

The Impact of the Right to Refuse Treatment in a Forensic Patient Population: Six-Month Review

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In December of 1987, the Wisconsin supreme court held that all involuntarily committed mental patients in the state had the right to refuse psychotropic medication unless a court held that they were incompetent to make treatment decisions. The authors studied the effects of this decision in a 165-bed forensic hospital over the first six months after implementation of the decision. They found that 29 percent of patients already on psychotropic medication initially refused further treatment as opposed to 75 percent of newly admitted patients. Of refusers, 32 percent eventually resumed taking medication voluntarily; courts overturned the refusals of all the 51 percent who maintained their refusals, after an average delay of over a month. The length of procedural delays actually increased over the six months of the study as the courts learned of the decision. The authors compare their findings with other reported studies of implementation of right to refuse treatment decisions and discuss differences between the right to refuse treatment for civilly and criminally committed patients.

There has been a considerable amount of research on the impact of implementation of the right to refuse psychiatric treatment,¹ but most of the court decisions and research have involved patients hospitalized under involuntary civil commitment. There are a few cases

and reports which concern forensic patients; federal courts have ruled that medication may not be used with insanity acquittees for mere behavioral control,^{2,3} and that even when used therapeutically, due process must be exercised in the use of medications with committed forensic patients.⁴ A few courts have recently extended the strict due process requirements more usually applied to civil patients to forensic patients as well.⁵⁻⁷ Several authors have looked at the impact of such decisions; Veliz and James⁸ studied treatment refusals at Bridgewater State Hospital, Massachusetts' maximum security correctional facility, after *Rogers*,⁵ and found that 20

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of 22 patients whose refusals were taken to court had them overturned; but the average waiting time before the court hearing was 4.5 months, and the staff chose not to challenge the majority of refusers because of the staff time required. Young et al.⁹ studied treatment refusals in the 200-bed forensic unit of Oregon State Hospital and reported that 13 percent of patients refused, with all refusals being overridden by the hospital director.

Callahan¹⁰ studied the impact of the *Davis*³ series of decisions in an Ohio forensic hospital for two years. All the patients had been transferred from prisons. She reported 501 refusers out of a population of 4,775 (10.5% of admissions), with an average of 9.5 refusals per month. Over half (54.5%) of refusers persisted through the hearing process (decisions were made by the hospital director, with a patient advocate present). By the end of the review process, 55.1 percent of refusals were overturned, 30.7 percent of patients had signed consent to take medication, and 14.2 percent continued to refuse treatment. Heller¹ (unpublished manuscript, 1987) also studied refusal in the same Ohio forensic hospital and reported an overall refusal rate of 8 percent. Rodenhauer^{11,12} reported on treatment refusal in a different Ohio forensic hospital; 14 of the 39 admissions (35.9%) to the 16-bed unit refused over the first year of the study.

Few studies have examined forensic patients separately from civilly committed patients, and none has attempted explicitly to study a population of pa-

tients committed for treatment to competency to stand trial; most have dealt with prison transfers or insanity acquittes.

Historically, courts have divided on whether a patient who has been committed after having been found incompetent to stand trial can be forced to accept medication designed to render him competent. Some courts held that defendants must be tried in a "natural state," (i.e., off medication), revealing a common legal misconception of the effects of psychotropic medication and also responding to pressure from defense attorneys who wished to demonstrate their clients' disordered behavior to juries.¹³ Later courts, in more sophisticated rulings, held that medication could be forced because of compelling state interest (such as ensuring that a defendant regains competency to stand trial) since the period of treatment would be brief and therefore the long-term risks of medication would be avoided.¹⁴ A third trend represents a compromise between these two positions. Several courts have held that an incompetent defendant may be involuntarily treated in order to restore competency to stand trial, but then went further to rule that once rendered competent, defendants could then refuse further treatment, thus permitting them to stand trial in a "natural state." And if, as a result of treatment refusal, competency was again lost, such defendants would still proceed to trial, having been judged to have, by virtue of an informed decision, voluntarily and competently waived their rights to be tried while competent.¹⁵⁻¹⁸ But few courts have explic-

itly placed defendants found incompetent to stand trial in the same category as civil patients. And few courts have explicitly addressed specific procedural requirements which can make significant differences in actual practice, such as whether evaluations for competency to make treatment decisions should (or can) be made at the time of the initial commitment hearing. On this issue, Massachusetts has said "no,"⁵ while Wisconsin has said "yes."¹⁹

The Wisconsin Supreme Court in *Jones and Galicia et al. v. Gerhardstein et al.*,¹⁹ which held that involuntarily committed mental patients have a right to refuse treatment absent a judicial determination of incompetency to make treatment decisions, explicitly included patients committed after findings of incompetency to stand trial and not guilty by reason of mental disease or defect in the classes of plaintiffs, for two reasons.²⁰ First, one of the named plaintiffs was an insanity acquittee. And second (and more substantive), the Wisconsin statutes concerning criminal commitments refer to the civil commitment statutes for patients' rights, including rights to refuse treatment.²¹ Although the court confined its discussion of the equal protection requirements for recognizing a right to refuse unless a patient has been judicially found to be incompetent to make treatment decisions to civil patients, its findings apply to forensic patients as well.

The court's decision requires judges to apply the same standards to all forensic patients that were previously applied only to defendants undergoing initial

evaluation for competency to stand trial. Thus, in order to override a patient's refusal in nonemergency situations, the judge must find probable cause that (1) the risks, benefits, and alternate forms of treatment have been explained to the patient and (2) that the patient is incapable of expressing a rational understanding of the proposed treatment.²¹ In addition, the court required proof that the proposed treatment would not interfere with the patient's participation in subsequent legal proceedings, again betraying the traditional judicial fear that medications are more likely to hinder a defendant's ability to assist counsel than they are to facilitate it.²² The court directed that the same trial court making the initial decision (competency to proceed or criminal responsibility) should also address the issue of treatment refusal if requested to do so by the state. The decision, similar to many others in the field,²² listed over a page of severe side effects to antipsychotic medication but omitted any mention of therapeutic effects.

Hypotheses

There were several hypotheses which we wished to test. They were based on the experience in other states with the implementation of similar statutes, as well as on our own experience with the criminal courts in Wisconsin.

1. Some patients who had been assenters to treatment will become refusers when proactive informed consent is required.

2. There will be a period of initial confusion, during which criminal judges

will require a significant increase in *viva voce* testimony by clinicians, most probably psychiatrists, on the issue of treatment refusal.

3. Outpatient evaluators for criminal responsibility and competency to proceed will frequently fail to address the issue of treatment in their initial reports, thus requiring that staff at inpatient forensic facilities deal with the issue after commitment. (Neither the court decision nor Wisconsin statutes explicitly address this issue.)

4. The refusals of forensic patients who are taken to court will be overwhelmingly overridden by the judges, but at a significant cost in clinical staff time and delay in provision of treatment. Therefore, patients will remain incompetent to stand trial longer than previously, some may never achieve competency if permitted to refuse, and insanity acquittees will be released after longer hospitalizations.

5. There will be an increase in the use of seclusion and in the numbers of transfers to maximum security units because of clinical deterioration secondary to refusing medication.

The Study

The study included all patients committed to the Mendota Forensic Center, a maximum security facility accepting only male patients, under Wisconsin Statutes 971.14(2) (evaluation of competency to stand trial), 971.14(5) (treatment to competency to stand trial), 971.17 (not guilty by reason of mental disease or defect), 975.06 (sex offenders) and 51.37 (involuntary transfers from jail or prison) who were hospitalized in

the Forensic Center at the time that the study commenced (January 1, 1988, when the court decision was implemented), and all those committed under these statutes for the subsequent six-month period. Because we were interested in monitoring the changes in implementation of the decision over time as courts and clinicians became familiar with its requirements, data from the first three months were initially analyzed separately from those for the second three months. Data collection depended on the use of patient names; but after data analysis, confidentiality was preserved by the reporting of statistical information only.

Results

There was a total of 165 patients in the Forensic Center at the time of implementation of the *Jones* decision. Of those patients, 133 were being treated with psychotropic medication; after they were informed that they had a right to refuse treatment, 39 refused over the six-month study period (29.3%). Of the 52 patients admitted to the center's admissions unit during the first three months of the study period, 24 were considered to need medications, and 19 refused initially (79.2%). Of the 55 patients admitted to the center's admissions unit during the second three months of the study period (April–June 1988), 45 were considered to need medications, and 33 refused initially (73.3%). The refusal rate of patients newly admitted during the study period and considered clinically to need medication was therefore 52/69 (75.4%), as compared to 29.3 percent of patients taking medication at the begin-

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ning of the study: and the refusal rate for all patients was 91/202 (45.0%). Three of those classified as refusers indicated at one point that they would accept medication but were so ambivalent about treatment that we sought court orders to permit consistent treatment.

Of refusers, 50 were committed for evaluation of, or treatment to, competency to stand trial; 36 were insanity acquittees; and there were four prison transfers and one sex offender. Primary diagnoses included schizophrenia (78 patients); affective disorders (12 patients); schizoaffective disorder (four patients); atypical psychosis (three patients); organic psychosis (three patients); and attention deficit disorder (one patient).

Reasons for refusal included denial of illness (63 patients); assertion of legal rights (24 patients); complaints about side effects of medication (14 patients); use of medication refusal as a bargaining tool with staff over issues unrelated to medication (seven patients); too disorganized to be considered competent to refuse or consent (three patients); the assertion that medication had not helped in the past (one patient); and "I don't want it!" (one patient). Several patients gave more than one reason for refusing.

Of the 91 refusers, 29 ultimately accepted medication voluntarily; the average time of their refusal was 17.6 days, *SD*, 26.4 days (range, 1–90 days.) Thirty-nine patients had their refusals overturned by the courts, and two finally accepted medication after petitions had been lost due to procedural foulups in

the courts. Two patients were transferred to other facilities before resolution of their refusals. The delay due to waiting for court action during the first three months of the study was 22.6 ± 19.2 days (range, 1–61 days). During the second three months of the study, the average delay was 38.4 ± 35.4 days (range, 3–132 days). These averages were significantly different (one-tailed $t = 1.71$, $df = 39$, $p = 0.045$.)

Thirteen patients were considered competent to refuse during the six-month study period. Eight continued their refusals throughout the study period; four ultimately resumed voluntary acceptance after an average refusal period of 22.5 days, *SD* 33.2 days (range, 3–72 days). One patient regressed to the point where an order to treat involuntarily was obtained. An additional six patients were found to be competent to stand trial without medications despite mental disorders which clinically indicated treatment with medication.

Reasons given by the 29 refusers who subsequently consented to medication voluntarily included acceptance of a need for medication (nine patients); acceding to persistent coaxing by staff (nine patients); abandonment of refusal as a negotiating ploy (four patients); and realization that they had little chance of being released without medication (two patients). In contrast to data from Minnesota²³ and New York (Zito et al., unpublished manuscript, 1988), with the exception of two patients who ultimately consented to treatment with antipsychotic medication at doses lower than they had been taking, refusers (both

those who ultimately consented and those being treated under court order) were treated with the same doses with which they had been (or would have been) treated had they not refused.

There were four transfers of patients into maximum security units from medium or minimum security units following refusal of medication and subsequent clinical deterioration, not a significant increase over pre-*Jones* experience. The incidence of seclusion on the admissions unit (which housed the great majority of refusing patients) increased dramatically after the *Jones* decision, a total of 1,924 hours as compared with 322 in the comparable six-month period of 1987 (one-tailed $t = 4.36$, $df = 10$, $p < 0.001$). The increase reflected not just increased lengths of seclusion, but more individual incidents of seclusion; there were 62 seclusions in January–June 1987 as compared to 157 in 1988 (one-tailed $t = 2.87$, $df = 10$, $p = 0.01$).

Caution must be exercised, however, in attributing this increase entirely to patients refusing medication, as several other variables contributed to the changes. There was a significant increase in the admission rate to the Forensic Center because of the addition of a large county to our catchment area, from 82 between January and June 1987 to 105 in the same period of 1988. The average inpatient days per month in the Forensic Center in January–June 1988 was $4,707.7 \pm 179.0$, as compared to $4,378.7 \pm 180.9$ for the comparable period in 1987 (one-tailed $t = 3.166$, $df = 10$, $p = 0.0045$); there was also a waiting list for admissions as high as 18 patients at a

time during much of the 1988 period. In addition to the larger catchment area, the increased census was due also to an increased length of hospitalization, which in turn was due both to medication refusal and to the refusal of the new county (which was responsible for over 40% of all our admissions) to pick up patients once their evaluation periods were over. The increased admission pressure and census resulted in greater acuity of patient disorders which caused the atmosphere on all of the units (particularly the admissions unit) to become more disturbed, and which in turn was at least partially responsible for the increased seclusions.

Judicial Responses Clear trends were demonstrable during the study period. At first, few criminal court judges or attorneys were even aware of the *Jones* decision. No formalized procedures had been established to implement the court's decision, and we found that the majority of judges granted orders authorizing involuntary treatment virtually on demand, frequently without the formal hearings clearly required by the decision. In one case, when one of us (GVR) called a judge to inform him that we would be petitioning for an order to treat, the judge granted the order over the telephone, without informing the patient, his attorney, or the district attorney! In a number of other cases, hearings were perfunctory, often without the patient being present (or even knowing that the hearing was being held).

As the *Jones* decision became better known, the state Department of Health and Social Services developed forms to

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be used for petitions for orders to treat. The decision required that such petitions be presented to the court by the district attorney in forensic cases; this requirement was widely ignored in the early phase of implementation but became a major problem after the judges recognized it, largely due to failure by district attorneys to file the petitions we had sent them. Procedural delays increased at that time because the issue of competency to make treatment decisions could not be heard at the same time as competency to proceed.

Some judges, still misinterpreting the decision, refused to hear the issue of competency to make treatment decisions at the time of the initial competency hearing when evaluations had been done by outpatient clinicians, even though the proper petitions had been presented at the time of the hearing. They argued that they wanted inpatient evaluation of competency to refuse treatment before making their decisions. One judge found a defendant incompetent to make treatment decisions but then initially withheld an order to treat because he did not know if he had the authority to order treatment for an incompetent patient. Another refused to hear the issue because civil guardianship proceedings were pending against the defendant, and the judge ruled that he had no authority to rule on competency to make treatment decisions for such a defendant.

In one case involving an acutely psychotic patient who denied his illness and refused to listen to anything about medications despite repeated attempts to in-

form him, the judge ruled initially that the technical requirements of the decision had not been met—i.e., we had not demonstrated that the required information had actually been *presented* to him. One of us (RM) had to travel to the jail, several hours away, and read the information to him while the patient continued to stare at the wall and hallucinate, before the judge would rule that he was incompetent to refuse treatment.

As a result of these trends, the delay between filing of petitions for court determination of patients' competency to make treatment decisions and commencement of treatment increased significantly from the first half to the second half of the study. One factor which also contributed to the length of delays was the existence of a waiting list for admission to the Forensic Center for much of the study period, and patients could not always be readmitted for treatment as soon as they had been found incompetent to make treatment decisions. However, this is not an independent variable, since delays in treatment were a major reason for the existence of the waiting list.

Staff Time Required A major concern of staff after the *Jones* decision was that considerable time would be devoted to testifying at such hearings, since our facility serves the entire state of Wisconsin. Prior to the *Jones* decision, over 80 percent of our reports on competency to proceed had been accepted by stipulation, without testimony; after the decision, a much greater percentage of judges wanted testimony on the issue of

competency to make treatment decisions, in part because of their unfamiliarity with the issues involved, and also because the extremely biased presentation by the supreme court of the medications' risk/benefit ratio caused concern among judges previously unfamiliar with psychotropic medications.

It would have been prohibitively difficult to accurately estimate all the additional staff time required as a result of the *Jones* decision. Much of the additional time spent discussing treatment with patients can be considered justified on clinical grounds, but the staff time spent in attempting to manage acutely psychotic patients (all of whom improved clinically when they resumed medications) was clearly unnecessary and immeasurable. Time spent in preparing petitions and in talking to judges and attorneys to explain the process also could not be measured.

Initial fears of the amount of staff time which would be required for testimony proved unfounded. During the first three months of the study, testimony from our staff was required in 13 of 20 cases (2 patients were admitted with orders to treat, and it was not known whether or not testimony had been required). Live testimony was required in two cases; and telephone testimony, recently accepted by the state supreme court,²⁴ was accepted in 11 cases. During the second three months, testimony in court from our staff was required in two cases, and telephone testimony was required in 11 cases. Seven patients had been admitted with orders to treat. Overall, telephone testimony required 1.9 hours of staff

time per case, as compared with 8.8 hours for live testimony (one-tailed $t = 6.8$, $df = 23$, $p < 0.001$).

Telephone testimony saved valuable clinical time and did not require transportation of acutely psychotic patients back to jail and court. It also permitted both the evaluator (frequently a psychologist) and the treating psychiatrist to testify without both having to lose a whole work day. The supreme court's requirements for telephone testimony specified only that all parties involved in the case before the court be able to hear the testimony; it did not specify at which end of the line they should be. After the initial confusion before most courts understood the *Jones* decision, defendants were returned to court for most hearings, where they, along with the judge and both attorneys, talked to the expert witnesses who remained at the hospital. In cases in which defendants were considered by the court to be too severely ill to warrant transportation to court, attempts were made to permit the defendant to attend the hearing at the hospital, along with the expert, on a speaker phone at the hospital. In some such cases, defense attorneys were also present at the hospital; but in most, they remained in the courtroom. The hearings proceeded according to the rules of evidence, and were neither more nor less formal than they had been when experts were required to be present in court. The major problem with such testimony occurred in cases when either the judge or the defense attorney decided that the defense attorney should be present at the hospital for the hearing. In these cases,

delays occurred because of conflicts in the attorneys' schedules; attorneys had the same objections to the travel time involved as did clinicians.

Discussion

Most of our original hypotheses were supported by the data. Twenty-nine percent of patients who had been accepting medication prior to *Jones* refused at some point during the six-month study period. Judges required *viva voce* testimony on treatment refusal in 62.5 percent of cases, as compared with fewer than 20 percent prior to *Jones*. Our data did not permit us to measure the number of cases in which outpatient evaluators failed to address the issue of competency; but in 9 of 14 (64.3%) cases in which initial evaluations were done prior to admission to our facility, no order to treat accompanied patients, whereas courts ultimately issued such orders in every such case once we pursued the issue, as well as in all other cases in which we filed petitions. Transfers to maximum security did not increase, but hours of seclusion increased more than fivefold ($\chi^2 = 130.29$, $df = 5$, $p < 0.001$).

As predicted, there was initial confusion as the criminal court judges were informed of the *Jones* decision, its requirements for judicial determination of competency to make treatment decisions, and the procedures required. After an initial period in which orders to treat were quickly forthcoming with little regard for due process, bureaucratic procedures developed which caused an increase in the delay before treatment

could be implemented but did not ultimately result in judicial findings that any forensic patients were competent to refuse treatment. Although clinically significant delays in obtaining orders to treat involuntarily did occur, they were much shorter than the average of 4.5 months reported for judicial determinations in Massachusetts' maximum security forensic hospital⁸, for at least two reasons. First, unlike Massachusetts, the *Jones* decision permits determination of competency to make treatment decisions at the initial competency to stand trial hearing, although the judges did not always choose to do so, thus often avoiding the delay caused by having to schedule an additional hearing. Second, the forensic inpatient facilities are overcrowded in Wisconsin, partially as a result of economic and procedural barriers to civil commitment, and the resulting unavailability of beds has put pressure on the criminal courts to expedite hearings so that treatment can proceed and beds will become available for new admissions.

The 100 percent concurrence with clinical requests for orders to treat was not surprising; most previous studies have demonstrated similar findings under judicial review. In our system, it was clear that judges were unwilling to permit defendants who were incompetent to proceed to avoid trial by choosing to refuse treatment, and also that few defense attorneys seriously challenged our recommendations for involuntary treatment.

The amount of professional clinical time required for testimony also was

significantly less than the average of over 10 hours per hearing reported from Massachusetts.⁸ The major reason for this finding was the use of telephone hearings, which eliminated time spent in travel and in waiting in the court for the case to be called. We found that we often had to actively suggest and persuade judges to accept telephone testimony, but most realized its advantages and were receptive.

Critics of expansion of a right to refuse treatment for involuntarily committed psychiatric patients have argued not only that the very disorders for which treatment with medication is indicated prevent them from accepting the need for that treatment; but that once treated, patients will regain the capacity to appreciate their need for treatment and to recognize its effectiveness.²⁵⁻²⁷ Our data support this viewpoint since patients already receiving treatment with medications were much less likely to refuse when given the right than newly admitted patients who were not being treated.

The most common reason given by our patients for refusal of medication was denial of illness, as has been previously reported by several other authors.²⁸⁻³⁰ What differs from other reports, however, is that over a fifth of patients cited their legal right to refuse as a basis for refusal, which is significantly higher than in other reported studies.

Although various differences in methodologies and reporting formats make comparisons with reports from other jurisdictions difficult, it is clear that the refusal rates we found are also signifi-

cantly higher than those reported elsewhere in the literature. We believe that there are several explanations for these comparative findings. First, we were dealing exclusively with forensic patients, whose refusal rates have been higher than those for civil patients in other jurisdictions. Forensic patients might be expected to be more informed about, and thereby more willing to invoke, their legal rights than civil patients, not only because of their greater previous familiarity with legal procedures, but also because of their ongoing association with attorneys during the legal proceedings and after insanity acquittals. Civil patients, although provided with representation at hearings to determine the need for continuing commitment, do not develop and sustain relationships with the same attorney over time.

We found, however, that most attorneys, while generally vigorous in their representation concerning the criminal issues involved, were relatively passive in regards to supporting their clients' wishes to avoid treatment. Many told us, or made it clear during hearings on competency to make treatment decisions, that they felt that treatment was in their clients' best interests within the criminal justice system—both to restore competency to stand trial and to gain release from hospitalization after acquittal by reason of insanity.

Second, patients reflect the values of their society; Wisconsin has traditionally been more protective of individual rights than many other states, and mental patients would certainly be expected to

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reflect these values. The higher percentage of patients citing their legal right to refuse treatment as a reason for medication refusal as compared with other reports would support this hypothesis.

Third, it is probable that the way in which patients are informed of their rights, and asked for their consent, has a significant effect on refusal rates. It is quite possible that requiring affirmative written consent rather than permitting passive assent to treatment increases refusals.³¹ In addition, state regulations following *Jones* require that all patients committed to state facilities in Wisconsin are to be given explicit written and verbal explanations of their right to refuse treatment. It is not clear from other reports whether similar policies are followed in other jurisdictions, but the proactive policies in Wisconsin would certainly be expected to maximize refusals.

Fourth, some studies have classified refusals according to cases brought to a review hearing, and because of logistical reasons many refusing patients have not been challenged.⁸ We sought review on all refusing patients whom we felt to be incompetent to make treatment decisions, thus maximizing the reported refusals.

Civil versus Forensic Patients Few rights, even constitutional ones, are absolute; they must be considered in light of other rights with which their exercise may conflict. Thus, a patient's right to refuse treatment must be considered in light of the state's interest in treating him. While most courts have agreed that individual liberty interests justify treat-

ment refusal by competent civil patients, good arguments exist (at least for forensic patients found incompetent to proceed) in favor of involuntary treatment, both because of the arguably greater state interest in bringing defendants to trial and preventing them from avoiding prosecution by remaining incompetent, and because of the fact that treatment to restore competency to proceed is time-limited.^{32,33} In addition, defendants' rights to a speedy trial and to be tried while competent are also violated if they are permitted to refuse treatment.

Another problem specific to the newly established right to refuse treatment procedures for forensic patients in Wisconsin is that while there is a system of hearings already established at specific intervals (72 hours and 14 days after initial commitment in Wisconsin) for civil patients, there are no such specifications in the case of patients committed as incompetent to stand trial or not guilty by reason of insanity. As a result, the criminal courts are under little pressure to schedule timely hearings at which the issue of patients' abilities to make competent treatment decisions can be addressed; and while few attorneys actively supported treatment refusal, there is little incentive for overworked prosecutors or public defenders to take the initiative to speed up the scheduling of hearings, especially when to do so would mean returning psychotic and disruptive defendants from hospitals to jails.

Benefits of Implementation of the Right Although we are critical of the *Jones* decision because of the delays in treatment and staff time required for

testimony, there have clearly been some significant benefits. Seventy percent of patients under treatment at the time of the implementation of the *Jones* decision agreed to continue medication voluntarily; 28 percent of new admissions consented, and 33 percent of all refusers ultimately consented to treatment. In all of these cases, staff spent time with the patients, explaining the risks and benefits of medication and soliciting cooperation with treatment. Eight of the 13 patients considered by clinical staff to be competent to refuse medications were able to maintain their competency (and their remissions) without medication over the study period. Six patients were felt to need medication clinically but to be competent to stand trial without it. In each of these cases, patients were more educated about their medications and were granted more autonomy by the *Jones* decision than they might have had before it and were able to provide meaningful input into their treatment plans.^{34,35}

We agree with the legal argument that a finding of incompetency to stand trial or insanity does not automatically mean that a patient is also incompetent to make treatment decisions, particularly since chronic mental patients are often much more sophisticated in their knowledge of their responses to medication than are other types of patients. But we do argue that judicial review of patient competency to make treatment decisions is unnecessary, since it actually provides *less* protection of patients' rights to refuse than clinical review,³⁶ wastes valuable clinical and judicial

time, and results almost entirely in delays in implementing treatment. The benefits of recognition of a right to refuse treatment in terms of increased staff time spent with patients and the resulting greater feeling of autonomy in at least some patients could (and has been demonstrated to be in jurisdictions with clinical review of patient treatment decisions) result equally from a system of clinical review such as exists currently in the majority of states which have recognized a formal right to refuse treatment.

It might be argued that there is benefit in having patients hear recommendations for taking medication from both clinicians and judges, after having had their "day in court,"³⁷ perhaps the combination might be more persuasive than hearing only the opinions of clinicians alone. We have no data to support or reject this hypothesis, but our clinical experience with the patients in our facility would tend to reject it. No patients during the study whose refusals had to be taken to court returned from their medication hearings any more willing to take medication than they had been when they went to court.

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References

1. Miller RD: Involuntary Civil Commitment of the Mentally Ill in the Post-Reform Era. Springfield, IL, Charles Thomas, 1987, pp 129-70
2. Scott v. Plante, 532 F.2d 939 (3rd Cir. 1976)
3. Davis v. Watkins, 344 F.Supp. 1196 (N.D.Ohio 1974); Davis v. Balson, 410

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- F.Supp 842 (N.D.Ohio); Davis v. Hubbard, 506 F.Supp. 915 (N.D.Ohio 1980)
4. United States v. Leatherman, No. 82-0091 (D.D.C., Oct. 5, 1983)
 5. Rogers v. Okin, 478 F.Supp. 1342 (D.Mass. 1979)
 6. Keyhea v. Rushen, 223 Cal.Rptr. 746 (Cal.App. 1st Dist. 1986)
 7. United States v. Charters, No. 86-5568 (4th Cir., decided May 8, 1988)
 8. Veliz J, James WS: Medicine court: *Rogers* in practice. Am J Psychiatry 144:62-7, 1987
 9. Young JT, Bloom JD, Faulkner LR, Rogers JL, Pati PK: Treatment refusal among forensic in-patients. Bull Am Acad Psychiatry Law 15:5-13, 1987
 10. Callahan LA: Changing mental health law: butting heads with a billygoat. Behav Sci Law 4:305-14, 1986
 11. Rodenhauser P: Treatment refusal in a forensic hospital: ill-use of the lasting right. Bull Am Acad Psychiatry Law 12:59-63, 1984
 12. Rodenhauser P, Schwenker CE, Khamis HJ: Factors related to drug treatment refusal in a psychiatric hospital. Hosp Community Psychiatry 38:631-7, 1987
 13. State v. Murphy, 56 Wash.2d 761, 355 P.2d 323, 326 (1960)
 14. State v. Law, 270 S.C. 664, 244 S.E.2d 302 (1978)
 15. State v. Jojola, 553 P.2d 1296 (M.M. 1976)
 16. State v. Hayes, No. 78-021 (Sup. Ct. N.H., June 19, 1978)
 17. People v. Parsons, 82 Misc.2d 1090, 371 N.Y.S.2d 840 (Nassau Cty. Ct. 1975)
 18. Commonwealth v. Louraine, 390 Mass. 28, 455 N.W.2d 437 (1983)
 19. Jones and Galicia *et al.* v. Gerhardstein *et al.*, 141 Wis.2d 710, 416 N.W.2d 883 (1987)
 20. Miller RD: *Jones v. Gerhardstein*: right to refuse medication. Newsletter Am Acad Psychiatry Law 13:13-4, 1988
 21. Wisconsin Statutes Sec. 51.61(g)
 22. Gutheil TG, Appelbaum PS: "Mind control," "synthetic sanity," "artificial competence," and genuine confusion: legally relevant effects of antipsychotic medication. Hofstra Law Review 12:77-120, 1983
 23. Zito JM, Routh WW, Mitchell JE, Rorig JL: Clinical characteristics of hospitalized psychotic patients who refuse antipsychotic drug therapy. Am J Psychiatry 142:822-6, 1985
 24. Fulin J, Williams TS: Teleconferencing comes to Wisconsin courts. Wisconsin Bar Bulletin 20(1): 8, 10, 70, 1988
 25. Weinstein RW: Patient attitudes toward mental hospitalization: a review of quantitative research. J Health Social Behav 20:237-58, 1979
 26. Toews J, El-Guebaly N, Luckie A: Patients' reactions to their commitment. Canadian J Psychiatry 26:251-4, 1981
 27. Kane JT, Quitkin F, Rifkin A, *et al*: Attitudinal changes of involuntarily committed patients following treatment. Arch Gen Psychiatry 40:374-7, 1983
 28. Wilson JD, Enoch MD: Estimation of drug rejection by schizophrenic in-patients, with analysis of clinical factors. Br J Psychiatry 113:209-11, 1967
 29. Van Putten T: Why do schizophrenic patients refuse to take their drugs? Arch Gen Psychiatry 31:67-72, 1974
 30. Appelbaum PS, Gutheil TG: Drug refusal: a study of psychiatric inpatients. Am J Psychiatry 137:340-6, 1980
 31. Marder SR, Mebane A, Chien C-p, Winslade WJ, Swann E, Van Putten T: A comparison of patients who refuse and consent to neuroleptic treatment. Am J Psychiatry 140: 470-2, 1983
 32. Fitch WL: A poorly charted decision. Developments in Mental Health Law 8(1):2-3, 1988
 33. Bonnie R: A fundamentally flawed opinion. Developments in Mental Health Law 8(1): 17-8, 1988
 34. Brooks AD: Law and antipsychotic medications. Behav Sci Law 4:247-63, 1986
 35. Roth LH: The right to refuse psychiatric treatment: law and medicine at the interface. Emory Law Journal 35:139-61, 1986
 36. Appelbaum PS: The right to refuse treatment with antipsychotic medications: retrospect and prospect. Am J Psychiatry 145:413-9, 1988
 37. Ensminger JJ, Liguori TD: The therapeutic significance of the civil commitment hearing: an unexplored potential. J Psychiatry Law 6:5-44, 1978