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# Salvation or a Lethal Dose? Attitudes and Advocacy in Right to Refuse Treatment Cases

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*PRACTICE UPDATE*

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“Salvation” or a “Lethal Dose”?  
Attitudes and Advocacy  
in Right to Refuse Treatment Cases

Michael L. Perlin, JD

**ABSTRACT.** The debate surrounding the right to refuse treatment controversy continues unabated in the relevant law and social science literature. However, there are two areas where scant research attention is found. These include the *attitudes* of patients and staff regarding right to refuse treatment decisions and the *adequacy* of counsel availed to patients who assert their constitutionally protected right to refuse. This article examines both issues, mindful of what they tell us about sanism and pretextuality with respect to mental disability law and right to refuse treatment jurisprudence. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2004 by The Haworth Press, Inc. All rights reserved.]

**KEYWORDS.** Right to refuse treatment, patient/staff attitudes, adequacy of counsel, sanism, pretextuality

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### INTRODUCTION

The debate over the right to refuse treatment predictably follows several well-worn paths: doctrinal analyses of the underlying legal principles that have informed the 25 years of litigation in this area;<sup>1</sup> philosophical discourses about personhood and autonomy;<sup>2</sup> clinical studies of the impact of anti-psychotic medications on brain functioning;<sup>3</sup> political polemics about the “intrusion” of law into the domain of psychiatry.<sup>4</sup> Each of these has been the subject of extensive writings in the legal, philosophical and behavioral literature.

But there has been surprisingly little literature about two of the most important issues that affect the way the right to refuse treatment is implemented in an institutional setting: the *attitudes* of the parties concerned (patients and staff), and the *adequacy* of counsel that is made available to patients seeking to invoke their constitutional right to refuse. The lack of literature on these issues reflects, I believe, a deeper issue: the extent to which we, as a society, trivialize what is at stake in the right to refuse treatment litigation and trivialize the personhood of those in institutions subject to such medications. It is this deeper issue that I wish to address in this paper.

My title draws on Bob Dylan’s masterpiece, *Shelter from the Storm*. In it, Dylan warns us of placing our trust in those who offer us such shelter in a variety of life situations. In the penultimate verse, he sings:

In a little hilltop village, they gambled for my clothes . . . I offered up my innocence and got repaid with scorn, “come in,” she said, “I’ll give you shelter from the storm.”<sup>5</sup>

The critic Tim Riley characterizes *Shelter* as a “parable about the fragility of faith and the necessity of belief, when nothingness and doom are everything.”<sup>6</sup> As a society, we have “fragile faith” in the power of anti-psychotic drugs to be a “salvation” that ameliorates lives of persons in institutions. All too often, to patients, such drugs are seen as a “lethal dose,” administered in an atmosphere of “nothingness and doom.” I write this paper, in part, in a preliminary exploration of some hidden issues, the resolution of which may better illuminate whether institutional drugging can *ever* offer “shelter from the storm.”

## ***ATTITUDES***

There has been, it is true, *some* attention paid in recent years to important questions of empirical data—to what extent the hospital staff complies with court orders; how many patients actually wish to refuse anti-psychotic medication; to what extent they are representative of all patients; the impact that refusal has on treatment; the economic factors involved—but little of this data appears to have had any significant impact on the law and on the policy in this area. And this is even more surprising than it might otherwise be, given the especially impressive body of literature by the MacArthur Foundation’s Network on Mental Health and the Law that touches on these issues.<sup>7</sup> As I will discuss below, the astounding lack of attention paid to this body of literature is perhaps the most powerful evidence of our societal dis-ease with this entire issue.

### ***Staff Compliance***<sup>8</sup>

The degree to which institutional staff feels compelled to comply with judicial mandates—through the moral imperative of the court order, through moral suasion, or in response to the directives of supervisory personnel—is the “joker” in *any* assessment of the extent to which there will be compliance with equitable court orders involving institutional conditions. In right-to-refuse-treatment cases—where lower-level staff have frequently been singled out by courts for its inappropriate “treatment” of patients<sup>9</sup>—staff compliance becomes both more speculative and more critical.

A commentator<sup>10</sup> has pointed out, “[m]ental hospital staffs that adamantly oppose a judicial decree are in an excellent position to undermine it,”<sup>11</sup> noting that, in New Jersey, “doctors at every level—including the Division of Mental Health directorate—ignored and subverted the rules.”<sup>12</sup> Yet another commentator<sup>13</sup> has suggested that some of the noncompliance might have been caused by passive-aggressive behavior on the part of the defendants themselves.<sup>14</sup>

### ***Patients’ Wishes to Refuse***<sup>15</sup>

In the course of his precedent-shattering opinion establishing a broad-based right to refuse treatment, Judge Stanley Brotman looked carefully at this issue from the perspective of the patient:

The author of one study noted, “schizophrenics have been asked every question except, ‘How does the medication agree with you?’ Their response is worth listening to.”<sup>16</sup>

Some empirical evidence has begun to emerge. In one clinical study, Drs. Paul Appelbaum and Thomas Guthiel divided refusers into three groupings—situational refusers, stereotypic refusers, and symptomatic refusers<sup>17</sup>—and concluded that only for the symptomatic group<sup>18</sup> “did the act of refusal result in serious clinical consequences.”<sup>19</sup> Subsequent studies analyzed ten refusing patients (out of 1,187 total admissions in a 150-bed community mental health center) and concluded that, while there were some economic consequences of refusal (as a result of longer periods of hospitalization), on at least one scale—length of time out of hospital before readmission—the refusers “did . . . better” than a control group.<sup>20</sup> These researchers suggested that the refuser’s success might have been a result of a “healthy skepticism” that they retained “about doctors, medicine, and psychiatry and some sense of themselves as not without power and control over their lives.”<sup>21</sup>

Other research is in accord. Empirical surveys demonstrate that half the patients discharged from short-stay treatment programs (including one conducted at an Ivy League medical school’s teaching hospital) did not know the name or the appropriate dosage of the anti-psychotic medications prescribed for them or why they were being asked to take *these* medications,<sup>22</sup> and other studies confirm patients’ lack of knowledge about their medication regimen.<sup>23</sup> At least one court has considered the potential significance of such knowledge in the formulation of a constitutionally based right to refuse treatment doctrine, reasoning:

A prisoner’s right to refuse treatment is useless without knowledge of the proposed treatment. Prisoners have a right to such information as is reasonably necessary to make an informed decision to accept or reject proposed treatment, as well as a reasonable explanation of the viable alternative treatments that can be made available in a prison setting.<sup>24</sup>

### *Characteristics of Treatment Refusers*<sup>25</sup>

Since Appelbaum and Guthiel’s first study on treatment refusers,<sup>26</sup> the group of researchers that studied treatment refusal in Minnesota<sup>27</sup> has also compared the clinical conditions of refusers to drug consenters.<sup>28</sup> They found that the refusers were no more assaultive than

consenters, that they were less often diagnosed as having schizophrenia, but more often as having manic-depressive or schizoaffective illnesses.<sup>29</sup>

### ***Awareness of Professionals***<sup>30</sup>

Finally, empirical research has begun on the important, but frequently hidden, question of professional awareness of the law governing the right to refuse treatment.<sup>31</sup> Two years after the State of New York promulgated a regulation dealing with a patient's right to refuse,<sup>32</sup> 20% of psychiatric residents responding to a survey did not know it existed, 75% had never seen a copy of it, and 61% did not know of the existence of an appeal process through which a refusing patient could seek to have the right implemented.<sup>33</sup>

The surveyors—both lawyers/doctors—found these results to be “particularly disturbing” since they came in a state with both a “precise regulation” and a tradition of “strong patient advocacy.”<sup>34</sup> In addition, other survey results—indicating that doctors who had actually seen the regulation were more comfortable with the practice of informing patients of their rights than those with only a partial knowledge of the regulation, but those with partial knowledge were *less* comfortable than those with a “total lack of awareness”<sup>35</sup>—suggested that, in the area of the right to refuse treatment, “a little knowledge is worse than none.”<sup>36</sup>

Finally, at least one commentator has read the available evidence to show that psychiatric opposition to treatment refusal, at its base, is not really premised on the extent to which patients chose to refuse. Rather, it arises from their (psychiatrists') defense against challenges to their professional and institutional autonomy, an opposition to what they perceive as legal interference in their work, and their belief that this responsibility is a joint one: to the community and patient's family, as well as to the patient.<sup>37</sup>

### ***The MacArthur Study***<sup>38</sup>

For the past decade, the MacArthur Foundation's Network on Mental Health and the Law has conducted an extensive study of three areas that are essential to an informed understanding of mental disability law: competence, coercion, and risk.<sup>39</sup> Among the Network's findings of significance is the conclusion that mental patients are not always incompetent to make rational decisions, and that mental patients are not inherently more incompetent than non-mentally ill patients;<sup>40</sup> In fact, on

“any given measure of decisional abilities, the majority of patients with schizophrenia did not perform more poorly than other patients and non patients.”<sup>41</sup> In short, the presumption in which courts have regularly engaged—that there is both a *de facto* and a *de jure* presumption of *incompetency* to be applied to medication decisionmaking<sup>42</sup>—appears to be based on an empirical fallacy.

It is probably not an exaggeration to say that this is the most significant body of such research developed in the 30 years since “mental disability law” has become a discrete area of legal practice. Yet, courts—state and federal, civil, and criminal—continue to ignore this evidence, and consistently fail to incorporate it into case decisions.<sup>43</sup>

### COUNSEL<sup>44</sup>

The assumption that individuals facing involuntary civil commitment are globally represented by adequate counsel is an assumption of a fact not in evidence.<sup>45</sup> The data suggests that, in many jurisdictions, such counsel is woefully inadequate—disinterested, uninformed, roleless, and often hostile.<sup>46</sup> A model of “paternalism/best interests” is substituted for a traditional legal advocacy position, and this substitution is rarely questioned.<sup>47</sup> Few courts have ever grappled with adequacy of counsel questions in this context; fewer yet have found assigned involuntary civil commitment to be inadequate.<sup>48</sup>

The question of adequacy of counsel in the context of involuntary civil commitment has at least been subject to some scholarly attention.<sup>49</sup> There is scant literature, however, that addresses the question of the availability and adequacy of counsel in right to refuse medication hearings.<sup>50</sup> 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.<sup>51</sup>

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.<sup>52</sup> The track record of lawyers representing persons with mental disabilities has ranged from indifferent to wretched;<sup>53</sup> 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*.<sup>54</sup> Further, simply educating lawyers about psychiatric technique and psychological nomenclature does not materially improve lawyers’ performance where underlying attitudes are not

changed.<sup>55</sup> If counsel is to become even minimally competent in this area, it is critical that the underlying issues here be confronted.<sup>56</sup> 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.<sup>57</sup> 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.<sup>58</sup> 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 appointed, and hearing procedures 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;<sup>59</sup> *Rennie v. Klein*, one of the first federal cases finding a substantive constitutional right to refuse originally mandated the appointment of counsel,<sup>60</sup> but 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 [anti-psychotic medication]." <sup>61</sup>

A handful of statutes mandate the application of counsel in right to refuse treatment hearings;<sup>62</sup> on the other hand, at least one court has held that failure to appoint counsel is not reversible error.<sup>63</sup> And only a few cases have spoken to the role or scope of counsel at medication hearings.<sup>64</sup> Although more courts are beginning to articulate the criteria to be considered at a medication refusal hearing,<sup>65</sup> this level of specificity is simply not present in the assessment of the role and responsibilities of counsel.<sup>66</sup>

Without such an articulation of specificity, the authentic meaning of a "right to refuse" remains murky. A right without a remedy<sup>67</sup> is no right at all; worse, a right without a remedy is meretricious and pre-textual—it gives the illusion of a right without any legitimate expectation that the right will be honored.<sup>68</sup> This is especially significant in light of the research in procedural justice done by Professor Tom Tyler 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."<sup>69</sup> And subse-



quent research by Dr. Hoge and Prof. Feucht-Haviar provides further empirical support for Prof. 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."<sup>70</sup>

Empirical surveys consistently demonstrate that the quality of counsel "remains the single most important factor in the disposition of involuntary civil commitment cases."<sup>71</sup> Certainly, the presence of adequate counsel is of critical importance in the disposition of right to refuse treatment cases as well. What's more, 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.<sup>72</sup>

Again, these findings take on even more importance when considered in the context of the findings by the MacArthur Research Network<sup>73</sup> (as discussed above) that mental patients are not always incompetent to make rational decisions, and are not inherently more incompetent than non-mentally ill medical patients.<sup>74</sup> Yet, what Prof. Winick refers to as "Nineteenth Century notions equating mental illness with incompetence,"<sup>75</sup> still, in practice, "continue to influence legal rules and practices in this area."<sup>76</sup>

If judges uncritically conflate institutionalization with incompetency, lack of meaningful counsel—to structure statutory, case law-based, and empirical arguments—may be fatal to the patient's case.<sup>77</sup> The mere *existence* of counsel on behalf of institutionalized mental patients is often invisible to trial courts<sup>78</sup>; 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 make equivalent "incompetent" with "makes bad decisions" and to assume, in the face of conflicting statutory and case law, that incompetence in decision making can be presumed from the fact of institutionalization,<sup>79</sup> 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. And, as part of that right to counsel should come a right to independent expert assistance.<sup>80</sup>

In spite of the impressive body of case law outlined above, the existence of a right to refuse treatment remains enigmatic—at best—for many clinicians.<sup>81</sup> Some are resistant, arguing—unsuccessfully in court, 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.<sup>82</sup>

### CONCLUSION

I have written extensively about the impact of sanism<sup>83</sup> and pretextuality<sup>84</sup> on our right-to-refuse-treatment jurisprudence.<sup>85</sup> Consider the relevant issues:<sup>86</sup>

- the attitudes of trial judges towards patients;
- the attitudes of counsel towards patients;
- the implication of courts' articulating expansive remedies in right to refuse class action litigation, without making provision of counsel to represent patients in individualized cases;
- the assignment of non-specialized counsel and uneducated judges to represent patients in right to refuse cases;
- the failure of appellate courts to take seriously the *pro forma* quality and nature of hearings in many instances;
- the propensity of decision makers to make equivalent “incompetent” with “makes bad decisions” and to assume, in face of statutory and case law, that incompetence in decision making can be presumed from the fact of institutionalization;
- the perception of a positive relationship between implementation of the right to refuse and failed deinstitutionalization policies; and
- the perception of drugs as the only “cure” for dangerousness.<sup>87</sup>

Each of these issues must be considered. If sanist trial judges assume that patients are incompetent (and thus discredit their testimony), the entire enterprise may be doomed to failure, and any hearings will become little more than empty shells. What difference will the MacArthur Network Study's recommendations make—as to the ability of these patients to engage in autonomous medication-choice decision making—if trial judges simply ignore patients' testimony? If sanist counsel similarly disparage their clients' stories—or, just as inappropriately, present them to the court with an overt or covert “wink” that asks the judge to share in a complicitous sham (suggesting that the lawyer is simply par-

ticipating in what he sees as a charade)<sup>88</sup>—then, again, the potential impact of the Study’s findings is seriously compromised.<sup>89</sup>

If appellate courts enter broad orders in right to refuse cases without thinking about the operationalization of these orders in subsequent individual cases (or if only perfunctory assignment of disinterested counsel is made),<sup>90</sup> the initial order becomes little more than a pretext. And if other appellate courts close their eyes to the level of inadequacy of counsel, this “willful blindness” simply adds one extra layer of pretextuality to the process.

Finally, we need to consider some other underlying social issues. The common wisdom is clear here. Drugs serve two major purposes of social control: They “cure” dangerousness, and they are the only assurance that some deinstitutionalized patients can remain free in community settings.<sup>91</sup> 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 will self-medicate becomes the critical variable in case dispositions);<sup>92</sup> 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 *faux* “ordinary common sense”<sup>93</sup> to point out the dangerous pitfalls of heuristic thinking<sup>94</sup>—these assumptions will continue to dominate and control the disposition of individual right to refuse treatment cases, notwithstanding the MacArthur Network Study’s recommendations.

Again, counsel’s significance increases even more drastically here in the context of the improper “presumption of incompetency” discussed earlier. Professor Winick suggests, “Unless a *parens patriae* commitment statute requires an individualized determination of incompetence to engage in hospital admission decision making, it would seem deficient as a matter of substantive due process.”<sup>95</sup> Without vigorous, independent counsel, it is doubtful that such challenges would ever be launched. This is especially problematic in light of the fact that the equation of incompetency to mental illness *does* appear consonant with “ordinary common sense.”<sup>96</sup> Counsel’s role is especially important in areas of the law where “ordinary common sense” is so dissonant with empirical fact. If there is any expectation that these issues be considered thoughtfully and critically, it is essential that the issue of counsel presence and adequacy be moved to center stage.

Few—if any—areas of mental disability law have been subject to as much critical analysis as the question of the right to refuse treatment. Yet, surprisingly, scant attention has been paid to two critical sub-topics—attitudes and advocacy—the resolution of which will have a significant (perhaps dispositive) impact on the way that the right is operationalized in hospitals and courtrooms both in high-impact and in “invisible” cases.<sup>97</sup> Returning to the Dylan lyric that gave rise to this paper’s title, anti-psychotic medications have been ballyhooed as “salvations” and they have been critiqued as providing little more than a “lethal dose.”<sup>98</sup> But this debate cannot be resolved until we look carefully at the issues raised here. For if we do not deal frontally with issues of attitudes and issues of advocacy, the law of right to refuse treatment remains a pretext.<sup>99</sup> Only when they are resolved will we be able to tentatively predict whether state hospital drugging ever can provide, in Dylan’s words, again, “shelter from the storm.”

## NOTES

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

2. See e.g., Harold I. Schwartz et al., *Autonomy and the Right to Refuse Treatment: Patients’ Attitudes After Involuntary Medication*, 39 *HOSP. & COMMUNITY PSYCHIATRY* 1049 (1988); Bruce Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 *VILL. L. REV.* 1705 (1992).

3. See e.g., Douglas Mossman, *Unbuckling the “Chemical Straitjacket:” The Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis*, 39 *SAN DIEGO L. REV.* 1033 (2002).

4. See e.g., Stephen Rachlin, *With Liberty and Psychosis for All*, 48 *PSYCHIATRIC Q.* 410, 410 (1974) (criticizing restrictive civil commitment laws and citing disadvantages to patient treatment); Darryl Treffert, *In Search of a Sane Commitment Law*, 6 *PSYCHIATRIC ANNALS* 56, 56-81 (1976) (arguing that legalization of commitment diverts money away from patient care).

5. [www.bobdylan.com/songs/shelter.html](http://www.bobdylan.com/songs/shelter.html) (visited Dec. 2, 2003).

6. TIM RILEY, *HARD RAIN: A DYLAN COMMENTARY* 241-42 (Vintage ed. 1993). I have used the title of the song in an earlier law review article exploring other aspects of mental disability law. See Michael L. Perlin, *“I’ll Give You Shelter From The Storm:” Privilege, Confidentiality, and Confessions of Crime*, 29 *LOYOLA L.A. L. REV.* 1699 (1996).

7. See *infra* text accompanying notes 38-44.

8. See 2 PERLIN, *supra*note 1, § 3B-14.1.

9. *Rennie v. Klein*, 462 F. Supp. 1131, 1136 (D.N.J. 1978), *suppl.*, 476 F. Supp. 1294 (D.N.J. 1979), *modified*, 653 F.2d 836 (3d Cir. 1981), *vacated and remanded*, 458 U.S. 1119 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983).

10. This commentator was the trial counsel in *Rennie*. See Sheldon Gelman, *Mental Hospital Drugs, Professionalism, and the Constitution*, 72 GEO. L.J. 1725 n.\* (1984).

11. *Id.* at 1765.

12. *Id.* at n.213.

13. This commentator was the trial counsel in *Mills vs. Rogers*. 457 U.S. 291 (1982). See *Contributors*, in REFUSING TREATMENT IN MENTAL HEALTH INSTITUTIONS viii, x (A.E. Doudera & J.P. Swazey, eds. 1979).

14. Richard Cole, *Patients' Rights vs. Doctors' Rights: Which Should Take Precedence?*, in *id.* at 56, 66: Another serious allegation was that providing patients the right to refuse medication at Boston State created an adversarial relationship between staff and patients, making treatment impossible. However, the evidence demonstrated that only when the order initially went into effect was the treatment relationship affected by the order. During this "adjustment period," there was an alteration in the power relationship between the doctors and patients. One of the unit directors said:

There seemed to be an adversary relationship set up between the patients and staff by the TRO, by the suit. Staff were afraid to intervene with the patients for fear that the patients might take this to mean that they are trampling on their rights, the rights of patients. Again, these situations quieted down in time.

In fact, the unit director admitted that most of the deleterious effects caused in his unit, allegedly by the TRO, were caused by the defendants' own conduct. It was admitted that the defendants failed to read the court's order until a week after it was issued, and that the staff panicked because it misinterpreted the court's order as a prohibition from medicating or secluding in all circumstances. As the unit director declared: "Once this was clarified, things calmed down in that respect somewhat."

See generally, Gelman *supra* note 10, at 249-53 (on *Rennie* compliance).

15. See 1 PERLIN, *supra* note 1, §3B-14.2.

16. *Rennie*, 476 F. Supp. at 1306 (quoting Theodore Van Putten & Philip Ray, *Subjective Response as a Predictor of Outcome in Pharmacotherapy*, 35 ARCH.GEN.PSYCHIATRY 477, 478-80 [1978]).

17. Paul Appelbaum & Thomas Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 AM. J. PSYCHIATRY 340 (1980).

18. "Symptomatic refusers" were defined as "young, relatively acutely ill patients whose refusal, often based on delusional premises, was sustained over a long period and successfully stymied treatment efforts." *Id.* See also, Paul Appelbaum & Thomas Gutheil, "Rotting With Their Rights On:" *Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients*, 7 BULL. AM. ACAD. PSYCHIATRY & L. 306, 342 (1979), and Anne Hull, *the Mentally Ill's Right to Refuse Drug Treatment: A Panacea or a Bitter Pill to Swallow?*, 29 WASHBURN L.J. 62, 103-04 n. 321 (1989) (discussing Appelbaum and Gutheil's research).

19. *Id.* at 345. See also . . . Rodenhausen, *Treatment Refusal in a Forensic Hospital: Ill-Use of the Lasting Right*, 12 BULL. AM. ACAD. PSYCHIATRY & L. 59, 62 (1984) (drug refusal a manifestation of grandiosity and psychotic denial, not of a "rational appreciation for legal rights").

20. Irwin Hassenfeld & Barbara Grumet, *A Study of the Right to Refuse Treatment*, 12 BULL. AM. ACAD. PSYCHIATRY & L. 65, 68, 72 (1984).

21. *Id.* See also Ellen Clayton, *From Rogers to Rivers: The Rights of the Mentally Ill to Refuse Medication*, 13 AM. J. L. & MED. 7, 52 (1987) (vindication of patients' right to refuse medication "requires re-education of health care providers and consumers, who must recognize that choices of therapy are not solely medical decisions").

22. See Cathryn Clary et al., *Psychiatric Inpatients' Knowledge of Medication at Hospital Discharge*, 43 HOSP. & COMMUN. PSYCHIATRY 140 (1992).

23. See also Jeffrey Geller, *State Hospital Patients and Their Medication: Do They Know What They Take?*, 139 AM. J. PSYCHIATRY 611 (1982) (only 22% of patients tested could name their medications; 41% gave correct frequency of administration); David Soskis, *Schizophrenic and Medical Inpatients as Informed Drug Consumers*, 35 ARCH. GEN'L PSYCHIATRY 645 (1978) (35% of patients tested knew correct medication dosages); . . . Greenberg et al., *Attitudes Toward Having Been Forcibly Medicated*, 24 BULL. AM. ACAD. PSYCHIATRY & L. 512 (1996) (60% of sample of patients retrospectively agreed with having been coerced). Compare . . . Valenstein et al., *Agreement Between Seriously Mentally Ill Veterans and Their Clinicians About Medication Compliance*, 49 PSYCHIATRIC SERV. 1043 (1998) (seriously mentally ill patients and their clinicians showed little agreement about medication beyond that expected by chance).

24. *White v. Napoleon*, 897 F.2d 103, 113 (3d Cir. 1990).

25. See 2 PERLIN, *supra* note 1, § 3B-14.3.

26. See *supra* text accompanying notes 17-19. See also Stephen Marder, et al., *A Comparison of Patients Who Refuse and Consent to Neuroleptic Treatment*, 140 AM. J. PSYCHIATRY 470 (1983) (refusers found to be significantly more symptomatic than consenters).

27. See Julie Zito et al., *The Treatment Review Panel: A Solution to Treatment Refusal?* 12 BULL. AM. ACAD. PSYCHIATRY & L. 349 (1984).

28. For important research, see . . . Mahler et al., *Psychiatric Evaluation of Competency in Physically Ill Patients Who Refuse Treatment*, 41 HOSP. & COMMUN. PSYCHIATRY 1140 (1990) (“[i]f [a patient] takes his medication, his competency is never questioned”); Thomas Grisso & Paul Appelbaum, *Mentally Ill and Non-Mentally Ill Patients' Abilities to Understand Informed Consent Disclosures for Medication: Preliminary Data*, 15 LAW & HUM. BEHAV. 377, 385-86 (1991) (Evidence does not support “generalized presumptions” about the capacities of mentally ill patients in comparison to non-mentally ill patients, but does suggest a greater risk of “very poor understanding” of treatment disclosures among schizophrenic patients).

29. Zito, *supra* note 27, at 825-26.

30. See 2 PERLIN, *supra* note 1, § 3B-14.4

31. See “On the difference in risk perception on the parts of judges and psychiatrists,” Harold Bursztajn et al., *Medical and Judicial Perceptions of the Risks Associated with Use of Antipsychotic Medication*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 271 (1991).

32. The regulation's title—*Care and Treatment: Right to Object and Appeal*, N.Y.S. DEP'T MENT. HEALTH REG. § 27.8—was ambiguous.

33. . . . Johnson & . . . Weinstein, *Right to Refuse Treatment: The Knowledge Gap*, 7 J. PSYCHIATRY & L. 457, 459 (1979).

34. *Id.* at 460.

35. *Id.*

36. *Id.*

37. . . . Brown, *The Right to Refuse Treatment and the Movement for Mental Health Reform*, 9 J. HEALTH POL., POL'Y & L. 291, 298 (1979). See also, e.g., ELIOT FREIDSON, *PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE* (1970); . . . Perry, *The Measurement of Attitudes Towards the Rights of Psychiatric Patients*, in PSYCHIATRIC PATIENT RIGHTS AND PATIENT

ADVOCACY: ISSUES AND EVIDENCE 227 (B.L. Bloom & S.J. Asher, eds. 1982); Irving Zola, *Medicine as an Institution of Social Control*, 4 SOCIOLOGICAL REV. 487 (1972). Cf. Winsor Schmidt, *Critique of the American Psychiatric Association's Guidelines for State Legislation on Civil Commitment of the Mentally Ill*, 11 NEW ENG. J. CRIM. & CIV. CONFINEMENT 11, 12 n.10 (1985) (data shows that there is little difference in the way psychiatrists and lawyers view issues; key schism is between the organized psychiatry's leadership and the rank-and-file). See also, Susan Ruscher et al., *Psychiatric Patients' Attitudes About Medication and Factors Affecting Noncompliance*, 48 PSYCHIATRIC SERV. 82 (1997) (desire to change medication regimen positively related to level of patient's education).

38. See 2 PERLIN, *supra* note 1, §3B-14.5.

39. Bruce Winick, *Foreword: A Summary of the MacArthur Treatment Competence Study and an Introduction to the Special Theme*, 2 PSYCHOLOGY, PUB. POL'Y & L. 3 (1996). For a sampling of relevant research, see e.g., Paul Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study. I: Mental Illness and Competence To Consent to Treatment*, 19 LAW & HUM. BEHAV. 105 (1995); Thomas Grisso et al., *The MacArthur Treatment Competence Study. II: Measures of Abilities Related to Competence To Consent to Treatment*, 19 LAW & HUM. BEHAV. 127 (1995).

40. Michael Perlin & Deborah 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 PSYCHOLOGY, PUB. POL'Y & L. 114 (1996), discussing research in Thomas Grisso & Paul Appelbaum, *The MacArthur Treatment Competence Study. III. Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 LAW & HUM. BEHAV. 149 (1995).

41. Grisso & Appelbaum, *supra* note 40, at 169.

42. On this presumption in general, see Bruce Winick, *The MacArthur Treatment Competence Study: Legal and Therapeutic Implications*, 2 PSYCHOL., PUB. POL'Y & L. 137 (1996).

43. Astonishingly, the MacArthur Network's Research has only been cited *one* time in a reported American law case, and in that, the trial judge rejected the expert witness's MacArthur-based testimony on the question of trial competence. See *Commonwealth v. Morasse*, 2001 WL 1566407, § (Mass. Super. Ct. 2001).

44. See 1 PERLIN, *supra* note 1, §3B-11; MICHAEL L. PERLIN, *THE HIDDEN PREJUDICE* 146-49 (2000).

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

46. *Id.* at 43.

47. *Id.* at 43-44.

48. *But see In the Matter of the Mental Health of K.G.F.*, 29 P.3d 485 (Mont. 2001) (establishing broad right to counsel in civil commitment cases). I discuss *K.G.F.* in this context in Michael L. Perlin., "You Have Discussed Lepers and Crooks:" *Sanism in Clinical Teaching*, 9 CLINICAL L. REV. 683 (2003).

49. See e.g., Perlin, *supra* note 45, at 43-45 nn. 21-34 (citing sources); 1 PERLIN, *supra* note 1, chapter 2B (2d ed. 1998).

50. See Melvin Shaw, *Professional Responsibility of Attorneys Representing Institutionalized Mental Patients in Relation to Psychotropic Medications*, 22 J. HEALTH & HOSP. L. 186 (1989) (characterizing lawyers' arguments seeking to vindicate a right to refuse medication as an "injustice").

51. For recent literature, *see e.g.*, 2 PERLIN, *supra* note 1, §3B-1, at 155 n.1, and § 3B-2, at 157 n.2 (citing sources).

52. *See generally*, Perlin & Dorfman, *supra* note 40, at 60-61.

53. *See* Perlin, *supra* note 45, at 43-45; *see also, e.g.*, 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, 662 (1989-90) (describing “wholesale lack of legal advocacy” available to patients in public mental institutions).

54. 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) (attorneys received \$25 per case).

55. Norman Poythress, *Psychiatric Expertise in Civil Commitment: Training Attorneys to Cope With Expert Testimony*, 2 LAW & HUM. BEHAV. 1, 15 (1978); *see generally*, Perlin, *supra* 48, 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 Hypothesis*, 28 J. RES. CRIME & DELINQ. 360 (1991).

56. For a rare judicial acknowledgement 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 & 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”).

57. *See e.g.*, *In re 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, 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 40, at 120 n. 67.

58. *See e.g.*, Bruce Winick, *Restructuring Competency to Stand Trial*, 32 U.C.L.A. L. REV. 921, 941 (1985); *see also* Alan H. Macurdy, *The Americans With Disabilities Act: Time For Celebration, or Time for Caution?*, 1 PUBLIC INT. L.J. 21, 29 (1991); John Parry, *Rights Aplenty But Not Enough Money: A Paradox in Federal Disability Policies*, 12 MENT. & PHYS. DIS. 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).

59. *Rivers v. Katz*, 504 N.Y.S. 2d 74, 81 (1986). Representation in *Rivers* hearings is provided by the state-funded Mental Hygiene Legal Services (MHLS) office. Application of St. Luke’s-Roosevelt Hosp. Center, 607 N.Y.S. 2d 574, 580 n. 11 (Sup. 1993).

60. *Rennie*, 462 F. Supp. 1131, 1147 (D.N.J. 1978), suppl., 476 F. Supp. 1294 (D.N.J. 1979), mod., 653 F. 2d 836 (3d Cir. 1981), vacated and remanded, 458 U.S. 119 (1982), on remand, 720 F. 2d 266 (3d Cir. 1983).

61. *Rennie*, 476 F. Supp. at 1311. *See also id.* at 1313 (Patient Advocates may be attorneys, psychologists, social workers, registered nurses, or paralegals, “or have 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 involun-



tary civil commitment of juveniles. *But see*, United States v. Humphreys, 148 F. Supp. 2d 949 (D.S.D. 2001) (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).

62. *See e.g.*, OKLA. STAT. ANN. §5-212 (B) (1); WIS. STAT. ANN. §880.33 (1); N.M. STAT. ANN. § §43-1-4; 43-1-15; 405 ILL. COMP. STAT. Ann. 5/2-107.

*See also*, *In re Jones*, 743 N.E. 2d 1090 (Ill. App. 2001) (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).

63. *In re Steen*, 437 N.W. 2d 101, 105 (Minn. App. 1989). *Steen*, interestingly, has not been cited a single time in the 14 years since it was decided.

Compare *Cornett v. Donovan*, 51 F. 3d 894 (9th Cir. 1995) (right to legal assistance extended only through pleading stage of habeas or civil rights action).

64. *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"); *Matter of Jarvis*, 433 N.W. 2d 120, 123-24 (Minn. 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 *reconsid. den.* (Md. 1990) (criticizing failure to give counsel opportunity to present evidence or cross-examine witnesses).

65. *See e.g.*, *Virgil D. v. Rock County*, 524 N.W. 2d 894, 899-900 (Wis. 1994), *reconsid. den.*, 531 N.W. 2d 331 (Wis. 1995).

66. *See Perlin*, *supra* note 45 at 56 n.101 (as mental disability law becomes more complex, essential that counsel for patients understand differing right to refuse treatment doctrines and their rationales).

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

68. 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.

69. Tom Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433, 443 (1992). *See* Michael Perlin, *A Law of Healing*, 68 U. CIN. L. REV. 407, 415 (200) (discussing Tyler's insights in this context).

70. 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). And *see id.* ("our 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 Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection*, 28 HOUS. L. REV. 15, 46-47 (1991); Zito et al., *supra* note 27.

71. 1 PERLIN, *supra* note 1, § 2B-2, at 192-94.

72. *See generally*, Perlin & Dorfman, *supra* note 40.

73. *See supra* text accompanying notes 38-44.

74. *See generally*, Grisso & Appelbaum, *supra* note 40.

75. Winick, *supra* note 42, at 153.

76. *Id.* (for an explanation of these “Nineteenth Century notions,” see *id.* at 151).

77. On counsel’s *educative* role, see 1 PERLIN, *supra* note 1, §2B-8.3d, at 241-42; 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).

78. See e.g., *In re C.P.K.*, 516 So. 2d 1323, 1325 (La. Ct. App. 1987), discussed *supra* note 57.

79. See e.g., Brian Ladds et al., *The Disposition of Criminal Charges After Involuntary Medication to Restore Competency to Stand Trial*, 38 J. FORENS. 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).

80. There is little caselaw on the right of persons to an independent expert at this stage. See e.g., *In re Mental Illness of Vass*, 2000 WL 327221, \*5 (Ohio App. 2000) (discussing statutory right). The law on this question is mixed as it applies to civil commitment hearings. In *Goetz v. Crosson*, 967 F. 2d 29, 34 (2d Cir. 1992), the Second Circuit held that the due process clause did not require the appointment of a psychiatrist in every involuntary civil commitment case, but added:

Some proceedings may present a need for independent psychiatric testimony in addition to that offered by the state to ensure an accurate decision. As a practical matter such proceedings are limited to cases in which the presiding judge determines that the record leaves unexplored or unanswered questions and that additional psychiatric testimony is necessary. In such cases, the individual’s interests in both freedom and self-protection are directly affected, and the failure to provide such testimony may implicate due process concerns.

*Id.* Compare *Ake v. Oklahoma*, 470 U.S. 68 (1985) (indigent criminal defendant who makes a threshold showing that insanity is likely to be a significant factor at trial is constitutionally entitled to a psychiatrist’s assistance).

81. 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*, 123 S. Ct. 2174 (2003) (establishing procedures in cases of persons incompetent to stand trial who wish to refuse the administration of antipsychotic medication).

82. See e.g., Paul Appelbaum & Thomas 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); Darryl 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).

83. See e.g., PERLIN, *supra* note 44, at 21-58; 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, 226-27 (2000):

“Sanism” is an irrational prejudice of the same quality and character as 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 so-

cially 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") and heuristic reasoning in an unconscious response to events both in everyday life and in the legal process

84. See PERLIN, *supra* note 44, at 59-76; Perlin, *supra* note 82, at 227:

"Pretextuality" means that courts accept (either implicitly or explicitly) testimonial dishonesty and engage similarly in dishonest (frequently meretricious) decision-making, 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, blasèè judging, and, at times, perjurious and/or corrupt testifying.

85. See PERLIN, *supra* note 44, at 125-56.

86. See generally, Perlin & Dorfman, *supra* note 40, at 134.

87. See cases cited in 1 PERLIN, *supra* note 1, §2C-5.2, at 409-13 nn.782-803.

88. On the problems raised when a lawyer feels "foolish" or "awkward" in the representation of an individual at an involuntary civil commitment hearing, see Perlin & Sadoff, *supra* note 77, at 167. See also, Perlin, *supra* note 48, at 700, quoting Perlin & Sadoff, *supra* note 77, at 163:

Also, because of the nature of the subject matter, "the issues raised by investigating ethical standards in civil commitment representation may dredge up unconscious feelings which lead to avoidance—by clients, by lawyers, and by judges—of the underlying problems."

89. See Perlin & Sadoff, *supra* note 77, at 166 (on how a lawyer's perceptions that his client is not credible can have a "devastating" impact on the presentation of the client's case). For a thoughtful and comprehensive analysis of the role of lawyers in the representation of mentally disabled individuals, see Jan Costello, "Why Would I Need a Lawyer?:" *Legal Counsel and Advocacy for Persons with Mental Disabilities*, in LAW, MENTAL HEALTH, AND MENTAL DISORDER 15 (Bruce Sales & Daniel Shuman eds. 1996).

90. On a startling variation between jurisdictions, see 1 PERLIN, *supra* note 1, § 2B-9, at 245-46 (contrasting experiences in Minnesota and Virginia).

91. See e.g., Deborah A. Dorfman, *Through a Therapeutic Jurisprudence Filter: Fear and Pretextuality in Mental Disability Law*, 10 N.Y.L. SCH. J. HUM. RTS. 805 (1993); Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63 (1991); Frances Cournois, *Involuntary Medication and the Case of Joyce Brown*, 40 HOSP. & COMMUN. PSYCHIATRY 736 (1989).

92. See e.g., Michael L. Perlin, *Pretexts and Mental Disability Law: The Case of Competency*, 47 U. MIAMI L. REV. 625, 672 (1993); Michael L. Perlin, *Therapeutic Jurisprudence and Outpatient Commitment: Kendra's Law as Case Study*, 9 PSYCHOL. PUB. POL'Y & L. 183, 193 (2003).

93. See Michael L. Perlin, “*The Borderline Which Separated You From Me: The Insanity Defense, The Authoritarian Spirit, The Fear of Faking, and The Culture of Punishment*,” 82 IOWA L. REV. 1375 1425 (1997).

94. “Heuristics” refers to principles that individuals use in attempting to simplify complex information-processing tasks. Application of the heuristic method leads to distorted and systematically erroneous decisions and lead decisionmakers to “ignore or misuse items of rationally useful information.” See Perlin, *supra* note 90, at 81-82 n. 113 (citing sources); Michael L. Perlin, *Psychodynamics and the Insanity Defense: ‘Ordinary Common Sense’ and Heuristic Reasoning*, 67 NEB. L. REV. 3, 12-22 (1990).

95. Winick, *supra* note 42, at 145.

96. See also, *id.* at 145 (“While the assumption that all mentally ill people are incompetent may not be irrational, the MacArthur study strongly suggests its incorrectness”).

97. See 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, 32 (1999).

98. See e.g., Hull, note 18.

99. See Perlin, *supra* note 48, at 686 n. 14; Michael L. Perlin, *Decoding Right to Refuse Treatment Law*, 16 INT’L J. L. & PSYCHIATRY 151 (1993).