphrases those two symptoms. The patient will also receive a maximum score (but no additional points) if he or she includes those two but adds others that were not disclosed to him or her. The patient will receive no credit if he or she remembers none of the symptoms or if he or she brings up other symptoms—even if they are bona fide symptoms of schizophrenia—that he or she did not hear in the disclosure and he or she fails to name disclosed items.

7. The POD measures people's appreciation of their illness and its treatment. The POD requires that one apply general information to one's own situation. There are two subtests, the Non-Acknowledgment of Disorder (NOD) subtest and the Non-Acknowledgment of Treatment Potential (NOT) subtest. The NOD measures the patient's failure to acknowledge his or her diagnosis, the severity of his or her condition, or the symptoms he or she has been demonstrating. “Objective” measures of these three are provided by the diagnosis given in the patient's medical chart, the severity of his or her symptoms as measured by the Brief Psychiatric Rating Scale, and the symptoms recently reported in his or her medical chart.

The NOT measures patients' failure to acknowledge the potential value of treatment for their illnesses even when successful treatment is likely. It focuses on the extent to which patients believe (1) any treatment might be of benefit to them, (2) medication specifically might benefit them, and (3) the course of improvement is likely to be lessened absent treatment. If patients fail to acknowledge the potential benefits of treatment, they are provided a hypothetical premise that logically nullifies their reasoning (*e.g.*, “imagine that a doctor tells you that there is a medication that has been shown in research to help 90% of people with your problem, *even people who had not gotten better with any other medication*). Non-acknowledgment is scored only if the patient fails to acknowledge the potential benefits of treatment under the hypothetical condition. The NOT does not assess whether patients would agree to the medication—just whether they believe it might be of possible benefit.

There are three additional elements of the POD that have been included for exploratory reasons only. These items assess patients' acknowledgment of potential side-effects of medication generally, their perceptions of the beneficence of the hospital staff, and their perceptions of their own need for hospitalization.

Rationally About Treatment instrument (TRAT), which measures one's reasoning skills as one decides about a hypothetical treatment dilemma based on one's own condition.⁸ A subset of the TRAT measures one's

See Paul S. Appelbaum & Thomas Grisso, *Manual for Perceptions of Disorder (POD)* (1992) (unpublished manual available from authors).

8. The TRAT measures patients' ability to think rationally about treatment. The instrument gives a vignette including information about a disorder, various treatment alternatives, and their probable risks and benefits. It then asks the subject to recommend one of the treatments to a friend with the relevant illness and to describe the reasons for the selection. The patient's reasoning is scored for various cognitive activities that are considered important to making a decision. A second set of procedures examines more formal cognitive functions relevant to decision making.

The cognitive functions identified are Seeking Information (tendency to seek information beyond what is provided), Consequential Thinking (consideration of consequences of treatment alternatives), Comparative Thinking (simultaneous processing of information about two treatment alternatives, such that they are considered in relation to each other), Complex Thinking (attention to the full range of treatment alternatives), and Generating Consequences (generation of potential real-life consequences of the liabilities described in the informed consent disclosure, such as how a side-effect of medication might affect job performance). The TRAT measures three additional cognitive functions independent of the vignette: Weighting Consequences (tendency for consistent application of preferences), Transitive Thinking (assessment of relative quantitative relationships between several alternatives based on paired comparisons), and Probabilistic Thinking (ability to distinguish correctly the relative values of percentage probabilities). The abilities measured by the TRAT were derived from discussions in the literature on essential reasoning abilities.

The vignette abilities are scored by presenting the vignette to the patient, asking him or her if he or she needs further information, and asking him or her to choose one of the alternatives and give him or her reasons for doing so. The patient is then asked for further reasons, as well as for his or her least preferred choice and his or her reasons for his or her preferred choice. Scoring occurs by seeing how many of the kinds of cognitive operations identified earlier occur. For instance, did the patient compare risks and benefits of the alternatives with each other? The three further abilities (weighting consequences, transitive thinking, and probabilistic thinking) are scored by presenting the patient with a series of questions that tap into those abilities. For instance, to test Probabilistic Thinking the patient is told that some event has a 90% probability of occurring and is then asked if he or she thinks it likely to occur.

Finally, the TRAT has a question that measures the patient's ability to Express a Choice. A full score is received if the patient unambiguously chooses an option, and partial credit is received if the patient initially chooses two or no alternatives, but then chooses one alternative during a "repeat" inquiry.

Early indications are that two of the cognitive operations—Weighting Consequences and Seeking Information—are frequent outliers, and when factor analyses are performed with these subscales removed, they produce two very consistent factors; Consequential, Comparative, and Complex Thinking on the one hand, Transitive and Probabilistic Thinking together with Generating Consequences on the other. *See* THOMAS GRISSE &

ability to express a choice. Appelbaum and Grisso have designed these instruments to comport with standards of legal competency found in case law and statutes⁹ and are careful to distinguish between capacity and competency. "Capacity" refers to abilities relevant to performing a task, while "competency" is a legal judgment that one has sufficient abilities to perform the task. Appelbaum and Grisso have designed their instruments to measure *capacities*.¹⁰ A subject is "impaired" when he or she scores two standard deviations below the mean of those studied.¹¹

The MacArthur researchers have recently designed a treatment capacity instrument to be used for actual evaluations rather than for research purposes (the MacArthur Competence Assessment Tool-Treatment, or MacCAT-T).¹² The MacCAT-T incorporates many of the questions found in the research instruments, yet is more efficient to administer and is tailored to the individual's particular situation. The investigators are careful to say that MacCAT-T scores do not determine competency.¹³ Clinical judgment is required to make a definitive finding. The authors suggest that the MCAT-T be used in conjunction with a clinical evaluation that takes into account such things as contextual variables.

The results of the MacArthur research are intriguing. The most important is that a significant proportion of patients and nonpatients in all categories scored in the non-impaired range, although the schizophrenic patients did the least well. "Impaired" was defined as two standard deviations below the mean for the aggregate of everyone studied, patients and nonpatients alike. Given this definition,

PAUL S. APPELBAUM, *MANUAL FOR THINKING RATIONALLY ABOUT TREATMENT* (1993) (unpublished manual available from authors).

9. See, e.g., *Constructing Competence*, *supra* note 5, at 363; *Hospitalized*, *supra* note 5, at 121; *MacArthur I*, *supra* note 5, at 108.

10. See, e.g., *ASSESSING COMPETENCE*, *supra* note 1, at 11.

11. See, e.g., *Constructing Competence*, *supra* note 5, at 373. This paper uses the terms "competency," "capacity," and "impaired" in the same way as do Berg, Appelbaum, and Grisso.

12. THOMAS GRISSO & PAUL S. APPELBAUM *MACARTHUR COMPETENCE TOOL-TREATMENT (MCCAT-T)* (1995) (unpublished manual available from authors). The MacCAT-T is a streamlined version of the MacArthur research instruments which aggregates all three research instruments (the UTD, POD, and TRAT). The evaluator is required to personalize the questions to the patient's particular situation. There is a greater effort than in the research instruments to try to determine the bases for the patient's answers, counting as impaired only answers based on considerations that appear grossly to distort reality. The researchers do not offer standardized means of determining what constitutes impairment. Rather, according to the MCAT-T the evaluator uses clinical judgment in determining which responses are impaired.

13. See, e.g., *id.*

approximately 25% of the schizophrenic patients scored in the impaired range on each of the three principal instruments, and approximately 50% scored as impaired when the scores on the different instruments were aggregated. (This means, of course, that 50% of the schizophrenic patients scored in the *nonimpaired* range when the scores were aggregated.)¹⁴

The second important finding of the study was that the three different instruments seemed to be picking out different patients. While scores on the UTD and the TRAT correlated well, scores on the POD did not correlate with scores on either the UTD or TRAT. The researchers conclude that because the research instruments pick out different groups of people as impaired, all should be incorporated in the MacCAT-T.

In terms of setting an actual standard for competency, the researchers consider two alternatives. The first is to use a fixed level of performance as a basis for a finding of competency—such as understanding, appreciating, and reasoning about 75% of the information provided. The second way of setting a standard is to vary the level of ability required based upon the net balance of expected benefits and risks of the patient's choice compared to the alternatives (i.e., more capacity is required for decisions when the risks are greater). The researchers suggest that they prefer the latter.¹⁵

III. CHALLENGES TO THE MACARTHUR RESEARCH

The MacArthur instruments are based upon normative choices. A challenge to the MacArthur studies is to explain and justify these choices in a more detailed manner than has been done to date. Consider the

14. The researchers noted that their study likely understated the rate of impairment, because the most disturbed patients were not deemed suitable for participation. Yet, this point is not entirely clear. The study looked only at recently hospitalized patients who were likely to be in the throes of the most acute phase of their illness. Later in their hospital stay their capacities may have improved. And a study evaluating schizophrenics in different settings, such as day hospitals, community mental health centers, and group homes, might well have found a higher percentage of schizophrenic patients scoring in the nonimpaired range. These patients, of course, also have to make treatment decisions. Insofar as schizophrenia is a chronic illness, studying schizophrenics' decision making abilities should include schizophrenic patients in a variety of settings, across a variety of times. In short, many patients—even those with the most severe psychiatric disorder—may be capable of making their own decisions.

15. See *infra* note 16.

following three areas that merit further normative discussions. First, the MacArthur researchers pick out certain capacities for their instruments to measure and label specific levels of these capacities “impaired.” Clearly, the researchers have deemed the chosen capacities relevant to competency and have determined that a certain level of the capacities—or their absence—is significant and should be considered in assessing competency. Next, the MacArthur researchers suggest that we should adopt a variable competency standard so that choices with a higher potential cost would require a higher level of competency.¹⁶ Finally, the MacArthur researchers point out that the three main research instruments seem to be picking out different populations of patients, so that a treatment capacity instrument (the MacCAT-T) should aggregate the three measures. This judgment presupposes that all the skills measured by the three instruments are important to competency—a claim that merits further attention.¹⁷

Below we examine the MacArthur instruments in more detail. We first identify the abilities identified as essential to competency and then examine the extent to which the specific instruments protect all the values implicated in defining competency.

IV. EVALUATING SPECIFIC RESEARCH INSTRUMENTS

The MacArthur research instruments are designed to measure capacities relevant to the assessment of competency. The capacities measured by the instruments are: 1) pure comprehension of relevant information (the UTD);¹⁸ the ability to assess evidence and form appropriate beliefs about that information (the POD);¹⁹ the ability to

16. See, e.g., *Constructing Competence*, *supra* note 5, at 385-87; ASSESSING COMPETENCE, *supra* note 1, at 127-48.

17. See, e.g., *Constructing Competence*, *supra* note 5, at 380-81. The authors suggest that there are *empirical* grounds to aggregate the standards because they pick out different groups. Aggregating the standards also raise a *normative* consideration, however, given that the standards pick out different groups. The normative consideration speaks to whether we think the capacities judged are important to competency.

18. By “pure comprehension” we mean grasping the meaning of what is said without necessarily believing what one has grasped. See Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945, 952-56 (1991).

19. The MacArthur’s UTD and POD incorporate more than merely the distinction between pure understanding and formation of beliefs. This distinction, however, between pure understanding and formation of beliefs, is an important aspect of the distinction drawn between what the UTD and POD measure. Elyn R. Saks & M. Litt, *Competency to Decide on Treatment and Research: The MacArthur Capacity Instruments*, in 2 NAT’L BIOETHICS ADVISORY COMM’N, RESEARCH INVOLVING PERSONS

reason with that information (the TRAT); and the ability to evidence a choice (subset of the TRAT). All of these abilities can be normatively justified as necessary for competent decision making.

Pure comprehension or understanding of relevant information is essential to competence. Imagine being asked to make an important decision, the implications of which are described in a foreign language. One is simply not in a position to decide. Pure understanding, then, is a clear prerequisite for competency.²⁰

Pure understanding, while necessary, is not sufficient. The ability to assess evidence and form appropriate beliefs is also necessary. MacArthur's inclusion of this ability in its capacity instruments makes eminent sense. Because making a decision in one's best interests requires assessing how those interests are likely to be affected, the patient must be able to form adequate beliefs in order to be a competent decision maker.²¹

In addition to pure understanding and the ability to assess evidence and form appropriate beliefs, one also must be able to reason with some degree of intactness. Reasoning allows one to put together the relevant information one has purely understood and, having assessed, has formed beliefs about. Consider the following. A person desires *x* and wants to obtain *x*. She believes that *y* is the way to get *x* and knows that *not*

WITH MENTAL DISORDERS THAT MAY AFFECT DECISIONMAKING CAPACITY 59 (1999).

20. Consider as well the following thought experiment. John, a captive, is forced, on pain of death, to decide between two contraptions. One of the contraptions will torture him and the other will grant his every wish. John cannot tell from looking at the contraptions what they will do, and he cannot understand his captors' explanation of them because they speak a foreign language that he does not understand. It seems plausible to say that John is incompetent to decide between the two contraptions—with one reservation. We may want to reserve the term "incompetent" for people who are not simply ignorant. Although well-known philosophers have justified paternalism in the face of ignorance (recall, e.g., John Stuart Mill's example of stopping a person from crossing an unsafe bridge in JOHN STUART MILL, *ON LIBERTY* 97-98 (Alburey Castell ed. 1947)), the law may prefer to reserve the term "incompetent" for those who lack abilities, perhaps as a function of their mental illness, rather than those who simply lack knowledge. Whatever we decide in the real world, surely most people would want, in our example above, to be disabled from deciding for themselves, and to have benign and knowledgeable others decide for them.

21. Decisions are based on desires and beliefs: One desires *x*, and believes that *y* is the way to get *x*, and thus one decides to do *y*. A deficiency in one's beliefs may therefore severely affect one's decision making capacity. One forms beliefs as a result of assessments of the evidence, so that the skill tapped here is the ability to assess evidence. This skill is clearly needed in some degree or another for competency.

doing y will guarantee *not* getting x. If she then concludes *not* to do y on the basis of deficient reasoning, her choice not to do y is not a competent choice. The MacArthur instruments rightly contain a measure of reasoning.

Finally, should making known (i.e., conveying to another) one's choice be considered a necessary skill for making a competent choice? It could reasonably be argued that making a choice known is not necessary to make a competent choice.²² Nevertheless, *assessing* competency requires the communication of a choice that can then be assessed. Thus, the subtest in the MacArthur instruments measuring the ability to communicate a choice is justified.

The MacArthur instruments identify and assess abilities necessary and helpful in making decisions: understanding relevant information; assessing the evidence and forming appropriate beliefs about it; reasoning about the evidence with a degree of intactness; and communicating a choice. As such, the MacArthur Instruments are clearly sensitive to ensuring that vulnerable patients have the skills required to make important choices. In a word, the instruments safeguard the value of paternalism. How do the instruments factor in the values of autonomy and nondiscrimination?

A. *The UTD and TRAT*

The UTD is an impressive instrument. It spells out items of information that patients ought to understand, explains the information with a simple vocabulary, and tests understanding of the information in several different ways in order to allow patients full scope to demonstrate what they have learned. We would like to raise the question of whether the manner in which the UTD assesses pure understanding requires too high a price in the way of autonomy.

Consider that the UTD does not give credit for information patients give about their disease over and above what is recited in the UTD. Thus, a patient receives no points if she mentions real symptoms that were not part of the disclosure. The UTD's treatment of extra-disclosure information makes sense up to a point. It is important to assess whether the patient is able to listen and understand what he or she has been told.

22. Consider, for example, a man who is paralyzed and unable to communicate. He may very well decide after careful consideration that he would like some procedure done. Suppose that by any (other) measure we could formulate he would be deemed competent. Does his inability to say what he wants make him incompetent? Not necessarily, insofar as we distinguish between *making* and *communicating* a choice. Of course, one can only *assess* a choice if that choice has been communicated.

Absent this ability, a patient cannot assimilate (and eventually assess) information relevant to his or her decision. On the other hand, respect for unconventionality—and so autonomy—might counsel allowing the patient completely to diverge from what has just been read, provided the patient recites *true* information about the relevant illness. Patients may get just as good information—or better information for their situation—from other sources. Perhaps they should be entitled to choose what information is important to them about their illness, as long as they understand *that* information. Indeed, given the patient's unique symptomatology, he or she may have better information relevant to his or her particular decision than that which the researcher has provided. What may be most salient about schizophrenia to the patient, for instance, may not be the voices mentioned in the disclosure, but the disorganization of his or her thinking process. That is what the patient recites as a symptom of schizophrenia. By slight alterations in the UTD, we might be able both to protect the vulnerable and to further promote their autonomy.

The TRAT does an impressive job in identifying and testing reasoning abilities necessary for competency. Just as with the UTD, however, a question can be raised concerning whether the TRAT requires too high a price in terms of protecting other values. The TRAT runs this risk in two ways: First, it may sometimes require abilities that do not really add to the individual patient's decision making process, and second, it may underestimate how often the cognitive processes deemed essential for competency are actually occurring.

Assessing the ability to reason is essential to assessing competency. Yet, how much reasoning ability should be required? It is unclear that pure or pristine reasoning plays an essential role in *all* effective decision making. Intuitive and idiosyncratic processes may actually improve decision making in certain instances (consider cases in which people dream of solutions to difficult mathematical problems, or police officers who solve a case on a "hunch"). Perhaps more important, even generally effective decision makers who indisputably have the ability to form accurate beliefs misuse statistics, misunderstand probabilities, and accord undue weight to vivid examples. They may also be profoundly affected by irrational and unconscious factors. Unless we are willing to declare most people incompetent, declaring only the mentally ill who lack reasoning skills incompetent risks unjustifiably discriminating against individuals on the basis of mental illness.

While the TRAT does seem to require the presence of only basic

abilities (e.g., in testing the understanding of probabilities, it requires only the understanding of a grossly obvious inference), it must also attempt to justify giving better scores for showing *more* abilities. A particular decision, for instance, may involve only two alternatives. In such a case, the relevance, say, of transitive thinking or complex versus comparative thinking may not be pertinent. More important, a patient might not engage in many of these cognitive functions because, for her, one consideration is decisive. As an example, she may so disvalue a risk of one of the alternatives that thinking consequentially is all she needs to do to choose between two alternatives. Thus, the patient's autonomy may be undervalued.

Another challenge to the TRAT is its requirement that one *evidence* (indicate the presence of) all of these other functions—functions that may be occurring at an implicit level. For instance, a woman who says “I want x and not y because I am terribly frightened of the significant seizure risk carried by y—my father died in a car accident as a result of a seizure when I was three” will often have gauged that x does not carry such a seizure risk (or anything equally aversive to the patient). She may well have done so and may simply not *say the words* “and I have compared x to y and x does not have any such abhorrent consequences to me.” In this case, she would not receive full credit on the TRAT. Perhaps instead of simply asking for reasons, the patient, once having given a reason, should be asked *directly* if she compared y to x and, if so, what in the comparison led to her choice. By possibly overlooking the patient's acceptable reasons for her choice, the TRAT may unnecessarily tread upon her autonomy.

B. *The POD*

The POD taps the ability to assess evidence. As a consequence, it examines the quality of the patient's beliefs. Deciding what beliefs a patient must have to be deemed competent is a precarious endeavor indeed.

Accurate beliefs about the world are essential to competency, because decisions take effect in the world. Yet consider the following points. First, more often than we like to think, whether a belief is true is an open question. Very few beliefs are indisputable. As a consequence, requiring particular beliefs may not further our interest in protecting the vulnerable; if the belief we require is wrong, the patient is in no better position to decide. Freedom includes freedom to decide what is *true* no less than what is *good*. If we require particular beliefs, we prevent the patient from pursuing the truth according to his or her own lights. While

limits should be placed on what a patient can believe, too stringent limits severely curtail patients' freedom to be unconventional in their pursuit of truth. Moreover, many people have distorted beliefs that form the bases for their decisions. We risk discriminating against the mentally ill if we hold schizophrenics not competent on the basis of beliefs held by other, presumptively competent decision makers. Thus, too strictly assessing beliefs may infringe upon autonomy and nondiscrimination without offering clear protection to the vulnerable. How does the POD balance these three values?

The POD appears to require that patients believe what their doctors believe about their illness and treatment. A lower score is given on the POD for a patient who denies that he or she is ill, disagrees with the diagnosis given by his or her treater, or is more pessimistic about his or her prognosis than the treater. A subset of the POD, the NOD (Non-Acknowledgment of Disorder) measures appreciation of one's illness. The patient receives a full score if he or she accepts the diagnosis the doctor has provided, judges the illness as severe as a particular measure of symptom severity does, and accepts the symptoms reported in the chart. A second subset of the POD, the NOT (Non-Acknowledgment of Treatment Potential), measures acknowledgment of treatment potential. The NOT requires one to accept a good prognosis when treatment and medication exist for the condition, and a worse prognosis without treatment.²³

Two challenges can be raised to the NOD. First, a doctor may be wrong about a patient's diagnosis. The reliability and validity of psychiatric diagnoses are often in doubt. Doctors often disagree about diagnoses, and sometimes disagree about the category of illness (e.g. psychotic disorder vs. mood disorder vs. personality disorder) and about whether a patient even has a significant illness. Put another way, the NOD is limited by the reliability and validity of psychiatric diagnosis. While the patient may be quite willing to believe an earlier doctor's diagnosis or even that he or she is seriously ill, the patient is counted as impaired by the NOD if he or she disagrees with this particular diagnosis.²⁴

23. If the patient has reasonable grounds to disagree with the doctor's judgment, a hypothesis nullifying his or her premise is presented, and he or she is again asked his or her beliefs. ("Imagine that a doctor tells you there is a medication that has been shown in research to help 90% of people with your problem, *even people who had not gotten better with any other medication.*").

24. The patient is told what diagnosis he or she has been given and then is asked

Second, the NOD asks whether the patient rates his or her symptoms as severe as the Brief Psychiatric Rating Scale (BPRS) does. A deviation from the BPRS counts against the patient. Yet, a response that diverges from the BPRS is not necessarily a profound distortion of reality. Moreover, the NOD is limited to the extent that the severity ratings of the BPRS are not highly reliable or valid.²⁵

A challenge to the NOT is that doctors may simply be wrong about one's *particular* likelihood of benefiting from treatment and deteriorating without treatment. For instance, some patients may become demoralized and depressed at the need to take medication. Some of these patients may give up, stop trying to get better, just as some patients may regress in hospitals and never want to leave. It may be clear how patients on average do with and without a particular treatment—but averages don't speak to this particular patient, who may be *right* that he will be in the 10% that do not respond to a treatment.²⁶ Because no one can predict the future with complete confidence, it may be problematic to require patients to form beliefs about a particular outcome they will experience in the future. Asking patients to understand what happens generally makes sense; asking them to believe that the general rule will apply to them is a more complicated affair.²⁷

whether he or she agrees with this diagnosis. If the patient strongly or probably disagrees with the diagnosis, he or she receives a “zero” (as opposed to a “one” or “two”) on that item. The POD asks not only whether your doctor thinks you have this illness, but whether you think you have this illness as well. Because there are six parts of the POD (three for denial of illness and three for disagreement about prognosis with and without treatment), denial of illness alone would probably not render one incompetent, although it might render one “impaired.”

25. The third measure of the NOD seems less of a challenge to the value of autonomy. It asks whether patients acknowledge the presence of symptoms mentioned in their chart. Many of these symptoms will be grossly demonstrable. If a patient denies that he or she has just been frenetically pacing, or hasn't slept in days, he or she is severely distorting reality. Some symptoms, on the other hand, involve more interpretation. Is the patient agitated? Maybe not for him or her. Still other symptoms essentially duplicate the illness question, such as whether the patient is experiencing hallucinations or delusions (as opposed to asking whether the patient is seeing or hearing things that are not really there, or believing things that others don't believe). Alternatives should be considered to framing the question in terms of whether the patient is experiencing “delusions” or “hallucinations.”

26. In the MacCAT-T, the MacArthur researchers allow a patient to get a full score if he or she says he or she expects to be in the bottom 10% because previous treatments have failed for him or her. But the patient may also have his or her own reasons—perhaps even superstitious ones—for thinking that treatment will fail now and he or she will be in the bottom 10%. Once again, he or she may be right—many people are simply pessimistic about treatment. Or, the patient may be reacting defensively to guard against the possibility of future disappointments, a recognized and sometimes effective strategy.

27. To look at this in another way, the NOT may actually measure optimism and

How might these challenges to the POD be met? Beliefs one could require for competency cover a range. At the far end is the view incorporated in the POD, which provides full credit when the patient believes what the doctor believes. At the other end of the range is the view that patients can believe virtually anything, except, perhaps, things impossible by their very nature. Within these extremes other standards are possible. Perhaps competency should be premised on believing what *most* doctors would believe about an illness and treatment. Or perhaps competency should be premised on believing what most *people* would believe. Or upon what most *reasonable* people believe. Or perhaps we should dispense with norms altogether and attempt to characterize a competency standard in a way that does not refer to majorities.

We suggest a standard for competency that finds a middle ground between an “impossible belief” standard, on the one hand, and a “believe what your doctor believes” standard, on the other. As we see it, a standard of competency should not turn on whatever a doctor believes about an illness and its symptoms, treatment, and prognosis. Conversely, beliefs that grossly distort reality, that are based on little or no evidence, or that are indisputably false or patently delusional should, in our opinion, render one incompetent.

The standard we propose is a “patently false delusional belief” standard. Patently false beliefs are beliefs that are grossly improbable, for any one of several reasons. First, patently false delusional beliefs may violate the laws of nature. An example would be that *thoughts can kill*. Second, a patently false delusional belief may also be a belief that does not violate the laws of nature, but one that is practically impossible; that is, a belief so improbable that we feel confident in saying it is false without additional evidence. An example would be that one is able to calculate as fast as a supercomputer. Finally, a patently false delusional belief may be a belief that represents a gross distortion of obvious facts; that is, a belief that flies in the face of empirical happenings obvious to everyone. An example would be that a large spaceship lies in the middle of New York’s Central Park. Patently false delusional beliefs are beliefs that are grossly improbable in one of these three ways. Religious and cultural beliefs are exempted from the definition of patently false beliefs, as are beliefs commonly held in a society or culture even if they appear odd or idiosyncratic to people outside the society or culture.

pessimism. Many people are unduly optimistic or pessimistic about many things. The NOT may require patients to manifest a trait—optimism—that many people may lack.

We would like to propose further normative discussion about the POD in another regard by suggesting that mere denial of mental illness should not necessarily count against one in a competency assessment.²⁸ This claim—that denial of a mental illness does not always count against competency—can be made without denying either the reality of mental illness or the severe suffering it causes. One can also hold this view and continue to subscribe to the medical model.²⁹ Consider the following seven reasons a patient might deny his or her illness.

First, a person denying he or she is mentally ill may simply not be willing to admit to something that is stigmatizing and carries negative consequences in our society. Attempting to avoid the negative consequences of a diagnosis may be a rational strategy as a way to move on in one's life.

Second, a person denying his or her illness may be acting on the basis of an understandable defense. Denial of difficult things is quite common. Denial can be a way to protect one from the narcissistic injury of having a mental illness.

Third, denial can be adaptive. Evidence suggests that people with serious physical illnesses live longer if they deny the seriousness of their illness.³⁰ A person denying he or she is mentally ill might draw on resources he or she would be too discouraged to use if the person admitted the illness.

Fourth, diagnoses of mental illness are generally less certain than many diagnoses of physical illnesses. Unlike physical illnesses, where there often are definitive findings that unequivocally establish the diagnosis, there are no physical tests for any nonorganic mental illness. This point is epistemological, not ontological. To say that we cannot definitively prove someone has soft tissue damage is not to deny that there is such an illness as soft tissue damage or that soft tissue damage can cause considerable pain and disability. The two issues are different. We can hold to the medical model, retain our belief in the reality of mental illness, and still claim that denial of mental illness ought not automatically to count against competency.

Fifth, many members of society are skeptical about mental illness—or at least about whether particular behavior patterns or symptom

28. See Saks, *supra* note 18, at 988-92 (discussing denial of mental illness). Since that publication, Saks' views on denial have changed somewhat.

29. In this context, the "medical model" is the model according to which mental illnesses are real disease entities, as much so as any physical illnesses, and therefore respond to treatments of various kinds. According to the medical model, mental illness is not simply "problems in living."

30. See Saks, *supra* note 18, at 990 (mentioning sources supporting this claim).

constellations amount to a mental illness.³¹ Beliefs that mental illness is a failure of will, consists of problems in living, or is motivated by a desire to be cared for are not uncommon. While some such beliefs amount to frank prejudice, or are at the very least based on ignorance, the point is that if these beliefs are not uncommon, then a particular patient's similar belief does not represent a gross departure from ordinary ways of thinking. To hold that such a belief should render one incompetent is to risk discriminating against the mentally ill.

Sixth, it *does* represent a patent distortion of reality to deny that one is suffering from grossly demonstrable symptoms. But the patient who can admit that he or she is agitated, pacing, scared—whatever his or her symptoms happen to be—has reason to accept treatment that doctors say will help those symptoms abate. It is not clear that we need to make the patient admit to having a mental illness. It risks forcing a humiliation on the person to do so.³²

Finally, many populations of patients are notoriously noncompliant with treatment recommendations.³³ Such noncompliance could be

31. Beliefs such as these about mental illness seem much more common than beliefs about physical illness. Even certain mental health professionals have similar views about mental illness; Szasz, for instance, denies that any nonorganic mental illness is real. See, e.g., THOMAS S. SZASZ, *THE MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT* (2nd ed. rev. 1974).

32. Perhaps, however, we should require more. For example, we should require that patients need to accept not only that they are pacing, but that they have *some* condition, even if it is not the condition their doctors say they have. Or perhaps we should require the patient to admit that he or she has some condition that *looks like* schizophrenia that most doctors would so diagnose, and that is thought antecedently to be as likely to benefit from treatment as any other similar presentation. These claims are fairly indisputable in many cases. We don't *need* a physiological test to establish them. Thus, while a patient may not trust what the individual doctor is telling him or her about his or her diagnosis, the patient can and should accept the fact he or she has symptoms commonly used by psychiatrists to identify mental disorders (e.g., the patient simply denies their significance in terms of whether he or she "has" the illness.). See AMERICAN PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-IV)* (4th ed. 1994). It seems a close call whether we require these additional beliefs or whether simply admitting to one's symptoms and one's doctor's belief in potential benefit of treatment is enough to establish competency. An intermediate position would be to require patients to admit, simply, that "something's wrong."

33. See, e.g., Joyce A. Cramer et al., *How Often Is Medication Taken as Prescribed? A Novel Assessment Technique*, 261 JAMA 3273 (1989); Richard L. Ruffalo et al., *Patient Compliance*, 31 AM. FAM. PHYSICIAN 93 (1985); Barbara J. Stephenson et al., *Is This Patient Taking the Treatment as Prescribed?*, 269 JAMA 2779 (1993).

interpreted as an unconscious denial of illness. To the extent this interpretation is plausible, we risk discriminating against the mentally ill by penalizing *their* denial.

Given these reasons for denial, it seems appropriate to probe when a patient denies he or she is mentally ill in order to see if the patient's reasoning is understandable.³⁴ Perhaps the patient is not speaking honestly. For example, perhaps a man is narcissistically wounded but, in his heart of hearts, knows the truth. Perhaps he thinks of his behaviors as his choice. Perhaps he holds widely held views about mental illness that lead him to think he is not really ill, beliefs that are reinforced by his family or friends. In short, one should explore whether a given case of denial amounts to a patent distortion of reality (e.g., "aliens are causing me to suffer to save the world"). On this view, if a belief is not impossible, then one must consider how plausible it is, and whether it is an understandable or common belief, to determine whether the belief patently distorts reality.

One final cautionary note about denial: Allowing denial to be a basis for a finding of incompetency—and thus forced treatment—is fraught with danger. Not only would finding incompetency on the basis of denial permit us to force treatment on an obsessive-compulsive person who denies that he or she is ill—and who among us is free of maladaptive personality traits?—but it would also allow us to characterize political dissidents as ill, and then to use their understandable denial that they are ill as a basis for their involuntary treatment.

In sum, more substantive points for future normative discussion can be raised about the POD than about the UTD or TRAT. This discussion might fruitfully explore what kind of beliefs are sufficient for competency and what kind of beliefs are not. As examples, a standard might look to whether the patient denies what his or her doctor says, what most doctors say, what most reasonable people would say, what is patently true, what must be true, and what cannot be true. Future

34. A failure to probe may result in *underestimating* the presence of incompetency by focusing too exclusively on disavowal of what one's doctor believes and not enough on the degree of distortion which the belief represents. Take the patient who admits he or she has the diagnosis the doctor gives and agrees with the doctor's prognosis with and without treatment. This person would receive a full score on the POD. But suppose he or she also believes that he or she has the diagnosis the doctor gives because aliens are manipulating his or her neurotransmitters from afar, and that taking the medication will enrage the aliens and cause them to destroy the earth—even though he or she thinks it will cure his illness. Again, this person would receive a full score on the POD. But is he or she really competent to refuse treatment? Do we not want to look for patently false beliefs and not just disagreement (or agreement) with what one's doctor says?

scholars would establish which level of each belief to require. We suggest a patently false belief standard as a likely candidate to separate those competent to make decisions from those who are not. Whichever standard is chosen, serious consideration will need to be given to the role of denial in assessing competency.

The MacArthur research instruments identify the abilities both helpful and necessary to make decisions and thus serve the value of protecting the vulnerable. Their emphasis on protecting the vulnerable, however, necessarily comes at the price of placing less emphasis on other values implicated in setting standards for competency: the value of protecting autonomy, even when autonomous choices are unconventional, and the value of safeguarding against discrimination. A challenge to the MacArthur researchers is to justify striking this balance in the manner they have. For example, an objection could be raised to their way of balancing values by claiming that freedom of choice includes both the freedom to choose and the freedom to choose *how* to choose—the patient’s decision making *process* implicates the same normative issues as does the patient’s *choice*. And we should not require more of mentally ill patients in this regard than we do of any other individuals.

C. *The MacCAT-T*

The MacCAT-T is a streamlined version of the three research instruments. It is designed to aid in assessing competency in an actual clinical setting. The MacCAT-T is the best instrument currently available of its kind. We raise three points to consider about the MacCAT-T’s application in direct clinical care.

First, the “appreciation” component of the MacCAT-T acknowledges the difference between nonagreement with one’s doctor that is nondelusional (i.e., has some reasonable explanation) and nonagreement that is “based on a delusional premise or some other belief that seriously distorts reality and does not have a reasonable basis in the patient’s cultural or religious background.”³⁵ The range of “reasonable explanations” given, however, may be overly narrow. Only culturally or religiously sanctioned beliefs are permitted to ground “reasonable” disagreements. The MacCAT-T scores as “zero” a patient’s belief that

35. THOMAS GRISSO & PAUL S. APPELBAUM, MACARTHUR COMPETENCE ASSESSMENT TOOL—TREATMENT (MACCAT-T) 12 (1995) (unpublished manual available from authors).

his symptoms are related to circumstances other than a psychiatric disorder, such as stress or overwork. Given widespread beliefs in our society about psychological distress, a patient could be holding non-*patently* false ideas were he to attribute the cause of his symptoms to reasons outside what the MacCAT-T views as permissible.

A second point to consider about the MacCAT-T, insofar as it will be the instrument used in an actual clinical setting, is the suggestion³⁶ that competency exists on a sliding scale, and that the individual evaluator will play a central role in setting the standard when the patient is faced with a choice about treatment. If the patient chooses an alternative that goes against conventional wisdom—say, to reject a treatment with proven efficacy for a serious illness—the evaluator could require a higher level of abilities of the patient. Put another way, according to the MacCAT-T the standard for competency will vary as if on a sliding scale: If patients are about to choose something that will not help them and may harm them, the MacCAT-T deems it especially important to assess whether they know what they are getting themselves into. The evaluator conducting the assessment would judge whether the level of ability would need to be raised given the particular choice at issue and would do so according to how he or she deemed it appropriate.

A challenge to this proposal arises. Doing so seems only a distant cousin to declaring people who make good choices competent and people who make bad choices incompetent. One might respond to the challenge by pointing out that in assessing competency, autonomy is balanced against well-being, so that striking the balance differently when well-being is likely to be affected more seriously makes perfect sense. But there is a difference between saying that one must have certain abilities as a general matter in order to take responsibility for one's own choices, without scrutiny of particular choices, and saying that one must have *more* abilities when society judges that a *particular* choice is bad, or at least not as good as other choices. In addition, this manner of assessing competency allows the evaluator to determine that a choice is problematic based upon his or her own values, rather than on a set of values identified through normative discussion.³⁷ Perhaps at the end of the day competency doctrine should set the balance once, in order to avoid second-guessing patients' decisions. It could convincingly be argued, for example, that giving a third party the power to decide what is

36. See *supra* note 16.

37. Individual evaluators will make decisions regarding which direction, and how far, the scale should "slide." These decisions will inevitably be based upon normative considerations. It is not clear that such considerations should be left to individual mental health professionals, rather than made through normative deliberation.

a good and a not-so-good choice defeats the very notion of competency—that the concept of competency leaves the choice up to the *patient*. One possibility would be to increase the level that we require of patients only in the most exigent circumstances: when a choice exposes the patient to a serious risk of very substantial, perhaps irreversible harm. This policy would minimize the occurrence of individual evaluators making normative judgments about a patient's choice of treatment.

Third, there is a real danger that an investigator faced with a requirement to use the MacArthur instruments may simply adopt its definition of "impairment" as the cutoff point for incompetence, or decide that the line the MacArthur researchers say indicates clear competence should also be the line below which a person is deemed incompetent. That is to say, in practical terms future competency administrators may mistake the nature of certain of the instruments so that "impairment" simply translates into "incompetency," or that the standard given for "clearly competent" on the MacCAT-T is used to divide the competent from the incompetent. It will be important to see whether such mistakes are being made.

V. IMPORTING THE MACARTHUR INSTRUMENTS INTO THE RESEARCH CONTEXT

The MacArthur instruments were designed for measuring capacities relevant to competency to consent to treatment. Two questions arise at the prospect of importing the instruments into the research arena: First, what, if any, normative considerations unique to participation in research will need to be addressed?³⁸ Second, to the extent that the same abilities are relevant in both the treatment and research contexts, will the manner of assessing these abilities need to be adapted to the research setting?

In regard to the first question, research implicates normative issues not raised in the treatment context. As an example, we must factor into our

38. The MacArthur researchers have a book chapter in press that discusses adapting their instruments to the research context. See *Subjects' Capacity*, *supra* note 5. The authors state that the instruments must be adapted to the research context (e.g., the UTD must disclose information appropriate to participation in research), and they point to the added value of increasing scientific knowledge. The authors also suggest adopting a sliding scale approach, so that each evaluator is free to draw the line between autonomy and paternalism as he or she sees best.

balance of autonomy, paternalism, and nondiscrimination a new value: that of advancing science. A question raised by the addition of this new value is whether competence in the research context requires greater capacities. Reasons argue both for and against requiring greater capacities.

In terms of reasons for raising the standard for capacity, consider that the patient/subject will be consenting to participate in activities for the benefit of others, possibly to his or her detriment.³⁹ We may therefore want patient/subjects to play a larger role in evaluating a decision to participate in research, so that correspondingly higher capacities are required. In addition, we may think that as a risk-of-error matter evaluators are likelier to have an interest in finding competency so that their patients will be able to consent to research that will help the researchers. To offset this likely bias, the standard for competency should likewise be raised.⁴⁰ Finally, given the intense transference people sometimes bring to doctor/patient interactions, the patient/subject may not be in a good position to protect himself or herself—that is, to make the best judgment for himself or herself in the absence of a doctor whose *sole* concern it is to assist in making a good judgment for the patient.⁴¹ Reasons that speak against requiring a higher level of competency include a desire to participate in therapeutic research when nothing else seems to help. In addition, people can derive great utility from the thought of helping others and can feel terribly demeaned when their choice to do so is not respected.

39. A variation on this position is that not a great deal is lost by not allowing patient/subjects the opportunity to participate in research. A second variation is that the decision to participate in research is of less benefit to the patient/subject than is the decision to consent to conventional treatment. While the reader will readily appreciate situations in which the second variation is not true, as a broad generality it seems sound.

40. The National Bioethics Advisory Commission recommends an independent professional to assess the subject's capacity to consent to research that involves more than a minimal risk. See *Recommendation 8*, 1 NAT'L BIOETHICS ADVISORY COMM'N, RESEARCH INVOLVING PERSONS WITH MENTAL DISORDERS THAT MAY AFFECT DECISIONMAKING CAPACITY (1998) (visited July 2, 1999) <<http://www.bioethics.gov/capacity/TOC.htm>>.

41. Patients may have many unconscious reasons to consent to research when a doctor asks them to do so. A positive transference—a desire to please the doctor—may be the most powerful, but the subject/patient may also experience a desire not to be the object of the doctor's animus; a belief that the doctor offers protection from all harm and that the doctor *must* have only the patient's interests at heart. In addition, patients may believe that they will not get other therapeutic treatment if they are unwilling to participate, will get the best treatment only if they participate, will be able to survive financially only if they are treated through a research protocol. Finally, the doctor may put some pressure on the patient to consent, and many people have a difficult time saying no.

The question of whether additional capacities are appropriate for competency to consent in the research context will require a thorough normative discussion. The fundamental condition of research, that the patient/subject serves the interests of both the patient and another,⁴² speaks in favor of protecting the vulnerable. Allowing patient/subjects the choice to participate in research, and not requiring more of the mentally ill than other populations before consent is valid, speak in favor of autonomy and nondiscrimination. Discussion and debate are required to find the best balance of the values at play.

Second, the MacArthur instruments have been designed to aid in assessing competence to consent to treatment, and their manner of assessing capacities will therefore need to be adapted for the research context. The UTD, for example, will need to include the most important information patient/subjects need to understand about the research.⁴³ Most important, patient/subjects will need to understand that nontherapeutic research will not help them, and that research doctors have a primary interest in conducting research, not in providing care. The POD will need to be adapted in order to assess the patient's appreciation (belief formation) on these and other matters relevant to the research. Thus, the various instruments will need content that speaks to research.

VI. CONCLUSION

The MacArthur instruments make an enormous contribution to the literature on competency. This article has raised and discussed areas where further discussion may prove fruitful. First, the normative underpinnings of the project merit further discussion. Second, the balance between autonomy, paternalism, and nondiscrimination merits further examination with an eye toward possible reassessment in certain, specific areas. Third, the role of denial merits reconsideration, especially the question of whether denying one's mental illness is in all cases relevant to the question of competency. Finally, a standard of belief in the appreciation instrument could be adopted. To the extent that the normative inquiry leads to a "patently false belief" standard, that

42. In nontherapeutic research, the patient may have a strong interest in wanting to help others.

43. See *supra* note 6.

standard will need to be operationalized.⁴⁴ Notwithstanding these areas

44. A 1996 symposium issue of *Psychology, Public Policy, and Law* that was devoted to the MacArthur Treatment Capacity research instruments contains a number of articles critiquing the POD. See Christopher Slobogin, "Appreciation" as a Measure of Competency: Some Thoughts About the MacArthur Group's Approach, 2 PSYCHOL. PUB. POL'Y & L. 18 (1996) (critiquing approach based on earlier writings of Elyn Saks); Susan Stefan, *Race, Competence Testing, and Disability Law: A Review of the MacArthur Competence Research*, 2 PSYCHOL. PUB. POL'Y & L. 31 (1996) (critiquing instrument on similar grounds); Trudi Kirk & Donald Bersoff, *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*, 2 PSYCHOL. PUB. POL'Y & L. 45 (1996) (critiquing instrument).

The authors have several responses to this critique. First, they note that the critics all seem to want *some* measure of appreciation of illness and treatment to be included in a competency instrument, even if they object to the precise measure used. Second, they suggest that they may well not be all that far apart from their critics in the measure they want: The researchers acknowledge that mere nonacknowledgment of one's disorder, or of the realistic consequences of treatment, is not enough to constitute incapacity. The MacArthur researchers believe that, to speak to the question of capacity, the acknowledgment must be related to delusional thinking or other medical or psychological conditions that are responsible for a serious distortion of reality. They add that they accept the concept of a "patently false belief," provided it is not restricted to delusions but may also include nondelusional reasons for denying the existence of one's disorder, such as parietal lobe damage or intolerable anxiety related to recognition of the disorder. Third, they acknowledge that their instrument does not formulate a criterion for "patently false beliefs," and suggest that it was difficult for them to operationalize this concept; they invite others to try. Finally, the MacArthur researchers note that the MacCAT-T requires clinicians to make a judgment about patients' reasons for denial of their symptoms in order to rate their appreciation. The requirement represents an effort to include the "patently false belief" component in the capacity standard. The authors thought it possible to do so only by relying on clinical judgment, at the cost of sacrificing some psychometric reliability. Thomas Grisso & Paul S. Appelbaum, *The Values and Limits of the MacArthur Treatment Competence Study*, 2 PSYCHOL. PUB. POL'Y & L. 167 (1996).

The authors' first point is well-taken. A decision maker's beliefs are central to competency. The authors' second point, however, merits further discussion. The authors say they want to pick out only beliefs that seriously distort reality. While there may be a variety of reasons for serious distortions of reality, such as anxiety or dissociation (although if the distortions are serious, don't they necessarily *amount* to delusions?), it remains that denial of *mental* illness is often *not* a sufficient distortion of reality to justify a finding of incompetency.

The authors' third point, that (although they generally approve of the notion), they find the concept of a "patently false belief" difficult to operationalize, is a challenge that awaits future research. It will be important first to define a patently false belief as precisely as possible. The manner in which the MacArthur researchers discuss this concept indicates important conceptual differences in how a "patently false delusional belief" has been defined and discussed elsewhere.

Finally, the authors note that the MacCAT-T attempts to introduce the notion of a "patently false belief" by requiring examiners to assess the reasons for patients' denial.

of future work, the MacArthur instruments are an enormously impressive achievement and will no doubt be a focal point for the discussion of competency for many years to come.

Given this approach, well-reasoned bases for disagreement with one's doctor would not count against one's competency, as they currently do according to the POD. While this approach seems correct and workable, the reasons that the researchers *would* allow to justify disavowals may be overly restrictive.



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The Use of Mechanical Restraints in Psychiatric Hospitals

Elyn R. Saks†

Julia, a newly admitted psychotic patient, suddenly breaks a plastic spoon while she is eating lunch. She appears amused, slightly fearful, and a touch defiant. Staff suggest that she needs to be restrained. When Julia resists, six orderlies converge on her, pin her to her bed, and, despite her struggles, cuff her limbs with thick leather straps. Finally, they immobilize her torso with a body net. Tied spread-eagle to the bed, unable to move, Julia is now in “six point” restraints.¹

In time Julia’s physical pain will increase. Her ankles and wrists will bruise, her body will ache from the forced immobility. Although she will beg for release (many patients do), Julia will neither be let go, nor be told when staff plan to untie her. Alone, frightened, and in pain, she will begin to struggle again—a signal to the staff that she needs to be restrained longer.²

Julia was a patient in a well-staffed, highly regarded university hospital when this episode occurred. In most jurisdictions, she would not even have a colorable claim that any of her civil rights or liberties had been violated. Her case is by no means unique; in New York state, which has one of the most stringent and carefully written restraints statutes in the country, in a single month’s time in 1984, nearly 500 patients were restrained in well over 1,100 incidents.³ In fact, Julia was lucky, because she left the hospital unharmed. Between 1979 and 1982, nearly 30 psychi-

† I wish to thank Stephen Behnke for his extensive assistance in the preparation of this Note.

1. “Mechanical restraints” will be used in this Note to refer to the more severe restraining devices, such as “four” and “six point” restraints, body sacks, and camisoles. It will not be used to refer to less severe restraining devices such as arm splints or geriatric chairs, which raise some different issues. This Note takes no position on the acceptability of such devices.

2. For a personal account of a disturbing time in restraints, see C. BEERS, *A MIND THAT FOUND ITSELF* (5th ed. 1921).

3. See Way, *The Use of Restraint and Seclusion in NYS Psychiatric Centers: February 15-March 14, 1984* (Dec. 1984), reprinted in N.Y. STATE COMM’N ON QUALITY OF CARE FOR THE MENTALLY DISABLED & MENTAL HYGIENE MED. REV. BD., *IN THE MATTER OF CHRISTOPHER DUGAN*, Attachment II, at 1-3 (Jan. 1985) (Executive Summary) (one month study shows 397 individuals in restraints or seclusion and 2,228 episodes of restraint or seclusion in N.Y. facilities; patients with six or fewer episodes, amounting to 95% of total, studied in greater detail; 54% in restraints). It is difficult to estimate nationwide how often restraints are used. Only one other incidence study exists: Soloff, *Behavioral Precipitants of Restraint in the Modern Milieu*, 19 *COMPREHENSIVE PSYCHIATRY* 179, 182 (1978) (3.6% of patients in two wards of military teaching hospital restrained at least once) [hereinafter cited as *Precipitants*].

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atric patients died in New York state from being restrained or secluded.⁴ Ironically, what we allow to happen daily to hundreds of psychiatric patients, we, as a society, would not allow to happen to a person who had committed even the most heinous of crimes.⁵

I. A DEVIATION IN THE LEGAL LANDSCAPE

Concern for the liberty and dignity of the members of our society permeates American jurisprudence.⁶ Our legal system has spent much effort balancing these extremely personal and highly individual rights against other societal interests. The law's treatment of mechanical restraints deviates sharply from this legal landscape. Compared to the balance struck between other medical interests and patients' interests in liberty and dignity, the rules that govern restraints are disturbing anomalies.

Both the common law and statutes zealously safeguard the liberty and dignity of the patient by protecting the individual's right to choose what is

4. During the four year period between 1979 and 1982, 19 patients died in state facilities and 11 in private facilities as a result of being restrained or secluded. 89.4% of the 19 examined deaths involved restraints only. See Way, *Restraint and Seclusion Deaths in NYS Psychiatric Centers: 1979-1982* (Dec. 1983), reprinted in N.Y. STATE COMM'N ON QUALITY OF CARE FOR THE MENTALLY DISABLED & MENTAL HYGIENE MED. REV. BD., IN THE MATTER OF CHRISTOPHER DUGAN, Attachment I, at 1, 2 and Table 4 (Jan. 1985).

5. Restraining a prisoner to his bed at four points would seem to be impermissible for either safety or punishment reasons. See, e.g., *Spain v. Procunier*, 600 F.2d 189, 198-99 (9th Cir. 1979) (tying prisoner to object permitted only in emergency); *Pena v. State Division for Youth*, 419 F. Supp. 203, 211 (S.D.N.Y. 1976) (restraining youth to furniture impermissible); *Gates v. Collier*, 349 F. Supp. 881, 900 (N.D. Miss. 1972), *aff'd*, 501 F.2d 1291, 1306 (5th Cir. 1974) (enjoining handcuffing to fences, bars, fixtures); *Landman v. Royster*, 333 F. Supp. 621, 647-48 (E.D. Va. 1971) (chaining prisoner where unable to eat or use toilet, resulting in lack of sleep, pain, and scars, violated Eighth Amendment). The Ninth Circuit has held that restraints may be used on prisoners only in transport, if there is danger, or under medical advice, *Spain v. Procunier*, 600 F.2d 189, 198-99 (9th Cir. 1979). The Fifth Circuit has declared that they may not be used as a punishment. *Ruiz v. Estelle*, 666 F.2d 854, 866 (5th Cir. 1982). At least two courts have considered the use of restraints for medical purposes in prisons. See *French v. Owens*, 538 F. Supp. 910, 919, 928 (S.D. Ind. 1982) (chaining psychotic prisoners spread-eagle to their beds without medication enjoined); *Inmates of Allegheny County Jail v. Wecht*, 565 F. Supp. 1278, 1284-86 (W.D. Pa. 1983) (restraining women stripped to underwear to cot without mattress unacceptable).

6. Liberty, of course, is explicitly recognized in our Constitution. Dignity has received less formal recognition, but is vital nonetheless. To violate a person's dignity is to pay insufficient regard to his intrinsic worth as a human being. Cruel and unusual punishments do just that; they are so painful or degrading that they demean the human spirit. Thus the Eighth Amendment may be seen as a dignity measure. See *Trop v. Dulles*, 356 U.S. 86, 100 (1958) (plurality opinion) ("The basic concept underlying the Eighth Amendment is nothing less than the dignity of man."); *Furman v. Georgia*, 408 U.S. 238, 291 (1972) (Brennan, J., concurring) ("[T]he deliberate extinguishment of human life by the State is uniquely degrading to human dignity."); *Glass v. Louisiana*, 105 S. Ct. 2159, 2168 (1985) (Brennan, J., dissenting from denial of cert.) (execution by electrocution violates "dignity of man"); *Jackson v. Bishop*, 404 F.2d 571, 579-80 (8th Cir. 1968) (whipping prisoners violates Eighth Amendment because it violates human dignity of prisoners).

Similarly, common law rules on battery, false imprisonment, and reasonable force all implicate dignity. See, e.g., W. PROSSER & W. KEATON, *THE LAW OF TORTS* 41 (West 1984) ("The element of personal indignity involved [in batteries] always has been given considerable weight."). See generally *id.* §9, at 39, § 11, at 47, § 19, at 124, and § 20, at 129.

in his own best interests. Except in an emergency, patients have the right under the common law to choose which treatments they will and will not undergo, including the right to elect a treatment that doctors do not believe is the best choice.⁷ "Death with dignity" statutes allow a patient to choose even death over what he perceives to be violations of his personal dignity.⁸ And by looking to what the patient would have wanted if competent, rather than to what is medically indicated, certain states guard even an incompetent patient's right to choose medical treatment.⁹ In short, our law has given primacy to individual dignity over medical interests by allowing patients to choose how their dignity will best be preserved.¹⁰

Civil commitment for mental illness involves issues closely analogous to those implicated in mechanical restraints cases. Like restraints, civil commitment represents "a massive curtailment of liberty,"¹¹ a fact which has led the Supreme Court to hold that certain alleged "treatment-benefits" of commitment (that it affords a patient "milieu therapy," or raises his stan-

7. See generally W. PROSSER & W. KEATON, *THE LAW OF TORTS* § 32, at 189-92 (1984). The most helpful work on this subject of informed consent is J. KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984). Originally, all that was required before a doctor could "touch" a patient was consent. *Pratt v. Davis*, 118 Ill. App. 161 (1905), *aff'd*, 224 Ill. 300, 79 N.E. 562 (1906). However, *Salgo v. Leland Stanford Jr. University Bd. of Trustees*, 154 Cal. App.2d 560, 317 P.2d 170 (1957), introduced the idea that the consent must be *informed*. See also *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960). This notion was extended in *Canterbury v. Spence*, 464 F.2d 772, 786-87 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) and *Cobbs v. Grant*, 8 Cal.3d 229, 243, 104 Cal. Rptr. 505, 514, 502 P.2d 1, 10 (1972), which introduced the notion that the disclosure standard must be patient-based. The development of the informed consent doctrine has accorded increasing weight to patients' autonomy and dignity; patients must be given enough information to make a decision that best accords with their personal values. Furthermore, in giving this information, doctors must take account of what patients want and need to know, not of what other doctors think it medically best for them to know. See also Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137 (1977); Plante, *An Analysis of "Informed Consent,"* 36 *FORDHAM L. REV.* 639 (1968). For a strong defense of patient autonomy, see Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 *YALE L.J.* 219 (1985).

8. See, e.g., Freeman, *Death with Dignity Laws: A Plea for Uniform Legislation*, 5 *SETON HALL LEGIS. J.* 105 (1982); Martyn & Jacobs, *Legislating Advance Directives for the Terminally Ill: The Living Will and Durable Power of Attorney*, 63 *NEB. L. REV.* 779 (1984).

9. For the substituted judgment standard as used in the case of the mentally ill, see, e.g., *Rogers v. Comm'r of Mental Health*, 390 Mass. 489, 458 N.E.2d 308, 315 (1983) ("The recognition of that right [to refuse treatment] must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both. . .") (quoting Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 745, 370 N.E.2d 417, 427 (1977)); *In re Boyd*, 403 A.2d 744, 750-51 (D.C. 1979). Notice that a "best medical interests" standard rather than a "substituted judgment" standard may reflect a judgment that searching for a patient's competent wishes is generally fruitless, and most patients want what their doctors advise anyway, rather than a judgment that a patient's medical interests are more important than his dignity interests.

10. Religious values have also been held to supersede medical interests, sometimes even if refusal of treatment will mean death. See *In re Osborne*, 294 A.2d 372, 374-75 (D.C. 1972). Religious refusals of treatment are more commonly upheld when death is not an issue, however. For cases where the patient is mentally ill, see *Winters v. Miller*, 446 F.2d 65 (2d Cir.) *cert. denied*, 404 U.S. 985 (1971) (Christian Scientist has right to refuse psychotropic medication), and *Osgood v. District of Columbia*, 567 F. Supp. 1026 (D.D.C. 1983) (same).

11. *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

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dard of living) are constitutionally insufficient to justify commitment.¹² Most states have gone even farther. They have forbidden commitment for the sake of any kind of treatment at all,¹³ and have limited it solely to those who are dangerous to themselves or others or who are gravely disabled. Only in these extreme circumstances are liberty and dignity violations believed to be justified.

Accordingly, substantial procedural protections accompany civil commitment to ensure that the infringement upon an individual's dignity and liberty is justified.¹⁴ To determine whether patients meet the commitment criteria, most states entitle patients to a hearing:¹⁵ to notice, to a right to confront and cross examine witnesses, and to representation by counsel.¹⁶ Moreover, the Supreme Court has held that patients must be found to meet the commitment criteria by "clear and convincing" evidence.¹⁷ Mandatory review procedures are common.¹⁸

A substantial majority of states also apply a "least restrictive alternative" mandate to civil commitment, requiring that any infringement upon a patient's liberty must be the absolute minimum necessary to achieve the

12. See *O'Connor v. Donaldson*, 422 U.S. 563 (1975). The Court did not reach the issue of whether treatment in general justifies commitment, *id.* at 573, but it did consider these particular alleged "treatment benefits." The court below had found that milieu therapy in this case was nothing more than confinement in the milieu of the hospital—not enough treatment to justify the patient's injuries. *Id.* at 569. And if treatment is a defense to commitment, then whether something is treatment is justiciable. *Id.* at 574 n.10. Moreover, the "mere presence of mental illness," the Court found, "does not disqualify a person from preferring his home to the comforts of an institution," *id.* at 575. The Court found a person's desire for freedom more important than the material gains provided by institutionalization.

13. As of 1974, only 17 states still allowed commitment based on the "need for treatment" alone. See Note, *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1201-07 (1974) [hereinafter cited as *Developments*].

14. *But cf.* *Parham v. J.R.*, 442 U.S. 584 (1979), which gives children fewer procedural protections than adults. *Parham* also seems to give doctors more authority, and to view commitment as more a medical decision, than did *O'Connor v. Donaldson*. But in *Parham* the determination that doctors are called on to make—that the child is mentally ill and could benefit from hospital treatment—is a medical determination, while the value-decision of whether the benefits of treatment are worth the detriments of hospitalization has already been made by the parents. The parents have decided that their child's being "in need of treatment" is a good enough reason for hospitalization.

15. As of 1974, only ten states used administrative, rather than judicial, hearings to make this determination (although some provided for judicial hearings as an alternative). See *Developments supra* note 13, at 1269 n.36.

16. On notice, see, e.g., CONN. GEN. STAT. § 17-178(a) (1985); IOWA CODE ANN. § 229.7 (West 1985); MONT. CODE ANN. § 53-21-121(3) (1983); WASH. REV. CODE ANN. § 71.05.460 (1975). On the right to cross-examine, see, e.g., CONN. GEN. STAT. § 17-178(c) (1985); IOWA CODE ANN. § 229.12(1) (West 1985); MONT. CODE ANN. § 53-21-126(3) (1983); WASH. REV. CODE ANN. § 71.05.200(1)(d) (1975). On the right to appointed counsel, see, e.g., CONN. GEN. STAT. § 17-178(b) (1985); IOWA CODE ANN. § 229.8(1) (West 1985); MONT. CODE ANN. § 53-21-122(3) (1983); WASH. REV. CODE ANN. § 71.05.460 (1975).

17. *Addington v. Texas*, 441 U.S. 418 (1979).

18. Most states require periodic judicial review of commitment decisions. See, e.g., CONN. GEN. STAT. § 17-178(g) (1985); MONT. CODE ANN. § 53-21-128(2) (1983); S.D. CODIFIED LAWS ANN. § 27A-12-17 (1984); WASH. REV. CODE ANN. § 71.05.320(2) (West 1986). Of course, habeas corpus review is available to anyone who believes he or she is illegally committed.

state's end.¹⁹ These least restrictive alternative statutes are in keeping with the long-articulated principle that intrusion upon an individual's constitutional rights will be permitted only to the extent necessary to achieve another legitimate state interest.²⁰

One area, however, in which some courts and legislatures have been striking the balance in favor of the state interest has been the field of psychotropic medication. Patients' choices not to have psychotropic medication have been overridden in these jurisdictions not only in situations of danger, but also when the treatment-benefits have been deemed great enough,²¹ such as when there are no other less intrusive ways to bring about improvement or when other treatments will take significantly longer to be effective.²² In reaching these decisions, the jurisdictions have given great weight to the vast and largely undisputed literature which asserts that medication is a very effective treatment for most major mental illnesses.²³ But even here—where nearly the entire medical community

19. Least restrictive alternative mandates have been incorporated into at least twenty state statutes explicitly, and fourteen implicitly. See Note, *The Right to Treatment in the Least Restrictive Alternative: The Confusion Remains After Youngberg v. Romeo*, 19 NEW ENG. L. REV. 175, 182-88 (1983) (twenty states have least restrictive alternative mandate explicitly, fourteen, implicitly); see also Hoffman & Foust, *Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of its Senses*, 14 SAN DIEGO L. REV. 1100 (1977); Comment, *The Scope of the Involuntarily Committed Mental Patient's Right to Refuse Treatment with Psychotropic Drugs: An Analysis of the Least Restrictive Alternative Doctrine*, 28 VILL. L. REV. 101 (1982).

20. Historically, this doctrine has been applied to cases involving the First Amendment, see, e.g., *Shelton v. Tucker*, 364 U.S. 479, 488 (1960) (right of association); the due process clause, see, e.g., *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965) (right of privacy); and the equal protection clause, see, e.g., *Dunn v. Blumstein*, 405 U.S. 330, 343 (1972) (right to vote). The doctrine has also been extended to the mental health context. See, e.g., *Lake v. Cameron*, 364 F.2d 657, 660 (D.C. Cir. 1966) (civil commitment); *Covington v. Harris*, 419 F.2d 617, 623-25 (D.C. Cir. 1969) (intra-hospital disposition to high security ward); *De Angelas v. Plaut*, 503 F. Supp. 775, 781 (D. Conn. 1980) (civil commitment of incompetent accused). The constitutional status of the doctrine in the mental health context, however, is uncertain in light of the failure of *Youngberg v. Romeo*, 457 U.S. 307 (1982), to adopt the least restrictive alternative analysis of the lower court.

21. A small number of states expressly allow involuntary psychiatric medication of patients without providing a standard for when such action is acceptable. See, e.g., ALASKA STAT. § 47.30.772 (1984); ARK. STAT. ANN. § 59-1415(2) & (4) (Supp. 1985); CONN. GEN. STAT. § 17-206d(b) (1985).

22. See, e.g., Delaware Department of Health and Social Services, Division of Mental Health, Delaware State Hospital Policy § 1.50 (1985) (on file with author) [hereinafter cited as Delaware State Hospital Policy § 1.50]; Michigan Department of Mental Health, Public Mental Health Manual: Administration of Psychotropic Medication and For Protection of Recipients' Rights 6 (Aug. 2, 1984) [hereinafter cited as Michigan Administration of Psychotropic Medication]; N.J. Reg § II(2)(a) & (b); North Carolina Department of Human Resources, Division of Mental Health, Mental Retardation, and Substance Abuse Services, Human Rights for Clients of State Owned and Operated Facilities, APSM 95-1, at J. 0400-1 to J.0400-2 (1984) [hereinafter cited as North Carolina, Human Rights].

23. See, e.g., Appleton, *Fourth Psychoactive Drug Usage Guide*, 43 J. CLIN. PSYCHIATRY 12 (1982); R. BALDESSARINI, *CHEMOTHERAPY IN PSYCHIATRY* (1985); L. KOLB & H. BRODIE, *MODERN CLINICAL PSYCHIATRY* 809 (10th ed. 1982); D. MORGAN, *PSYCHOPHARMACOLOGY: IMPACT OF CLINICAL PSYCHIATRY* (1985); *GUIDELINES FOR THE USE OF PSYCHOTROPIC DRUGS* (H. Stancer, P. Garfinkel & V. Rakoff eds. 1984).

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agrees upon the efficacy of psychotropics—a number of states have adopted procedural protections governing involuntary medication.²⁴

From these four areas of law, it is possible to draw four general principles which seem to guide society's balance of medical interests against a patient's liberty and dignity interests. First, a patient should be deprived of his liberty only when failure to do so either presents a risk of serious physical harm to himself or others or prevents medical treatment which has clearly been shown to be effective. Second, a patient should be deprived of his liberty only to the extent necessary to achieve the desired goal. Third, a patient's right to choose among treatments should be protected wherever possible. Fourth, when a patient must be deprived of liberty, a set of strict procedures should be imposed to ensure that the infringements upon his liberty and dignity will be kept to an absolute minimum.

The law's current treatment of restraints substantially departs from these principles. Most states allow hospital staff to put patients in restraints when there is no serious threat of injury and without any clear showing of their efficacy.²⁵ Little effort is made to ensure that only that

24. A number of states provide for review by statute. *See, e.g.*, IND. CODE ANN. § 16-14-1.6-7 (Burns 1983); KY. REV. STAT. ANN. § 202A.196 (Baldwin 1985); MD. HEALTH-GENERAL CODE ANN. § 10-708 (Supp. 1985). A number of other states provide for review in regulations or policy directives. *See, e.g.*, Delaware State Hospital Policy § 1.50 (1985), *supra* note 22; Michigan Administration of Psychotropic Medication, *supra* note 22; North Carolina, Human Rights, *supra* note 22; TEX. ADMIN. CODE tit. 25, § 405.808 (1984).

25. Most state restraints statutes do not use a dangerousness standard. Restraints statutes may be divided into seven categories. First is the statute that requires the use of restraints to be recorded: W. VA. CODE § 27-5-9(e) (1980).

Second are the statutes that proscribe unnecessary or excessive restraints: ARK. STAT. ANN. § 59-1416(23) (Supp. 1985); KY. REV. STAT. ANN. § 202A.191(h) (Baldwin 1985); N.D. CENT. CODE § 25-03.1-40(4) (1978); VA. CODE § 37.1-84.1(6) (1984).

Third are the statutes that require restraints to be prescribed by a designated authority, usually a physician: D.C. CODE ANN. § 21-563 (Supp. 1985); NEV. REV. STAT. § 433.484(2) (1985); OHIO REV. CODE ANN. § 5122.27(F)(7) (Page 1981); TEX. REV. CIV. STAT. ANN. art. 5547-86 (Vernon 1986).

Fourth are the statutes that allow restraints only if required by the "medical needs" of the patient: ME. REV. STAT. ANN. tit. 34-B, § 3803(3) (Supp. 1985); OKLA. STAT. ANN. tit. 43A, § 92 (West 1979); OR. REV. STAT. § 426.385(3) (1985); PA. STAT. ANN. tit. 50, § 4422 (Purdon 1969); S.C. CODE ANN. § 44-23-1020 (Law. Co-op. 1985); TENN. CODE ANN. § 33-3-104(4) (Supp. 1985); UTAH CODE ANN. § 64-7-47 (Supp. 1985); VT. STAT. ANN. tit. 18, § 7704 (1968); WYO. STAT. § 25-10-119 (1982).

Fifth are the statutes that allow restraints, roughly, for either safety in an emergency or on a professional's written order explaining the rationale for the restraint: MONT. CODE ANN. § 53-21-146 (1983); N.J. STAT. ANN. 30:4-24.2(d)(3) (West 1981); S.D. CODIFIED LAWS ANN. § 27A-12-6 (Supp. 1986).

Sixth are the statutes that allow restraints, roughly, for either the safety or the treatment of the patient: ARIZ. REV. STAT. ANN. § 36-513 (1986); HAWAII REV. STAT. § 334E-2(18) (Supp. 1980); IND. CODE ANN. § 16-14-1.6-6 (Burns 1983); LA. REV. STAT. ANN. § 28:171(D) (West Supp. 1986); MICH. COMP. LAWS ANN. § 330.1742(2) (West 1980) (seclusion); N.C. GEN. STAT. § 122C-60 (Supp. 1985); WIS. STAT. ANN. § 51.61(1)(i) (West Supp. 1985).

Seventh are the statutes that do require dangerousness to self or others: ALASKA STAT. § 47.30.825(d) (1984); CONN. GEN. STAT. § 17-206e(a) (1985); GA. CODE ANN. § 37-3-165 (Supp.

amount of restraint is exercised which is required to achieve the desired end,²⁶ and, as a matter of course, patients are given no choice in the manner of restraint.²⁷ Finally, few, if any, procedural safeguards attend the patient's initial deprivation of liberty, or are called into play to determine how long the deprivation will continue.²⁸ Overall, current law overwhelmingly sees restraints as a practice best regulated by internal professional norms, and thus leaves to doctors and hospital staff most decisions about how restraints are to be used.²⁹

II. IS A LAISSEZ-FAIRE POLICY JUSTIFIED?

Three reasons may be offered in defense of the law's laissez-faire attitude toward the use of mechanical restraints: first, that the medical benefits derived from their use justify the intrusion into patients' liberty and dignity; second, that the mentally ill do not have as great an interest in liberty and dignity as do other patients; third, that a strict legal standard governing the use of restraints would be too great an intrusion into medical institutions. A close examination of each of these reasons indicates that none warrants the law's "hands-off" policy toward the use of mechanical restraints.

1985); IDAHO CODE § 66-345 (Supp. 1986); ILL. REV. STAT. ch. 91 ½, § 2-108 (1982); KAN. STAT. ANN. § 59-2928 (1983); MD. HEALTH-GENERAL CODE ANN. § 10-701(c)(3) (Supp. 1985); MASS. GEN. LAWS ANN. ch. 123, § 21 (West Supp. 1985); MICH. COMP. LAWS ANN. § 330.1740 (West 1980) (restraints); MINN. STAT. ANN. § 253B.03(1) (West 1982); MO. ANN. STAT. § 630.175 (Vernon Supp. 1986); N.Y. MENTAL HYG. LAW § 33.04 (Consol. 1978). *See also* Tardiff & Mattson, *A Survey of State Mental Health Directors Concerning Guidelines for Seclusion and Restraint* in *THE PSYCHIATRIC USES OF SECLUSION AND RESTRAINT* 141, 144 (K. Tardiff ed. 1984) [hereinafter cited as *USES*] (21 states have regulations that allow restraints only to prevent harm to self, others, or property, but some may not apply state-wide). These statutes, however, contain inadequate procedures and other deficiencies. *See infra* notes 71-85 and accompanying text.

26. No statute adequately distinguishes between restraints and seclusion, resulting in the use of restraints even when there are less restrictive alternatives. *See infra* note 76. The proposal below does limit restraints to when they are the least restrictive alternative. *See infra* notes 72-77 and accompanying text.

27. Only two states mention the issue of choice. Oklahoma allows patients to choose seclusion or restraints over medication (but not vice versa) "if practical." OKLA. STAT. ANN. tit. 43A, § 54.8D (West Supp. 1985). Alaska requires that the patient's choice among forms of restraint be consulted and "considered," if "practicable." ALASKA STAT. § 47.30.825(d) (1985). The proposal below, *see infra* notes 78-80 and accompanying text, goes beyond these statutes.

28. *See infra* notes 81-83.

29. In *Youngberg v. Romeo*, 457 U.S. 307, 321-23 (1982), the Supreme Court decided that the constitutional standard is an "actual professional judgment" standard. Existing common law restraints cases rely on a malpractice standard, which is also based on professional norms. *See* Annot., 8 A.L.R.4th 509, 512 §§ 13, 15 (1981); 25 A.L.R.3d 1450 (1969).

Mechanical Restraints

A. Casting Doubt on Treatment Efficacy: The British Experience

A comparison of British and American practices governing the use of restraints raises serious doubts about the alleged "medical benefits" offered by mechanical restraints.

The American medical community readily accepts the use of physical controls.³⁰ American psychiatrists do not even see mechanical restraints as a "regrettable but permissible emergency liberty infringement."³¹ Rather, in their view, restraints can be justified by one of two "medical benefits" theories: they are either a form of therapy (the "treatment" view) or a form of patient management, with medical indications and contraindications (the "management" view).³²

30. Although this Note focuses on restraints, and discusses seclusion and emergency medication only insofar as they bear upon the use of restraints, in discussions of the theory and practice of restraints, some reference will be made to the more voluminous literature on seclusion. Seclusion is different from restraints in some respects: it may be used for destimulation, and it may result in sensory deprivation. If care is taken to except these features, however, the literature on seclusion can be helpful, for seclusion and restraints share the important feature of limiting destructive behavior, and may be presumed to have similar causes and effects. Some commentators go so far as to suggest that seclusion and restraints are interchangeable, *see infra* note 80—not a position held in this Note. Moreover, restraints often take place in seclusion; thus a knowledge of seclusion is helpful to an understanding of restraints.

31. Guthell & Tardiff, *Indications and Contraindications for Seclusion and Restraint*, in *USES*, *supra* note 25, at 11.

32. For some of the most important discussions in favor of the use of restraints and seclusion, see, e.g., *THE PSYCHIATRIC USES OF SECLUSION AND RESTRAINT*, *supra* note 25 (discussing restraints and seclusion in wide variety of contexts, e.g. use on the psychiatrically ill, the elderly, and the developmentally disabled); Bursien, *Using Mechanical Restraints on Acutely Disturbed Psychiatric Patients*, 26 *HOSP. & COMM. PSYCHIATRY* 757 (1975) (giving indications for use of restraints); Rosen & DiGiacomo, *The Role of Physical Restraint in the Treatment of Psychiatric Illness*, 39 *J. CLIN. PSYCHIATRY* 228 (1978) (same). The most important discussion opposing the use of restraints is Guirguis, *Management of Disturbed Patients: An Alternative to the Use of Mechanical Restraints*, 39 *J. CLIN. PSYCHIATRY* 295 (1978) (discussing disadvantages of use of restraints).

See also Cubbin, *Mechanical Restraints: To Use or Not to Use?* 66 *NURSING TIMES* 752 (1970); Fitzgerald & Long, *Seclusion in the Treatment and Management of Severely Disturbed Manic and Depressed Patients*, 11 *PSYCHIATRIC CARE* 59 (1973); Gair, *Limit-Setting and Seclusion in the Psychiatric Hospital*, *PSYCHIATRIC OPINION*, Feb. 1980, at 15; Guthell, *Observations on the Theoretical Bases for Seclusion of the Psychiatric Inpatient*, 135 *AM. J. PSYCHIATRY* 325 (1978); Guthell, *Restraint Versus Treatment: Seclusion as Discussed in the Boston State Hospital Case*, 137 *AM. J. PSYCHIATRY* 718 (1980); Kilgalen, *The Effective Use of Seclusion*, *J. PSYCHIATRIC NURSING & MENTAL HEALTH SERVICES* Jan. 1977, at 22; *ASSAULT WITHIN PSYCHIATRIC FACILITIES* (J. Lion & W. Reid eds. 1983); Plutchik, Karasu, Conte, Siegel & Jerrett, *Toward a Rationale for the Seclusion Process*, 166 *J. NERVOUS AND MENTAL DISEASE* 571 (1978) [hereinafter cited as Plutchik]; Reid, *Controlling the Fight/Flight Patient*, *CAN. NURSE* Oct. 1973, at 30; *CLINICAL TREATMENT OF THE VIOLENT PERSON* (L. Roth ed. 1985); Soliday, *A Comparison of Patient and Staff Attitudes toward Seclusion*, 173 *J. NERVOUS & MENTAL DISEASE* 282 (1985); McElroy, *Consumers of Psychiatric Services and Staff: Worlds Apart on the Issue of Seclusion*, 173 *J. NERVOUS & MENTAL DISEASE* 287 (1985); Chamberlin, *An Ex-Patient's Response to Soliday*, 173 *J. NERVOUS & MENTAL DISEASE* 288 (1985); Jensen, *Comments on Dr. Stanley M. Soliday's "A Comparison of Patient and Staff Attitudes toward Seclusion,"* 173 *J. NERVOUS & MENTAL DISEASE* 290 (1985); Soloff, *Physical Restraint and the Nonpsychotic Patient: Clinical and Legal Perspectives*, 40 *J. CLIN. PSYCHIATRY* 302 (1979) [hereinafter cited as *Restraint and the Nonpsychotic Patient*]; Strutt, Bailey, Peermohamed, Forrest & Corton, *Seclusion: Can It Be Justified?*, 76 *NURSING TIMES* 1629 (1980) [hereinafter cited as Strutt].

The "treatment" view³³ sees restraints as therapy for psychotic patients who are disorganized, delusional, and often impulsive. Restraints are supposed to calm these patients by reassuring them that they will not be allowed to lose control,³⁴ and are said to "give definition [to] disrupted ego-boundaries."³⁵ The literature analogizes the restraining process to a mother holding her crying, kicking child until the child is able to regain control.³⁶

Under the "management" view, restraints are indicated to prevent violence, to calm agitated patients, and to preserve the "therapeutic milieu."³⁷ In practice, restraints are most often used for the latter two reasons.³⁸ Management theorists recommend that restraints be used at the earliest sign of disturbance.³⁹

For discussions of the legal issues raised by seclusion and restraints, see Wexler, *Seclusion and Restraint: Lessons from Law, Psychiatry, and Psychology*, 5 INT'L J. L. & PSYCHIATRY 285 (1983) (discussing implications of *Youngberg v. Romeo* for restraint and seclusion practices); Wexler, *Legal Aspects of Seclusion and Restraint*, in USES, *supra* note 25, at 111 (same) [hereinafter cited as *Legal Aspects*]; Dix, *Legal and Ethical Issues in the Treatment and Handling of Violent Behavior*, in CLINICAL TREATMENT OF THE VIOLENT PERSON, *supra*, at 187 (discussing issues raised by emergency and behavior modification uses of restraints and seclusion).

33. Several commentators state or suggest that restraints are a form of "treatment." See, e.g., Straker, *Guidelines for the Elderly*, in USES, *supra* note 25, at 103. Nowhere in the literature on restraints is this treatment theory spelled out, however. This Note therefore borrows from the literature on seclusion, as well as from discussions with numerous professionals, to piece together the "treatment" view of restraints.

This treatment view of restraints is not new. In the past restraints were thought to torture patients out of "their madness," see THREE HUNDRED YEARS OF PSYCHIATRY 254 (R. Hunter & I. MacAlpine eds. 1963) (section discussing and quoting F. van Helmont) [hereinafter cited as 300 YEARS]; THREE HUNDRED YEARS OF PSYCHIATRY 325 (R. Hunter & I. MacAlpine eds. 1963) (section discussing and quoting P. Blair), or to suppress physical excitement and thereby tranquilize the mind, see THREE HUNDRED YEARS OF PSYCHIATRY, 473, 478 (R. Hunter & I. MacAlpine eds. 1963) (section discussing and quoting W. Cullen).

Even pro-restraints theorists have long been aware that restraints can put patients in a *more* disturbed state of mind. See Reid, *supra* note 32, at 33; Kronberg, in ASSAULT WITHIN PSYCHIATRIC FACILITIES, *supra* note 32, at 23; Rosen & DiGiacomo, *supra* note 32, at 232; Mattson & Sacks, *Seclusion: Uses and Complications*, 135 AM. J. PSYCHIATRY 1210, 1212 (1978). Opponents of restraints, such as Guirguis, think that exacerbation of disturbance is the usual result of restraints. See Guirguis, *supra* note 32, at 297. See also Conolly, *infra* note 42.

34. See, e.g., Kilgalen, *supra* note 32, at 24; Soloff, *Precipitants*, *supra* note 3, at 180; Wells, *The Use of Seclusion on a University Hospital Psychiatric Floor*, 26 ARCH. GEN. PSYCHIATRY 410, 412 (1972).

35. See Soloff, *Restraint and the Nonpsychotic Patient*, *supra* note 32, at 302; see also Soloff, *Precipitants*, *supra* note 3, at 188; Soloff, *Physical Controls: The Use of Seclusion and Restraint in Modern Psychiatric Practice*, in CLINICAL TREATMENT OF THE VIOLENT PERSON, *supra* note 32, at 124, 129 [hereinafter cited as *Physical Controls*]. In a related vein, Soloff also sees restraints as bringing about the restitution of internal controls. See Soloff, *Restraint and the Nonpsychotic Patient*, *supra* note 32, at 305.

36. See Reid, *supra* note 32, at 32; Gair, *supra* note 32, at 15-16.

37. See Gutheil & Tardiff, *supra* note 31, at 11-12. The "therapeutic milieu" is that atmosphere of the ward which is supposed to be therapeutic for patients. Simply stated, "preserving the milieu" means maintaining calm on the ward.

38. See, e.g., Gutheil, *Review of Quantitative Studies*, in USES, *supra* note 25, at 125, 130-37; Soloff, *Physical Controls*, *supra* note 35, at 129-35.

39. See Gutheil & Tardiff, *supra* note 31, at 11.

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On both the “treatment” and “management” views, then, it is clear that restraints are recommended for earlier and longer use than they would be for safety reasons alone.⁴⁰

In contrast to their American counterparts, British psychiatrists have successfully done without the major forms of mechanical restraint for many years.⁴¹ The non-restraint movement in Britain was begun by John Conolly in the last century,⁴² and today’s British psychiatrists recommend using physical controls (like seclusion) only when absolutely necessary,

40. For the “management” theorist’s position, see *id.* For the “treatment” theorist’s position, see Rosen & DiGiacomo, *supra* note 32, at 230–31.

41. Although the British do still use minor restraining devices such as arm splints and geriatric chairs, they do not employ the major forms of restraint. See British Mental Health Act Commission, Patients Presenting Particular Management Problems § 8.6.1 (Proposed Regulations) (on file with author). These recommendations of the Mental Health Act Commission, a body established to write a Code of Practice for psychiatrists, will be submitted to the Secretary of State, who will “consult such bodies as appear to be concerned” and then lay the proposals before Parliament. See Mental Health Act 1983, at § 118 (3) & (4), 1983 PUB. GEN. ACTS & MEAS. ch. 20. While Patients Presenting Particular Management Problems § 8.6.1 prescribes procedures to be used in the case of the minor restraining devices, this proposed regulation also states that: “In Britain, major forms of mechanical restraint have long been abandoned. . . .” The Mental Health Act Commission has stated that “major forms of mechanical restraint” include manacles, straightjackets, and four point restraints. Letter from Mental Health Act Commission (Feb. 20, 1986) (on file with author). See also Dewhurst, *The New Methods of Restraint*, 66 NURSING TIMES 749, 751 (1970) (finding no evidence that major forms of restraint, including posey vest and four points, used in British psychiatric hospitals).

42. Conolly was the most famous spokesperson for the non-restraint movement in Britain. His book, *THE TREATMENT OF THE INSANE WITHOUT MECHANICAL RESTRAINTS* (1856), thoroughly documented the salutary effects of removing patients’ shackles. Although Conolly did allow for the use of seclusion in some circumstances, *id.* at 212, 232–33, he recommended a policy of forbearance toward patients’ inappropriate behavior, *id.* at 235, 40, 115–16, and managed to forego the use of restraints for over ten years. His accomplishment was even more remarkable in that he did not have antipsychotic drugs with which to calm his patients. Moreover, contrary to what Soloff suggests in *Physical Controls*, *supra* note 35, at 125–26, Conolly’s hospital did care for acute as well as chronic patients; see, e.g., *THE TREATMENT OF THE INSANE WITHOUT MECHANICAL RESTRAINTS* (1856), at 35–37, 224–25, and 262. Forty other large public asylums quickly replicated Conolly’s success. *Id.* at 342.

Conolly did have some predecessors. Philippe Pinel began the non-restraint movement in Europe in 1793. R. Hill experimented with the total abolition of restraint at the small hospital in Lincoln, England: “in a properly constructed building, with a sufficient number of suitable attendants, restraint is never necessary, never justifiable, and always injurious, in all cases of Lunacy whatever.” See 300 YEARS, *supra* note 33, at 890 (emphasis in original); see also *id.* at 897 (discussing and quoting Prichard, credited by Hill as first person to adopt non-restraint system in full); Knoff, *Modern Treatment of the “Insane”: An Historical View of Nonrestraint*, 60 N.Y.S. J. MED. 2236 (1960); Soloff, *Historical Notes on Seclusion and Restraint*, in USES, *supra* note 25, at 1.

For accounts of more recent efforts to reduce the use of restraints and seclusion in America, see Greenblatt, *Seclusion as a Means of Restraint*, PSYCHIATRIC OPINION, Feb. 1980, at 13; Solomon, *Half a Century of Hospital Psychiatry*, 19 HOSP. & COMM. PSYCHIATRY 367 (1968). See also M. GREENBLATT, R. YORK & E. BROWN, FROM CUSTODIAL TO THERAPEUTIC CARE IN MENTAL HOSPITALS 60, 307 (1955) (patient hours in seclusion dropped from over 600 hours a month to under 50 hours a month within two and a half years at one hospital; from 265 hours a week to one hour a week within four months at another hospital); Jacoby, Babikian, McLamb & Hohlbein, *A Study in Non-Restraint*, 115 AM. J. PSYCHIATRY 114, 119 (1958) (40 patients in restraints a day to zero a day in six weeks; no seclusion used). While these studies show that American hospitals are able to reduce the use of seclusion and restraints, despite their initial pessimism about the process, comparison with the British experience suggests that American hospitals still have a long way to go.

and then only to the smallest possible degree.⁴³ For example, a British Commission has recommended that using physical controls to preserve the milieu in British hospitals be forbidden.⁴⁴

The statistics demonstrate the success of the British philosophy. Despite the absence of mechanical restraints, the British use seclusion less often than American psychiatrists,⁴⁵ and there is no evidence that they use medication or physical restraint⁴⁶ more than American psychiatrists.⁴⁷ Indeed, the British mental hospital today uses little coercion of any kind; most

43. As the Royal College of Psychiatrists says:

The degree of force should be the minimum required to control the violence and it should be applied in a manner that attempts to reduce rather than provoke a further aggressive reaction. The number of staff involved should be the minimum necessary to restrain the patient while minimizing injury to all parties.

British Department of Health and Social Security, Health Services Management: The Management of Violent, or Potentially Violent, Hospital Patients, Health Circular HC[76]11, Appendix by Royal College of Psychiatrists. Compare Lion & Soloff, *Implementation of Seclusion and Restraint*, in USES, *supra* note 25, at 19, 23 (discussing American psychiatry's recommendation of "show of force" as best means of averting or minimizing violence). Similarly, British Mental Health Act Commission, Patients Presenting Particular Management Problems (Proposed Regulations) (on file with author) clearly and cogently states a minimalist approach to the use of physical controls.

For further examples of British seclusion guidelines, see Royal College of Nursing, *Seclusion and Restraint in Hospitals and Units for the Mentally Disordered* (April 1979) (on file with author); Nursing Management Directive: Seclusion—The Use of Single and Protective Rooms, No. 3 (April 1984) (on file with author); Royal College of Psychiatrists, *Locking up Patients By Themselves*, 6 BULL. ROYAL COLLEGE OF PSYCHIATRISTS 199 (1982). See also Royal College of Psychiatrists, *Isolation of Patients in Protected Rooms During Psychiatric Treatment*, 5 BULL. ROYAL COLLEGE OF PSYCHIATRISTS 96 (1981).

44. See British Mental Health Act Commission, Patients Presenting Particular Management Problems §8.2 (Proposed Regulations) (on file with author): "Both informal and detained patients may exhibit behaviour other than violence which may cause management problems. This may include irresponsible behaviour; un-cooperativeness; socially embarrassing behaviour; sexually inappropriate behaviour; aimless wandering; self-injury. Only close supervision, individual plans of care, and a suitable setting or environment should be used for such behaviour."

45. For British seclusion rates, see Strutt, *supra* note 32, at 1632 (average secluded in month: .26%; maximum time: 2 hours and 40 minutes); Mental Health Act Commissioner, *The Practice of Seclusion in Psychiatric Hospitals* (on file with author) (only 35 of 42 public hospitals use seclusion; average time: one half hour to an hour); Higgins, *Four Years' Experience of an Interim Secure Unit*, 282 BRIT. MED. J. 889, 890 (1981) (seclusion used for only "a few hours in four years" in facility for most difficult patients). But cf. Campbell, *The Use of Seclusion*, 78 NURSING TIMES 1821, 1822-23 (1982) (seclusion used on 75% of patients; still, average only 2.6 hours, maximum, 23 hours; year long study with no control for days at risk). Compare American rates, cited in Gutheil, *Review of Quantitative Studies*, *supra* note 38, at 126-27 (range from 1.9% to 44%, with an average of 18.8%; range in average times from less than three hours to 20 hours, with an average of 9.7 hours).

On restraints rates in America, see *supra* note 3. But note also that in Schwabb & Lahmeyer's study, *The Uses of Seclusion on a General Hospital Psychiatric Unit*, 42 J. CLIN. PSYCHIATRY 228, 230 (1979), 18% of the patients in seclusion were also in restraints, and that in Tardiff's study, *Emergency Control Measures for Psychiatric Inpatients*, 169 J. NERVOUS & MENTAL DISEASE 614, 615 (1981), the figure of 1.9% refers to patients in seclusion or restraints.

46. "Physical restraint" means holding a patient down but not tying him up.

47. Nor is there evidence that the British have a higher rate of injuries as a result of not using restraints. Indeed, the evidence that restraints prevent violence is somewhat equivocal: half of all assaults on staff in American psychiatric hospitals occur during restraint and seclusion episodes. See Lion & Soloff, *supra* note 43, at 22, citing ASSAULT WITHIN PSYCHIATRIC FACILITIES, *supra* note 32. Restraints and seclusion may so frighten or anger some patients that they are likelier to become violent.

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wards are unlocked, and voluntary patients—the vast majority—are free to leave the hospital without notice.⁴⁸

That British psychiatrists so vigorously oppose the use of mechanical restraints, and that they care for their patients with little recourse to them, calls the American “treatment” view into doubt. Indeed, the evidence in favor of the efficacy of restraints is at best anecdotal,⁴⁹ and even proponents of the “treatment” view would be hard-pressed to claim that this evidence is anything like that in favor of psychotropic medication. If it is permissible to deprive a patient of his liberty for treatment purposes only when the benefits of the treatment are clear, then the “treatment” rationale for the use of restraints must fail.

The British experience provides an even stronger case against the “management” theory of restraints. British psychiatrists have found that mechanical restraints are simply not needed in order to manage patients and maintain the therapeutic milieu. In contrast, American “management” practice calls for restraints early and often, encouraging psychiatrists to act immediately rather than to wait and see if the perceived threat materializes.

Some examples of the use of restraints give a flavor of what the “management” theory will justify. In the first a patient is subjected to physical controls for repeatedly lacerating himself superficially to get staff attention; the “treatment” provided a “face-saving way to give up the regressive behavior.”⁵⁰ In the second, a patient—never actually violent—is restrained for pacing more vigorously than usual.⁵¹ In the third, a patient is

48. See Public Policy Committee of the Royal College of Psychiatrists, *Locked Wards and Informal Patients*, 4 BULL. ROYAL COLLEGE OF PSYCHIATRISTS 8, 9 (1980) (“the vast majority of psychiatric patients are cared for and treated in open wards”); MIND, A PRACTICAL GUIDE TO MENTAL HEALTH LAW ch. 1 (1983) (90% admissions “informal;” informal or voluntary patients may leave hospital without notice).

49. No *experimental* evidence documents the effects of restraints or seclusion. Anecdotal evidence goes both ways, but where studies have been done, physical controls appear in a uniformly bad light.

The most impressive study of how patients in fact react to seclusion (often, seclusion and restraints) is in Wadeson & Carpenter, *Impact of the Seclusion Room Experience*, 163 J. NERVOUS & MENTAL DISEASE 318 (1976). This study was not intended to document the effects of seclusion, thus the danger of patients attempting to please their doctors is minimized. Wadeson and Carpenter found that:

Delusional material and affective response to seclusion directly represent fear, terror, anger, and resentment. In the art productions, patients presented a universally negative view of the seclusion experience when reacting directly to the event. . . . The nonpsychotic feeling of bitterness over being placed in seclusion was usually a prevailing attitude, even at 1-year follow-up, not simply an immediate reaction. For a few of our patients, bitterness about being secluded colored their entire perception of their hospitalization.

Id. at 327–28. See also Soliday, *supra* note 32 (study showing patients have much more negative view of seclusion than staff); Chamberlin, *supra* note 32, at 288 (ex-patient reports that patients find seclusion form of “torture”); Plutchik, *supra* note 32, at 575 (study showing patients have largely negative response to seclusion).

50. Wells, *supra* note 34, at 412–13. The patient was secluded.

51. Confidential source in New Haven hospital.

restrained for being rude to staff.⁵² The spoon-breaker discussed earlier could be cited under each category: as potentially violent, as agitated, and as disruptive of the milieu.⁵³

Professor Wilhelm Griesinger long ago addressed the danger of the argument that the use of restraints is good and only the abuse is blameable. "No one," he said, "can say where the use ends and the abuse begins. . . ."⁵⁴

B. *The "Lesser Liberty" Argument*

The second justification for a laissez-faire attitude toward the use of mechanical restraints is that society need not weigh the liberty and dignity interests of psychiatric patients as heavily as it does those of other individuals. Psychiatric patients, the argument might run, cannot appreciate their actions in the way other individuals can. As a consequence, we should be less concerned about protecting their liberty.

This argument fails for two reasons. First, nothing suggests that psychiatric patients do not value and appreciate their freedom at least as much as anyone else does.⁵⁵ On the contrary, familiarity with the commitment

52. Binder, *The Use of Seclusion on an Inpatient Crisis Intervention Unit*, 30 HOSP. & COMM. PSYCHIATRY 266, 268 (1979) (also giving examples of patients secluded for yelling at staff, being sarcastic, and refusing medications).

53. Restraints and seclusion may easily be used in inappropriate and untherapeutic ways. See, e.g., Gutheil & Tardiff, *supra* note 31, at 14 and 17; Soloff, *Physical Controls*, *supra* note 35, at 139-40. The most disturbing cases are those in which restraints seem to be used as a form of punishment. Consider these cases: patient restrained for not getting out of bed (confidential source in Connecticut hospital); not remaining in day area (confidential source in Philadelphia hospital); cutting loose a restrained patient, Soloff, *Restraint and the Nonpsychotic Patient*, *supra* note 32, at 304; repeated slamming of doors, Mattson & Sacks, *supra* note 33, at 1211.

It is true that a number of statutes proscribe the use of restraints as punishment. See, e.g., ILL. REV. STAT. ch.91 ½, § 2-108 (1982); LA. REV. STAT. ANN. § 28:17(D) (West Supp. 1986). Yet it is difficult to argue with the claim that restraints were used, not as punishment, but because the milieu was disrupted, or because the patient's "medical needs" called for the use of restraints (i.e. punishment will help him).

The danger that staff will use restraints to meet their own needs (to punish or to manage), whatever the ostensible reason for the restraints, is noted even in the pro-restraints medical literature. Thus Gutheil & Tardiff, *supra* note 31, at 16-17, acknowledge that staff may use restraints or seclusion inappropriately to deal with their own problems—to avoid dealing with difficult patients, to engage a distant doctor, or to scapegoat. Binder, *supra* note 52, at 268, notes that seclusion, in his study, appeared sometimes to be used as a method of retaliation.

Guirguis, who disapproves of restraints, points out similar dangers. The habituation potential in staff is too great: restraints may replace more appropriate measures because they are an easy way to handle patients. Similarly, there is the potential for a more profound kind of abuse: "staff can act out their own conflicts by way of punishing the patient." *Supra* note 32, at 297. See also Strutt, *supra* note 32, at 1631.

54. 300 YEARS, *supra* note 33, at 1032 (quoting Griesinger's 1867 comment).

55. During the course of personal conversations, a number of psychiatrists have suggested that restraining a mentally ill patient is not like restraining a "normal" person, that mentally ill patients experience being restrained "differently" than would a "normal" person. Conversations with patients who have been restrained, however, strongly suggest that they are no less sensitive to the pain and indignity of being strapped down than any other person would be.

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system, where patients confined involuntarily in hospitals strenuously contest their confinement, may well lead one to precisely the opposite conclusion.⁵⁶ Second, a standard of liberty based upon an individual's level of functioning would require troubling decisions about the weights and merits of the liberty interests of different individuals and groups in our society.⁵⁷

Indeed, by protecting patients' freedom, society can, first, reinforce in these individuals what freedom they do retain,⁵⁸ second, give these individuals the dignity of making those choices they are in the best position to make, and third, reaffirm its commitment to the dignity and value of each of its members. As a consequence, the decision to restrain a patient, if it is to be made at all, should be made in response to his dangerous actions, not to assumptions about the relative value of his freedom.

C. *The "Intrusion" Justification*

The claim that the law should allow a liberal use of restraints because a more restrictive standard would be too great an intrusion into the medical milieu⁵⁹ fails for two reasons. First, medical regulation of restraints is often not even *conceptually* sound. Second, no convincing argument has been put forth that a new law governing the use of restraints would make institutional life worse.

We may be wary of intruding too much on medical practice because we think that doctors are best situated to know what their patients need. Thus, we hesitate to burden the profession with extra-medical rules which we fear will not serve patients' interests well. But we often subject medical practice to outside constraints in the belief that patients' needs and interests go beyond the purely medical.⁶⁰

In fact, many decisions to restrain (like decisions to commit) are not medical decisions at all. What degree or imminence of danger justifies restraints? Do the social consequences of mental regression justify re-

56. Interview with Professor Stephen Wizner, Director of Clinical Studies and Professor (Adjunct) of Law, Yale Law School (June 6, 1986).

57. Thus the law seems to shun this kind of argument: in deciding the civil commitment issue in *O'Connor v. Donaldson*, 422 U.S. 563 (1975), e.g., the Court was not heard to argue that the liberty of mentally ill people was less valuable than that of others. *But cf. Schall v. Martin*, 467 U.S. 253 (1984) (youths' interest in freedom weakened by fact that youths always in someone's custody).

58. See, e.g., Nigrosh, in *ASSAULT WITHIN PSYCHIATRIC FACILITIES*, *supra* note 32, at 269.

59. This is one of the Court's main concerns in *Youngberg v. Romeo*, 457 U.S. 307, 322 (1982). It may be some reassurance to note that the non-restraint movement in England, while launched by physicians, was fueled by Parliamentary inquiries in 1815 and 1816, as well as by legislation on restraints some years later. 300 YEARS, *supra* note 33, at 696-97.

60. I have already discussed how patients must give their informed consent before being treated, and may not be civilly committed solely on the ground that commitment is medically the optimal course. See *supra* notes 7-13 and accompanying text.

straints?⁶¹ These questions implicate acute moral and social values such as the importance of freedom and the rights of the individual against the group. The physician's superior medical knowledge does not vest him with a unique ability to make these collective, ethical choices. The questions are properly social, not medical, and the answers should properly be supplied by social mechanisms.⁶²

A second concern with intruding on medical practice within institutions is that it may have unpredictable effects, actually harming instead of improving institutional life. The success of the non-restraint movement in Britain, however, suggests that this fear is unfounded. Moreover, present rules governing the use of restraints⁶³ have clearly negative consequences in that they do little to discourage the use of restraints and much to encourage it. Current law credits doctors with predictive powers they do not have⁶⁴ and indulges doctors' fears of liability for injuries they could not have predicted.⁶⁵ As a consequence, current law actually *encourages* doctors to over-predict violence, and thus to restrain patients unnecessarily.⁶⁶

III. A MODEL RESTRAINTS STATUTE

The abuse of mechanical restraints needs to be addressed in a legislative rather than judicial forum. The recent Supreme Court case of *Youngberg v. Romeo*⁶⁷ has effectively foreclosed federal constitutional law as a source of controlling the use of restraints, and, if history is any guide, state court

61. See *O'Connor v. Donaldson*, 422 U.S. 563, 575-76 (1975) for a negative answer to the similar question of whether the vagrant mentally ill can be committed for the sake of the public.

62. Naturally, the precise nature of the distinction between social and medical judgments is unclear. Still, one may at least tentatively call "social" those judgments about people that do not depend on esoteric knowledge of the body or mind.

For an interesting discussion of the distinction between "political" and "medical" decisions, see Gelman, *Mental Hospital Drugs, Professionalism, and the Constitution*, 72 GEO. L. J. 1725 (1984).

63. Notice that with these existing rules we *already* intrude into medical institutions. Thus the issue is not whether to intrude, but how to do so in the manner best to protect society's and individuals' interests.

64. See J. MONAHAN, *PREDICTING VIOLENT BEHAVIOR* (1981) (psychiatrists wrong in two out of three long-term predictions of violent behavior).

65. For liability for patients injuring themselves, see, e.g., 70 A.L.R.2d 347 (1960); 19 A.L.R.4th 7 (1983). The duty is to exercise such reasonable care for the patients' safety as their mental condition may require. Notice that doctors appear to fear liability more than is warranted. See Kroll & MacKenzie, *When Psychiatrists are Liable: Risk Management and Violent Patients*, 34 HOSP. & COMM. PSYCHIATRY 29, 29 (1983). Nevertheless, the fear does still govern their behavior.

66. Restraints laws are so loose that liability for inappropriately restraining patients is almost impossible to prove. Moreover, most often the injuries resulting from restraints are dignitary; injured patients may feel it is not worth their while—or the publicity—to sue when an award for damages is not likely to be great.

It might be argued that the present liability scheme is sound, because we are more interested in deterring serious physical injuries than in deterring dignitary violations. But the harms to be compared here are the *many* serious assaults on dignity and liberty caused by restraints as against the *rare* physical injury.

67. 457 U.S. 307 (1982) ("professional judgment" standard).

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interpretations of their own constitutions⁶⁸ are likely to follow the federal.⁶⁹ Common law approaches to the problem face a number of serious doctrinal and statutory roadblocks,⁷⁰ and are in any event unable to provide the detailed and certain guidelines which a statute can provide.

A. A Rigorous "Dangerousness" Standard

A new statute should use a high threshold dangerousness standard. Because the treatment benefits of restraints are highly speculative, a practice so restrictive and degrading as mechanical restraints is justified only in the face of imminent and serious danger. A new statute should therefore state that restraints are permissible only to protect a patient from imminent and serious violence to himself that there is a substantial likelihood of occurring. Examples of serious violence would be significant disfigurement, impairment of bodily function, or grave physical injuries which would require immediate medical attention.⁷¹

B. Distinguishing Between Restraints and Seclusion

The second important feature of a new statute should be to distinguish between restraints and seclusion. Of the two, restraints are the more serious deprivation,⁷² and patients overwhelmingly prefer seclusion to re-

68. The most powerful state constitutional argument against unnecessary restraint is that liberty is a fundamental interest which should be abridged only for compelling reasons—hence, not for speculative treatment benefits or in the face of minor or remote risks.

69. See, e.g., Note, *Developments in the Law: The Interpretation of State Constitutional Rights*, 95 HARV. L. R. 1324, 1493-94 (1982).

70. At least three common law arguments are possible: 1) the conventional argument that, absent an emergency, treatment without consent is a battery (but "emergency" can be interpreted weakly enough that many impermissible uses of restraints would be permitted by this argument); 2) a novel argument that restraints decisions should be subject to assessment by a reasonable person standard as to whether the injuries to liberty and dignity are outweighed by the benefits; 3) a similarly novel argument that restraints decisions should be assessed by ordinary battery standards applicable to restraint of the non-ill. All of these arguments could be undermined, however, by the fact that many states statutorily permit restraints for the sake of treatment or to meet patients' "medical needs." See *supra* note 25.

71. See similar standard proposed by INST. JUD. ADMIN.—ABA JOINT COMM'N ON JUVENILE JUSTICE STANDARDS, STANDARDS RELATING TO ABUSE AND NEGLECT § 2.1A commentary at 63-65 (1981). The high threshold of danger set forth in this standard for removal of a child from his home seems appropriate in the restraints context for similar reasons: Intervention is only clearly advantageous in extreme situations.

72. Different commentators and states have ranked restraints and seclusion (as well as emergency medication) in different ways, see Wexler, *Legal Aspects*, *supra* note 32, at 115-16, although some of these differences may relate to whether medication is used merely as a restraint or also as a form of treatment, whether the restraint is envisioned as public, etc. That reasonable people may differ does not mean that an effort to adopt a presumptive ranking of modalities is misplaced. Indeed, ranking these modalities is made easier now that we know of *patients'* clear preference for seclusion over restraints. See *infra* note 73. Doctors' arguments for a different ranking, in light of this preference, are unpersuasive. See, e.g., Soloff, *Physical Controls*, *supra* note 35, at 140, who prefers restraints to seclusion because staff can feel less fearful of contact with patients. See also Rosen and DiGiacomo, *supra* note 32, at 232, who inexplicably state that locked seclusion (or even locked wards) cannot be

straints.⁷³ A patient in a seclusion room can walk around, do jumping jacks, lie in a corner; a patient in restraints can do nothing. A patient in restraints suffers the physical pain of forced immobility; a patient in seclusion does not. Finally, restraints are the more severe dignity violation. Nothing in our day-to-day routine prepares us for being strapped down, while being alone in a room—even in a locked room—is a part of most individuals' life experience.⁷⁴

Today, however, restraints are recommended, and are being used, where seclusion would do just as well: for danger to others, agitation, regression, and the preservation of the "therapeutic milieu."⁷⁵ No existing statute properly distinguishes between restraints and seclusion.⁷⁶

A model statute, therefore, would confine the use of restraints to when there is an imminent danger of harm to self.⁷⁷ Seclusion can be substituted when there is danger of harm to others, but not to self. The main exception to this rule is triggered when a patient chooses restraints in public over seclusion.

considered less restrictive than restraints, even though they advocate that restraints take place in a solitary room, *id.* at 228.

73. See Soliday, *supra* note 32, at 284 (74% of patients surveyed think restraints are more unpleasant than seclusion).

74. On the other hand, patients restrained in public, but not secluded, can socialize with others. Observation and discussion with patients suggest that most feel too humiliated to do so, however. This point may be less valid when patients are in less degrading forms of restraint, e.g., restrained unobtrusively to a chair.

Consider further that being restrained to a bed would be impermissible punishment in a prison, because it is too degrading, *see supra* note 5. Moreover, 89.4% of the seclusion/restraints deaths in the N.Y. study were a result of restraints only. *See Way, supra* note 4.

75. *See, e.g., Rosen & DiGiacomo, supra* note 32, at 229-30; Soloff, *Physical Controls, supra* note 35, at 135-37.

76. Fifteen states have a law only on restraints, not on seclusion. Of the states that have laws referring to both, only two have different laws for each. Michigan allows restraints only for safety, MICH. COMP. LAWS ANN. § 330.1740(2) (West 1980), but seclusion if it would be "of clinical or therapeutic benefit for the resident," MICH. COMP. LAWS ANN. § 330.1742(2) (West 1980). Illinois requires a two-day break—unless authorized by the facility director—after 24 hours of restraints, ILL. REV. STAT. ch. 91 ½, § 2-108 (e) (1982). In the case of seclusion the break is to occur after only 16 hours, ILL. REV. STAT. ch. 91 ½, § 2-109 (d) (1982). *See also* Tardiff & Mattson, *supra* note 25, at 144 ("Indications for seclusion and restraint were basically the same.").

This legal indifference to the distinction between seclusion and restraints is paralleled by a medical indifference. Some institutions show a clear preference for restraints, others for seclusion, but there is no evidence that the behaviors triggering the different controls are distinguishable. This means that in the former facilities, restraints are often (or always) used where seclusion would be sufficient.

In New York State facilities, for example, 53.6% of control episodes involved restraints, and 46.4% involved seclusion. Ten of the thirty one facilities surveyed used only restraints. *Way, supra* note 3, Table 6.

77. In addition to using restraints for danger to self, restraints may be used in three further, limited situations: a concurrent medical condition requires an unwilling patient to stay in bed; the medical condition requires an initial physical examination; or it requires physical monitoring more than four times an hour (for the doctor to be non-negligent). On the other hand, if a patient is too violent to be given a mental status exam, then that exam must wait.

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C. *Allowing The Patient Choice*

The third general feature of a new statute should be to give the patient a choice among appropriate control measures, and to require staff to respect his choice. For instance, to avoid extended seclusion (and loneliness), a patient dangerous to others might sometimes choose restraint in the company of other patients instead of seclusion.

It makes sense to give patients a choice among appropriate control measures,⁷⁸ even if the patients are of questionable competence,⁷⁹ because doctors have failed to make a persuasive medical case for any particular ranking of these measures.⁸⁰ Furthermore, patients are most likely to know their own states of mind and how the various measures will affect them. In any case, if no ranking can be shown to be objectively better or worse than the others, the patient's choice will never be wrong, and allowing him to choose intrudes less on his liberty and dignity than does imposing one control or another.

To maximize the role patients play in determining which control measure shall be used, they should be advised, on admission, of the advantages and disadvantages of each method. They should be asked to rank these measures in order of their personal preference. Any change of heart during an emergency, however, should be respected, and the patient's choice should be sought every half hour he spends controlled.

D. *Procedural Safeguards*

A new statute should also impose a series of procedural requirements to ensure that patients are appropriately restrained and are released once the requisite degree and imminence of danger has passed. First, a doctor should be required to renew her order for restraints each hour, after having personally examined the patient each time.⁸¹ Second, every two hours

78. Patients dangerous to others should have a choice of medication, seclusion, or restraints in the company of staff or other patients. Patients dangerous to self should have a choice of medication or restraints in the company of staff or other patients. These patients should be told that medication may prove insufficient alone, but may be tried first at their request.

79. *But cf.* Note, *Developments*, *supra* note 13, at 1359 n.193 (desirable to give patients choice, but *parens patriae* patient's choice may be overridden if it does not comport with treatment program).

80. Doctors widely disagree on rankings of measures. Rosen and DiGiacomo prefer restraints, but admit the choice is "subjective." Rosen & DiGiacomo, *supra* note 32, at 232. And while Gair thinks physical restraint is, for some patients, too stimulating and diverting, Gair, *supra* note 32, at 16, Cubbin regards it as the preferred method, Cubbin, *supra* note 32, at 752. In the absence of a medically supported ranking, patients should be permitted to make their own choice.

81. Three states in the "safety or other rationale" category now require the first type of protection—the order must be renewed every 24 hours. *See* MONT. CODE ANN. § 53-21-146 (1983); N.J. STAT. ANN. § 30:4-24.2(d)(3) (West 1981); S.D. CODIFIED LAWS ANN. § 27A-12-6 (Supp. 1986). One state in the "safety or treatment" category also requires renewal every 24 hours. *See* WIS. STAT. ANN. § 51.61(1)(i)(1) (West Supp. 1985). Six of the ten "safety only" states require the order to be renewed: Georgia every 24 hours, GA. CODE ANN. § 37-3-165(b) (Supp. 1985); Illinois every 16

the patient should be released, and should remain out of restraints unless he makes an overt attempt to injure himself.⁸² Third, every fifteen hours the facility director should be required to personally examine the patient, and renew the order for restraints.⁸³

In addition, there should be extra-institutional protections. At the end of 24 hours, a legal representative should be required to attend the patient (to inform him of his rights and watch him being released from restraints). At the end of 72 hours, an independent psychiatrist should be required to assess the patient's restraint in the presence of his counsel. If the patient remains in restraints after 72 hours, he should have a hearing before a judge, and should again be represented by counsel.⁸⁴

hours, ILL. REV. STAT. ch. 91 ½, § 2-108(a) (1982); Kansas every 3 hours (except between 12 a.m. and 8 a.m.), KAN. STAT. ANN. § 59-2928 (1983); Massachusetts every 3 hours, MASS. GEN. LAWS ANN. ch. 123, § 21 (West Supp. 1985); N.Y. every 4 hours (except between 9 p.m. and 9 a.m.), N.Y. MENTAL HYG. LAW § 33.04(d) (Consol. 1978); *see also* Tardiff & Mattson, *supra* note 25, at 146 (most states have 24 hour time limit; Florida has one hour time limit).

A short initial review time for restraints makes sense, especially in light of Soloff's finding that the duration of seclusion and restraints appears to be independent of patient behavior. *See* Soloff, *Physical Controls*, *supra* note 35, at 135.

82. Four states now require release every two hours. In three of the four, it is unclear whether this is to enable the patient to exercise his limbs, or to test his readiness for release. Tardiff & Mattson, *supra* note 25, at 146. In New York it is to test readiness for release. N.Y. MENTAL HYG. LAW §33.04(f) (Consol. 1978).

83. Off-unit review of the staff's decision to restrain a patient is uncommon, and, even then, often does not require personal examination of the restrained patient. For example, Georgia statutorily requires review by the chief medical officer, but only of a written report. GA. CODE ANN. § 37-3-165(b) (Supp. 1985). Illinois requires daily review (of some unspecified kind) by the director of the facility. ILL. REV. STAT. ch. 91 ½, § 2-108(d) (1982). *See also* Tardiff & Mattson, *supra* note 25, at 146 (nine states require off-unit review of some kind after 24 hours, three states, after eight hours).

84. The experience of New York, the state with one of the strictest restraints laws, suggests that, with adequate and frequent checks, prolonged restraint is minimized. Thus, in a one-month study in New York, most restraints orders were for four hours (the length before required physician review), followed by a large minority which were for two hours (the length before test-release). Way, *supra* note 3, at Table 8. Moreover, 95.5% of the patients were restrained no longer than four hours, with most of these under two hours. *Id.* at Table 9.

Nevertheless, the first two procedures are insufficient to keep restraints within reasonable bounds. Consider that 2% of the cases in the New York study were restraint episodes of nine hours or more, and 1% were episodes of twelve hours or more. *Id.* at Table 9. Moreover, the figures are for patients restrained six or fewer times in the month studied. Patients restrained over six times were likelier to receive orders for nine hours or more (11% vs. 2%, *id.* at 4; 24% vs. 16% in one facility, *id.* at 5), and these individuals accounted for 39% of all episodes of restraint or seclusion. *Id.* at 1.

Connecticut provides examples of prolonged restraint as well. One doctor candidly acknowledges that he restrains patients, on occasion, for several weeks at a time (confidential source in New Haven hospital). Another hospital has restrained a small girl, whenever she is not in locked seclusion, for over two years (confidential source in New Haven hospital).

The last three procedural protections are therefore offered as failsafe measures, to protect patients from the prolonged restraint which now occurs, and which is legally permitted in many states. Only the first has even a rough parallel in existing law: ILL. REV. STAT. ch. 91 ½, § 2-201(c) (1982) (notice to the "Guardianship and Advocacy Commission" if the patient desires).

The use of independent psychiatrists to review restraints episodes would be perhaps less costly than might at first appear, for some states are now adopting regulations on medication refusal which call for or authorize evaluation by independent psychiatrists. *See, e.g.*, N.J. Ad. Bull. 78-3 § II(E)I; Ohio Department of Mental Health, Policy on Client Participation in Medication Decisions 18-19 (June 13, 1984); 25 TEX. ADMIN. CODE tit. 25, § 405.808 (6) (1984). The same is true for representation.

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While requiring such an extensive set of procedures would be costly,⁸⁵ the hope is that the costliness of the procedures—as well as the high degree of danger required—will deter the use of restraints in all but the most exigent circumstances.

E. *Liability Limits For Doctors*

To redress the flaws of the existing liability scheme, a new principle of liability should be designed to deter doctors from using restraints out of a fear that malpractice suits will be brought. Liability should be strengthened for unreasonably restraining patients.⁸⁶ Doctors, however, should not be held liable for injuries resulting from a failure to restrain patients, unless a person of the most common understanding⁸⁷ would have foreseen serious injuries of the kind described in the statute.⁸⁸

This principle of liability⁸⁹ recognizes the limits of doctors' ability to

See, e.g., Michigan Administration of Psychotropic Medication, *supra* note 22; N.Y. ADMIN. CODE tit. 14, § 27.8 (d) (1984) (attorney or other "concerned person"); Ohio Department of Mental Health, Policy on Client Participation in Medication Decisions 12 (June 13, 1984).

85. Note that while the proposed procedures are designed especially to protect against the prolonged use of restraints, all but the last should also be in force whenever the total length of time a patient spends in separate periods of restraint, within 30 days, equals the specified number of hours. When a patient spends 72–120 non-successive hours in restraints, a hearing should be provided only if his representative alleges an impermissible use of restraints. When he spends more than 120 non-successive hours in restraints, a hearing should automatically be provided.

Note also that if a patient is claimed to have consented to treatment by restraints, he should nonetheless be seen after 15 hours by the facility director to ensure that the consent is genuine and competent, and similarly by the patient advocate after 24 hours. Patients are often said to go "willingly" into restraints when they do not resist, even if they have been presented with a show of force and given no alternative. The patient advocate should determine whether review by an independent psychiatrist or the court is warranted.

86. For example, one could establish some specific damages for violating the statute; these would have to be set not so high as to risk jury nullification, nor so low as to become merely a cost of doing business. Alternatively, one could raise a presumption of a battery for violation of the statute, to be rebutted only by a showing that extraordinary circumstances existed.

87. Compare *McCall v. McDowell*, 15 F. Cas. 1235, 1240 (C.C.D. Cal. 1867) (obeying superior's commands defense to illegal action unless person of the most common understanding would know command illegal).

Other ways of weakening liability for injuries resulting from failure to restrain a patient would be to put a cap on damages or to use a "gross negligence" standard. But the former penalizes doctors for proper behavior—i.e. waiting to restrain a patient until the danger is patent—and protects doctors for improper behavior—i.e. not restraining a patient when the danger is patent. And the latter misleadingly implies that waiting to restrain a patient until the danger is patent is negligent.

88. This is not to say that failing to use measures short of restraints—e.g. restricting a patient to a lounge, "specialling" a patient—would not subject a doctor to liability unless a person of the most common understanding would predict violence; on the contrary, an "ordinary doctor" standard would be used in such a case.

89. There are other situations in tort law in which the standard of care is lowered in order that concerns about malpractice not govern physicians' actions. The most notable is the situation covered by "Good Samaritan" laws. These attempt to encourage physicians (and others) to intervene to help a person toward whom no duty of care was owed at common law. Most such statutes hold a physician who so intervenes liable for injuries caused only by "gross negligence," or some similar form of misconduct. See *Mapel & Weigel, Good Samaritan Laws—Who Needs Them? The Current State of Good Samaritan Protection in the United States*, 21 S. TEX. L. J. 327, 342–46 (1981); Note, *Good*

predict violence. It eases the pressure on doctors who may feel besieged by conflicting demands—both to protect patients and not to restrain them—by making a clear value-choice: Great numbers of patients should not be restrained in order to protect against the rare occurrence of self-inflicted injury.

Most importantly, the rule is designed to reduce both the use of restraints and the supervision of patients' choices. The fear that, if effective, the rule would cause a dramatic rise in self-injuries is unfounded, as may be seen from the situation in England. A serious increase in the use of other controls also need not occur: English doctors have not significantly resorted to seclusion or medication to compensate for not using mechanical restraints.

In America, a proposed restraints law may eventually have to be supplemented by a seclusion and emergency medication law. In the meantime, a new statute would spare some patients the pain of unnecessary restraint. Given the grave injury to individual liberty and dignity caused by restraints, that alone would be well worth achieving.

Samaritan Statutes: Time for Uniformity, 27 WAYNE L. REV. 217, 224-25 (1980). The idea of such a lower standard, as in the case of the restraints law, is to encourage physicians to act (or not act) by lowering the risks of malpractice consequent upon their action (or inaction).

Consider also the area of constitutional torts, where an objective standard of qualified immunity limits government actors' liability so as to encourage vigorous decision-making. For the standard, see *Harlow v. Fitzgerald*, 457 U.S. 800 (1982). On appropriate incentives for government actors, see P. SCHUCK, *SUING GOVERNMENT* (1983).

MENTAL HEALTH LAW: THREE SCHOLARLY TRADITIONS

ELYN R. SAKS*

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.¹ As in other areas of law, advocates for the civil rights of patients made more strides earlier in this period than later.² 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.³

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,⁴ although this is not to say that many do not continue to work in this tradition.⁵ Arguments tended to be framed in doctrinal terms. A right to refuse treatment, for example, was based in a Fourteenth Amendment privacy

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

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.¹⁰

Nevertheless, some legal scholars continued to write in this doctrinal tradition, framing their arguments on state constitutional, common law, or statutory grounds.¹¹ 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.¹² 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.¹³

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

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.¹⁴ At the inception of the therapeutic jurisprudence movement, traditional mental health law issues were looked at through this lens,¹⁵ but over time all manner of issues came to be scrutinized in this way.¹⁶

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.¹⁷ Further, incompetency findings should be made sparingly, because they are stigmatizing and,

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.¹⁸ Indeed, many who came to the therapeutic jurisprudence school were originally in the constitutional scholarship camp and shared the agenda of that camp.¹⁹

Therapeutic jurisprudence explicitly fashioned itself as having a law-reform agenda.²⁰ 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.²¹ 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.²² 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

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.²³ 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.²⁴ For instance, Stephen Morse has discussed responsibility,²⁵ including volitional tests of insanity.²⁶ And Michael Moore has discussed the nature of mental illness, responsibility, and the unity of the self.²⁷

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.

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.²⁸

II. A PROPOSAL FOR FUTURE WORK IN THE THIRD TRADITION

My own work is located mostly in the third tradition.²⁹ I will elaborate briefly on two contributions I have made to this tradition: on competency to make treatment decisions³⁰ and on the criminal

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).³¹ 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).³² 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.³³

More recently, the field has been advanced considerably by the MacArthur Mental Health Law Network researchers, one of whose topics has been treatment capacity.³⁴ 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.³⁵

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?³⁶

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.

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.³⁷ 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 Medicine³⁸ 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

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.

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

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.³⁹ 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.⁴⁰ But people with MPD are often cognitively and volitionally intact at any one given time. However,

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.⁴¹

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.⁴²

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.⁴³

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.⁴⁴ 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?

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.⁴⁵

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.⁴⁶

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

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.

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'

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.