Treatment Refusal among Forensic Inpatients

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Although the United States Supreme Court has not offered a definite opinion, some states have established the qualified right of involuntarily committed patients to refuse treatment. Controversy continues between psychiatry and law over what procedural protections should be provided to patients when therapists seek to override nonemergency refusal of treatment. The authors review Oregon's administrative approach and its application to the treatment refusal of 33 state hospital forensic patients. Patient characteristics, refusal patterns, and implications of treatment refusal are also described.

Controversy surrounding the right to refuse treatment has shifted from argument as to whether or not the right exists to the procedures necessary for overriding treatment refusal in nonemergency situations. Many jurisdictions have recognized that involuntarily committed patients have a limited right to refuse treatment.[1] This right is based both on the fact that modern civil commitment statutes separate commitment from civil competency and on certain constitutional provisions.[2] The right is limited in emergency situations when protection of the patient, other patients, or staff is deemed more important than safeguarding the right to refuse treatment.

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Nationally, three procedural models have emerged to review and potentially override patient refusal. Massachusetts developed a procedure with an initial judicial determination of an individual's competency to refuse. If found incompetent, a substituted judgment is then made of what the individual would have chosen if competent.[3,4] New Jersey developed procedures based on an internal review of the refusal by employees of the hospital in which the patient is committed.[5] Utah amended its civil commitment statute by adding incompetency to make treatment decisions to the criteria for commitment.[5,6] In Utah, the right to refuse is thus extinguished at the time of commitment. In Massachusetts and New Jersey, procedures for overriding refusal are invoked after refusal takes place and when the hospital staff believes the patient's decision should be challenged.

Oregon's procedure for overriding nonemergency refusal was adopted by

administrative rule in 1983. The procedure is similar to that developed originally in New Jersey.[7] The new rule was patterned after an existing statute governing electroshock treatment, which specified that involuntary patients have a right to be free from "unusual or hazardous treatment procedures including electro-shock therapy unless they have given their express and informed consent."[8] The statute further specified that "this right may be denied to such persons for good cause only by the director of the facility in which the person is confined, but only after consultation with and approval of an independent examining physician."[9] The administrative rule for right to refuse treatment provides that, if the treating physician feels that good cause exists, a request to treat the patient involuntarily is sent to the hospital superintendent or chief medical officer. An independent psychiatrist, not an employee of the mental health division, then examines the patient to determine if treatment should be instituted. If good cause for involuntary treatment is found to exist, and the chief medical officer or superintendent agrees, then treatment may be given.

In a previous paper[10] we examined the use of the new administrative rule in a population of civilly committed patients in one of Oregon's three state hospitals during the rule's first year of operation. This paper describes the use of the rule during the same time period in the Oregon State Hospital (OSH) forensic unit. The forensic unit primarily serves two groups of patients: those persons charged with crimes, found incompetent to stand trial, and committed to the hospital for treatment in order to restore competency; and those persons found not guilty by reason of insanity and committed to the jurisdiction of the Oregon Psychiatric Security Review Board (PSRB).[11] Our primary goal in this paper is to study right to refuse treatment procedures in these special patient populations.

Method

Late in 1984 one of the authors (J.Y.) performed a retrospective record review of all patients on the forensic unit whose physician had requested permission to override their refusal of treatment. The requests to override treatment refusal were made between the time the procedure was implemented, in April 1983, and December 1983. The following data were collected on the identified patients: (1) demographic characteristics, including the crime leading to involvement with the legal system; (2) the reason for and pattern of medication refusal; (3) the reason for physician/treatment team's request to override refusal; (4) the use of emergency medication, seclusion, and/or restraints during the refusal period; and (5) the medication refusal pattern and length of hospitalization.

Results

The OSH forensic unit consists of 200 beds, divided into six wards. In 1983 there was a total of 358 admissions to the OSH forensic unit.

Thirty-five patients on the forensic unit refused treatment from April to December 1983. Seventeen (49%) were sent to OSH by the courts as incompetent to stand trial (pretrial group), and 16 (46%) patients were under PSRB ju-

risdiction (PSRB group). One (3%) was a civilly committed patient accepted in transfer from another state hospital and placed in the forensic unit because he was believed to be extremely dangerous, and one (3%) was admitted to the forensic unit voluntarily for the sake of convenience, because she had been well known to the ward staff in the past. Because the circumstances of the placement of the last two patients on the forensic unit were unusual, only the data pertaining to the 33 patients in the pretrial and PSRB groups will be presented in this report.

Each of the 33 patients was interviewed by one of seven different independent examining psychiatrists. They recommended refusal override in all (100%) cases and the chief medical officer followed their recommendation in all but one case (3%). In this instance, one month later the patient was felt to have deteriorated, a second consultation was performed by a different examiner, treatment was recommended, and this time the chief medical officer agreed to override.

Patient Characteristics As shown in Table 1, the typical patient in this group was a relatively young Caucasian male who had completed high school, was unemployed at the time of arrest, was single, divorced, or separated, lived alone or with his nuclear family, had a diagnosis of schizophrenia, and had a history of previous psychiatric admissions. One third of the patients had a current or past additional diagnosis of substance abuse. The characteristics of the PSRB and pretrial groups were very similar.

Table 1
Characteristics of 33 Treatment Refusers

Sex		Age (yrs)	Race			Education (yrs)			Employment Status		Living Arrangements					Marital Status				Primary Diagnosis					Previous Psychiatric Admission			Substance Abuse Dx or Hx	
M	F		Caucasian	Black	Other	12	12	12	Unemployed	Employed	Family	Alone	Sheltered	Transient	Unknown	Married	Single	Divorced/ Separated	Unknown	Schizophrenia	Affective Disorder	OBS	MR	Pers Dis	None	1–5	6–10	11+	Yes	No
30	3	mean, 36	29	2	2	10	19	4	23	10	8	10	6	3	6	2	21	7	3	28	3	1	0	1	8	21	2	2	11	22
91%	9%	median, 33	88%	6%	6%	30%	58%	12%	70%	30%	25%	30%	18%	9%	18%	6%	64%	21%	9%	85%	9%	3%	0%	3%	24%	64%	6%	6%	33%	67%

Dx, diagnosis; Hx, history; OBS, organic brain syndrome; MR, mental retardation; Pers Dis, personality disorder.

In previous papers we have developed a crime seriousness score[12,13] that ranks 83 crimes according to seriousness and assigns each a numerical score, from 10 for murder to 800 for false fire alarm. The offenses that led to the original court appearance or to eventual placement under PSRB jurisdiction were scored, and the mean was 358, with a range of 10 for murder to 760 for misdemeanor harassment. These scores show that people were placed in the forensic unit for a wide range of crimes in both the pretrial and PSRB groups.

Patterns of Medication Refusal There were essentially three patterns concerning the timing of the medication refusal. Sixteen (94%) of the pretrial patients refused medication from admission, compared to three (19%) of the PSRB patients. Ten (63%) of the PSRB patients initially took the recommended medication and then later refused, whereas none of the pretrial patients did so. One (6%) pretrial and one (6%) PSRB patient took the recommended medication intermittently, whereas two of the PSRB patients apparently refused medication immediately upon its recommendation, some time after admission. In addition to medication refusal, eight (47%) pretrial and eight (50%) PSRB patients also refused one or more other recommended procedures or treatments such as physical examination, laboratory tests, vital signs, dental work, food, and group or similar therapies.

Reasons for Patients' Refusal of Medication Only six (35%) records of the pretrial patients revealed specific reasons for their medication refusal, whereas some explanation for refusal was found in the records of all 16 (100%) PSRB patients. Two of the six (33%) pretrial patients denied any illness and consequent need for medication, whereas seven (44%) of the PSRB patients did so. Two (33%) pretrial and two (13%) PSRB patients complained of anticipated or present side effects. One (17%) pretrial and two (13%) PSRB patients had delusional ideas about the medication. For example, one PSRB patient claimed the medication capsules contained "urine and semen." Only one (6%) PSRB patient explicitly stated he was asserting his "right to refuse" medication. The reasons given for refusal by one (17%) pretrial and four (25%) PSRB patients were so vague or thought disordered that they were indecipherable.

Reasons for Request to Overrule Refusal Table 2 lists the reasons that staff requested an override. On the average, there were two reasons given per patient for each override request. Deteriorating or unstable mental status, stable mental status with no improvement, threats to others, and deteriorating physical condition were the most common reasons given.

Use of Emergency Medication, Seclusion, and/or Restraints Table 3 reports the use of emergency procedures before and after override in the pretrial group. Data on the one pretrial patient who refused after admission are not available because he refused at an unknown date, making the start of his refusal period uncertain. These data are unavailable for PSRB patients because most of these patients were admitted months to years before the treatment refusal that occurred during the 1983 study period.

Table 2
Reasons for Requesting Permission to Override Refusal

	Pretrial (N = 17)	PSRB (N = 16)
Deteriorating and/or unstable mental status	1 (6)	10 (63)
Threats to others	11 (65)	11 (69)
Physical attacks	7 (41)	3 (19)
On staff	3 (18)	0
On patients	2 (12)	3
On property	2 (12)	0
Deteriorating physical condition	5 (29)	2 (12)
Stable mental status with no improvement	12 (71)	6 (37)
Suicide attempts/threats	0	1 (6)
Total reasons	36	33

Numbers in parentheses, percentage.

Table 3
Use of Emergency Medication, Seclusion, and/or Restraints for Pretrial Patients (N = 16)

Use	Emergency Medication		Seclusion		Restraints	
	No. of Patients	%	No. of Patients	%	No. of Patients	%
Yes	3	19	12	75	5	31
No	13	81	4	25	11	69
Episodes of use	No. of episodes		No. of episodes		No. of episodes	Total
Before override	4		28		4	36
After override	1		36		3	40

Three (19%) patients received emergency medication, accounting for five episodes of use. In all but one instance the emergency medication was prescribed before override and the initiation of regular medication. Twelve (75%) patients were secluded, for a total of 64 episodes, with the majority (56%) occurring after override. Five (31%) patients received restraints, for a total of seven episodes, with the majority (57%) before override.

The 16 pretrial patients who refused medication from admission accounted for a total of 148 refusal days, which is defined as the time between refusal and override. This yields a mean of nine refusal days per patient. There were 36 total episodes of emergency treatment in the 148 days before override (Table 3), or 0.24 episodes per day. These patients spent a total of 627 days in the hospital after override, with a mean of 39 days per patient. There were 40 episodes of emergency treatment after override, or 0.6 episodes per day.

Medication Refusal Pattern and Length of Stay Table 4 presents the average length of hospitalization between admission, override, and discharge for each refusal pattern. There does appear to be a trend for PSRB patients to be overridden more slowly than pretrial patients in each refusal pat-

Table 4
Medication Refusal Pattern and Length of Stay

	Refused on Admit		Refused Later	
	Pretrial (N = 16)	PSRB (N = 3*)	Pretrial (N = 1)	PSRB (N = 11*)
Admit to override	9	35	24	561
Override to discharge/survey date				
Those d/c before survey	39	105 (2)	159	329 (1)
Those in hospital at survey		334 (1)		460 (8**)
Admit—Discharge/survey date				
Those d/c before survey	48	149 (2)	183	627 (1)
Those in hospital at survey		340 (1)		1110 (8**)

Values are given as mean days. Numbers in parentheses, N. d/c, discharge.
* Two PSRB patients are not included because it was unclear in the record when the patients actually refused medication and when it was proposed (at admission or later).
** This group does not include two PSRB patients who at the time of the survey were on unauthorized leave.

tern. In addition, regardless of the timing of the medication refusal, PSRB patients experience longer hospitalization before discharge. Considering each group as a whole, the average stay of pretrial patients is 56 days, whereas that of PSRB patients is 713 days (t-test, $p < .001$).

Discussion

There are several findings from our study that warrant discussion. First, at least for this one year, the treatment refusal rate among forensic inpatients in Oregon was somewhat lower than the rate among nonforensic civilly committed inpatients. If extrapolated to a yearly rate, the 35 refusers during the nine months of our study would become 47, which represents 13 percent of the 358 forensic admissions during 1983. This compares to a refusal rate of 24 percent of the civilly committed patients in another Oregon state hospital during this same time period.[10]

Second, the treatment refusers considered in this study were very seriously ill. They were predominantly young single male schizophrenics who had previous psychiatric admissions at the time of their offense. The independent consultants and chief medical officer were impressed by the seriousness of their illnesses, as almost every case (97%) was overridden. Seven different psychiatrists were asked to assess the treatment refusers for involuntary treatment. Although four of these physicians accounted for the majority of the consultations (90%), the high degree of consensus does not reflect one consultant's bias. In reviewing these cases retrospectively, it is our judgment that their decisions were appropriate. In addition, almost all patients improved significantly by discharge or the end of the study period. Our study of the civil commitment population found a similar (95%) rate of override approval.[10] In the only other published study that looked at such data, Zito *et al.*[14] found a 67 percent override in a Minnesota hospital. The Oregon and Minnesota procedures were slightly different; patients in Minnesota were reviewed at monthly intervals whereas in Oregon the determination was made

only once, with the decision binding for a one-year period.

Third, most pretrial patients refused medication from the time of hospital admission, whereas PSRB patients tended to refuse later on in their hospital course. There are several possible explanations for this finding. Although both groups of patients had a past history of psychiatric hospitalization, most pretrial patients were not in active outpatient treatment at the time of their arrest. In contrast, about half the PSRB patients were on conditional release with medication before admission. The other half were placed under PSRB jurisdiction and sent directly to the hospital for treatment but were probably less disorganized than the pretrial group because they were presumably competent to go through the criminal justice system. Therefore, on admission many of the PSRB patients were either already partially treated or were well enough to pass through the criminal justice process. Amarasingham's discussion[15] of the social factors involved in medication refusal also may help to shed some light on the delayed refusals of the PSRB group. Because the PSRB patients were hospitalized much longer, it is possible that other patients on the ward encouraged noncomplicance or they eventually refused medication as a means of asserting their independence.

Fourth, the forensic inpatients in our study refused medication for a variety of reasons. Our data do not easily lend themselves to the refusal categories suggested by Appelbaum and Gutheil.[16] They defined situational refusers as a diverse group of patients who responded with brief medication refusal to a wide variety of circumstances. Stereotypic refusers were those chronically ill, predominantly paranoid patients who responded to stress with medication refusal. Symptomatic refusers were young, acutely psychotic patients whose refusal was related to delusional beliefs associated with their illness. We might postulate, however, that those patients who refused from the moment treatment was suggested were symptomatic refusers, whereas those who refused later on were stereotypic refusers. All five of the symptomatic refusers described by Appelbaum and Gutheil[16] claimed a right to refuse treatment, whereas only one PSRB patient in our study refused for this reason. Our findings are similar to those of Rodenhauser,[17] who found this reason in one of 13 forensic unit treatment refusers.

Fifth, emergency procedures were used very infrequently considering the seriousness of patient pathology and the frequency of threatening or violent behavior. During the refusal period, an emergency procedure was used for a pretrial patient about once every four days. This compares to the use of an emergency procedure about once every 15 days in the civilly committed population.[10] The greater frequency in the forensic population may indicate not only the seriousness of their psychopathology, but also the fact that these patients were hospitalized after the commission of crimes, many very serious in nature.

Sixth, the time periods that occurred throughout the override process were substantially longer for the PSRB patients. The longer time required to re-

quest an override in the PSRB group may be another reflection of their partial treatment and/or less disorganized behavior on admission. It may take longer for PSRB patients to become unmanageable. PSRB patients also required longer treatment after override before they were ready for discharge. This reflects the different treatment goals for the two groups. For the pretrial group the goal was restoration of competency so that the person could stand trial. The level of functioning required for competency is not as high as that required for discharge from the hospital. PSRB patients are discharged from hospital and placed on conditional release only when a careful release plan has been worked out and approved by the PSRB. It may also be that treatment refusal by PSRB patients works against their hospital discharge. The administrative rule appears to work smoothly for the pretrial patients but may present problems for the PSRB patients. More work needs to be done to understand the implications of refusal for the PSRB group.

Finally, it is premature to recommend changes in the Oregon system. We need more detailed data over a longer period of time from both Oregon and other jurisdictions in order to recommend any design changes in the current system. Needless to say, these data are extremely important because we are dealing with an expensive procedure that involves delay of treatment and may have more long-ranging consequences for the PSRB population.

In conclusion, in the first year of the Oregon procedure forensic inpatients refused psychiatric treatment about half as often as civilly committed patients (13% versus 24%, respectively).[10] Those forensic patients that did refuse treatment were very seriously mentally ill and frequently threatened or actually attacked other patients or staff. Despite this, emergency procedures appeared to be used infrequently at OSH. The treatment refusal of these patients reflected their psychotic illness rather than a rational decision-making process regarding a right to refuse treatment. Involuntary treatment with medication restored the competency of all 16 (100%) pretrial patients and allowed them to return to the criminal justice system for disposition of their cases. Three of 16 (19%) PSRB patients improved enough by the end of the study to return to the community. Finally, it appears that the high rate of override approval was appropriate under the clinical circumstances found in this study.

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