First Year of Maryland's New CRP Statute in One State Hospital

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The first year of Maryland's new Clinical Review Panel (CRP) statute in one state psychiatric hospital is reviewed. CRPs provide a nonjudicial means to administer medication to an involuntarily committed psychiatric patient refusing medicines in a nonemergency situation. While the statute adds appropriate formal procedural protections and while the CRP process "works," the statute also adds the possibility of unnecessary legal proceedings. Clinical decisions about medications should be made by psychiatrists and not by lawyers or judges.

On May 29, 1990, Maryland's highest court judged the existing statute regarding Clinical Review Panels (CRPs) "violated procedural due process protections governed by both the State and Federal Constitutions." [1] CRPs provided a nonjudicial means to administer medication to an involuntarily committed psychiatric patient refusing medicines. The decision did not affect the emergency use of medication.

The Director of the Maryland Mental Hygiene Administration ordered CRPs not be used in state facilities until new legislation could be designed. For the initially indefinite interim, in order to medicate patients over their refusal, guardianship proceedings via full adversarial court hearings were required.

In a prior report, I tracked a representative patient through the very long legal guardianship proceedings and discussed the deleterious effects on the patient, other patients, and the system. [2]

Since July 1, 1991, a new CRP statute has been in effect. This statute requires "broad due process provisions for patients which include advance notice, right to be present at the proceeding, to present evidence, to cross-examine witnesses, [and] receive assistance of an advisor who understands the psychiatric issues involved." [3] The statute also provides for possible additional legal appeals. If the CRP, composed of three clinicians, including two physicians, decides medication is to be given, there is a 48-hour waiting period. Medication may not be given except in emergency. The patient has this period to lodge an appeal. If he does not appeal, medication is started. If he does appeal, a hearing is set up with an administrative law judge

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within seven calendar days of the Panel's decision. This setting is similar to the more familiar civil commitment hearings. Again, the patient may not be given nonemergency medication until the hearing. If the administrative law judge rules the standards and procedures of the statute were met, medication may then be started over the patient's refusal. The patient may still appeal to circuit court, but must continue taking medication until then.

I now report on the first year of the new statute at our state facility. The Walter P. Carter Center is the largest comprehensive community mental health center in Maryland. Among many services, there are three adult general psychiatry inpatient units, licensed for 18 beds each, but are usually overcensus. We serve an approximately 170,000 person catchment area in innercity Baltimore. We have approximately 700 admissions per year. About 40% are involuntary or court-ordered.

Our facility had the first CRP under the new statute, one day after the statute went into effect. In total, between July 1, 1991 through June 30, 1992, 15 CRPs concerning 12 persons (three had two CRPs on separate admissions) were scheduled. One person started medications before the scheduled Panel, and so 14 Panels were held. Another person at the Panel agreed to take medication and the Panel was withdrawn. The Panel approved medications in the 13 remaining instances. There were three appeals to the administrative law judge who in all three instances decided the patient had to take the medication. One of these three persons started an appeal to circuit court but eloped from the hospital before a court hearing was held.

Discussion

It is important to say that the CRP process works. Clinically, there must be a way to evaluate the need, and if the need is found, to administer medication to a refusing involuntarily committed or court-ordered patient. Otherwise, the patient "rots with his rights on." [4] Hoge *et al.* [5] note, "The refusal of antipsychotic medication is associated with major deleterious effects on patient care." Research suggests the longer medication is withheld, the worse the condition of the patient and the worse the prognosis ("Psychotic Relapse: A Multisystems Perspective," APA Symposium, May 3, 1992).

Doctors at our hospital were given no role in the drafting of the new statute. This illustrates a problem between the Mental Hygiene Administration central office and its professional staff in the field. A new statute was not needed. Adding formal procedural protections to the existing statute would have sufficed. Waiting for the new statute meant over a year passed when CRPs were not available. Besides procedural safeguards, the new statute added the automatic possibility of legal appeals. The appeal to the administrative law judge may hold up starting medication for a week. A lot can happen in this time, both in the patient's condition and concerning possible deleterious effects on other patients and the treatment milieu. For example, over-

crowding is aggravated, which may lead to increased violence [6] Time spent in paperwork and testimony is again stolen "from the most valuable resource in any public facility: direct time spent by the clinician with the patient" [7] The cost of not only clinical staff time, but that of the legal staff, lawyers and judge, and the patient advocate (client rights advisor), must also be considered.

Interestingly, at our facility, the number of CRPs decreased by one-third to one-half. Prior to the new statute, our facility did not keep precise records of the number of CRPs. This itself indicates the process before was perhaps too informal with a lack of standardized procedures. However, there were estimated 25–30 CRPs per year (Rolfe Finn, M.D., Acting Clinical Director, Walter P. Carter Center, personal communication). A "tightening up" of the process with stated procedural safeguards and formal panel hearing was needed. I believe this responsible for the decreased number of CRPs. On the other hand, the automatic possible legal appeals are not necessary. Some may say that this is the component that led to the decreased number of CRPs, saying doctors only presented cases that would "hold up" in court. Doctors at our hospital denied this. One could test this by eliminating this component for a period and reevaluating the number of subsequent CRPs. Our patients used the appeal process only three times and the CRP was upheld each time. This is consistent with Schouten and Gutheil's [7] Massachusetts experience that in full court hearings, 99% of petitions concerning medications are granted over the patient's objection.

The statute is now halfway through its two-year course. Required review is built in concerning whether or not to continue it. I support the CRP process with formal procedural safeguards. However, automatic possible legal appeals are not necessary. "Due process does not have to mean judicial process." [8] Appelbaum and Gutheil [9] note, "Legal conceptions of a right to refuse treatment may not accurately portray the realities of the clinical situation, in which patients' refusal is determined by the dynamics of their illness rather than reflecting a principled exercise of their legal rights."

Prescription of medications is a medical and not a legal decision. There is legal support for this. The United States Supreme Court in its February 27, 1990 decision in *Washington v. Harper* judged the interests of the patient (an inmate in a Washington State prison) were "adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge." [10] The Court further noted that nothing in the Constitution stops the state from allowing physicians to make medical decisions "under fair procedural mechanisms," and that risks associated with medications were medical risks and "best assessed by medical professionals." [10]

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References

1. Williams v. Wilzak et al. 573 A. 2d 809 (Md. 1990)

2. Storch DD: Clinical review panels versus court hearings in treatment refusal by involuntary patients. Hosp Community Psychiatry 43:1033–5, 1992
3. Bell C: Resident grievance system—clinical review panels. Linkage 2 (Spring):3–5, 1992
4. Gutheil TG: In search of true freedom: drug refusal, involuntary medication, and "rotting with your rights on" (editorial). Am J Psychiatry 137:327–8, 1980
5. Hoge SK, Appelbaum PS, Lawlor T, *et al:* A prospective multicenter study of patients' refusal of antipsychotic medication. Arch Gen Psychiatry 47:949–56, 1990
6. Palmstierna T, Huitfeldt B, Wistedt B: The relationship of crowding and aggressive behavior on a psychiatric intensive care unit. Hosp Community Psychiatry 42:1237–40, 1991
7. Schouten R, Gutheil TG: Aftermath of the Rogers decision: assessing the costs. Am J Psychiatry 147:1348–52, 1990
8. Ford M DeG: The psychiatrist's double bind: the right to refuse medication. Am J Psychiatry 137:332–9, 1980
9. Appelbaum PS, Gutheil TG: Drug refusal: a study of psychiatric inpatients. Am J Psychiatry 137:340–6, 1980
10. Washington v. Harper 494 U.S. 210 (1990)