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ESSAY

Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research*

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I. INTRODUCTION

Mental health law, which originated only about twenty years ago,[1] has reached a turning point. Born in the aftermath of the civil rights movement, and seizing the momentum of the criminal procedure and prisoners' rights revolution, the field was built on a constitutional foundation that grew out of concern for protecting the rights of patients. But that constitutional foundation is now crumbling, and as

* Copyright 1991 by David B. Wexler and Bruce J. Winick. This essay is a revised version of a chapter in D. WEXLER & B. WINICK, ESSAYS IN THERAPEUTIC JURISPRUDENCE (1991).

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1. *See* B. ENNIS, PRISONERS OF PSYCHIATRY (1972); *see also* Brooks & Winick, *Foreword: Mental Disability Law Comes of Age*, 39 RUTGERS L. REV. 235, 235 (1987).

a result mental health law seems to have lost its driving force and much of its lustre.

Bruce Ennis, appropriately described as the founder of the mental health bar,[2] set the stage for advocacy and scholarship in a 1971 article which argued that "if persons are involuntarily to be confined because of mental illness, the standards and procedures for confinement should guarantee no fewer rights than those afforded criminal defendants."[3] While early case law seemed to embrace this premise,[4] the attraction soon wore off.[5] Indeed, even in the heyday of mental health law, the courts rarely accorded mental patients the full-blown rights accorded to criminal defendants.[6] In any event, the criminal procedure revolution has now surely been quelled,[7] leading to a concomitant calm in the evolution of mental health law.[8] A new perspective is needed to rejuvenate the area and to infuse it with aca-

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2. R. ISAAC & V. ARMAT, MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL 109 (1990).

3. Ennis, *Civil Liberties and Mental Illness*, 7 CRIM. L. BULL. 101, 108 (1971). The article's publication in the Criminal Law Bulletin is in itself a significant statement regarding the original relationship between mental health law and the criminal law field.

4. *See, e.g.*, Jackson v. Indiana, 406 U.S. 715 (1972) (recognizing equal protection and substantive due process rights for defendants committed as incompetent to stand trial); Baxtrom v. Herold, 383 U.S. 107 (1966) (recognizing equal protection rights of mentally ill prisoners at expiration of prison term to receive due process commitment hearings normally accorded civil patients); Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972) (concerning procedural and substantive due process requirements for civil commitment), *vacated on other grounds*, 414 U.S. 473 (1974); Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala.) (requiring minimum due process standards for mental institutions).

5. *See, e.g.*, Parham v. J.R., 442 U.S. 584 (1979) (holding informal clinical determination sufficient as matter of due process for institutionalization of minor child being committed by parent); Addington v. Texas, 441 U.S. 418 (1979) (rejecting beyond a reasonable doubt standard of proof for civil commitment in favor of clear and convincing evidence standard); O'Connor v. Donaldson, 422 U.S. 563 (1975) (avoiding decision on whether institutionalized patients have a constitutional right to treatment).

6. *See, e.g.*, R. REISNER & C. SLOBOGIN, LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 702, 712, 723 (2d ed. 1990) (discussing whether rights to counsel, jury trial, and probable cause hearings apply in civil commitment context).

7. *See, e.g.*, Arizona v. Fulminante, 111 S. Ct. 1246 (1991) (applying harmless error doctrine to coerced confessions). One sign of the decline is the growing attempt to base constitutional claims on *state* constitutional provisions. *See* Brennan, *State Constitutions and the Protection of Individual Rights*, 90 HARV. L. REV. 489 (1977) (discussing constitutional criminal procedure issues). The call for relying on state constitutions has been made in the mental health law area as well. Meisel, *The Rights of the Mentally Ill Under State Constitutions*, 45 LAW & CONTEMP. PROBS. 7 (1982); Perlin, *State Constitutions and Statutes as Sources of Rights for the Mentally Disabled: The Last Frontier?*, 20 LOY. L.A.L. REV. 1249 (1987).

8. *See, e.g.*, Washington v. Harper, 494 U.S. 210 (1990) (rejecting prisoner's assertion of right to refuse antipsychotic medication); Jones v. United States, 463 U.S. 354 (1983) (permitting indefinite confinement of insanity acquittees).

demic appeal. The time has come to conceptualize new approaches and research directions.

This Essay seeks to stimulate discussion about the future of mental health law, and to offer a new approach. Our research interests have increasingly focused on what we have come to call therapeutic jurisprudence—the extent to which substantive rules, legal procedures, and the roles of lawyers and judges produce therapeutic or antitherapeutic consequences.[9] The purpose of the present essay is to describe what we mean by therapeutic jurisprudence and to explain how the therapeutic jurisprudence perspective can be used to identify a fresh set of research issues for law and mental health, and to develop the foundation for a second generation of law reform.

Therapeutic jurisprudence is interdisciplinary, empirical, and international in its orientation. It seeks to sensitize legal policy makers to a frequently ignored aspect of mental health law policy analysis—the therapeutic impact of legal rules and procedures—and to serve as a tool to frame a new and useful research agenda. Ironically, mental health law—one of the potentially most interdisciplinary of legal fields—has fallen considerably short of accomplishing its interdisciplinary potential. Not only has far too little empirical work been done in the field, but much of what has been done focused on ques-

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9. *See* D. WEXLER, THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT (1990); D. WEXLER & B. WINICK, ESSAYS IN THERAPEUTIC JURISPRUDENCE (1991). For other explicit applications of the therapeutic jurisprudence perspective, see Klotz, *Limiting the Psychotherapist-Patient Privilege: The Therapeutic Potential*, 27 CRIM. L. BULL. 416 (1991); Schopp, *The Psychotherapist's Duty to Protect the Public: The Appropriate Standard and the Foundation in Legal Theory and Empirical Premises*, 70 NEB. L. REV. 327 (1991); Schopp & Wexler, *Shooting Yourself in the Foot with Due Care: Psychotherapists and Crystallized Standards of Tort Liability*, 17 J. PSYCHIATRY & L. 163 (1989); Wexler, *Health Care Compliance Principles and the Insanity Acquittee Conditional Release Process*, 27 CRIM. L. BULL. 18 (1991) [hereinafter Wexler, *Health Care Compliance*]; Wexler, *Inducing Therapeutic Compliance Through the Criminal Law*, 14 LAW & PSYCHOLOGY REV. 43 (1990) [hereinafter Wexler, *Inducing Therapeutic Compliance*]; Wexler, *Insanity Issues After* Hinckley*: Time for a Change*, 35 CONTEMP. PSYCHOLOGY 1068 (1990); Wexler, *Training in Law and Behavioral Sciences: Issues from a Legal Educator's Perspective*, 8 BEHAV. SCI. & L. 197 (1990); Wexler & Schopp, *How and When to Correct for Juror Hindsight Bias in Mental Health Malpractice Litigation: Some Preliminary Observations*, 7 BEHAV. SCI. & L. 485 (1989); Wexler & Schopp, *Therapeutic Jurisprudence: A New Approach to Mental Health Law*, in HANDBOOK OF PSYCHOLOGY AND LAW (D. Kagehiro & W. Laufer eds.) (forthcoming); Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection*, 28 HOUS. L. REV. 15 (1991) [hereinafter Winick, *Competency to Consent to Treatment*]; Winick, *Competency to Consent to Voluntary Hospitalization: A Therapeutic Jurisprudence Analysis of* Zinermon v. Burch, 14 INT'L J.L. & PSYCHIATRY 169 (1991) [hereinafter Winick, *Competency to Consent to Voluntary Hospitalization*]; 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) [hereinafter Winick, *Wagering with the Government*].

tions that are not especially significant to legal decisionmakers. As a result, the impact of such research too often has been minimal.

One empirical question rarely asked concerns the therapeutic implications of various legal rules and practices. Is a particular legal rule, either presently in effect or proposed, therapeutic or antitherapeutic to patients (and perhaps to society as a whole)? Legal decisionmaking should consider not only economic factors, public safety, and the protection of patients' rights; it should also take into account the therapeutic implications of a rule and its alternatives. For example, the decision whether to abolish the legal insanity defense should turn, at least in part, on the therapeutic implications abolition would have on patients and on society as a whole. Similarly, the complex problem of whether to recognize a right to refuse treatment should turn, at least in part, on the therapeutic impact of the right. In addition, governmental policies in a variety of areas not as closely related to mental health law per se should take account of therapeutic impact in any rational decisionmaking process that assesses the effects of alternative legal approaches. It is natural that therapeutic jurisprudence initially focus on the core content areas of mental health law. It also, however, will have applications in forensic psychiatry, health law, and a variety of allied legal fields, including criminal law, juvenile law, and family law, and probably across the entire legal gamut.[10]

Let us, at the outset, emphasize that therapeutic jurisprudence does not embrace a vision of law, or even mental health law, as serving exclusively or primarily therapeutic ends. We do not call for a return to the "therapeutic state" or extol what Wexler once called "therapeutic justice."[11] The law serves many ends, and our suggestion that the impact of legal rules and practices on therapeutic values should be analyzed does not mean that therapeutic values should predominate others. Nor do we suggest that the law should assume a deferential posture toward clinical expertise. Many of the issues at the heart of mental health law are legal, not clinical, in nature.[12]

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10. Even in an area far removed from mental health law, the Supreme Court has indicated a willingness to consider therapeutic values. United Steelworkers v. American Mfg. Co., 363 U.S. 564, 568 (1960). The Supreme Court has even been described as having a therapeutic function, often serving as a non-directive psychotherapist. W. BISHIN & C. STONE, LAW, LANGUAGE, AND ETHICS 399-402 (1972). Professor Weckstein has asserted that the concept of justice embraces much more than truth, and that therapy might itself be a component of justice. Weckstein, *The Purposes of Dispute Resolution: Comparative Concepts of Justice*, 26 AM. BUS. L.J. 605, 608, 624 (1988). Although therapeutic jurisprudence probably ought to begin by focusing on on mental health law, it can obviously have implications and applications far beyond the mental health law area.

11. Wexler, *Therapeutic Justice*, 57 MINN. L. REV. 289, 291 (1972).

12. For example, what is considered a mental disorder for a variety of legal purposes,

Legal issues should not be permitted to masquerade as clinical ones; indeed, rather than deference, the law should adopt a healthy skepticism toward claims of clinical expertise. The several examples of therapeutic jurisprudence at work provided later in this essay should drive home the essential point that therapeutic jurisprudence is neither a surrogate for paternalism nor an excuse for coercion. Indeed, a therapeutic jurisprudence analysis often will provide support for civil-libertarian claims.

Legal judgments are often based on factual predicates that remain unexamined empirically and that might prove false. Some legal judgments disregard the potential impact they may have on therapeutic values. Our aim is to suggest that legal decisionmakers explicitly take account of this impact, that they become more sophisticated about and make better use of the insights and methods of the behavioral sciences, and that behavioral scientists audit law's success or failure in this regard.

We are sensitive to the potential criticism of therapeutic jurisprudence that has often been made of law and economics scholarship. By suggesting the need to identify the therapeutic and antitherapeutic consequences of legal rules and practices, we do not necessarily suggest that such rules and practices be recast to accomplish therapeutic ends or to avoid antitherapeutic results. Whether they should is, of course, a normative question that calls for a weighing of other potentially relevant normative values as well, such as patient autonomy, constitutional rights, and community safety.

Therapeutic jurisprudence simply seeks to focus attention on an often neglected ingredient in the calculus necessary for performing a sensible policy analysis of mental health law and practice—the therapeutic dimension—and to call for its systematic empirical examination. To identify this as a significant consideration is not intended to suggest that it trumps other considerations. The premise that a rule or practice is antitherapeutic, like the premise that a rule is inefficient, does not support the conclusion that the rule should be changed in the absence of a shared, although perhaps unarticulated, normative major premise.

Modern analytical philosophy has made us sophisticated about the function of language and the important differences between descriptive and normative propositions. One simply cannot reason from the "is" to the "ought" without implicitly embracing a norma-

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although partially a clinical question, is essentially a normative or legal issue. *See* Winick, *The Right to Refuse Mental Health Treatment: A First Amendment Perspective*, 44 U. MIAMI L. REV. 1, 46-53 (1989).

tive principle justifying the leap—at least not without committing what G. E. Moore termed the "naturalistic fallacy."[13]

We assume there is general agreement that, other things being equal, mental health law should be restructured to better accomplish therapeutic values. But whether other things are equal in a given context is often a matter of dispute. Although therapeutic jurisprudence seeks to illuminate the therapeutic implications of legal practices, it does not resolve this dispute, which requires analysis of the impact of alternative practices on other relevant values.

In addition to its usefulness in performing a policy analysis of legal rules and practices, therapeutic jurisprudence holds great potential as a new research tool for mental health law and related areas. Although this essay does not suggest a particular substantive research agenda, it seeks to show how such an agenda might be constructed. In what follows, we illustrate the potential contribution of therapeutic jurisprudence to research by describing some ongoing research efforts, suggesting some new avenues of research, and demonstrating how the academic and research community might use the therapeutic jurisprudence lens to identify novel research issues.

II. RESEARCH APPROACHES

Therapeutic jurisprudence research has both an empirical and a non-empirical dimension. The non-empirical aspect can be performed by legal academics who are comfortable working with mental health and behavioral science literature, and by behavioral scientists who are comfortable working with legal materials. Typically, the intellectual enterprise is to tease out the potential therapeutic and antitherapeutic implications of a legal rule and its alternatives. When there is a substantial literature available, this type of research basically relates a body of therapeutically relevant behavioral science to a body of law and explores the fit between the two. In the process, certain legal schemes and arrangements may stand out as comporting particularly well with therapeutic interests, while others may seem less satisfactory from a therapeutic viewpoint. If the therapeutically appropriate legal arrangements are not normatively objectionable on other grounds, those arrangements may point the way toward law reform.[14]

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13. G.E. MOORE, PRINCIPIA ETHICA 66 (1903).

14. For articles following this stylistic format, see Wexler, *Grave Disability and Family Therapy: The Therapeutic Potential of Civil Libertarian Commitment Codes*, 9 INT'L J.L. & PSYCHIATRY 39 (1986); Wexler, *Health Care Compliance*, *supra* note 9; Wexler, *Patients, Therapists, and Third Parties: The Victimological Virtues of* Tarasoff, 2 INT'L J.L. & PSYCHIATRY 1 (1979) [hereinafter Wexler, *Victimological Virtues*].

The empirical research domain is, of course, best inhabited by the behavioral scientist, although legal consultation typically will prove fruitful. Principally, the empirical task is to view the relevant law, rule, procedure, or legal role as an independent variable and to ascertain the therapeutic consequences that flow from alternative legal arrangements. Settling on appropriate measures of therapeutic outcome is an interesting and integral conceptual and methodological component of the overall task.

The situation presented in *Parham v. J.R.*[15] is illustrative. In *Parham*, the Court rejected an adversarial judicial hearing when parents seek to commit a minor child to a mental hospital.[16] Although Chief Justice Burger defended his judgment based on concerns that a hearing would burden the family relationship and be detrimental to the therapeutic goals of hospitalization, others have questioned these assumptions and suggested that there is therapeutic value in holding formal commitment hearings.[17] In order to resolve this controversy, the conflicting therapeutic consequences of such hearings must be identified and defined in ways that can be measured. Moreover, there must be general agreement on how to compare these consequences. It may be difficult to reach agreement on standards for conducting such a comparison of perhaps conflicting therapeutic consequences; this essentially involves the sharing of normative premises about which there may be no consensus. But research from the therapeutic jurisprudence perspective should at least allow the identification and empirical examination of a number of the factual premises that are central to the respective contentions.

An additional methodological question concerns the appropriate time frame to be considered when assessing therapeutic and antitherapeutic consequences. Transferring patients from a hospital or nursing home to the community, for example, may appear antitherapeutic if only the short-term impact (and accompanying "transfer trauma")[18] on patients is considered. When the assessment is made

15. 442 U.S. 584 (1979).

16. *Id.* at 610.

17. *See, e.g.*, Ensminger & Liguori, *The Therapeutic Significance of the Civil Commitment Hearing: An Unexplored Potential*, 6 J. PSYCHIATRY & L. 5 (1978); Perlin, *An Invitation to the Dance: An Empirical Response to Chief Justice Warren Burger's "Time-Consuming Procedural Minuets" Theory in* Parham v. J.R., 9 BULL. AM. ACAD. PSYCHIATRY & L. 149 (1981); Perry & Melton, *Precedential Value of Judicial Notice of Social Facts:* Parham *as an Example*, 22 J. FAM. L. 633 (1983-84).

18. *See, e.g.*, Cohen, *Legislative and Educational Alternatives to a Judicial Remedy for the Transfer Trauma Dilemma*, 11 AM. J.L. & MED. 405 (1986); Colette, *Liberty from Transfer Trauma: A Fundamental Life and Liberty Interest*, 9 HASTINGS CONST. L.Q. 429 (1982); Karalis, *Transfer Trauma: The Medicolegal Aspects*, 15 LEGAL ASPECTS MED. PRAC. 4

after a period of community adjustment, however, the therapeutic advantages may outweigh the short-term antitherapeutic impact. The *Parham* Court's intuitive understanding of these issues is reflected by its comment that "it is appropriate to inquire into how such a [commitment] hearing would contribute to the successful *long range treatment* of the patient."[19]

There is, of course, a clear-cut link between the literature-based assessments and the empirical studies. Typically, the former efforts will produce theoretically derived speculations about the therapeutic consequences of certain legal schemes. But only fresh empirical work specifically tailored to measuring the therapeutic outcome of particular legal arrangements will reveal whether the world in fact works in the way the armchair academics speculated it would.

III. CURRENT RESEARCH

Without doubt, the most ambitious empirical research effort ever conducted in mental health law is currently being undertaken by the MacArthur Foundation Research Network on Mental Health and the Law.[20] The twelve-member task force, chaired by John Monahan of the University of Virginia, conducts and commissions major mental health law research studies. The beginning stages of the multi-year program are devoted to research in three principal areas: competence (both civil and criminal), risk (*i.e.*, prediction of dangerousness), and coercion.

While the MacArthur Network is not explicitly focused on matters of therapeutic jurisprudence, its basic mission—to test the assumptions underlying current mental health law—is entirely consonant with the therapeutic jurisprudence approach. Moreover, some of its studies can clearly be conceptualized as falling within the therapeutic jurisprudence domain. In the area of competence, for instance, the Supreme Court's recent decision in *Zinermon v. Burch*,[21] which focused attention on the previously neglected issue of competency to consent to voluntary hospitalization, has prompted the MacArthur Network, and particularly task force members Paul Appelbaum and

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(Mar. 1987); Levitan, *Nursing Home Dilemma? Transfer Trauma and the Noninstitutional Option: A Review of the Literature*, 13 CLEARINGHOUSE REV. 653 (1980); Comment, *Involuntary Relocation of Nursing Home Residents and Transfer Trauma*, 24 ST. LOUIS U.L.J. 758 (1981).

19. 442 U.S. at 610 (emphasis added).

20. The authors of this Essay are directly involved with the research conducted by the MacArthur Foundation. Professor Wexler is a task force member, and Professor Winick is a consultant.

21. 494 U.S. 113 (1990).

Thomas Grisso, to pursue the development of instruments that will provide an empirical foundation for examination of this issue. Presumably, that research may help shed light on the distinction between clinical competence and the ability to express assent, and will pave the way for other researchers to study the therapeutic consequences of treating assent as competence or as incompetence. In his recent critique of *Zinermon*, Winick, writing from the perspective of therapeutic jurisprudence, constructs a theoretical justification, grounded in principles of cognitive and social psychology, for the presumed therapeutic advantages of voluntary hospitalization over involuntary commitment.[22] Winick suggests that *Zinermon*, if taken literally, could undermine much of the therapeutic value of the voluntary hospitalization process by requiring an inquiry into competency as a condition for voluntary admission. He then explores several models of assessing competency in this context, arguing that a formal judicial model should be rejected in favor of an informal model relying on assessment by an independent clinician, lawyer, or lawyer-supervised lay advocate. Winick's theoretical analysis of these issues raises important questions meriting empirical examination. The MacArthur research on competency could enable such an empirical assessment. At a time when state legislators and administrators are considering needed revisions to voluntary admission procedures to meet *Zinermon*'s concerns, such research could serve as an essential predicate to informed and sensible decisionmaking.

In the area of risk, the MacArthur Network is studying not only predictors of dangerousness (*e.g.*, delusions, impulsivity, psychopathy, and anger control), but, through the efforts of Paul Slovic, also the phenomenon of the perceived dangerousness of mentally ill persons. There already exists a lively labeling theory literature on the stigma of a mental illness or mental patient label.[23] But there have been no studies examining the effects of labeling patients as dangerous. Such a label might be affixed to a patient as a byproduct of a legal proceeding or as a result of public authorities demanding that a dangerously disabled person take therapeutic steps to control the disability.[24]

Slovic is investigating a number of fascinating aspects of the process of labeling individuals as dangerous, such as whether a label of

22. *See* Winick, *Competency to Consent to Voluntary Hospitalization*, *supra* note 9.

23. *See, e.g.*, Link, Cullen, Frank & Wozniak, *The Social Rejection of Former Mental Patients: Understanding Why Labels Matter*, 92 AM. J. SOCIOLOGY 1461, 1463-70 (1987) (reviewing research on the stigma of labels).

24. Wexler, *Inducing Therapeutic Compliance*, *supra* note 9, at 46-50 (discussing the possibility of bringing reckless endangerment prosecutions against dangerously disabled noncompliant persons).

dangerousness "decays" more slowly than other labels, including labels which merely recast the phenomenon of dangerousness as the probability of doing harm.[25] Obviously, the intensity and durability of a stigmatizing label can have major consequences for the labeled person. From a therapeutic jurisprudence standpoint, it would be interesting to study not only the reaction of others to the label, but also the extent to which the label affects the self-concept and future behavior of the labeled individual. Thus, the question whether the law should rely on a prediction of dangerousness as a predicate for legal consequences, ranging from civil commitment to enhanced punishment, should turn not only on the accuracy with which clinicians can predict future dangerousness and the impact on public safety and constitutional values,[26] but also on the future therapeutic consequences for the labeled patients.

The area of coercion, the last of the MacArthur Network's initial triad of research interests, is the one that has to date been the least systematically investigated. Accordingly, the Network's opening research efforts focus not on coercion in any objective sense, but look instead at patients' subjective perceptions of being coerced. Initially, coercion is being viewed as a dependent variable. Ultimately, the project should fit nicely into a therapeutic jurisprudence framework, for "subsequent research will explore what the effects of such perceptions or experiences are on outcomes such as treatment compliance and treatment efficacy."[27] Indeed, Winick, probing the psychological literature on choice, suggests that voluntary treatment and hospitalization arrangements, as opposed to those which patients perceive as coercive, will increase patient compliance and intrinsic motivation to succeed.[28] Accordingly, Winick suggests, legal rules, such as those defining competency to consent to treatment and hospitalization and the procedures mandated for their assessment, should be structured to take into account these therapeutic implications. The principles on which Winick builds his analysis deserve empirical assessment in the

25. Slovic, *Studies of Perceived Risk and Perceived Dangerousness of Mentally Ill Persons* 4-5, 15-18, 26-27 (Jan. 11, 1991) (unpublished working draft on file with authors).

26. *See, e.g.*, Barefoot v. Estelle, 463 U.S. 880 (1983); J. MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR (1981); Dix, *Expert Prediction Testimony in Capital Sentencing: Evidentiary and Constitutional Considerations*, 19 AM. CRIM. L. REV. 1 (1981).

27. Monahan, Hoge, Lidz, Roth, Bennett, Gardner & Mulvey, *Toward a Theory of Coercion in Mental Hospital Admission* 2 (Jan. 10, 1991) (unpublished working draft on file with authors).

28. Winick, *Competency to Consent to Treatment*, *supra* note 9, at 46-53; Winick, *Competency to Consent to Voluntary Hospitalization*, *supra* note 9, at 192-99; Winick, *Wagering with the Government*, *supra* note 9, at 752-72.

particular contexts he discusses, and the MacArthur Network's research on coercion could enable such assessment.

The MacArthur Network research effort on coercion is being guided in part by the social psychological literature on procedural justice.[29] That literature relates compliance with legal decisions to a litigant's perceptions of fairness in the process. How much "voice" has the litigant had? How much influence? How much support from others? The literature looks at both a litigant's process control and his or her outcome control. This initiative plainly has therapeutic jurisprudence implications for the design of procedural requirements in numerous settings affecting patients, offenders, juveniles, families, and others.[30] Moreover, these participatory process values sometimes may have an important role in shaping even *substantive* legal rules, such as the distinction Winick proposes in his work on the informed consent doctrine between assent and objection in the definition of competency.[31]

IV. USING THE THERAPEUTIC JURISPRUDENCE LENS

Obviously, one interested in therapeutic jurisprudence could mine the procedural justice literature with a view to considering how legal proceedings in the mental health area, such as commitment and conditional release hearings, might be modified to increase a litigant/patient's perception of fairness and, perhaps, to increase treatment compliance and treatment efficacy. The therapeutic jurisprudence perspective can provide a useful lens through which to view an existing body of literature in order to discover new value and applications. Thus, a legal researcher attuned to the therapeutic jurisprudence perspective might read a work on health care compliance principles with an eye on how the mental health legal system might exploit those principles, an exercise recently conducted by Wexler.[32] Similarly, the behavioral expert in health care compliance might

29. *See, e.g.*, E. LIND & T. TYLER, THE SOCIAL PSYCHOLOGY OF PROCEDURAL JUSTICE (1988); T. TYLER, WHY PEOPLE OBEY THE LAW (1990); Lind, Kanfer & Early, *Voice, Control, and Procedural Justice: Instrumental and Noninstrumental Concerns in Fairness Judgments*, 59 J. PERSONALITY & SOC. PSYCHOLOGY 952 (1990). For analysis of the participatory value of hearings from a legal perspective, see Winick, *Forfeiture of Attorneys' Fees Under RICO and CCE and the Right to Counsel of Choice: The Constitutional Dilemma and How to Avoid It*, 43 U. MIAMI L. REV. 765, 801-06 (1989).

30. *See* Melton, *Taking* Gault *Seriously: Toward a New Juvenile Court*, 68 NEB. L. REV. 146 (1989).

31. Winick, *Competency to Consent to Treatment*, *supra* note 9, at 27-46.

32. *See* Wexler, *Health Care Compliance*, *supra* note 9, at 19, 31-34 (suggesting that judges at conditional release hearings could facilitate compliance with medication orders by invoking psychological principles of health care compliance, such as use of behavioral contracts).

approach the legal literature with an eye to exploring how the legal system might best accommodate the body of health care compliance knowledge. In this way, therapeutic jurisprudence can provide a useful tool to maximize the utility of existing interdisciplinary research by identifying its perhaps previously unappreciated value and by spotting new and beneficial applications.

The therapeutic jurisprudence lens has even greater potential in the design of new interdisciplinary research projects. In the past, interdisciplinary research has often probed the wrong questions, or at least has failed to probe questions that are critical to legal decision-making. Therapeutic jurisprudence identifies a new scale on which legal rules, procedures, and roles can be weighed. The results will be extremely useful in the design and redesign of such legal arrangements. Therapeutic jurisprudence can thus identify a series of issues, many of which have never been examined, that can help resolve a variety of open legal issues, can provide new ammunition for dismantling legal arrangements that frustrate therapeutic values, and can lay the foundation for a new system of mental health law that is more consonant with its fundamental therapeutic mission.

The therapeutic jurisprudence lens may operate to generate new research topics which have high law-reform potential. Its usefulness in the identification of new research questions, the answers to which can significantly affect legal doctrine, can be illustrated by an examination of three important areas: the right to refuse treatment, the constitutionality of coercive treatment of death row inmates found incompetent to be executed, and the need to consider new mechanisms to improve treatment of criminal defendants found incompetent to stand trial.

A. *The Right to Refuse Treatment*

The right to refuse treatment is one example of how therapeutic jurisprudence can identify a new area of research that will be useful in the resolution of a critical question in mental health law.[33] The controversy concerning recognition of a patient's right to refuse treatment has largely ignored the question whether such recognition would be therapeutically beneficial or detrimental to the patient. Would such recognition lead to refusal of beneficial treatment so that

33. *See, e.g.*, Washington v. Harper, 494 U.S. 210 (1990); Winick, *supra* note 12, at 2-3 & nn.2 & 3 (citing expanding body of case law and commentary on the right to refuse treatment question).

patients will "rot with their rights on," as some have suggested?[34] Or would its recognition, by empowering patients, provide them with a context in which they could learn self-determining behavior, acquire decisionmaking skills, and attain functional capacities that would be extremely useful in community adjustment?

In addition, will providing choice concerning treatment enhance the potential that such treatment will be efficacious? Will it engage such potentially significant psychological mechanisms as the goal setting effect, or the Hawthorne effect or other interactive mechanisms that enhance the potential for therapeutic success?[35] Moreover, will according patients a right to refuse treatment restructure the doctor-patient relationship in ways that will enhance its therapeutic potential? Will it encourage doctors to negotiate with their patients and explain to them the rationale for recommending a particular course of treatment, rather than treating them paternalistically?[36] Will recognition of the right promote the dialogic process and increase its significance in ways that will produce greater patient compliance with treatment recommendations, set up patient expectancies that will facilitate success, improve patient attitudes toward treatment, and increase patient motivation to improve?

The therapeutic jurisprudence approach identifies these largely unexamined empirical questions as critical to a sensible resolution of the right-to-refuse-treatment dilemma. The approach suggests that legal commentators need to re-examine the existing literature on subjects such as the psychological value of choice.[37] It suggests that empirical research be performed to determine whether the theories and hypotheses that can be generated from this literature apply to mental patients, as opposed to other populations. Finally, it suggests the need for a third generation of right to refuse treatment research, supplementing the legal theoretical work that has been done[38] and the empirical studies of the impact of various right to refuse treatment

34. *See, e.g.*, Gutheil, *In Search of True Freedom: Drug Refusal, Involuntary Medication, and "Rotting with Your Rights On,"* 137 AM. J. PSYCHIATRY 327 (1980).

35. *See* Winick, *Competency to Consent to Treatment*, *supra* note 9, at 46-53 (analyzing therapeutic value of patient choice).

36. *See* R. BURT, TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS (1979); Wexler, *Doctor-Patient Dialogue: A Second Opinion on Talk Therapy Through Law*, 90 YALE L.J. 458 (1980) (reviewing R. BURT, TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS (1979)).

37. *See supra* note 28.

38. *See, e.g.*, Winick, *Legal Limitations on Correctional Therapy and Research*, 65 MINN. L. REV. 331 (1981); Winick, *supra* note 12; Winick, *The Right to Refuse Psychotropic Medication: Current State of the Law and Beyond*, in THE RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION 7 (D. Rapoport & J. Parry eds. 1986).

cases on patient, judicial, or hospital staff behavior.[39] Whether a right to refuse treatment should be recognized may ultimately be a constitutional question, but judicial and statutory definition of its parameters and procedural requirements can be critically affected by the answers to questions raised by examination of the right from the therapeutic jurisprudence perspective.

B. *Treatment for Incompetent Death Row Inmates*

In *Ford v. Wainwright*, the Supreme Court decided that the cruel and unusual punishment clause of the eighth amendment prohibits a state from executing a defendant who has been sentenced to death but whose mental health has so deteriorated while on death row that he has become incompetent to be executed.[40] Virtually all states had previously recognized, either by statute or case law, that execution of a death row inmate who had become incompetent should be suspended during the period of the defendant's incompetency, and could occur only following mental health treatment which succeeds in restoring the defendant's ability to understand and appreciate the reason for the execution. Although the Supreme Court's opinion in *Ford* constitutionalized this practice and imposed procedural due process requirements for determination of the incompetency-to-be-executed issue, the Court's decision did not address whether the state could coercively treat the incompetent death row inmate in order to restore him to competency so that the death penalty could be administered.

In 1990, however, in the case of *Perry v. Louisiana*,[41] the Supreme Court granted certiorari to consider this previously unresolved question: Do such death row inmates possess a right to refuse treatment that is designed to restore them to competency? *Perry* presents the right-to-refuse-treatment question in a difficult ethical context for clinicians. The American Medical Association and the American Psychiatric Association submitted a joint amicus curiae brief arguing that such coercive treatment placed clinicians in an untenable ethical role.[42] Aside from this submission, *Perry* was

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39. *See, e.g.*, Appelbaum & Hoge, *Empirical Research on the Effects of Legal Policy on the Right to Refuse Treatment*, in THE RIGHT TO REFUSE ANTIPSYCHOTIC MEDICATION, *supra* note 38, at 87; DeLand & Borenstein, *Medicine Court, II:* Rivers *in Practice*, 147 AM. J. PSYCHIATRY 38 (1990); McKinnon, Cournos & Stanley, Rivers *in Practice: Clinicians' Assessments of Patients' Decision-Making Capacity*, 40 HOSP. & COMMUNITY PSYCHIATRY 1159 (1989); Veliz & James, *Medicine Court:* Rogers *in Practice*, 144 AM. J. PSYCHIATRY 62 (1987); Zito, Haimowitz, Wanderling & Mehta, *One Year Under* Rivers: *Drug Refusal in a New York State Psychiatric Facility*, 12 INT'L J.L. & PSYCHIATRY 295 (1989).

40. 477 U.S. 399, 410 (1986).

41. 110 S. Ct. 1317 (1990).

42. Brief for the American Psychiatric Association and the American Medical Association

briefed and argued along conventional constitutional lines, with the defendant asserting a fundamental constitutional right to refuse intrusive mental health treatment, and the state asserting a compelling governmental interest in imposing such treatment in order to allow it to accomplish its compelling interest in carrying out the state's capital punishment scheme. After hearing argument, the Supreme Court decided to avoid resolution of the question for the time being and remanded the case to the state court for reconsideration in light of its intervening decision in *Washington v. Harper*.[43] *Harper* had rejected a constitutional right to refuse treatment claim in the context of a state prison's assertion of the need to involuntarily treat a dangerous prison inmate with antipsychotic medication.[44] The constitutional issue framed by *Perry* thus remains open, to be considered by a variety of state and lower federal courts prior to what almost inevitably will be the Supreme Court's resolution of the issue in the future.

Therapeutic jurisprudence suggests an additional dimension that should be considered in the resolution of the *Perry* issue: What are the therapeutic implications of permitting the state to treat coercively a defendant found incompetent to be executed? First, the consequences to the healing professions, the psychiatrists and psychologists asked to provide such treatment, should be considered, and these would appear to be antitherapeutic. Does the use of therapists as an adjunct to the administration of capital punishment undermine their primary role as healers? Does it corrode their sense of themselves as members of a healing profession? Does it raise grave ethical and emotional conflicts that deter many good clinicians from working in the correctional context? Does it decrease the standing of these subgroups with other professional peers? Does it deter some from becoming psychiatrists or psychologists? Does it breed distrust among patients generally? If the answer to at least some of these questions is yes, then the practice of coercive treatment of incompetent death row inmates could seriously diminish the quality of treatment that prisoners (and perhaps other institutionalized populations) receive, and drive many ethical and sensitive practitioners from the field or deter them from entering it.

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as Amici Curiae at 16, Perry v. Louisiana, 111 S. Ct. 449 (1990) (No. 89-5120) [hereinafter Amici Brief]. The ethical dilemma had received widespread discussion in the literature. *See, e.g.*, Appelbaum, *Competency to be Executed: Another Conundrum for Mental Health Professionals*, 37 HOSP. & COMMUNITY PSYCHIATRY 682 (1986); Radelet & Barnard, *Treating Those Found Incompetent for Execution: Ethical Chaos with Only One Solution*, 16 BULL. AM. ACAD. PSYCHIATRY & L. 297 (1988); Note, *Medical Ethics and Competency to Be Executed*, 96 YALE L.J. 167 (1986).

43. 110 S. Ct. 1028 (1990).

44. *Id.* at 1039-40.

Second, is such "therapy" efficacious? Death row inmates facing execution upon successful treatment would inevitably be motivated to attempt to resist and, indeed, to frustrate such treatment. Even organic treatment like psychotropic drugs may require a degree of patient compliance to succeed. Moreover, expectancy theory and other strands of cognitive psychology would suggest that psychological mechanisms which play an essential role in treatment success might also be important ingredients in the success of organic treatment techniques.[45] It therefore could be predicted that patients are likely to exhibit a behavioral response to such treatment that sets up failure or, at a minimum, makes success difficult. This is not to say that patients cannot be restored to competency by involuntary treatment, but only that it probably will be difficult, frustrating, and ultimately dehumanizing work for both clinician and patient.

Although this class of patients might be incompetent for some purposes, such as execution, their incompetency will not necessarily prevent them from responding behaviorally to what they undoubtedly will understand to be the consequence of successful treatment—their execution.[46] This would seem to be a particularly salient example of what in therapeutic jurisprudence terminology is known as "law-related psychological dysfunction" or "juridical psychopathology."[47] This example is similar to a number of the dysfunctional elements of the criminal justice mental health system that Wexler described in his early work on criminal commitment contingency structures.[48] It is also reminiscent of a similarly dysfunctional aspect of Florida law on competency to stand trial that Winick has criticized.[49]

The Florida provision in question produced what Winick described as a predictable behavioral response on the part of Florida incompetent-to-stand-trial defendants. The provision, a former Flor-

45. *See, e.g., Harper*, 110 S. Ct. at 1050 n.15 (Stevens, J., dissenting); Rennie v. Klein, 462 F. Supp. 1131, 1144 (D.N.J. 1978), *aff'd in part, modified in part, and remanded*, 653 F.2d 836 (3d Cir. 1981), *vacated and remanded*, 458 U.S. 1119 (1982); Durham & LaFond, *A Search for the Missing Premise of Involuntary Therapeutic Commitment: Effective Treatment of the Mentally Ill*, 40 RUTGERS L. REV. 303, 367-68 (1988); Winick, *Competency to Consent to Treatment*, *supra* note 9, at 50 & n.118.

46. *See* B. BRAGINSKY, D. BRAGINSKY & K. RING, METHODS OF MADNESS: THE MENTAL HOSPITAL AS A LAST RESORT 49-52 (1969); Wexler, *Token and Taboo: Behavior Modification, Token Economies, and the Law*, 61 CALIF. L. REV. 81, 84-87 (1973) (describing examples of rational, self-regarding behavior of mental patients).

47. D. Wexler, *supra* note 9, at 5.

48. PERSPECTIVES IN LAW AND PSYCHOLOGY: THE CRIMINAL JUSTICE SYSTEM 121 (B. Sales ed. 1977).

49. *See* Winick, *Incompetency to Stand Trial: Developments in the Law*, in MENTALLY DISORDERED OFFENDERS: PERSPECTIVES FROM LAW AND SOCIAL SCIENCE 3, 24 (J. Monahan & H. Steadman eds. 1983).

ida Rule of Criminal Procedure,[50] was adopted in the early 1970's as a result of an apparent misreading of *Jackson v. Indiana*.[51] *Jackson* placed constitutional limits on the duration of commitment of defendants found incompetent to stand trial, requiring that those for whom restoration to competency was unlikely would have to be either civilly committed or released.[52] The Florida rule went beyond *Jackson*, declaring that all permanently incompetent defendants, those who under *Jackson* appeared unlikely ever to be restored to trial capacity, be adjudicated not guilty by reason of insanity.[53] Defendants facing serious charges were thereby given an incentive to become permanently incompetent, and the number of such defendants on Florida's forensic wards noticeably swelled. It can be hypothesized that a similar contingency structure occurring in the context of treatment of incompetent death row inmates, which makes the ultimate aversive consequence of execution available contingent on the defendant's successful response to treatment, will cripple the therapeutic enterprise.

Permitting involuntary treatment of death row inmates found incompetent to be executed predictably will have a number of strongly negative implications for therapeutic values for both professionals and patients. The existence and extent of these negative therapeutic implications are empirical questions deserving careful research as a predicate to the sensible resolution of the issue left open in *Perry*. If shown to exist, these negative implications should be factored into the inevitable balance that the courts will need to perform in analyzing the constitutionality of involuntary treatment in this context.

This analysis may not be dispositive of the *Perry* issue, but it provides a potential argument for striking a different balance than the Supreme Court has on the basic question of the constitutional validity of the death penalty. In cases like *Gregg v. Georgia*,[54] the Court has basically determined that the state's interest in capital punishment outweighs the death row inmate's interest in his life. When the issue is the constitutionality of involuntary treatment designed to enable the prisoner to be executed, in addition to the state's interest in carrying out a death sentence, the prisoner's interest in avoiding it, and the intrusions of unwanted mental health treatment, therapeutic jurisprudence identifies previously unrecognized considerations that may well tip the balance in favor of finding such treatment unconstitutional.

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50. FLA. R. CRIM. P. 3.210(a)(5) (1972) (repealed 1977).

51. 406 U.S. 715 (1972).

52. *Id.* at 731-39; *see also* Winick, *Restructuring Competency to Stand Trial*, 32 UCLA L. REV. 921, 939-40 (1985).

53. FLA. R. CRIM. P. 3.210(a)(5) (1972) (repealed 1977).

54. 428 U.S. 153 (1976).

A potentially countervailing therapeutic implication can be invoked, however. If death row inmates found incompetent to be executed are not subject to involuntary treatment, they presumably would remain in a permanent incompetent state. This too could be seen as a law-produced dysfunctional effect, one that would have to be counted as a negative therapeutic implication. What should we do with such defendants? In their joint amicus brief in *Perry v. Louisiana*, the American Medical Association and American Psychiatric Association suggest that we automatically commute their sentences to life imprisonment, and this seems a sensible and humane proposal.[55] Defendants then could be offered treatment on a voluntary basis, which presumably would be accepted free of the disincentives producing the strongly negative motivation for treatment that execution would obviously provide. Such treatment probably would be effective in restoring such patients to a greater degree of mental health. This result would have only positive therapeutic implications. It would also avoid the presumably negative impact which coerced treatment has on professionals.

Unfortunately, the automatic commutation of sentences would make the status of being found incompetent to be executed more desirable, and probably would produce a predictable behavioral response on the part of death row inmates. But this identical behavioral response already is encouraged by the Supreme Court's constitutional holding in *Ford v. Wainwright*.[56] Because *Ford* requires that death row inmates found incompetent to be executed have their executions suspended, they will already be provided an incentive to become incompetent or to pretend to be so.[57] How much additional motivation in this direction will commutation of sentence provide? Perhaps only a marginal amount. If so, then this objection would not be a serious one.

As this preliminary and somewhat speculative analysis suggests, conducting a therapeutic jurisprudence assessment of compulsory treatment of death row inmates who are incompetent to be executed

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55. *See* Amici Brief, *supra* note 42, at 25.

56. 477 U.S. 399 (1986).

57. In this respect, *Ford* exemplifies "law-related psychological dysfunction." *See* D. WEXLER, *supra* note 9, at 5. Although perhaps dysfunctional, the *Ford* decision is fully defensible on considerations other than those relating to therapeutic values. A normative principle—the notion that it does not comport with human dignity to execute a defendant who is so mentally ill that he is unable to understand and appreciate why he is being put to death—drives the *Ford* analysis. In our view, this normative principle justifies the Court's decision in *Ford* even if it is shown to be antitherapeutic in effect. This analysis illustrates that therapeutic values, although relevant to a great many legal decisions, may not be dispositive of the legal issue.

involves difficult and unexamined empirical questions. Therapeutic jurisprudence identifies these questions as critical ones that need to be probed as part of the difficult balancing required for resolution of the question of coercive treatment for incompetent death row inmates. It thus suggests a research agenda for social scientists, and the Supreme Court's remand in *Perry v. Louisiana*, by leaving the constitutional question open, at least for now, paves the way for comparative research in states that take differing approaches to the issue. Perhaps this research will suggest that the therapeutic implications are conflicting or that they point decisively in one direction. In any case, such research is needed so that this complex and troubling constitutional, moral, and professional issue can be resolved based on full consideration of the consequences of alternative approaches.

C. *Treatment for Incompetency to Stand Trial*

Although much work has been done on the assessment of competency to stand trial, little empirical research has examined the treatment process for criminal defendants found incompetent to stand trial. As a result, almost nothing is known about the treatment provided to defendants placed in this status. Because of the confusion documented in the literature by clinical evaluators who frequently equate the incompetency-to-stand-trial standard with the existence of mental illness,[58] it is likely that most defendants found incompetent are treated like civil patients presenting the same psychiatric diagnosis. Treatment is probably rarely tailored to the specific abilities needed to be competent to stand trial. Treatment probably focuses on the patient's psychopathology, rather than the short-term goal of restoration to trial competence, or more appropriately, to competency to perform the specific trial-related task the defendant has been found incapable of performing adequately.

In his prior work on competency to stand trial, Winick has suggested that a system of trial continuances replace the formal competency process now existing for defendants asserting their incompetency as a bar to trial.[59] The suggestion is that a continuance of reasonable duration may be granted to the defendant based on a certificate of counsel that the defendant is, in counsel's opinion, incompetent. Counsel could be required to certify that the continu-

58. *See, e.g.*, R. ROESCH & S. GOLDING, COMPETENCY TO STAND TRIAL 83-91 (1980); Winick, *supra* note 52, at 982.

59. *See* Winick, *Incompetency to Stand Trial: An Assessment of Costs and Benefits, and a Proposal for Reform*, 39 RUTGERS L. REV. 243, 281-84 (1987) [hereinafter Winick, *Incompetency to Stand Trial*]; Winick, *supra* note 52, at 979-83.

ance is sought in good faith and on reasonable grounds and to set forth the specific observations and statements of the defendant that form the basis for his request.

A request for continuance, or a subsequent request for a renewed continuance, could also be conditioned upon the defense attorney's submission of a statement from a clinician certifying that the defendant is incompetent to stand trial, stating that the defendant is receiving appropriate treatment, and predicting that the defendant will be restored to competency within a reasonable period. This statement could include a specific treatment plan, detailing the kinds of treatment attempted and proposed, and the anticipated outcome. The defendant would be permitted substantial freedom in electing the type of treatment to restore his or her competency. Of course, the place of treatment will depend on the defendant's bail status. If the defendant is in custody, treatment will occur either in a jail or in a secure mental health facility; if released, treatment will occur in the community as an outpatient or voluntary inpatient.

Based upon the literature on the psychology of choice,[60] it can be hypothesized that the potential for successful treatment of defendants who are incompetent to stand trial increases when the defendant accepts treatment voluntarily rather than as a result of court coercion, which typically involves an incompetency commitment to a forensic facility. Winick's proposal can accordingly be viewed as an application of therapeutic jurisprudence.

Whether Winick's proposal for a restructuring of the incompetency-to-stand-trial process would bring about more effective treatment for incompetent defendants is an empirical question that deserves examination. A jurisdiction wishing to experiment with the continuance alternative to the traditional formal competency evaluation process can be matched with one that does not. This will enable a test of whether defendants in the continuance sample respond to treatment better than a sample of similar defendants from the other jurisdiction subjected to court ordered treatment after a formal adjudication of incompetency.

Winick's proposal for voluntary treatment as a condition for the granting of a trial continuance could be joined with his "wagering" proposal[61] to suggest a new approach to treatment for trial incompetency that also could be examined empirically. In order to further increase the efficacy of treatment, the defendant and the court could enter into a contingency contract. Under the contract, the defendant

60. *See supra* note 28.

61. Winick, *Wagering with the Government*, *supra* note 9.

would receive the requested trial continuance in exchange for his agreement to participate in an appropriate treatment program and for making periodic progress toward the goal of restoration to trial competency, perhaps based on a specified schedule of target goals and dates, culminating in a restoration to trial competency within a specified period. This contingency contract or "wager" with the court should, according to Winick's theory, enhance the efficacy of a treatment program for trial incompetency, and the validity of this hypothesis could be tested empirically.

One problem with a wagering model in this context is that for many defendants the goal of seeking incompetency-to-stand-trial status is to avoid trial indefinitely or even permanently. As a result, such defendants may have a disincentive to show progress toward the goal of restoration to competency. An additional reinforcer is thus needed to offset this disincentive.

In many jurisdictions, the defendant does not automatically receive credit against his ultimate sentence for time spent in incompetency commitment.[62] Other jurisdictions, however, mandate such sentence credit. The American Bar Association's *Criminal Justice Mental Health Standards* recommend that such sentencing credit be given,[63] but this proposal may be criticized from a therapeutic jurisprudence standpoint. Providing sentencing credit will predictably strengthen the disincentive for incompetent defendants to be restored to competency quickly. This would be a further illustration of law-produced psychological dysfunction.

Nonetheless, a method may be available whereby sentence credit can be used in a wagering context to promote therapeutic ends without seriously running the risk of creating this law-produced dysfunction. In jurisdictions that do not mandate sentence credit, this credit may be used as a reinforcer in the proposed contingency contract. To achieve this end, sentencing credit would be provided contingent upon demonstrated progress towards restoration to competency to stand trial. Psychological theory suggests that we should reward competency, not incompetency. Specific credit against any ultimate sentence can be given for meeting intermediate treatment goals on schedule, and eventually for reaching the goal of restoration to competency to stand trial. To prevent shamming near the point of restoration, the court may take away or reduce sentence credit already earned for meeting intermediate treatment goals if the defendant demonstrates slippage. The incentives of the wager should increase treat-

62. *See* Winick, *supra* note 52, at 947.

63. *See* ABA CRIMINAL JUSTICE MENTAL HEALTH STANDARDS § 7-4.15 (1989).

ment efficacy both for defendants accepting treatment in custodial settings and for those treated in the community.

Restructuring the incompetency-to-stand-trial process so that it substitutes the use of trial continuances for the formal competency evaluation process and permits the contingency contracting described, should expedite efficacious treatment and successful restoration to competency. Of course, the success of such a proposal depends upon the availability to incompetent defendants of a range of effective treatment methods and programs tailored to their needs. Recent literature has proposed a number of innovative treatment programs for defendants found incompetent to stand trial, including a structured cognitive problem-solving group therapy approach focusing on incompetency-to-stand-trial issues, and a psycho-educational intervention using videotape, a model of a courtroom, and discussions with defendant-patients concerning the trial process.[64] Such innovative treatment programs designed specifically for incompetent defendants present a fruitful area for research.

Whether hospitals or other treatment facilities use innovative treatment programs or conventional approaches, research would be desirable concerning the suggested applications of therapeutic jurisprudence in the competency-to-stand-trial context. This research, if conducted with the court's permission, would not seem to violate legal requirements. There seems to be no constitutional impediment to replacing much of the existing competency evaluation process with a system of trial continuances. Moreover, to the extent that a statutory right to formal competency evaluation exists, the granting of a continuance requested by the defendant and his counsel (although not necessarily its denial) could simply be conditioned upon the waiver of that right. With judicial approval, researchers could conduct a study of the proposed trial continuances model.

Would it work? Would attorneys seek to manipulate it for delay? Can judges exercise sufficient controls to minimize abuse? Would it save money? Would it provide incentives for more expeditious competency restoration? These are several questions that could be examined. Researchers could select jurisdictions for study that deny automatic sentence credit for time spent undergoing treatment so that sentence credit could be used as a reinforcer in the contingency contract. This discussion illustrates how therapeutic jurisprudence can be used to frame new proposals for changes in law, and to identify

64. *See* Siegel & Elwork, *Treating Incompetence to Stand Trial*, 14 LAW & HUM. BEHAV. 57 (1990).

new areas of empirical research that can be extremely useful in guiding law reform.

V. A COMPARATIVE LAW APPROACH

Unlike traditional mental health law, therapeutic jurisprudence does not necessarily depend on the Supreme Court aggressively spinning out new constitutional rights for its nourishment and survival. The limited extent of its constitutional dependence enables therapeutic jurisprudence to become more international and comparative in its scope, allowing for greater interchange among scholars from different nations. Let us look briefly at two examples.

Elsewhere, Wexler has argued that a rule requiring psychotherapists to warn a particular victim of a patient's potential dangerousness may be therapeutically sound: if patients overwhelmingly threaten intimates and family members, as they do in the United States, a warning rule may operate to bring the potential victim into family therapy.[65] In a comparative context, we should of course be interested in learning whether the pattern of threatening intimates holds true in other jurisdictions. If it does not, "transplantation"[66] of the rule might work more therapeutic harm than good.

Another example of comparative therapeutic jurisprudence could look at the use of psychological health care compliance principles to increase the probability that a conditionally released mental patient will take prescribed medication. We know, for instance, that if a court encourages the patient to enter into a behavioral contract and to make a public commitment to comply, the likelihood of compliance is enhanced.[67] But, in a comparative exercise, we should ask whether a public commitment is more likely to yield compliance in rural or homogeneous societies than in urban or heterogeneous ones.[68] Likewise, a court composed of a single judge is arguably better able to apply these psychological health care compliance principles than an administrative body, such as Oregon's Psychiatric Security Review Board.[69] How, one may ask, might a British mental health review tribunal fare in using the health care compliance principles?[70]

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65. *See* Wexler, *Victimological Virtues*, *supra* note 14, at 1.

66. *See* Kahn-Freund, *On Uses and Misuses of Comparative Law*, 37 MOD. L. REV. 1 (1974).

67. *See* Wexler, *Health Care Compliance*, *supra* note 9, at 27-29.

68. *See* Massaro, *Shame, Culture and American Criminal Law*, 89 MICH. L. REV. 1880 (1991).

69. Wexler, *Health Care Compliance*, *supra* note 9.

70. Peay, *Mental Health Review Tribunals*, in PRINCIPLES AND PRACTICE OF FORENSIC PSYCHIATRY 1259 (R. Bluglass & P. Bowden eds. 1990).

In this way, the comparative perspective can provide an international laboratory for therapeutic jurisprudence research. Just as we learn much about our own language by studying a foreign language, the comparative perspective is inherently illuminating. But the therapeutic jurisprudence approach allows even greater opportunities. Domestic legal restrictions—those emanating from judicial construction of a constitutional provision, for example—might make a change in legal arrangements appear impossible. This appearance inevitably will discourage research concerning the impact of legal rules or procedures thought of as unchangeable. The perception of unchangeability may thus be self-perpetuating, preventing research that examines the premises on which the constitutional perception of unchangeability is based. Research based on how other nations deal with an issue thought beyond change domestically can, however, allow for the questioning of these premises. Therefore, using the international arena as a laboratory for therapeutic jurisprudence research can create new research opportunities that can be used to critically examine assumptions so embedded in domestic law that they are never questioned.

Winick's prior research on the American competency-to-stand-trial doctrine illustrates how therapeutic jurisprudence research conducted in the international laboratory can be used to examine the wisdom of a legal rule thought to be constitutionally unchangeable. Winick has proposed restructuring the existing incompetency-to-stand-trial process to allow defendants who are able to articulate a desire to stand trial or plead guilty to do so notwithstanding the fact that their competency is diminished by mental illness, provided their counsel concur in this judgment.[71] As indicated in the previous discussion of incompetency-to-stand-trial treatment, for defendants who do not have such a preference but wish to assert their mental illness as a basis for postponing their trial, Winick proposes substituting a system of trial continuances for the formal competency evaluation process.

Winick's latter suggestion concerning trial continuances could be the subject of empirical examination in a domestic laboratory—a state wishing to experiment with this proposal. On the other hand, Winick's former proposal—to allow marginally incompetent defendants to stand trial or plead guilty—may be considered impossible to implement without violating constitutional doctrine. At least this has been the received wisdom as a result of the Supreme Court's dicta in

71. *See* Winick, *supra* note 52, at 979; Winick, *Incompetency to Stand Trial*, *supra* note 59, at 281.

Pate v. Robinson.[72] *Pate* has been assumed to stand for the broad proposition that the Constitution places an absolute prohibition on trying the incompetent defendant.[73] This assumption has hampered empirical research in the competency-to-stand-trial area.[74] Winick has criticized the assumption that the Constitution imposes an absolute prohibition on the trial of an incompetent defendant who wishes to be tried, but it is unlikely that states will be willing to experiment with the trial of such defendants for fear that any ensuing convictions would be vulnerable to due process attack.

Although Winick suggests that there would be therapeutic and other advantages to permitting the trial of such defendants, it is thus unlikely that this aspect of his proposal will be testable in a domestic laboratory. Other countries, however, dealing with the incompetency-to-stand-trial problem without the restrictions of the *Pate v. Robinson* gloss on due process, are free to experiment with Winick's proposal. Indeed, it is possible (if not likely) that at least some countries permit mentally ill defendants to stand trial or plead guilty if they wish to do so, their mental impairment notwithstanding. The experience in these jurisdictions could accordingly be examined to probe the wisdom of Winick's suggestions, and they could be used as laboratories for empirical research on the question. Should such research document the existence of therapeutic value and the other advantages of Winick's proposal, then it would be open for American courts to discard the *Pate v. Robinson* dicta.

We do not suggest that all constitutional restrictions be open to reconsideration in light of the results of a therapeutic jurisprudence assessment. Many constitutional rules—such as *Ford v. Wainwright*'s ban of execution of a person found to be incompetent—will be fully justified on normative grounds even if they produce negative therapeutic consequences.[75] In at least some other situations—involving a rule that seems to be grounded in the Constitution but turns out to be supported by dicta only, for example, or one based on empirical assumptions that turn out to be false—the therapeutic jurisprudence approach can suggest the possibility of reconsideration, and the international laboratory can be used as a locus for research that may reveal whether such reconsideration is warranted.

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72. 383 U.S. 375, 378 (1966) ("[T]he conviction of an accused person while he is legally incompetent violates due process . . . ."). For analysis of this statement as dicta, see Winick, *supra* note 52, at 968-70.

73. *See* Winick, *supra* note 49, at 926 & n.13 (discussing ABA Criminal Justice Mental Health Standards).

74. *Id.* at 926.

75. *See supra* note 57 and accompanying text.

We thus hope that researchers will develop a comparative lens as well as a therapeutic jurisprudence lens and that they will view the world through that pair of glasses. The exciting prospect is that those glasses will enable us to forge a research agenda that is at once truly interdisciplinary as well as truly international.

VI. CONCLUSION

Mental health law needs new directions. We have suggested one reflecting the assumption that mental health law should serve rather than disserve the mental health of those it affects. Substantive rules, and the practices and procedures that implement them, should be analyzed to determine their impact on therapeutic values. This frequently ignored dimension should be systematically examined with the tools of the behavioral sciences and the results should factor into the policy analysis that must precede sensible law reform efforts.

Mental health law has much to contribute to improving the condition and well-being of patients. To reach its full potential, it must become more empirical and truly interdisciplinary. We propose an approach in which behavioral scientists and legal analysts join together to forge a new generation of mental health law scholarship that can better serve the aims of mental health law.