Involuntary Administration of Medication in the Community: The Judicial Opportunity

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In a state in which patient refusal of antipsychotic medication in all nonemergency situations must be respected, lawyers and psychiatrists in western Massachusetts have employed probate court decisions as involuntary outpatient treatment orders. The legal, administrative, and clinical issues in sustaining court-ordered outpatient treatment are discussed by focusing on case examples demonstrating some successes, some challenges, and some failures. Judicially sanctioned involuntary outpatient treatment presents an alternative model to statutorily based outpatient commitment.

One of the most controversial trends in the law governing care and treatment of the mentally ill is the right of patients to refuse nonemergency administration of neuroleptic medication, and the concomitant requirement for judicial or clinical review for those who may require chemotherapy on an involuntary basis.[1]

The Commonwealth of Massachusetts has been in the forefront of this medico-legal development. Current law in this state requires patient refusals of antipsychotic medication to be respected in all nonemergency situations; defines emergencies quite narrowly; places the authority to make treatment decisions in the hands of a judge after a cumbersome, adversarial process; limits nonemergency involuntary treatment to those who lack the ability to make their own informed decision; and even requires judicial review of antipsychotic treatment for those incompetent patients who are accepting their medication, in order to provide the same "informed consent" required in any other physician-patient relationship.[2]

Early responses by the Massachusetts psychiatric community to this right to refuse treatment were negative.[3–5] Criticism continues. Judicial decision-making is seen as an encroachment on the terrain of the psychiatric profession. The attendant delay in initiating treatment is considered a disservice to the welfare of

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the patient. The required time commitment of the physician in consulting with legal counsel, testifying in court, and providing the treatment monitor with relevant data during the length of the court order is described as burdensome. The societal cost in medical, legal, judicial, and clerical resources is lamented as exceedingly high. And the patient's integral participation in the entire process is often labeled countertherapeutic.

However, there are actual and potential benefits. It should be clear that the physician gains the advantage of insulation from liability for certain kinds of malpractice. It can be argued that the incompetent patient benefits from what is, in effect, a quality assurance mechanism for the development and implementation of his treatment plan. Also, if the legal process for procuring and maintaining a court order for treatment is pursued vigorously and consistently by the care provider, it can successfully function as a case management tool for the recalcitrant psychiatric patient.

In western Massachusetts, the Department of Mental Health (DMH) has made a concerted effort to use the legal process to treat patients who would otherwise refuse treatment and to maintain inconsistent patients on medication, even after their hospital discharge, to break the cycle of recidivism. This undertaking has required cooperation among the clinical staff throughout the service delivery system, the DMH legal office, and the courts, to develop and then mandate treatment plans for the most difficult patients. To date, DMH legal staff have secured court orders for treatment with psychotropic medication for over 250 patients. The vast majority were refusing medication at the time the court process was initiated. The rest had some history of noncompliance with medication.

Many of the 250 patients eventually developed enough insight into their condition and its treatment to be adjudicated competent to make their own treatment decisions. On the other hand, over 100 patients currently remain subject to court-ordered treatment plans. All but a handful live in the community.

Implementation of court orders for treatment proved to be generally successful. Sometimes, the mere fact of a court order secured the refusing patient's cooperation with treatment, perhaps because judges are seen as authority figures but doctors are not. Sometimes patients received advice from their attorneys to comply. Some patients yielded to the more aggressive, directive case management implicitly sanctioned by the order. For patients decompensated enough to be committed to a hospital setting, often injectable medications had to be included in the treatment plan so that, at least initially, the order could be physically enforced. For patients discharged to home from the hospital, for whom compliance remained an issue despite the court order, the decanoate form of the neuroleptic was often used in order to better monitor compliance. Although continued compliance with oral medication, such as lithium, remained an issue for a dozen patients upon hospital discharge, the vast majority became consistent compliers. Absent further study,

the reasons for this success rate remain anecdotal and speculative.

A detailed statistical analysis of the impact of the 250 orders on patient recidivism rates and length of hospitalization is currently being conducted. At this time, case summaries can serve to demonstrate the possible outcomes of court-ordered treatment. The discussion that follows illustrates some clear, positive results in the lives of certain patients; a few challenges that can be met with careful legal, clinical and administrative planning; and two problems which are presently unsolvable and await further evolution of treatment modalities.

The Successes

The Chronic Inpatient The psychiatric inpatient who benefits from antipsychotic medication with no significant side effects, but chronically refuses its administration, is the quintessential example of "rotting with your rights on."[3-5] Such a state can exist for prolonged time periods [6] and has adverse effects on the patient and on the inpatient milieu.[7] When the inpatient is involuntarily treated to the point of symptom remission, the inability to continue involuntary administration of medication in the community may be extending to the patient "one right too many."[8]

Case 1

Mr. Adams is a 60-year-old male diagnosed as having chronic, paranoid schizophrenia. His 30-year psychiatric history includes a pervasive delusional system, frequent threatening and violent behavior, and consistent noncompliance with prescribed psychotropic medication. His 13 psychiatric admissions, including three to the state's maximum security forensic facility, were interrupted by community tenures of each under six months' duration. Without medication in the community, Mr. Adams would threaten or attempt murder and would be rehospitalized.

Mr. Adams' delusional system prohibited him from consenting to medication. He believed that he was only hospitalized to perform undercover work for the F.B.I. He consistently refused psychotropic medication during the first four years of his last hospitalization until November 1984 when a court order was procured for forcible administration of antipsychotic medication, lithium and carbamazepine.

Once on a consistent regimen of medication, Mr. Adams' condition improved markedly. His delusions of being an undercover agent for the FBI diminished, his paranoid ideation dissipated, his reality testing improved, and his combativeness disappeared. Upon his discharge, nine months after involuntary treatment was initiated, his only pronounced residual symptom was denial. In the community, Mr. Adams continued to accept medication only because of the court order. His compliance was monitored by staff at his community residence.

In December 1986 after 16 months of involuntary community treatment, the psychiatrist and the court agreed to dismiss the order for medication on the grounds that Mr. Adams was now competent. He showed sufficient insight into his condition and his ongoing need for

maintenance medication that court supervision was no longer necessary or appropriate. In fact, he laughed at his own delusions, lamented his wasted years, and was thankful for his medication. Shortly thereafter, he left his community residence for independent living. To date he has stayed on his medication and has been free of arrests and hospitalizations.

The Rapid Recidivist Patients whose pattern of psychiatric care and treatment is one of repeated admissions and discharges drain fiscal and personnel resources to an extraordinary degree with little benefit to themselves. [9, 10] Some of these patients may be refractory to antipsychotic medication; others' recidivism is rooted in noncompliance.[10] This latter groups' use of services can be altered and their level of functioning significantly improved by the appropriate application of coercive treatment.

Case 2

Mr. Baxter is a 40-year-old, single man with bipolar affective disorder, manic subtype. Between 1974 and 1986, Mr. Baxter had at least 48 psychiatric admissions. His pattern was to accept medication upon admission and quickly stabilize; refuse medication and aftercare services upon discharge; act out in a way that resulted in criminal charges; and end up back in the psychiatric hospital. Over time, he managed to stay outside a hospital setting for increasingly shorter periods of time and to refuse treatment once admitted for longer periods of time. His last admission occurred five days after his preceding discharge, and he refused medication in the hospital.

Mr. Baxter's lack of insight into his need for medication was the basis of the court's incompetency finding in March 1986. (This is true for 90% of all our cases.) His recompensation on antipsychotic medication and lithium was rapid and marked. He was euthymic, coherent, and his disruptiveness ceased. Upon discharge in June, he accepted aftercare services for the first time; including residential, case management, and medication services. Residual symptoms included delusions and denial.

In 29 months of follow-up in the community, Mr. Baxter had only one rehospitalization, this caused by noncompliance with medication. Prompt enforcement of the court order for treatment resulted in his discharge from the hospital within 24 hours.

The Outpatient Since civil commitability and lack of competency to refuse medication are distinct,[11, 12] the person who does not meet criteria to be civilly committed may still meet criteria for court-ordered substituted judgment.

Case 3

Mr. Davis is a 34-year-old male whose symptoms of schizophrenia, chronic, undifferentiated type—agitation, loose associations, hallucinations, bizarre delusions, and grossly impaired judgment—are intermittently exacerbated by alcohol. He had not taken antipsychotic medication for many years.

Mr. Davis' fourteenth state hospital admission resulted in a discharge without treatment because he was not

deemed to be committable. Hospital staff recommended a court-order for treatment with antipsychotic medication, lithium, and carbamazepine be sought for Mr. Davis while he was an outpatient.

Since procurement of the court order for treatment in September 1986, Mr. Davis' condition has stabilized. Not only are his overt psychotic symptoms in remission, he cooperates with supervision and treatment, holds a job, and socializes with others. He has not required hospitalization during the two years of the court order.

The Challenges

Lack of Continuity of Care Failure of continuity of care, labeled by Stone "the greatest failing of the modern mental health system" has, according to Stone, been intensified by legal reform.[13] Court-ordered treatment has been shown, however, to be able to facilitate continuity of care. The authority of the court can be used to change a convoluted system of care into an effective one.

Case 4

Ms. Eliot, diagnosed with schizophrenia, chronic, undifferentiated type, has a 15-year history of psychiatric hospitalizations. In April 1985 while residing in a semisupervised apartment program, Ms. Eliot discontinued her medication and began to decompensate in her characteristic fashion. In an effort to avoid her fourteenth state hospital admission, community staff decided to seek a court order for treatment. It was not considered an emergency, so the court order was not achieved until seven months later. (Unfortunately, prompt judicial response for community cases is currently unavailable absent an emergency, and these cases are scheduled with the rest of the court's busy docket.) At that time, Ms. Eliot was refusing to see her psychiatrist, had dropped out of her day treatment program, had become increasingly seclusive, and was showing poor hygiene. Upon implementation of the court's order for treatment with antipsychotic medication, Ms. Eliot recompensated considerably. She was calmer, more cooperative, more coherent, and more organized in her speech and behavior.

However, during the summer of 1986, Ms. Eliot was suspected of cheeking her medication. The court order was amended to permit the use of fluphenazine decanoate. A brief hospitalization was required to initiate this new regimen. Then, in October, despite her medication regimen, Ms. Eliot was rehospitalized for setting a fire. She presented as confused, disorganized, hostile, and paranoid. Professional staff concluded that she required more supervision than she had been receiving at her staffed apartment. She spent a year in the hospital while waiting for a more intensely supervised placement. During that time, she was treated by no fewer than six different physicians. Her medication was changed a few times, and there was even a trial period off medication. Two attempted discharges to unstructured settings failed. The court became increasingly concerned that different doctors were prescribing different medica-

tions and that there was an apparent lack of consensus concerning her course of treatment. By way of solution, a meeting was convened of all the state hospital physicians and the one community physician involved in her care. Information was exchanged, consensus was reached, primary providers identified, and a cogent plan presented to the court.

Ms. Eliot was successfully discharged two years ago to a highly supervised community residence where she still resides.

Refusal of Court-Ordered Treatment

Another problem, one more difficult to resolve, stems from the patient's refusal to comply with court-ordered treatment on an outpatient basis. In our experience in western Massachusetts, the fact of the court order and persistent case mangement secured compliance for the vast majority of patients. But occasionally, the most organized and persistent case management and supervision fails to maintain the patient's compliance outside of the hospital setting.

Case 5

Mr. Franks is a 45-year-old single male with a diagnosis of schizoaffective disorder. His dominant symptom is a fixed delusion that he is a psychiatrist. When off medication, Mr. Franks' symptoms include delusions, agitation, hostility, irritability, explosiveness, assaultiveness, and dysphoria. Mr. Franks has a lengthy history of recompensating on medication while hospitalized, discontinuing medication after discharge to his community program, and gradually deteriorating to the point of requiring hospitalization.

During his fifteenth psychiatric admission, a court order for treatment was obtained. After recompensation on an enforced treatment protocol, Mr. Franks was discharged. Despite the order, compliance with his oral medication regimen in the community remained sporadic. A trial of long-acting, injectable medication was successful in ensuring Mr. Franks received his medication, but was therapeutically ineffective in controlling his psychosis. Oral medication was resumed and compliance was again inconsistent. Mr. Franks has had six hospitalizations since the court order has been in effect.

It is noteworthy that the length of these hospitalizations has been significantly shorter than his previous average. This is attributable to treatment being initiated immediately upon admission. No time is lost cajoling Mr. Franks into medication acceptance. But more successful enforcement of the order on an outpatient basis would be preferable. The court has expressed a willingness in this case to order involuntary transportation to, and medication administration at, the state hospital's admission room whenever the patient is noncompliant. Presumably, after one or two such quick trips to the hospital for "outpatient" involuntary medication, the patient would realize the futility of refusing his court-ordered medication and would become more cooperative.

It is worth commenting upon our reasoning in opting not to try to forcibly enforce these involuntary treatment orders at community mental health centers. Usually, such centers do not have staff who are trained in the nonviolent

restraining techniques that might be necessary. Also, these centers are private, nonprofit agencies that prefer to avoid the insurance and liability problems such a function might pose. Nor do they want their many voluntary patients exposed to the specter of an occasional, forcible administration of medication. And, philosophically, we would like to maintain the state hospital as the only component of the service delivery system where physical force is used.

It is remarkable that community compliance has been problematic in only a handful of our cases. But it would be ideal if this issue, too, could be addressed effectively.

The Competent, Medicated Patient

A third challenge presented by implementing court-ordered chemotherapy involves attempts to break the recidivist cycle of the patient who, on medications, presents as competent. Under the law of Massachusetts and all other states, the court only has jurisdiction to consider making decisions on behalf of an individual if that individual is truly incapable of making his own informed decisions.[14] If the patient subject to a court order for treatment recompensates to the point where he can rationally weigh the risks and benefits of treatment, dismissal of the court order is required.

Case 6

Mr. Goddard is a 40-year-old divorced male with bipolar affective disorder. When decompensated off his antipsychoic medication and lithium carbonate, he presents as delusional, paranoid, agitated, and aggressive.

Hospitalization and consequent resumption of his medications results in the abatement of virtually all his symptoms. Off medication, he shows no insight into his condition and responds to offers of medication with delusional statements. Once on medication, he carries on intelligent conversations about medication in a calm and rational way, acknowledging that they help him with his mental illness. This pattern has been consistently demonstrated through 17 state hospital admissions and discharges over a 15-year period.

Hence, when a court order for medication was procured in 1985, it was dismissed within six weeks. But, while "competent," Mr. Goddard again stopped taking his medication and suffered another decompensation. This cycle was repeated twice more before the involved legal and mental health professionals began to question the depths of the competency assessment. During the course of the fourth court order for treatment, the psychiatrist, with the advice of legal counsel, conducted a more detailed assessment of Mr. Goddard's ability to weigh the risks and benefits of treatment. She focused on two inquiries: (1) Was Mr. Goddard's insight into his condition thorough? Did he really understand the need for maintenance of his medication regimen? (2) Was Mr. Goddard's claimed insight credible? Since he had some record of lying to professionals about his medication compliance, perhaps he was also lying when he seemed to demonstrate insight into his need for medication.

These inquiries resulted in a judicial decision to consider Mr. Goddard incompetent, despite his competent-

sounding verbalizations and to maintain him subject to a court order. This should succeed in ensuring he takes his medication and thus breaking the cycle of recidivism.

The Failures

The Refractory Patient Antipsychotic medication can prevent relapse in a substantial number of patients with chronic schizophrenia, but some patients are refractory to currently available psychopharmacologic interventions.[15] Failure to recognize this has done a disservice to the chronic mentally ill.[16,17] The refractory patient requires treatment approaches other than involuntary pharmacologic interventions. Such approaches may be limited to asylum until more effective treatments are available.

Case 7

Ms. Howard is a 55-year-old, single female with a 28-year psychiatric history and 19 psychiatric hospitalizations for chronic, paranoid schizophrenia. Ms. Howard's 17th admission followed a period of erratic medication compliance accompanied by grossly delusional ideation, grandiosity, derailed thinking, and several episodes of fire-setting in her community residential program. During this hospitalization, a court order for medication was obtained and fluphenazine decanoate was begun.

Ms. Howard recompensated in the hospital, as she had on previous admissions, although this time the regular administration of medication was ensured by the court order. Ms. Howard was discharged to the community residence, followed on court-ordered fluphenazine decanoate.

Ms. Howard was readmitted four months later after she was found to be delusional, paranoid, demonstrating impaired judgment, hitting other residential clients, and playing with fire in her room. She was continued on the fluphenazine decanoate in the hospital, again recompensated, and was discharged three and one-half months later.

Ms. Howard returned to her community residence and remained on the fluphenazine decanoate. Five months later she was readmitted, having been found to be delusional, paranoid, dysphoric, and frighteningly careless with smoking materials.

Throughout each period of community tenure under the court-order, Ms. Howard had received her scheduled fluphenazine injections. Her recompensation in the hospital and decompensation in the community including dangerous fire-related behavior, were apparently related to the hospital's milieu and structure, rather than to compliance/noncompliance with neuroleptic medication.

The Illusory Quick Fix There has been inadequate attention paid to the process of change with the chronic mentally ill[18] and perhaps undue pessimism about to their ability to change.[19] When a dramatic improvement is realized by a patient, particularly through coercion, providers of service need to proceed cautiously in bestowing increased degrees of autonomy to the newly improved chronic patient.

Case 8

Mr. Hudson was a state hospital recidivist who, when off medication, mani-

fested grandiosity, aggressiveness, delusions, hostility, incest, and once, homicide. His noncompliance with medication on an outpatient basis frequently and consistently resulted in his decompensation and rehospitalization. In fact, he spent only four and one-half of the last 14 years of his life outside a psychiatric hospital setting.

For a time, Mr. Hudson was released from the hospital on visit, conditioned upon his taking his antipsychotic medication. After two years of intermittent compliance, he discontinued medication completely, and was rehospitalized. During this admission, Mr. Hudson's assessment led to a change in diagnosis from schizophrenia to bipolar affective disorder. A court order was obtained for both neuroleptic medication and lithium carbonate. Mr. Hudson's improvement was dramatic. Within six weeks, he was released from the hospital, apparently euthymic and nonpsychotic.

Upon discharge, an involuntary treatment protocol was established. There was a debate about whether or not the court would grant a further involuntary treatment order due to Mr. Hudson's apparent competency. A decision was made to continue enforced treatment and to seek continued court sanction of that treatment.

Mr. Hudson complied with the plan by showing up daily for medication for four days. When he failed to show up on the fifth day, providers were not concerned because of Mr. Hudson's stable mental status the preceding days. Providers did not act until the *third* day of noncompliance. Mr. Hudson had committed suicide the preceding day.

Obviously, securing consistent compliance with medication did not resolve all of the clinical problem surrounding the treatment of Mr. Hudson. While securing such compliance is one focal point of the outpatient plan, attention to all the clinical needs of the discharged patient is necessary.

Summary and Conclusions

Generally, states that do not require physicians to respect nonemergency refusals of neuroleptic medication have not developed laws or procedures for court-ordered treatment. Practitioners in states that do have such requirements consider them burdensome. But such court processes can both benefit hospital inpatients and be used to maintain patients in the community.

For the previously long-term institutionalized patient, a court order for outpatient treatment, with its coercive component, can be crucial to medication maintenance in the community until insight is achieved. For the rapid recidivist, such an order can procure the compliance with medication necessary to stay out of the hospital. And, for the outpatient, a court order can obviate the need for hospitalization altogether.

Crucial to successful implementation of court-ordered treatment on an outpatient basis is a comprehensive network of services, particularly case management. But that network must also have flexibility. Coordinated treatment planning between inpatient and outpatient care providers is pivotal. Implementation measures, such as short hospitalizations or even outpatient coercion, may be needed for patients who refuse their

medication despite the court's order. And careful reassessment of the competency determination on a newly recompensated patient might avoid the mistake of not renewing or dissolving the court order before continued compliance is assured.

It is illusory to believe legal mechanisms, such as court orders for involuntary treatment, can obviate all the difficulties entailed by outpatient psychiatric treatment of the chronic mentally ill. Some patients are simply refractory to treatment; therefore, compliance with medication is not the issue. For them, asylum may be necessary.

The legal, administrative, and clinical resource commitment necessary to sustain court-ordered outpatient treatment on a systemic level is substantial. But the positive, human results for the most chronic patients of the public mental health system are significant. Court orders mandating the involuntary administration of psychotropic medications are proving to be an important addition to the therapeutic armamentarium of the psychiatric practitioner.

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