

# The Influence of the Right to Refuse Treatment on Precommitment Patients

Joseph D. Bloom, MD; Mary H. Williams, MS; Sally L. Godard, MD; and Larry R. Faulkner, MD

**The unplanned extension of the right to refuse treatment to the precommitment period is described in this paper. This extension of the right to refuse treatment has important public policy implications for the civil commitment process. These implications, as well as the pros and cons of the extension of the right to refuse treatment, are discussed.**

The right to refuse treatment has generally been accepted as a limited right of civilly committed mental patients.<sup>1</sup> The right is derived from modern commitment statutes, which separate competency from civil commitment. Most of the case law and scientific literature regarding the right to refuse treatment has been concerned with the refusal of civilly committed patients. To date there has been little focus on the precommitment period where in most jurisdictions a person "alleged to be mentally ill" can be hospitalized and treated before a formal commitment hearing. For example, in Oregon a person may

be admitted on an emergency basis to an approved psychiatric facility by police officers and physicians if found to be dangerous to self or others and "in need of immediate care or treatment for mental illness."<sup>2</sup> This admission is for five days, during which time an investigation is conducted and a decision is reached regarding the necessity for holding a formal commitment hearing.<sup>3</sup> In addition to determining the need for a formal commitment hearing, this five-day period was also designed to allow for emergency treatment that might help avert a commitment.

Does an individual have a right to refuse treatment during this precommitment hospitalization? In the course of ongoing research focusing on the implementation of an Oregon administrative procedure designed to handle treatment refusal,<sup>4-6</sup> we noted that patients in the precommitment period were being granted a right to refuse treatment

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Dr. Bloom is Professor and Chairman, Ms. Williams is Research Associate, Dr. Godard is Adjunct Assistant Professor, and Dr. Faulkner is Associate Professor and Director of Residency Training, Department of Psychiatry, Oregon Health Sciences University, Portland, OR. Dr. Godard is also Director of Training, Oregon Mental Health Division. Address reprint requests to Dr. Bloom, Department of Psychiatry, Oregon Health Sciences University, 3181 S.W. Sam Jackson Park Rd., Portland, OR 97201.

by state hospital staff, even though there exists in Oregon no supporting statute, case law, or administrative rule that authorizes this policy. In fact, in Oregon, statute and custom clearly provide a framework for treatment during the five-day emergency hospitalization. This paper will review the data that led us to recognize that precommitment patients were being granted a right to refuse treatment. We will also discuss the possible implications of this expansion of the right to refuse treatment on the design of civil commitment statutes.

### Methods

In 1983 Oregon promulgated an administrative rule on informed consent.<sup>7</sup> This rule included a section that established a procedure for determining how treatment refusal by a civilly committed patient in a nonemergency situation could be overridden. The procedure calls for the appointment of an independent psychiatric examiner to interview the refusing patient and to make a recommendation to the hospital superintendent about whether the patient's objection to treatment should be overridden.

In a series of papers, we have examined this procedure during its first two years of operation in Oregon's three state hospitals<sup>4,5</sup> and in the state forensic unit.<sup>6</sup> As a part of the data collection for our most recent study,<sup>5</sup> we performed an in-depth chart review on a sample of patients civilly committed to one state hospital during a six-month period in 1984. This record review enabled us to make a distinction between patients initially admitted to this state

hospital on a precommitment hold and eventually committed and those patients admitted to the state hospital after a formal civil commitment hearing. This latter group of patients spent their precommitment period in a community hospital before their commitment hearing. In this paper we will compare data pertaining to the patients initially admitted to the state hospital in precommitment status and then committed (precommitment group) with data pertaining to those admitted after being civilly committed (commitment group).

### Results

A total of 73 patients refused medication at this hospital in the first six months of 1984. We<sup>4</sup> previously identified three patterns of treatment refusal in these patients: those who refused medication from the time of hospital admission, those who initially took medications and later refused, and those who were intermittently noncompliant. In order to more clearly present data on the precommitment and commitment groups we present data only on those patients who refused medication from the time of hospital admission, the most common pattern of refusal. Of the 73 patients who refused in the first six months of 1984, 38 (52%) refused treatment from the time of hospital admission. Of these 38 patients, 11 (29%) met the definition of our precommitment group while 27 (71%) met the definition of our commitment group.

There were no significant differences between the groups demographically. The mean age was 36. There were 21 (55%) men and 17 (45%) women.

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Twenty-two patients (58%) were high school graduates, and 35 (92%) were unemployed at the time of hospital admission. Most were either single, divorced, or separated ( $n = 29$ , 76%). Schizophrenia was the most common diagnosis ( $n = 24$ , 63%), followed by bipolar disorder, manic type ( $n = 13$ , 34%). The patients had a mean of at least two previous hospital admissions. Thirty-one (82%) patients were discharged during the study period and were listed as improved by hospital staff.

All of the patients in this study had their treatment refusal overridden by the hospital superintendent on the advice of the independent examining psychiatrist. In previous studies<sup>4-6</sup> we were interested in the amount of time it took for the override process to run its course. For this paper we note that the mean length of time between hospital admission and the override decision was about 12.5 days for both groups. The precommitment group, however, spent its 12.5 days divided between five days in precommitment status and another 7.5 days after commitment before their refusal was overridden and they were treated. Looking at this another way, the precommitment group was overridden significantly more quickly from the time of commitment, an average of 7.7 versus 12.4 days ( $t = 1.87$ ,  $df = 36$ ,  $p < .05$ , one-tailed). We also found that the precommitment group spent a significantly shorter period of time hospitalized, an average of 61 days compared with 107 days, for the commitment group ( $t = 2.04$ ,  $df = 31.58$ ,  $p < .05$ , one tailed).

## Discussion

The data presented in this paper on patients refusing treatment are in line with other papers in the literature.<sup>8</sup> All of our patients were seriously ill, and most were single and unemployed, with previous hospital experience. As in most studies, patients' refusal was overridden in almost every case. In our previous study of the statewide use of this procedure,<sup>5</sup> overriding occurred in 95 percent of cases. Most patients were eventually discharged (82%) and were viewed by their physicians as improved on discharge.

We expected and found no differences demographically between our precommitment and commitment groups. We found no real difference in the average number of days it took to override patient refusals. There were differences in how the time was divided, however. The precommitment group spent an average of five of their refusal days in precommitment status and an additional 7.5 refusal days after commitment. The commitment group spent the total 12.5 refusal days after commitment before override and treatment. On the surface the granting of refusal to the precommitment group may not seem that significant because both groups spent the same number of refusal days before override. However, we also know anecdotally that many psychiatrists in Oregon's general hospitals are no longer vigorously treating precommitment patients who refuse medication. Two reasons are generally given for this behavior. First, these psychiatrists are concerned about the right to refuse treatment and whether they

are at greater risk of being sued if they treat a precommitment patient against his or her wishes. Second, they feel that partially treated patients appear less seriously ill than they actually are at court hearing and are often not committed. If our anecdotal evidence is correct and a significant number of these patients are not being treated in community hospitals, then the use of these expensive hospital days should be questioned because the costs to the mental health system are substantial.<sup>9</sup>

Based on the data presented in this paper and the available anecdotal information, we feel that the right to refuse treatment has had an unplanned impact on the precommitment period in Oregon. This has occurred without careful consideration of whether or not a right to refuse treatment should apply to the precommitment period. There are good reasons to support either side in a debate about treatment refusal in the precommitment period. Those arguing for a precommitment right to refuse treatment might say that the patients admitted to a hospital by police and/or physicians before commitment are only alleged to fit the statutory definition of mental illness. They have not had a court hearing and should be considered at least as competent as those patients admitted after a commitment hearing. On the other hand, it could be argued that patients admitted for emergency hospitalization represent an extremely needy group of mentally ill patients, admitted specifically by statute for treatment in emergency situations. Treatment for this group could be considered as emergency treatment for very seri-

ously ill patients based on the clear statutory directive for the purpose of these precommitment hospitalizations.

This issue clearly needs careful consideration. Extending the right to refuse treatment to the precommitment period should not occur by default. If it is decided that a qualified right to refuse treatment does exist, then the length of time in the precommitment period should be shortened to require that the legal aspects of the commitment process be completed as quickly as possible so that valuable hospital resources are not wasted in the process. This system would come to resemble refusal after commitment where refusers would receive minimal treatment during precommitment unless an immediate emergency situation exists in the hospital. It should be recognized, however, that this situation would likely result in more patients being committed and in increased hospitalization time and costs. We feel that this point may be illustrated by our finding that the precommitment patients were hospitalized for a significantly shorter time period. Although we are not certain how to interpret this finding at this point, it is possible that had these patients been treated in the precommitment period they might have responded quickly enough to not require commitment. This particular area certainly needs more study.

If the decision is to treat refusers in the precommitment period, the treatment should be adequate, with the goals of alleviating suffering and avoiding more lengthy hospitalization. The ultimate goal of this position is that ade-

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quate short-term treatment might make it possible for many seriously ill patients to avoid the need for civil commitment hearings and lengthy state hospitalizations.<sup>10</sup>

Our intent in this paper was to focus the attention of the forensic psychiatric community on the expansion of the right to refuse treatment to the precommitment period. If this is occurring in other jurisdictions it should be reported and further discussion should begin about whether precommitment patients should have a right to refuse treatment. There are substantial theoretical and practical consequences regarding such a decision, given the high prevalence of refusal thus far reported.<sup>5,8,11</sup> It would be unfortunate to neglect this issue, causing an uninformed drift to a de facto recognition of the right to refuse without understanding the potentially deleterious effects of this position on the overall civil commitment and mental health systems.

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