
The Impact of Judicial Review of Patients' Refusal to Accept Antipsychotic Medications at the Minnesota Security Hospital

Michael G. Farnsworth, M.D.

In 1988, the Minnesota Supreme Court ruled that premedication judicial review was required to force antipsychotic medications on incompetent committed patients in Minnesota. Before this decision all patients refusing antipsychotic medications at state hospitals were reviewed by an internal multidisciplinary peer review organization called the Treatment Review Panel (TRP). The author examined the impact of judicial review of medications at the Minnesota Security Hospital. Thirty-one patients reviewed by the Treatment Review Panel (TRP) between July 1986 and December 1987 were compared with 37 patients reviewed by the TRP and the court between January 1988 and December 1989. There was nearly unanimous agreement between the TRP and the court in approving antipsychotic medications for patients. However, for patients awaiting judicial review for medication, an average delay of 80 days was encountered, and there was a significant increase in the number of emergencies occurring on the treatment unit before the initiation of treatment. Complications of the long delay in approving medications included the diversion of limited mental health money to cover the costs of judicial review, diversion of physicians from direct patient care to provide testimony, inconsistent judicial medication and monitoring decisions, and compromise of medical judgment to meet judicial requirements. The study concluded that there was no advantage of judicial review over the previous Treatment Review Panel function.

The right of psychiatric patients to refuse antipsychotic medication has received a great deal of scrutiny and heated debate. The *Rogers*¹ and *Rennie*² decisions produced fundamental conflicts between psychiatrists and legal advocates on the need for treatment of mental disorders versus the inherent right of any person to refuse unwanted or intrusive treat-

ment. Psychiatrists feared that effective treatment would disappear and state hospitals would once again become warehouses for the chronically mentally ill. Gutheil articulated these concerns as "rotting with their rights on."³ Legal advocates, in contrast, regarded the emerging right to refuse treatment as a safeguard against inappropriate mistreatment of patients and as a mechanism to improve the delivery of psychiatric care to the mentally ill.⁴ Applebaum has re-

Dr. Farnsworth is assistant professor, Department of Psychiatry, University of Minnesota Medical School at St. Paul-Ramsey Medical Center, 640 Jackson Street, St. Paul, MN 55101-2595.

viewed the evolution of patient's rights to refuse treatment and the due process procedures created in many states to evaluate the mentally ill refuser.⁵

Minnesota initially responded to the challenges posed by the emerging right to refuse treatment by mandating creation of internal peer review committees at each state hospital in 1980. A comprehensive overview of the origin of the Minnesota Treatment Review Panel (TRP) has been written and will not be detailed here.⁶ The Treatment Review Panel format remained in effect until 1988, when the Minnesota Supreme Court released its opinion on *Jarvis v. Levine*.⁷

Glomer Jarvis was indeterminately committed to the Minnesota Security Hospital in March 1977 as mentally ill and dangerous. He underwent four separate courses of antipsychotic medication treatment. Each time he complained of severe side effects from the medications, and there was no evidence in the record that he benefitted from the treatment. On the fourth attempt to treat Jarvis with medication, in September 1984, he filed suit against the Commissioner of Human Services with the contention that the TRP procedure did not sufficiently protect his rights under Minnesota and Federal law.

The case was extremely convoluted with multiple reviews by the Treatment Review Panel, appeals to the medical director, and reviews by the hospital review board. In the 12 months of deliberation, the TRP determined, on seven occasions, that involuntary treatment with antipsychotic medication was un-

warranted. Jarvis was eventually forced to take the medication for nine months when the medical director, on appeal from the physician, overruled the TRP decision.

In January 1988, the Minnesota Supreme Court concluded that the Minnesota constitution guaranteed the right to privacy and that involuntary neuroleptic treatment of committed mental patients constituted intrusive treatment.⁸ It established pretreatment judicial review procedures to be used before the imposition of all intrusive forms of treatment on nonconsenting committed patients. The court cited the potential for tardive dyskinesia as a prominent reason to conclude that antipsychotic medications were intrusive. In rendering its decision the court acknowledged that the additional procedural process would cause some additional limitations on the freedom of physicians to treat patients in mental institutions. The court also believed that that decision would effect only a small number of patients.

Incompetent consenters, individuals who accepted medication but who did not appear competent to sign informed consent, were allowed to receive antipsychotic medication with the approval of the TRP and a guardian *ad litem*. However, after *Schmidt*,⁹ incompetent consenters were required to have written informed consent by their court appointed guardian *ad litem*, TRP approval, and a summary order from the court before medications could be administered.

The purpose of this article is to examine the impact of pretreatment judi-

cial review on the involuntary treatment of committed patients with neuroleptic medications at the Minnesota Security Hospital.

Setting and Method

The Minnesota Security Hospital is the forensic division of the St. Peter Regional Treatment Center, one of eight regional treatment centers in Minnesota. The Security Hospital houses 218 men and 18 women on nine living units. The male admissions unit is a 25-bed facility that receives patients from all counties in Minnesota under warrant of commitment as mentally ill, mentally ill and dangerous, and as psychopathic personalities. The admissions unit also receives patients for evaluation of competency to stand trial, criminal responsibility (insanity defense), and for presentencing evaluations of convicted individuals. Lastly, the admissions unit receives dangerous or violent committed patients from the other regional treatment centers who could not be managed safely at those facilities.

The unit is staffed by security, nursing, social services, and psychology personnel. The author has served as the consulting psychiatrist since July 1986. Diagnostic evaluations, court reports, initiation of treatment, and stabilization of mental disorders before transfer to other treatment units or facilities are the primary tasks of the admissions unit.

The records of all patients who were recommended for involuntary administration of antipsychotic medications between July 1986 and December 1989 were retrospectively reviewed. The au-

thor wrote the physician's certificate of need for medication in each case. The records were divided into pre-*Jarvis* and post-*Jarvis* categories. All patients between July 1986 and December 1987 were assigned to the pre-*Jarvis* category, the remainder to the post-*Jarvis* category. The variables on which data were collected included (1) patient age, (2) number of previous hospitalizations, (3) diagnosis, (4) number of days from admission to the date of the written certificate of need, (5) number of days after certificate that the case was reviewed by the TRP, (6) the type of certificate (emergent versus nonemergent), (7) the TRP decision, (8) and the number of days after the TRP decision that medications were initiated. Additional information on the post-*Jarvis* cases included (9) the number of days from the TRP approval to judicial review, (10) number of days from judicial review to the date of court order, and (11) the number of days from the court order to the initiation of treatment.

Results

Pre-*Jarvis* Data Two hundred and seventeen (217) patients were evaluated on the admissions unit between July 1986 and December 1987. Fifty-five percent (119) of the patients were committed to the hospital. The remainder were court ordered evaluations for whom *Jarvis* did not apply. Thirty-one (26%) men were referred to the TRP for consideration of involuntary administration of antipsychotic medication. Twenty-nine (93%) were white and two (7%) were black. The average age of the group was

33 years ($SD = 6.91$). This pre-*Jarvis* group averaged 6.81 ($SD = 4.59$) previous psychiatric hospitalizations and ranged from 1 to 21 separate hospitalizations. Eighteen patients (58%) met DSM-III¹⁰ diagnostic criteria for schizophrenia. Nine (29%) met diagnostic criteria for bipolar mood disorder. Two patients were diagnosed with schizoaffective disorder and two with organic psychotic disorders.

Twenty-three (74%) patients reviewed by the TRP were nonemergency medication evaluations. Eight (26%) were emergency medication reviews. These two groups will be examined separately.

Nonemergency Pre-*Jarvis* On average, the physician's certificate of need to the TRP for medication review occurred at 31 ($SD = 30.89$) days into the patient's hospitalization. The range, however, varied from 7 to 154 days. The Treatment Review Panel averaged 2.52 ($SD = 2.60$) days to review the case and approved the use of antipsychotic medications in 20 (87%) of the 23 patients. Two patients whose medications had been approved by the TRP appealed to the medical director; he subsequently upheld the TRP's decision and the medication was started. None of the three rejections by the TRP were appealed by the physician to the medical director and medication was not administered. On average the patients began their medication .53 ($SD = .96$) days after approval was received by the Treatment Review Panel. The total number of days from admission to the start of medications for the nonemergent pre-*Jarvis* patients av-

eraged 34.16 ($SD = 32.88$) days and ranged from 8 to 155 days.

Emergent Pre-*Jarvis* The pre-*Jarvis* emergency TRP petitions were, on average, written 16.5 ($SD = 27.00$) days into admission and ranged from 1 to 81 days. The certificate of need was written on the same day that the patient required emergency treatment with antipsychotic medication. Thus, these patients differed from the nonemergent cases in that they were receiving medications at that time their case was reviewed by the TRP. The review panel examined the records 3.75 ($SD = 3.06$) days after the onset of the emergency and approved the emergency administration of medication in seven of the eight cases. The one case that was rejected by the TRP was not appealed to the medical director and the medication was discontinued. The patient subsequently accepted voluntary antipsychotic medication and did not require further review by the TRP.

Post-*Jarvis* Data The admissions unit evaluated 255 patients January 1988 through December 1989. Sixty percent (153) of the patients were committed to the hospital. Thirty-seven (24%) of the patients were referred to TRP for review of involuntary antipsychotic medication administration. Thirty-four (90%) of the post-*Jarvis* patients were white; three (10%) were black. The men averaged 34.5 ($SD = 9.5$) years. The post-*Jarvis* group averaged 3.97 ($SD = 3.29$) previous psychiatric hospitalizations and ranged from 1 to 13 separate hospitalizations. Twenty-seven (73%) met the DSM-III-R¹¹ criteria for schizo-

phrenia. Seven (19%) of the patients met diagnostic criteria for schizoaffective disorder, and the remaining three (8%) patients met diagnostic criteria for bipolar mood disorder.

Twenty-one (57%) patients reviewed by the TRP were nonemergency medication evaluations. Sixteen (43%) were emergency evaluations. These two groups will be examined separately.

Nonemergent Post-Jarvis The average length of time after admission that the petition to the TRP was written by the physician for the nonemergent post-Jarvis group was 46.38 ($SD = 34.45$) days and ranged from 1 to 120 days. The TRP reviewed the petition, on average, 3.19 ($SD = 2.18$) days after the petition was filed. Twenty (95%) of the 21 cases were approved by TRP and forwarded to the court for a judicial review. The one case rejected by TRP was not appealed to the medical director nor was the case forwarded to the court. Four patients, before *Schmidt*, did not object to the administration of antipsychotic medication. The guardians provided informed consent and approved the administration of the medication after the favorable TRP review. Of the remaining 16 cases, the *Jarvis* hearing was held, on average, 51.69 ($SD = 29.57$) days after the TRP decision was rendered and an additional 16.25 ($SD = 21.21$) days were required before the written order was issued by the court with the recommendation regarding the medication. Fifteen (93%) of the patients were found incompetent and approved for antipsychotic medications by the court. The one exception was unusual and involved a pa-

tient who was ruled to be competent. Despite the finding of competence the judge ordered the patient to receive antipsychotic medications against his will. As a group the total length of time from admission to the initiation of medication was 115.07 days ($SD = 51.75$) and ranged from 6 to 252 days.

Emergent Post-Jarvis The post-Jarvis emergency TRP certificant of need were, on average, written 39.40 ($SD = 32.34$) days admission and ranged from 2 to 89 days. The TRP reviewed these emergency cases 3.60 ($SD = 2.59$) days after the initiation of medication. All sixteen (100%) of the cases were approved by the TRP and were maintained on their antipsychotic medications until their *Jarvis* hearing. Subsequently, 7 of the 16 patients regained competence to sign informed consent before their hearing and did not have a judicial review. For the remaining nine patients the *Jarvis* hearing was held 34.44 ($SD = 24.99$) days after the TRP hearing, and the orders were written 8.33 ($SD = 8.02$) days after the *Jarvis* hearing. In all hearings the court approved the continued administration of the antipsychotic medications. At the time of the *Jarvis* hearing, the patients had been on antipsychotic medications an average of 47 ($SD = 23.41$) days.

Pre- and Post-Jarvis Comparisons

The impact of judicial review on the administration of medication to treatment refusers is summarized in Table 1. The pre-Jarvis and post-Jarvis populations did not significantly differ in percentage of admissions requiring forced

Table 1
Impact of Judicial Review on Nonemergent and Emergent Medication Administration

Variable	Nonemergent			Emergent		
	Pre-Jarvis	Post-Jarvis	Significance	Pre-Jarvis	Post-Jarvis	Significance
No. of cases	23	21		8	16	$\chi^2 = 4.93$ $df = 1, p < .05$
No. of days to TRP Petition	31.00 $SD = 30.89$ range (7-154)	46.38 $SD = 34.45$ range (1-120)	$t = 1.53$ $df = 42$ NS	16.5 $SD = 27.00$ range (1-81)	39.40 $SD = 32.34$ range (2-89)	$t = 1.65$ $df = 22$ NS
No. of days to TRP Review	2.52 $SD = 2.6$ range (1-11)	3.19 $SD = 2.18$ range (2-9)	$t = .90$ $df = 42$ NS	3.75 $SD = 3.06$ range (1-8)	3.60 $SD = 2.59$ range (2-9)	$t = .12$ $df = 22$ NS
TRP Approval	87%	95%	$\chi^2 = 1.2$ $df = 1, NS$	87.5%	100%	$\chi^2 = 2.25$ $df = 1, NS$
No. of patients having Jarvis hearing	—	16		—	9	
No. of days to Jarvis hear- ing	—	51.69 $SD = 29.57$ range (8-124)		—	34.44 $SD = 24.99$ range (1-85)	
No. of days to written order	—	16.25 $SD = 21.21$ range (1-76)		—	8.33 $SD = 8.02$ range (1-21)	
Judicial approval	—	93%*		—	100%	
Total hospital days to medica- tion start	34.16 $SD = 32.88$ range (8-155)	115.07 $SD = 51.75$ range (27-205)	$t = 5.81$ $df = 37$ $p < .001$	16.5 $SD = 27.00$ range (1-81)	39.40 $SD = 32.34$ range (2-89)	$t = 1.65$ $df = 22$ NS
No. of days to Medical Re- view	—	—		-3.75 $SD = 3.06$	-47.00 $SD = 23.41$	$t = 4.87, df = 15$ $p < .001$

* One patient was found competent by court, but ordered to take the antipsychotic medication involuntarily.

medication review, race ($\chi^2 = 2.11$, degree of freedom (df) = 1, $p > .1$), or age ($t = .720$, $df = 66$, $p > 1$). Approximately 25 percent of the admissions between July 1986 and December 1989 were referred to the TRP for forced medication review. Ninety percent of the patients were white and aged in their early to mid-thirties.

Ninety-two percent of the post-*Jarvis* patients were diagnosed with schizophrenia or schizoaffective disorder. The remaining eight percent were diagnosed with bipolar disorder. In contrast only 64.5 percent of the pre-*Jarvis* group were diagnosed with schizophrenia or schizoaffective disorder and a significantly larger group was diagnosed with bipolar mood disorder ($\chi^2 = 22.03$, $df = 3$, $p < .001$).

The post-*Jarvis* group demonstrated a significant increase in number of emergency applications to the TRP ($\chi^2 = 4.93$, $df = 1$, $p < .05$). The average number of days from admission to the physician's request for a TRP review did not differ significantly for either the non-emergent ($t = 1.53$, $df = 42$, $p > .1$) or emergent ($t = 1.65$, $df = 22$, $p > .1$) populations.

The number of days required for the TRP to review the cases did not significantly differ for either the nonemergent ($t = .90$, $df = 42$, $p > .1$) or the emergent ($t = .12$, $df = 22$, $p > .1$) populations. Likewise, TRP approval averaged nearly 90 percent and did not significantly differ in either the nonemergent ($\chi^2 = 1.2$, $df = 1$, $p > .1$) or emergent ($\chi^2 = 2.25$, $df = 1$, $p > .1$) populations.

The largest contrast in the nonemer-

gent group, regarded the total hospital days before medication initiation. The pre-*Jarvis* group averaged 34.16 days, the post-*Jarvis* group averaged 115.07 days ($t = 5.81$, $df = 37$, $p < .001$). The most important contrast in the emergent pre-*Jarvis* and post-*Jarvis* populations is the number of days on medication before review. The pre-*Jarvis* group averaged 3.75 days on medication before receiving TRP approval. In contrast the post-*Jarvis* group averaged 47 days on medication before judicial approval of the medication ($t = 4.87$, $df = 15$, $p < .001$). Judicial approval of medications was 93 percent in the post-*Jarvis*, non-emergency population and 100 percent in the post-*Jarvis*, emergency population.

Discussion

In *Jarvis*, the Minnesota Supreme Court concluded that only a judicial determination of the need for antipsychotic medications would protect the involuntarily committed patient against undo intrusion. The court drew its conclusion from one atypical case in which a physician persisted in pursuing forced medication despite lack of approval from the hospital treatment review panel. From this case the court concluded that the "(TRP) superstructure, while commendable in form, is rendered meaningless in substance unless further procedural protections are required." The court concluded that the decision would likely affect only a small number of patients and that when the TRP approved a physician's medication pro-

posal “court approval should be quickly forthcoming with little difficulty.”

These data illustrate the impact that premedication judicial review had on the treatment of mentally ill male patients at the Minnesota Security Hospital. The percentage of patients that refused the medication before and after *Jarvis* were comparable to reviews from other states.⁶ Contrary to the court’s expectation, a significant percentage of the patients committed to the hospital required TRP or judicial review.

The pre-*Jarvis* cases were not characterized by repeated denials by the TRP and appeals to the medical director as was the case in *Jarvis*. Eighty-seven percent of the pre-*Jarvis* TRP reviews were approved and patients were started on medications within 24 hours of the approval. TRP review of patients started on medications for emergencies were also conducted quickly, usually within 3 to 4 days.

In contrast, judicial reviews were significantly delayed. Nonemergent patients were hospitalized an average of 80 additional days before the court approved medication—despite the fact that the TRP had approved the treatment as quickly as before *Jarvis*. However, the fear that judicial review would result in many patients not receiving medication did not materialize. All the patients who were eventually reviewed by the court were ordered to take medication. The nearly 100 percent judicial approval rate is consistent with findings in other jurisdictions that also employ court review.¹²⁻¹⁴

The imposition of judicial review did

not impact on patient selection criteria or the documentation submitted to the TRP. The certificate of need consisted of a detailed clinical history, diagnosis, medical rationale for medication, evidence of the patient incapacity to provide informed consent, alternatives to the proposed forced administration of medication, potential side effects, and an assessment of the likely outcome of the patient’s course if medications were not administered. The certificate remained the same before and after *Jarvis*.

The imposition of the TRP in 1981 created a greater awareness of the criteria for administration of antipsychotic medication, not the judicial review. The nearly unanimous agreement between the TRP and the courts raises the question of a lack of substantive due process in the court hearing. The courts heavily relied on the TRP conclusions to render opinions on forced treatment. Even the goal of procedural due process may be subverted by judges. For example, in one case a judge found a patient competent but still ordered the patient to take a specific medication, at a specific dose, and barred the use of other psychotic medication. In another case, a different judge committed a patient as mentally ill and dangerous and ordered antipsychotic medications be given before the treating physician or the TRP even reviewed the clinical history.

In contrast to the nonemergent patient, who received no medication for nearly 12 weeks before judicial review, emergent patients received medication an average of six weeks before their court hearing. If the goal of judicial review was

to minimize the risk of inappropriate exposure to the side effects of antipsychotics and the development of tardive dyskinesia, then these patients were poorly served by the long delay.

The long delays had some unanticipated consequences. Only 68 percent of the patients reviewed by the TRP were actually reviewed by the court. Five of the nonemergent patients had approval of medication by a guardian (before *Schmidt*). Seven of 16 emergently treated patients regained their competence while waiting for their court hearing and signed a voluntary consent to continue their medication.

An unanticipated complication of *Jarvis* was extension of the court's duty as finder of fact in the competency issue to rendering medical decisions regarding the actual medication to be dispensed to the patient. Every decision reviewed by the court, even the one in which the patient was found competent, was accompanied by an order that specified which drug could or could not be used, doses that could be utilized, duration of treatment, and specified the medication review mechanism. These varied widely by case. In some cases, patients were ordered medication for the duration of their commitment, others for 30 days. Some cases required a letter to the court each time the physician wanted to change the medication or dose, others required a TRP review each time medication was adjusted.

Judicial restrictions on medical treatment have had adverse consequences. In one case, for example, a patient received an emergency administration of medi-

cation, but was approved by the court to receive only two-thirds of the medication that was needed to stabilize his mental disorder. Reducing the medication to comply with the court order resulted in deterioration of the patient's condition.

The *Jarvis* decision also produced an unanticipated financial impact on the mental health system. Daily hospital costs at the Security Hospital are approximately \$160. A conservative estimate for the 16 patients who waited an additional 80 days before initiation of medication cost approximately \$205,000. Court, transportation, and expert witness costs may have increased this expense another \$150,000.

Conclusion

Judicial review has had a definite impact on the delivery of care to the mentally ill at the Minnesota Security Hospital. As is true in other jurisdictions, nearly all of the patients that required treatment with antipsychotic medications eventually did receive treatment. However, the *Jarvis* mechanism appeared to be inefficient. Hearings were not held in a timely fashion and idiosyncratic judicial opinions often interfered with patient management.

Judicial review did not change policies or procedures at the Security Hospital. Careful selection criteria and documentation was already in place for TRP review. Judicial review replaced the role of the hospital medical director to arbitrate the infrequent appeals made by patients or physicians disputing the TRP decision.

It is beyond dispute that patients have a right to privacy and are entitled to a due process procedure that protects that right when imposition of forced medications is considered. It is less clear whether the Treatment Review Panel or the courts are better suited to quickly and efficiently respond to that need. The results of this review suggest that, for patients at the Minnesota Security Hospital, the courts offered no real advantage over the Treatment Review Panel. Further appraisal of these issues is clearly needed.

Acknowledgments

The author thanks Dr. Dallas Erdman for assistance in data collection and Mrs. Joan Mudge for secretarial assistance.

References

1. *Rogers v. Commissioner of Dept. of Mental Health*, 458 N.E. 2d 308 (Mass. 1983)
2. *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J., 1978), remanded, 458 U.S. 1119 (1982), remanded, 720 F.2d 266 (3rd Cir. 1983)
3. Gutheil TG: In search of true freedom: drug refusal, involuntary medication, and "rotting with your rights on" (editorial). *Am J Psychiatry* 137:327-8, 1980
4. Cole R: Patient's rights vs doctor's rights: which should take precedence? in *Refusing Treatment in Mental Health Institutions—Values in Conflict*. Edited by Doudera AE, Swazey JP. Ann Arbor, MI. AUPHA Press in cooperation with the American Society of Law & Medicine, 1982
5. Appelbaum P: The right to refuse treatment with antipsychotic medications: retrospect and prospect. *Am J Psychiatry* 145:413-9, 1988
6. Zito JM, Lentz SL, Routh WW, Olson GW: The treatment review panel: a solution to treatment refusal? *Bull Am Acad Psychiatry Law* 12:349-58, 1984
7. *Jarvis v. Levine*, 418 N.W. 2d 139 (Minn. 1988)
8. *Price v. Sheppard*, 307 Minn. 250, 239 N.W. 2d 905 (1976)
9. *Matter of Schmidt*, 443 N.W. 2d 824 (Minn. 1989)
10. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders* (ed 3). Washington, DC. American Psychiatric Association, 1980
11. *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed, rev. Washington, DC. Am Psychiatric Assn, 1987
12. Appelbaum PS, Hoge SK: The right to refuse treatment: what the research reveals. *Behav Sci Law* 4:279-92, 1986
13. Hoge SK, Gutheil TG, Kaplan E: The right to refuse treatment under *Rogers v. Commissioner*: preliminary empirical findings and comparisons. *Bull Am Acad Psychiatry Law* 15:163-9, 1987
14. Miller RD, Bernstein MR, Van Rybroek GJ, Maier GJ: The impact of the right to refuse treatment in a forensic patient population: six month review. *Bull Am Acad Psychiatry Law* 17:107-19, 1989