Treatment Delayed is Treatment Denied

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The past few decades have witnessed the steady development of a mental health jurisprudence dedicated to the preservation of human rights. Self-determination and personal autonomy are critical aspects of this perspective, pervading every facet of institutional psychiatric care. Of considerable concern, however, are those cases in which rote procedural approaches produce unintended consequences for the very persons such maneuvers were designed to protect. Delays—inherent in court-based procedures—may ironically lead to an acute illness becoming chronic, and to a single bout of inpatient services being transformed into a lifetime of revolving-door psychiatric admissions. This discussion is not about lawyers or lawyering; rather, it is about the proposition that a better system can and should be devised for advocates who must make do with the options they are dealt. A particularly problematic example is the "Rogers Guardianship" model currently prevalent in Massachusetts. Laws that effectively place on counsel and courts the challenge of second-guessing medical treatment decisions—with minimal latitude for counsel to exercise measured professional judgment—will inevitably generate, and empirically do generate, a degree of delay that ironically deprives patients of the liberation from illness that is the common goal of all stakeholders. Possible solutions to these difficulties are also suggested.

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The majority of people with mental illness do not engage in criminal violence. However, those with serious mental illness do have a higher risk of engaging in violence when compared with the average person in the community.[1–5] Among the minority of mentally ill persons who are, in fact, dangerous, many cannot recognize that they are ill and have no insight into the effects of that illness. As a consequence of this "anosognosia," they do not recognize any need for hospitalization or other treatment,[6] thus reducing treatment adherence and increasing the prospect of violent behavior. Every jurisdiction thus provides a legal mechanism by which a physician, judge, or both can arrange involuntary confinement (commitment) to a treatment setting for dangerous patients so that they can be treated safely and then discharged back into the community as expeditiously as feasible.

While many dangerous persons are not mentally ill, involuntary commitment is based on dangerousness as the result of mental illness. Without specific evidence-based treatment, that patient, if unchanged, must remain in a locked hospital with little hope of progressing to discharge.[7] Without treatment, commitment ultimately turns the hospital into a jailhouse or warehouse for patients with severe mental illness, denying them freedom to make other life choices due to their inability to recover from their afflictions. Moreover, because the data show that judges by and large favor the opinion of the treating physician, continuing, postponing, and rescheduling hearings only delay treatment rather than granting the patient the right to refuse it. In a study by Schouten and Gutheil of more than 2,000 "Rogers" petitions, Massachusetts judges granted these psychiatrist-submitted involuntary civil commitment requests 99.1 percent of the time, thus rendering involuntary treatment delays worthwhile in less than one percent of all cases.[8] Due-process medication hearings do not necessarily cause harm to patients; however, delays in the process do.

Research has also identified unintended negative consequences for rights-driven commitment models as opposed to commitment models that emphasize

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physician decision-making. Kasper *et al.*[9] determined that patients involuntarily treated under Massachusetts' Rogers scheme fared worse than those involuntarily committed in Virginia, where psychiatrists had at their disposal more streamlined options for overriding a lack of consent under circumstances in which serious mental deterioration may occur. These researchers compared their patient population to that of another study done by Hoge *et al.*[10] studying a Massachusetts population. Both groups found that patients in both Massachusetts and Virginia who refused treatment were sicker than those who voluntarily accepted treatment, and the Kasper *et al.* group found that those who were involuntarily committed in Virginia had shorter delays to treatment and shorter hospitalizations than their counterparts in Massachusetts.[9,10] The Virginia group also found that involuntarily committed Virginia patients had better outcomes than those committed voluntarily, and noted many instances in which physicians who had the authority to override treatment refusal were careful about attempting to gain valid consent from patients or their authorized representatives.[9,10]

Separating confinement from cure is another way medication hearings delay much-needed care and speedy recovery. This separation has little logical or clinical basis because the commitment is principally conceptualized and enforced as a mechanism to deliver treatment in a safe setting. Two classic cases capture this point. *Stensvad v. Reivitz*[11] contains the phrase, "Nonconsensual treatment is what commitment is all about" (p. 131). Similarly, *AE v. Mitchell*[12] treats the commitment decision as authorizing involuntary treatment. The model commitment statute proposed by Stromberg and Stone[13] supports similar reasoning. In sum, courts and scholars have accepted the manner in which involuntary commitment and involuntary treatment are logically consistent as well as complementary notions.

Modern psychiatry's appropriate consensus is to empower patients to be autonomous and to achieve the highest quality of life they can, despite their vulnerability to the effects of stigmatization. As we will demonstrate, the goal of the antipsychotic medication hearing was to protect the right of mentally ill persons to make choices about their treatment, but in practice the delay in treatment created by legal maneuvering during commitment periods is itself inconsistent with this goal. Our analysis will demonstrate that treatment delayed via adversarial legal procedures may constitute treatment denied, at significant costs to patients, to hospitals, and to the community as a whole.

The History of the *Rogers* Procedure

The Massachusetts legislature declared in 1970 that mere admission to a psychiatric hospital is not, in itself, tantamount to a finding of incompetence.[18] We accept the principle that a specific finding of incompetence is a necessary predicate for treatment over objection, both legally and ethically. Within that framework, however, procedures for making the competence determination can be designed in many different ways. Unfortunately, the cumbersome procedures in Massachusetts were created in a complicated series of judicial decisions during litigation initiated in 1975, which passed through several Massachusetts state and federal courts over eight years. Beginning as *Rogers v. Okin,* the final version in 1983 was captioned *Rogers v. Commissioner.*[14–17] The case holding, extensively analyzed elsewhere, constituted significant departures from both *Stensvad* and *AE and RR* noted above.[11,12] The primary implications can be summarized as follows:

> Unlike all other medications, antipsychotic medications alone cannot be authorized by guardians.
>
> Guardians are no longer substitute decision-makers for incompetent patients, but are monitors of the patient's possible return to competence.
>
> Only judges can decide whether involuntary medication can be given to the incompetent patient; only in emergencies can treatment be given directly.
>
> The judge's decision occurs in the context of a) a finding of incompetence and b) an adversarial hearing identifying a list of approved medications. This last provision in particular has served as the occasion for critical delaying factors.

An additional dimension of *Rogers* was the provision that, rather than using a best-interests model, the judge should use substituted judgment in the vicarious treatment decision. Substituted-judgment principles, in contrast to best-interests principles, seek to identify what a given individual incompetent patient would want if he or she were competent. This approach can be

applied for medical or surgical procedures. However, in the present context, a paradox is created: if the incompetency stems from a mental illness that requires medication, the patient, if competent (and no longer manifesting characteristic anosognosia), would no longer be ill and would presumably not need the medication. Taking this paradox literally, no patient could ever be treated involuntarily despite the need.[19]

Contemporary rulings at the time of *Rogers* were by no means uniformly dismissive of physician's decision-making role with respect to compulsory institutional services. In *Youngberg v. Romeo*,[20] the Supreme Court of the United States held that "in determining what is 'reasonable' . . . we emphasize that courts must show deference to the judgment exercised by a qualified professional" (p. 322). In *Rennie v. Klein*,[21] the Federal District Court of New Jersey noted that "appropriate deference would be given to a decision by an independent psychiatrist to allow a hospital to forcibly medicate an involuntary patient" (p. 1312).

Clinical Implications of Delayed Treatment

A steadily growing body of literature shows that delaying treatment in persons with acute mental illness may lead to a host of negative consequences.[22,23] When treatment is delayed for acute episodes of mental illness, several problems arise, including the increased use of coercive methods in treatment, higher medical comorbidity, increased systemic costs, and the development of refractory mental illnesses with poorer prognoses in the long run. In the situation where a hospital has been unable for months at a time to get a Rogers treatment plan in place because of systemic legal delays, the typical sequelae of acute and untreated psychosis or mania result in one crisis after another.

Untreated mental illness leads to more agitated behavior and greater risk of suicide attempts, and, in response, often to more seclusion and restraints. For example, schizophrenia is associated with increased violence when complicated by treatment noncompliance.[23] Violent incidents tend to occur as a result of acute and untreated symptoms such as persecutory delusions, where patients, convinced that others are conspiring against them, act in perceived self-defense.[24] In an untreated state, such patients place themselves, as well as others in close proximity, in danger. Hospital staffs are placed in the precarious position of waiting for an emergency, as defined by the law, to medicate the patient forcibly, instead of creating a well-planned collaborative approach to treating agitation.

The stop-and-start nature of the haphazard treatment employed in emergent situations, also described as "one punch, one shot" in clinical literature,[19] is not only stressful for staff; it is also risky for the patient and for others receiving treatment in the same facility. Despite their protective effects, seclusion and restraints can traumatize individuals and have a negative impact on the care and treatment of those who are mentally ill.[24] Legal delays in getting the Rogers treatment plan in place often increase the need for seclusion and restraints and have negative effects on the hospital milieu,[9,10] because hospital staff can only manage patients with medications in an emergency situation. Moreover, once the patient settles after the emergency restraint and medication, they are left to struggle quietly in a disturbed mental state without regular maintenance dosing of antipsychotic medication, which is how these medications are meant to be administered. In a cyclical manner, staff are forced to await the next dangerous eruption of the minimally treated psychotic episode to give the patient potentially life-saving medications that are effective on a regular schedule; instead, staff in essence are waiting for the "one punch" to give "one shot" of medication.

While the sequelae of dangerous behaviors are a short-term risk in a delayed Roger's hearing, there are also problematic long-term risks. Studies reveal a poor prognosis for patients whose treatment is delayed during the early stages of a psychotic episode. These individuals have a higher risk of suicide and serious violence as well as more severe impairments in daily function, cognition, and understanding of social cues. Evidence from multiple meta-analyses of clinical trials shows that the longer patients with schizophrenia wait to be treated, the poorer their response to antipsychotic medication and the more severe their mood and cognitive symptoms. In addition, their relapses and hospitalizations increase, as does their risk of suicide.[22,25] Increasing clinical evidence also reveals that affective disorders like depressive and bipolar disorders have poorer outcomes when left untreated, including a worse response to pharmacological treatment, relapse, chronicity, and higher rates of suicide and medical comorbidities.[25–27]

While it remains inconclusive whether the psychotic state damages brain structures,[28,29] there is a consistent correlation between long delays to treat-

ment and poor outcomes.[30] Longer durations of untreated psychosis have been associated with significantly lower IQ scores. One study looked at 82 chronically psychotic patients and found lower scores in 9 of 11 subtests of the Wechsler Adult Intelligence Scale (WAIS), including the weighted total score, IQ-verbal score, IQ-performance score and the IQ total score.[38] Another study looked at 786 files of subjects with early psychosis and a history of offending behaviors in Melbourne, Australia. This study found that a history of offending behavior was linked with a longer duration of untreated illness and was not only an independent variable but a baseline characteristic of this population with offending histories.[31] In the case of the Rogers hearing, which can add weeks to months of delay between hospital admission and treatment, research indicates that these patients are likely becoming irreversibly sicker.

On the other hand, early social interventions and treatment with medications have shown a reduction in both symptom severity and symptom chronicity in schizophrenia[32] indicating that intervention is a necessary component in achieving remission. A large study published in the *American Journal of Psychiatry* in 2005 reported that a shorter duration of untreated psychosis had a more robust response to antipsychotic medication.[31] Thus, the longer one waits before receiving medication, the greater the possibility that the medication will not be as effective in treating symptoms.

Other studies confirm that untreated bipolar disorder and depression can have a negative impact on prognosis and treatment response. In one study, bipolar patients with longer duration of untreated illness displayed a higher frequency of suicide attempts, a higher number of suicide attempters than those who were treated sooner, and a longer duration of illness.[33] The study recommended early pharmacological interventions with mood stabilizers. Another study looked at the impact of not treating bipolar disorder in the Brazilian population and found that longer durations of untreated bipolar disorder resulted in elevated rates of rapidly cycling moods, increased anxiety disorders, and lower rates of full remission.[34] A study looking at patients with untreated depression noted that those who were treated earlier had significantly higher odds of responding to treatment, a faster course toward remission, and less depression-related disability.[35]

There is a persistent disparity in mortality between those with and without mental illness. Those with mental illness have an increased mortality and lifetime disability,[36] and those with chronic psychosis have a life expectancy decrease of 22.5 years.[37] This has been attributed, in part, to the overprotection of the patient's right to refuse treatment without a proper assessment of that refusal. A recent series of articles in the *New England Journal of Medicine* describes the complexity medical professionals face in distinguishing rational thought from delusional belief in the context of treatment refusal. Within that complexity, decisions to override patient refusals can be ethically and legally challenging due to the difficulty inherent in enforcing treatment, leading doctors to accede to a mentally ill person's non-adherence to life-extending care. Such non-adherence in the context of both chronic and acute illness eventually leads to gross discrepancies in life expectancy for persons with mental illness.[38,39,40]

Given this disparity, it becomes apparent that legal avenues to address capacity for those with mental illness should be efficient and responsive. However, a single law cannot address the entire problem. Similar to the way in which overuse of potent broad-spectrum antibiotics to treat infections that only required a specific antibiotic causes treatment-resistant "superbugs,"[41] an overzealous broad-spectrum legal approach to protecting patient choices made against medical advice can create treatment-resistant mental illness. Such "critogenic harms" (harms resulting from the normal process of law) reflect the fact that "the law can effect significant social change and protection of rights that may be therapeutic even at the individual level—but it is a blunt instrument."[42]

Superimposed on the financially strapped institutions where the hearings may be held, the economic burden of the Rogers procedure on the state system is striking. Because each Rogers hearing requires at least two attorneys, a judge, and a reporter, in addition to other court officials and independent medical examiners, significant administrative costs are involved, none of which goes to the direct treatment of the patient in often underfunded institutions. These costs are incurred in attorney hours, particularly on contested cases, and in physician hours on preparing affidavits, talking with attorneys, and testifying on the stand. Additionally, there is a high cost to paralegals who extensively prepare the filed guardianship petition for court as well as the cost in judges, security

officers, clerks, and independent experts all consigned to countless hours of preparing and executing these hearings.[8]

The Lawyer's Dilemma

Perhaps nowhere within the broad ambit of legal representation—both civil and criminal—is counsel's role more conflicted and confusing than in that associated with the *Rogers* guardianship. Taken at face value, counsel's obligation is to pursue the client's expressed wishes and to do so consistently with the time-honored obligation of "zealous advocacy."[43] What is counsel to make, however, of situations in which persons voicing their wishes are so mentally compromised as to be determined dangerous, too incompetent to understand why they need psychiatric hospitalization, and likely to be detained for a prolonged period of time?

If counsel personally forms what is essentially a lay opinion, albeit one informed by years of relevant experience, that the treatment for which confinement was intended is actually necessary for the client's well-being and possibly the client's ultimate release, should the fervency of counsel's arguments be tempered as a result? Or rather, should counsel oppose the doctor's recommendations all the more forcefully, perhaps as a tacit admission that a broader legal principle rather than the client's wishes is actually the focus? What occurs here is a separate form of substituted judgment that in effect substitutes the lawyer's judgment for that of the doctor in what are often highly specialized medical issues.

Paradoxically, the more fervently the lawyer argues for avoiding treatment during the commitment, the longer the client will likely remain confined in the hospital due to untreated mental illness. The criminal practitioner, except in those situations in which dangerousness is the court's primary concern, learns early to brandish the client's mental impairment as a basis for incompetency to stand trial, mitigation, or an outright finding of insanity (and thus acquittal). This makes for an uneasy transition when attorneys who were trained to argue illness in the past must now argue against perceived impairments by the patient in decision-making and a finding of competence.

The zealous advocacy touted as the litigator's professional aspiration might better be characterized as appropriate advocacy in cases where the client's best options are unclear and the capacity for personal decision-making is impaired or even non-existent. This is anticipated by the American Bar Association's *Model Rules of Professional Conduct*, which addresses what occurs when "a client's capacity to make adequately considered decisions in connection with a representation is diminished."[44] We propose that it is here, in the context of Rogers procedures, as the lawyer's role, and not just the traditional label, counselor could most appropriately be invoked. Patients here find themselves transformed into legal clients[45] by what is essentially an outgrowth of decades-old appellate history.

The counselor role is touted in other contexts as well. For instance, the American Bar Association's *Standards of Practice for Lawyers Who Represent Children in Abuse and Neglect Cases*[46] asserts that "the lawyer's advice and guidance can often persuade the child to change an imprudent position or to identify alternative choices if the child's first choice is denied by the court"[46]; the American Bar Association's *Standards of Practice for Lawyers Who Represent Children in Custody Cases*[47] similarly encourages counsel to recognize that "a child's therapist may help the child to understand why an expressed position is dangerous, foolish, or not in the child's best interests."[47] We propose that similar reasoning would be highly relevant to the Rogers context.

Conclusion

Massachusetts communities are fervently searching for answers on how to fix their broken mental health system, as reflected in a six-part series recently published in the *Boston Globe*.[48] Investigative reporters chronicled the aftermath of 50 years of deinstitutionalization of the mentally ill, questioning at every turn why it is so difficult to obtain treatment for persons suffering from psychiatric illness.

One obvious remedy, as described by this analysis, is to rethink and revise the current Rogers procedures, where protracted legal arguments and consequently postponed psychiatric care create a process fraught with delays to appropriate treatment. These legal delays create a dangerous environment for all the patients in the psychiatric facility. Not only is the doctor–patient relationship sometimes ruptured in the adversarial system, but patients refusing treatment are also at greater risk of harming themselves and others, of being forced into coercive treatment, and more likely to suffer a poorer prognosis in recovery.[49] In a system where it is difficult enough for

caregivers and communities to address mental illness, the legal procedures often needlessly sideline the patient's medical team due to what is often little more than formulaic skirmishing.

The debacle of *Rogers* is solvable. However, it has gone virtually unaddressed for decades, particularly because it is professionally daunting and may seem ethically suspect to review a law that was meant to protect the freedom of choice in a vulnerable population. Yet we must reconsider the ultimate utility and appropriateness of adversarial legal proceedings as the avenue for every potential instance of substituted judgment, with psychiatrists compelled to testify and undergo cross-examination during contested hearings in the patient's presence. In the meantime, patients are unclear, confused, or too sick to know what they are refusing and why they are refusing it. This surreal process has no parallel in other areas of medical care. When gratuitously applied—often without any urging on the patient's part at all—these hearings may irreparably harm the therapeutic alliance between the patient and doctor, making future treatment a needless war of wills rather than a partnership in healing.

As promulgated by the American Medical Association, *The Principles of Medical Ethics*[50] specifies that physicians "shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient." Psychiatrists are obligated to question the Rogers procedures from a patient-centered perspective, educating lawmakers and the public alike on the medical toll taken by the system given the data and evidence known today. Patients who reject treatment on the basis of disorganized or paranoid thought processes and impaired insight and judgment ironically live without freedom and in confinement. Unable to get the health care they need and deserve, they merely sit in a locked setting. A recent article, "The Treatment of Mental Illness is a Human Right," highlights that special populations remanded to jail or prison incarceration have a constitutional right to mental health care. The author indicates that delays to "meaningful and effective" treatment are considered cruel and unusual punishment; legal delays to accessing proper treatment may also be subjected to such scrutiny.[51] Some remedies to address delays might include special appointment and training of "medical judges," sophisticated in the nature of psychotropic medications; acceleration of the process for inpatients; mediation outside of the court setting with both doctors and lawyers; use of video conferencing in the courtroom to help remote parties be available for earlier hearings; and use of administrative law procedures and settings that might be able to act more promptly. All stakeholders stand to benefit from such changes.

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