# A Controlled Comparison of Involuntarily Hospitalized Medication Refusers and Acceptors

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Involuntarily hospitalized psychiatric patients consecutively admitted over a sixmonth period who successfully refused medication (n = 37) are compared with a randomly selected group of medication-accepting patients committed during the same time period (n = 37). The overall refusal rate was 15.6 percent during the study period. Acceptors and refusers did not differ on age, sex, diagnosis, ethnicity, marital status, or preadmission living status. Differences between the groups indicate that refusers are sicker and lower functioning, are more behaviorally acute on the ward, and stay in the hospital twice as long as acceptors. Refusers also have a significantly negative impact on the overall ward milieu. The impact of institutional factors on the rate and outcome from medication refusal are discussed.

Voluntary psychiatric patients have always had the right to refuse treatment. This same right has only recently been extended to involuntarily hospitalized patients, and most states now have laws or judicial procedures that deal with this issue.<sup>1-3</sup> However, studies examining the characteristics and impact of medication refusers have had varying results, due, in no small measure, to methodological issues and problems.<sup>4-14</sup>

A recent study by Hoge *et al.*<sup>1</sup> resolved some of these problems by using a prospective and randomized procedure to examine the characteristics, course, and impact of medication refusers in acute care state psychiatric facilities. They found that medication refusers are sicker, stay longer, and are more disruptive to the treatment milieu than medication acceptors, regardless of their legal admission status. This study, the most rigorous to date, also found that there were three distinct outcomes after medication refusal: those patients who are involuntarily medicated, those who eventually take medication voluntarily, and those who have no further neuroleptic treatment. They found that those refusers who are subsequently involuntar-

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ily medicated are most likely a distinct population of refusers. They tended to be more symptomatic, have longer stays, have less insight into their illness, and were much more likely to be judged incompetent and then hospitalized involuntarily than other refusers.

The study to be reported here, the second to use a randomized design to compare a sample of medication refusers and acceptors, will specifically examine the more debilitated end of the inpatient spectrum represented by those patients who are involuntarily hospitalized. We will compare all involuntarily hospitalized medication refusers admitted during a six-month period (all of whom petitioned for judicial review) with a randomly selected group of involuntarily hospitalized medication acceptors from the same facility admitted during the same time period. We will explore whether the relationships found among all refusers and acceptors in the Hoge et al.<sup>1</sup> study are also found in a more debilitated population, who, very importantly, are also in a different institutional context.

Specifically, we will compare medication refusers with consenters on diagnosis, overall functioning level, reasons for commitment, length of stay, behavioral disturbance on the ward, and demographic variables. Based on findings from Hoge *et al.*<sup>1</sup> we would predict no differences between the groups on demographic variables or diagnosis; however, we expect that the refusers will be lower functioning, have longer hospital stays, and have more negative behaviors on the wards than acceptors.

Four other questions will be explored. First, what is the overall rate of medication refusal? Previous studies have found widely varying refusal rates, and it has been suggested that studies that define refusal based on reaching judicial review, as in the present study, greatly underestimate the rate and impact of refusal. Therefore, we expect a lower refusal rate than in the Hoge et al.<sup>1</sup> study. Second, what are the reasons for medication refusal given by the subjects at the time of refusal? Other studies have found that very ill refusers gave highly delusional reasons for refusing medication; therefore, we would predict that a majority of refusers in this study would give delusional reasons for refusal.

Third, what is the impact of the refusers on the overall behavioral acuity of the wards they are on? In previous studies, the impact of refusers on the ward milieu was based on limited retropective assessment by hospital personnel. The present study will use far more rigorous data based on daily staff assessments of patient functioning on the ward, and we predict refusers will be more behaviorally acute on the ward than acceptors. Four, what is the outcome of medication refusal? Given the different institutional context, it is possible that the outcome of refusal will differ, although no predictions can be offered.

### Method

*Setting* The setting of the study was the Psychiatry Department of the University of California-Irvine Medical Center (UCIMC), a large teaching hospital located in Orange County, California.

Patients admitted to this hospital are primarily those experiencing an acute exacerbation of their serious mental illness; most patients receive Social Security Disability as well as Medicaid and/ or Medicare. Upon admission through the psychiatric emergency room, patients are assigned to one of three wards, based on the availability of beds.

Concerning the institutional and judicial context for this study, the 1989 appellate court decision of *Reise v. St. Mary's Hospital*,<sup>15</sup> gave involuntarily hospitalized psychiatric patients in California the right to refuse psychotropic medication. This ruling was implemented at UCIMC beginning August 1, 1989. According to this ruling, involuntarily admitted patients who refuse medication are reviewed judicially if the patient requests it and if staff dispute the medication refusal. These reviews are generally conducted three times per week.

The hospital in the present study is a private facility that is under third party insurance reimbursement pressures for expedient and medication-focused care. Also, because it is the only psychiatric hospital in the county that accepts Medicaid reimbursement, there is census pressure for rapid ameliorization of symptoms and discharge of patients. The average length of stay for involuntarily hospitalized patients is approximately 12 days.

**Procedures** A retrospective chart review by the senior author of the records of all involuntarily hospitalized adult patients identified via petition to the courts as medication refusers admitted the first

six months after the implementation of the ruling (Aug. 1, 1989, to Jan. 25, 1990) was conducted (n = 37). In addition, charts from a randomly selected comparison group of equal size, involuntarily hospitalized during the same time period but accepting of medication. were reviewed.

Information collected consisted of demographic characteristics such as age, sex, ethnicity, and marital status; DSM III-R diagnosis at admission and discharge, including Global Assessment of Functioning (GAF) scores as recorded on Axis V; reason for commitment; preadmission living status; length of stay; and the reasons, number of times in, and total number of hours in seclusion. All admission information including Axis I diagnosis, reason for commitment, and GAF scores was recorded by emergency room staff before the administration of any treatment, and without knowledge of a patients' medication status on the ward. In addition, reasons for medication refusal as recorded by the nursing staff were collected. For the medication refusers, additional data were collected on which day they refused medication, whether they eventually took medication, and the number of days they spent unmedicated.

To examine the interrater reliability of the instrument used to extract the chart data, the first and third authors (S.L. and P.T.) independently rated 10 charts. These ratings yielded an average intraclass correlation of .80, and a 90 percent average interrater agreement rate. Interrater reliabilities were raised above these levels with additional training.

To assess the impact of medicationrefusing patients on the ward milieu. patient acuity ratings from a period six months before the ruling and six months after were analyzed. These acuity assessments are made daily by each patients' primary nurse. Ratings are made for seven target problem areas; physiological health status, self-care, level of activity, cognition, self/social interaction, coping skills, and teaching needs. A total of 36 characteristics are rated within the seven target areas. Based on total scores. patients are then assigned an acuity rating ranging from Level 1, low acuity, to Level 5, physical or psychiatric emergency requiring 1:1 care.

Developed and tested by a national consulting firm, the acuity rating forms have been used by the Department of Nursing in Psychiatry for over 10 years, and have achieved satisfactory interrater and interitem reliability (B. Briscoe, personal communication, Aug. 3, 1990). Each nursing staff member is trained during their orientation on the proper use of the form.

## RESULTS

*Medication Refusers* Of the 237 patients admitted involuntarily during the first six months after the ruling, 37 (15.6%) refused medication. As shown in Table 1, medication refusers were judged by the emergency room staff, unaware of the patients medication wishes, to be quite ill on admission, with an average GAF score of 24. They were most likely to be homeless before hospitalization, although the second most frequent living situation was with family. The reason for their involuntary hospitalization was generally "grave disability," defined in California as being unable to provide for one's own food, clothing, or shelter by virtue of a mental illness.

Concerning the outcome of medication refusal, refusers were most likely to decline medication on the first day of their admission. They spent an average of 5.7 days unmedicated, ranging from 1 to 13. Thirty-one patients were ordered by the court to take medication and were medicated involuntarily; five patients began to take medication voluntarily after the petition for court review was filed, and one patient was discharged before the court review. No refusing patients were left unmedicated after judicial review. Concerning another issue, medication refusers in California can be medicated against their will in emergency situations. Although we do not have complete data on how many refusers were given emergency medication, there is evidence to suggest that up to 30 percent of the present sample was given at least one dose of antianxiety medication while waiting for judicial review. It is a *de facto* hospital policy not to give antipsychotic medication to refusers in emergency situations.

Medication refusers were hospitalized an average of 21 days. Only one incident report was filed on a member of this group. Thirty-five percent of the medication refusers required locked seclusion during this period. They were most

	Refusers $(n = 37)$	Acceptors $(n = 37)$	
Sex			
Male	16	14	$y^2 = .22$
Female	21	23	$\hat{d}f = 1$
Age	$\ddot{x} = 41.54$	$\bar{x} = 39.41$	t = .69
5	SD = 13.32	SD = 13.46	df = 72
Ethnicity			
Caucasian	28	30	
African-American	0	1	$\chi^2 = 5.94$
Vietnamese	3	2	$\hat{d}f = 4$
Hispanic	2	4	
Other	4	0	
Living status before admission			
With family	11	14	
Supervised	4	9	$y^2 = 5.21$
Independent	9	5	df = 4
Homeless	12	8	
Other	1	Ō	
Marital status			
Married	0	3	
Single	22	19	$\chi^{2} = 5.69$
Divorced	12	10	df = 4
Widowed	1	0	
Separated	2	5	
Legal hold			
Danger to self	3	14	
Danger to others	1	2	$\chi^2 = 13.12^{**}$
Gravely disabled	25	11	df = 3
Mixed	8	10	
Admission diagnosis			
Axis I			
Schizophrenia	16	17	
Bipolar	12	6	$\chi^{2} = 6.08$
Major depression	0	4	df = 3
Other	9	10	
Axis V (GAF)	$\bar{x} = 23.85$	$\bar{x} = 37.69$	$t = 4.40^{***}$
	SD = 11.22	SD = 14.22	df = 64
_ength of stay	$\bar{x} = 20.84$	$\bar{x} = 10.78$	$t = 3.34^{***}$
	SD = 11.31	SD = 14.40	df = 72
Acuity	$\bar{x} = 4.04$	$\bar{x} = 3.77$	$t = 2.17^{*}$
	SD = .59	SD = .46	df = 72
Number of seclusions	$\bar{x} = 1.11$	0	
	SD = 11.31		
Hours in seclusion	x = 15.54	N/A	
	SD = 12.67		
Days unmedicated	$\bar{x} = 5.73$	N/A	
	SD = 2.68		
Took medication			
Court order	31	N/A	
Voluntarily	5		
Other	1		
Discharge diagnosis			
Axis		. –	
Schizophrenia	18	15	<b>0 -</b>
Bipolar	14	8	$\chi^2 = 7.16$
Major depression	0	.3	df = 3
Other	5	11	
Axis V (GAF)	$\bar{x} = 36.64$	$\bar{x} = 49.30$	$t = 3.43^{***}$
	SD = 14.37	SD = 16.29	df = 67
Unange in GAF	$\bar{x} = 13.47$	$\bar{x} = 11.94$	t = .46
	SD = 11.56	SD = 15.12	dt = 63

Table 1 Characteristics of Medication Refusers and Nonrefusers

•  $p \le .05$ ; \*\*  $p \le .01$ ; \*\*\*  $p \le .001$ .

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likely to be put in seclusion for a combination of verbal threats, physical assaultiveness, and physical destruction of their environment. Twelve of the 13 had five or fewer episodes of seclusion; one patient was secluded 16 times.

The content analysis, using the first relevant statement recorded in the chart by the nursing staff, revealed that the reasons for refusing medication generally fell into four groups. Ten patients denied being ill, with a typical response being "Look, I don't need medication. There's nothing wrong with me." Nine patients gave what were considered delusional reasons for refusing medication, i.e., "Satan is telling me not to eat and not to take any medication." Concern about side effects was mentioned by nine patients, and four flatly refused to take medication, offering no reason.

Three further analyses were done. First, to assess whether the subgroup of refusers who were placed in seclusion was distinguishable from those who were not, the two groups were compared using a Mann-Whitney nonparametric procedure. There were no significant differences between the groups in age, sex, diagnosis, or GAF scores on admission or discharge, number of days unmedicated, or the day on which they refused medication.

Second, the potential influence of the three different wards was also explored using the one-way Kruskal-Wallis test. No significant differences were found in the amount of time spent in seclusion, the number of times put in seclusion, or the number of days spent unmedicated.

Finally, the impact of remaining un-

medicated was assessed. This was possible due to the unexpected range in unmedicated days (1–13). From Table 2 it can be seen that there is no significant relationship between the number of days unmedicated and length of stay, number of seclusions, or overall functioning level. However, the significant findings suggest that as functioning level increases, the length of stay decreases and the number of times in seclusion increases.

*Comparison With Medication Acceptors* As shown in Table 1, no significant differences were found between the two groups for Axis I or Axis II diagnoses on admission or discharge, the presence or absence of an Axis III diagnosis at either point, age, sex, ethnicity. marital status, or living situation before hospitalization.

Medication refusers differed significantly from the group that accepted medication in several ways. Overall, refusers had lower admission GAF scores. than nonrefusers. As both groups showed a similar rate of improvement on the GAF, it is not surprising that the discharge GAF ratings for the refusing group were also significantly lower than the comparison group. Medication refusers were most likely to be committed as "gravely disabled" (67%), whereas 43.2 percent of acceptors were committed as "danger to self" or "danger to others," and only 29.7 percent were committed as "gravely disabled."

Medication refusers stayed in the hospital significantly longer than medication acceptors. If one medication-accepting patient who stayed a highly un-

Medication Refusers					
	GAF Admission	GAF Discharge	Number Seclusions	Days Unmedicated	
GAF discharge	.40**			· .	
Number seclusions	.43**	.58***			
Days unmedicated	11	.18	.07		
Length of stay	34*	09	.23	04	

Table 2 Evening the Deletionships A 

\*  $p \le .05$ ; \*\*  $p \le .01$ ; \*\*\*  $p \le .001$ .

usual 76 days is removed from the analysis, the average length of stay for this group drops to 8.9 days, less than half the average length of stay for the medication-refusing group. Whereas 35 percent of the medication refusers needed locked seclusion, no one in the medication-accepting group required seclusion during their admission. Consistent with these findings, medication refusers had significantly higher behavioral acuity ratings when compared with nonrefusers.

To assess the impact of medication refusers on the overall behavioral acuity of the wards they were on, average daily acuity ratings for all three wards were compared for the six months before the implementation of the ruling and six months after its implementation. This analysis was done including all patients on the three wards regardless of their admission status because the purpose of the analysis was to examine any changes in the total ward milieu. A check of the average number of patient days during each period revealed no significant differences.

To assess whether these time series data were autocorrelated, they were examined using the Box-Jenkins autoregressive integrated moving average (AR-IMA) model.<sup>16,17</sup> This procedure revealed no autocorrelation between observations (days): therefore, regression techniques could be used to evaluate the impact of the ruling. Using the total number of patient acuity ratings as the unit of analysis, the average behavioral acuity on the wards before the ruling was 3.6, rising to 3.7 after the ruling. This difference is statistically significant (F = 11.2, p < .001, df 1, 994); the clinical significance of this finding will be discussed in the next section.

## Discussion

Our sample size of 37 patients who refused medication represents a refusal rate of 15.6 percent over a six-month period. This is nearly twice the rate found in the Hoge  $et al.^1$  study. (This difference is even greater if our definition of refuser is used because only 1.3% of Hoge's sample were judicially reviewed.) This finding is surprising for several reasons. First, our definition of medication refusal was based on reaching judicial review, which is far more stringent than in the Hoge *et al.*<sup>1</sup> study; therefore, we hypothesized that our rate would be lower. Second, both studies

were done in states with similar judicial models for handling medication refusal.<sup>3</sup> The difference in refusal rates is difficult to explain based on the present data. It is possible that our sample is sicker, or the newness of the ruling at this facility could contribute to the number of patients exercising their rights to refuse medication. Similarly, staff might be very vigilant at this time about informing patients of the procedures.

There is also a large difference in the number of judicial reviews in the two samples, 15.6 percent versus 1.3 percent. Therefore, either far more individuals try to refuse medication at our setting. or they are handled differently, or both. Clinical experience at this facility suggests that once a patient verbally refuses medication, staff immediately pushes for judicial review. This staff behavior might be related to institutional pressures. For example, in this setting the third-party insurers equate reimbursible acute care with a medication regimen. Second, the average length of stay for involuntary patients at our facility (12 days) is considerably shorter than at the facilities in the Hoge et al.1 study (59 days). This might lead the staff at our facility to be reluctant to negotiate with medication-refusing patients before a petition for judicial review is filed, which would result in a high rate of judicial review once a patient refuses medication.

Concerning the outcome of refusers who are judicially reviewed, in both studies 100 percent of the judicial reviews resulted in the order to take medication. This is similar to the results of other studies.<sup>1</sup>

Our other findings reveal that medication refusers did not differ significantly from those that accepted medication on diagnosis or demographic variables. The variables on which the two groups did differ indicate that medication refusers are more ill, are more behaviorally acute and uncontrollable on the ward, and stay longer. The use of daily ward data found that refusers have a significantly negative impact on the overall ward milieu. The content analysis of the reasons for refusal showed 30 percent denied they were ill, despite an average admission GAF score of 24, and 27 percent offered highly delusional reasons for refusing medication. These findings corroborate and extend those of Hoge *et al.*,<sup>1</sup> and it must be emphasized that the similarity in the results of the two studies occurred in spite of important differences in the populations of refusers studied and in the institutional contexts.

Concerning the results of the present study, it is unlikely that a labeling effect can account for all of the differences found. Admission GAF scores and legal status are determined before a patient's medication wishes are known. In addition, medication refusers and consenters were both rated as improving about the same number of points on the GAF between admission and discharge, arguing against clinicians rating patients lower simply because they had refused medication. Similarly, a minority of refusers were put in seclusion, arguing against the routine use of seclusion for medication refusal.

Another issue with regard to these findings concerns the data on overall behavioral acuity on the wards. Although the statistically significant rise in acuity ratings (from 3.6 to 3.7) hardly seems clinically significant, we report it for the following reasons. First, the involuntarily hospitalized patients represent less than 10 percent of the entire ward population, and yet they had a palpable impact on the entire milieu. Second, this finding suggests that as the proportion of involuntary patients increases, so would the corresponding problems in the total milieu.

Overall, the results from this as well as the Hoge *et al.*<sup>1</sup> study suggest an important dynamic. First, lower functioning patients are more likely to refuse medication, with a significantly negative overall impact. Very importantly, this relationship holds even in the lowest functioning inpatient population, those who are involuntarily hospitalized, and across institutional contexts. Secondly, the number of refusals and their outcomes might be influenced by specific institutional factors.

There are several policy implications from the results of this study. Although the movement toward increasing rights of involuntarily held patients has been clear and progressive for the past 25 years, three issues require that careful thought be given to the extension of the right to refuse medication. First, our results corroborate the earlier findings that medication refusers are more ill than acceptors. As others have pointed out,<sup>17,18</sup> the needs of the mentally ill are not always consistent with their rights.

A second issue concerns the impact of these patients on the ward milieu. Although refusers represent only 15.6 percent of the involuntarily hospitalized patient population, their presence is enough to raise the overall behavioral acuity of the ward. Thus, the rights of the other patients to be protected and treated must be considered, along with the concerns of the staff about working in a dangerous environment. Third, the nearly double length of stay for refusers found in this and the Hoge *et al.*<sup>1</sup> study represents significantly higher costs, and may ultimately represent less resources available for other patients who are willing to comply with the treatment regimes prescribed by their physicians. In another vein, a recent study<sup>2</sup> examines the administrative costs of the right to refuse treatment in Massachusetts.

Although we found that refusers are sicker and more behaviorally acute than nonrefusers, from this study it is not possible to know whether these differences are due to lower patient functioning (or other patient characteristics) or to the absence of medication. Although this study was not designed to answer this question, our analysis showed no significant relationship between the number of days unmedicated and length of stay, number of seclusions, or overall functioning level. This suggests that for this very ill group of refusers, medication might not impact their length of stay or temper their negative behaviors on the ward. In fact, length of stay and the number of times secluded are more strongly related to the patients' level of functioning than to how long they remained unmedicated. Therefore, these preliminary data indicate that the complex issues involved in medication refusal might also include the administration of a treatment that has little impact on certain critical clinical dimensions. Clearly more rigorous experimental research is needed to assess the impact of medicating refusers on their course and outcome of treatment.

There are several areas for continued investigation. First, given the implications of these kinds of data for the rights of all patients whether they refuse medication or not, replications of these findings across institutions and geographic sites serving similar or variant psychiatric populations is essential to control for or understand the impact of these differences on the phenomenon of medication refusal. Comparing our results with those of other studies suggests that institutional factors, such as funding and census pressure, might impact refusal rates and outcomes. The influence of different judicial protocols on these phenomena also warrants careful study.

Second, as discussed earlier, studies exploring the impact of medication on refusers are essential to being able to provide efficacious treatment, as well as to contribute sound data to the debate on patients' rights. Clearly, experimental trials using groups of medicated and unmedicated refusers present enormous ethical problems. However, an alternative strategy is to use within-subject time series designs to compare naturally occurring subject time periods with and without medication (such as while waiting for judicial review) on symptomatology and behavioral measures.

The degree to which staff attitudes influence the course and outcome of a medication-refusing patient's hospital stay needs careful study. It is possible that attitudes toward medication refusal can exacerbate or ameliorate an already difficult situation, and might influence the rates and outcomes of medication refusers.

Given that there are some patients for whom medication offers scant symptomatic relief, and sometimes produces increased physiological discomfort, it is important to assess patterns of symptomatology and history of medication responsiveness when studying the variables that account for refusal. The literature on nonresponders to neuroleptic treatment could be used to develop categories and test hypotheses about refusers.

Finally, given that the right to refuse medication continues to be debated in the courts and legislatures, strategies for increasing treatment compliance in those patients who initially refuse medication should be investigated.

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