Forensic Psychiatry, Statutory Law, and Administrative Rules

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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.

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This commentary focuses on the relationship of forensic psychiatry to regulatory and legislative matters.[1] Although these areas are mentioned in the Ethics Guidelines of the American Academy of Psychiatry and the Law (AAPL), it is my contention that these areas have not been sufficiently emphasized as key components of the specialty of forensic psychiatry.

AAPL was formed in 1969. The original Bylaws defined forensic psychiatry to "include all aspects of psychiatry which remain in close and significant contact with the law, legislation, or jurisprudence."[2] This definition was followed by a long list of specific areas of interest to the forensic psychiatrist. Later revisions of the by-laws[3] substituted the term "psychiatry and the law" for the term "forensic psychiatry" but retained much of the same content areas that were of interest to AAPL. Thus, the term "forensic psychiatry" disappeared from the AAPL Bylaws but re-entered AAPL's official language in its Ethics Guidelines, which defined forensic psychiatry as "a specialty of psychiatry in which scientific and clinical expertise is applied in legal contexts involving civil, criminal, correctional, regulatory or legislative matters, and in specialized clinical consultations in areas such as risk assessment or employment."[1]

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The new organization, formed in an era of great social unrest,[4] expanded its horizons to differentiate the general field of interest of law and psychiatry from a specific area of psychiatric expertise, in effect, a psychiatric subspecialty named forensic psychiatry. Definitional questions became apparent in the literature of that time. Robitscher[5] wrote of a dynamic and growing field, one that moved beyond the narrow focus on aspects of criminal jurisprudence and into a broader area that encompassed medicine, psychiatry, psychology, sociology, anthropology, and education. Robitscher named his new forensic psychiatry "social-legal psychiatry." This definition did not survive that era.

It was Seymour Pollack,[6] writing in the same era, who made the categorizing distinctions when he defined the difference between psychiatry and the law and forensic psychiatry. He focused his definitions on the psychiatric profession. He defined law and psychiatry as the body of law that any general psychiatrist should be expected to know to successfully practice the clinical specialty of psychiatry. And he defined forensic psychiatry as the application of psychiatry to legal issues for legal ends, with the chief goal being the augmentation and support of the rule of law. Pollack's definitions, modified over time, form the basis of the current boundaries of our field.

Pollack felt that a working knowledge of the main areas and topics related to psychiatry and the law was a requirement for all psychiatrists. For example, a general psychiatrist could not practice competently 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 superintendant 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,[12] 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[13] 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[6] 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[14] or recent changes in motor vehicle laws that attempt to replace antiquated driving laws with a more modern approach to driving restrictions.[15]

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.

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