

“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

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I. INTRODUCTION

For over thirty years, lawyers have argued that involuntarily committed psychiatric patients have a right to refuse treatment (basing this argument, variously, on the First, Fourth, Fifth, Sixth, Eighth, Ninth and Fourteenth

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Amendments, as well as on state common law and constitutional law).¹ For the same period of time, this has been the most contentious issue in the “turf” battle between what is incorrectly characterized as “law and psychiatry,”² and is seen as the “pivotal issue in the determination of the future direction of the relationship between law and mental health,”³ or “the most important subject matter under consideration in the area of the legal regulation of mental health practice.”⁴

At this point, legally, there can be little question that the ball game is over. The Supreme Court’s decisions in *Washington v. Harper*,⁵ *Riggins v. Nevada*,⁶ and, most recently, *Sell v. United States*,⁷ make it clear that: a qualified right to refuse medication is located in the Fourteenth Amendment’s Due Process Clause; the pervasiveness of side effects is a key factor in the determination of the scope of the right; the state bears a considerable burden in medicating a patient over objection, and the “least restrictive alternative” mode of analysis must be applied to right to refuse cases.⁸ Nonetheless, the controversy over the right continues unabated.⁹

During this same thirty years, scholars have carefully considered the right to refuse from a rich array of perspectives, including, but not limited to, clinical perspectives, civil libertarian perspectives, philosophical perspectives, and political perspectives.¹⁰ Yet, virtually all of this—remarkably—passes over what I believe is the single most important issue in “real life.” This issue is the most relevant to the actual (as opposed to paper) existence of the right and the actual (as opposed to paper) implementation of that right: the availability and adequacy of counsel to represent patients seeking to assert this right to refuse. In spite of the extensive literature and caselaw that has developed in this area of the law, the topic remains egregiously underdiscussed and underlitigated.

1. See generally 2 MICHAEL L. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* ch. 3B (2d ed. 1999).

2. It is, rather, between lawyers representing patients and lawyers representing state hospital systems.

3. Michael L. Perlin, *The Right to Refuse Treatment: A New Right Emerges*, 1 *ADVOC. NOW: J. PATIENT RTS. & MENTAL HEALTH ADVOC.* 8, 8 (1979).

4. Michael L. Perlin, *Reading the Supreme Court’s Tea Leaves: Predicting Judicial Behavior in Civil and Criminal Right to Refuse Treatment Cases*, 12 *AM. J. FORENSIC PSYCHIATRY* 37, 40 (1991).

5. 494 U.S. 210 (1990) (discussing the right to refuse treatment in prisons).

6. 504 U.S. 127 (1992) (discussing the right to refuse treatment at insanity defense trial).

7. 539 U.S. 166 (2003) (discussing the right to refuse treatment in determination of defendant’s competency to stand trial).

8. See, e.g., *id.* at 177–83.

9. See, e.g., William M. Brooks, *Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs*, 31 *IND. L. REV.* 937, 937–38 (1998).

10. See 2 PERLIN, *supra* note 1, § 3B-2, at 165–67 nn. 24–33 (citing sources).

Simply put, if active, trained counsel is not provided for patients seeking to interpose this right, then the right becomes nothing more than a paper document: useless and meaningless (and perhaps, counterproductive) in the “real world.” Anyone with more than a passing interest in mental disability law is familiar with the concept of the “paper victory,” and how such “victories” are one of the shameful pretexts in this area of the law.¹¹

In this Paper, I will discuss: (1) the generally mediocre job done by lawyers in the involuntary civil commitment process, (2) more particularly, the equally mediocre job done in the right to refuse treatment process, especially where both courts and legislatures have failed to articulate a universal right to counsel in right to refuse cases, (3) the reasons why counsel is so critical in such cases, (4) the significance of what I call “sanism” and what I call “pretextuality,” and the application of a “therapeutic jurisprudence” mode of analysis to the topic in trying to understand all of this, and (5) my recommendations for the future.

My title comes from Bob Dylan’s early song, *Just Like Tom Thumb’s Blues*. In this couplet, he shares with the listener his sense of frustration and confusion with his place in the world:

Now if you see Saint Annie
Please tell her thanks a lot
I cannot move
My fingers are all in a knot
I don’t have the strength
To get up and take another shot
And my best friend, my doctor
Won’t even say what it is I’ve got¹²

One of the reasons why the right to counsel is so critical in right to refuse cases is that it may be the only way of ensuring that the patient’s doctor (the “best friend” descriptor is ironic in these circumstances) actually *does* tell the patient “what it is [he’s] got.” That would be a step in the right direction.

11. See, e.g., Michael L. Perlin, “*Life Is in Mirrors, Death Disappears*”: Giving Life to Atkins, 33 N.M. L. REV. 315, 315 (2003); Michael L. Perlin, “*Their Promises of Paradise*”: Will Olmstead v. L.C. Resuscitate the Constitutional “Least Restrictive Alternative” Principle in Mental Disability Law?, 37 HOUS. L. REV. 999, 1049 (2000). See generally Michael S. Lottman, *Paper Victories and Hard Realities*, in PAPER VICTORIES AND HARD REALITIES: THE IMPLEMENTATION OF THE LEGAL AND CONSTITUTIONAL RIGHTS OF THE MENTALLY DISABLED 93 (Valerie Bradley & Gary Clarke eds., 1976).

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

II. COUNSEL IN THE CIVIL COMMITMENT PROCESS¹³

The assumption that individuals facing involuntary civil commitment are globally represented by adequate counsel is an assumption of a fact not in evidence.¹⁴ The data suggests that, in many jurisdictions, such counsel is woefully inadequate—disinterested, uninformed, roleless, and often hostile.¹⁵ A model of “paternalism/best interests” is substituted for a traditional legal advocacy position, and this substitution is rarely questioned.¹⁶ Few courts have ever grappled with adequacy of counsel questions in this context; fewer yet have found assigned involuntary civil commitment to be inadequate.¹⁷

Only the Supreme Court of Montana has ever adopted meaningful and complex performance standards for counsel in such cases.¹⁸ In *In re the Mental Health of K.G.F.*,¹⁹ that court dramatically launched a rewriting of this area of the law. K.G.F. was a voluntary patient at a community hospital in Montana, whose expressed desire to leave the facility prompted a state petition alleging her need for commitment. Counsel was appointed, and a commitment hearing was scheduled for the next day. The state’s expert recommended commitment, and the patient’s counsel presented the testimony of both the plaintiff herself and a mental health professional, who recommended that the patient be kept in the hospital a few days so that a community-based treatment plan could be arranged nearer to her home. The court ordered commitment, and K.G.F.’s appeal was premised, in part, on allegations of ineffective assistance of counsel.²⁰

In a thoughtful and scholarly opinion, the Montana Supreme Court relied on state statutory and constitutional sources to find that “the right to counsel . . . provides an individual subject to an involuntary commitment proceeding the right to effective assistance of counsel. In turn, this right affords the individual with the right to raise the allegation of ineffective assistance of counsel in challenging a commitment order.”²¹ In assessing what constitutes “effectiveness,” the court—startlingly, to my mind—eschewed

13. See generally 1 PERLIN, *supra* note 1, § 2B-11; MICHAEL L. PERLIN, THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL 146–49 (2000).

14. Michael L. Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases*, 16 LAW & HUM. BEHAV. 39, 39 (1992).

15. *Id.* at 43.

16. *Id.* at 43–44.

17. See generally Michael L. Perlin, “You Have Discussed Lepers and Crooks”: Sanism in Clinical Teaching, 9 CLINICAL L. REV. 683, 686–90 (2003).

18. The text, *infra*, accompanying notes 19–45 is largely adapted from Perlin, *supra* note 17, at 691–94.

19. 29 P.3d 485 (Mont. 2001).

20. *Id.* at 488–89.

21. *Id.* at 491.

the *Strickland v. Washington* standard²² (used to assess effectiveness in criminal cases) as insufficiently protective of the “liberty interests of individuals such as K.G.F., who may or may not have broken any law, but who, upon the expiration of a 90-day commitment, must indefinitely bear the badge of inferiority of a once ‘involuntarily committed’ person with a proven mental disorder.”²³ Interestingly, one of the key reasons why *Strickland* was seen as lacking was the court’s conclusion that “reasonable professional assistance”²⁴—the linchpin of the *Strickland* decision—“cannot be presumed in a proceeding that routinely accepts—and even requires—an unreasonably low standard of legal assistance and generally disdains zealous, adversarial confrontation.”²⁵

In assessing the contours of effective assistance of counsel, the court emphasized that it was not limiting its inquiry to courtroom performance. Even more important was counsel’s “failure to fully investigate and comprehend a patient’s circumstances prior to an involuntary civil commitment hearing or trial, which may, in turn, lead to critical decision-making between counsel and client as to how best to proceed.”²⁶ Such prehearing matters, the court continued, “clearly involve effective preparation prior to a hearing or trial.”²⁷ The court further stressed state laws guaranteeing the patient’s “dignity and personal integrity” and “privacy and dignity”²⁸ as a basis for its decision: “[q]uality counsel provides the most likely way—perhaps the *only* likely way’ to ensure the due process protection of dignity and privacy interests in cases such as the one at bar.”²⁹

After noting that the focus of its condemnation was not assigned counsel in the case before it, (but rather “the failure of the system as a whole, one that through the ordinary course of the efficient administration of a legal process threatens to supplant an individual’s due process rights”),³⁰ the court again focused on the issue of dignity, quoting an

22. 466 U.S. 668 (1984) (establishing a weak effectiveness of counsel standard). See generally 1 PERLIN, *supra* note 1, § 2B-11.2 (criticizing *Strickland* standard).

23. *K.G.F.*, 29 P.3d at 491.

24. See *Strickland*, 466 U.S. at 689.

25. *K.G.F.*, 29 P.3d at 492 (citing Perlin, *supra* note 14, at 53–54 & n.84 (identifying *Strickland* standard as “sterile and perfunctory” where “reasonably effective assistance” is objectively measured by the “prevailing professional norms”)).

26. *K.G.F.*, 29 P.3d at 492.

27. *Id.*

28. *Id.* at 493 (quoting MONT. CODE ANN. §§ 53-21-101(1), 53-21-142(1) (1979)).

29. *Id.* at 494 (citing Perlin, *supra* note 14, at 47).

30. *Id.*

article by Professor Bruce Winick: “Perhaps nothing can threaten a person’s belief that he or she is an equal member of society as much as being subjected to a civil commitment hearing’ and when ‘legal proceedings do not treat people with dignity, they feel devalued as members of society.’”³¹

The court continued by considering the issues of prejudice, stereotyping, and stigma,³² and specifically held that even pejorative language—the court here quoted a 1977 state supreme court case that had referred to persons with disabilities as “idiots and lunatics”³³—was “repugnant to our state constitution.”³⁴ Having set out this legal framework, the court observed that state statutes offered “little assistance” in determining the scope of “effective counsel,” and thus sought to give depth to the terse statutory language.³⁵

“At a bare minimum,” the court observed, “counsel should possess a verifiably competent understanding of the legal process of involuntary commitments, as well as the range of alternative, less-restrictive treatment and care options available.”³⁶ In the initial investigation, counsel must:

conduct a thorough review of all available records . . . necessarily involv[ing] the patient’s prior medical history and treatment, if and to what extent medication has played a role in the petition for commitment, the patient’s relationship to family and friends within the community, and the patient’s relationship with all relevant medical professionals involved prior to and during the petition process.³⁷

Also, counsel should be prepared to discuss with his or her client “the available options in light of such investigations,” as well as the “practical and legal consequences of those options.”³⁸ It is “imperative,” the court stressed, “that counsel request a reasonable amount of time for such an investigation prior to the hearing or trial on the petition.”³⁹ Moreover, counsel “should also attempt to interview all persons who have knowledge of the circumstances surrounding the commitment petition, including family members, acquaintances and any other persons identified by the client as having relevant information, and be prepared to call such

31. *Id.* at 495 (quoting Bruce J. Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 J. CONTEMP. LEGAL ISSUES 37, 44–45 (1999)).

32. *Id.* at 495–96 (citing Michael L. Perlin, *On “Sanism”*, 46 SMU L. REV. 373, 374 (1992)); Winick, *supra* note 31, at 45).

33. *Id.* at 495 (quoting *In re Sonsteng*, 573 P.2d 1149, 1153 (Mont. 1977)).

34. *Id.*

35. *Id.* at 497.

36. *Id.* at 498.

37. *Id.*

38. *Id.* (quoting *National Center for State Courts’ Guidelines for Involuntary Civil Commitment*, 10 MENTAL & PHYSICAL DISABILITY L. REP., 409, 465 pt. E2 (1986) [hereinafter *Guidelines*]).

39. *Id.*

persons as witnesses.”⁴⁰

After similarly elaborating on counsel’s role in the client interview and the need to insure that the patient understands the scope of the right to remain silent, the court concluded by underscoring counsel’s responsibilities “as an advocate and adversary.”⁴¹ The lawyer must “represent the perspective of the [patient] and . . . serve as a vigorous advocate for the [patient’s] wishes,” engaging in “all aspects of advocacy and vigorously argu[ing] to the best of his or her ability for the ends desired by the client,” and operating on the “presumption that a client wishes to not be involuntarily committed.”⁴² Thus, “evidence that counsel independently advocated or otherwise acquiesced to an involuntary commitment—in the absence of any evidence of a voluntary and knowing consent by the patient-respondent—will establish the presumption that counsel was ineffective.”⁴³ In conclusion, the court stated:

[I]t is not only counsel for the patient-respondent, but also courts, that are charged with the duty of safeguarding the due process rights of individuals involved at every stage of the proceedings, and must therefore rigorously adhere to the standards expressed herein, as well as those mandated under [state statute].⁴⁴

Although *K.G.F.* provides an easily transferable blueprint for courts that want to grapple with adequacy of counsel issues in this context, but are reluctant to explore totally uncharted waters,⁴⁵ the decision remains the exception to the usual practice. *K.G.F.* has only been cited once outside of Montana, and in that case, the Washington Court of Appeals took issue with the *K.G.F.* court’s rejection of the *Strickland* standard.⁴⁶ But globally, counsel’s continuing failure here still appears to be inevitable, given the bar’s abject disregard of both consumer groups (made up predominantly of former recipients, both voluntary and

40. *Id.* at 498–99.

41. *Id.* at 500.

42. *Id.* (quoting *Guidelines*, *supra* note 38, at 465 pt. E2; *id.* at 483 pt. F5).

43. *Id.*

44. *Id.* at 501.

45. *See, e.g., In re A.S.*, 87 P.3d 408, 413 (Mont. 2004) (relying in part on *K.G.F.* to find that parents have a due process right to effective assistance of counsel in proceedings to terminate parental rights).

46. *In re Detention of T.A. H.-L.*, 97 P.3d 767, 771–72 (Wash. Ct. App. 2004) (“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. The *Strickland* standard appears to be sufficient to protect the right to the effective assistance of counsel for a civil commitment respondent in this state.”).

involuntary, of mental disability services) and individuals with mental disabilities, many of whom have written carefully, thoughtfully, and sensitively about these issues.⁴⁷ This inadequacy further reflects sanist practices—and I will soon elaborate on what this means—on the part of the lawyers representing persons with mental disabilities, as well as the political entities vested with the authority to hire such counsel. Although a handful of articulate scholars take this question seriously,⁴⁸ the questions raised here do not appear to be a priority agenda item for litigators or for most academics writing in this area.

The issue *was* addressed over twenty years ago, however, in an article by John Ensminger and Thomas Liguori,⁴⁹ in which the authors looked carefully at the way that the commitment process actually works, the effect it has on the individuals subject to commitment, and how state hospital employees respond to the litigational process.⁵⁰ In arguing that the civil commitment process had great therapeutic potential, the authors stressed that such hearings are therapeutic because, *inter alia*, they give patients an opportunity to present and hear evidence in a meaningful court procedure.⁵¹ Writing about this topic some nine years ago, I speculated that “[t]hese same benefits can be attributed to medication hearings, particularly as these hearings are, in some jurisdictions, more

47. On the involvement of consumer groups in important patients’ rights litigation, see I PERLIN, *supra* note 1, §1-2.1, at 10 n.43; Michael L. Perlin, “*Things Have Changed: Looking at Non-Institutional Mental Disability Law Through the Sanism Filter*,” 46 N.Y.L. SCH. L. REV. 535, 540 (2003). See generally *Challenging the Therapeutic State: Critical Perspectives on Psychiatry and the Mental Health System*, 11 J. MIND & BEHAV. 1–328 (David Cohen ed., 1990) (symposium issue).

48. See, e.g., Joshua Cook, *Good Lawyering and Bad Role Models: The Role of Respondent’s Counsel in a Civil Commitment Hearing*, 14 GEO. J. LEGAL ETHICS 179 (2000); Stanley S. Herr, *The Future of Advocacy for Persons with Mental Disabilities*, 39 RUTGERS L. REV. 443 (1987); Stanley S. Herr, *Representation of Clients with Disabilities: Issues of Ethics and Control*, 17 N.Y.U. REV. L. & SOC. CHANGE 609 (1989–1990); Peter Margulies, “*Who Are You To Tell Me That?*”: *Attorney-Client Deliberation Regarding Nonlegal Issues and the Interests of Nonclients*, 68 N.C. L. REV. 213 (1990); Paul R. Tremblay, *On Persuasion and Paternalism: Lawyer Decisionmaking and the Questionably Competent Client*, 1987 UTAH L. REV. 515; Steven J. Schwartz, *Damage Actions as a Strategy for Enhancing the Quality of Care of Persons with Mental Disabilities*, 17 N.Y.U. REV. L. & SOC. CHANGE 651 (1989–1990); Christopher Slobogin & Amy Mashburn, *The Criminal Defense Lawyer’s Fiduciary Duty to Clients with Mental Disability*, 68 FORDHAM L. REV. 1581 (2000).

49. John J. Ensminger & Thomas D. Liguori, *The Therapeutic Significance of the Civil Commitment Hearing: An Unexplored Potential*, 6 J. PSYCHIATRY & L. 5 (1978), reprinted in THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT 245 (David B. Wexler ed., 1990) [hereinafter THERAPEUTIC JURISPRUDENCE].

50. I discuss the significance of the Ensminger/Liguori article in Michael L. Perlin, *A Law of Healing*, 68 U. CIN. L. REV. 407, 414–15 (2000).

51. Ensminger & Liguori, *supra* note 49, as reprinted in THERAPEUTIC JURISPRUDENCE, *supra* note 49, at 249–53.

formal than commitment hearings.”⁵² Not one thing has happened in the intervening years to remotely change my mind.

It is to this question that I now wish to turn.

III. COUNSEL IN RIGHT TO REFUSE CASES⁵³

There is scant literature that addresses the question of the availability and adequacy of counsel in right to refuse medication hearings.⁵⁴ This near-total lack of attention is even more striking when juxtaposed with the extensive scholarship that has developed discussing the law reform/test case litigation that led directly to the judicial articulation of a right to refuse treatment.⁵⁵

Lawyers representing individuals with mental disabilities must familiarize themselves with information about the right to refuse treatment, both as to the law and as to the pharmacology.⁵⁶ The track record of lawyers representing persons with mental disabilities has ranged from indifferent to wretched;⁵⁷ in one famous survey, lawyers were so bad that a patient had a better chance of being released at a commitment hearing if he appeared *pro se*.⁵⁸ Further, simply educating lawyers about psychiatric

52. Michael L. Perlin et al., *Therapeutic Jurisprudence and the Civil Rights of Institutionalized Mentally Disabled Persons: Hopeless Oxymoron or Path to Redemption?*, 1 PSYCHOL., PUB. POL’Y, & L. 80, 114 (1995).

53. This section is largely adapted from Michael L. Perlin, “Salvation” or a “Lethal Dose”? *Attitudes and Advocacy in Right to Refuse Treatment Cases*, 4 J. FORENSIC PSYCHOL. PRAC. No. 4, at 51 (2004).

54. See Melvin R. Shaw, *Professional Responsibility of Attorneys Representing Institutionalized Mental Patients in Relation to Psychotropic Medication*, 22 J. HEALTH & HOSP. L. 186, 192 (1989) (characterizing lawyers’ arguments seeking to vindicate a right to refuse medication as an “injustice”).

55. For recent literature, see, for example, 2 PERLIN, *supra* note 1, § 3B-1, at 155 n.1, and § 3B-2, at 157 n.2.

56. See generally Michael 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, 135–36 (1996).

57. See Perlin, *supra* note 14, at 43–45; see also, e.g., Schwartz, *supra* note 48, at 662 (describing the “wholesale lack of legal advocacy” available to patients in public mental institutions).

58. Elliott Andalman & David L. Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal*, 45 MISS. L.J. 43, 72 (1974). One-half of the lawyers assigned to represent individuals in civil commitment cases in Dallas were unaware of the existence of either of the two treatises written specifically about Texas’s mental health law. Daniel W. Shuman & Richard Hawkins, *The Use of Alternatives to Institutionalization of the Mentally Ill*, 33 SW. L.J. 1181, 1193–94 (1980) (noting that attorneys received \$25 per case).

technique and psychological nomenclature does not materially improve lawyers' performance where underlying attitudes are not changed.⁵⁹ If counsel is to become even minimally competent in this area, it is critical that the underlying issues here be confronted.⁶⁰ This is underscored by judges' lack of basic knowledge about mental disability law; in one astonishing case, a Louisiana civil commitment order was reversed where the trial court did not even know of the existence of a state-mandated Mental Health Advocacy Service.⁶¹ If lawyers continue to so abdicate their advocacy role, it is not surprising that so many areas of application of the right to refuse treatment remain judicially unexplored.

Like other legal rights, the right to refuse treatment is not self-executing.⁶² A statement by a state supreme court or a federal court of appeals that a patient has a "qualified right to refuse treatment" does not, in and of itself, automatically translate into a coherent structure through which hearings are scheduled, counsel is appointed, and hearing procedures are established. Of the important right to refuse cases, only *Rivers v. Katz* establishes any mechanism for the appointment of counsel in individual right to refuse cases.⁶³ Although *Rennie v. Klein*—one of the first federal cases to find a substantive constitutional right to refuse—originally

59. Norman G. Poythress Jr., *Psychiatric Expertise in Civil Commitment: Training Attorneys to Cope with Expert Testimony*, 2 LAW & HUM. BEHAV. 1, 15 (1978); see also Perlin, *supra* note 17, at 690. There is similar evidence in other areas of the law that knowledge alone is an insufficient impetus for attitudinal change. See, e.g., Robert M. Bohm et al., *Knowledge and Death Penalty Opinion: A Test of the Marshall Hypotheses*, 28 J. RES. CRIME & DELINQ. 360 (1991).

60. For a rare judicial acknowledgment of the impact of lawyer incompetency in another area where inadequate counsel leads to morally intolerable results, see Engberg v. Meyer, 820 P.2d 70, 104 (Wyo. 1991) (Urbigkit, C.J., dissenting in part and concurring in part): "We . . . let 'chiropractors' with law degrees perform the equivalent of brain surgery in capital cases and, predictably, the 'patient' often dies. This is intolerable."

61. See, e.g., *In re Judicial Commitment of C.P.K.*, 516 So. 2d 1323, 1325 (La. Ct. App. 1987) (reversing commitment order where trial court failed to comply with statute expressing explicit preference for representation by state Mental Health Advocacy Service, and rejecting as "untenable" argument that trial court should be excused "since it did not know . . . whether the Service really existed"). I discuss *C.P.K.* in this context in Perlin & Dorfman, *supra* note 56, at 120 n.67.

62. See, e.g., Bruce J. Winick, *Restructuring Competency to Stand Trial*, 32 UCLA L. REV. 921, 941 (1985); see also Alan H. Macurdy, *The Americans With Disabilities Act: Time for Celebration, or Time for Caution?*, 1 B.U. PUB. INT. L.J. 21, 29 (1991); John Parry, *Rights Aplenty But Not Enough Money: A Paradox in Federal Disability Policies*, 12 MENTAL & PHYSICAL DISABILITY L. REP. 486 (1988) (pointing out that while there has been legislation to enhance the civil rights of persons with disabilities, the laws are not always fully implemented due to the lack of funding and other resources).

63. *Rivers v. Katz*, 495 N.E.2d 337, 343-44 (N.Y. 1986). Representation in *Rivers* hearings is provided by the state-funded Mental Hygiene Legal Services (MHLS) office. *In re St. Luke's-Roosevelt Hosp. Ctr.*, 607 N.Y.S.2d 574, 579 n.11 (N.Y. Sup. Ct. 1993), *aff'd*, 675 N.E.2d 1209 (N.Y. 1996).

mandated the appointment of counsel,⁶⁴ it later receded from this position and required only the presence of “Patient Advocates” (employees of the state Division of Mental Health and Hospitals) to serve as “informal counsel to patients who wish to refuse [antipsychotic medication]”).⁶⁵

A handful of statutes mandate the appointment of counsel in right to refuse treatment hearings;⁶⁶ however, at least one court has held that failure to appoint counsel is not reversible error,⁶⁷ and only a few cases have spoken to the role or scope of counsel at medication hearings.⁶⁸ Although more courts are beginning to articulate the criteria to be considered at a medication refusal hearing,⁶⁹ this level of specificity is simply not present in the assessment of the role and responsibilities of counsel.⁷⁰

Without such an articulation of specificity, the authentic meaning of a “right to refuse” remains murky. A right without a remedy is no right at all,⁷¹ worse, a right without a remedy is meretricious and pretextual—it

64. *Rennie v. Klein*, 462 F. Supp. 1131, 1147 (D.N.J. 1978), *suppl.*, 476 F. Supp. 1294 (D.N.J. 1979), *modified*, 653 F.2d 836 (3d Cir. 1981), *vacated*, 458 U.S. 1119 (1982).

65. *Rennie*, 476 F. Supp. at 1311; *see also id.* at 1313 (“[Patient Advocates] may be trained attorneys, psychologists, social workers, registered nurses or paralegals, “or have any equivalent experience.”). This recession followed the Supreme Court’s decision in *Parham v. J.R.*, 442 U.S. 584 (1979), allowing for relaxed procedures in the cases of the involuntary civil commitment of juveniles. *But see United States v. Humphreys*, 148 F. Supp. 2d 949 (D.S.D. 2001) (holding that lay advocate, who was supposed to appear on defendant’s behalf at involuntary medication hearing, but who actually testified against him, did not meet requirements of due process).

66. *See, e.g.*, OKLA. STAT. ANN. 43A § 5-415(A)(1) (West Supp. 2005); WIS. STAT. ANN. § 880.33(2)(a)(1) (West 2002); N.M. STAT. ANN. §§ 43-1-4, 43-1-15 (Michie 2000); 405 ILL. COMP. STAT. ANN. 5/2-107.1(a)(3) (West 1997 & Supp. 2004); *see also In re Jones*, 743 N.E.2d 1090, 1094 (Ill. App. Ct. 2001) (holding that trial court committed reversible error in appointing guardian *ad litem* to represent individual in medication hearing, as he had a statutory right to an attorney).

67. *In re Steen*, 437 N.W.2d 101, 105 (Minn. Ct. App. 1989). *Steen*, interestingly, has only been cited by the Minnesota Court of Appeals in the fourteen years since it was decided. *Cf. Cornett v. Donovan*, 51 F.3d 894 (9th Cir. 1995) (concluding that the right to legal assistance extends only through pleading stage of habeas or civil rights action).

68. *See, e.g., Rennie*, 476 F. Supp. at 1313 (“[Patient Advocates] must be given training in the effects of psychotropic medication and the principles of legal advocacy.”); *In re Jarvis*, 433 N.W.2d 120, 123–24 (Minn. Ct. App. 1988) (criticizing failure to give counsel adequate time to explore basis for treating psychiatrist’s choice of medications); *Williams v. Wilzack*, 573 A.2d 809, 821 (Md. 1990) (criticizing failure to give counsel opportunity to present evidence or cross-examine witnesses).

69. *See, e.g., Virgil D. v. Rock County*, 524 N.W.2d 894, 899–900 (Wis. 1994).

70. *See Perlin, supra* note 14, at 56 & n.101 (asserting that as mental disability law becomes more complex, it is essential that counsel for patients understand differing right to refuse treatment doctrines and their rationales).

71. Donald H. Zeigler, *Rights Require Remedies: A New Approach to the*

gives the illusion of a right without any legitimate expectation that the right will be honored.⁷² This is especially significant in light of Professor Tom Tyler's research in procedural justice finding that individuals subject to involuntary civil commitment hearings, like all other citizens, are affected by such process values as participation, dignity, and trust, and that experiencing arbitrariness in procedure leads to "social malaise and decreases people's willingness to be integrated into the polity, accepting its authorities and following its rules."⁷³ Also, subsequent research by Dr. Hoge and Professor Feucht-Haviar provides further empirical support for Professor Tyler's insights. Their study of long-term psychiatric patients found, in an informed consent context, that "capable patient involvement is an important check on a physician's judgment."⁷⁴

"Empirical surveys consistently demonstrate that the quality of counsel 'remains the single most important factor in the disposition of involuntary civil commitment cases.'"⁷⁵ Certainly the presence of adequate counsel is of critical importance in the disposition of right to refuse treatment cases as well. Furthermore, the research makes clear that jurisdictions are wildly inconsistent in the implementation of the right to refuse laws in general, especially with regard to the specific issue of the provision of counsel, both from jurisdiction to jurisdiction and within jurisdictions.⁷⁶

Again, these findings take on even more importance when considered in the context of the findings by the MacArthur Research Network⁷⁷ that mental patients are not always incompetent to make rational decisions

Enforcement of Rights in the Federal Courts, 38 HASTINGS L.J. 665, 678-79 (1987); see also, Donald H. Zeigler, *Rights, Rights of Action, and Remedies: An Integrated Approach*, 76 WASH. L. REV. 67 (2001).

72. This is not to suggest that the existence of a constitutional right is somehow illegitimate if it is not honored in each individual case seeking to vindicate it. Rather, "honored" here refers to the presence of a legally legitimate hearing at which a decision as to whether to honor the right is fairly assessed.

73. Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433, 443 (1992); see Perlin, *supra* note 50, at 415 (discussing Tyler's insights in this context).

74. Steven K. Hoge & Thomas C. Feucht-Haviar, *Long-Term, Assenting Psychiatric Patients: Decisional Capacity and the Quality of Care*, 23 BULL. AM. ACAD. PSYCHIATRY & L. 343, 349 (1995) ("[O]ur findings seem to undermine physicians' arguments that informed consent is an unnecessary intrusion into the doctor-patient relationship, which interferes with the provision of effective treatment."); see also Bruce J. Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection*, 28 HOUS. L. REV. 15, 46-47 (1991) (discussing the therapeutic value of patient choice); Julie Magno Zito et al., *The Treatment Review Panel: A Solution to Treatment Refusal?*, 12 BULL. AM. ACAD. PSYCHIATRY & L. 349, 357 (1984).

75. Perlin & Dorfman, *supra* note 56, at 120 (quoting Perlin, *supra* note 14, at 49).

76. See generally Perlin & Dorfman, *supra* note 56, at 122-24.

77. See 2 PERLIN, *supra* note 1, § 3B-14.5, at 373-74.

and are not inherently more incompetent than nonmentally ill medical patients.⁷⁸ Yet, what Professor Winick refers to as “19th-century notions equating mental illness with incompetence,”⁷⁹ still, in practice, “continue to influence legal rules and practices in this area.”⁸⁰

If judges uncritically conflate institutionalization with incompetency, lack of meaningful counsel—to structure statutory, caselaw-based, and empirical arguments—may be fatal to the patient’s case.⁸¹ The mere *existence* of counsel on behalf of institutionalized mental patients is often invisible to trial courts,⁸² certainly, there is no reason for optimism about judicial knowledge or interest in this area of the law, absent aggressive, advocacy-focused counsel.

If ward psychiatrists demonstrate a propensity to categorize “incompetent” as an equivalent of “makes bad decisions” and assume, in the face of conflicting statutory and case law, that incompetence in decisionmaking can be presumed from the fact of institutionalization,⁸³ then lack of counsel—to inquire into the bases of these views on cross-examination and to demonstrate to the court that they are dissonant with established case and statutory law—may similarly make the legal process an illusory safeguard.

In spite of the impressive body of caselaw outlined above, the existence of a right to refuse treatment remains enigmatic—at best—for many clinicians.⁸⁴ Some are resistant, arguing—unsuccessfully in court,

78. See generally Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 LAW & HUM. BEHAV. 149 (1995).

79. Bruce J. Winick, *The MacArthur Treatment Competence Study: Legal and Therapeutic Implications*, 2 PSYCHOL., PUB. POL’Y, & L. 137, 153 (1996).

80. *Id.* (for an explanation of these “19th-century notions,” see *id.* at 151).

81. On counsel’s educative role, see 1 PERLIN, *supra* note 1, § 2B-9, at 247; Michael L. Perlin & Robert L. Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process*, 45 LAW & CONTEMP. PROBS. 161, 168–73 (Summer 1982).

82. See, e.g., *In re* Judicial Commitment of C.P.K., 516 So. 2d 1323, 1325 (La. Ct. App. 1987), discussed *supra* note 61.

83. See, e.g., Brian Ladds et al., *The Disposition of Criminal Charges After Involuntary Medication to Restore Competency to Stand Trial*, 38 J. FORENSIC SCI. 1442 (1993); Brian Ladds et al., *Involuntary Medication of Patients Who Are Incompetent to Stand Trial: A Descriptive Study of the New York Experience with Judicial Review*, 21 BULL. AM. ACAD. PSYCHIATRY & L. 529 (1993).

84. I have been presenting papers on this topic to mental health professionals for the better part of thirty years. Consistently, there are always questions from the audience expressing surprise that there *is* such a right, and often expressing the view that such a right is clinically unwarranted. For the Supreme Court’s most recent foray into this area of the law, see *Sell v. United States*, 539 U.S. 166 (2003), in which the court established

but, perhaps, more successfully in clinical practice—that the existence of the right is destructive; certainly the provocative titles of early articles written by prominent forensic psychiatrists about the right to refuse treatment suggest a basic tension that may not be resolvable absent sensitive articulation of the underlying legal concepts.⁸⁵

IV. THE NEED FOR ORGANIZED COUNSEL

It is my conclusion that organized and regularized counsel is essential if there is to be *adequate* counsel in individual right to refuse treatment cases. Without such counsel, the meaningful implementation of rulings in class action/law reform cases and/or appellate decisions will be virtually impossible.

First, there is no evidence that occasional counsel has any concept of the complexity of the legal issues, the conflicts in medical research, the skills needed for effective cross-examination, or the potential range of available less restrictive alternatives that can be suggested to the court. The little literature that is available reflects the lack of competence on the part of counsel generally assigned to do such cases.

Eight years ago, Deborah Dorfman and I studied the right to refuse process in Utah, California, and Washington. We concluded that the litigation of individual right to refuse cases offered “no coherent framework” for policymakers seeking to create a global structure for such hearings.⁸⁶ We further noted the significant disparity in the way right to refuse cases were litigated and decided, both inter-jurisdictionally and intra-jurisdictionally,⁸⁷ finding that, in many counties, such hearings were nothing more than an “empty shell (offering only an illusion of due process).”⁸⁸ I have found nothing in the literature to suggest that there has been any significant improvement in the past eight years.

Perhaps the best and most important study that has been done on this issue has been the research reported by Professor Grant Morris on his experience as a California hearing officer whose role was to determine

procedures for use in cases of persons incompetent to stand trial who wish to refuse the administration of antipsychotic medication.

85. See, e.g., Paul S. Appelbaum & Thomas G. Gutheil, “Rotting With Their Rights On”: *Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients*, 7 BULL. AM. ACAD. PSYCHIATRY & L. 306 (1979); Darold A. Treffert, *Dying with Their Rights On*, 130 AM. J. PSYCHIATRY 1041 (1973); Steven Rachlin, *One Right Too Many*, 3 BULL. AM. ACAD. PSYCHIATRY & L. 99 (1975).

86. Perlin & Dorfman, *supra* note 56, at 124.

87. *Id.* at 124–29.

88. *Id.* at 130; see also Sana Loue, *The Involuntary Civil Commitment of Mentally Ill Persons in the United States and Romania: A Comparative Analysis*, 23 J. LEGAL MED. 211, 235 n.120 (2002) (same).

patients' competence to refuse medication.⁸⁹ Professor Morris's study tells us that, often, hospital doctors failed to tell patients the risks and benefits of the medications that were prescribed for them,⁹⁰ yet, this failure to inform—a necessary predicate, it seems to me, of “informed consent” under *any* definition of that term—was virtually never challenged by patients' counsel.⁹¹ In other cases, patients might have had rational reasons to refuse, such as their familiarity with side-effects from past experiences with the drug in question,⁹² but if the *rationality* of this request were not stressed by counsel (either on direct examination, cross-examination, or summation), then the hearing would, in fact, be the exact sort of “empty shell” that Dorfman and I described.

Without such counsel, it is likely that there will be no meaningful counterbalance to the hospital's “script,” and the patient's articulated constitutional rights will evaporate. A recent piece by Professor Wenona Whitfield looked at Illinois practice in this area, and concluded that the attorneys assigned to do these cases—on behalf of *both* the hospital and the patient—“have little incentive or interest in making this area of the law their specialty.”⁹³ And, few judges have the depth or breadth of knowledge (or, frankly, the interest) to “save” the ineffective

89. Grant H. Morris, *Judging Judgment: Assessing the Competence of Mental Patients to Refuse Treatment*, 32 SAN DIEGO L. REV. 343, 364 (1995). These hearings were held in partial implementation of the California decision in *Riese v. St. Mary's Hospital & Medical Center*, 271 Cal. Rptr. 199, 211 (Ct. App. 1987); see generally 2 PERLIN, *supra* note 1, § 3B-7.2c, at 276–79.

90. Morris, *supra* note 89, at 388.

91. *Id.* at 425–30.

92. The Supreme Court has explicitly linked the possibility of side effects to the rationale for Constitutional due process protections in right to refuse cases. See *Washington v. Harper*, 494 U.S. 210, 229–30 (1990) (“[I]t is also true that the drugs can have serious, even fatal, side effects . . . tardive dyskinesia, perhaps the most discussed side effect of antipsychotic drugs . . . [is] irreversible in some cases, [and is] characterized by involuntary, uncontrollable movements of various muscles, especially around the face.”); *Riggins v. Nevada*, 504 U.S. 127, 137 (1992) (“[It was] suggested that the dosage administered to [the defendant] was within the toxic range, and could make him ‘uptight’ [or make him] suffer from drowsiness or confusion. . . . It is clearly possible that such side effects had an impact upon not just [defendants'] outward appearance, but also the content of his testimony . . . , his ability to follow the proceedings, or the substance of his communication with counsel.” (internal citations omitted)); *Sell v. United States*, 539 U.S. 166, 185 (2003) (“Whether a particular drug will tend to sedate a defendant, interfere with communication with counsel, prevent rapid reaction to trial developments, or diminish the ability to express emotions are matters important in determining the permissibility of medication to restore competence . . .”).

93. Wenona Y. Whitfield, *Capacity, Competency, and Courts: The Illinois Experience*, 14 WASH. U. J.L. & POL'Y 385, 404–05 (2004).

counsel. Whitfield notes that, similarly, the assigned judges “generally have little judicial experience and little incentive to develop expertise in this area.”⁹⁴

But this issue has largely been the subject of a stunning lack of commentary in the law journals. In the introduction to the symposium in which Dorfman and I published our paper, Professor Bruce Winick referred to this stage as a “critical and almost entirely unexamined aspect of the competency determination process.”⁹⁵ Again, eight years later, it remains unexamined.

V. SANISM, PRETEXTUALITY, AND THERAPEUTIC JURISPRUDENCE

The failure to assign adequate counsel bespeaks sanism and pretextuality, and a failure to consider the implications of therapeutic jurisprudence. Sanism is an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry. It infects both our jurisprudence and our lawyering practices. Sanism is largely invisible and largely socially acceptable. It is based predominantly upon stereotype, myth, superstition, and deindividualization, and is sustained and perpetuated by our use of alleged “ordinary common sense” (OCS)⁹⁶ and heuristic reasoning in an unconscious response to events both in everyday life and in the legal process.⁹⁷

Pretextuality defines the ways in which courts accept (either implicitly or explicitly) testimonial dishonesty and engage similarly in dishonest (and frequently meretricious) decisionmaking, specifically where witnesses, especially expert witnesses, show a high propensity to purposely distort their testimony in order to achieve desired ends. This pretextuality is poisonous; it infects all participants in the judicial system, breeds cynicism and disrespect for the law, demeans participants, and reinforces shoddy lawyering, blasé judging, and, at times, perjurious and/or corrupt

94. *Id.* at 404.

95. Bruce J. Winick, *Foreword: A Summary of the MacArthur Treatment Competence Study and an Introduction to the Special Theme*, 2 PSYCHOL., PUB. POL’Y, & L. 3, 15 (1996).

96. OCS is a “powerful unconscious animator of legal decision making.” Michael L. Perlin, “*She Breaks Just Like a Little Girl*”: *Neonaticide, The Insanity Defense, and the Irrelevance of “Ordinary Common Sense”*, 10 WM. & MARY J. WOMEN & L. 1, 25 (2003); see Richard K. Sherwin, *Dialects and Dominance: A Study of Rhetorical Fields in the Law of Confessions*, 136 U. PA. L. REV. 729, 737 (1986–1987) (stating that OCS exemplified by the attitude of “What I know is ‘self evident’; it is ‘what everybody knows’”).

97. Perlin, *supra* note 96, at 24–25 (citing Michael L. Perlin, “*Half-Wracked Prejudice Leaped Forth*”: *Sanism, Pretextuality, and Why and How Mental Disability Law Developed as it Did*, 10 J. CONTEMP. LEGAL ISSUES 3, 4–5 (1999)).

testifying.⁹⁸ All aspects of mental disability law are pervaded by sanism and by pretextuality, whether the specific presenting topic is involuntary civil commitment law, right to refuse treatment law, the sexual rights of persons with mental disabilities, or any aspect of the criminal trial process.⁹⁹

Therapeutic jurisprudence presents a new model by which we can assess the ultimate impact of case law and legislation that affects mentally disabled individuals, studying the role of the law as a therapeutic agent, recognizing that substantive rules, legal procedures, and lawyers' roles may have either therapeutic or antitherapeutic consequences, and questioning whether such rules, procedures, and roles can or should be reshaped so as to enhance their therapeutic potential, while not subordinating due process principles.¹⁰⁰

I have suggested elsewhere that therapeutic jurisprudence should be employed to “expose pretextuality and strip bare the law’s sanist facade” and to be used as a “powerful tool that will serve as ‘a means of attacking and uprooting the “we/they distinction that has traditionally plagued and stigmatized the mentally disabled.””¹⁰¹ How, then, do these concepts “fit” in the analysis I have undertaken in this Paper?

Recently, I have written critically of the way that lawyers—even lawyers who identify themselves as public interest lawyers—are often sanist. I have argued:

Sanism permeates the legal representation process both in cases in which mental capacity is a central issue, and those in which such capacity is a collateral question. Sanist lawyers (1) distrust their mentally disabled clients, (2) trivialize their complaints, (3) fail to forge authentic attorney-client relationships with such clients and reject their clients’ potential contributions to case-strategizing, and (4) take less seriously case outcomes that are adverse to their clients.¹⁰²

Sanist lawyers cannot be relied upon to provide adequate representation to their clients in right to refuse treatment cases.

Judicial complicity in the assignment and performance of inadequate counsel evidences sanism. Again, the fact that, in the two and a half years since *K.G.F.* was decided, not another state has endorsed the

98. Perlin, *supra* note 96, at 25.

99. *Id.*

100. 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, 228 (2000).

101. Perlin, *supra* note 47, at 544; PERLIN, *supra* note 13, at 301.

102. Perlin, *supra* note 17, at 695.

Montana Supreme Court's "take" on sanism is stark evidence of the fact that this issue is simply "off the docket" for the judicial system.¹⁰³ Passive sanism remains sanism.

I have often recounted the most chilling sanist comment that I have ever heard from a sitting trial judge:

[No example of judicial hostility] is perhaps as chilling as the following story: Sometime after the trial court's decision in *Rennie* [*v. Klein*],¹⁰⁴ I had occasion to speak to a state court trial judge about the *Rennie* case. He asked me, "Michael, do you know what I would have done had you brought *Rennie* before me?" (The *Rennie* case was litigated by counsel in the N.J. Division of Mental Health Advocacy; I was director of the Division at that time). I replied, "No," and he then answered, "I'd've taken the son-of-a-bitch behind the courthouse and had him shot."¹⁰⁵

It is probably no coincidence that the focal point of this conversation was a right to refuse treatment case.

When Dorfman and I did our initial survey about counsel in right to refuse cases, we stressed the pretextual nature of the enterprise:

The common wisdom is clear here. Drugs serve two major purposes of social control: They "cure" dangerousness, and they are the only assurance that deinstitutionalized patients can remain free in community settings. Both of these assumptions are reflected in the case law that has developed in individual involuntary civil commitment cases (in which a judge's perception of the likelihood that an individual self-medicates becomes the critical variable in case dispositions); they are also reflected in the public discourse that is heard in classrooms, hospital corridors, and courtrooms.

Neither of these assumptions has any basis in science or in law. Yet, without counsel to serve as a brake—to ask questions, to challenge assumptions, to identify false ordinary common sense, to point out the dangerous pitfalls of heuristic thinking—these assumptions will continue to dominate and control the disposition of individual right to refuse treatment cases¹⁰⁶

Again, I have seen no evidence that there has been any change in these attitudes in the eight years since we reported our findings.

In his comprehensive and masterful book, *The Right to Refuse Mental Health Treatment*, Professor Bruce Winick discussed some of the ways that the implementation of such a right might advance therapeutic jurisprudence ends: such implementation could involve patient involvement in the design of her treatment program,¹⁰⁷ make it more likely that

103. See text accompanying note 46 (discussing *In re Detention of T.A. H.-L.*, 97 P.3d 767 (Wash. Ct. App. 2004)).

104. 462 F. Supp. 1131 (D.N.J. 1978) (granting involuntarily committed mental patients a limited right to refuse medication).

105. See, e.g., Perlin, *supra* note 97, at 16 n.70.

106. Perlin & Dorfman, *supra* note 56, at 135 (internal citations omitted).

107. BRUCE J. WINICK, *THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT* 84, 328–29 (1997).

treatment goals actually be articulated and set,¹⁰⁸ better ensure that informed consent was authentically honored,¹⁰⁹ and more likely lead to more ethical practices.¹¹⁰ Similarly, in another law review article that I wrote with Keri Gould and Dorfman, I argued that the right to refuse treatment served the therapeutic jurisprudence value of “fairness”:

The perception of receiving a fair hearing is therapeutic because it contributes to the individual’s sense of dignity and conveys that he or she is being taken seriously. Other studies show that medication judicial-administrative proceedings can be therapeutic because they allow patients the opportunity to discuss thoroughly the medications and their benefits and risks with their doctors. By holding medication hearings, doctors must again discuss the medications, their purpose, and potential side effects. At the same time, patients have the opportunity to explain the reasons they do not want the medication and ask questions about the drugs. This may be therapeutic because the patients’ medication concerns can be better considered in making medication determinations, thus enhancing the efficacy of medication decisions. This benefit is particularly important at large public hospitals where doctors, because of large caseloads, often have less time to spend with their patients on a day-to-day basis.¹¹¹

The research reported on by, variously, Ensminger and Liguori,¹¹² Dorfman and myself,¹¹³ Gould, Dorfman, and myself,¹¹⁴ Whitfield,¹¹⁵ and Tyler¹¹⁶—when read together—tells us that (1) counsel has an important role in effectuating such aims and ensuring dignity¹¹⁷ in the entire mental disability law process, and (2) counsel has—globally—failed miserably in bringing about these ends in the right to refuse medication arena. An infusion of trained, focused counsel would prove to be a therapeutic jurisprudence elixir.

VI. CONCLUSION

What, then, are my recommendations? Here are a few:

1. Each state should adopt procedures that guarantee the appointment

108. *Id.* at 330–32.

109. *Id.* at 341.

110. *Id.* at 400–02.

111. Perlin et al., *supra* note 52, at 114.

112. Ensminger & Liguori, *supra* note 49.

113. Perlin & Dorfman, *supra* note 56.

114. Perlin et al., *supra* note 52.

115. Whitfield, *supra* note 93.

116. Tyler, *supra* note 73.

117. I discuss the significance of dignity values in this context in Michael L. Perlin, “Dignity was the First to Leave”: *Godinez v. Moran, Colin Ferguson, and the Trial of Mentally Disabled Criminal Defendants*, 14 BEHAV. SCI. & L. 61 (1996).

of effective, trained counsel to represent patients at *both* involuntary civil commitment hearings and at right to refuse treatment hearings.

2. State attorneys general and county counsels should insist that lawyers representing hospitals in such cases be equally effective and trained.¹¹⁸

3. Judicial educational agencies such as the National Judicial College should offer regular courses in all aspects of the right to refuse treatment for state court judges.¹¹⁹

4. All participants in the system should acknowledge the ways in which sanism and pretextuality corrupt the judicial process (especially *this* aspect of the judicial process), confront that corruption, and take seriously the significance of that corruption.¹²⁰

5. A therapeutic jurisprudence lens should regularly be applied to this entire area of the law, and courts should begin to consider the issues discussed here through a therapeutic jurisprudence filter.

6. Scholars should seriously consider adding this issue to their research agendas. I have but scratched the surface of the problem in this Paper, and there is far more to be done.

Recall the title of this Paper. (*Just Like Tom Thumb's Blues* is a difficult song to deconstruct (I have been working on it more or less fruitlessly for forty years), but the verse that I draw upon for my title seems to be a perfect fit here. Recall now my reference to Professor Morris's paper in which he chides counsel for not challenging hospital doctors for their failure to explain much about the medication process to their patients. If the doctor will not explain to the patient "what it is [he's] got," then that doctor is certainly *not* the patient's "best friend." But this failure is compounded by lawyer apathy. In the last line of the

118. For one of the rare considerations of the role of the prosecuting/hospital attorney in civil commitment cases, see David B. Wexler, *Inappropriate Patient Confinement and Appropriate State Advocacy*, in THERAPEUTIC JURISPRUDENCE, *supra* note 49, at 347. See also *supra* text accompanying note 95 (reporting on the "little incentive or interest" on the part of Illinois state attorneys in the representation of the state in such cases); Whitfield, *supra* note 93, at 404–05.

119. It is not enough that lawyers and judges learn about mental illness, diagnoses, etc.; it is essential that they learn also about attitudes. See *supra* note 59, at 15 (discussing Poythress). Poythress concluded that the "trained" lawyers' behavior in court was not materially different from that of "untrained" lawyers because the former group's attitudes toward their clients had not changed. Mere knowledge of cross-examination methods, he noted, "did not deter them from taking [the] more traditional, passive, paternal stance toward the proposed patients." As one trainee noted: "I really enjoyed your workshop and I've been reading over your materials and its [sic] all very interesting, but this is the real world, and we've got to do something with these people. They're sick."

120. See *Falter v. Veterans' Admin.*, 502 F. Supp. 1178, 1185 (D.N.J. 1980) (stating that the central inquiry is "how [persons with mental disabilities] are treated as human beings"). I discuss *Falter* in this context in Perlin, *supra* note 47, at 541 n.49.

song, Dylan sings, “I’m going back to New York City/I do believe I’ve had enough.” In a few hours, *I* will be going back to New York City, and when it comes back to the behavior of lawyers in this area of the law, I, too, have had enough.

