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Review Article

The Right to Refuse Treatment in Involuntary Psychiatric Care

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ABSTRACT

Involuntary commitment and the right to refuse treatment rest on two different legal tests -- dangerousness and decision-making capacity -- that do not always align, leaving a persistent gap in how forced medication is actually governed.

This review traces the U.S. case law behind the current framework, from O'Connor v. Donaldson through Rogers v. Okin's independent-review requirement to Washington v. Harper's more permissive standard, and examines why psychiatric symptoms complicate capacity assessment more than physical illness typically does.

It then turns to the sharpest challenge to this framework: the UN Convention on the Rights of Persons with Disabilities, which treats capacity-based substituted decision-making as discriminatory and calls for supported decision-making instead, a standard most domestic law has not yet adopted.

We also assess psychiatric advance directives and Ulysses contracts as a third path letting patients bind their future, less capable selves in advance, finding that uptake remains low and enforcement frameworks remain underdeveloped.

We conclude that no single framework resolves this tension, and that closing the gap with the CRPD's critique depends more on rigorous capacity assessment and independent review than on any single doctrinal fix.

Keywords: involuntary treatment; right to refuse treatment; decision-making capacity; psychiatric advance directives; mental health law

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INTRODUCTION

A person can be detained in a psychiatric hospital

against their will and still, in most jurisdictions, retain a formal right to refuse the medication that hospital wants to give them. That combination sounds

contradictory, and in practice it often is: the legal architecture that permits involuntary commitment and the legal architecture that protects the right to refuse treatment were built at different times, by different courts, for different reasons, and they do not always sit together comfortably [1]. Commitment law asks whether a person is dangerous or gravely disabled; refusal law asks whether that same person has the capacity to make a treatment decision. A patient can fail the first test and pass the second, and when that happens the practical question -- can the hospital medicate this person over their objection -- has no clean answer built into the commitment order itself.

This is not a peripheral question in psychiatric ethics; it sits at the center of what involuntary care is supposed to accomplish. Early right-to-refuse litigation in the United States treated forced medication as a serious enough intrusion on bodily autonomy and thought itself to require its own due process, separate from and in addition to whatever process justified the commitment [2]. That premise has held up, broadly, in the decades since, but it has been joined by a second and more disruptive premise: that any legal regime allowing treatment to be imposed on someone found incapable, however carefully bounded, is itself a human rights violation that should be phased out rather than refined [3]. The tension between these two positions -- refine involuntary treatment's safeguards versus abolish the category altogether -- runs through nearly everything written on this subject in the past decade, and this review tries to lay out both sides fairly before saying where the evidence currently points.

We proceed in four parts. First, we describe the legal architecture that has developed around involuntary treatment and treatment refusal, largely through case law. Second, we examine how decision-making capacity is actually assessed and why psychiatric illness complicates that assessment in ways that physical illness usually does not. Third, we take up the challenge posed by the UN Convention on the Rights of Persons with Disabilities (CRPD), which rejects capacity-based substituted decision-making outright. Fourth, we look at psychiatric advance directives and Ulysses contracts as an attempt to let patients bind their future, less capable selves in advance, and ask how well that mechanism actually resolves the underlying conflict.

THE LEGAL ARCHITECTURE OF INVOLUNTARY TREATMENT

American mental health law did not begin with a right to refuse treatment; it began with a right not to be confined without cause. *O'Connor v. Donaldson* established that a state cannot constitutionally confine a non-dangerous person capable of surviving safely outside an institution, without more [4]. That case addressed confinement, not medication, but it set a template later courts extended to treatment itself: liberty interests protected by the Due Process Clause

do not evaporate simply because a person has been lawfully committed. *Rogers v. Okin* took that template and applied it directly to forced medication, holding that competent, involuntarily committed patients retain a right to refuse antipsychotic drugs except in emergencies, and that incompetent patients are entitled to a substituted-judgment process rather than a purely clinical decision made by hospital staff [2].

The U.S. Supreme Court narrowed this considerably in *Washington v. Harper*, upholding a prison policy permitting involuntary medication of a mentally ill inmate found dangerous to himself or others, so long as the decision was reviewed by medical staff rather than a court, and applying a lower "reasonably related to legitimate penological interests" standard rather than strict scrutiny [5]. *Harper* signaled that the judiciary was not going to require full adversarial court hearings before every instance of involuntary medication, at least in institutional settings where safety concerns predominate; procedural protection could be administrative rather than judicial and still satisfy due process. *Zinerman v. Burch*, decided the same year, addressed a related but distinct problem: a hospital's failure to determine, before admitting a patient as a "voluntary" admission, whether that patient was actually competent to consent to admission at all, holding that the state could be liable for the procedural gap itself [6]. Read together, these cases describe a patchwork rather than a single doctrine -- due process requirements that vary by setting, by the nature of the intrusion, and by how the underlying decision (commitment, admission, medication) is procedurally structured.

An early and still frequently cited legal-ethical analysis of these developments argued that the right to refuse treatment could not be justified purely on constitutional grounds; it also needed a clinical rationale, since a rule that ignored the realities of acute psychiatric crisis would be unworkable regardless of its doctrinal pedigree [7]. A recent Congressional Research Service survey of Fourteenth Amendment due process protections in civil commitment underscores how much of this architecture still varies state by state, particularly around what counts as adequate periodic review of an ongoing commitment and what standard of proof it requires [1]. Commentary aimed at clinicians has long tried to translate this legal patchwork into something usable at the bedside, generally converging on the same practical rule regardless of jurisdictional detail: emergency medication to prevent imminent harm is treated differently, and more permissively, than non-emergency medication imposed to treat the underlying illness [8]. Forensic psychiatric literature reviewing the doctrine has reached a similar conclusion, noting that the right to refuse treatment, wherever it is recognized, is functionally a right to a particular kind of process -- a second look by someone other than the treating clinician -- rather than an absolute right to refuse indefinitely [9]. That distinction,

between a right to refuse and a right to a fair process before refusal is overridden, is easy to state and considerably harder to operationalize consistently across hospitals and courts.

DECISION-MAKING CAPACITY AND ITS ASSESSMENT

Everything in the preceding section depends on a judgment that sounds simple and is not: whether a given patient, at a given moment, has the capacity to make this particular treatment decision. The now-standard framework for that judgment, developed by Grisso and Appelbaum, breaks capacity into four abilities -- understanding relevant information, appreciating one's own situation and its consequences, reasoning about treatment options, and communicating a choice -- and insists that capacity is decision-specific and time-specific rather than a global trait a person either has or lacks [10]. A patient can lack capacity to refuse antipsychotic medication during an acute psychotic episode and regain it within weeks, and a patient can have full capacity to make some decisions (where to live) while lacking it for others (whether a specific drug is medically indicated).

Psychiatric illness complicates this assessment in a way that most physical illness does not, because the very cognitive and affective processes capacity assessment relies on -- insight, risk appraisal, the ability to weigh consequences -- can themselves be distorted by the condition prompting the evaluation. A patient in the grip of a persecutory delusion about a medication may satisfy every procedural element of "understanding" the information given (they can repeat it back accurately) while failing to "appreciate" it in any way that connects to their actual situation, because their delusion has reorganized what the situation is taken to mean [11]. Reviews of decisional capacity in the treatment-refusal context have emphasized that this gap between formal understanding and genuine appreciation is where most difficult capacity determinations actually live, not in patients who simply cannot repeat back the facts [12]. Bedside guidance for non-psychiatric clinicians tends to compress this into checklists, useful for routine consent but not obviously adequate for a contested psychiatric refusal where the stakes and the diagnostic uncertainty are both higher [13,14].

The legal system's own engagement with capacity disputes bears this out. A ten-year review of capacity litigation before England's Court of Protection found that cases involving mental illness, as opposed to cognitive impairment from dementia or intellectual disability, were disproportionately contested and disproportionately likely to turn on close, fact-specific findings about appreciation rather than understanding -- exactly the harder half of the Grisso-Appelbaum framework [15]. That empirical pattern is a reasonably direct rebuttal to any claim that capacity assessment is

a mechanical, low-stakes gatekeeping step; in psychiatric practice it is closer to the central ethical and evidentiary battleground of the entire treatment-refusal question.

THE CRPD CHALLENGE: FROM SUBSTITUTED TO SUPPORTED DECISION-MAKING

Everything discussed so far assumes that capacity-based substituted decision-making -- someone else deciding for a patient found to lack capacity -- is a legitimate category, one that merely needs better process and better assessment tools. The UN Convention on the Rights of Persons with Disabilities rejects that assumption. The CRPD Committee's interpretation of Article 12 treats any legal mechanism that permits a substitute decision-maker to override a person's stated wishes on the basis of impaired mental capacity as a form of disability-based discrimination, to be replaced entirely by supported decision-making, in which assistance is provided but the person's own will and preferences remain determinative [3]. Under this reading, involuntary psychiatric treatment is not something to be procedurally improved; it is something that should not exist in its current form at all, regardless of how careful the capacity assessment or how independent the reviewing body. Historical reviews of coercive psychiatric practice make the underlying worry concrete: the same clinical authority that justifies involuntary treatment on therapeutic grounds has, at various points and in various political systems, also been used to suppress dissent or manage social deviance under a medical label, which is part of why CRPD advocates are unwilling to accept "better safeguards" as a sufficient answer [16].

Advocates of this position have argued that mental health legislation should be understood as, at most, an interim compromise on the way to full abolition of psychiatric coercion, not a stable end state -- law that keeps the door open for detention and forced treatment functions, on this account, as "a key" rather than "a straitjacket" only if it is explicitly framed as transitional [17]. A recent comparative mapping of involuntary mental healthcare legislation across the FOSTREN research network's member countries found enormous variation in how far domestic law has moved toward the CRPD's supported-decision-making model, with most countries retaining some form of capacity-based override even where CRPD ratification is formally in place [18]. That gap between the CRPD's stated standard and actual domestic legislation is itself instructive: it suggests either that the standard is not yet operational at the scale of an entire mental health system, or that most states have made a considered choice not to fully adopt it, or some mixture of both.

Recent scholarship has tried to soften the binary between "keep substituted decision-making" and "abolish it entirely" by reframing what counts as

success. One proposal treats every instance of involuntary treatment as a sentinel event -- something to be reviewed afterward the way a hospital reviews a serious adverse event, with the goal of reducing the rate of such events over time rather than declaring the category permissible or impermissible in the abstract [19]. Others have argued that the more useful shift is cultural and clinical rather than purely legal: moving mental health systems from treating coercion as "a necessary evil" toward what has been called "the dignity of risk," in which the possibility that a supported patient might make a choice clinicians consider unwise is accepted as a cost of taking autonomy seriously, rather than something new legislative guidance can eliminate through better drafting alone [20]. Both proposals share an implicit concession that full, immediate abolition is not currently achievable, while still keeping the CRPD's substantive critique -- that impaired capacity should trigger support rather than override -- as the direction of travel.

PSYCHIATRIC ADVANCE DIRECTIVES AND ULYSSES CONTRACTS

One mechanism designed to reduce the tension between autonomy and involuntary treatment without waiting for either legal architecture to change is the psychiatric advance directive: a document, executed while a person has capacity, stating what treatment they consent to or refuse should they later become acutely unwell and lose that capacity. In its strongest form, sometimes called a Ulysses contract after the mythical figure who had himself bound to the mast so he could hear the sirens without steering his ship onto the rocks, the directive explicitly authorizes treatment the person might resist in the moment, precisely because they anticipated, while well, that their future objection should not control [21]. Early advocacy for these instruments framed them as a genuine third option beyond "treat over objection" and "respect the refusal absolutely" -- a way of honoring the person's own long-term values even when their immediate, symptomatic preference diverges from those values [22].

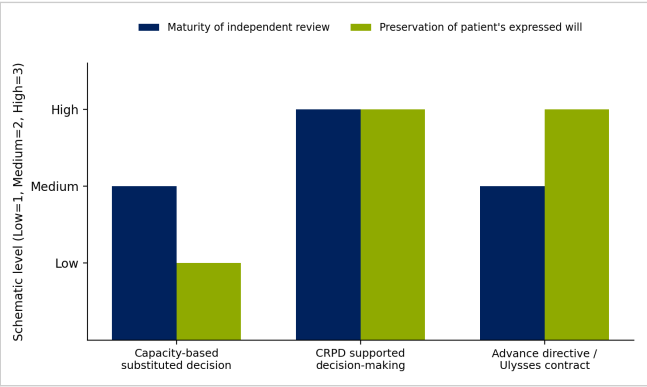
The mechanism raises its own hard questions, though. If a person can bind their future self to accept treatment, can they also bind their future self to refuse it, even in a crisis their past self did not fully anticipate, and should clinicians honor that refusal with the same weight? Comparative legal work on jurisdictions that have recently introduced statutory frameworks for these instruments -- Italy's law 219/2017 on informed consent and advance directives, for instance -- has found that most existing statutes are not actually built with the Ulysses-contract case in mind, and struggle to specify how a directive should be revoked, overridden, or reconciled with a contemporaneous objection from the same person it was meant to bind [23,24]. A more recent legal analysis has gone further, arguing that most jurisdictions lack the specific statutory criteria

needed to make psychiatric advance directives enforceable in the way patients and clinicians both assume they already are, leaving the instrument more aspirational than operative in practice [25].

Table 1. Three frameworks for governing treatment refusal in involuntary psychiatric care, compared by who decides, the safeguard relied on, and the main criticism raised against each.

Framework	Who decides when the patient is acutely unwell	Primary safeguard	Main criticism
Capacity-based substituted decision-making	A court, tribunal, or independent clinician, once incapacity is found	Independent review separate from the treating team	Retains a moment where someone else's judgment displaces the patient's own
CRPD supported decision-making	The patient, with assistance; no override on capacity grounds	Supported decision-making rather than substitution	Not yet operationalized at the scale of a full mental health system
Advance directive / Ulysses contract	The patient's own prior, capacitated instructions	Contemporaneous consent given in advance, while well	Statutory frameworks rarely specify how to handle a later, in-the-moment objection

Figure 1. Schematic comparison of the three frameworks discussed in this review on two dimensions: maturity of independent review mechanisms and how far each preserves the patient's own expressed will (illustrative, not derived from a single empirical study).



Uptake has also lagged well behind the ethical case made for these instruments. Even where psychiatric advance directives are legally available, relatively few patients complete one, and clinicians report inconsistent access to a patient's directive at the moment it matters most -- during an acute crisis, when the record may not be in front of the treating team at all. A 2025 study of integrating psychiatric advance directives into patient-accessible electronic health records found real promise in closing that access gap, but also concrete technical and workflow limitations, including inconsistent recognition of the directive

across care settings and uncertainty among staff about how legally binding a given directive actually was [26]. Table 1 summarizes how the three major frameworks addressed in this review -- capacity-based substituted decision-making, the CRPD's supported decision-making model, and advance-directive-based self-binding -- differ along the dimensions that drive most of the disagreement between them, and Figure 1 places the same three frameworks on a schematic comparison of procedural protection and preservation of the patient's expressed will.

CONCLUSION

No framework surveyed here fully resolves the conflict between protecting a person from the acute consequences of their own untreated illness and respecting their stated refusal of treatment. Capacity-based substituted decision-making, the dominant model in most jurisdictions' current law, has the advantage of decades of case law refining its procedural safeguards, from *Rogers v. Okin*'s insistence on independent review to *Washington v. Harper*'s more permissive administrative standard, but it retains, irreducibly, a moment at which someone else's judgment displaces the patient's own. The CRPD's supported decision-making model answers that objection directly but has not yet been operationalized at the scale of a full mental health system anywhere its logic has been most forcefully argued for, and reframing proposals like sentinel-event review or a shift toward "the dignity of risk" read as attempts to make the existing system more defensible rather than replacements for it. Psychiatric advance directives offer patients a genuine, if imperfect, third path -- letting a person's considered, capacitated values bind a future crisis -- but legal frameworks for enforcing them remain underdeveloped and uptake remains low even where they exist.

What the literature converges on, more than any single doctrinal fix, is that the right to refuse treatment cannot be evaluated apart from the quality of the capacity assessment underneath it and the independence of whoever reviews a proposed override. Improving either of those -- more rigorous, appreciation-focused capacity evaluation, and genuinely independent review separate from the treating clinician -- would narrow the gap between the current legal patchwork and the CRPD's substantive critique of it, even short of the wholesale abolition of involuntary treatment that the Committee's interpretation calls for. Whether that is a durable compromise or simply a slower route to the same destination is likely to remain contested for as long as involuntary psychiatric care itself exists.

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Conflict of Interest

The authors declare no conflicts of interest relevant to this work.

Author Contributions

Mette Marques conceived the review, drafted the sections on legal architecture and capacity assessment, and coordinated the overall manuscript. Lars Moreau developed the analysis of the CRPD challenge and supported decision-making, and critically revised the manuscript for conceptual clarity. Chiara Pedersen contributed the section on psychiatric advance directives and Ulysses contracts and prepared the comparative table and figure. All authors read and approved the final manuscript.

Ethics Statement

As a literature review synthesizing previously published legal and bioethical scholarship, this article did not involve new data collection from human or animal subjects and did not require institutional ethics committee approval.

Data Availability

No new data were generated or analyzed for this review. All sources discussed are cited in the reference list and are publicly available through their respective publishers or court reporters.

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