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Pursuing Justice for the Mentally Disabled

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Pursuing Justice for the Mentally Disabled

Grant H. Morris*

I. Assessing the Competence of Counsel in Right to Refuse Treatment Cases

If Michael Perlin spoke in a forest, and no one heard him speak, would he still make a sound? That is the question I ask you to consider as I respond to Michael's article.¹

Lawyers who represent mentally disabled clients in civil commitment cases and in right to refuse treatment cases, Michael tells us, are guilty of several crimes. They are inadequate. They are inept. They are ineffective. They are invisible. They are incompetent. And worst of all, they are indifferent. Is Michael right in his accusations? You bet he is!

The very ethics of our profession require lawyers to represent their clients

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¹Michael L. Perlin, "*And My Best Friend, My Doctor/ Won't Even Say What It Is I've Got*": *The Role and Significance of Counsel in Right to Refuse Treatment Cases*, (address presented at conference on Capacity to Consent to Treatment and/or Research: Legal and Psychiatric Dimensions, conducted at Southern California Law Center, April 17, 2004).

competently² and to act as zealous advocates for their clients³ “pursu[ing] their clients’ objectives single-mindedly, without regard to the interests of others.”⁴ Let me just discuss one example to demonstrate that lawyers representing the mentally disabled do not act competently and as zealous advocates. In 1966, a California legislative subcommittee issued a report that questioned the legal, moral, and practical worth of California’s civil commitment laws and recommended fundamental changes in the commitment system.⁵ In response, the California Legislature enacted the Lanterman-Petris-Short Act (LPS), which embodied the subcommittee’s recommendations.⁶ LPS has

²“A lawyer should represent a client competently.” MODEL CODE OF PROF’L RESPONSIBILITY Canon 7 (1980).

³See MODEL CODE OF PROF’L RESPONSIBILITY EC 7-19 (1980); MODEL RULES OF PROF’L CONDUCT preamble (2003) (“A lawyer's responsibilities as a representative of clients, an officer of the legal system and a public citizen are usually harmonious. Thus, when an opposing party is well represented, a lawyer can be a zealous advocate on behalf of a client and at the same time assume that justice is being done.”).

⁴Catherine J. Lanctot, *The Duty of Zealous Advocacy and the Ethics of the Federal Government: The Three Hardest Questions*, 64 SO. CAL. L. REV. 951, 959-60 (1991).

⁵SUBCOMM. ON MENTAL HEALTH SERVICES, ASSEMBLY INTERIM COMM. ON WAYS AND MEANS, CAL. LEGIS., THE DILEMMA OF MENTAL COMMITMENTS IN CALIFORNIA—A BACKGROUND DOCUMENT (1966).

⁶Division 5 of the California Welfare and Institutions Code, entitled Community Mental Health Services, was added by the California Mental Health Act of 1967, ch. 1667, § 36, 1967 Cal. Stats., ch. 1667, § 36. Division 5 consists of two parts: the Lanterman-Petris Short Act, CAL. WELF. & INST. CODE §§ 5000-5550 (West 1998 and Supp. 2005), and the Bronzan-McCorquadale Act (formerly the Short-Doyle Act), *id.* §§ 5600-5772.5. The Bronzan-McCorquadale Act provides the legislative framework for the organizing and financing of “community mental health services for the mentally disordered in every county through locally administered and locally controlled community

been hailed as “the Magna Carta of the mentally ill.”⁷ LPS has served as a model of progressive legislation, has been commended by writers⁸ and judges,⁹ and copied by other state legislatures.¹⁰ With only some minor tinkering over the years, LPS remains the law today in California.

A key component of LPS is the elimination of indeterminate commitment of nondangerous, mentally ill persons and the creation of a conservatorship process designed to provide continuing assistance to gravely disabled patients who need such assistance after they have been treated in a mental hospital for seventeen days or less. For an LPS mental health programs.” *Id.* § 5600 (West 1998).

⁷The statement is attributed to Maurice Rodgers, spokesperson for the California State Psychological Association. EUGENE BARDACH, *THE SKILL FACTOR IN POLITICS: REPEALING THE MENTAL COMMITMENT LAWS IN CALIFORNIA* 126 (1972). Other writers also state that LPS has been described as the Magna Carta of the mentally ill, but they do not reveal the source of the statement. *See, e.g., Hearings on the Constitutional Rights of the Mentally Ill Before the Subcomm. On Constitutional Rights of the Senate Comm. On the Judiciary, 91st Cong., 1st & 2nd Sess.* 316 (1970) (statement of Dr. Roger Egeberg, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education and Welfare); Marc L. Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law*, 23 *HOSP. & COMMUNITY PSYCHIATRY* 101,105 (1972).

⁸*See, e.g., FRANK W. MILLER ET AL., THE MENTAL HEALTH PROCESS* xvi (2d ed. 1976) (characterizing the California experiment as “innovative” and declaring that LPS “must be considered throughout any discussion of mental health programs”).

⁹*See, e.g., David Bazelon, Implementing the Right to Treatment*, 36 *U. CHI. L. REV.* 742, 753 (1969) (asserting that LPS “promises virtually to eliminate involuntary hospitalization except for short term crisis situations. . . . The procedural protections it promises are impressive indeed when compared with commitment proceedings in other states.”).

¹⁰*See, e.g., WASH. REV. CODE ANN. §§ 71.05.010-71.05.910* (West 2002).

conservator to be appointed, the court must find that the patient is gravely

University of San Diego Public Law and Legal Theory Research Paper Series, Art. 31 [2005]

disabled—defined as “a condition in which [the] person, as a result of mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter.”¹¹ The LPS conservatorship is established for a one-year period, but it may be renewed upon proof of continuing grave disability.

Eight years after LPS was enacted into law, I asked students in my seminar in Law and Mental Disorder to observe the LPS conservatorship proceedings in the San Diego County Superior Court and gather data on the performance of attorneys representing individuals for whom a conservatorship was proposed.¹² The students observed sixty-three court hearings, and here’s what they reported.¹³ Eight hearings were one minute or less in duration. Nineteen hearings were between one and two minutes in duration. Nine hearings were between two and three minutes in duration. Thus, more than half the hearings—a total of thirty-six of the sixty-three that were observed—were completed in three minutes or less.¹⁴ Ironically, the LPS conservatorship hearings were of a shorter average duration than the 4.7 minute average of pre-LPS civil commitment hearings.

In forty-two of the sixty-three cases, counsel representing a proposed conservatee

¹¹CAL. WELF.& INST. CODE §5008(h)(1)(A) (West 1998).

¹²See Grant H. Morris, *Conservatorship for the “Gravely Disabled”*: California’s Nondeclaration of Nonindependence, 15 SAN DIEGO L. REV. 201, 225 (1978).

¹³See *id.* at 232-33.

¹⁴Only nine hearings were more than eight minutes in duration. *Id.* at 232, n.173.

asked no questions of the reporting psychiatrist. In most of the remaining twenty-one cases, the lawyer asked only one question. In only one case did the proposed conservatee's counsel request either the assistance of a psychiatrist or the examination of the proposed conservatee by another psychiatrist. There was not a single case in which counsel for the proposed conservatee offered testimony of an independent psychiatrist. In fifty-six of the sixty-three cases, no questions were asked of the proposed conservatee. In fifty-eight of the sixty-three cases, counsel for the proposed conservatee neither proposed alternatives to conservatorship nor even suggested that others explore these possibilities. In only one case did a lawyer urge that the proposed conservatee be permitted to retain his driver's license, and in no case did a lawyer resist the imposition of contractual disability—the right to enter into contracts—on his or her client.

Clearly, the conservatorship hearings observed by my students were meaningless formalities, “show” trials, an “empty shell” to borrow words from Michael Perlin, “offering only an illusion of due process.”¹⁵ Rolling over and playing dead is not competent representation. Rolling over and playing dead is not zealous advocacy on behalf of one's client.

Perhaps, it could be argued, that such attorney inaction at the conservatorship hearing was appropriate. Perhaps the attorney made a reasoned decision not to contest

¹⁵Michael L. Perlin & Deborah A. Dorfman, *Is It More Than “Dodging Lions and Wastin’ Time”? Adequacy of Counsel, Questions of Competence, and the Judicial Process in Individual Right to Refuse Treatment Cases*, 2 PSYCHOL. PUB. POL’Y & L. 114, 130 (1996).

conservatorship because the evidence of grave disability was so overwhelming that

University of San Diego Public Law and Legal Theory Research Paper Series, Art. 31 [2005]

resistance was both futile and unwarranted. But not so. Attorney nonperformance at trial was a direct result of the failure of attorneys to investigate the facts and to fully prepare their clients' cases. For the small fee that the county paid them,¹⁶ most attorneys made one visit to the client in the facility where he or she was detained, ensured that the papers in the case were in order, and made an appearance at the conservatorship hearing. Some attorneys did even less. Several were observed meeting their clients for the first time at the hearing itself. Appointed counsel almost never attended the psychiatric evaluation of their client that was performed a few days prior to the hearing, although they were welcome to do so. Most attorneys did not even examine the psychiatric report prior to the hearing, even though the report was almost always entered into evidence upon stipulation and was often the most significant evidence in the case supporting the appointment of a conservator. Some attorneys expressed concern that if they "make waves" at the hearing, they could jeopardize their chances of being appointed to represent proposed conservatees in future cases.

Nevertheless, one might assert, proof of inadequate performance by attorneys in conservatorship cases tells us nothing about the performance of attorneys in civil

¹⁶At the time of the study, private attorneys were paid only \$75 for each case in which they served as appointed counsel for a proposed conservatee. Morris, *supra* note 12, at 234. Today, indigent proposed conservatees are represented by attorneys from the Office of the Public Defender which contracts with the county to represent them in conservatorship hearings.

commitment cases and in right to refuse treatment cases. But not so. It tells us ^{Morris:} everything. If an LPS conservatorship is established, the court may grant the conservator the authority to place his or her conservatee in a mental hospital¹⁷ and to require the conservatee to receive treatment to remedy or prevent the recurrence of the conservatee's condition of grave disability.¹⁸

The statutes in California provide that a person may apply for voluntary admission to a mental treatment facility when he or she is mentally competent to apply, or if he or she is an LPS conservatee, when his or her conservator applies if the court has granted the conservator the authority to place the conservatee in a mental treatment facility.¹⁹ However much the conservatee protests, he or she is admitted to that facility as a voluntary patient. Although other voluntary patients may depart the facility by giving notice of a desire to do so, LPS conservatees may depart only if notice is given by their conservators.²⁰ However much the conservatee protests, he or she may be required to take psychotropic medication that his or her doctor prescribes and the conservator, exercising a substituted judgment for the conservatee, authorizes. Although the court, in appointing a conservator for a gravely disabled person, has discretion to grant or to

¹⁷CAL. WELF. & INST. CODE § 5358(a) (2) (West 1998).

¹⁸*Id.* § 5358(b)

¹⁹*Id.* §§ 6000(a) & 6002 (West 1998).

²⁰*Id.*

withhold the placement authority, the court almost always grants that authority to the

University of San Diego Public Law and Legal Theory Research Paper Series, Art. 31 [2005]

conservator. In each and every one of the sixty-three cases that my students observed, the court granted the conservator this placement power.²¹

Elsewhere, I characterize these conservatorship statutes as “California’s nondeclaration of nonindependence,”²² laws that allow civil commitment and coerced treatment without the crunch.²³ For LPS conservatees, there is no involuntary civil commitment hearing. For LPS conservatees, there is no right to refuse treatment hearing. California’s so-called “Magna Carta of the mentally ill” allows carte blanche control over the mentally ill, and attorneys representing mentally ill clients play their role—or should I say, their roll-over—in assuring that result. In only two of the sixty-three cases that my students observed, did the proposed conservatee’s lawyer even question whether the conservator should be empowered to involuntarily confine his or her client as a voluntary patient and to require the client to submit to the administration of psychotropic medication. Who argued, on behalf of his or her client, that an inability to provide for food, clothing, and shelter—the criteria necessary to establish a conservatorship—does not necessarily equate to an inability to understand the risks, benefits, and alternatives to psychotropic medication? Who demanded, on behalf of his or her client, that the court

²¹Morris, *supra* note 12, at 228.

²²*See id.* at 201.

²³*Id.* at 215.

make a separate finding of fact that the proposed conservatee lacked the capacity to understand the risks, benefits, and alternatives to psychotropic medication—the criteria necessary to give or withhold informed consent—before it granted the conservator the authority to order that such treatment be imposed over the conservatee’s objection? There were no such arguments; there were no such demands.

II. Why Are Patients’ Counsel Incompetent?

Michael provides us with the reason for this sorry state of affairs: sanism. Sanism is a word that Michael did not create,²⁴ but one that he has certainly popularized in various contexts in numerous writings and speeches.²⁵ Sanism, he tells us, is irrational prejudice against the mentally disabled. It is, as Michael has described it, “The Hidden

²⁴Morton Birnbaum is generally credited with coining the word “sanism.” See Morton Birnbaum, *The Right to Treatment: Some Comments On Its Development*, in MEDICAL, MORAL AND LEGAL ISSUES IN HEALTH CARE 97, 106-07 (Frank Ayd ed., 1974).

²⁵See, e.g., Michael L. Perlin, “*You Have Discussed Lepers and Crooks*”: *Sanism in Clinical Teaching*, 9 CLINICAL L. REV. 683, 683-729 (2003) (discussing the meaning of sanism, sanist courts and lawyers, sanism and clinical teaching, and sanism and clinical law students); Michael L. Perlin, “*For the Misdemeanor Outlaw*”: *The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities*, 52 ALA. L. REV. 193, 234-36 (2000) (discussing sanism as applied to criminal defendants who claim to be mentally incompetent to stand trial or who plead insanity as a defense to a crime); MICHAEL L. PERLIN, THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL 21-58 (2000) (discussing the concept of sanism, the roots of sanism, and sanist attitudes of the public and the legal system toward mentally disabled persons). This book also discusses sanism in specific contexts, such as involuntary civil commitment law, *id.* at 92-98, the right to sexual interaction, *id.* at 167-69, the Americans with Disabilities Act, *id.* at 200-03, competence to plead guilty and to waive counsel, *id.* at 218-19, and the insanity defense, *id.* at 237-38.

Prejudice.”²⁶ Sanism is just like any other prejudice. We are prejudiced against some

University of San Diego Public Law and Legal Theory Research Paper Series, Art. 31 [2005]

people because we don’t like the way they look, the way they think, or the way they act.

They are different from us, and we know we are superior to them in looks, in thought, or in the way we act. We are right, and they are wrong. We know that we are better than they are; therefore, they must be inferior.

Africans were never treated as equals. Their religion, their culture, their civilization was deemed primitive. And so, as superior beings from an advanced society, we enslaved them—a whole race of people—so that their cheap labor could enable our cotton to be picked.²⁷ When slavery ended, we mandated that African Americans be kept separate and unequal. We could not risk that they co-mingle with those of us who were superior beings. Did you think that only the Nazis were concerned about the need to maintain the purity of the Aryan race?

Women were the weaker sex. Surely they were not fit to vote or work. A woman’s place was in the home. Their role was limited to cooking, cleaning, childbearing, and child rearing. After all, they promised to love, honor, and especially to obey their superior male counterparts.

Gay people engage in conduct that we view as not merely unacceptable but as

²⁶MICHAEL L. PERLIN, *THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL* (2000).

²⁷“Hollow man lookin’ in a cotton field / For dignity.” BOB DYLAN, *Dignity, on BOB DYLAN’S GREATEST HITS, VOL. 3* (1994).

perverted. Not that long ago, homosexuality was characterized as a mental disorder. If ^{Morris:} unchallenged, the gay lifestyle threatens the very core of our religious beliefs. And so we love the sinner, but hate the sin. Unfortunately, most of us tend to equate the perceived sinner with the perceived sin.

We hate Jews because they deny the deity of Christ. It seems like only yesterday that Jews were portrayed as Christ killers. As a matter of fact, it was only yesterday—in the most popular movie of 2004.²⁸

Surely the mentally ill are appropriate targets for our prejudice. After all, they are mentally “ill,” and we are mentally healthy. They are mentally “disabled,” and we are mentally able. They are mentally “disordered”—their thinking is irrational—and our thinking is always well-ordered and rational. They must be inferior beings. We know their disordered thinking makes them dangerous. Don’t try to confuse us with recent studies confirming that psychotic symptoms, such as delusions or hallucinations, currently

²⁸The movie is: *The Passion of the Christ*, whose gross box office receipts were over \$145 million in its first week of distribution in the United States and over \$354 million in the six and one-half week period between Ash Wednesday, when it opened, and Easter Sunday. David Germain, ‘*Passion*’ Returns to Top Spot Over Easter Weekend, THE TRIBUNE (San Luis Obispo, CA), Apr. 12, 2004, at B5. This box office total more than doubles the \$160 million reportedly raised by President George W. Bush in several months of fund-raising to support his campaign for re-election. See Mark 12:17: “And Jesus said to them, ‘Render to Caesar the things that are Caesar’s; and to God the things that are God’s.’ And they were amazed at Him.” See also Matthew 22:21-22.

being experienced by a person, do not elevate his or her risk of violence.²⁹ We know

University of San Diego Public Law and Legal Theory Research Paper Series, Art. 31 [2005]

better. Every day, or so it seems, we read about some crazy person committing a horrible crime and avoiding punishment by hiring a clever lawyer who uses a dishonest psychiatrist to successfully hoodwink the jury into finding the defendant not guilty by reason of insanity.

And even those mentally disabled people who aren't dangerous, they need to take their medicine so they don't walk around the streets annoying us by their panhandling and their strange talk. Why don't they just get jobs and live a normal life? Don't try to confuse us with recent studies linking an increased risk of diabetes, obesity, and heart disease to the use of Clozaril, Resperidal, Zyprexa and other antipsychotic medications³⁰

²⁹MacARTHUR RESEARCH NETWORK ON MENTAL HEALTH AND THE LAW, MacARTHUR VIOLENCE RISK ASSESSMENT STUDY, *Executive Summary* (April 2001), at <http://macarthur.virginia.edu/risk.html> (last visited Feb. 11, 2005). See also Henry J. Steadman et al. *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES GEN. PSYCHIATRY 393, 400 (1998) (reporting that the MacArthur Violence Risk Assessment Study found that the prevalence of violence among ex-mental patients without symptoms of substance abuse and others living in the same neighborhoods without symptoms of substance abuse was statistically indistinguishable); Bruce G. Link et al., *The Violent and Illegal Behavior of Mental Patients Reconsidered*, 57 AM. SOC. REV. 275, 290 (1992) (finding that the risk of violence from mentally disabled people—even people who are currently experiencing psychotic symptoms—is “comparable to the risks associated with common social statuses [e.g., male gender, young age, limited education] and a trivial contribution to the overall level of violent/illegal behavior in American society”).

³⁰*Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes*, 27 DIABETES CARE 596 (2004). Participants in the conference included the American Diabetes Association, the American Psychiatric Association, the North American Association for the Study of Obesity, and the American Association of Clinical Endocrinologists.

or that link an increased risk of suicide to the use of Paxil, Prozac, Zoloft and other anti-depressant SSRIs.³¹ We know these are powerful, mind-altering drugs, but these people are crazy and they need these drugs to make them sane. These drugs are all FDA-approved, and we trust their doctors to weigh the risks and benefits and to prescribe them only when appropriate for use by their patients.

Although our society is far from perfect, at least we have made some progress in combating, though not eradicating, discrimination. “The times they are a changin’”.³² (It would not be possible to pay tribute to Michael Perlin without at least some mention of the lyrics of Bob Dylan).³³ Today, African American children attend, and are even welcomed, at schools and universities throughout America, and Rosa Parks no longer sits in the back of the Birmingham bus. Today, when women graduate college—and they

³¹Gardiner Harris, *FDA: Antidepressants Can Lead to Suicide*, SAN DIEGO UNION-TRIBUNE, Mar. 23, 2004; *New Warning Urged About Depression Medication*, THE TRIBUNE (San Luis Obispo, CA), Mar. 23, 2004, at A3.

³²BOB DYLAN, *The Times They Are A-Changin’*, on THE TIMES THEY ARE A-CHANGIN’ ALBUM (1964).

³³For those readers who may be unaware of Michael’s attraction to the words of Bob Dylan, let me merely note that beginning in 1996 (with three articles in that year alone), the prolific Michael Perlin has consistently used Bob Dylan song titles or lyrics in the titles of the numerous law review articles he has written. In the text of his articles, Michael always explains the applicability of Dylan’s words to the subject upon which Michael is writing. See, e.g., Michael L. Perlin, “*The Executioner’s Face is Always Well-Hidden*”: *The Role of Counsel and Courts in Determining Who Dies*, 41 N.Y. SCH. L. REV. 201 (1996); Michael L. Perlin, “*I’ll Give You Shelter From the Storm*”: *Privilege, Confidentiality, and Confessions of Crime*, 29 LOY. L.A. L. REV. 1699 (1996); Michael L. Perlin & Deborah A. Dorfman, *supra* note 15, at 114.

graduate in numbers that equal, if not surpass, their male counterparts—and find

University of San Diego Public Law and Legal Theory Research Paper Series, Art. 31 [2005]

employment, they are no longer automatically relegated to the secretarial pool. Just last year, all across this country—from San Francisco in the west to New Paltz in the east—more than 4,000 gay couples exchanged vows of marriage. And no, San Francisco, that Sodom of the West, and New Paltz, that Gomorrah of the East, have not yet been destroyed by fire and brimstone,³⁴ or even by a simple earthquake.³⁵

But progress in combating discrimination against the mentally disabled? “Th[at] groom’s still waiting at the altar.”³⁶ Why do lawyers advocate zealously for criminal defendants charged with child molestation or serial murder, but not for a mentally disabled person who faces involuntary confinement when he or she has committed no crime? Why do lawyers advocate zealously for Timothy McVeigh and Terry Nichols, or for John Allen Muhammad and Lee Boyd Malvo, but not for a mentally disabled person who merely wishes to exercise the right to refuse psychotropic medication?

Lawyers who represent the mentally disabled in civil commitment proceedings

³⁴19 *Genesis* 24: “Then the LORD rained upon Sodom and upon Gomorrah brimstone and fire from the LORD out of heaven”

³⁵It should be noted, however, that six months after same-sex marriages began being performed in San Francisco, the California Supreme Court ruled that city and county officials lacked authority to issue marriage licenses to, solemnize marriages of, and register certificates of marriage for same-sex couples; and that marriages conducted between same-sex couples in violation of the applicable statutes were void and of no legal effect. *Lockyer v. City and County of San Francisco*, 95 P.3d 459, 499 (Cal. 2004).

³⁶BOB DYLAN, *The Groom’s Still Waiting at the Altar*, on SHOT OF LOVE ALBUM (1981).

don't believe they are prejudiced against their clients. In fact, the possibility that their ^{Morris:} sanist beliefs may cause them to roll over and play dead in civil commitment proceedings does not even enter their conscious thought. Our society, and I include lawyers and judges as members of our society, characterizes mental disorder through a medical model. Mentally "ill" people are sick, and because they are "out of their minds," they do not realize that they need medicine to make them well, so that they will again be "in their right minds." And who can tell us whether a person is mentally ill and needs to be hospitalized for inpatient treatment? Obviously, doctors are the experts on diagnosing illness, not lawyers or judges.

Even though the Supreme Court has acknowledged that involuntary hospitalization, especially when accompanied by coerced treatment, is "a massive curtailment of liberty,"³⁷ somehow we don't view an adversarial proceeding as appropriate when the curtailment of liberty is not for the purpose of punishing a criminal, but rather, for the purpose of treating a person's mental illness in order to make him or her well. And so we defer to the doctors. Tell us doctor, is the proposed patient suffering from a mental illness? Tell us doctor, is the proposed patient's mental illness sufficiently severe that the person satisfies our vaguely worded commitment statute requiring danger to self or others or inability to provide for one's basic necessities? Did the doctor answer "yes" to both questions? Case closed.

³⁷Humphrey v. Cady, 405 U.S. 504, 509 (1972).

Although many articles have been written about the inadequacy of counsel in civil
University of San Diego Public Law and Legal Theory Research Paper Series, Art. 31 [2005]

commitment proceedings,³⁸ surprisingly, as Michael mentions in his article,³⁹ almost nothing has been written about the inadequacy of counsel in right to refuse medication

³⁸In 1966, Fred Cohen wrote an article describing the lawyer who represents a proposed patient in a typical civil commitment hearing as “a stranger in a strange land without benefit of guidebook, map, or dictionary.” Fred Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEX. L. REV. 424, 424 (1966). Over the years, several articles have echoed a similar theme—that the lawyer representing a mentally disordered client is uncertain whether to choose a “best interest” role model (i.e., the lawyer should determine the client’s best interests and pursue those interests in the civil commitment or other hearing involving the client) or the traditional, adversarial model (i.e., the client should make the ultimate decisions on all matters and the lawyer should advocate the position expressly favored by his or her client). Most of these articles have discussed the role of counsel in civil commitment proceedings. See, e.g., Michael Blinick, *Mental Disability, Legal Ethics, and Professional Responsibility*, 33 ALB. L. REV. 92 (1968); Elliot Andalman & David Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal*, 45 MISS. L.J. 43 (1974); Thomas R. Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 CAL. L. REV. 816 (1974); Note, *The Role of Counsel in the Civil Commitment Process: A Theoretical Framework*, 84 YALE L. J. 1540 (1975); Michael L. Perlin & Robert L. Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process*, 45 LAW & CONTEMP. PROBS. 161 (Summer 1982); Virginia Aldige Hiday, *The Attorney’s Role in Involuntary Civil Commitment*, 60 N.C. L. REV. 1027 (1982); Michael L. Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases*, 16 LAW & HUM. BEHAV. 39 (1992); Donald H. Stone, *Giving a Voice to the Silent Mentally Ill Client: An Empirical Study of the Role of Counsel in the Civil Commitment Hearing*, 70 UMKC L. REV. 603 (2002). Most of these articles contain or cite data demonstrating that legal representation of the mentally disordered client in the civil commitment context is inadequate and assert that lawyers should apply the traditional adversarial model in representing their mentally disordered clients.

³⁹Michael L. Perlin, *supra* note 1, at manuscript p. 14.

hearings—a striking, near-total lack of attention.⁴⁰ I am not surprised. Here again, the medical model is used, this time to determine what medication is appropriate to treat the person’s mental illness. Who can tell us what medication is appropriate to treat our involuntarily confined mental patient? Obviously, doctors are the experts in prescribing medication, not lawyers or judges.

Even though the Supreme Court has acknowledged that a mentally ill person—in fact, even a mentally ill, sentence-serving prisoner—“possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs,”⁴¹ again, we don’t view an adversarial proceeding as appropriate when the curtailment of that liberty interest is not for the purpose of punishing a criminal, but rather, for the purpose of treating the person’s mental illness in order to make him or her well. And so we defer to

⁴⁰Among the few articles written on the subject are: Michael L. Perlin, “*Salvation or a “Lethal Dose”?* *Attitudes and Advocacy in Right to Refuse Treatment Cases*, ___ J. FORENS. PSYCHOL. PRAC. ___ (2004) (in print); Perlin & Dorfman, *supra* note 15, at 114 (1996); Melvin Shaw, *Professional Responsibility of Attorneys Representing Institutionalized Mental Patients in Relation to Psychotropic Medications*, 22 J. HEALTH & HOSP. L. 186 (1989).

⁴¹Washington v. Harper, 494 U.S. 210, 221-22 (1990). *See also* Riggins v. Nevada, 504 U.S. 127, 135 (1992) (holding that the Fourteenth Amendment prohibits the forcing of antipsychotic medication on criminal defendants held for trial “absent a finding of overriding justification and a determination of medical appropriateness”); Sell v. United States, 539 U.S. 166, 178-83 (2003) (discussing and relying upon *Harper* and *Riggins* as setting the framework for determining whether and under what circumstances the government may forcibly administer antipsychotic medication to render a criminal defendant competent to stand trial). *See* Grant H. Morris, *Mental Disorder and the Civil/Criminal Distinction*, 41 SAN DIEGO L. REV. 1177, 1197-207 (2004) (critiquing the *Sell* decision).

the doctors. Tell us doctor, is the medication that you are prescribing for this patient

University of San Diego Public Law and Legal Theory Research Paper Series, Art. 31 [2005]

medically appropriate for the patient's condition despite any potential side effects that the patient may experience? Would a rational person take that medication despite those potential side effects? Did the doctor answer "yes" to both questions? Case closed.

But deference to doctors is not the only reason the right to refuse treatment is not taken seriously. In addition to a medical judgment that the proposed treatment is appropriate, there has also been a legal judgment that this person's mental illness is sufficiently serious to warrant his or her placement in a mental hospital for treatment. In essence, the civil commitment decision gives a legal imprimatur—a seal of approval—to the person's status as less than a full-fledged human being. We don't need to listen to this person's objections to treatment—no matter how rational those objections are—because we believe that the civil commitment decision "proved" that his or her ideas, concerns, and worries are not worthy of our consideration.

Despite numerous appellate court decisions holding that a person's incompetence to make treatment refusal decisions is not established by a decision to involuntarily civil commit that person and that a separate hearing on that issue is required,⁴² we do not

⁴²*See, e.g.,* Riese v. St. Mary's Hosp. & Med. Ctr., 271 Cal. Rptr. 199, 201, 210 (Cal. Ct. App. 1987) (holding that in nonemergency situations, antipsychotic medication cannot be administered to involuntarily committed civil patients without their consent absent a judicial determination of their incapacity to make treatment decisions); Rogers v. Comm'r, 458 N.E.2d 308, 314 (Mass. 1983) (holding that involuntarily committed civil patients do not lose the right to make treatment decisions unless they are adjudicated incompetent by a judge in incompetency proceedings); Rivers v. Katz, 495 N.E.2d 337, 342, 342-44 (N.Y. 1986) (holding that involuntary civil commitment, without more, does

accept the separate hearing requirement as anything but a meaningless and unnecessary,^{Morris:} formalistic impediment to treatment. If mental illness alone does not equate with incompetence, then surely a decision to civilly commit the mentally ill person must equate. After all, the court has ordered this person placed in a mental hospital, and hospitals are for treatment. We can't allow this sick patient to transform the hospital into a prison, remaining there untreated for an indefinite period of time. Obviously, we conclude, the doctor's medical judgment on what treatment should be administered should trump the involuntary mental patient's claim of a legal right to refuse treatment.

III. Will Competent Counsel Be an Adequate Remedy?

To change this purely theoretical right—this “paper” right, as Michael characterizes it⁴³ into a right with a real remedy, Michael recommends that organized and regularized counsel be appointed—lawyers who are specifically trained to represent individual mental patients who assert a right to refuse treatment.⁴⁴ “[T]he presence of adequate counsel,” he informs us, “is of critical importance in the disposition of right to refuse treatment

not establish that the committed person lacks the mental capacity to comprehend the consequences of medication refusal decisions and that a judicial determination that the patient lacks that capacity is required before the state may administer antipsychotic drugs over the patient's objection). Utilizing the informed consent doctrine, “virtually every court that has considered the matter now recognizes a ‘right to refuse’ psychotropic medication for institutionalized populations.” RALPH REISNER ET AL., *LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS* 923 (4th ed. 2004).

⁴³Perlin, *supra* note 1, at manuscript p. 3.

⁴⁴*Id.* at manuscript p.21.

cases.”⁴⁵ Just as with civil commitment cases, the quality of counsel is “the single most important factor”⁴⁶ in the decisions that are reached in those cases. A mentally disabled person will be fully valued as a member of our society only if a competent lawyer vigorously advocates for him or her in any legal proceeding in which that person is involved.

Is Michael right? Yes, of course he is. However, I qualify my affirmative response with a large asterisk. What if Michael rallies lawyers to his cause? What if they do start advocating aggressively for the mentally disabled? What if they demonstrate that some mentally disabled patients are competent to give or withhold their consent to psychotropic medication? What if courts follow lead of the Montana Supreme Court in its landmark *K.G.F.*⁴⁷ decision, requiring that counsel for the mentally disabled be competent and imposing specific performance standards on them to assure that they are competent—although, as Michael tells us, not a single court in any of the other forty-nine states has yet done so since that case was decided?⁴⁸ Surely, if this happens, mental

⁴⁵*Id.* at manuscript, p. 19.

⁴⁶*Id.*

⁴⁷In re *K.G.F.*, 29 P.3d 485 (Mont. 2001).

⁴⁸Perlin, *supra* note 1, at manuscript p. 26. In fact, only one case has even cited *K.G.F.* in the three and one-half years since it was decided. In that case, the Court of Appeals of Washington specifically rejected *K.G.F.*'s refusal to presume the effective assistance of counsel in the civil commitment context, asserting: “We do not share the Montana Supreme Court’s dim view of the quality of civil commitment proceedings, or their adversarial nature, in the state of Washington.” In re *T.A. H.-L.*, 97 P.3d 767, 771

patients who assert a right to refuse treatment will be more successful in the court proceedings in which their competency to decide is in issue.⁴⁹

Michael will have succeeded, but will he be satisfied by the success he has achieved? In the words of Lady Macbeth, “Naught’s had, all’s spent, where our desire is got without content.”⁴⁹ (Did you think that Bob Dylan is the only source of literary inspiration?).⁵⁰ Although the Supreme Court has acknowledged that involuntarily confined mental patients “possess[] a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs,”⁵¹ many states do not require a court hearing to determine the patient’s competence as a due process protection to enforce that right. Those states use a medical decision maker model, allowing a staff psychiatrist or hospital committee to make an informal judgment of the patient’s competence.⁵² In essence, the

(Wash. Ct. App. 2004).

⁴⁹WILLIAM SHAKESPEARE, *MACBETH* act III, sc. 2.

⁵⁰For those, like Michael, who demand a Dylan fix for every quotation, I offer this more succinct, but less dramatic, alternative: “She knows there’s no success like failure / And that failure is no success at all.” BOB DYLAN, *Love Minus Zero/No Limit*, on BRINGING IT ALL BACK HOME ALBUM (1965).

⁵¹*Washington v. Harper*, 494 U.S. 210, 221-22 (1990). *See supra* note 41.

⁵²*See, e.g.*, MD. CODE ANN., HEALTH §10-708 (2000) (using a medical review panel); N.C. GEN. STAT. § 122C-57(e) (2003) (using a second physician to review the professional judgment of the treating physician); Catherine E. Blackburn, *The “Therapeutic Orgy” and the “Right to Rot” Collide: The Right to Refuse Antipsychotic Drugs Under State Law*, 27 HOUS. L. REV. 447, 479 & n.101, 493 & n.147 (1990) (citing fourteen states that use a medical decision maker model and eighteen states that use a judicial decision maker model to decide whether an involuntarily committed mental patient’s treatment refusal will be upheld).

patient's liberty interest—i.e., his or her legal interest—in avoiding the unwanted

University of San Diego Public Law and Legal Theory Research Paper Series, Art. 31 [2005]

administration of antipsychotic drugs is converted into a determination of the patient's medical interest as that interest is measured by the patient's physician or a hospital committee reviewing that physician's decision.⁵³ Competent and zealous advocacy by patients' attorneys in right to refuse treatment court hearings will not vindicate these patients' right to refuse treatment because, in these states, there are no court hearings to determine the patients' competence to refuse treatment.

What about those states, including the nation's five most populous states

⁵³In *Harper*, 494 U.S. at 227, the Supreme Court held: “[T]he Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest.” Further, the *Harper* Court ruled that the prisoner was not entitled to a judicial hearing to determine whether he was competent to refuse medication. *Id.* at 222, 226, 228. The Court upheld administrative hearing procedures in which a hearing committee, composed of a psychiatrist, psychologist, and the associate superintendent of the facility reviews the medical treatment decision. *Id.* at 215, 232-33. In *Sell v. United States*, 539 U.S. 166 (2003), the Supreme Court, relying on its *Harper* decision, 123 S. Ct. at 2183, upheld the involuntary administration of antipsychotic medication on a criminal defendant who was incompetent to stand trial provided the treatment was medically appropriate, was substantially unlikely to have side effects that could undermine the fairness of the trial, and was necessary to significantly further important governmental, trial-related interests. 123 S. Ct. at 2184. Additionally, the *Sell* Court held that conditions that limit forced medication to restore trial competence need not be considered if forced medication is warranted for a different purpose—such as when the defendant lacks the mental competence to make the treatment decision or when the patient's failure to accept medication poses a risk of injury to the patient or to others. 123 S. Ct. at 2185. Although *Harper* involved a sentence-serving, mentally ill prisoner and *Sell* involved a criminal defendant who was incompetent to stand trial, the two cases suggest that the Supreme Court is likely to uphold the constitutionality of a medical decision maker model in right to refuse treatment situations involving civilly committed patients.

(California, Texas, New York, Florida, and Illinois),^{Morris:} that require a formal hearing on the patient's competence before a judge or other independent, law-trained decision maker?

Surely, one could assert, competent and zealous advocacy by patients' attorneys will have a significant impact on the results of those hearings. For example, for the calendar years 2000 and 2001 combined, a total of 687 hearings were conducted in Illinois to determine patient competence to refuse treatment.⁵⁴ In only fifty-six of those hearings, did the patient prevail.⁵⁵ Thus, under current practice in Illinois, patients were successful in only 8.2 percent of right to refuse treatment cases. If attorneys adequately prepared their cases and argued them vigorously, they should be able to achieve a much higher success rate for their clients. Perhaps 100, or 150, or even 200 patients will prevail. But is this the appropriate measure of success?

During the two-year period in which 687 competency hearings were conducted in Illinois, there were a total of 23,035 patients in the state's mental health centers.⁵⁶ Thus 22,348 patients, i.e., over ninety-seven percent of the total, did not have competency hearings. These 22,348 patients did not have lawyers to assist them because they did not protest their doctors' orders. There were no competency hearings for these patients because psychiatrists assume that patients who accept treatment are competent to do so.

⁵⁴See Wenona Y. Whitfield, *Capacity, Competency, and Courts: The Illinois Experience*, 14 WASH. U. J.L. & POL'Y 385, 403 n.68 (2004).

⁵⁵*Id.*

⁵⁶*Id.*

Because the right to refuse treatment is not self-executing, these patients had no lawyers
University of San Diego Public Law and Legal Theory Research Paper Series, Art. 31 [2005]

to demand that psychiatrists meet their information disclosure obligation before patient consent to treatment was obtained. Michael's proposal for competent and zealous attorney advocacy focuses narrowly on the 687 patients who refused treatment, not more broadly on the 22,348 who accepted it.

And yet, does anyone really believe that all of these 22,348 patients gave their voluntary, informed, and competent consent to treatment with psychotropic medication? When psychiatrists are asked whether they inform patients of the potential risks and benefits of, and alternatives to, the proposed treatment, they typically answer in the affirmative. However, in many right to refuse treatment hearings that I conducted in California,⁵⁷ psychiatrists testified that they informed patients only about medication benefits.⁵⁸ For example, in one case, the psychiatrist testified that he told the patient "that haloperidol would help reduce her feelings of anxiety and would reduce some or all of her hostility." In another case, the psychiatrist testified that he informed the patient that "she would feel less agitated and that her thinking would improve if she agreed to medications." In another case, the psychiatrist simply stated: "I informed the patient that medication would be necessary to help her with her distress and encouraged her to take

⁵⁷See Grant H. Morris, *Judging Judgment: Assessing the Competence of Mental Patients to Refuse Treatment*, 32 SAN DIEGO L. REV. 343, 384-431 (1995) (reporting on my experience as a mental health hearing officer in right to refuse treatment cases).

⁵⁸*Id.* at 426.

it.”

Morris:

Even when psychiatrists did discuss risks, they did not divulge “all information relevant to a meaningful decisional process”⁵⁹—the test of disclosure imposed by the California Supreme Court. To obtain a patient's informed consent, that test requires the psychiatrist to divulge all risks that are material to the patient's decision.⁶⁰ Sometimes psychiatrists spoke about risks in general terms, informing patients that any medication can have detrimental as well as beneficial effects. At other times, psychiatrists discussed some side effects but not others. Typically, the psychiatrist would inform the patient of non-neurological side effects such as sedation or anticholinergic side effects, i.e., dry mouth, blurred vision, urinary retention, and constipation, but would omit any discussion of neurological side effects such as dystonia, Parkinsonism, akathisia, akinesia, and tardive dyskinesia. Obviously, if the risk of non-neurological side effects is material to a patient's decision, the risk of neurological side effects is likely to be even more so.

⁵⁹Cobbs v. Grant, 502 P.2d 1,10 (1972).

⁶⁰The California Supreme Court summarized the physician's disclosure duty as follows:

In sum, the patient's right of self-decision is the measure of the physician's duty to reveal. That right can be effectively exercised only if the patient possesses adequate information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is whatever information is material to the decision. Thus the test for determining whether a potential peril must be divulged is its materiality to the patient's decision.

Id. at 515.

When psychiatrists disclosed the risk of neurological side effects, they usually sugar-coated the information. I deliberately chose the word “sugar-coated.” In one hearing I conducted, in response to my question: “Did you treat the patient with antipsychotic medication during this admission?,” the psychiatrist testified: “No and yes. I managed to sweet talk him into taking Navane a couple of times—three days in a row.”

Sometimes psychiatrists testified that they used a written advisement to inform patients about medication side effects. Typically, those so-called consent forms contained no information about risks but merely asserted that the prescribing physician had provided information about medication risks and benefits. Often those forms were used ritualistically to substitute for the process of obtaining informed consent rather than as evidence that informed consent was, in fact, obtained.

Based on the testimony I heard as a decision maker in right to refuse treatment hearings, I would have to say that nondisclosure or, at best, inadequate disclosure of risks was the norm; full disclosure was the rare exception. This failure of full disclosure is not established, however—in fact, it is not even an issue—if the patient does not refuse treatment and no hearing is conducted. For most patients, no hearing is conducted because most patients obediently accept—or are coerced into accepting—medication that their psychiatrists prescribe. Don’t expect your psychiatrist to come up here and fully discuss risks with you. He’s far too busy doing other things. “Johnny’s in the basement

mixing up the medicine.”⁶¹

Morris:

And even in those relatively few cases in which lawyers competently and zealously represent patients who refuse treatment, what is the likely result? What happens if the patient is found competent to refuse treatment? Do you think that psychiatrists and hospital administrators will allow that patient to remain at their hospital—taking up valuable bed space while refusing treatment? No way. We’ll just release the patient. But when his or her mental disorder kicks up again, and he or she comes to the attention of the police, we won’t accept this person as a patient. Instead, he or she will be charged with some petty crime—e.g., obstruction of the sidewalks or public places, loitering, aggressive solicitation, or, if we’re in Santa Barbara, leaning against a building or a store.⁶² This mentally disabled person will be processed through the criminal justice system.⁶³ Think of it. The three largest hospitals in the United States for the treatment of

⁶¹BOB DYLAN, *Subterranean Homesick Blues*, on BRINGING IT ALL BACK HOME ALBUM (1965). Perhaps another Bob Dylan lyric is equally appropriate to characterize the failure of psychiatrists to communicate to their patients the risks of medication they are prescribing: “We never did too much talkin’ anyway.” BOB DYLAN, *Don’t Think Twice, It’s All Right*, on THE FREEWHEELIN’ BOB DYLAN ALBUM (1963).

⁶²The National Coalition for the Homeless reports these crimes as typical offenses charged against homeless people, at <http://www.nationalhomeless.org/civilrights/crim2003/index.html> (last visited Feb. 11, 2005).

⁶³See generally Paul F. Stavis, *Why Prisons Are Brim-Full of the Mentally Ill: Is Their Incarceration a Solution or a Sign of Failure* 11 GEO. MASON U. CIV. RTS. L.J. 157 (2000); see also Abramson, *supra* note 7, at 103(asserting that mentally disordered individuals are often arrested and prosecuted for nuisance offenses as a convenient and

serious mental illness are not hospitals at all. Rather, they are the three largest jails in the country: Riker's Island in New York City, the Cook County Jail in Chicago, and the Los Angeles County Jail.⁶⁴ And after this person has gone through this revolving door a number of times, when he or she is arrested yet again, maybe he or she will be fortunate enough to be diverted to a newly-created mental health court where the judge will propose a deal that the person cannot refuse: If you agree to take your medicine, you won't go to jail for this latest offense.⁶⁵

California has another option. Under LPS, if a person, as a result of mental disorder, is believed to be a danger to others, or to himself or herself, or gravely disabled, he or she may be detained for an initial seventy-two-hour evaluation period. Thereafter, the person may be certified for a fourteen-day intensive treatment period if any of these three criteria is determined to exist. If the patient refuses treatment, a competency

more reliable alternative to assure their involuntary detention than the LPS civil commitment process).

⁶⁴Stavis, *supra* note 63, at 159 (citing E. Fuller Torrey, *Jails and Prisons—America's New Mental Hospitals*, 85 J. PUB. HEALTH 1611, 1611-13 (1995)).

⁶⁵See Michael L. Perlin, "On Desolation Row": *The Blurring of the Borders Between Civil and Criminal Mental Disability Law, and What It Means to All of Us*, manuscript p. 24 (keynote address presented at the annual meeting of the American Association of Psychiatry and the Law, Newport Beach, CA, Oct.. 2002) (manuscript of address available from the author) (noting that mental health courts "identify mentally ill, non-violent offenders and order or sentence them to receive mental health services in lieu of confinement in a jail or prison"); Debra Baker, *Special Treatment: A One-of-a-Kind Court May Offer the Best Hope for Steering Nonviolent Mentally Ill Defendants into Care Instead of Jail*, 84 A.B.A. J. 20 (June 1998) (describing the first such mental health court, established in Broward County, Florida).

hearing is conducted during this fourteen-day period. If the patient is found to have the mental capacity to refuse treatment, the hospital can immediately initiate conservatorship proceedings.⁶⁶ And once the person is placed on a conservatorship—or even a temporary conservatorship before the full hearing is conducted⁶⁷—the conservator can consent to the administration of medication over the patient’s objection.⁶⁸

How popular is this option? In the most current report available,⁶⁹ the California Department of Mental Health discloses that in the 2000-2001 fiscal year, 125,895 adults were detained on seventy-two-hour evaluation holds as dangerous to self, dangerous to others, or gravely disabled. Of that number, 51,268 were detained on fourteen-day intensive treatment certifications. How many of those people were detained for a 180-day period as demonstrably dangerous to others? You will be delighted to learn that only sixty met that standard. Think of it: For a whole year, after only seventeen days or less of inpatient hospitalization, there were only sixty dangerously mentally ill people in the

⁶⁶CAL. WELF. & INST. CODE § 5352 (West 1998).

⁶⁷*Id.* § 5352.1 (authorizing the court to issue an *ex parte* order establishing a temporary conservatorship pending the determination of the petition for a conservatorship). The powers granted to a temporary conservator may be as broad as the powers granted to a conservator. *Id.* § 5353.

⁶⁸*Id.* § 5358(a)(2), (b). *See supra* text accompanying notes 17-21.

⁶⁹STATISTICS & DATA ANALYSIS, CA. DEP’T OF MENTAL HEALTH, *Involuntary Detention Data—Fiscal Year 2000-01 (July 1, 2000-June 30, 2001)*, at www.dmh.cahwnet.gov/SADA/docs/Involuntary-Detention-Data/Rep0001_FINAL.pdf (last visited Feb. 11, 2005).

entire state of California. But many of those who were initially detained as dangerous to
University of San Diego Public Law and Legal Theory Research Paper Series, Art. 31 [2005]

others were suddenly found to be gravely disabled and processed through the LPS conservatorship route. For fiscal year 2000-2001, a total of 7,198 conservatorships were established. When the legal standard and procedural safeguards for lengthy civil commitment and coerced treatment is perceived as too protective of the mentally disabled—too difficult for us to achieve—we simply bypass them and substitute an alternative, but far easier route to reach the desired result.

Our sanist society will continue to find ways to require the mentally disabled to act as obedient children and take their medicine.⁷⁰ Even if lawyers do advocate vigorously for their clients in individual right to refuse treatment cases, little will change. The goal,

⁷⁰Involuntary outpatient commitment, euphemistically called “assisted outpatient treatment,” is another example demonstrating that society’s preferred, and perhaps its “final solution” for the problem of the mentally disabled, is coerced treatment with psychotropic medication. Under recently enacted statutes patterned after New York’s Kendra’s Law, a mentally disabled person can be required to take psychotropic medication while living in the community, and if the person does not comply, her or she may be involuntarily hospitalized. *See, e.g.*, N.Y. MENTAL HYG. LAW § 9.60(n) (McKinney 2002). Critics contend that these laws, by coercing noncivilly committed persons to accept treatment under threat of institutionalization, erode fundamental human rights and the process by which these rights are protected in the courts. *See, e.g.*, Erin O’Connor, *Is Kendra’s Law a Keeper? How Kendra’s Law Erodes Fundamental Rights of the Mentally Ill*, 11 J.L. & POL’Y 313, 342-49 (2002); Kristina M. Campbell, Note, *Blurring the Lines of the Danger Zone: The Impact of Kendra’s Law on the Rights of the Nonviolent Mentally Ill*, 16 NOTRE DAME J.L. ETHICS & PUB. POL’Y 173, 185-87, 192-98 (2000); Michael L. Perlin, *supra* note 65 at manuscript pp. 11-14. Critics of statutes establishing involuntary outpatient commitment might well agree with Bob Dylan’s assessment of the legislative process: “Fools making laws for the breaking of jaws / And the sound of the keys as they clink / But there’s no time to think.” BOB DYLAN, *No Time to Think*, on STREET LEGAL ALBUM (1978).

the objective, the prize, as Michael knows ^{Morris:} so well, is not the vindication of the right to refuse psychotropic medication for the few mentally disabled clients who are courageous enough to raise that issue and whose lawyers advocate vigorously for them. The goal, the objective, the real prize is acceptance of mentally disabled individuals as people, with the same rights that other people have—the end of discrimination against the mentally disabled; the end of sanism. Sadly, zealous lawyer advocacy in individual right to refuse treatment cases will move us only marginally toward that goal.

The failure of lawyers, judges, psychiatrists, and society to treat mentally disabled people as people—i.e., with dignity and respect—has left me dejected, depressed, even despondent. As Bob Dylan wrote, in the quotation that Michael recited in his article, “I don’t have the strength / To get up and take another shot.”⁷¹

But not so for Michael Perlin. He remains defiant, determined, and most of all, devoted. Just like Don Quixote de la Mancha, this gallant knight remains dedicated to his cause.⁷² He continues to speak, and to write, and to hope.⁷³ He pursues justice⁷⁴ for the

⁷¹BOB DYLAN, *Just Like Tom Thumb’s Blues, on HIGHWAY 61 REVISITED* ALBUM (1965).

⁷²In tribute to Michael Perlin:

May you grow up to be righteous,
May you grow up to be true,
May you always know the truth
And see the lights surrounding you
May you always be courageous,
Stand upright and be strong
And may you stay forever young.

mentally disabled.⁷⁵ Although we do not hear him and do not heed him, he will continue
University of San Diego Public Law and Legal Theory Research Paper Series, Art. 31 [2005]

his quest. The windmills that Michael contests are not mere figments of his imagination.

They are real and continuing problems. Michael is an irresistible force. But our

attitude—our prejudice—toward the mentally disabled may well be an immovable object.

How long will Michael continue to speak in a forest, while we hear only “sounds of

silence”?⁷⁶ Or as Bob Dylan inquired: “[H]ow many ears must one man have / Before he
can hear people cry?”⁷⁷

BOB DYLAN, *Forever Young*, on PLANET WAVES ALBUM (1974).

⁷³Miguel de Cervantes: “When life itself seems lunatic, who knows where
madness lies? . . . Too much sanity may be madness. And maddest of all, to see life as it
is and not as it should be.” DALE WASSERMAN, *MAN OF LA MANCHA* (1965).

⁷⁴“Justice, justice shalt thou pursue, that thou mayest live, and inherit the land
which the LORD thy God giveth thee.” 16 *Deuteronomy* 20.

⁷⁵I saw a man pursuing the horizon;
Round and round they sped.
I was disturbed at this;
I accosted the man.
“It is futile,” I said,
“You can never—“
“You lie,” he cried,
And ran on.

STEPHEN CRANE, *POEMS OF STEPHEN CRANE* 15 (Gerald D. McDonald, ed.
1964).

⁷⁶PAUL SIMON & ART GARFUNKEL, *The Sound of Silence*, on THE SOUNDS
OF SILENCE ALBUM (1964) (lyrics by Paul Simon).

⁷⁷BOB DYLAN, *Blowin’ in the Wind*, on THE FREEWHEELIN’ BOB DYLAN
ALBUM (1963). Or as Bob Dylan phrased it twenty-seven years later, “She ain’t hearing
a thing, the silence is a-stickin’ her deep.” BOB DYLAN, *Cat’s in the Well*, on UNDER

Morris:

THE RED SKY ALBUM (1990).

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