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Management of Forensic Psychiatry Patients Who Refuse Medication—Two Scenarios

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ABSTRACT: An Ohio federal court set *Wyatt*-type standards for treatment rights of forensic psychiatry patients and ordered legal due process-type hospital hearings to protect patients from what the court considers harmful clinical practices. Experience with this legal method for management of patients who refuse medication is examined for its impact on staff and patient care. Under legal pressure Ohio has built new regional forensic psychiatry hospitals. In one, spurred by legal activism, the prevalence of patients refusing medication has become pandemic. In its typical 16-bed ward, when 2 or more patients refuse medication, danger escalates rapidly for patients and staff. The method adopted to manage these situations is to assess the emergency of danger to patient or others, and if warranted to administer medication despite objections. This emergency management is dramatic in improving patient behavior and defusing milieu tensions. The psychiatrist ordering emergency management, however, faces challenges from several quarters—patient advocates, outside patients' rights legal advocates, and the commissioner of mental health. The clinically managed process contrasts markedly also with the legally imposed one in its impact on the personal and professional integrity of the responsible psychiatrist. Both scenarios illustrate the task yet remaining—integration of the clinical and legal concerns into a multisystem resolution of diverse interests, values, ethics, and rights.

KEYWORDS: psychiatry, jurisprudence, mental illness

Interests, values, ethics, and rights meet in the arena of the forensic psychiatry hospital, where clinical and legal systems solve and create problems, separately and simultaneously. Both systems are manifest early in the process of hospital treatment. Forensic psychiatry patients are met on admission by a patient advocate who explains the treatment authorization form for signature before the patient meets the admitting psychiatrist.

Legal systems use maximum security hospital settings for the protection of society from committed, psychiatrically ill individuals whose right to privacy and autonomy is thereby modified. Yet, the involuntary patient's right to privacy and autonomy is upheld by the court in defense of treatment refusal.

Whether admitted for competency evaluation, sanity determination, or treatment of chronic mental illness, each patient is considered competent to refuse treatment and, unless declared otherwise by way of a separate legal process, remains so even if found incompetent to stand trial, not guilty by reason of insanity, or in need of continued maximum security hospitalization because of chronic mental illness. The support for treatment refusal rights is based in

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part on an impression that psychotropic medications are mind-controlling [*1*]. Nevertheless, courts accept recommendations of competency to stand trial contingent upon continuation of psychotropic medication [*2*].

A 1974 federal mandate to provide treatment for Ohio's forensic psychiatry patients provided the genesis for two still evolving systems of forensic psychiatric hospital practice. The initial impact of *Davis v. Watkins* on Ohio forensic psychiatric hospital practice in the mid 1970s, particularly at Lima State Hospital, has been documented [*3*]. In response to the *Davis* case, the forensic psychiatry division of the Ohio Department of Mental Health developed a plan to phase out the deteriorating Lima State Hospital and to replace it with regional forensic psychiatry hospitals. The first of three planned hospitals, Dayton Forensic Hospital, was completed on the grounds of the Dayton Mental Health Center in June 1980. At this time, the second facility, the Timothy B. Moritz Forensic Unit at the Columbus Psychiatric Hospital, and the Forensic Unit of Dayton Mental Health Center are providing all the maximum security beds (184 beds) for Ohio's hospitalized population of nonpenal forensic psychiatry patients. Currently, Lima State Hospital houses only convicted felons in need of treatment.

Nine years into the aftermath of *Davis v. Watkins*, a stark contrast emerges between forensic psychiatry practices at today's Lima State Hospital and at the Dayton Mental Health Center Forensic Unit. Two disparate scenarios—one based on legal imperative, the other on clinical prerogative—are described in this paper, with attention to the role of the clinician. The scenarios reflect the independent and simultaneous development of two clinical roles.

Scenario 1

In 1974, *Davis v. Watkins* in the Federal District Court of Northern Ohio established the right to treatment of patients in the State's Forensic Hospital, imposing *Wyatt*-type standards and a special court-appointed Master for surveillance of implementation. In the permutations of this landmark federal case that followed, *Davis v. Balson* [*4*] (1978) and *Davis v. Hubbard* [*5*] (1980), the court, after regarding indefensible clinical practices that had existed but no longer exist at Lima State (LSH), the hospital in question, found that the medication practices involved a constitutionally protected liberty issue and that patients required fourteenth amendment due process protection.

Many if not most clinicians find this development a disruptive imposition on the clinical process. Deeply disturbing, to start with, is the court decision itself, essentially a sweeping indictment of the use of psychotropic medications, interpreting the medical-psychiatric literature somewhat out of context, at least not with a balanced perspective, being swayed by a number of notorious reviews by legal professionals in legal journals that are distinctly adversarial and biased in perspective. The point is that in treatment with psychiatric medications there are many hazards, some certainly serious. That reality in no way vitiates the other, overriding reality that psychotropic medication can be used properly, with reasonable safety, and can be very effective. We can and do applaud the court's indictment of the bad clinical practices. We are taken aback, however, by the court's inability to differentiate in its sweeping opinion the bad practices from proper practice in prescribing psychotropic medication. Finally, the most bitter pill of all is the recognition that the due process protection ordered by the court is in effect a judicial statement that the patient needs protection from his therapist. One may worry about the prospects of therapy in an adversarial relationship.

At Lima State Hospital the ordered due process protection has been incorporated in a policy requiring signed consent by the patients. In the case of a nonconsenting patient, psychotropic medication may not be administered without a delay for a hearing before the medical director or designee functioning as an "impartial person." The patient may be represented by legal counsel and may have his own outside expert, but at his own expense. The hospital must provide the patient with a lay advocate (from its own staff). Witnesses may be called and cross-examined by the medical director or the patient or his advocate. The medical director's deci-

sion must be in writing and may affirm, modify, or overrule the clinical judgment of the patient's therapist, a member of his medical staff. The patient may appeal the medical director's decision, a process requiring an outside psychiatrist at state expense and three weeks of time to a decision. While the appeal is pending, the medical director's decision is implemented. Emergency interventions, defined as situations in which the patient is a present danger to self or others, are exempt from consent but not necessarily from due process protection, since, in the language of the court order, even emergency intervention should be followed by some *ex post facto* procedures.

Implementation of these due process procedures started at Lima State Hospital in late July 1981. In the first week 46 hearings were held by the medical director. Limitations were imposed on the number of hearings a patient could have in a given period of time, and 15 min were allotted per hearing. These restrictions were considered pragmatic and necessary. From the point of view of justice, such restrictions are necessarily arbitrary and chilling to the prospects of actually providing the intended protection. The rate of patients refusing medication quickly slacked off remarkably. In the first 14 months, including the first big week, 277 instances were recorded of patients refusing medication. One-hundred eighty-five cases were reviewed in hearings before the medical director. In 131 cases the medical director denied the patients' refusals, and medication was administered. In 53 cases the medical director affirmed the patients' refusals. Nine cases went to appeal before an outside psychiatrist (coming to Lima State Hospital for the hearing). In these appeal cases, the medical director's decision was affirmed in six instances, modified in one, and reversed in one (leaving one case with the record of the appeal decision unclear). In a typical week in late 1982, there were five instances of patient refusal of medication. Before coming to hearing one of the five was resolved by an accommodation between patient and therapist. Of the four that came to hearing, the medical director sustained the member of his medical staff in three cases. The overall appeal rate was around 4%, and in 80% or more of the appeals the medical director's decision was affirmed.

There are many criticisms to be made in regard to the due process solution. First and foremost is the opprobrium of the message of the court's opinion and order. Can the court, by imposing its methods, ensure the ends of treatment, or by imposing its forms ensure content? The advent of these legal requirements and imposed legal trappings certainly has raised the consciousness of both patients and staff on the issue of treatment with informed consent. On that issue of principle we must pay due respect to the law. But is that all, and is there a price? Can the adversarial method have any reasonable place in the hospital setting, in the therapeutic process? Even in the legal arena, where it is the time-honored method for assuring justice, it is perfectly plain that the adversarial system works imperfectly.

If its end in the hospital setting, as seen in operation at Lima State Hospital, were *justice*, we see that it works imperfectly, because of limitations of time and circumstance. How can one expect the medical director to spend his whole week in hearings? By limiting the hearings to 15 min and the number of hearings per patient per time, the medical director spent half of the first week in hearings. It is extraordinary that no one raised the issue that certainly passed through the minds of some: Can that be justice? One has to consider the alternative—that the procedure is a charade. The "impartial person," in the language of the requirement of the court order, is the medical director sitting in judgment on members of his own medical staff. The first court order spoke of the clinical case for medication as "charges" against the patient. The staff assume the roles of prosecution or defense. Considerate discussion with patients is an essential and strong element of the therapeutic process. At Lima State Hospital, under adversarial conditions, in a population in which the wisdom and wiles of the correctional inmate flourish, the adversarial process in matters of agreement to take medication takes on the color of plea bargaining. Does the due process mechanism inhibit the use of medication in the psychiatric hospital? Does it improve the quality of medication practice? Does it advance or serve the aims of hospital therapy? As seen in operation at Lima State Hospital, it appears that the answer to any or all of these questions, and a great many more, is in some ways yes, and many

ways no. Of course, there are delays in patient medication or instances of prolonged nonmedication, distinctly to the patient's loss in many cases. Of course, the ordering of medication is done more carefully, which does not guarantee that it is done more effectively. Defensive practice of medicine is not necessarily better practice of medicine.

Medication is the tool with which psychiatry is most experienced, the tool it finds most efficacious for the management and treatment of the conditions of hospitalized patients. In the forensic psychiatry hospital there is a heightened sense of investment in the availability of the medication resource. In all psychiatric hospitals medication is in the forefront of treatment. In forensic psychiatry hospitals it is likely to be more so. At Lima State Hospital one sees that medication in treatment is still very much alive, mostly without benefit of due process. Of the minority who invoke due process procedures, we see that a sizeable portion go on to accommodation without hearings, many ultimately accepting medication. In the complex of hospital practice there are many subtle and gross factors for appealing to, persuading, and reaching accommodation with patients. In many civil hospitals in these days of court enforcement of the patient right to refuse medication, it is seen that by clinical methods alone accommodation can be achieved with most patients, seldom with more than a little delay in time [*6*]. The experience at Lima State Hospital demonstrates the same potential, largely outside of due process methods and to a considerable degree within due process also. The question underscored is: is due process the only or best way to achieve the desired end? And what about the effects on the primary psychiatrist? What difference does it make when he or she is thrust into the adversary role? Second guessed by the medical director? Reduced to the role of carrying out the orders of another? And should one also raise the issue of cost?

The foregoing paragraphs are an onward rambling sampling of many factors on many levels, and how they may be affected as seen in the experience with due process methods at Lima State Hospital. It really is not profitable to pursue evaluation in more depth and detail in this way. The courts, attending to formal, defined issues taken in isolation, miss the larger picture. Treatment, in whatever parameters, is a relatively new adventure in forensic psychiatric hospital practice. Historically and today, the priorities of service that forensic psychiatry hospitals face are, in order:

(1) service to the criminal courts,
(2) public safety, and
(3) treatment.

Treatment is a weak third priority, given the demands of the other two and the unrealistic expectations that psychiatric treatment can provide guarantees of public safety. For reality's sake, one should also look at the fact that internal safety, for the patient and for other patients and staff, is at very high risk in forensic psychiatry hospitals. Admittedly, when it is a given that the typical patient resorts quickly to threats as a major interpersonal defense, and when patient-staff tensions run high, medication may be overused, may be used punitively, or used for "control rather than treatment," as the court noted in its *Davis* judgment. But concern over safety to life and limb cannot easily be allayed. In such circumstances control and therapy issues begin to fuse. If the use of medication is inhibited (the court still allows its use in emergencies), danger may escalate, and pressure may promote other methods of intervention, most commonly seclusion or restraint, or both. In the case of the latter we have again the issue of control versus therapy, more dicta from the court, and other specific due process protection orders. In the end, for the patient who combines trouble with the law with mental disorder, psychotherapy is at an undeveloped level and faced with misguided and unrealistic expectations.

Scenario 2

The Dayton Mental Health Center Forensic Unit was designed and staffed for a stated unique purpose: treatment for forensic psychiatry patients. In its almost three years of ser-

vice, difficult clinical management situations have been abundant, especially in regard to treatment refusal.

This unit has managed to remain free from the legally mandated *Wyatt*-type standards for treatment rights of patients, and therefore does not have a legal due process or other complicated institutional mechanism for adjudicating or appealing treatment refusal. Here, responsible psychiatrists have an uncommon opportunity to demonstrate their ability to manage by clinical precept independently of legal mandates. Especially with the consultation advantages afforded by a team approach to treatment, the psychiatrist is capable of a formal, pragmatic, philosophic, and professional thinking through of the clinical and legal issues toward a pragmatic outcome.

The Dayton Forensic Unit's mechanism for managing treatment refusal is the application of individualized clinical judgement—in emergency and nonemergency situations.

There are major concerns about the legal profession's entry into the health care profession, and controversy about psychiatric testimony in the courtroom is increasing [*7*]. The crosscurrents of law and psychiatry impact heavily on the forensic psychiatric hospital setting, which is beset from within by disturbances of emotion, thought, perception, and behavior in a patient population of a street-wise subculture. From without, there are concentric and overlapping pressures stemming from administrative, clinical, and legal concerns.

Part of the problem seems to be that psychiatry and the law each have shortcomings in their approach to the forensic psychiatry problem. Psychiatry has its tradition of "clinical autocracy" and the law professes "legal impartiality" [*8*]. Professor Wood has called upon both components to acknowledge a systematic solution that is beyond the precepts and prejudices of both psychiatry and the law—a solution by the methods of administration [*8*]. Nonetheless, psychiatry still has a fundamental clinical responsibility and concern about quality of patient care [*9*], a difficult mission in the face of intense pressures from adversarial and advocacy systems.

What is treatment? A typical forensic psychiatry patient's concept of treatment is filtered through degrees of disturbance of intellection, perception, emotion, and behavior, often predicated on deeply ingrained, long-standing maladaptive reaction patterns and little tolerance of frustration. Typically, a forensic psychiatrist's concept of treatment is colored with concerns about legal, administrative, public safety, and internal security issues, and not simply the mental disorder. The freedom to carry out treatment of the mental disorder is heavily weighed upon.

In a psychiatric hospital, hierarchical categories of patient privileges are integral parts of treatment. In a forensic psychiatry setting, the range of privileges is from unsupervised hallway passage, through confinement to the ward (with or without supervised activities), through wrist-to-waist (with or without ankle) restraints, through seclusion with four-point (arm and leg) restraints. All are forms of therapy. When privileges permit, activity therapies are strongly encouraged. Psychosocial forms of treatment like "talking" therapies, activities, and curtailments of activities, viewed as noninvasive by the courts, are applicable without legal restriction to all patients by clinicians; however, withdrawn psychotic patients often stagnate clinically because they refuse activities while the staff have no recourse. In regard to psychosocial forms of treatment, neither the patients nor the courts raise the issue of the right to refuse at the Dayton Forensic Unit. For all practical purposes, the issue of invasive therapy in the light of the court's concern is limited to psychotropic medication.

Why refuse treatment? From their review of the literature Appelbaum and Gutheil described three broad categories of reasons for drug refusal: intended drug effect, drug side effects, and effect on and resulting from relationships [*6*]. In each of these categories, the views and values of clinician and patient can literally be worlds apart. In their own study of inpatient drug refusal, Appelbaum and Gutheil describe three clinical groupings of drug refusers:

> (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) symptomatic refusers—young, relatively acutely ill patients whose refusal, often based on delusional premises, was sustained over a long period and successfully stymied treatment efforts [*6*].

The defensive posture of illness denial is admittedly important to the patient; however, the processes of involuntary admission and the patient advocate reinforcement of rights serve to uphold the denial as a persistent mechanism, leaving the psychiatrist with two strikes already against him. What the clinician sees, as exemplified in a cross-sectional diagnostic picture of a typical forensic psychiatry ward, is intensified by the reinforced denial of illness. Illnesses denied at least in part by patients sharing a 16-bed Dayton Forensic Unit ward at one point in time included 14 with primary diagnoses of schizophrenia, most associated with personality disorders (antisocial, passive-aggressive, or mixed), one with an affective disorder, and one with alcoholic dementia. The frequency of personality disorder in this select population might explain the aggressiveness with which denial is expressed. The same factor might explain a shift from the preponderance of situational refusers documented in the study by Appelbaum and Gutheil [*6*] to a preponderance of symptomatic refusers on the described ward. As in the Appelbaum and Gutheil study, experience with this ward setting clearly supports the contention that attitudes toward treatment and drug refusal are derived from aspects of psychiatric illnesses—of psychotic proportions.

In the absence of treatment authorization and opportunity for informed consent [*10*], clinical discretion to treat in instances of patient refusal is limited to "emergency circumstances," as stated in the two landmark cases on the right to refuse treatment, *Rogers v. Okin* and *Rennie v. Klein* [*11*]. How does a clinician estimate "substantial likelihood" or the process that "creates danger"? Realistically, interpretations of dangerousness would include consideration of the developmental, psychiatric, and criminal histories and diagnoses [*12*]. But, more than predicting the likelihood, predicting the timing of forensic psychiatric hospital violence seems to be the most immediate task. Forensic psychiatric hospital patients are themselves violence-prone [*13*], and they are prominently violence-provoking. The natural resolution of dangerousness is equally difficult to predict.

Treatment refusal on the Dayton unit is handled in two ways. Based on the concept that in states of emergency there is a duty to treat, the psychiatrist makes a determination. If it is a case of emergency, the psychiatrist may order psychotropic drugs to be given, despite the patient's refusal. In the ward experience, this emergency management has been dramatic in improving patient behavior and defusing milieu tensions. The second method deals with refusing patients in nonemergency cases. These are handled by temporizing, managing by trying to work through the patient's resistance. The results in these cases are at best mixed and often result in long delays and frustration in the theraprutic process.

In undertaking to treat, the Dayton Forensic Unit psychiatrist does so at the hazard of potential challenge by the patient, the patient advocate staff, external legal rights organizations, and the Office of the State Commissioner of Mental Health. In decisions to not treat, which are often based on patient's refusal of recommended treatment, the psychiatrist risks challenge by the same agents, especially if untreated behaviors end in untoward results. Gutheil has observed the successful suits in the late 1960s for not medicating committed, drug-refusing patients in Minnesota and New York, and the contrasting suit in Massachusetts in the late 1970s for medicating drug-refusing patients [*1*].

Considerations in the decision to treat against a patient's wishes have been well defined by Michels: "the nature of the alternatives to forced treatment, the probable duration of treatment its risk/benefit ratio, its probably impact on future attitudes toward long-term care, its probable impact on the duration of involuntary institutionalization, and the nature and intensity of the patient's refusal" [*14*].

In the closed system of the forensic psychiatric hospital ward, the individual and his environmen are inseparable. The rights of the individual patient and others in the ward environ-

ment are often in conflict [*15*]. Protecting the rights of an individual patient might result in milieu disturbances that infringe on the security of other patients and staff [*16*].

The psychiatrist, with the help of a multidisciplinary team, serves as a monitor of milieu influences such as admissions, discharges, stirring visitations or phone calls, anticipated court appearances, and transference and countertransference issues. The team provides a broad base of information from which to evaluate environmental and intrapsychic influences on behavior as well as to design and implement treatment plans. The use of the multidisciplinary team approach to treatment in psychiatry is widespread, despite the fact that its members have various philosophical subtleties [*17*]. By some in the legal profession, the multidisciplinary team approach to treatment has been considered a viable alternative to the traditional reliance solely on the psychiatrist, especially in cases of treatment refusal [*18*]. Dayton Forensic Unit teams are staffed in a complementary fashion with a psychiatrist, a psychologist, a social worker, a psychiatric nurse, an educator, an activities therapist, and one or more psychiatric aides. Regular meetings and frequent informal contacts facilitate the development of a broad-based information system. A team's sensitivity to and integration with the milieu provides the platform from which a psychiatrist can derive the resources, the support, and the means to manage clinical complexities, including the resistance of patients.

Summary

A 1974 class action suit brought forth in northern Ohio the legal opinion that psychotropic medication is mind-controlling and invasive. Clinicians, on the contrary, consider psychosis as a malignant invasion and a form of mind control [*1*]. Polarization of perspective and purpose has poised legal and clinical systems on a tightrope of right-to-treatment/right-to-refuse-treatment issues.

In dealing with this deeply complex balance of issues, two distinctly different styles of forensic psychiatric practice have been evolving in Ohio. One system is more congenial to the outlook of clinicians, and is more flexible. One has more form than content, and is more rigid and also more costly. One is effected by the free functioning of clinical methods, the other, by imposition of legal controls.

If justice is the purpose, there is probably no great disparity. Clinical methods today are very conscious of rights and can factor respect for patient rights into the clinical equation. Both systems—legal and clinical—should be concerned with clinical effectiveness. In fact, clinical effectiveness is a questionable issue. Therapy is probably a nonissue. Neither forensic psychiatry hospital is really, primarily devoted to treatment.

Both scenarios poignantly portray the persistent shortcomings of treatment in the forensic psychiatry setting, and the limitations of solutions from either the legal or clinical systems alone. The disparity of the two scenarios suggests a multisystem problem requiring an administrative solution—one that is flexible and sufficiently free and independent to integrate the diverse interests, values, ethics, and rights pertaining to the treatment of forensic psychiatry patients.

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