

Medication Refusal—Clinical Picture and Outcome After Use of Administrative Review

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To determine the effectiveness of the Administrative Review as a tool in discerning which patients who refuse medication should be medicated involuntarily; define characteristics of voluntarily and involuntarily committed patients who refuse medication; and compare posttreatment status of patients who successfully refused medication with those who were administered medication involuntarily.

Treatment refusal can be a frustrating issue in clinical medicine. For patients whose problem is essentially physical, this problem is mitigated by the ability of the patient to understand the consequences of such refusal and the ability to search for other opinions. In psychiatry, however, treatment refusal has more significance because it is frequently caused by the same mental symptoms that the proposed medications are expected to alleviate.

Whether patients with psychiatric problems have the right to determine if they will take medication is a complicated issue. There are, on the one hand, patients with severe problems who may be potentially violent and who, in an untreated state, have the potential of

harming both themselves and others. These will be treated almost without exception. At the other extreme, however, are those severely ill patients who pose no danger to anyone and could benefit from treatment.¹ Should such patients be forced to take medication for their own sake with results that may only be temporary and at the risk of undesirable side effects? And how do we absolutely discern those patients who are potentially violent from those who are not? The debate revolves, in fact, around the rights of patients who demonstrate adequate mental competence for refusal—and ways to determine that competence.

Legal Parameters

The U.S. Supreme Court has approved involuntary treatment for mentally ill prisoners who have refused treatment.² In most states, involuntarily committed patients who refuse may only be given medication after a judicial declaration of incompetence.³ This proce-

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ture has been described as a cumbersome "illusory solution",⁴ entailing an inordinate expenditure of time and resources.⁵⁻⁷ It has been criticized for, among other things, allowing patients to "rot with their rights on".⁸ Some states including Louisiana permit physician-determined treatment of patients committed involuntarily without recourse to a judicial process.^{9,10} This unrestricted authority does not, however, generally extend to voluntarily committed patients.^{11*}

The Louisiana policy does not take into account patients who are severely ill although below the threshold demanded for legal commitment. It also does not take into account voluntary patients who have committed themselves while severely delusional. As a result, such patients may well not receive medication from which they could benefit.

In some states an intermediate position has been adopted, whereupon the medical director in consultation with an independent psychiatrist determines whether medication should be administered to a refusing patient. This is determined case-by-case, and decisions are based on the patient's history, present mental competence, and the potential for altered prognosis, including the effect on hospital stay and prevention of further deterioration.^{12,13}

* Legislative Act (798) that amended several articles of the Louisiana Mental Health Law mandated administrative reviews as a prerequisite of forcing medications on involuntary patients.²⁶ It was approved in 1992, one year after the termination of the present work. Act 798 was amended in 1993 by Act 891, which provided for the administering of medication or treatment to patients without the patient's consent.²⁷

Louisiana Law

In Louisiana, patients are admitted for hospitalization either voluntarily or if involuntarily via an Order of Protective Custody (OPC).¹⁰ Any coroner or judge may order a person to be taken into protective custody and transported to a treatment facility for immediate examination when a peace officer or other credible person executes a statement specifying the person is mentally ill or suffering from substance abuse and is in need of treatment to protect the person or others from physical harm. This is known as an Order of Protective Custody.¹⁰

A patient in custody is then examined by a physician or psychologist to determine the severity of the mental status. If the conditions of danger to self or others or grave disability are present, patients may be admitted and detained for observation, diagnosis, and treatment for a period not to exceed 15 days.

The authority for detention is permitted by the Physician Emergency Certificate (PEC).¹⁰ The certificate must be confirmed within 72 hours by the independent examination by a coroner, after which a Coroner's Emergency Certificate (CEC) is issued. At the time this work was done, Louisiana Mental Health Law authorized involuntary treatment of patients committed by PEC.¹⁰

When the 15-day period of commitment is over, if continued treatment is deemed necessary and the conditions of dangerousness and/or grave disability persist, a petition may be filed in court after which the patient may be commit-

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ted, via Judicial Commitment (JC) for further treatment for an additional period not to exceed three months.¹⁰ Continuation after this period is predicated on another court hearing.

Hospital Policy

Once admitted, treatment of patients is determined both by willingness to accept medication and by the patient's legal status. In cases where medication is refused, the course of action is determined both by established legal parameters and by the policy of the hospital.

In the Medical Center of Louisiana in New Orleans (formerly Charity Hospital), the assigned physician explains to the patient refusing medication why the specific medication is necessary, including its expected results and side effects. The patient is then questioned about the reason for refusal. If refusal persists, a second psychiatrist examines the patient to either endorse or modify the proposed treatment.

Patients are informed of the results of this consultation. If treatment has been supported and refusal persists, a patient's advocate is brought in to explain legal rights, including the right to have the advocate present in the administrative process that follows. The patient is then referred to the medical director for administrative review. The administrative review is a policy developed within the hospital's mental health services and is not legislatively determined by the state of Louisiana.* The function of the review is to identify and empower those patients who although mentally ill are competent to refuse treatment.

All aspects of the medication refusal issue are analyzed in the review. The possibility of using different medications and alternative treatments is discussed with the patient. Ultimately, the medical director determines the status of the patient's refusal based on assessment of the stability of the patient during the process. The principal criterion used for overriding refusals is "incompetent refusal", that is, refusals based on severe delusional thinking. Other criteria include significant history of mental illness; history of response to medication; severity of present clinical symptoms; and potential for violence.†

Legal Versus Clinical Dilemma

The dilemma, which precludes an easy answer to the question of administering medicine to a refusing patient, is whether involuntary medication is a philosophical/legal or a clinical issue.^{12, 14} Even the simple statement that "the interests of the patient should prevail" only provokes the question "which interests?"

There are, however, aspects of this question that are easily quantifiable. Legal limitations on physicians' authority to order involuntary treatment have resulted in more frequent, longer-term hospitalizations, increases in severity of illness, and concomitant elevations in the cost of hospital treatment.¹⁵ The literature clearly demonstrates that as a

† Variables to be considered in the administrative review are codified in detail in Legislative Act 978 of 1992.²⁶ In a more general form they also were present in the Mental Health Services policy of the Medical Center of Louisiana in 1990, when the present study was done.²⁸

group, patients who refuse medication exhibit increased psychopathology, including violent behavior.¹⁵ They also have a history of more frequent hospitalizations and significant social dysfunction.¹⁶

Are these characteristics affected by administering medication against the will of the patient? In truth, courts consistently support physicians' petitions for involuntary medication, especially in cases involving violent behavior.¹⁷ The resulting data indicate such medication does lead to short-term improvement, resulting in shorter hospitalizations. However, significant long-term gains in the overall clinical picture or prognosis have not been demonstrated.¹⁸

Study

During a one-year period, from 1990 to 1991, 1,969 patients were admitted to the psychiatric services of the Medical Center of Louisiana in New Orleans. Of those patients, 40 refused neuroleptic medication despite efforts to convince them to accept it voluntarily. Seventeen (42.5%) of these patients presented admission behaviors that were defined as "emergencies" necessitating medication. Once the emergency was over, these patients were included in the study when they again refused medication deemed necessary for treatment. All 40 patients were then referred to administrative review to determine if medication would be withheld or administered.

Data collection was begun during the administrative review process and continued after discharge. Data collected included general demographic informa-

tion; past psychiatric history; legal status at times of refusal and discharge; compliance with outpatient follow-up; social functioning between hospitalizations; circumstances that led to the present admission and discharge; DSM III-R diagnosis; patient's reasons for medication refusal; instances of forced medication on emergency basis; discharge plans, including living situation and type of psychiatric follow-up; duration of the forced medication process; and number and clinical characteristics of patients who received involuntary medication at the end of the process.

Analysis of the data included correlating characteristics of refusing patients with their success or failure in refusing medication. Chi-square (χ^2) was used for statistical analysis and levels of significance of probability (p) were assigned. In cases where the numbers were too low to determine significance, percentage values (%) were given.

The variables that were analyzed included:

1. Psychosocial functioning. Psychosocial functioning was considered to be adequate when patients were living successfully at home or in a group home in the year prior to the last hospitalization and had received follow-up at a mental health center. Inadequate functioning was characterized as patients who were homeless, not taking medication, or had had no follow-up.
2. Diagnosis. DSM-III-R diagnoses on discharge from the hospital.
3. Medication refusal. The basis of patients' refusals was divided into

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four categories: (a) personal, the feeling it would not be of help, or just not wanting to take it; (b) fear or previous experience with side effects; (c) delusional state; and (d) an inability to explain, often owing to severely disorganized thought processes.

4. Potential for violence
5. Prescribed post-hospital care

In addition, the administrative review was analyzed for effectiveness in discerning patients who should be medicated involuntarily.

Results

The 40 patients in this study represented 2% of the 1,969 admissions to the five psychiatric wards of the Medical Center of Louisiana in New Orleans during 1991. The group consisted of 19 men and 21 women ranging in age from 25 to 75 years, with a mean of 39 years. Average age of all psychiatric patients admitted during the same period was 34.75 years. Average length of stay for all psychiatric patients was 17 days compared with 34 days for the study population.

Twenty-seven (67%) of the 40 patients refusing medication were admitted involuntarily via OPC (Table 1). This figure represents a large number in comparison with all psychiatric admissions to the hospital, of which only 25 percent are involuntary. The other 13 refusers were admitted voluntarily.

Violence immediately before admission was the presenting complaint in 21 of the 40 patients. Three patients were admitted because of problems with

placement, 15 because of noticeable decompensation in the days or weeks before admission, and one patient was admitted because of suicidal ideation.

The average duration of the presenting episode for the patients refusing medication was 7.5 weeks and the average length of illness was estimated at 20 years, based on the information available in the medical records. A random selection of 50 patients who did not refuse medication showed an average duration of illness of 14 years. This difference is not statistically significant and the available information did not indicate longer courses of illness in the group of patients refusing medication.

The results of the administrative review showed that of the 40 patients, 29 (72.5%) received medication involuntarily and 11 (27.5%) did not. These two groups of patients were compared to the following variables:

Psychosocial Functioning The involuntarily medicated group demonstrated increased psychosocial dysfunction before admission (Table 1).

Diagnosis Most patients in both groups were diagnosed with schizophrenia, bipolar mood disorders, or schizoaffective disorder. Diagnoses were made on clinical grounds alone. There was no statistical difference in the frequency of diagnoses between medicated and non-medicated refusing patients. The exact number of hospitalizations could not be determined from the information available in the clinical records. Three of the 40 patients were hospitalized for the first time (Table 2).

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Table 1
Comparison of refusing patients who were medicated involuntarily with those who were not medicated

	Medicated Involuntarily		Not Medicated	
	N = 29		N = 11	
	n	%	n	%
Legal status				
Voluntary	7	24.1	6	54.5
Involuntary	22	75.9	5	45.5
		$\chi^2 = 3.36$		
		$p = .006$		
History of violence	17	80.95	4	19.05
Functioning before admission				
Adequate	9	31.0	6	54.5
Inadequate	20	69.0	5	12.5
		$\chi^2 = 6.930$		
		$p \leq .008$		

Table 2
Discharge diagnoses of refusing patients who were medicated involuntarily and those who were not medicated

	Medicated Involuntarily		Not Medicated	
	N = 29		N = 11	
	n	%	n	%
Schizophrenia (all types)	18	62.0	7	63.6
Bipolar mood disorder	6	20.7	2	18.2
Schizoaffective	4	13.8	0	0.0
Personality disorder	0	0.0	1	0.0
Psychosis NOS*	1	0.0	1	9.1

* NOS indicates not otherwise specified.

the small number of cases in each diagnostic category, no attempt was made to find a statistical correlation between diagnoses and different reasons for refusal. Delusions were, however, the most often cited reason for refusal, as described by other authors (Table 3).¹⁹

It is important to point out that 16 of the 17 patients who had received preadmission medication on an emergency basis also received involuntary medication after the administrative review.

Violence Violence was a good predictor of which involuntarily committed

patients would receive medication involuntarily.¹⁷ Of the 27 patients refusing medication admitted involuntarily, 22 were medicated after the administrative review (Table 1). Of these, 16 (72%) had a history of violence. By comparison, only 7 of 13 patients who were admitted voluntarily were medicated involuntarily, and of these only 1 (14%) of the 7 had a history of violence.

Posthospitalization Care There were no demonstrable differences in prescribed posthospitalization care between the refusing patients who were medi-

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Table 3
Comparison of refusing patients who were medicated involuntarily with those who were not medicated for delusion as reason for refusing medication

	Medicated Involuntarily		Not Medicated	
	N = 29		N = 11	
	n	%	n	%
Delusional	21	72.4	4	36.3
Non-delusional	8	27.5	7	63.6
$\chi^2 = 4.42$ $p < .04$				

cated involuntarily and those who were not. Recommendations generally prescribed follow-up at the mental health center or transfers to the state hospital for further psychiatric care. Further follow-up is necessary to determine if this lack of difference was maintained over time. However as a group, patients who refused medication fared less well than the general patient population. During the study only 8.6 percent of all psychiatric patients were transferred to the state hospital for further treatment, compared with 27 percent in the refusers group of patients who refused medication.

The Administrative Review

Reasons given for medicating 29 of the 40 patients against their will included potential violence (15 cases), severe delusional thinking (26 cases), and gross confusion or a combination of these symptoms (4 cases).

The duration of forced medication varied from one to 20 days, with an average of 4.9 days. Seven patients began to take medication voluntarily in 2 or fewer days. This shift from involuntary

to voluntary medication indicates a positive change during the hospitalization.

More than two thirds of the administrative reviews were done in five days; none exceeded 10 days. Under ideal circumstances the process could be completed in three days. The cooperation of the psychiatry residents, consulting psychiatrists, and patient's advocates made this possible and prevented extraordinary prolonging of the hospitalizations.

Discussion

In this study, patients who had been brought in involuntarily were most likely to be medicated involuntarily. An overriding characteristic of this group was the threat of or actual violence. In the entire group of 27 involuntary patients, only five were not medicated involuntarily.

The most frequent discharge diagnoses in all patients were schizophrenia, mood disorder, and schizoaffective disorders. Contrary to previous studies,²⁰ the presence of extrapyramidal symptoms was not the motivating factor in the majority of refusals. Refusal of medication was more frequently based on personal reasons or severe delusional thinking.^{19, 21-23}

The potential for violence was a determining factor in overriding patients' refusal. Once involuntary treatment was initiated, most patients switched quickly to voluntary intake of medications, as has been the case in other studies.²⁴ This suggests that even one or two doses of neuroleptic medication improves a patient's ability for decision making. There is also, however, the possibility that

being forced to take medication weakens patients resolve to refuse, instilling a sense of impotence in them. This last aspect is worrisome and requires careful investigation.

On a positive note, however, opinion polls of involuntarily medicated patients taken at the time of discharge have shown that about two thirds felt that treatment refusal had been correctly overridden and felt they should be treated against their will again, if necessary.²⁵

It is not possible to learn from this study if there were long-term improvement of the patients' condition. That 31 (77.5%) of these patients requested and were granted voluntary legal status before discharge indicates some general degree of improvement after a brief hospitalization.‡

An essential part of this study was to establish the efficacy of the administrative review used during our study. It compares favorably with the reported average of 4.5 months for a judicial declaration of incompetence and appointment of a curator.¹⁸ The waiting period involved in this procedure posed no problem in instituting treatment. Patients who were violent were efficiently treated on emergency basis. Other patients remained untreated until the completion of the administrative review. Interestingly, because the procedure itself increased contact between staff and patients, many patients who initially refused medication changed their minds

in the preliminary stages of the review, thus confirming the experience of others along the same lines.¹⁴ This is a strong indication that the practice of listening to patients reasons for refusal and consistently respecting their human rights tends to improve the quality of care. It is also an excellent learning experience for residents and staff.

Conclusion

This study confirmed that an efficient administrative review provides benefits in the acute phase of psychiatric treatment. The experience with a procedure to medicate patients involuntarily was described. There was prompt symptomatic improvement in most patients, whether or not treated. It indicated that forced medication alone is not responsible for this improvement, but combined with other aspects of short-term hospital treatment it turned out to be a beneficial experience in the treatment of an especially difficult group of mental patients.

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‡ Average length of stay for the study group was 34.5 days, with a range of 13 to 126 days. Average length of stay for the psychiatric service at that time was 21 days.

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