

Drug Treatment Refusal and Length of Hospitalization of Insanity Acquittees

Mary H. Williams, MS; Joseph D. Bloom, MD; Larry R. Faulkner, MD; Jeffrey L. Rogers, JD; and Sally L. Godard, MD

Thirty-three insanity acquittees who had refused drug treatment were matched to a sample of nonrefusing hospitalized insanity acquittees in an attempt to measure the effect of treatment refusal on length of hospital stay. No measurable effects on the length of hospitalization were found. However, upon comparing the amount of time under court jurisdiction spent in the hospital and on conditional release in the community, it becomes evident that refusers spent significantly greater proportions of time hospitalized than the average hospitalized insanity acquittee, who had less hospitalization and spent more time on conditional release. These differences do not seem to be related to the issue of treatment refusal.

It is now generally accepted that involuntarily committed patients have a qualified right to refuse treatment, because in most jurisdictions civilly committed patients are regarded as legally competent to make treatment decisions. Much of the current debate in this area centers on the procedures necessary to override refusal in nonemergency situations.¹ In Oregon the procedure developed by administrative rule in 1983² specifies that the right to refuse treatment may be overridden only after the treating physician feels there is sufficient reason to treat the patient involuntarily,

the patient is examined by an independent psychiatrist who concurs, and the hospital superintendent agrees with the override decision.

In previous articles we examined the use of this procedure for civilly committed patients who refused treatment in one state hospital,³ and for the entire Oregon state hospital system.⁴ The 1983 administrative rule was also applied to hospitalized forensic patients who refused treatment. In a third article⁵ we examined the application of this rule in the state hospital forensic unit during 1983. The forensic population in this study included persons found incompetent to stand trial (IST) and sent to the hospital for restoration of competency, and those found not guilty by reason of insanity (NGRI) and hospitalized under the jurisdiction of the Oregon Psychiat-

Ms. Williams and Drs. Bloom, Faulkner, Rogers and Godard are affiliated with the Oregon Health Sciences University, Portland, OR. Address reprint requests to Ms. Williams, Department of Psychiatry, Oregon Health Sciences University, 3181 SW Sam Jackson Park Rd., Portland, OR 97201.

ric Security Review Board (PSRB). In brief, the PSRB is analogous to a parole board responsible for monitoring insanity acquittees. The board has the authority to place insanity acquittees either in the forensic hospital or on conditional release in the community. The length of PSRB jurisdiction is determined by the trial court judge at the time of the NGRI finding.⁶

In the previous study of forensic patients⁵ we found that PSRB patients experienced significantly longer hospitalizations when compared with the pretrial, IST group. We felt these findings were a reflection of the different treatment goals for the two groups: to restore competency to stand trial for the pretrial group versus a more stringent criteria of functioning on conditional release for the PSRB, insanity acquittee, group.

Little research has been reported exploring the effects of treatment refusal in forensic hospitals in general, and more specifically on the length of hospitalization. Recently, Rodenhauser *et al.*⁷ reviewed the hospital records for 421 admissions and discharges in an Ohio forensic psychiatric hospital during a three and one-half year period. Among the variables studied was the influence of treatment refusal on hospital length of stay. Thirty-five percent ($n = 147$) of their sample refused treatment. Of these treatment refusers, 48 percent (16% of the larger sample) were medicated involuntarily. Although the authors did not separate IST from NGRI patients, they found a significant relationship between drug treatment refusal and hospital length of stay. Refusers averaged

hospital stays of 148 days, compared with 78 days for nonrefusers. No significant differences in length of hospitalization were found between refusers who received medication involuntarily and those who did not receive medication. The authors were not able to conclude that refusal caused the increased length of hospital stay; the timing of the drug treatment refusal may have influenced this relationship but was not included in the analysis. Because it has now been consistently reported that most treatment refusal is overridden,⁸ we have been particularly interested in the after-effects of treatment refusal, especially the relationship of refusal to possible increased length of hospitalization. Our interest stems from both the economics of the situation and the fact that the procedures to override may themselves be expensive undertakings that produce little of value to either the patient or the hospital.

As did Rodenhauser and colleagues, we speculated that treatment refusal might work against hospital release for the PSRB patient. In the present study we sought to clarify the effects of treatment refusal on the length of hospitalization of these patients.

Method

In the two-year period, 1983 through 1984, 82 patients who refused drug treatment on the state forensic psychiatric unit were handled under the procedures established in the 1983 administrative rule.² Of these 82 patients, 33 were insanity acquittees hospitalized under PSRB jurisdiction. Treatment refusal

Insanity Acquittees

was overridden in all 33 cases. Since all refusers were overridden, we had no way to compare the subsequent hospital course of those refusers who were overridden against those who were not overridden. We decided that for the 33 PSRB patients (refusal group), we would construct a matched sample of 33 patients (nonrefusal group) drawn from the total population of 885 individuals placed under the jurisdiction of the PSRB since its inception in 1978. It was hoped that this comparison would allow us to determine whether refusal alone might influence length of hospital stay. Subjects were matched for age, sex, crime leading to PSRB placement, time of initial placement under PSRB jurisdiction, and the requirement that the subjects were hospitalized during the 1983 through 1984 study period.

Previously we developed a system of categorizing crimes in terms of the nature and seriousness of the crime.⁹ The scale ranks 83 crimes from murder, with a score of 10, to false fire alarm, with a score of 830. In this system crimes are also organized into ten felony and ten misdemeanor categories based on the nature of the crime. In cases in which an exact crime match was not available, a nonrefusal subject was chosen who had been charged with a crime in the same category and with a similar seriousness score as the crime with which the refusal subject was charged.

The match produced two groups with the following characteristics. In each group 31 of the 33 subjects were male (94%). Their ages ranged from 18 to 62 with a mean age of 30. The mean seri-

ousness score was 228 for the refusal group and 226 for the nonrefusal group. The great majority of subjects in each group (n = 29, 88%) were found NGRI after being charged with felony crimes and most were diagnosed schizophrenic (n = 23, 70%). One third of the subjects in each group (n = 11, 33%) were assigned to the jurisdiction of the PSRB during the two-year study period, 1983 through 1984. Of the remaining subjects, seven (21%) were assigned in 1982, two (6%) in 1981, two (6%) in 1980, three (9%) in 1979, and eight (24%) in 1978. The eight subjects assigned to PSRB jurisdiction in 1978 were found NGRI before the inception of the Board. All of the time calculations presented for this group date from January 1, 1978, the day when PSRB became operational. Data on the percentages of time an insanity acquittee spent in the system before 1978 are not reliable.

Results

We compared the two groups on the total amount of time, from assignment to PSRB through 1986, that these patients spent hospitalized and on conditional release in the community and found no significant differences. The refusal group spent an average of 49 months hospitalized and four months on conditional release; the nonrefusal group spent an average of 46 months hospitalized and eight months on conditional release.

In order to further clarify the effects of refusal on subsequent hospitalization and to control for the varying amounts of time spent under PSRB jurisdiction,

we computed the percentage of total PSRB time that the refusal group spent hospitalized before (96%) and after (92%) the time of treatment refusal. We compared these figures to the overall percentage of PSRB time spent in hospital for the nonrefusal group (86%). For the refusal group we found no significant difference in the percentages of time spent hospitalized before and after the refusal incident. Further, a matched pairs *t* test showed no significant difference between the percentage of time refusal subjects spent hospitalized subsequent to treatment refusal and the overall percentage of time nonrefusal subjects spent hospitalized.

The percentage of time that both of these groups spent hospitalized seemed high in light of our previous work with the PSRB population. In order to explore this discrepancy further, the treatment refusal group was compared with the larger sample of 284 nonrefusal PSRB individuals who had spent a proportion of their time hospitalized during the two-year study period, 1983 through 1984. This sample included the original 33 matched nonrefusers. We found no significant differences in age, sex, diagnosis, or average criminal seriousness score (228 for the refusal group and 258 for the 284 nonrefusal patients). However, a significant difference was found in the proportion of time each group spent hospitalized. The 284 hospitalized PSRB nonrefusers spent an average of 79 percent of their time hospitalized, significantly less than the 92 percent average hospitalization time for PSRB refusers ($t = 3.42$, $df = 51.3$, $p < .001$; *F*

test of equal variances rejected at alpha of .05, *t* test for separate variances used).

Because the treatment refusal group did not significantly differ from the 284 nonrefusal PSRB individuals on the demographic characteristics for which data were available, we next considered whether the two groups differed on the time of assignment to PSRB jurisdiction. Although we found no significant difference between the two groups, a larger proportion of the treatment refusal group consisted of individuals assigned to PSRB jurisdiction in 1978, the year PSRB came into existence. In 1978 approximately 150 individuals who had previously been found NGRI were assigned to the Board's jurisdiction. These individuals represent a unique population for the PSRB and previous work¹⁰ has shown that they tend to have more serious crime scores and lengthier hospitalizations. We excluded these individuals and again compared the overall percentage of time hospitalized while under PSRB jurisdiction for the 25 treatment refusers against the percentage of time for the 252 individuals assigned to PSRB after January 1, 1978, and hospitalized during the study period. Although treatment refusers again spent a greater proportion of their PSRB time hospitalized than members of the larger nonrefuser sample (90% and 79%, respectively), the difference was not significant.

Discussion

In our previous article focusing on treatment refusal in the forensic setting,⁵ we suggested that refusal within the PSRB system may work against a pa-

Insanity Acquittees

tient's chances for hospital discharge—either a discharge on conditional release or a complete discharge from the PSRB jurisdiction. In our present sample, we were unable to establish that the treatment refusal incident itself had an effect on the patient's length of stay in the hospital. Instead, our comparison of PSRB refusers with the overall PSRB population suggests that PSRB patients who refuse treatment represent a segment of the PSRB population who spend more of their time hospitalized than the average PSRB patient.

The controlling factor here appears to be the pre-1978 NGRI cohort. When the PSRB came into existence in 1978 it was given responsibility for all previous insanity acquittees still in the system. Many were lost to follow-up in the community. However, the most identifiable group consisted of those individuals still in the forensic hospital. Many of these patients were long-term hospital patients. Our data suggest that this pattern of long-term hospitalization continued into the post-1978 period. Of the eight refusers found NGRI before 1978, five had no conditional release time during the nine years of data collection, 1978 through 1986.

In our previous work³⁻⁵ we reported that refusal was primarily explained as a function of serious and very acute mental illness. Acute mental illness is probably not applicable to a majority of PSRB patients in our sample who refused treatment. More likely, they represent a more generally chronic and dysfunctional group of patients than the group of average PSRB patients who

were hospitalized on a long-term basis and for whom treatment refusal as an organized procedure became available during 1983 and 1984.

Refusal in this group of patients seems to have little long-term significance. Treatment refusal was overridden in all cases and the override process was relatively short. Data were not available for the entire sample on the amount of time between the treatment refusal and the override decision. However, data available for treatment refusal in 1983 indicated that the average amount of time between refusal and the override decision for 14 PSRB patients was 11 days.⁵ According to the administrative rule,² once the patient's refusal is overridden it cannot be brought up by the patient for a one-year period. Thus, the refusal episode and use of the procedure represent a very brief interlude in the patient's hospital career.

Refusal in this unique environment may be the result of the interaction of specific patients, the ward milieu, and factors related to requirements for conditional release. To adequately understand treatment refusal in this forensic setting will require additional investigations using a design that investigates the characteristics, behavior, and course of specific patients as they progress through the forensic treatment system. This should be a major emphasis for further research on the right to refuse treatment in the forensic setting.

References

1. Callahan L, Longmire D: Psychiatric patients' right to refuse psychotropic medica-

- tion: a national survey. *Mental Disability Law Reporter* 7:494-9, 1983
2. Oregon Administrative Rules, 309-114-000 through 309-114-025, Oregon Mental Health Division, 1983
 3. Bloom JD, Faulkner LR, Holm VM, et al: An empirical view of patients exercising their right to refuse treatment. *Int J Law Psychiatry* 7:315-28, 1984
 4. Godard SL, Bloom JD, Williams MH, Faulkner LR: The right to refuse treatment in Oregon: a two-year statewide experience. *Behav Sci Law* 4:293-304, 1986
 5. Young JR, Bloom JD, Faulkner LR, Rogers JL, and Pati PK: Treatment refusal among forensic inpatients. *Bull Am Acad Psychiatry Law* 15:5-15, 1987
 6. Rogers JL, Bloom JD: The insanity sentence: Oregon's Psychiatric Security Review Board. *Behav Sci Law* 3:69-84, 1985
 7. Rodenhauser P, Schwenker CE, Khamis HJ: Factors related to drug treatment refusal in a forensic hospital. *Hosp Community Psychiatry* 38:631-7, 1987
 8. Appelbaum PS, Hoge SK: The right to refuse treatment: what the research reveals. *Behav Sci Law* 4:279-92, 1986
 9. Bloom JD, Rogers JL, Manson S, Williams MH: Lifetime police contacts of discharged Psychiatric Review Board clients. *Int J Law Psychiatry* 8:57-80, 1985
 10. Bloom JD, Rogers JL, Manson SM: After Oregon's insanity defense: a comparison of conditional release and hospitalization. *Int J Law Psychiatry* 5:391-402, 1982