The Treatment Review Panel: A Solution to Treatment Refusal?

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During the last ten years, forensic psychiatry has witnessed a sharp inversion of one of its most thorny problems — from the “right to receive treatment” to the “right to refuse treatment.” Judicial decisions such as Rogers in Massachusetts and Rennie in New Jersey have created clinical dilemmas for mental health professionals; the courts’ recognition of the psychiatric patient’s right, albeit qualified, to refuse antipsychotic drug therapy complicates treatment even if ultimately enhancing the treatment process.

Adopting the model of in-house peer review suggested by some of the decisions, the Minnesota Department of Public Welfare with assistance from the Attorney General’s office has developed a Treatment Review Panel (TRP) to evaluate the merits of involuntarily medicating committed patients in both acute (emergency) and nonemergency situations.

This article presents an overview of the evolution of the Minnesota Treatment Review Panel process, emphasizing judicial events and administrative responses, and summarizes activities of the TRP during its initial twenty months of operation. A discussion details the clinical significance and the administrative and legal implications of the trends suggested by the findings.

Evolution of the Minnesota Treatment Review Panel

The present involuntary medication protocol (Section XII of the Minnesota Department of Public Welfare Institutions Manual) began in 1980 as a response to litigation. Its predecessor, Policy Bulletin 26, adopted in 1974, was a broad-brushed policy dealing with all forms of involuntary treatment. Policy Bulletin 26 defined “emergency” expansively, gave extensive powers to the hospital to administer treatment in emergencies, and provided only limited review and recommendation powers to an outside hospital review board. For example, the policy allowed the hospital to administer ECT without consent in an “emergency,” which was defined to include any urgent psychiatric condition in which immediate treatment might help.

During this period, a minor patient at the Minnesota Security Hospital was given ECT without the consent of his mother, who subsequently sued. In its 1976 decision, Price v. Sheppard, the Minnesota Supreme Court, recognizing the pri-
vacy and liberty interests affected, established in *dicta* a judicial review procedure to precede involuntary administration of ECT or other "intrusive" therapies. Because of the potential for harm, judicial review was required to determine the necessity for treatment, with consideration given to changes to be effected by the treatment, risks of adverse side effects, medical acceptance or experimental nature of the treatment, extent of bodily intrusion and pain, and the patient's competence to self-determine the desirability of treatment.

The court specified use of this review procedure when ECT or psychosurgery was involved while exempting the use of mild tranquilizers or therapies requiring cooperation. Left hanging in the balance was the question of major tranquilizers or antipsychotics. Two subsequent trial court decisions in adjoining counties reached different conclusions on whether the *Price* decision applies to antipsychotics. *In re Lundquist* ruled that drugs are intrusive, while *In re Fussa* held antipsychotics to be nonintrusive and therefore exempt from judicial review.

Following the *Price* decision, the Minnesota Department of Public Welfare adopted rules implementing the decision with respect to treatments it classified as "intrusive." However, the looser procedure permitted by Policy Bulletin 26 apparently remained unchanged with respect to antipsychotics for the next four years. In April 1980, an eighteen-year-old patient at Anoka State Hospital sued its medical director. She claimed her rights were violated by the forced administration of antipsychotics as well as by the hospital's failure to follow the departmental policy. Although the lawsuit was resolved extrajudicially, it precipitated the office of the Attorney General to draft a detailed protocol on "Involuntary Administration of a Major Tranquilizer in State Hospitals," that is, Section XII. This protocol was resisted initially by the Department of Public Welfare, both in its development and its implementation. Section XII was finally promulgated in March 1981, and its application was piloted at Anoka State Hospital beginning April 1981. Based on the initial 14 months' experience at Anoka State Hospital, a redrafted version, issued in October 1982 and ratified as statewide policy, remains in effect to date. The present revision of Section XII, in light of 20 months' experience, is near ratification. It will be the subject of a subsequent paper summarizing 26 months' experience at Anoka State Hospital and its impact on clinical practice and administrative policy.

Although the Minnesota Commitment Act was substantially revised in 1982, it remained silent on procedures for refusal of psychiatric treatment, and the language might lend itself to several interpretations. However, commitment is not a determination of legal incompetence in Minnesota, and except as otherwise provided in the commitment act, "no person by reason of commitment or treatment pursuant to this chapter shall be deprived of any legal right. . . ." The statute does not say that such treatment may be carried on without prior consent. Rather, the legislature's silence, coupled with the retention of
rights provisions, simply leaves the development of requirements in this complex area to constitutional and administrative sources.

The courts have clearly recognized at least a qualified constitutional right to refuse treatment as well as a "liberty interest in avoiding the unwanted administration of antipsychotic drugs." The Supreme Court has not yet articulated the form of due process necessary to protect this liberty interest. In *Mills v. Rogers* it sent the case back to the lower court to allow consideration of applicable state law. In the interim, Section XII represents Minnesota's attempt to afford a minimum of procedural due process.

Section XII applies only to involuntary patients in state institutions. Despite its detailed format, its application differs in various institutions. This discussion of its application is limited to Anoka State Hospital, a 236-bed facility serving the Minneapolis-St. Paul metropolitan area with an at-risk population of approximately two million people. Olson has shown that the hospital was entering the era of the "young adult chronic" patient as early as 1972, in contrast to the outstate hospitals. With approximately 80 percent of all admissions referred from public and private inpatient settings, the seriously ill, functionally incapacitated, treatment-resistant patient is typical.

Section XII mandates hospital-based, clinical peer review of forced administration of antipsychotics. It does not incorporate any judicial procedure to determine competency, as the lower courts in *Mills* required, nor does it require outside hearing examiners or experts. Its strengths, like its weaknesses, are those of an internal peer review process.

Anoka's multidisciplinary treatment review panel, an entity separate from the patient's treatment team, is composed of five or more staff members including a physician, psychologist, social worker, nurse, and patient advocate. Because the present patient advocate at Anoka is an attorney who perceived a conflict in both representing and judging, another administrative voting member has been appointed. At Anoka, the TRP also includes a clinical pharmacist and a consulting psychiatrist. The panel meets weekly to review instances of emergency forced medication and referrals for nonemergency medication. Antipsychotics may be administered in an emergency if the behavior at issue "poses an almost certain risk of physical harm to the patient or to other persons and... represents a significant change from past behavior." In addition, the documentation must show the reasons for refusal, the consideration of alternatives, and the efforts to gain the patient's cooperation. TRP review must occur within seven days of the referral, and emergency medication may continue during that period. For emergencies, as for nonemergencies, the TRP meets with the patient, the advocate, and a treatment team member. After its decision, a written summary of its findings is entered into the patient's medical record.

Review of emergencies occurs retrospectively. While appeal to the medical director and nonbinding procedural review by the outside hospital review board are possible, no sanctions for noncompliance with the emergency procedure are explicitly provided. However, one of the most dramatic effects of the TRP has
been the change from a predominance of emergency referrals to a situation in which emergencies constitute less than 10 percent of cases. To illustrate, prior to formation of the TRP, drug refusals were referred to the hospital review board, a monthly external review procedure operating under the loose criteria of Policy Bulletin 26 and emphasizing the need for emergency conditions to justify forced treatment. Data from a separate five-month survey of their activities showed nine emergencies for every nonemergency referral. After five months of the TRP operation, this ratio plunged to one emergency for every two nonemergencies. Similarly, a dramatic change in the review board approval rates was observed. Whereas only 32 percent of forced medication referrals were approved by the review board prior to TRP implementation, this rate rose to 64 percent in the months following the start-up of TRP.

In nonemergent situations, the procedure is prospective and the criteria are more complex. The patient must be committed, and documentation similar to that required for emergencies is needed. The documentation and staff member presentation must enable the TRP to reach the following conclusions if forced medication is to be approved:

1. The patient is unable to engage in a rational decision-making process regarding the acceptance of treatment;
2. The patient suffers from a major mental illness with severe functional incapacity;
3. (a) There has been remission with previous antipsychotic drugs and deterioration when they were discontinued, or
   (b) Documented behavior is such that the known benefits clearly outweigh the risks.

During the TRP's meeting with the patient and a member of the treatment team, the patient is represented by the patient advocate. If the criteria are met, the TRP may approve a thirty-day trial of forced medication. The patient or the treatment team may appeal to the medical director. Procedural review by the hospital review board is also possible. Once the initial period has elapsed, one month extensions may be granted under the protocol.

**Twenty-Month Summary of TRP Activities**

In the 20 months since its inception (April 22, 1981 to December 31, 1982), TRP activities may be divided into four intervals, consisting of a pilot period of nine weeks followed by three blocks of six months' duration. To describe aggregate data of activities of the TRP, three dimensions were distinguished: (1) Patients (N=170): original, unduplicated individuals, (2) Patient Referrals (N=314): appearances made by a patient who may have appeared previously (all individuals, duplicated and unduplicated), and (3) Type of Action: a breakdown of referrals into Emergency (N=62), one-month Nonemergency (N=191), two months' continuous Nonemergency (N=54), and more than two months' Nonemergency Treatment (N=19), for a total of 326 actions taken on 314 patients referred, 170 of whom were original, unduplicated patients. Table 1 illustrates
that despite rising mentally ill admissions among the whole hospital population, the trend of total TRP referrals appears to be stable in the three six-month periods evaluated. However, even though the total number of new patients referred decreased over the three intervals, it is most striking that the pool of those with more than 2 referrals (>2 x referrals) increased. This suggested that serious drug refusers are a discrete subpopulation of mentally ill patients.

A frequency distribution of referrals (emergency and nonemergency) is illustrated in Table 2. Multiple referrals were either contiguous or intermittent over the twenty months. The distribution contrasts the very small number of patients who required more than two TRP appearances compared with the large number of 1- and 2-TRP referral patients. While 58.8% of patients experienced one-time-only TRP events, and 20% had two TRP referrals, the remaining 37 (22%) patients reflect 148 (47.2%) — nearly half of all referrals. The workload for these 37 recurring patients indicates that they represent 148 out of 314 appearances (47%) of TRP activity to date. Converted to dollars, this represents a cost of over $24,000.

<table>
<thead>
<tr>
<th>Table 2. Frequency Distribution of Referrals</th>
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<tr>
<td>Number Referrals/Patient</td>
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<td></td>
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<tr>
<td>1</td>
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<td>3</td>
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<tr>
<td>4</td>
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<td>5</td>
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<td>6</td>
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<td>7</td>
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<tr>
<td>8</td>
</tr>
<tr>
<td>14</td>
</tr>
<tr>
<td>Total</td>
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Table 3. Significantly Greater Rate of Referral from Acute Treatment Units Compared with Continued Treatment Units

<table>
<thead>
<tr>
<th>Unit</th>
<th>Referrals</th>
<th></th>
<th>Number</th>
<th>Percent</th>
<th>Beds</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute treatment</td>
<td>313</td>
<td></td>
<td>175</td>
<td>55.9</td>
<td>50</td>
<td>23.6</td>
</tr>
<tr>
<td>Continued treatment</td>
<td>138</td>
<td></td>
<td>23.6</td>
<td>162</td>
<td>76.4</td>
<td></td>
</tr>
</tbody>
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\[ \chi^2 = 181.60, \text{df} = 1, p < .001 \] in comparing actual versus expected (based on number of beds) number of referrals for the two types of units.

Table 4. Significant Change in the Ratio of Emergency to Nonemergency Referrals

<table>
<thead>
<tr>
<th>Six-Month Interval</th>
<th>Emergency</th>
<th>Nonemergency</th>
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<tbody>
<tr>
<td>I 7-1-81/12-31-81</td>
<td>22</td>
<td>49</td>
</tr>
<tr>
<td>II 1-1-82/6-30-82</td>
<td>24</td>
<td>54</td>
</tr>
<tr>
<td>III 7-1-82/12-31-82</td>
<td>10</td>
<td>72</td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
<td>175</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 10.79, \text{df} = 2, p < .01 \]

Table 3 displays a statistically significant difference \((p < .001)\) in patient referrals from two acute, short-term units compared with the four continued-treatment units. Psychogeriatric patients represent a group distinct from general psychiatric patients and so are excluded. Thus, patients referred to TRP are more often on locked, acute-care units. These units maintain 24 percent of the hospital's beds but have made 56 percent of the TRP referrals.

Early on, it became apparent that emergency referrals were being less frequently presented with a concomitant rise in nonemergency referrals. Inspection of the data in Table 4 illustrates this trend over time; emergency referrals dropped to a low of ten in interval III. The difference between emergency/nonemergency ratios in intervals I, II, and III is statistically significant \((p < .01)\). This trend suggests greater acclimation of treatment staff members to the TRP referral process and their acceptance of the nonemergency situation as a viable one for forced medication administration. Earlier intervention also may be responsible for fewer crisis episodes. Thus, “emergency” has become defined more narrowly over time, and nonemergency situations are viewed as the norm. The clinically limited therapeutic goals of the emergency use of medication, essentially using antipsychotic drugs as “chemical restraints,” was perceived by the medical director as “treatment paralysis” and led to his assertive role in developing the TRP process.

Table 5 illustrates the significantly higher \((p < .001)\) approval rate for emergencies, a condition not unaffected by the retrospective nature of the emergency referral. In the prospective nonemergency referral situation, the TRP members may function in a more collaborative role. The nonemergent context may also be an area in which more ground for disagreement exists. The retrospective emergency judgment, however, has a different tenor. Discussion of precipitating fac-
tors and of clinical judgments already rendered has a quality of "second guessing," and perhaps decisions are more often accepted in good faith. Overall, 95 percent of emergency referrals were approved, while only 67 percent of non-emergency referrals were approved during the period studied.

To evaluate the direct clinical and administrative costs of operating the TRP, we estimated time that panel members and appeal members devote to this task and cost of each member's time. An estimated $557 per week is suggested, not including additional secretarial, photocopying, ward clerk, and overhead expenses. This results in an estimated cost of $162 per-patient TRP appearance, given an average of 3.72 appearances per week for the study period.

In an attempt to capture the epidemiologic proportions of the TRP experience, the "incidence of serious drug refusal" was calculated. "Serious drug refusal" is operationally defined as refusal resulting in a TRP referral. The incidence rate was calculated by dividing TRP episodes (177 episodes, * one episode per admission) by the total at-risk population (mentally ill, committed patients = 920 admissions plus 246 in-house population on 4/1/81) during the 20-month study period. Thus, consistency in numerator and denominator is achieved since each figure reflects "treatment episodes," and allows us to compute the proportion of admissions in which serious drug refusal occurred among admissions during this time period. Over these twenty months, an incidence rate of 15 percent suggests the seriousness of the drug refusal problem among Anoka's mentally ill population.

**Discussion**

**Medical Issues** While the TRP is still a relatively young enterprise and continues to undergo refinement, overall the effects of its presence on the Anoka State Hospital staff have been positive. Confronting the problems that mental health professionals would otherwise only read about in journals and hear about at professional meetings is a challenge and may provide the stimulus to bring fresh thought and new insight to the difficult-to-manage patient. But such potential for growth is not without a price. During the initial pilot program days, serious questions concerning the bioethical aspects of the failure to treat were very much in evidence among members of treatment teams. This was especially apparent among those charged with responsibility for behavior management and

*Of these, 163 were single episodes of unduplicated patients and 14 were multiple episodes of 7 duplicated patients. They were counted twice because they appeared at TRP in a subsequent hospital admission during the study period.*

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**Table 5. Significantly Greater Rate of Approval of Emergency Referrals Compared with Nonemergency Referrals**

<table>
<thead>
<tr>
<th></th>
<th>Approved</th>
<th>Disapproved</th>
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<tbody>
<tr>
<td>Emergency</td>
<td>59 (95%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Nonemergency</td>
<td>127 (67%)</td>
<td>64 (33%)</td>
</tr>
</tbody>
</table>

\[ \chi^2 = 19.00, df=1, p < .001 \]
treatment program goals. One of the greatest concerns voiced by staff members involves the rights of other patients who are affected by acting-out behaviors and uncooperativeness of the drug refuser. Malmquist has noted that the drug refusal right is a "matter of balancing interests." The refusing patient's right must be carefully balanced against the rights of fellow patients as well as of the community to which the refuser eventually will be returned.

Professional autonomy is an issue often cited in describing the conflicts that emerge in the right-to-refuse-treatment dialogue. It is an aspect difficult to assess in the working environs of a small facility in which clinical staff members wear many hats and experience in caring for the seriously mentally ill counts more than credentials. Thus, young psychiatrists may be more at ease in the treatment team context and gain support from more experienced staff members in, for example, nursing and social services. The presence of clinical pharmacists in treatment teams also may minimize gratuitous polypharmacy.

The TRP experience gives added recognition to the dynamic nature of standards of professional practice, and it has helped members articulate complex questions. Many of these questions concern the antipsychotic drugs, their efficacy, latency period, target symptoms, and side effects. A perplexing question concerns criteria for extensions of forced medication beyond thirty days: What length of trial of a well-documented medication is needed before a particular agent is regarded as ineffective? Psychopharmacology experts continue to debate this issue and trial periods range from 4 to 12 weeks, leaving the issue unresolved for the practicing clinician. In addition, judgments once intuitively made by a single prescriber become more troublesome in this group multidisciplinary context where consensus is sought and uncertainty must be abided.

In 1982, while discussing the drug treatment of schizophrenia, Blackwell stated: "Despite the tendency to overestimate 'curative' effects and underestimate unwanted effects, drug therapies remain the most parsimonious intervention in a condition that is resistant to every other known therapy." While the suppression of symptoms in the acute stage of psychosis is unquestionably significant, more difficult to assess are treatment outcomes that reduce hospitalizations and facilitate readiness for discharge. Our data to date do not permit us to speculate on the course of treatment and outcome of the TRP patient. Research is in progress to help answer this question.

Many of Anoka's difficult refusing patients may be incapable of achieving community readjustment. Roth and Appelbaum have recognized the limitations of generalizing early controlled clinical trial data to drug refusers: "even if it is known that drug treatment is beneficial for most schizophrenics, the question is whether these same benefits accrue when (or if) patients are forced to take medication."

As staff members struggle with the limits of current knowledge on the prediction of pharmacotherapy and begin to accept the idea that therapeutic monitoring may be a "value-laden" activity, as Roth and Appelbaum have noted, alternative approaches to treatment take on heightened importance. The use of seclusion,
often construed in the lay press as a negative, punishing activity, may assume a more therapeutic role in the management of the refusing patient. Appelbaum and Gutheil describe the clinical administration of space and suggest seclusion, that is, the prescription of minimal space, to control anxiety based assaultiveness and to provide the opportunity for coping and mastering impulses. Properly used, it can provide containment, isolation, and decreased sensory input for the patient with such needs. Its usefulness in reducing symptoms in the drug-refusing patient may be especially important.

Legal Issues From a legal advocacy perspective, the TRP has inherent limitations; its adequacy in providing a minimum of procedural due process has not yet been adjudicated. The tone of the TRP process reflects clinical evaluation rather than an impartial procedural hearing. The process affords limited opportunity for examination of witnesses other than the patient, and vigorous advocacy on the patient's behalf sometimes may be counterproductive. Because many TRP members are themselves responsible for managing difficult patients with scarce resources, the members' predisposition may be in favor of medication in questionable cases. Nevertheless, the experience to date suggests that the TRP affords consideration of patient concerns and treatment standards before antipsychotics are forced.

Additional legal dilemmas are posed by the need to provide treatment in the least restrictive alternative and by statutory mandates for periodic review of treatment programs. Refusing patients at Anoka State Hospital have not been "rotting with their rights on," as Appelbaum and Gutheil feared. On the other hand, there are often inherent tensions between the legal mandate to provide treatment and return patients to the community as expeditiously as possible, and the implementation of the patient's right to drug refusal.

Patient Issues The TRP process has profoundly affected the patient community at Anoka. No patient admitted today remains unaware of his or her right to refuse treatment for any period of time, given the vigorous patient advocacy available and the degree of interaction among patients. For some the process is undoubtedly beneficial, considering the long-standing belief that an active role in the therapeutic alliance between patient and therapist will be worthwhile. But this proposition requires that a relationship exist and that negotiation be possible. For some, such an ideal state is naive. Appelbaum and Gutheil's study of drug refusers at the Massachusetts Mental Health Center proposed three categories of refusers: Situational, Stereotypic, and Symptomatic. Only in the latter cases were serious clinical consequences thought to derive from drug refusal. A study is now being launched to evaluate differences in treatment outcome between treated and untreated refusers at Anoka.

At the present time, given our experience to date, the TRP process is at least providing the opportunity for patients to be heard and for clinical staff to review the decisions of their peers. It is hoped the future will bear out the fruits of these efforts in more successfully meeting patients' expressed needs and in providing improved treatment outcomes.
References


5. In re Fussa, No. 66110, Probate Ct., Hennepin County, MN (1976), petition for mandamus or prohibition denied, No. 46912 (Minn. S. Ct., June 14, 1976).


12. Rogers v. Okin, supra.


15. Roth LH and Appelbaum PS: What we do and do not know about treatment refusals in mental institutions, in Refusing Treatment in Mental Health Institutions—Values in Conflict. Edited by Dudera AE and Swazey JD. Ann Arbor, AUPHA Press, 1982.


17. Minn. Stat. 253B.09, subd. 5 (initial determinate commitment and 60 to 90 day report requirement); 253B.09 (statutory right to least restrictive setting and to maximum initial commitment of six months); 253B.03, subd. 7 (right to treatment best adapted to rendering further institutionalization unnecessary); 253B.12 (six month hearing on need for continued commitment).
