This commentary highlights the importance of statutory law and administrative rules to the practice of forensic psychiatry. Often small changes in laws and rules significantly shape the practice environment of psychiatrists, whether in the hospital setting or in the community. A case example is presented to illustrate how significant changes were made in the treatment refusal procedures in Oregon’s state hospitals with very little public notice or participation. This example illustrates the importance of focusing significant forensic psychiatric attention on the actions of state legislatures and the rules promulgated by the executive branch of state governments. The commentary concludes with a discussion that emphasizes the role of forensic psychiatry in helping to maintain a workable practice environment.
in his or her home state without knowing the rules related to informed consent, confidentiality and privilege, civil commitment, or the duty to protect. The laws related to these and many other key areas of psychiatric practice are made primarily in state legislatures, and the forensic psychiatrist as subspecialist should be expected to be a leader in these matters as well as in the relationship between psychiatry and the civil and criminal courts.

This commentary will use an example from Oregon to illustrate how significant changes in Oregon’s approach to the right to refuse treatment were developed and then significantly modified with only a small contribution from the Oregon Legislature and no input from a court. The commentary will conclude with a discussion of the issues raised and with suggestions as to how to raise the profile of dealing with regulatory and legislative matters within the framework of the training and functioning of forensic psychiatrists.

The Right to Refuse Treatment in Oregon

The right to refuse treatment has been a controversial issue at the interface of psychiatry and law for the past three decades. Much is now settled, and in summary, involuntarily committed psychiatric inpatients have a clearly recognized but limited right to refuse treatment. The right is guaranteed by both constitutional protections and by state civil commitment laws that separate civil competency from civil commitment. The right is limited by emergency situations in which a psychiatrist may act to protect the committed person or others in the committed person’s immediate environment from harm (danger to self or others). In a nonemergency situation, once a committed individual has refused treatment and the psychiatrist believes that the person should be treated, the committed individual must be granted a due process review of the refusal before treatment can be instituted. Two types of reviews have developed and both have been deemed constitutionally sufficient to satisfy due process requirements. Some states use a judicial review of the refusal, returning to court for a separate hearing to determine whether the committed person should be treated, while others use an administrative process within the hospital system combining staff psychiatrists and outside psychiatric consultants in a step-wise review of the refusal with a final decision coming from the hospital superintendent.7

In the mid-1980s Oregon developed an administrative approach to treatment refusal based on statutory law that governed the use of electroconvulsive therapy. In a section of the civil commitment statutes dealing with the rights of committed patients, the following subsection is found:

Mentally ill persons committed to the authority (mental health division) shall have the right to be free from potentially unusual or hazardous treatment procedures, including convulsant therapy, unless they have given their express and informed consent. . . . This right may be denied to such persons for good cause as defined in administrative rule 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 [Ref. 8].

This statutory section became the model for the development of an administrative rule that defined the procedure for providing due process for committed patients who refuse treatment. The rule became known as the good cause rule and was operational until 2009, when the rule was amended to add an additional step to the treatment refusal procedure. This was a significant additional step that now allows the refusing patient to appeal the decision of the hospital superintendent through an administrative hearing before an administrative law judge.9 This change was made without any significant input from the Oregon Legislature and was accomplished by the Oregon Addictions and Mental Health Division under its general statutory powers that grant the division the authority to “operate, control, manage and supervise”10 state mental institutions. The only legislative change that was related to this change in administrative rule was made in the 2009 Oregon Legislature with the passage of a bill that allowed “an authorized representative who is an employee of a nonprofit legal services program” who is supervised by an “attorney also employed by a legal services program” to represent a person in a “contested case hearing before a state agency involving . . . the right to be free from potentially unusual or hazardous treatment procedures under ORS426.385(3).”11

This legislative action was in many ways the clue to the major change that was taking place in the adjudication of treatment refusal in Oregon, which dramatically altered procedures that were viewed by many as adequately serving all sides in the treatment refusal debate. Over the years before these 2009 changes, legal advocacy groups for the mentally ill
had, on several occasions, introduced legislation that would have mandated a judicial model for treatment refusal hearings in Oregon. These bills failed to achieve legislative approval. However, in nonpublic negotiations between the Division and Disability Rights Oregon, the major disability rights organization in Oregon, the system was radically changed with only one bill needed in the legislature to help make the new system work. We are now awaiting empirical data on the workings of the new system, one of the more unique systems now in existence in the county.

**Discussion**

Over the years the right to refuse treatment has been one of the most widely debated legal and mental health controversies. The debate has produced countless articles in the psychiatric and legal literature, many lawsuits, and several critical Supreme Court cases. Yet in Oregon, the whole system was quietly and dramatically altered by administrative rule and a seemingly innocuous statutory change.

I am not going to argue the merits of this change in the context of this commentary. This commentary is written to illustrate a different point. Who should have been responsible for knowing that such changes were about to happen? In my opinion it is the forensic psychiatrists who live in Oregon who should have been attuned to the processes that led to these changes. We usually do better in this arena in Oregon. Acting through the Oregon Psychiatric Association (our APA district branch) and its Legislative Committee, we have worked hard to keep the treatment refusal procedures intact for 25 years. But we did not succeed in 2009, and the system changed dramatically without a public debate regarding the reasons for the change or its merits.

And there is a larger point. I believe that as forensic psychiatrists living in a particular state, we are responsible for being aware of these potential types of changes, regardless of whether they come from the courts, legislatures, or the executive branch of government. This means that, as subspecialists, forensic psychiatrists have a responsibility to all psychiatrists living in their state to be aware of the laws and the proposed changes that may affect the practice of psychiatry in that state. Each jurisdiction needs a balanced set of mental health laws that allows psychiatric practice to operate in a reasonable and effective manner. Forensic psychiatrists are key to the process that produces or changes mental health law, whether these “laws” derive from the legislature, the courts, or the executive branch of government.

Obviously, as subspecialists, we cannot individually know all about all areas of psychiatric practice, and as Pollack pointed out, nonforensic psychiatrists have their own responsibilities to know about legal matters related to their particular practices. But we should lead the way in this area, and where laws are involved we should form partnerships with general psychiatrists or other psychiatric subspecialists to make sure that we are putting together the best combined knowledge to the benefit of our patients and the practice of psychiatry. Recent examples of such coalitions in Oregon are forensic and geriatric psychiatrists working together for changes in the law that may facilitate the treatment of Alzheimer’s patients or recent changes in motor vehicle laws that attempt to replace antiquated driving laws with a more modern approach to driving restrictions.

Finally, it is important for the forensic fellowship programs to have a significant focus on regulatory and legislative matters within their programs. We have tried to emphasize the importance of local law in Oregon by developing a close liaison between the Legislative Committee of the Oregon Psychiatric Association (OPA), its legislative lobbyist, and the forensic fellowship program at the Oregon Health Sciences University. The Oregon Legislature now meets each year, and during the session, forensic fellows are encouraged to participate in the legislative committee and be aware of the many bills that are relevant to psychiatry. The committee and lobbyist also track the introduction and progress of potentially important administrative rules, and more can be done to involve the fellows in this level of legal change.

**References**