Treatment Refusal in a Forensic Hospital: Ill-Use of the Lasting Right

PAUL RODENHAUSER, MD

A forensic hospital patient's persistent treatment refusal—his or her last recourse and lasting right—virtually ensnarls our social system legally, clinically, and economically.[1] Meanwhile, the right to be mentally ill and the illness gather momentum. It has been recommended that dangerous patients, whose treatment refusal is upheld by the law, be diverted to the criminal justice system for disposition.[2] In practice, however, it is not the detention center that accommodates such assignments. Forensic hospital patients remain in large part unattended by the legal system beyond commitment for designated "clinical" purposes.

Based on information derived from first-hand clinical experience, this article raises questions about clinical, legal, economic, and social implications of forensic hospital treatment refusal and highlights the paradoxical nature of clinical management of involuntary, violence-prone patients in a closed (maximum security) system. Material is drawn from a 12-month experience as part-time staff psychiatrist for a 16-bed treatment ward at the Dayton (Ohio) Mental Health Center Forensic Unit, one of the regional forensic hospitals built in response to the *Davis v. Watkins* decision that provided federally mandated treatment for forensic patients in Ohio.[3] The hospital staff's mechanism for managing treatment refusal is the application of individualized clinical judgment in emergency and nonemergency situations.

Observations

Diagnostic categories represented on this 16-bed unit in one cross section of time are typical and include 14 with primary diagnoses of schizophrenic disorder (mostly paranoid or undifferentiated), one with an affective disorder, and one with alcohol-associated dementia. Most patients had an associated personality disorder (antisocial, passive-aggressive, or mixed). In many cases, there were suggested childhood histories of attention deficit and learning disorders.[4,5] Illustrating the violence-prone nature of this population,[6–8] the Table (next page) summarizes the criminal charges applicable to the 39 admissions during the one-year study. (The various charges and numbers of patients per charge are tabulated; the numbers of counts per patient are not included.)

Neuroleptic medication was clinically indicated in all but three of the year's 39 admissions. Altogether, 14 patients refused neruoleptic medication before or during treatment at least once. Four patients refused to sign

Dr. Rodenhauser is Associate Professor of Psychiatry, Director of Residency Training/Department of Psychiatry, Wright State University School of Medicine, P.O. Box 927, Dayton, OH 45401 (513-276-5233).

Table. Summary of Criminal Charges

Charges	Frequency
Aggravated murder	4
Attempted aggravated murder	1
Murder	5
Attempted murder	2
Felonious assault	7
Aggravated assault	2
Assault	3
Rape	2
Attempted rape	2
Sexual battery	1
Gross sexual imposition	2
Aggravated robbery	3
Robbery	2
Aggravated burglary	4
Breaking and entering	2
Aggravated arson	3
Attempted aggravated arson	1
Arson	1
Abduction	1
Carrying a concealed weapon	2
Receiving stolen property	1
Vandalism	2
Disorderly conduct	1

the treatment authorization form. One later changed his mind, signed, and accepted medication. The consistent refusal of two others presented no immediate dangers, although one later refused antibiotic medication. The fourth was one of the patients whose refusal created a continuous dilemma.

All treatment refusals were verbal rejections of medication expressed to the medication nurse or to the ward psychiatrist. The more quickly reversible refusals were brief, periodic, and apparently in response to an ad hoc event. Some chronic patients communicated problems through refusal. Other refusers demonstrated behavior apparently reflective of deeply entrenched belief systems usually expressed with heightened defiance. Observations from the Dayton Forensic Unit experience with drug refusal fit readily into the clinical groupings resulting from a study of drug refusal by Appelbaum and Gutheil:

> 1) situational refusers—a diverse group of patients who on occasion refuse medication for a short period of time and for one of a variety of reasons; 2) stereotypic refusers—chronically ill patients with paranoid traits who habitually and predictably responded to a variety of stresses with brief medication refusal; and 3) systematic refusers—young, relatively acutely ill patients whose refusal, often based on delusional premises, was sustained over a long period and successfully stymied treatment efforts.[9]

In this Dayton Forensic Unit study, there were only two situational refusers, one aged 24, the other, 32. Both had diagnoses of schizophrenic disorder, paranoid type, chronic. Neither had been previously hospitalized. Although both had suspicions about the meaning and intended effect of medication, their brief episodes of noncompliance were nonspecific in

regard to cause.

Stereotypic refusers numbered five. The average age was 40 (range 23 to 58). Three had diagnoses of schizophrenic disorder, undifferentiated type, chronic, and two were diagnosed as schizophrenic disorder, paranoid type, chronic. Previous admissions ranged from 6 to 14 with an average of 10. Refusals were generally predictable and short term, and seemed to be related to stresses such as visitation, phone calls, admissions to the ward, disturbed behavior in others, and anticipated court appearances.

Seven symptomatic refusers persevered. One indicated that he did not wish to become "competent." All employed massive denial of their illnesses. Four had schizophrenic disorders, paranoid type, chronic; two had schizophrenic disorders, undifferentiated type, chronic; and one had a schizo-affective disorder. Their age range was 21 to 36 with an average age of 27. The range of previous hospitalizations was 0 to 23; average was 7.

Only one patient, a symptomatic refuser, mentioned his legal rights to decline medication. His post-*Davis v. Watkins* education on civil rights at Lima State Hospital during one of his 23 previous psychiatric hospitalizations was one apparent influence on his refusing behavior. In this limited experience, risks of immediate side effects or risks of tardive dyskinesia were not offered as lasting reasons for refusing medication. Grandiosity[10] and denial of illness[9,11] were perceived as the leading causes of treatment refusal in this population.

Discussion

The rights of voluntary and involuntary patients to refuse treatment have become systematized into the practice of American psychiatry.[2] The right to refuse treatment in a forensic hospital, however, presents conflicts, contradictions, and paradoxes not so readily normalized.

The use of maximum security hospitals for protection of society from the mentally ill and dangerous[12] creates involuntary "patients" whose rights to privacy and autonomy, after admission, are almost nominal. Consent for participation in psychotherapy, milieu therapy and activities therapy, or restraint therefrom, is not a concern of the legal system, nor is there an attempt to obtain written authorization for release of clinical information to the courts. Once hospitalized, however, the patient's rights to privacy and autonomy are upheld by the courts in defense of treatment refusal, the only remaining option for exercise of choice. At the Dayton Forensic Unit, written authorization for treatment is obtained by the patient advocate *before* the patient meets the admitting psychiatrist. Both the timing[11] and the choice of conductor of this formal consent process speak to the degree of clinical influence in this setting.

Regardless of competency status to stand trial, competency to refuse treatment has been sustained on the basis that psychotropic medications are mind controlling.[13] Recommendations of competency to stand trial contin-

gent upon continuation of psychotropic medications are, however, accepted by the courts.[14,15] And if during compelled drug treatment on an emergency basis a patient reverses his or her refusal, there is usually no question of "mind controlling" drug influence on the decision.

Controversies surrounding criteria for[16–19] and actual[20–22] determinations of competency to refuse treatment are simultaneously intensified and clarified by reported findings that choice of tests of competency in unclear cases is based on likelihood of producing the desired medical or social end.[22] Recommended roles for psychiatrists in overriding patient objections to treatment have varied widely from one of unlimited application of indicated treatment for patients committed by the state's police power[12] to judicial control except in emergency situations.[23] A more moderate posture involves psychiatric determinations of time-limited incompetency for involuntary patients.[24]

Irrespective of the patient's pathway to treatment candidacy, however, there are some certainties: there are clinical concerns in a forensic hospital that supplement the list of generic considerations in the psychiatrist's decision to treat.[1] The welfare of the closed milieu requires vigilance. In particular, the impact of drug refusal on the freedom and safety of other patients and staff[17,25] can be devastating. In the clinical process of balancing right-to-treatment/right-to-refuse-treatment and individual/environment issues,[26] there has been no satisfactory assistance from the legal system.[27,28] The mainstay of applied clinical judgment, based on ethical considerations, continues to meet this progressively more complicated challenge.

Conclusion

Lasting drug refusal in this forensic hospital study was clearly a manifestation of grandiosity[10] and psychotic denial.[9,11] Rational appreciation for legal rights was not a factor in any case of drug refusal in this 12-month experience. In general, the reason for persistent drug refusal was the intended drug effect,[9] treatment of the mental illness. The severity of illnesses and frequency of personality disorders in this select population might explain in part the ubiquitous and aggressive refusals. The same factors might explain a shift from the predominance of situational refusers documented in the study by Appelbaum and Gutheil[9] to a predominance of symptomatic refusers in this population.

Although the multivarious roles of the forensic hospital psychiatrist[29] have been integrated into modern practice, reconciliation of the forensic hospital patient's right to refuse treatment is a far more formidable exercise. The treatment process is complicated by the trend toward embodiment of ethics as rights,[1] resulting in the costly sacrifice of clinical prerogative. On the other end of the social equation, questions arise about the multivarious roles of the rights-retaining forensic hospital patient, specifically about his/her concern for and obligation to the state.

References

1. Michels RP The right to refuse treatment: ethical issues. Hosp Community Psychiatry 32:251-58, 1981
2. Stone AA: The right to refuse treatment. Arch Gen Psychiatry 38:358-62, 1981
3. Heller A: Impact of Davis v. Watkins on Ohio forensic hospital practice. Bull Am Acad Psychiatry Law 7:39-62, 1979
4. Bellak L: Schizophrenic syndrome related to minimal brain dysfunction: a possible neurologic subgroup. Schizophr Bull 5:480-89, 1979
5. Morrison JR: Diagnosis of adult psychiatric patients with childhood hyperactivity. Am J Psychiatry 136:955-58, 1979
6. Dietz PE, Rada RT: Battery incidents and batterers in a maximum security hospital. Arch Gen Psychiatry 39:31-34, 1982
7. Rofman ES, Askinazi C, Fant E: The prediction of dangerous behavior in emergency civil commitment. Am J Psychiatry 137:1061-64, 1980
8. Monahan J: Clinical prediction of violent behavior. Psychiatric Ann 12:509-13, 1982
9. Appelbaum PS, Gutheil TG: Drug refusal: a study of psychiatric inpatients. Am J Psychiatry 137:340-46, 1980
10. Van Putten T, Crumpton E, Yale C: Drug refusal in schizophrenia and the wish to be crazy. Arch Gen Psychiatry 33:1443-46, 1976
11. Marder SR, Mebane A, Chien C: A comparison of patients who refuse and consent to neuroleptic treatment. Am J Psychiatry 140:470-72, 1983
12. Malmquist CP: Can the committed patient refuse chemotherapy? Arch Gen Psychiatry 36:351-54, 1979
13. Gutheil TG: In search of true freedom: drug refusal, involuntary medication, and "rotting with your rights on." Am J Psychiatry 137:327-28, 1980
14. Feldman HS: Psychopharmacology and the law: a forensic psychiatrist's viewpoint. J Clin Pharmacol 16:577-80, 1976
15. Haddox VG, Pollack S: Psychopharmaceutical restoration to present sanity (mental competence to stand trial). J Forensic Sciences 4:568-78, 1972
16. Ford MG: The psychiatrist's double bind: the right to refuse medication. Am J Psychiatry 137:332-39, 1980
17. Zusman J: Against the right to refuse treatment. Adv Now 5:12-26, 1979
18. Appelbaum PS, Roth LR: Clinical issues in the assessment of competency. Am J Psychiatry 138:1462-67, 1981
19. Bryne G: Conference report: refusing treatment in mental health institutions: values in conflict. Hosp Community Psychiatry 12:255-58, 1981
20. Roth LH, et al: The dilemma of denial in the assessment of competency to refuse treatment. Am J Psychiatry 134:910-13, 1982
21. Meisel A, Roth LH, Lidz CW: Toward a model of the legal doctrine of informed consent. Am J Psychiatry 134:285-89, 1977
22. Roth LH, Meisel A, Lidz CW: Tests of competency to consent to treatment. Am J Psychiatry 134:279-84, 1977
23. Dix GE: Realism and drug refusal: a reply to Appelbaum and Gutheil. Bull Am Acad Psychiatry Law 9:180-98, 1981
24. Mills MJ: The rights of involuntary patients to refuse pharmacotherapy: what is reasonable? Bull Am Acad Psychiatry Law 8:313-34, 1980
25. Gibson RW: The rights of staff in the treatment of the mentally ill. Hosp Community Psychiatry 27:855-59, 1976
26. Wilkerson CD, O'Connor WA: Human ecology and mental illness. Am J Psychiatry 139:875-90, 1982
27. Gutheil TG, Shapiro R, St. Clair RL: Legal guradianship in drug refusal: an illusory solution. Am J Psychiatry 137:347-52, 1980
28. Appelbaum PS: Limitations on guardianship of the mentally disabled. Law and Psychiatry 33:183-84, 1982
29. Rappeport JR: Differences between forensic and general psychiatry. Am J Psychiatry 139:331-34, 1982

□