

Denver Law Review

Volume 74
Issue 4 *Symposium on Coercion - An
Interdisciplinary Examination of Coercion,
Exploitation, and the Law*

Article 11

January 1997

Coercion and Mental Health Treatment

Bruce J. Winick

Follow this and additional works at: <https://digitalcommons.du.edu/dlr>

Recommended Citation

Bruce J. Winick, Coercion and Mental Health Health Treatment, 74 Denv. U. L. Rev. 1145 (1997).

This Article is brought to you for free and open access by the Denver Law Review at Digital Commons @ DU. It has been accepted for inclusion in Denver Law Review by an authorized editor of Digital Commons @ DU. For more information, please contact jennifer.cox@du.edu, dig-commons@du.edu.

Coercion and Mental Health Treatment

COERCION AND MENTAL HEALTH TREATMENT*

BRUCE J. WINICK†

I. INTRODUCTION: UNDERSTANDING COERCION

Any discussion of coerced mental health treatment must begin with a definition of the term "coercion." In its most basic meaning, the term coercion connotes force or duress, or at least the threat of force. In the context under consideration, civil commitment and court-ordered treatment are the paradigm cases. But coercion extends beyond the use of overt legal compulsion. Coercion may occur when individuals experience a loss of control over decisions that they would like to make for themselves through threats, pressure, persuasion, manipulation, or deception on the part of another.² Much coercion occurs in the shadow of the law. People impaired by mental illness may be especially vulnerable to suggestiveness and to official and familial pressures that those without such impairment would be better able to resist.³ Clinicians and family members often pressure patients with mental illness to accept voluntary admission to the hospital or needed treatment, sometimes threatening to invoke civil commitment, court-mandated treatment, and even criminal arrest if they decline.⁴ In addition, in the mental health context, as in other legal contexts—contract law and plea bargaining, for example—proposals or offers may sometimes be regarded as coercive.⁵

* Copyright © 1997 by Bruce J. Winick. This article was prepared for a Symposium on Coercion and Exploitation at the University of Denver College of Law held on March 14-15, 1997, and presented to the Bioethics and Health Law Working Group at the University of Miami School of Law in April of 1997. I appreciate the helpful comments of colleagues at the presentations, and the research assistance of Alina Perez, Alphas Harris, and Tricia Shackelford.

† Professor of Law, University of Miami School of Law, Coral Gables, Florida. A.B., Brooklyn College, 1965; J.D., New York University, 1968.

2. See John S. Carroll, *Consent to Mental Health Treatment: A Theoretical Analysis of Coercion, Freedom, and Control*, 9 BEHAV. SCI. & L. 129, 131-36 (1991) (analyzing types of coercion applied in the mental health process).

3. BRUCE J. WINICK, *THERAPEUTIC JURISPRUDENCE APPLIED: ESSAYS ON MENTAL HEALTH LAW* 401 (1997).

4. See, e.g., SAMUEL J. BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* 179-80 (3d ed. 1985); RALPH SLOVENKO, *PSYCHIATRY AND THE LAW* 202-04 (1973); John Monahan et al., *Coercion to Inpatient Treatment: Initial Results and Implications for Assertive Treatment in the Community*, in COERCION AND AGGRESSIVE COMMUNITY TREATMENT: A NEW FRONTIER IN MENTAL HEALTH LAW 251 (Deborah L. Dennis & John Monahan eds., 1996) [hereinafter A NEW FRONTIER]; WINICK, *supra* note 3, at 395-96 n.108; Janet A. Gilboy & John R. Schmidt, "Voluntary" Hospitalization of the Mentally Ill, 66 NW. U. L. REV. 429, 433 (1971); David B. Wexler, *The Structure of Civil Commitment: Patterns, Pressures, and Interactions in Mental Health Legislation*, 7 LAW & HUM. BEHAV. 1, 5 (1983); Bruce J. Winick, *Competency to Consent to Voluntary Hospitalization: A Therapeutic Jurisprudence Analysis of Zinnermon v. Burch*, 14 INT'L J.L. & PSYCHIATRY 169, 209-10 (1991).

5. See ALAN WERTHEIMER, *COERCION* 202-41 (1987); Alan Wertheimer, *A Philosophic Examination of Coercion for Mental Health Issues*, 11 BEHAV. SCI. & L. 239, 244-46 (1993);

The term coercion is not an entirely descriptive one, and it does not have an entirely objective and universally applicable meaning. Rather, it is a "contextually dependent, moralized phenomenon."⁶ In many respects, coercion has a significant normative content. Coercion is a pejorative label that judges invoke to condemn behavior that they find objectionable or to permit the invalidation of choices that they deem unfair or unreasonable in the circumstances.⁷

Moreover, coercion may have a significant subjective component. Although the law tends to define coercion based exclusively on the actions of the person who applies pressure to another, ignoring the subjective response of the recipient, this exclusive focus on the coercer seems artificial. The same actions may be perceived as coercive by one patient, but as not coercive by another. Significant numbers of patients who are involuntarily committed to psychiatric hospitals perceive their commitment to have been voluntary, whereas significant numbers of voluntary patients perceive coercion in the admission process.⁸ Thus patient perceptions of coercion are often incongruent with their official legal status. Furthermore, patient perceptions of coercion often differ from the perceptions of others who observe the patient in the hospital admission process, such as clinical staff and family members.⁹

What constitutes coercion, in short, may lie largely in the eye of the beholder.¹⁰ This subjective character of coercion does not argue that the law should avoid reliance on an objective definition of the term. People who are coerced in a legal sense may mistakenly believe that they were not coerced, and those whose actions were not coerced as a matter of law may feel coerced. But the law should take account of what makes people feel coerced in fashioning legal standards and procedures in this area.

Bruce J. Winick, *Harnessing the Power of the Bet: Wagering with the Government as a Mechanism for Social and Individual Change*, 45 U. MIAMI L. REV. 737 (1991) (discussing behavioral contracting).

6. WERTHEIMER, *supra* note 5, at 206; Monahan et al., *supra* note 4, at 13; Charles W. Lidz et al., *Perceived Coercion in Mental Hospital Admission*, 52 ARCHIVES GEN. PSYCHIATRY 1034 (1995); Wertheimer, *supra* note 5; Charles W. Lidz et al., *The Validity of Mental Patients' Accounts of Coercion Related Behaviors in the Hospital Admission Process* (1996) (unpublished manuscript on file with the author).

7. See David B. Wexler, *Reflections on the Regulation of Behavior Modification in Institutional Settings*, 17 ARIZ. L. REV. 132, 133 (1975); Bruce J. Winick, *Legal Limitations on Correctional Therapy and Research*, 65 MINN. L. REV. 331, 391-92 (1981). For a discussion of the normative nature of coercion, see JOSEPH RAZ, *THE MORALITY OF FREEDOM* 148-57 (1986); WERTHEIMER, *supra* note 5, at 211-17; Kathleen Sullivan, *Unconstitutional Conditions*, 102 HARV. L. REV. 1413, 1443, 1446 (1989).

8. Nancy S. Bennett et al., *Inclusion, Motivation, and Good Faith: The Morality of Coercion in Mental Hospital Admission*, 11 BEHAV. SCI. & L. 295 (1993); Deborah L. Dennis & John Monahan, *Introduction*, in A NEW FRONTIER, *supra* note 4, at 3; William P. Gardner et al., *Two Scales for Measuring Patients' Perceptions for Coercion During Mental Hospital Admission*, 11 BEHAV. SCI. & L. 307 (1993); Gilboy & Schmidt, *supra* note 4, at 433; Virginia A. Hiday et al., *Patient Perceptions of Coercion in Mental Hospital Admission*, 20 INT'L J.L. & PSYCHIATRY (1997); John Monahan et al., *Coercion and Commitment: Understanding Involuntary Mental Hospital Admission*, 18 INT'L J.L. & PSYCHIATRY 249 (1995); Monahan, *supra* note 4, at 23-27; Anne Rogers, *Coercion and Voluntary Admission: An Examination of Psychiatric Patient Views*, 11 BEHAV. SCI. & L. 259 (1993).

9. Bennett et al., *supra* note 8, at 300-01; Gardner et al., *supra* note 8, at 308; Hiday et al., *supra* note 8; Monahan, *supra* note 8, at 252.

10. See *infra* Part VI (discussing research on patient perceptions of coercion).

Absent fraud or mistake, when people subjectively experience their choices as voluntary, the issue of coercion ordinarily will not be raised. People who do not feel coerced are unlikely to commence legal proceedings to complain about the actions of others that might have contributed to their choice, nor to seek judicially to void choices they have made. When people feel coerced, however, they are more likely to complain about it, and it is more probable that judges will need to resolve the issue.

In cases in which patients raise the issue of coercion, courts are faced with the question of whether to characterize the actions of governmental officials or others as coercive or to characterize patient choices as coerced. In such cases courts will need to decide that either there was coercion or there was not. Although courts therefore will view coercion as a dichotomous inquiry—in which the patient is either coerced or not—coercion can be better understood as existing on a continuum—“from friendly persuasion to interpersonal pressure, to control of resources to use of force.”¹¹ Very few choices in life are wholly free of at least some degree of coercion.¹² In addition to the compulsion of the law, a variety of economic, social, familial, occupational, and psychological pressures inevitably impinge on individual decision making, sometimes leading individuals to experience their choices as coerced.

There are degrees of coercion falling along a continuum, and where the law chooses to place the dividing line between coercion and voluntariness is essentially a normative judgment.¹³ Once this normative character of the concept of coercion is recognized, we should strive to identify and weigh the various values that might be affected by differing legal standards defining the category and procedures governing its determination. These values include respect for individual autonomy and self-determination, our notions of the limits of governmental power over the individual, the desire to protect individuals from harm or unfair treatment, and in the case of medical and mental health treatment, the desire to foster the efficacy of such treatment. This last concern—the therapeutic—focuses attention on the relationship between perceived coercion and treatment outcome, a question that remains substantially unexplored empirically.¹⁴ Although our knowledge concerning this relationship remains incomplete, psychological theory would suggest that coercion may undermine treatment success and that its opposite—voluntary choice—may serve to promote it. After briefly examining the asserted justifications for coercion in the mental health context and considering some special problems raised by the application of coercion standards to the situation of institutionalized patients, this article will analyze this relationship and explore

11. Ronald J. Diamond, *Coercion and Tenacious Treatment in the Community: Applications to the Real World*, in A NEW FRONTIER, *supra* note 4, at 55. For a discussion of coercion as involving a continuum, see JOEL FEINBERG, HARM TO SELF 255-56 (1989); see also Robert D. Miller, *The Continuum of Coercion: Constitutional and Clinical Considerations in the Treatment of Mentally Disordered Persons*, 74 DENV. U. L. REV. 1169, 1172 (1997).

12. Winick, *supra* note 5, at 770; see also Robert D. Miller, *supra* note 11, at 1170-71.

13. *Id.*

14. BRUCE J. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT (1997); WINICK, *supra* note 3, at 78; see Virginia A. Hiday, *Coercion in Civil Commitment: Process, Preferences and Outcome*, 15 INT'L J.L. & PSYCHIATRY 359, 359 (1992).

how legal rules governing coercion and its determination, and the application of those rules, might affect therapeutic values.

II. WHEN THE LAW PERMITS INVOLUNTARY HOSPITALIZATION AND COERCIVE TREATMENT

All jurisdictions permit the civil commitment to psychiatric hospitals of those suffering from mental illness.¹⁵ Commitment of those dangerous to themselves or others is a traditional exercise of the state's police power.¹⁶ Commitment of those who are incompetent to engage in rational hospitalization decisions for themselves and who otherwise would be gravely disabled is an application of the state's historic *parens patriae* power.¹⁷ Although voluntary hospitalization is encouraged, those who refuse it and who meet statutory criteria may be hospitalized involuntarily.¹⁸

When patients are subjected to civil commitment, and sometimes even when they are not, they may be treated on an involuntary basis. Although the law has increasingly recognized a qualified right of mental patients to refuse various types of mental health treatment,¹⁹ the courts have recognized situations in which the government's interests in compelled treatment may outweigh the individual's right to refuse it.²⁰ For example, when an institutionalized patient or prisoner is dangerous to institutional staff, other patients, or inmates as a result of mental illness, the state may involuntarily administer psychotropic medication as long as it is medically appropriate for the individual and (in non-prison contexts) the least intrusive means of dealing with the problem.²¹ Similarly, courts have permitted forced treatment under the state's *parens patriae* power when mental illness has rendered patients incompetent to make treatment decisions for themselves.²² Another example involves criminal defendants found to be incompetent to stand trial who may be administered involuntary treatment designed to restore and maintain their competence, as long as it is medically appropriate and the least intrusive means of accomplishing this goal.²³

15. See, e.g., BRAKEL ET AL., *supra* note 4, at 34, 76-81 (table 2.1); 1 MICHAEL L. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* (1989); Note, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190 (1974). For an analysis of the mental illness requirement for civil commitment, see WINICK, *supra* note 3, at 93-199.

16. See BRAKEL ET AL., *supra* note 4, at 375; 1 PERLIN *supra* note 15, at 37-45; WINICK, *supra* note 3, at 162-66; Joseph M. Livermore et al., *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75 (1968) (discussing the public policy justifications for involuntary commitment); Note, *supra* note 15, at 1222-45.

17. See BRAKEL ET AL., *supra* note 4, at 428-29; 1 PERLIN, *supra* note 15, at 37-45; WINICK, *supra* note 3, at 166-71; Bruce J. Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection*, 28 HOUS. L. REV. 15, 16-18 (1991); Note, *supra* note 15, at 1207-22.

18. See BRAKEL ET AL., *supra* note 4, at 24; WINICK, *supra* note 3, at 201-13.

19. See WINICK, *supra* note 14.

20. *Id.* at 269-309.

21. *Riggins v. Nevada*, 504 U.S. 127, 135-36 (1992) (dictum); *Washington v. Harper*, 494 U.S. 210, 225 (1990); WINICK, *supra* note 14, at 285-88, 294-308.

22. See, e.g., *Rennie v. Klein*, 653 F.2d 836, 845 (3d Cir. 1981) (en banc), *vacated and remanded*, 458 U.S. 1119 (1982); *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. 291 (1982); WINICK, *supra* note 14, at 289-94.

23. *Riggins*, 504 U.S. at 127; WINICK, *supra* note 14, at 276-83; Bruce J. Winick, *Psycho-*

In addition to contexts involving institutionalized mental patients and criminal offenders, coercive mental health treatment has increasingly been applied in the community.²⁴ Such treatment has been mandated as part of involuntary outpatient commitment, preventive commitment, conditional release, and as a condition of parole, probation, or diversion from the criminal process.²⁵ Also, court-ordered treatment may be imposed in a variety of criminal and family court contexts.²⁶ Other than to offer the above brief outline of when the law authorizes involuntary psychiatric hospitalization and mental health treatment, this article does not attempt an analysis of the conditions under which coercion in the mental health context should be justified.²⁷

III. LEGAL STANDARDS OF COERCION AND THE POSSIBILITY OF THEIR SATISFACTION BY THOSE WITH MENTAL ILLNESS

A number of situations thus exist in which involuntary commitment is permitted and in which clinicians in public facilities and in the community will be authorized to administer mental health treatment coercively. In those circumstances in which the law authorizes coercive mental health intervention, the usual requirements of the informed consent doctrine will not need to be followed. Indeed, in these situations, clinicians will rarely discuss hospitalization and treatment options with their patients, but will make treatment decisions unilaterally and order that hospitalization and treatment be imposed involuntarily, even over objection. Although some judicial and legislative clarification has occurred concerning when patients have a right to refuse treatment and when they do not, many issues remain unresolved.²⁸

In situations in which involuntary hospitalization or coercive treatment is not permitted, the law will need to define the concept of coercion. Typical definitions incorporate the standard of coercion adopted in the Nuremberg Code, requiring "the knowing consent of an individual or his legally authorized representative, so situated as to be able to exercise free power of choice without undue inducement or any element of force, fraud, deceit, duress, or other form of constraint or coercion."²⁹ Patients institutionalized because of mental illness may be particularly vulnerable to coercive pressures, and their consent to treatment delivered within the institution cannot always be accepted at face value. It would be a mistake, however, to conclude that the fact of

tropic Medication in the Criminal Trial Process: The Constitutional and Therapeutic Implications of Riggins v. Nevada, 10 N.Y.L. SCH. J. HUM. RTS. 637, 646-51 (1993).

24. See A NEW FRONTIER, *supra* note 4.

25. *Id.*

26. For extensive treatment of this issue, see WINICK, *supra* note 14 (involuntary treatment); WINICK, *supra* note 3, at 93-199 (involuntary hospitalization and treatment).

27. *Id.*

28. See WINICK, *supra* note 14.

29. *The Medical Cases*, in 1 & 2 TRIALS OF WAR CRIMINALS BEFORE THE NUREMBERG MILITARY TRIBUNALS (1948), reprinted in JAY KATZ, EXPERIMENTATION WITH HUMAN BEINGS 292, 305-06 (1972). The principles set forth in the judgment of the Nuremberg Military Tribunal in the case of *United States v. Karl Brandt*—the trial of twenty-three German physicians for war crimes involving experiments with prisoners of war and civilians—have come to be known as the Nuremberg Code. See also 45 C.F.R. § 46.116 (1996) (U.S. Dep't of Health and Human Services regulations concerning the protection of human subjects).

institutionalization *per se* renders treatment choices involuntary.³⁰

Prisoners face similar institutional pressures, and it is useful to consider the related question of whether prisoners should be considered able to make free choices. In its report entitled *Research Involving Prisoners*, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research considered "whether prisoners are, in the words of the Nuremberg Code, 'so situated as to be able to exercise free power of choice'"—that is, whether prisoners can give truly voluntary consent to participate in research.³¹ Some of the commissioners argued that prisons, by their very purpose and character, make sufficiently free consent to research impossible.³² Similarly, several participants at a National Minority Conference on Human Experimentation held under the auspices of the National Commission objected in principle to the notion of truly voluntary consent by prisoners.³³ The National Commission, however, ultimately rejected the idea that prisons are so inherently coercive that voluntary consent is impossible, and concluded that at least some prison research could be undertaken with appropriate safeguards.³⁴ The Commission proposed a number of requirements to ensure "a high degree of voluntariness on the part of the prospective participants," including "adequate living conditions, provisions for effective redress of grievances, separation of research participation from parole considerations, and public scrutiny."³⁵ The U.S. Department of Health and Human Services regulations, initially adopted as a result of the Commission's work, include an additional protection for prisoners subjected to biomedical and behavioral research. The regulation requires an assurance that parole boards not take into account a prisoner's participation in such research in making parole decisions, and that prisoners be "clearly informed in advance that participation in the research will have no effect on his or her parole."³⁶

In the *Kaimowitz* Michigan psychosurgery case,³⁷ the court considered the impact on voluntariness of institutionalization and of the inducement created when release is tied to consent. The court held that involuntarily confined mental patients are unable as a matter of law to consent to experimental psychosurgery. The court's analysis has broad implications for the ability of all

30. The analysis that follows is drawn in part from my discussion of the requirement of voluntariness under the informed consent doctrine contained in WINICK, *supra* note 14, at 363-68.

31. NATIONAL COMM'N FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, *RESEARCH INVOLVING PRISONERS* 5 (1976) [hereinafter RESEARCH].

32. Roy Branson, *Prison Research: National Commission Says "No, Unless . . ."*, HASTINGS CENTER REP. Feb. 1977, at 15, 17 (quoting remarks of Commissioner King).

33. RESEARCH, *supra* note 31, at 42, 44. This was also the view of the American Correctional Association. See American Correctional Ass'n, *Position Statement: The Use of Prisoners and Detainees as Subjects of Human Experimentation*, Feb. 20, 1976, in RESEARCH, *supra* note 31, at 22-1 to 22-2 app.

34. Larry I. Palmer, *Biomedical and Behavioral Research on Prisoners: Public Policy Issues in Human Experimentation*, in RESEARCH, *supra* note 31, at 14-21 app.; see Branson, *supra* note 32, at 16.

35. RESEARCH, *supra* note 31, at 16.

36. 45 C.F.R. § 46.305(a)(6) (1996).

37. *Kaimowitz v. Michigan Dep't of Mental Health*, No. 73-19434-AW (D. Mich. July 10, 1973), reprinted in ALEXANDER D. BROOKS, *LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM* 902, 913-14 (1974).

institutionalized mental patients to provide informed consent, and therefore deserves careful analysis. The court stated that:

Although an involuntarily detained mental patient may have sufficient I.Q. to intellectually comprehend his circumstances . . . the very nature of his incarceration diminishes the capacity to consent to psychosurgery.

. . .

The fact of institutional confinement has special force in undermining the capacity of the mental patient to make a competent decision on this issue, even though he be intellectually competent to do so.

. . .

It is impossible for an involuntarily detained mental patient to be free of ulterior forms of restraint or coercion when his very release from the institution may depend upon his cooperating with institutional authorities and giving consent to experimental surgery.

Involuntarily confined mental patients live in an inherently coercive institutional environment. Indirect and subtle psychological coercion has a profound effect upon the patient population. . . . They are not able to voluntarily give informed consent because of the inherent inequality of their position.³⁸

The sweeping approach of *Kaimowitz*, however, has not been followed by other courts. The *Kaimowitz* court sought to limit its holding to experimental psychosurgery by stating that consent could be given to conventionally accepted procedures.³⁹ The logic, however, of the court's approach to coercion goes considerably beyond experimental treatment.

Although the *Kaimowitz* court may have reached the right result on the facts of that case,⁴⁰ the potential breadth of the court's holding concerning the effects of institutionalization and the promise of release on the capacity to give informed consent could give rise to absurd and constitutionally dubious results. Institutionalization may substantially diminish the ability of some patients to decide freely on therapy, and the lure of release or of avoiding hospitalization may be so potent that, for at least some patients, refusal to consent is virtually impossible. These factors, however, should not preclude all patients from being considered capable of making these decisions voluntarily. If institutionalization *per se* diminishes decision-making abilities so that patients are incompetent to elect psychosurgery, how can patients be considered competent to make other important decisions? Can they decide to have elective surgery or other medical treatment when needed, to choose particular recreational or therapeutic opportunities, or to agree to accept certain conditions of conditional release? Moreover, if the prospect of release renders confined individuals

38. *Kaimowitz*, No. 73-19434-AW, slip op. at 25-29; BROOKS, *supra* note 37, at 913-15.

39. *Kaimowitz*, No. 73-19434-AW, slip op. at 40; BROOKS, *supra* note 37, at 920.

40. See Robert Burt, *Why We Should Keep Prisoners From The Doctors*, HASTINGS CENTER REP., Feb. 1975, at 25.

incompetent to elect psychosurgery, how can patients be permitted to elect the variety of other hospital programs that are likely to result in early release?

The absurdity of a *per se* rule based upon the impact of institutionalization or the lure of release is demonstrated by its extraordinarily sweeping effect. An example drawn from the analogous context of the prison illustrates the difficulties with the *Kaimowitz* approach. A common example of use of the early release lure to modify prisoner behavior is the virtually universal practice of providing "good time" credit. As the Supreme Court noted in *McGinnis v. Royster*,⁴¹ "the granting of good-time credit toward parole eligibility takes into account a prisoner's rehabilitative performance."⁴² The state statute involved in *Royster* authorized such good time credit "for good conduct and efficient and willing performance of duties assigned."⁴³ Under a U.S. Bureau of Prisons rule, an award of "extra good time" may be made for, among other things, "[v]oluntary acceptance and satisfactory performance of an unusually hazardous assignment."⁴⁴ Under the *Kaimowitz* approach, these common and largely unobjectionable features of prison life would be deemed coercive. Although the lure of release from institutional confinement may make the voluntary choices made by patients in favor of treatment suspect, it would be a mistake to regard all such choices as inherently coerced even though they predictably may bring about earlier release from the hospital.

In the analogous situation of plea bargaining, the courts have rejected the notion that the opportunity or even the assurance of a shorter sentence necessarily renders a guilty plea involuntary. In *Brady v. United States*,⁴⁵ the defendant attacked the validity of his guilty plea, arguing that it was entered to avoid the possibility of the death penalty. Under the statute involved, the death penalty could be imposed following a jury determination of guilty but could not be imposed when a defendant waived trial and pled guilty. Stressing that "[t]he voluntariness of Brady's plea can be determined only by considering all of the relevant circumstances surrounding it,"⁴⁶ the Court rejected the coercion claim:

Even if we assume that Brady would not have pleaded guilty except for the death penalty provision . . . , this assumption merely identifies the penalty provision as a "but for" cause of his plea. That the statute caused the plea in this sense does not necessarily prove that the plea was coerced and invalid as an involuntary act. . . .

Of course, the agents of the State may not produce a plea by actual or threatened physical harm or by mental coercion overbearing the will of the defendant. But nothing of the sort is claimed in this

41. 410 U.S. 263 (1973).

42. *McGinnis*, 410 U.S. at 271.

43. *Id.* at 266-67 n.5 (quoting *Royster v. McGinnis*, 332 F. Supp. 973, 974-75 (S.D.N.Y. 1971)).

44. 28 C.F.R. § 523.16 (1996); see also 28 C.F.R. § 2.60(a), (b) (1996) (rule of U.S. Parole Commission permitting advancement of presumptive release date for "superior program achievement" in "educational, vocational, industry, or counselling programs").

45. 397 U.S. 742 (1970).

46. *Brady*, 397 U.S. at 749.

case. . . . Brady's claim is of a different sort: that it violates the Fifth Amendment to influence or encourage a guilty plea by opportunity or promise of leniency and that a guilty plea is coerced and invalid if influenced by the fear of a possible higher penalty for the crime charged if a conviction is obtained after the State is put to its proof.

. . .

We decline to hold, however, that a guilty plea is compelled and invalid under the Fifth Amendment whenever motivated by the defendant's desire to accept the certainty or probability of a lesser penalty. . . .⁴⁷

Not all pressures that succeed in inducing a plea will be deemed coercive. The *Brady* Court adopted as its standard of voluntariness the rule that a guilty plea "must stand unless induced by threats . . . misrepresentation . . . , or perhaps by promises that are by their nature improper," such as bribes.⁴⁸ The Court thus recognized that while certain plea offers could be coercive, an offer of leniency alone, however enticing, would not be deemed coercive. Even an offer that is difficult to refuse will be permitted absent improper threats or promises or some form of misrepresentation. Under the standard adopted by the Court, "a plea of guilty is not invalid merely because entered to avoid the possibility of a death penalty."⁴⁹

If avoidance of the possibility of a death sentence is not so inherently coercive as to invalidate a guilty plea, then it is difficult to see how the possibility or promise of early release from the hospital could be considered so inherently coercive as to invalidate a patient's choice of therapy. There was no suggestion in *Brady* that the prosecutor acted in bad faith, using his charging discretion improperly to lodge a baseless charge against Brady of an offense carrying the death penalty in order to engineer a guilty plea. Offering to dismiss a baseless charge in exchange for a guilty plea would have been an "improper" promise, and hence coercive.⁵⁰ Similarly, if the conditions of institutional confinement that would be avoided by the agreement of a hospitalized patient to accept treatment are inconsistent with the minimum standards mandated by the Constitution,⁵¹ an offer of potential release also would constitute an improper promise that would be coercive under the *Brady* standard.

47. *Id.* at 750-51.

48. *Id.* at 755 (quoting *Shelton v. United States*, 246 F.2d 571, 572 n.2 (5th Cir. 1957)). *Brady* did not actually involve plea bargaining. The statute under which Brady was charged made the death penalty unavailable in the case of a guilty plea. The pressure that Brady asserted had induced his plea was a product of the statutory scheme itself. The Supreme Court, however, subsequently applied the *Brady* standard in the context of plea bargaining. See *Bordenkircher v. Hayes*, 434 U.S. 357, 363 (1978). Indeed, *Brady's* concept of offers or proposals as coercive only when improper has emerged as a general legal approach to considering when offers are coercive. See WERTHEIMER, *supra* note 5, at 172, 267-68, 287, 301, 308; Winick, *supra* note 5, at 770 & n.107; see also RESTATEMENT (SECOND) OF CONTRACTS §§ 174-76 (1981) (standard of duress limited to physical compulsion or improper threats).

49. *Brady*, 397 U.S. at 755.

50. See *supra* note 48 and accompanying text.

51. See, e.g., *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd sub nom.* *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974).

Either case—the offer to dismiss a baseless charge or to remove legally inadequate conditions of confinement in exchange for a guilty plea—would constitute a coercive offer which would render unenforceable the defendant's plea made in response. Such an offer is objectionable because the conditions from which the individual is offered relief if he or she accepts the proposal are themselves improper. If rejected, the individual would be worse off than he or she has a right to be. The offer thus violates the individual's moralized baseline, rendering the pressures it creates coercive.⁵² By contrast, if the conditions of institutional confinement are not unconstitutional or otherwise improper, the promise of future release conditioned on acceptance of treatment would seem no different than a promise not to seek the death penalty or to dismiss capital charges that are appropriate in the circumstances in exchange for a guilty plea.

Of course, there may be cases in which the forces of institutionalization render a particular patient incapable of making truly voluntary choices. And there may be cases in which threats or promises are so potent that the particular patient's consent is virtually assured. Nevertheless, this does not mean that institutionalization or the opportunity of early release or of avoidance of confinement renders voluntary consent impossible.

Virtually no choice is totally free of at least some degree of psychological coercion.⁵³ Psychologist Israel Goldiamond has performed a useful behavioral analysis of voluntariness and coercion, defining situations of coercion and noncoercion through the use of a contingency analysis.⁵⁴ In this model, coercion is most severe when there are no genuine choices and the consequences contingent on behavior are critical.⁵⁵ Certainly plea bargaining is coercive under this model,⁵⁶ sometimes extremely so. Nevertheless, courts have accepted the basic legitimacy of plea bargaining, deeming this degree of coercion constitutionally tolerable.⁵⁷ The psychological pressures inherent in a particular situation will not alone render choices coerced for legal purposes. It is only

52. See WERTHEIMER, *supra* note 5, at 210.

53. Israel Goldiamond, *Protection of Human Subjects and Patients: A Social Contingency Analysis of Distinctions Between Research and Practice, and its Implications*, 4 BEHAVIORISM 1, 27 (1976) ("Coercion is not absolute; there are degrees of coercion as well as of freedom."); see Louis L. Jaffee, *Law as a System of Control*, in EXPERIMENTATION WITH HUMAN SUBJECTS 203, 216 (Paul A. Freund ed., 1969). For philosophical analyses of the concept of coercion, see RAZ, *supra* note 7; WERTHEIMER, *supra* note 5; REPRESENTATION: YEARBOOK FOR THE AMERICAN SOCIETY FOR POLITICAL AND LEGAL PHILOSOPHY 1-328 (J. Roland Pennock & John W. Chapman eds., 1968); Jeffrie G. Murphy, *Consent, Coercion and Hard Choices*, 67 VA. L. REV. 79 (1981); Robert Nozick, *Coercion*, in PHILOSOPHY, SCIENCE AND METHOD 440 (Sidney Morgenbesser et al. eds., 1969); Wertheimer, *supra* note 5; Alan Wertheimer, *Remarks on Coercion and Exploitation*, 74 DENV. U. L. REV. 889 (1997).

54. Goldiamond, *supra* note 53, at 20-34; Israel Goldiamond, *Singling Out Behavior Modifications for Legal Regulation: Some Effects on Patient Care, Psychotherapy and Research in General*, 17 ARIZ. L. REV. 105, 121-25 (1975).

55. Goldiamond, *supra* note 53, at 23.

56. See John H. Langbein, *Torture and Plea Bargaining*, 46 U. CHI. L. REV. 3, 12-13 (1978); Steven S. Nemerson, *Coercive Sentencing*, 64 MINN. L. REV. 669, 675-78 (1980).

57. See, e.g., *Corbitt v. New Jersey*, 439 U.S. 212, 222-23 (1978); *Bordenkircher v. Hayes*, 434 U.S. 357, 364 (1978); *Blackledge v. Allison*, 431 U.S. 63, 71 (1977). The Supreme Court even has suggested that plea bargaining, properly conducted, is worthy of encouragement. See *Santabello v. New York*, 404 U.S. 257, 260 (1971).

when improper pressures are brought to bear that courts will find coercion.

Most patients should be deemed, in principle, capable of consenting to even the most intrusive of treatment programs—programs that they otherwise would have a constitutional right to refuse. Because the inherent psychological pressures faced by institutionalized patients choosing treatment are simply not avoidable, courts should seek only to protect against additional or related pressures that are unfair or improper.⁵⁸ An analogy to plea bargaining is again useful. The inherent coerciveness of plea bargaining is mitigated by the presence and advice of counsel during the plea bargaining process,⁵⁹ and by the practice of giving pleas in open court where the judge is required to conduct a review of the extent of the defendant's knowledge of the rights about to be waived and the voluntariness of their waiver.⁶⁰ Similar protection could easily be fashioned in the context of consent to at least the more intrusive forms of mental health treatment. Indeed, some type of pretreatment hearing and independent review may be required by the guarantee of procedural due process.⁶¹ With these procedural qualifications, it seems likely that courts would uphold the validity of consent given by patients in connection with mental health or correctional therapies. Although institutionalization and the lure of release may provide pressures that render some choices made in response legally coerced, most patients will be able to satisfy the requirement of voluntariness notwithstanding these pressures, and to provide informed consent to treatment.

IV. A THERAPEUTIC JURISPRUDENCE APPROACH TO COERCION

Although the pressures inherent to institutionalization or the potent lure of release from hospital confinement will not by themselves render treatment choices coerced, in those contexts in which the law prohibits coerced hospitalization or treatment, there is need for further clarification concerning when persuasion and pressure to accept voluntary hospitalization or treatment cross the line into coercion. This is not an easy line for the law to draw, particularly in the mental health treatment context where persuasion and coping with patient resistance to change are essential parts of the therapeutic process. In this connection, it is important to understand the kinds of persuasion and pressure that patients perceive as coercive and offensive and those that they perceive as noncoercive and acceptable. Moreover, it is important to understand the relationship between these patient perceptions of coercion and noncoercion and therapeutic success or failure.

58. WINICK, *supra* note 14, at 363-68; Jeffrie G. Murphy, *Total Institutions and the Possibility of Consent to Organic Therapies* 5 HUM. RTS. Q. 25, 38 (1975); David B. Wexler, *Reflections on the Legal Regulation of Behavior Modification in Institutional Settings*, 17 ARIZ. L. REV. 132, 133 (1975).

59. See *Brady*, 397 U.S. at 758. Compare *Tollett v. Henderson*, 411 U.S. 258, 265 (1973), and *McMann v. Richardson*, 397 U.S. 759, 771 (1970), with *Fontaine v. United States*, 411 U.S. 213, 215 (1973).

60. See *Brady*, 397 U.S. at 758; *Boykin v. Alabama*, 395 U.S. 238, 241-44 (1969); *McCarthy v. United States*, 394 U.S. 459, 467 (1969); Fed. R. Crim. P. 11.

61. See WINICK, *supra* note 14, at 371-89.

Even when mandatory treatment or hospitalization is permitted by the law, it is important for both legal actors and clinicians involved in the treatment process to understand when patients subjectively perceive coercion, and the relationship between such perceptions and treatment outcome. Because the purpose of treatment delivered on an involuntary basis is to ameliorate the patient's psychopathology, it is crucial to inquire concerning what kinds of persuasion and pressure are conducive to the therapeutic mission and those which may undermine it. Legal actors and clinicians functioning within the coercive treatment context should therefore view the question of coercion through the lens of therapeutic jurisprudence.⁶²

Therapeutic jurisprudence is the study of the law as a therapeutic agent. Whether we appreciate it or not, the law is a social force that frequently imposes therapeutic or antitherapeutic consequences on the people it affects. Therapeutic jurisprudence is an interdisciplinary approach to the study of law that calls for a theoretical and empirical analysis of the impact of law on individuals' psychological health and functioning. By examining law in this way, therapeutic jurisprudence can generate a wide array of empirical and policy issues, many of which have not previously been raised, that can enrich our understanding of law and identify new and creative law reform proposals.⁶³ Law's therapeutic consequences are not the only ones worth studying or considering, of course, but they should not be neglected in any sensible policy analysis of law. When legal rules or procedures or the roles played by various legal actors (such as judges, lawyers, and clinicians) create antitherapeutic consequences, we should consider whether changes in law or in the way law is applied can be accomplished in a manner that will minimize these consequences consistent with considerations of justice and other relevant normative values.

Applying the therapeutic jurisprudence approach to the context of coercive mental health treatment allows us to identify a number of issues that are ripe for empirical research, the results of which will be crucial to legal decision making in this area. When the law permits coercive treatment in various contexts, it does so based on the assumption that such treatment is effective. But is such treatment effective when imposed coercively? Can coercion impose negative effects on the treatment process? How should clinicians deal with their patients when coercive treatment is authorized? How can legal rules permitting coercive treatment be structured in order to further and not diminish the potential for a successful treatment outcome? Even in the absence of empirical research on these issues, the need exists to apply psychological theory to speculate about the effects of coercion in the mental health process. The

62. See generally DAVID B. WEXLER & BRUCE J. WINICK, *ESSAYS IN THERAPEUTIC JURISPRUDENCE* (1991) (analyzing and illustrating law's role as a therapeutic agent); LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce J. Winick eds., 1996) (illustrating application of therapeutic jurisprudence to a wide spectrum of legal issues and containing commentary on this emerging approach to legal policy analysis) [hereinafter *LAW IN A THERAPEUTIC KEY*]; WINICK, *supra* note 3 (applying the approach of therapeutic jurisprudence to analyze the field of mental health law); Bruce J. Winick, *The Jurisprudence of Therapeutic Jurisprudence*, 3 *PSYCHOL. PUB. POL'Y & L.* (forthcoming 1997).

63. See *LAW IN A THERAPEUTIC KEY*, *supra* note 62 (anthology of therapeutic jurisprudence of theoretical and empirical work on a wide variety of legal issues).

remainder of this article will address these issues, conducting a therapeutic jurisprudence analysis of legal and clinical approaches to coercive treatment. The first question for analysis is whether coercive treatment works.

V. DOES COERCIVE TREATMENT WORK?

To the extent that the law permits involuntary treatment in order to improve mental health or restore a level of functional capacity, there is a need for social scientists to examine whether the law's objectives are accomplished. There have been various anecdotal reports of successful treatment in coercive situations.⁶⁴ There is a paucity of empirical research exploring the efficacy of involuntary treatment, however.⁶⁵ An extensive review of the literature on psychotherapy and psychotropic medication, the two most prevalent forms of treatment for those suffering from mental illness, found no persuasive evidence that coercive application of these two techniques to involuntarily committed patients was effective.⁶⁶ In recent years, there has been increased interest in the efficacy of aggressive community-based treatment.⁶⁷ Several researchers have conducted quasi-experimental studies of outpatient civil commitment, and have concluded that it is effective in reducing the length and number of hospitalizations, and in increasing patient continuance in treatment.⁶⁸ These studies, however, are preliminary and suffer from serious methodological difficulties—small sample sizes, use of retrospective data, lack of control groups, and failure to control for potential confounding variables, including the selection criteria used and the effects of informal coercion.⁶⁹ Some of these methodological difficulties may be inherent to the task of studying the efficacy of coerced treatment. A true experiment employing random assignment of patients thought to be in need of coerced treatment raises ethical dilemmas and may not be feasible.⁷⁰ Moreover, there is lack of agreement concerning proper outcome measures for judging the efficacy of treatment. For example, such factors as rehospitalization or recidivism, or increased continuation in treatment, may not adequately capture the effectiveness of treatment.

64. GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, *FORCED INTO TREATMENT: THE ROLE OF COERCION IN CLINICAL PRACTICE* 22-24, 81, 99-101 (1994) (including anecdotal reports of successful treatment in coercive situations, including treatment of children and adolescents, sex offenders, and employees treated for alcoholism or drug addiction when coercion is perceived by patient as fair and appropriate).

65. Phyllis Solomon, *Research on the Coercion of Persons with Severe Mental Illness*, in A NEW FRONTIER, *supra* note 4, at 129, 142-43.

66. Mary L. Durham & John Q. La Fond, *A Search for the Missing Premise of Involuntary Therapeutic Commitment: Effective Treatment of the Mentally Ill*, 40 RUTGERS L. REV. 303, 351-56, 367-68 (1988).

67. A NEW FRONTIER, *supra* note 4, at 2-3.

68. 'See, e.g., Virginia A. Hiday & Theresa L. Scheid-Cook, *A Follow-Up of Chronic Patients Committed to Outpatient Treatment*, 40 HOSP. & COMMUNITY PSYCHIATRY 52 (1989); Robert A. Van Putten et al., *Involuntary Outpatient Commitment in Arizona: A Retrospective Study*, 39 HOSP. & COMMUNITY PSYCHIATRY 953 (1988); Guido Zanni & Leslie de Veau, *Inpatient Stays Before and After Outpatient Commitment*, 37 HOSP. & COMMUNITY PSYCHIATRY 941 (1986).

69. Solomon, *supra* note 65, at 135; M.S. Swartz et al., *New Directions in Research on Involuntary Outpatient Commitment*, 46 HOSP. & COMMUNITY PSYCHIATRY 381, 382 (1995).

70. Monahan et al., *supra* note 8.

VI. THE PERCEPTION OF COERCION

We thus know very little about the efficacy of coerced treatment. More research plainly is needed.⁷¹ However, before we can properly study coercion as an independent variable in treatment outcome, a significant prior issue must be examined—coercion as a dependent variable, that is, what makes people feel coerced.⁷² As indicated earlier, the concept of coercion has a significant subjective component.⁷³ The issue of when people feel coerced—the determinants and correlates of perceived coercion—has been the subject of important recent research conducted under the auspices of the MacArthur Research Network on Mental Health and the Law.⁷⁴ This research examined attitudes of patients at the time of admission to mental hospitals. The preliminary results indicated that patient perceptions of coercion do not necessarily correlate with whether they have been subjected to formal legal compulsion, such as occurs in civil commitment, and that it is possible to study patients' perceptions of coercion independent of the formal legal status of voluntary or involuntary admission.⁷⁵

The MacArthur coercion study concluded that a number of important variables correlated with patient perceptions of coercion.⁷⁶ One of these was the motivation of the clinician or state actor—the extent to which the treatment provider was perceived as acting out of concern for the patient's well-being. Another was respect—the degree of respect with which the treatment provider dealt with the patient. Others included what in the psychology of procedural justice has come to be known as voice—the extent to which the patient was afforded an opportunity to express his or her opinion on the admission decision—and validation—the extent to which what the patient had to say was taken seriously.⁷⁷ Patients desire to be included in the process of determining whether they will be admitted to the hospital, and experience coercion to the extent they are excluded from that process.

71. Solomon, *supra* note 65.

72. A NEW FRONTIER, *supra* note 4, at 14; Bennett et al., *supra* note 8; Gardner et al., *supra* note 8.

73. See *supra* Part I.

74. A NEW FRONTIER, *supra* note 4; Bennett et al., *supra* note 8, at 297-99; Gardner et al., *supra* note 8.

75. A NEW FRONTIER, *supra* note 4; Lidz et al., *supra* note 6.

76. A NEW FRONTIER, *supra* note 4.

77. See E. ALLAN LIND & TOM R. TYLER, *THE SOCIAL PSYCHOLOGY OF PROCEDURAL JUSTICE* 26-34 (1988); JOHN THIBAUT & LAURENS WALKER, *PROCEDURAL JUSTICE: A PSYCHOLOGICAL ANALYSIS* (1975); TOM R. TYLER, *WHY PEOPLE OBEY THE LAW* (1990); Hiday et al., *supra* note 8, at 229-30; Stephen LaTour, *Determinants of Participation and Observer Satisfaction with Adversary and Inquisitorial Modes of Adjudication*, 36 J. PERSONALITY & SOC. PSYCHOL. 1531 (1978); E. Allan Lind et al., *Procedure and Outcome Effects on Reactions to Adjudicated Resolutions of Conflicts of Interest*, 39 J. PERSONALITY & SOC. PSYCHOL. 643, 652-53 (1980); E. Allan Lind et al., *Voice, Control, and Procedural Justice: Instrumental and Noninstrumental Concerns in Fairness Judgments*, 59 J. PERSONALITY & SOC. PSYCHOL. 952 (1990); Norman G. Poythress, *Procedural Preferences, Perceptions of Fairness, and Compliance with Outcomes*, 18 LAW & HUM. BEHAV. 361 (1994); John Thibaut et al., *Procedural Justice as Fairness*, 26 STAN. L. REV. 1271 (1974); Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433, (1992); see also Tom E. Hughes & Lon N. Larson, *Patient Involvement in Health Care: A Procedural Justice Viewpoint*, 29 MED. CARE 297 (1991).

Another important variable was the patient's perception of fairness—whether he or she was treated fairly and whether trickery or deception was used in the admission process. Finally, the extent to which pressure was applied in the admission process was deemed significant, that is, the degree of persuasion, inducement, threats, or force. Very high levels of perceived coercion were present when treatment providers used the negative pressures of threats and force, whereas positive approaches involving persuasion and inducement were associated with no increase in perceived coercion.⁷⁸

Patients in the admissions process who reported that others acted out of concern for them, treated them fairly, in good faith, with respect, and without deception, provided them with an opportunity for voice, and took what they said seriously were much less likely to experience coercion.⁷⁹ When these moral norms reflecting patient attitudes about how they should be treated are adhered to, many apparently coercive acts seem to be accepted by the patient as morally legitimate.⁸⁰ In any future research on the efficacy of coercive treatment, these findings must be taken into account in designing studies to measure the relationship between perceived coercion and treatment outcome. But they also should be taken into account in considering how clinicians should act toward their patients in involuntary hospitalization and treatment contexts.

VII. BALANCING THE POSITIVE AND NEGATIVE EFFECTS OF COERCION

To the extent that coercive treatment is effective, it must count, of course, as a positive therapeutic consequence of legal rules permitting coerced treatment. At least in some circumstances, coercion can improve the quality (or at least stability) of a client's life.⁸¹ Undoubtedly some patients who otherwise would reject treatment needed to reduce suffering and promote healthy functioning may benefit immensely from treatment provided on an involuntary basis.

Against these potentially positive effects of coercive treatment, however, must be weighed its potentially negative consequences. Patients may experience feelings of alienation and disaffection if they feel improperly coerced, with potentially negative effects on treatment compliance and efficacy.⁸² Even if patients comply with treatment when coerced to do so, long-range therapeutic outcomes may become tenuous because patients may be unlikely to adhere voluntarily to needed medication or psychosocial therapy once coercive conditions are removed.⁸³ Treatment imposed over objection reveals a failure of the therapeutic relationship that can produce negative effects on the therapeutic process that may be long-lasting.⁸⁴ Moreover, if coerced treatment is permit-

78. A NEW FRONTIER, *supra* note 4, at 23.

79. *Id.* at 24.

80. Bennett et al., *supra* note 8, at 304.

81. Diamond, *supra* note 11, at 59-60.

82. A NEW FRONTIER, *supra* note 4, at 14; Bennett et al., *supra* note 8, at 296; Hiday et al., *supra* note 8, at 237-38; Rogers, *supra* note 8.

83. Hiday et al., *supra* note 8, at 237-38.

84. Andrea K. Blanch & Jacqueline Parrish, *Reports of Three Roundtable Discussions on In-*

ted, the patient, as well as other patients, might be deterred from seeking treatment voluntarily out of fear that they might be committed.⁸⁵ Indeed, studies show that fear of involuntary hospitalization has kept patients from seeking treatment voluntarily at least once when they thought it was needed.⁸⁶

Because coercion diminishes and sometimes even negates choice, a therapeutic jurisprudence analysis of coercive treatment should probe the relationship between patient choice and therapeutic outcome. My own theoretical work on the psychology of choice suggests the existence of considerable psychological value in allowing individuals to exercise choice concerning a wide variety of matters, including decisions affecting their health.⁸⁷ Treatment imposed over objection may not work as well. In general, unless people themselves see the merits of achieving a particular goal, they often do not pursue it or do so without the degree of commitment necessary to attain it.

Research in the area of medical treatment generally suggests that when physicians do not allow patients to participate in treatment decisions and do not explain treatment to them, patients often do not comply with medical advice.⁸⁸ In general, treatment adherence increases when the patient is given choice and the ability to participate in the selection of treatment alternatives and goals.⁸⁹ Coerced hospitalization and treatment may make it less likely that the client will be willing to stay connected with the treatment system or continue to take medication after discharge from the hospital.⁹⁰ When patients exercise choice in matters of treatment, this may bring a degree of commitment, which mobilizes the self-evaluative and self-reinforcing mechanisms that facilitate goal achievement.⁹¹ A patient given the freedom to refuse hospitalization or treatment has a corresponding ability to choose to accept it. To the extent that a patient's agreement to accept a course of treatment recom-

voluntary Interventions, 1 PSYCHIATRIC REHABILITATION AND COMMUNITY SUPPORT MONOGRAPH 1 (1993); Diamond, *supra* note 11, at 61; see also DONALD MEICHENBAUM & DENNIS C. TURK, FACILITATING TREATMENT ADHERENCE: A PRACTITIONER'S GUIDE-BOOK 20, 76-79 (1987); Hiday et al., *supra* note 8, at 236.

85. LAW IN A THERAPEUTIC KEY, *supra* note 62, at 146-47; A NEW FRONTIER, *supra* note 4, at 14; Monahan et al., *supra* note 8.

86. Hiday et al., *supra* note 8, at 236; Lidz et al., *supra* note 6; Alicia Lucksted & Robert D. Coursey, *Consumer Perceptions of Pressure and Force in Psychiatric Treatments*, 46 PSYCHIATRIC SERVICES 146 (1995);

87. WINICK, *supra* note 3, at 87-91; WINICK, *supra* note 14, at 327-44; Winick, *supra* note 17 at 46-52; Winick, *supra* note 4; Bruce J. Winick, *The MacArthur Treatment Competency Study: Legal and Therapeutic Implications*, 2 PSYCHOL. PUB. POL'Y & L. 137 (1996); Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1705, 1755-68 (1992).

88. PAUL S. APPELBAUM ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 28 (1987); MEICHENBAUM & TURK, *supra* note 84, at 20, 76-79; BILL D. MOYERS, HEALING AND THE MIND 50 (1993); see Paul S. Appelbaum & Thomas Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 AM. J. PSYCHIATRY 340, 341 (1980).

89. MEICHENBAUM & TURK, *supra* note 84, at 157, 159, 175; Fredrick H. Kanfer & Lisa Gaelick, *Self-Management Methods*, in HELPING PEOPLE CHANGE 334-47 (Fredrick H. Kanfer & Arnold P. Goldstein eds., 1986).

90. Diamond, *supra* note 11, at 63.

91. ALBERT BANDURA, SOCIAL FOUNDATIONS OF THOUGHT AND ACTION: A SOCIAL COGNITIVE THEORY 338, 363, 368, 468-69, 470-71, 475-76, 478-79 (1986); SHARON S. BREHM & JACK W. BREHM, PSYCHOLOGICAL REACTANCE: A THEORY OF FREEDOM AND CONTROL 301 (1981); MEICHENBAUM & TURK, *supra* note 84, at 156-57; Carroll, *supra* note 2, at 137-38.

mended by a therapist constitutes an affirmative expression of choice by the patient in favor of treatment, such choice itself may be therapeutic. Compliance with a treatment regimen may be indispensable to treatment success.⁹² Yet compliance may be negatively correlated with coercion.

For many types of mental health treatment in particular, the effectiveness of treatment "is proportional to the degree of cooperation that is present. . . ."⁹³ Several strands of psychological theory help to explain why patient choice in treatment decision making is likely to increase treatment efficacy. A conscious, voluntary agreement to accept a course of treatment constitutes the setting of a goal. The goal-setting effect, a well-accepted psychological principle, posits that the setting of explicit goals is itself a significant factor in their achievement.⁹⁴ Indeed, the setting of a goal may be indispensable to the achievement of change.⁹⁵ When patients voluntarily agree to treatment recommended by a therapist, their agreement constitutes the setting of a goal that both they and their therapist predict can and will be accomplished. The setting of a goal that seems achievable sets up expectancies of success that themselves help to bring about favorable treatment outcomes.⁹⁶ Predictions and expectations of goal achievement stimulate feelings of self-efficacy in the patient, which in turn spark action and effort in furtherance of the goal.⁹⁷

Psychological theory therefore would support the prediction that choice in matters of treatment and hospitalization will work better than coercion. Self-determination promotes commitment, intrinsic motivation, satisfaction, and effective functioning.⁹⁸ By contrast, if the individual feels coerced to accept hospitalization or treatment that is not truly desired, motivation to succeed is likely to be reduced. Indeed, imposing treatment over objection may produce feelings of resentment and psychological reactance that reduce patient compliance and the likelihood of treatment success.⁹⁹

A persistent criticism of the mental hospital is that it fosters a form of

92. MEICHENBAUM & TURK, *supra* note 84.

93. Council of the Am. Psychiatric Ass'n, *Position Statement on the Question of Adequacy of Treatment*, 123 AM. J. PSYCHIATRY 1458, 1459 (1967).

94. Donald J. Campbell, *The Effects of Goal-Contingent Payment on the Performance of a Complex Task*, 37 PERSONNEL PSYCHOL. 23, 23 (1984); Vandra L. Huber, *Comparison of Monetary Reinforcers and Goal Setting as Learning Incentives*, 56 PSYCHOL. REP. 223 (1985); Daniel S. Kirschenbaum & Randall C. Flanery, *Toward a Psychology of Behavioral Contracting*, 4 CLINICAL PSYCHOL. REV. 598, 603-09 (1984); Edwin A. Locke et al., *Goal Setting and Task Performance 1969-80*, 90 PSYCHOL. BULL. 125, 125-31 (1981); James R. Terborg & Howard E. Miller, *Motivation, Behavior, and Performance: A Closer Examination of Goal Setting and Monetary Incentives*, 63 J. APPLIED PSYCHOL. 29, 30-31 (1978).

95. BANDURA, *supra* note 91, at 469.

96. *Id.* at 412-13, 467; Edward L. Deci & Richard M. Ryan, *The Empirical Exploration of Intrinsic Motivational Processes*, 13 ADVANCES IN EXPERIMENTAL SOC. PSYCHOL. 39, 59 (1980).

97. BANDURA, *supra* note 91, at 413; Albert Bandura, *Self-Efficacy: Toward a Unifying Theory of Behavior Change*, 84 PSYCHOL. REV. 191 (1977).

98. EDWARD L. DECI, *THE PSYCHOLOGY OF SELF-DETERMINATION* 208-10 (1980); *see also* CHARLES A. KIESLER, *THE PSYCHOLOGY OF COMMITMENT: EXPERIMENTS LINKING BEHAVIOR TO BELIEF* 164-67 (1971) (finding that the most effective method for behavior therapists to obtain desired results with patients was to give patients the perception that they had freedom and control).

99. JACK W. BREHM, *A THEORY OF PSYCHOLOGICAL REACTANCE* (1966); BREHM & BREHM, *supra* note 91, at 300-01.

institutional dependence that may prevent future adjustment in the community.¹⁰⁰ Mental hospitals too often have conditioned passivity and helplessness by reinforcing it and by discouraging assertiveness and autonomous behavior. Mental patients have been infantilized by the treatment they received from institutional clinicians and staff. Treating patients as incompetent objects of paternalism may strongly reinforce feelings of incompetency and hopelessness, destroying intrinsic motivation and feelings of self-efficacy, and even producing the syndrome of learned helplessness.¹⁰¹ When decisions that significantly affect the individual, such as those relating to treatment, are made by others without the individual's participation, the resulting disuse of decision-making powers may lead to further degeneration of existing capabilities and behaviors.¹⁰² Coercion undermines feelings of self-efficacy, which may be essential to the recovery process.¹⁰³

Treating patients as incompetent to make hospitalization or treatment decisions for themselves, which legal rules that permit coercion rather than requiring voluntary choice reinforce, therefore actually may promote psychological dysfunction. Exercising self-determination is a basic human need.¹⁰⁴ Studies show that allowing individuals to make decisions for themselves is intrinsically motivating, whereas denying choice "undermines [their] motivation, learning, and general sense of organismic well-being."¹⁰⁵ Indeed, the stress of losing the opportunity to be self-determining may cause "severe somatic malfunction and even death."¹⁰⁶ For a number of reasons, therefore, coercion may produce dysfunctional effects and other antitherapeutic consequences.

The above analysis of the psychological value of voluntary choice and the potentially dysfunctional and countertherapeutic effects of coercion, although consistent with much clinical experience, is based largely on principles of psychological theory derived from studies with more "normal" populations. More research is needed concerning the effects of choice and coercion on treatment outcome. This is particularly true for individuals suffering from serious mental illness, such as schizophrenia. A patient in a florid state of schizophrenia, for example, who is disoriented and hallucinating, may not possess a sufficient degree of competence to make a meaningful choice in favor of treat-

100. See generally ERVING GOFFMAN, *ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES* 3-74 (1962); CHARLES A. KIESLER & AMY E. SIBULKIN, *MENTAL HOSPITALIZATION: MYTHS AND FACTS ABOUT A NATIONAL CRISIS* 148 (1987); WINICK, *supra* note 2, at 35 n.81; Richard Cole, *Patients' Rights vs. Doctors' Rights: Which Should Take Precedence?*, in *REFUSING TREATMENT IN MENTAL INSTITUTIONS: VALUES IN CONFLICT* 59 (A. Edward Doudera & Judith P. Swazey eds., 1982); Edmund G. Doherty, *Labeling Effects in Psychiatric Hospitalization: A Study of Diverging Patterns of Inpatient Self-Labeling Process*, 32 *ARCHIVES GEN. PSYCHIATRY* 562 (1975).

101. ELLEN J. LANGER, *MINDFULNESS* 53 (1989); MARTIN E.P. SELIGMAN, *HELPLESSNESS: ON DEPRESSION, DEVELOPMENT AND DEATH* (1975); *HUMAN HELPLESSNESS: THEORY AND APPLICATIONS* (Judy Garber & Martin E.P. Seligman eds., 1980); WINICK, *supra* note 3, at 28-36.

102. Bruce D. Sales & Lynn R. Kahle, *Law and Attitudes Toward the Mentally Ill*, 3 *INT'L J.L. & PSYCHIATRY* 391, 392 (1980).

103. Diamond, *supra* note 11, at 61-63; Solomon, *supra* note 65, at 143.

104. DECI, *supra* note 98, at 208-09.

105. *Id.* at 209.

106. *Id.*

ment.¹⁰⁷ How much understanding and volition are necessary to engage the psychological mechanisms discussed earlier that can contribute to positive treatment response? Will choice by such a patient have the effect of producing the positive expectancies and intrinsic motivation that seem to be related to favorable treatment outcome? Because theoretical explanations for the relationship between patient choice and treatment success are based on studies with significantly less impaired populations, we should ask whether these findings can be generalized to more impaired patients suffering from at least severe cases of major mental illness. These questions remain largely unexamined empirically.

Even if many patients suffering from mental illness do not possess sufficient competence to enable their choices to trigger these positive psychological effects, however, allowing them as great a degree of choice as circumstances permit may still be therapeutic. The aim of treatment interventions for acutely psychotic patients is to ameliorate severe symptomatology and restore the patient to as great a degree of competence as is possible. After a brief period of medication, for example, most seriously disturbed patients will be sufficiently competent that their choices about future treatment presumably will have positive therapeutic value. Even if coercion is necessary for a patient suffering acute symptoms, whose mental illness might prevent rational decision making about treatment and who otherwise would refuse it, once the patient can participate in decision making and experience the psychological value of making treatment choices, the justifications for coercion will cease. Even when the law allows clinicians to impose treatment coercively, they should proceed in a manner that is sensitive to the psychological value of allowing patients to exercise the maximum degree of decision-making authority of which they are capable. Although there are situations in which coercive treatment may be both legally permissible and therapeutically appropriate, clinicians should be aware that too much coercion, and coercion applied after it is no longer necessary, may be antitherapeutic.

Apart from the psychological value of allowing patients to participate in treatment decision making to the maximum extent to which they are capable, legal rules in this area will have an inevitable effect on the therapist-patient relationship in ways that itself can have either positive or negative therapeutic consequences.¹⁰⁸ Will legal rules permitting coercive treatment be more or less conducive to the therapeutic mission of the therapeutic relationship than those that require the patients' voluntary informed consent? How should therapists act in regard to the issue of coercive treatment so as to maximize the professional relationship's potential as a therapeutic agent in its own right?

There is increasing recognition that, at least in psychotherapy, the therapeutic relationship itself plays an essential role in producing positive out-

107. See *Zinerman v. Burch*, 494 U.S. 113 (1990) (finding patient with schizophrenia assenting to voluntary admission to hospital incompetent to consent to hospitalization). For a detailed analysis of *Zinerman* and of the concept of competence to consent to voluntary hospitalization, see Winick, *supra* note 17.

108. See WINICK, *supra* note 3, at 83-90 (discussing effect of a right to refuse treatment on the therapeutic relationship); WINICK, *supra* note 14, at 338-42.

comes.¹⁰⁹ The effectiveness of psychotherapy is heavily dependent on the quality of the therapeutic relationship.¹¹⁰ The most effective therapeutic relationships are those in which mutual trust and acceptance are established and maintained, and in which the patient perceives that the therapist cares about and is committed to pursuing his or her interests.¹¹¹ Patients improve as a result of therapeutic relationships that generate the perception that the therapist is interested in and dedicated to the patient's well-being.¹¹² To succeed, the therapist must establish his or her credibility and trustworthiness at an early time in the relationship. A relationship in which the therapist is permitted to treat the patient as an object of paternalism whose participation in therapeutic decision making is unnecessary and undesirable will not inspire such trust and confidence and therefore may be counterproductive. Indeed, a relationship in which the therapist ignores the patient's expressed wishes concerning treatment may produce the perception that the therapist is more concerned with the welfare of the institution than with that of the patient, and is not truly committed to the patient's best interest. Rather than producing trust and confidence, a coercive approach by the therapist, particularly if not perceived as benevolently motivated, can inspire resentment and resistance.

Therapists, particularly those in public institutions, too often seem to misperceive the importance of the therapist-patient relationship. Not only do these therapists thereby forego therapeutic opportunities, but by their actions they may actually create a harmful division between therapist and patient. Too often, there is not a real connection or sense of community between therapist and patient. As a result, no real sense of trust and confidence develops on the part of the patient. Yet such trust and confidence may be a prerequisite for engaging those positive attitudes and expectancies that play an important role in producing a successful treatment response. The therapist-patient relationship is especially important in the context of psychotherapy, but it also may play a significant role in all areas of medical practice.¹¹³

109. BREHM & BREHM, *supra* note 91, at 151-55, 300-01; WEXLER & WINICK, *supra* note 62, at 173; WINICK, *supra* note 3, at 83; Deci & Ryan, *supra* note 96, at 70; Michael L. Lambert et al., *The Effectiveness of Psychotherapy*, in HANDBOOK OF PSYCHOTHERAPY AND BEHAVIOR CHANGE (Sol E. Garfield & Allen E. Bergin eds., 1986) [hereinafter HANDBOOK OF PSYCHOTHERAPY].

110. WINICK, *supra* note 3, at 83.

111. *See supra* note 107.

112. BREHM & BREHM, *supra* note 91, at 151-52, 300-02; WEXLER & WINICK, *supra* note 62, at 173; Larry E. Beutler et al., *Therapist Variables in Psychotherapy Process and Outcome*, in HANDBOOK OF PSYCHOTHERAPY, *supra* note 109, at 280-81; David E. Orlinsky & Kenneth I. Howard, *Process and Outcome in Psychotherapy*, in HANDBOOK OF PSYCHOTHERAPY, *supra* note 109, at 311.

113. NORMAN COUSINS, *HEALTH FIRST: THE BIOLOGY OF HOPE AND THE HEALING POWER OF THE HUMAN SPIRIT* (1990); Appelbaum & Gutheil, *supra* note 88, at 341; *see also* Stephen A. Eraker & Pam Polistser, *How Decisions are Reached: Physician & Patient*, 97 ANNALS INTERNAL MED. 262 (1982); Hughes & Larson, *supra* note 77, at 302; Edward J. Speedling & David N. Rose, *Building an Effective Doctor-Patient Relationship: From Patient Satisfaction to Patient Participation*, 21 SOC. SCI. MED. 115 (1985). A 1983 longitudinal study demonstrated a relationship between patients' sense of personal control over their health, fostered by the doctor-patient relationship that encouraged patient participation, that correlated with positive treatment outcomes. Melvin Seeman & Teresa E. Seeman, *Health Behavior and Personal Autonomy: A Longitudinal Study of the Sense of Control in Illness*, 24 J. HEALTH & SOC. BEHAV. 144, 144 (1983). Patients

Legal rules that broadly authorize coercive treatment will shape the therapist-patient relationship quite differently from those that generally require voluntary and informed consent. Legal rules requiring voluntariness will inevitably increase the likelihood that therapists will respect the dignity and autonomy of their patients, and recognize their essential role in the therapeutic process. Legal rules emphasizing voluntariness compared to those that broadly authorize coercion can reshape the therapists' role so as to increase the potential for a true therapeutic alliance in which therapists treat their patients as persons.¹¹⁴ The result can be more patient trust, confidence, and participation in decision making in ways that can cause patients to internalize treatment goals. A therapeutic relationship that stresses voluntariness—one in which the patient sees the therapist as his agent, assisting him to accomplish goals that the two of them define—rather than as a paternalistic director of the process or as the agent of the institution in which the patient is held—is more likely to create the atmosphere of trust and openness that is necessary for the therapeutic relationship to bring about healing and change.

A legal system in which the therapist needs the informed and voluntary consent of the patient is thus more conducive to allowing the relationship itself to realize its potential as a therapeutic agent. An informed consent requirement, by encouraging a therapist-patient dialogue, can create a significant therapeutic opportunity. Discussion and negotiation about a patient's objections to treatment can provide an important context for probing conscious and unconscious resistance, for forming a positive transference, and for earning the patient's trust and confidence.¹¹⁵

These considerations favoring therapeutic relationships based on voluntariness rather than coercion obviously have special force in the context of verbal psychotherapy.¹¹⁶ They also seem applicable, however, in the context of behavior therapy, many of the techniques of which, in order to succeed, require patient cooperation and involvement as well as trust and confidence in the therapist.¹¹⁷ Moreover, although to a considerably lesser extent, these considerations may apply as well even in the context of administration of psychotropic medication.¹¹⁸ Choosing the appropriate medication, for example, and maximizing the potential that it will be used appropriately, will often require communication with the patient and a high degree of cooperation.¹¹⁹ In addition, psychotropic drugs are not administered in isolation, but are part of an integrated treatment program that involves verbal psychotherapy as well as psychosocial therapy approaches. Even if psychotropic medication would be effective in reducing severe symptomatology when administered coercively,

with "a low sense of control [are] significantly associated with (1) less self-initiated preventive care; (2) less optimism concerning the efficacy of early treatment; (3) poorer self-rated health; and (4) more illness episodes, more bed confinement and greater dependence upon the physician." *Id.* at 152.

114. PAUL RAMSEY, *THE PATIENT AS PERSON: EXPLORATIONS IN MEDICAL ETHICS* (1970).

115. WINICK, *supra* note 3, at 85-88.

116. *See* WINICK, *supra* note 14, at 29-40 (discussing psychotherapy).

117. *See id.* at 41-59 (discussing behavior therapy).

118. *See id.* at 61-85 (discussing psychotropic medication).

119. Appelbaum & Gutheil, *supra* note 88, at 341.

the verbal therapy that should follow the reduction in symptoms would seem to be more effective to the extent that the individual chooses it voluntarily. Whatever the treatment approach, therefore, allowing the patient to exercise choice will predictably enrich and improve the quality of the treatment decision-making process and the treatment program.¹²⁰ Successful treatment planning and implementation require a thorough analysis of the patient's problems, of the social context that often perpetuates them, and of the patient's strengths and weaknesses. Patient trust, cooperation, and full and open communication are essential if the therapist is to obtain this information from the patient.

For several reasons, therefore, involuntary hospitalization and coercively imposed treatment may have antitherapeutic effects. Voluntary approaches in general would seem more conducive to long-range treatment success and to greater patient satisfaction. Although empirical investigation is needed to further explore the relationship between coercion and treatment outcome, a considerable body of theoretical work supports much clinical experience suggesting that coercion does not work as well as treatment undertaken voluntarily.

VIII. APPLYING THE LAW THERAPEUTICALLY IN COERCIVE CONTEXTS

Although there undoubtedly are situations in which a degree of coercion is both therapeutically appropriate and legally acceptable, clinicians should use coercion sparingly and involve the patient in the decision-making process to the fullest extent possible. Even when coercion is necessary, clinicians should seek to apply it in ways that minimize the patient's perception of coercion. In this respect, the research on coercion performed under the auspices of the MacArthur Research Network for Mental Health and the Law described earlier has special significance.¹²¹

Although empirical research has not as yet extensively probed the relationship between the perception of coercion and treatment outcome, the theoretical analysis contained in this article strongly suggests that patients who feel coerced do not respond as well as those who do not feel coerced. Therefore, clinicians who find it necessary to impose treatment coercively should heed the admonitions of the MacArthur research and interact with their patients in ways that minimize patients' subjective perceptions of coercion even though, in an objective sense, coercion is being applied. The MacArthur research suggests that positive approaches such as persuasion be used as a strategy of choice to attempt to convince people to accept treatment.¹²² Negative approaches such as threats should be used "only as a last resort to secure needed care."¹²³ Furthermore, in all circumstances (but especially when negative pressure has been used), patients should be given a sense of inclusion in the

120. See COUSINS, *supra* note 113, at 55 ("[F]ull communication between the patient and physician is indispensable not just in arriving at an accurate diagnosis but in devising an effective strategy for treatment."); JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 102-03 (1984) (analyzing the informed consent doctrine as furthering the doctor-patient relationship).

121. See *supra* Part VI.

122. A NEW FRONTIER, *supra* note 4, at 26.

123. *Id.*

hospital admission and treatment decision making processes and afforded as much process—"voice" and "validation"—as possible.¹²⁴ Clinicians should convey to their patients the notion that they are acting out of concern for their well-being. They should treat their patients fairly, with respect and without deception, give them an opportunity to tell their side of the story, and seriously consider their views in the hospitalization and treatment decision-making processes.¹²⁵ Clinicians finding it necessary to impose treatment coercively who heed these admonitions can thereby minimize the risk that coercion will have antitherapeutic effects.

IX. CONCLUSION

Coercion may sometimes be necessary, particularly in the treatment of severely ill patients. However, in light of the potential antitherapeutic consequences of coercion, clinicians should resort to it only when truly necessary and should involve the patient in the hospital admission and treatment decision-making processes to the greatest extent possible. As soon as coerced treatment has had the hoped-for effects, the clinician should cede to the patient increasing measures of treatment decision-making autonomy. Whenever possible, clinicians should use persuasion, education, negotiation, and inducement in preference to coercion, threats, negative pressure, and deception. Even when coercion is deemed necessary, clinicians should act toward their patients in ways that minimize the perception of coercion and maximize the patient's sense of voice and inclusion and the patient's appreciation that the treatment imposed is benevolently motivated and administered in good faith.

While more research is needed on the issue of the effectiveness of coercive treatment, we know enough to reshape clinical practice in the imposition of involuntary hospitalization and treatment to reduce coercion's antitherapeutic consequences. In defining "coercion" for legal purposes, and in specifying the procedural due process protections that must be accorded before coercion may be applied, the law also should take these findings into account. The civil commitment hearing and hearings relating to involuntary treatment, for example, should be reshaped to foster patient perceptions that involuntary hospitalization or treatment is being proposed by clinicians for benevolent reasons and to provide the patient with a sense of "voice" and participation.¹²⁶ Involuntary hospitalization and treatment can be structured and implemented in ways that permit many patients to "feel like they have voice and validation" and to "avoid force even in the absence of choice."¹²⁷ Even when hearings may not be required as a matter of procedural due process, there may be therapeutic value in providing them as a means of increasing patient perception of choice and participation in treatment decision making, with likely positive therapeutic effect.¹²⁸ "The challenge is to try to extend to all patients at the

124. *Id.* at 27.

125. *Id.*

126. See Tyler, *supra* note 77.

127. Hiday et al., *supra* note 8, at 235.

128. See *Marshall v. Jerrico, Inc.*, 446 U.S. 238, 242 (1980) (stating that one of "the central

time of their admission [or involuntary treatment] a demonstration in word and action that they are persons with opinions, desires, rights and dignity, and not just mental patients in an acute crisis."¹²⁹ Even when a hearing seems pointless because the criteria for involuntary hospitalization or treatment seem clearly met, the process values of providing patients with "voice", and their likely impact on therapeutic response, alone argue for affording the patient a hearing.¹³⁰

Apart from legal rules governing coercion and the application of coercive treatment and hospitalization, the codes of professional ethics of clinicians engaging in the treatment process should also reflect these insights. Because such professional ethics are based on principles of beneficence and nonmaleficence,¹³¹ clinicians should recognize that the way they act in applying the authority that the law may give them has an inevitable impact on the health and welfare of their patients and the clinical professions should develop appropriate guidelines in this area.

Legal rules governing coercion should protect individual autonomy regarding matters that vitally affect the individual, including health care decision making. Individual autonomy is at the root of our political and philosophical traditions,¹³² but in addition, the psychological value of self-determination should help to shape law and policy in this area.¹³³ Although autonomy and therapeutic values may at times conflict, they often will converge. To achieve the full promise of individual autonomy, legal rules and clinical practices relating to involuntary hospitalization and coercive mental health treatment thus should reflect a therapeutic jurisprudence orientation.

concerns of procedural due process" is "the promotion of participation and dialogue by two affected individuals in the decision making process"); *Codd v. Velger*, 429 U.S. 624, 636 (1977) (Stevens, J., dissenting); *Goldberg v. Kelly*, 397 U.S. 254, 264-65 (1970); JERRY L. MASHAW, *DUE PROCESS IN THE ADMINISTRATIVE STATE* 177-80 (1985) (discussing "the claim that the dignity and self-respect of the individual can be protected only through processes of government in which there is meaningful participation by affected interests"); John J. Ensminger & Thomas D. Liguori, *The Therapeutic Significance of the Civil Commitment Hearing: An Unexplored Potential*, 6 J. PSYCHIATRY & L. 5 (1978).

129. Hiday et al., *supra* note 8, at 225.

130. See Tyler, *supra* note 77 (discussing the therapeutic value of civil commitment hearings); Jack Susman, *Resolving Hospital Conflicts: A Study on Therapeutic Jurisprudence*, 22 J. PSYCHIATRY & L. 107 (1994). Even when the result of the hearing does not appear to reflect what the individual had to say, the opportunity for voice alone may have therapeutic value. See Tyler, *supra* note 77, at 440 & nn.64-65.

131. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 106 (3d ed. 1989); TOM L. BEAUCHAMP & LEROY WALTERS, *CONTEMPORARY ISSUES IN BIOETHICS* 28 (2d ed. 1982); RUTH FADEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* 10 (1986); WINICK, *supra* note 14, at 400.

132. Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1705, 1707-55 (1992).

133. See *id.* at 1755-68.