Patients' Rights vs. Patients' Needs: The Right of the Mentally Ill to Refuse Treatment in Colorado

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Some physicians I interviewed frankly admitted that the animals of nearby piggeries were better housed, fed, and treated than many of the patients on their wards. I saw hundreds of sick people shackled, strapped, straightjacketed, and bound to their beds. . . . I saw them crawl into beds jammed together, in dormitories filled to twice or three times their normal capacity. I saw them incarcerated in "seclusion rooms"—solitary isolation cells, really—for weeks and months at a time. I saw signs of medical neglect, with curable patients sinking into hopeless chronicity. I found . . . excruciating suffering stemming from prolonged, enforced idleness, herdlike crowding, lack of privacy, depersonalization, and the overall atmosphere of neglect.¹

Thus was the life of many inmates of mental institutions described twenty years ago. Since that time many factors have alleviated the inhuman and degrading conditions which persons, solely because of mental illness, have had to endure. Among these factors have been the development and utilization of psychotropic medication, the deinstitutionalization of mental patients, the patients' rights movement, and the community mental health centers movement.² Concurrently, the courts have recognized the right of mentally ill persons to be treated,³ the right to due process in civil commitment hearings,⁴ the right to the least restrictive treatment alternative,⁵ and the right to refuse treatment.⁶ As a result, the conditions sur-


². There are now more than 500 community mental health centers in operation, which have helped to reduce the inpatient population of mental institutions by two-thirds in 20 years. Bassuk & Gerson, Deinstitutionalization and Mental Health Services, 238 SCIENTIFIC AM. 46, 49 (1978).


rounding the treatment of mental patients have improved considerably.

The last of the patients’ rights to be recognized—the right to refuse treatment—has raised a number of conflicts between the medical and legal professions. In addition, some of the consequences of the exercise of the right to refuse treatment have raised serious questions about the direction in which the treatment of mental illness is heading and have shaken the philosophical underpinnings of the mental health treatment system.

In Colorado, the right to refuse medication was first recognized by the Department of Institutions, Division of Mental Health, in regulations published in July 1979.\(^7\) Prior to the promulgation of these regulations, however, a Colorado district court had issued a temporary restraining order enjoining the medication of an involuntary mental patient.\(^8\) The subsequent appeal of this order resulted in the Colorado Supreme Court’s recognition of the right to refuse medication in Goedecke v. Colorado\(^9\) in that an involuntary mental patient could refuse the administration of psychotropic medication unless his illness “has so impaired his judgment that he is incapable of participating in decisions affecting his health.”\(^10\)

The recognition of the right to refuse medication in Colorado has had considerable effect on the treatment of mental illness in the state. The author interviewed attorneys, mental health professionals, judges, and patients to ascertain the impact of the exercise of the right to refuse medication on the mental health treatment system. This paper will explore that impact, placing it in perspective through a brief discussion of the history of the treatment of mental illness and its legal bases, a description of the categories of mental illness and the medications used to treat them, and the effect of the exercise of the right to refuse medication on the patients, the mental health professionals, the community at large, and the mental health treatment system.

I. THE TREATMENT OF THE MENTALLY ILL: A HISTORICAL PERSPECTIVE

Throughout history the mentally ill have been cast among the rejects of society. Viewed with varying tolerance in different cultures, the principal method of dealing with the mentally ill until recently has been to segregate them from the general population.\(^11\) In colonial America, mentally ill per-

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\(^7\) Department of Institutions, Care and Treatment of Mentally Ill, Rules and Regulations, 2 C.C.R. 502-1 (effective Aug. 30, 1979) [hereinafter cited as 1979 Regulations].
\(^8\) Interview with Physician A. The writer interviewed a number of mental health professionals, psychiatrists, patients, judges, and attorneys. Because some requested anonymity, all will be referred to by letter. Physician A is a psychiatrist and the medical director of a community mental health center which has been involved in a number of hearings regarding the right to refuse medication.
\(^9\) 603 P.2d 123 (Colo. 1979).
\(^10\) Id. at 125.
\(^11\) See N. KITTRIE, THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY 56-65 (1971); THE MENTALLY DISABLED AND THE LAW 1-8 (rev. ed. S. Brakel & R. Rock eds. 1971) [hereinafter cited as Brakel & Rock]. In the Middle Ages, in addition to the insane being executed as witches or imprisoned, entire ships (“Ships of Fools”) were chartered and filled with insane persons for the purpose of transporting them to, and leaving them at, uninhabited
sons were often kept locked in rooms or outhouses if cared for by family or friends. When family or friends were unable to provide assistance, the mentally ill became subject to the institutions that developed both for the control of deviants and as a result of the poor laws. Mentally ill indigents often wandered from place to place with other social outcasts and paupers, or they were confined in houses of correction, jails, or almshouses with children, the aged, prostitutes, vagrants, and drunkards, where they were kept at the lowest possible cost to the community.

In the mid-eighteenth century, the mentally ill began to be viewed as treatable. Following the impetus of Philippe Pinel in France and William Tuke in England, Dr. Benjamin Rush began to use new theories and methods.

N. Kittrie, at 57. The feeling that the mentally ill are outcasts and that the bizarre and annoying members of the community should be removed still exists today. See Mechanic, Judicial Action and Social Change, in THE RIGHT TO TREATMENT FOR MENTAL PATIENTS 47, 69 (S. Golann & W. Fremouw, eds. 1976) [hereinafter cited as Golann & Fremouw]; Stone, The Right to Treatment and the Psychiatric Establishment, in PSYCHIATRISTS AND THE LEGAL PROCESS 289 (1977).


Cornelius Boarman, adjudged in 1797 to be "a lunatic of unsound mind," enjoyed lucid intervals but not so that he was capable of the management of himself and his property, consisting of two hundred acres of land, thirty Negro slaves, and other personal property. A trustee (Boarman's uncle) was appointed to care for Boarman and manage his estate. Throughout the next thirty years, his estate was enjoyed and wasted by his trustees although the estate of the lunatic was very productive, and more than sufficient to support him in every comfort and luxury, although he was very mild and inoffensive in his conduct; and they had kept him in an outhouse, which was not sufficient to protect him from the weather; and with not enough clothing, even of the coarsest kind, to shield him from the weather, not even enough to cover his body and conceal his nakedness.

Boarman's Case, 2 Bland Ch. 89, 94 (Md. 1824).

See N. Kittrie, supra note 11, at 63.

Id. at 60, 62.

Id. at 60, 62.


N. Kittrie, supra note 11, at 63. Houses of correction were first established to hold the criminal, the indigent, and the insane. Connecticut's first house of correction, authorized in 1727, provided for the incarceration of all rogues, vagabonds and idle persons going about in town or country begging, or persons feigning themselves to have knowledge in psysiognomy, palmistry, or pretending that they can tell fortunes, common persons and also persons under distraction and unfit to go at large, whose friends do not take care for their safe confinement.

Id.

A. Tyler, supra note 12, at 292; Saphire, supra note 15, at 239. The Boston House of Industry, for example, housed 60 insane or idiotic persons, about 130 ill and infirm, more than 100 children and infants, and 200 other "unclassified" inmates. A. Tyler, supra note 12, at 293.

Pinel, after unchaining and then curing some of the inmates of a hospital for the insane in Paris, wrote:

The insane man is not an inexplicable monster. He is but one of ourselves, only a little more so. Underneath his wildest paroxysms there is a germ, at least, of rationality and of personal accountability. To believe in this, to seek for it, stimulate it, build it up—here lies the only way of delivering him out of the fatal bondage in which he is held.

Quoted in A. Tyler, supra note 12, at 301. Pinel's "moral treatment" implied a mental condition which was curable in an appropriate psychological and social environment. Lipton & Burnett, Pharmacological Treatment of Schizophrenia, in DISORDERS OF THE SCHIZOPHRENIC SYNDROME 320 (1979).
ods to treat the mentally ill in the Philadelphia Hospital in 1783.\textsuperscript{19} He rejected punishment, cruelty, and most forms of restraint, while insisting that attendants have adequate training, be kind, and employ every means to improve the condition of the patients.\textsuperscript{20} The first private hospital for the insane was founded in Williamsburg, Virginia, in 1773,\textsuperscript{21} and the first state hospital was established in Kentucky in 1824.\textsuperscript{22} Nevertheless, as late as the 1840’s the majority of mentally ill persons were still confined in locked rooms, cages, outhouses, jails, or poorhouses where they received no therapeutic treatment.\textsuperscript{23} Dorothea Dix led the campaign for reform of the treatment of the mentally ill, beginning in Massachusetts in 1843.\textsuperscript{24} Through her leadership, state institutions for the mentally ill were founded in eleven states and the District of Columbia before the Civil War.\textsuperscript{25} By 1860, 28 of the 33 states had established insane asylums,\textsuperscript{26} and by 1870, nearly every state had at least one public mental hospital.\textsuperscript{27} These asylums were established in the anticipation that modern, informed, and humane treatment would be provided\textsuperscript{28} and represented a marked improvement in the treatment and care of the mentally ill.\textsuperscript{29}

Public laws providing for the incarceration of the mentally ill were enacted as early as the late eighteenth century. A 1788 New York statute was typical:

Whereas, there are sometimes persons who by lunacy or otherwise are furiously mad, or are so disordered in their senses that they may be dangerous to be permitted to go abroad; therefore, Be it enacted, that it shall and may be lawful for any two or more justices of the peace to cause such person to be apprehended and kept safely locked up in some secure place, and if such justices shall find it necessary, to be there chained.\textsuperscript{30}

One basis for the authority of the states to confine the mentally ill was

\begin{itemize}
\item \textsuperscript{19} The Philadelphia Hospital had opened in 1752 with a commission to care for “lunatics” in addition to the sick and poor. \textit{A. Tyler, supra} note 12, at 300; Brakel & Rock, \textit{supra} note 11, at 5.
\item \textsuperscript{20} \textit{A. Tyler, supra} note 12, at 301.
\item \textsuperscript{21} \textit{Id.} at 300. Other early private institutions for the insane were the Quaker Retreat, established near Philadelphia in 1817, the McLean Asylum in Massachusetts, founded in 1818, the Bloomingdale Hospital in New York City, opened in 1821, and the Retreat in Hartford, Connecticut, established in 1924. \textit{Id.} at 302.
\item \textsuperscript{22} \textit{Id.}
\item \textsuperscript{23} \textit{Id.} at 304.
\item \textsuperscript{24} \textit{Id.} at 305. In 1843, in an address to the Massachusetts legislature, Dix described the state of insane persons in the Commonwealth as being confined “in cages, closets, cellars, stalls, pens! Chained, naked, beaten with rods, and lashed into obedience.” \textit{Id.}
\item \textsuperscript{25} \textit{Id.} at 305-06.
\item \textsuperscript{26} \textit{Mechanic, supra} note 11, at 48.
\item \textsuperscript{27} \textit{Saphire, supra} note 15, at 240.
\item \textsuperscript{28} S.B. Stickney, Wyatt v. Stickney: \textit{Background and Postscript}, in Golann & Fremouw, \textit{supra} note 11, at 29.
\item \textsuperscript{29} Rone v. Fireman, 473 F. Supp. 92, 97 (N.D. Ohio 1979).
\item \textsuperscript{30} 1788 N.Y. Laws ch. 31. As late as 1890, the Indiana Supreme Court ruled that the Indiana commitment statute (§§ 5142-5150) was primarily for the “protection of the public from those whose insanity makes them dangerous to the community. It has in it no feature of charity to the individual, nor was it enacted with a view to benevolence.” Board of Comm’n v. Ristine, 124 Ind. 242, 24 N.E. 990 (1890). \textit{See also} Porter v. Rich, 70 Conn. 235, 39 A. 169 (1898).
\end{itemize}
their police power to protect the public health, safety, welfare, and morals by enacting laws and regulations.\textsuperscript{31} Under the police power, however, the means adopted for the protection of the public must be only those that are reasonably necessary to accomplish the objective of the law, and may not be unduly oppressive upon the individuals regulated.\textsuperscript{32}

A second basis under which states exercised control over the mentally ill was the \textit{parens patriae} power. At the time of the colonization of America, the King had powers and duties as the "father of the country" to act as "the general guardian of all infants, idiots, and lunatics" and all other persons under legal disabilities to act for themselves.\textsuperscript{33} After the American Revolution, the \textit{parens patriae} power of the King passed to the states and their legislatures.\textsuperscript{34} With regard to the mentally ill, the \textit{parens patriae} power was originally exercised to protect their property and to provide for their care.\textsuperscript{35}

It was not until 1845 that the \textit{parens patriae} power of the state was used to detain the mentally ill in order to facilitate their rehabilitation.\textsuperscript{36} While recognizing that under the police power "[t]he right to restrain an insane person of his liberty is found in that great law of humanity, which makes it necessary to confine those whose going at large would be dangerous to themselves or others," the Massachusetts Supreme Court found that a person could be confined under the doctrine of \textit{parens patriae} when restraint is "necessary for his restoration, or will be conducive thereto."\textsuperscript{37} Toward the end of the nineteenth century, the criterion of need for care and treatment was increasingly included in statutes regarding the commitment of the mentally ill.

\textsuperscript{31} Developments in the Law: Civil Commitment of the Mentally Ill, 87 HARV. L. REV. 1190, 1222 (1974) [hereinafter cited as Developments in the Law].


\textsuperscript{34} Hawaii v. Standard Oil Co., 405 U.S. 251, 257 (1971). See also Developments in the Law, supra note 31, at 1208. In Mormon Church v. United States, 136 U.S. 1 (1890), the \textit{parens patriae} power was said to be "inherent in the supreme power of every state . . . and often necessary to be exercised in the interest of humanity." Id. at 57.

\textsuperscript{35} English law distinguished between the idiot—a person who "hath no understanding from his nativity"—and the lunatic—a person who "hath understanding, but . . . hath lost the use of his reason." The statute \textit{De Praerogativa Regis}, enacted between 1255 and 1290, codified this distinction, and provided that the lands of idiots were granted to the King. After providing the idiot with necessaries, the King retained the profits from the land; the land was returned to the idiot's heirs after his death. Brakel & Rock, supra note 11, at 2. See Yeomans v. Williams, 43 S.E. 73 (Ga. 1907); Hughes v. Jones, 116 N.Y. 67, 22 N.E. 446 (1889).

Under the power delegated to the Chancery, in England by the King and in America by state legislatures, committees or guardians were appointed to manage the estate of the incompetent person. Brakel & Rock, supra note 11, at 3-4; Developments in the Law, supra note 31, at 1209. See McCord v. Ochiltree, 6 Blackf. (Ind.) 15, 16-17 (1848); Rebecca Owings Case, 1 Bland (Md.) 280 (1827); In re Mason, 1 Barb. Ch. (N.Y.) 436 (1847); Case of John Beaumont, 1 Whart. (Pa.) 52 (1835).

\textsuperscript{36} Developments in the Law, supra note 31, at 1209.

\textsuperscript{37} In re Josiah Oakes, 8 Law Rep. 123 (Mass. 1845). Oakes, who was not a violent person, had been detained because he allegedly suffered from hallucinations and displayed unsoundness of mind in conducting his business affairs. Only a few days after the death of his wife, Oakes, an elderly and ordinarily prudent man, had become engaged to a young woman of unsavory character.
in addition to the criterion of dangerousness to self and others.\textsuperscript{38}

As early as 1875, however, hospital administrators had begun to com-
plain that the original purpose of state hospitals for the mentally ill was
being subverted by the involuntary commitment of paupers, old people,
mental defectives, harmless eccentrics, and vagrants.\textsuperscript{39} The county alms-
houses were disappearing,\textsuperscript{40} and growing industrialization and urbanization
contributed to the increasing institutionalization of deviants of all sorts.\textsuperscript{41} In
addition, a "gentleman's agreement" emerged, in which physicians, judges,
and families found it convenient to commit unwanted people to state hospi-
tals.\textsuperscript{42} The institutions' increasing inability to cope with the growing
number of inmates led to an era of custodialism.\textsuperscript{43} By the middle of the
nineteenth century, nearly 600,000 mentally ill persons were hospitalized.\textsuperscript{44}
Most hospitals were overcrowded and understaffed. In spite of the fact that
patients were committed for care and treatment, they received only some
care and very little treatment.\textsuperscript{45} In 1961, the Joint Commission on Mental
Illness and Health estimated that more than half of all institutionalized
mental patients received no active treatment.\textsuperscript{46} Mentally ill persons—hope-
less and impoverished, with little power and discredited social status—were,
in effect, warehoused.\textsuperscript{47} The fault lay not with individual physicians, nurses

\textsuperscript{38} See \S 2217 of the California Political Code, as amended in 1881, cited in \textit{Ex parte Clary},
149 Cal. 232, 87 P. 580 (1906); Speedling v. County of Worth, 80 Iowa 153, 26 N.W. 50 (1885);
Van Deusen v. Newcomer, 40 Mich. 80 (1879); Richardson County v. Frederick, 24 Neb. 596,
39 N.W. 621 (1887); Brickway's Case, 80 Pa. 65 (1875). All fifty states now have commitment
statutes based on the \textit{parens patriae} rationale. Ford, \textit{The Psychiatrist's Double Bind: The Right to
Refuse Medication}, 137 AM. J. PSYCH. 332, 335 (1980); Note, \textit{The Nascent Right to Treatment}, 53 VA.
L. REV. 1134, 1138 (1967).

\textsuperscript{39} Stickney, supra note 28, at 30.

\textsuperscript{40} Id.

\textsuperscript{41} Mechanic, supra note 11, at 49.

\textsuperscript{42} Stickney, supra note 28, at 30.

\textsuperscript{43} Mechanic, supra note 11, at 49.

\textsuperscript{44} Peele, Chodoff & Taub, \textit{Involuntary Hospitalization and Treatability: Observations from the

\textsuperscript{45} At Bryce Hospital in Tuscaloosa, Alabama, in 1971, there were only three medical
doctors with some psychiatric training (including one board-eligible but no board-certified psy-
chiatrist), one Ph.D. clinical psychologist, and two M.S.W. social workers involved in therapeu-
tic programs for 5,000 patients. Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), \textit{aff'd sub nom.},
Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

\textsuperscript{46} Golann, \textit{The Core Problem Controversy}, in Golann & Fremouw, supra note 11, at 99.

\textsuperscript{47} Mechanic, supra note 11, at 50. A physician described one institution in the mid-fifties
as having huge barn-like structures which housed the patients, providing no privacy of any
kind. One method of keeping patients under control was the regular use of electroshock treat-
ment (ECT or EST). The facility was clean, however, and some patients who could work had a
job. There was very little in the way of treatment. Interview with Physician B. Physician B is
the director of psychiatry of a large private hospital. The psychiatric ward is small, and patients
come either through the emergency room or on a contract basis from a community mental
health center. The ward is crisis-oriented, and the average length of stay is five days.

A 1956 article reported, "Patients at Columbus State get EST once, twice, or three times a
week, and in a few cases oftener." Martin, \textit{Inside the Asylum}, SATURDAY EVENING POST, Nov. 10,
1956, 36, \textit{cited in Brakel & Rock}, supra note 11, at 163. These conditions continued into the mid-
seventies. A West Virginia court commented in 1974 that "the State of West Virginia offers to
those unfortunate who are incarcerated in mental institutions Dickensian squalor of uncon-

In 1976, an Ohio institution had living conditions substandard and dangerous to both
the mental and physical health of the patients. Housekeeping and maintenance were
extremely poor; many of the physical structures presented fire and safety hazards,
or attendants—underpaid, undervalued, and overworked as they were—but with the general community that not only tolerated but enforced these subhuman conditions through financial penury, ignorance, fear and indifference.\textsuperscript{48} Out of these conditions emerged the community mental health centers movement and the patients’ rights movement.\textsuperscript{49}

The development of comprehensive community-based treatment programs through community mental health centers was made possible by the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.\textsuperscript{50} Established with “seed money” from the federal government, the centers were to provide five essential services in areas with populations between 75,000 and 200,000: inpatient care, outpatient care, emergency treatment, partial hospitalization, and consultation and education.\textsuperscript{51} The feasibility of community mental health services was enhanced by the development and subsequent widespread use of antipsychotic medications\textsuperscript{52} which enabled thousands of patients who were previously manageable only in institutional settings to be released and treated as outpatients.\textsuperscript{53} In addition, a large number of patients were released because institutions were unable to meet the financial burden of enlarging and upgrading their facilities to relieve the overcrowding.\textsuperscript{54} By the mid-1970’s, the population of mental institutions had been reduced to less than 250,000.\textsuperscript{55}

The deinstitutionalization of mental patients was furthered by the judicial narrowing of criteria for commitment. Merely being mentally ill or in need of treatment could no longer serve as the basis for commitment. In \textit{O’Connor v. Donaldson},\textsuperscript{56} the United States Supreme Court found that “a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”\textsuperscript{57} Thus, dangerousness to self or others or incapacity to survive on one’s own are now the only

while patient areas were generally filthy and malodorous. Moreover, the cottages or patient living quarters were so crowded that privacy and quiet were nonexistent even during the night.


In addition to the antitherapeutic, dangerous, and inhuman conditions at that institution, patients were subjected to an alarming number of incidents of physical and sexual abuse by the staff, \textit{id.} at 101, adequate care and treatment was virtually impossible, \textit{id.} at 102, and medication was often administered inappropriately in light of the patients’ given diagnoses and symptomatology, \textit{id.} at 109.

\textsuperscript{48} Deutsch, Statement, \textit{supra} note 1, at 41-42.

\textsuperscript{49} Brakel & Rock, \textit{supra} note 11, at 9-10.


\textsuperscript{51} Bassuk & Gerson, \textit{supra} note 2, at 48.

\textsuperscript{52} \textit{See text accompanying notes 146-84 infra.}


\textsuperscript{55} \textit{A. STONE, MENTAL HEALTH AND THE LAW: A SYSTEM IN TRANSITION} 41 (1976).

\textsuperscript{56} 422 U.S. 563 (1975).

\textsuperscript{57} \textit{id.} at 576. Donaldson had been confined in the Florida State Hospital against his wishes for fifteen years. The jury had found that Donaldson, who was dangerous neither to himself nor to others, was provided no treatment. \textit{id.} at 577 n.12.
grounds upon which a mentally ill person can be committed.\textsuperscript{58}

The patients’ rights movement emerged in 1960 with the publication of an article on the right to treatment,\textsuperscript{59} although the duty of the state to treat those which it confined because of mental illness was recognized as early as 1915 in \textit{Hammon v. Hill}, where the court stated that the state’s duty “extends so far as to include every provision known to medical skill and science for the treatment of the diseased mind.”\textsuperscript{60} The right to treatment was first upheld in \textit{Rouse v. Cameron},\textsuperscript{61} in 1966. Since that decision, at least three constitutional arguments have been propounded to support this right. The first constitutional argument, on the grounds of due process, was articulated in \textit{Wyatt v. Stickney}.\textsuperscript{62} “To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process.”\textsuperscript{63} The right to treatment has also been upheld on the constitutional grounds of equal protection\textsuperscript{64} and cruel and unusual punishment.\textsuperscript{65}

A second right of persons with mental illness is the right to the least restrictive alternative treatment.\textsuperscript{66} Courts have held that patients have the right to be treated in the least restrictive setting within an institution\textsuperscript{67} and that alternatives less restrictive than hospitalization should be considered


\textsuperscript{60} 228 F. 999, 1001 (W.D. Pa. 1915) (dictum).

\textsuperscript{61} 373 F.2d 451 (D.C. Cir. 1976).


\textsuperscript{64} Welsch v. Likins, 373 F. Supp. 487 (D. Minn. 1974); Developments in the Law, supra note 31, at 1330-33; Harv. Comment, supra note 63, at 1292.

\textsuperscript{65} Arons, Working in the “Cuckoo’s Nest”: An Essay on Recent Changes in Mental Health Law and the Changing Role of Psychiatrists in Relation to Patient and Society, 9 U. Tol. L. Rev. 73, 87 (1977); Chambers, Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives, 70 Mich. L. Rev. 1107 (1972); Goodman, supra note 64, at 657; Schwartz, In the Name of Treatment: Autonomy, Civil Commitment and the Right to Refuse Treatment, 50 Notre Dame Law. 808, 833, 835 (1975); Developments in the Law, supra note 31, at 1245-53.

when committing the mentally ill.\(^6\) The community mental health centers movement\(^6\) has facilitated the implementation of the right to the least restrictive alternative treatment. The right to the least restrictive alternative has also been applied to organic therapies, including medication.\(^7\)

The most recent of mental patients’ rights to be recognized is the right to refuse treatment. Courts have upheld the right to refuse psychosurgery\(^7\) and electroconvulsive therapy (ECT),\(^7\) and the right to refuse seclusion if not properly supervised by a physician.\(^7\) Since 1978, the right to refuse medication has been sustained in New Jersey,\(^7\) Massachusetts,\(^7\) Oklahoma,\(^7\) Utah,\(^7\) Ohio,\(^7\) and Colorado.\(^8\) Five constitutional arguments have been advanced to justify the right to refuse treatment in general and medication in particular: the right to privacy, equal protection, due process, free expression, and cruel and unusual punishment.

The right to privacy,\(^8\) first upheld in Griswold v. Connecticut,\(^8\) is said to be found within “penumbras” surrounding the first, third, fourth, fifth, and ninth amendments.\(^8\) Several cases have since held that the right to privacy includes the right to decline medical treatment in certain circumstances.\(^8\) The right to privacy extends to protection against unwanted intrusions into bodily integrity, and in fact, this protection—“the right of every individual to the possession and control of his own person”—was first recognized in 1890.\(^8\) The freedom from unwanted bodily intrusions has been applied in a

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\(^6\) Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966); Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972); Harv. Comment, supra note 63, at 1295.

\(^7\) See text accompanying notes 50-55 supra.

\(^8\) See A. STONE, supra note 55; DuBose, supra note 53; Ford, supra note 38; Griffith & Griffith, supra note 58; Plotkin, Limiting the Therapeutic Orgy: Mental Patients’ Right to Refuse Treatment, 72 NW. U. L. REV. 461 (1977); Schwartz, supra note 66; Comment, Advances in Mental Health: A Case for the Right to Refuse Treatment, 48 TEMP. L.Q. 354 (1975) [hereinafter cited as Advances in Mental Health]; Comment, Forced Drug Medication of Involuntarily Committed Mental Patients, 20 ST. LOUIS U.L.J. 100 (1975) [hereinafter cited as Forced Drug Medication].


\(^14\) See A. STONE, supra note 55; DuBose, supra note 53; Ford, supra note 38; Griffith & Griffith, supra note 58; Plotkin, Limiting the Therapeutic Orgy: Mental Patients’ Right to Refuse Treatment, 72 NW. U. L. REV. 461 (1977); Schwartz, supra note 66; Comment, Advances in Mental Health: A Case for the Right to Refuse Treatment, 48 TEMP. L.Q. 354 (1975) [hereinafter cited as Advances in Mental Health]; Comment, Forced Drug Medication of Involuntarily Committed Mental Patients, 20 ST. LOUIS U.L.J. 100 (1975) [hereinafter cited as Forced Drug Medication].

\(^15\) In re the Mental Health of K.K.B., 609 P.2d 747 (Okla. 1980).

\(^16\) Davis v. Hubbard, 49 U.S.L.W. 2215 (U.S.D.C., Ohio, Sept. 16, 1980).

\(^17\) Goedecke v. State, 603 P.2d 123 (Colo. 1979).

\(^18\) The existence of a right to privacy was first suggested in the article, Warren & Brandeis, The Right to Privacy, 4 HARV. L. REV. 193 (1890).

\(^19\) 381 U.S. 479 (1965). Griswold held that a married couple had a constitutional right to privacy which protected their use of contraceptives in the home. Justice Goldberg’s concurring opinion stated that “the Framers did not intend that the first eight amendments be construed to exhaust the basic and fundamental rights which the Constitution guaranteed to the people.” Id. at 490 (Goldberg, J., concurring).

\(^20\) Id. at 483.


\(^22\) Union Pac. Ry. v. Botsford, 141 U.S. 250 (1891). This case forbade a district court to
number of different contexts, including the right to refuse medication. It has been held that in a nonemergency situation, "it is an unreasonable invasion of privacy, and an affront to basic concepts of human dignity, to permit forced injection of a mind-altering drug into the buttocks of a competent person unwilling to give informed consent."

The right of mental patients to refuse treatment has also been based on equal protection and due process grounds. Competent physically ill persons may refuse treatment unless there is a life-threatening emergency, in which situation treatment will be administered against the wishes of the patient only in very limited circumstances. In contrast, mentally ill persons are not per se incompetent solely because they have been diagnosed as being mentally ill. To deny the mentally ill the right to refuse medication simply because of their illness violates their right to equal protection. Since competence is the criterion upon which is grounded the ability to give, or refuse to give, informed consent for the administration of medication, the involuntary administration of medication without a prior determination of lack of competence violates due process in the clear absence of any compelling or rational state justification.

The first amendment's protection of freedom of expression also supports the right to refuse medication: "A person's mental processes, the communication of ideas, and the generation of ideas, come within the ambit of the First Amendment. To the extent that the First Amendment protects the dissemination of ideas and the expressions of thoughts, it equally must protect the individual's right to generate ideas." In order to communicate, the ability to think is essential, and medication administered in the treatment of

order a surgical examination in a tort case. See also Roe v. Wade, 410 U.S. 113 (1973); Forced Drug Medication, supra note 71.

86. In Huguez v. United States, 406 F.2d 366 (9th Cir. 1968), a rectal search, based on "mere suspicion," made at the Mexican border was held to be unconstitutional. Perhaps the most famous case involving the violation of bodily integrity and the right of privacy was based on the fourth amendment. In Rochin v. California, 342 U.S. 165 (1952), the Supreme Court ruled that the pumping of a suspected narcotics dealer's stomach to obtain evidence was "illegal breaking into the privacy of the petitioner," id. at 172, and constituted "conduct that shocks the conscience," id.


89. Plotkin, supra note 71, at 496. In Winters v. Miller, 446 F.2d 65 (2d Cir.), cert. denied, 404 U.S. 965 (1971), the court held that a woman, who had been committed involuntarily because of mental illness but who was competent and who refused medication on religious grounds, could refuse medication.

90. "If we were dealing here with an ordinary patient suffering from a physical ailment, the hospital authorities would have no right to impose compulsory medical treatment against the patient's will and to do so would constitute . . . battery." Winters v. Miller, 446 F.2d 65, 68 (2d Cir.), cert. denied, 404 U.S. 965 (1971).

91. Plotkin, supra note 71, at 496.

92. Id. at 494.

mental illness often impairs that ability. In fact, one purpose of the use of antipsychotic medication is to change aberrant thought patterns. The Supreme Court has written that "our whole constitutional heritage rebels at the thought of giving government the power to control men's minds." Thus, under the first amendment, mental patients have the right to refuse medication which affects their thought processes.

A final argument supporting the right to refuse medication is that forced medication subjects a patient to cruel and unusual punishment. Courts have supported the right of mentally ill persons to refuse medication on this ground only in a criminal context.

II. MENTAL ILLNESS, DRUG TREATMENT, AND POSSIBLE SIDE EFFECTS

The diagnostic classifications of major mental illnesses are depression, manic-depressive disorder, schizophrenia, and schizoaffective disorder. Medication is a major form of treatment for each classification; however, all medications have potential side effects which, if they occur, may be more disturbing to the patients than the mental illness itself.

A. Manic-depressive disorder

Manic-depressive disorder, also known as bipolar affective disorder, is a cyclic affective disorder characterized by either recurrent attacks of mania or alternating attacks of mania and depression. In the manic phase, symptoms include a bizarre increase in psychomotor activity, grandiosity, reduced need for sleep, flight of ideas, elation, poor judgment, aggressiveness, and sometimes hostility. In the depressive phase, the symptoms resemble those of major depression.

Lithium carbonate is the preferred treatment for manic-depressive illness; however, the onset of the drug's action is slow, as it becomes effective only after two weeks of continuous administration. For these reasons, acute, severely manic patients are often treated concurrently with antipsychotic medication, and severely depressed patients are treated concur-
rently with tricyclic antidepressants. For lesser degrees of mania, lithium alone is usually sufficient. Because lithium carbonate acts as a prophylactic, it is often used on a long-term maintenance basis to prevent or diminish the intensity of subsequent manic or depressive episodes.

Lithium carbonate is potentially very toxic and has a low therapeutic index; that is, there is a very small margin between a therapeutic dose and a toxic dose. Toxicity may therefore occur at dosages close to therapeutic levels. Among the symptoms of toxicity are nausea, diarrhea, thirst, sluggishness, dazed feelings, muscle weakness, and hand tremors. As toxicity increases, symptoms include lack of coordination, drowsiness, coarse tremors, muscle twitching, and eventually stupor, coma, and death. In addition, upon initial administration of lithium carbonate, patients may experience mild and transient nausea, mild thirst, and general discomfort, which usually disappear within a few days. Long-term use of lithium carbonate may lead to thyroid enlargement with diminished thyroid function.

B. Depression

Depression is characterized by feelings of sadness, fatigue, loss of interest in the social environment, self neglect, lowering of functional activity, insomnia, hopelessness, and fear that the condition is permanent. Suicidal preoccupation, depersonalization, apathy, anorexia, and guilt feelings may also be present. There are several different approaches to the classification of depression.

111. See Melmon & Morrelli, supra note 101, at 867.
112. Interview with Physician D. Physician D is the staff psychiatrist in charge of a division of a large residential treatment center. He has had a number of patients who have refused medication. He has gone to court on two occasions for hearings on petitioners’ requesting the involuntary administration of medication. Medication was ordered in both. See Melmon & Morrelli, supra note 101, at 867.
113. DORLAND’S ILLUSTRATED MEDICAL DICTIONARY 990 (24th ed. 1965) [hereinafter cited as MEDICAL DICTIONARY]; PHYSICIAN’S DESK REFERENCE, supra note 102, at 1518. Also known as nephrotoxicity, the symptoms are the result of damage to the kidney cells. Drug Toxicity and Physician’s Liability, 3 Mass. General Hospital Newsletter, Biological Therapies in Psych. 21 (1980); MEDICAL DICTIONARY, at 992.
114. These are the symptoms of the onset of mild toxicity. As toxicity increases, symptoms include lack of coordination, drowsiness, coarse tremors, muscle twitching, and eventually stupor and coma. Melmon & Morrelli, supra note 101, at 867; PHYSICIAN’S DESK REFERENCE, supra note 102, at 1519.
115. PHYSICIAN’S DESK REFERENCE, supra note 102, at 1520. If any of the symptoms of toxicity appear the drug should be stopped immediately, as continued use of the drug is potentially lethal. Melmon & Morrelli, supra note 101, at 867; PHYSICIAN’S DESK REFERENCE, supra note 102, at 1519-20.
117. N. Kline, Depression: Its Diagnosis and Treatment 10 (1969); MEDICAL DICTIONARY, supra note 113, at 400.
118. N. Kline, supra note 117, at 10.
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the depressive disorder,119 among which are major vs. minor,120 psychotic vs. neurotic,121 endogenous vs. reactive,122 and bipolar vs. unipolar.123 No matter which classification is used, all forms of depression may be treated with medication.124 In the less serious forms of depression, medication is most likely to be used on a short-term basis to relieve the immediate acute symptoms. In the more serious forms of depression, medication may be used on a long-term maintenance basis.125

Tricyclic antidepressants are the drugs most often used to treat depression.126 They elevate the person's mood and biochemically increase the person's ability to cope.127 Tricyclic antidepressants may produce a number of side effects including such anticholinergic symptoms as dry mouth and blurred vision; allergic reactions such as rash, itching, and increased sensiti-


120. The following criteria are used to diagnose a major depressive disorder:
A. One or more distinct periods of dysphoric mood or pervasive loss of interest or pleasure.
B. Five or more of the following:
1. Increase or decrease in appetite or weight.
2. Excessive or insufficient sleep.
3. Low energy, fatigability, or tiredness.
4. Psychomotor agitation or retardation.
5. Loss of interest or pleasure in usual activities.
7. Decreased ability to think or concentrate.
8. Recurrent thoughts of death or suicide.
C. Duration of dysphoric features for at least two weeks.
D. Sought help or sustained functional impairment.
E. No other major diagnoses (e.g., schizophrenia).

Minor depression is diagnosed when some of the features of the major depressive disorder are present, but the most prominent feature is a prevailing mood of depression with no psychotic episodes. A. Beck, supra note 108, at 360.

121. The American Psychiatric Association, in its 1968 Diagnostic and Statistical Manual (DSM-II), distinguished a single nonpsychotic depression (depressive neurosis) and five types of psychotic depression (psychotic depressive reaction; involuntional melancholia; and manic-depressive illness, manic, depressed, and circular types). A. Beck, supra note 108, at 362.

122. Endogenous depressions are thought to have a biochemical cause. According to this theory, the persons affected are prone to depression because of some lack of neurotransmission in the “coping system” of the brain. Stresses, to which a normal person would react by having a transient feeling of the “blues” and with which they would be able to adequately cope, caused reactions in the person with endogenous depression greatly disproportionate to the precipitating event.

Reactive depressions, on the other hand, are thought to be caused solely by a stressful event to which the degree of depression is usually proportionate. In this form of depression, interest, ability to cope, and ability to work may be diminished but are not entirely absent. Melmon & Morelli, supra note 101, at 850. See also A. Beck, supra note 108, at 363; N. Kline, supra note 117, at 1315; Kuhn, Clinical Experiences with a New Antidepressant, in DEPRESSIVE ILLNESS, DIAGNOSIS, ASSESSMENT, TREATMENT 195 (1972).

123. Bipolar depression is the depressive phase of manic-depressive disorder. See text accompanying notes 100-10 supra. Unipolar depressions are distinguished from manic-depressive disorders because of the absence of manic periods and fewer total episodes of depression. Melmon & Morelli, supra note 101, at 850.

125. Id. at 356.
126. Id. at 355.
127. PHYSICIAN’S DESK REFERENCE, supra note 102, at 1016. Tricyclic antidepressants vary both in their sedative and their anticholinergic effects, and the choice of drug is usually made with these variances in mind. Melmon & Morelli, supra note 101, at 855.
zation to the sun; and such gastrointestinal reactions as nausea, peculiar taste, and abdominal cramps.\textsuperscript{128} In addition, they may cause adverse psychological effects, including confusional states accompanied by hallucinations, disorientation, delusions, anxiety, restlessness, insomnia, panic, and nightmares.\textsuperscript{129} Both neurological and cardiovascular reactions may also occur,\textsuperscript{130} and a toxic overdose may produce, among other things, shock, stupor, coma, and death.\textsuperscript{131} Older persons may not be able to take antidepressants;\textsuperscript{132} consequently electroconvulsive therapy (ECT) may be the only effective treatment for elderly persons with severe psychotic depression.

Monoamine oxidase (MAO) inhibitors have also been used in the treatment of depression.\textsuperscript{133} They are rarely the first drugs used and are most suitable for patients who have failed to respond to tricyclic antidepressants.\textsuperscript{133} They have been found to be effective in depressed patients classified as “atypical,” “nonendogenous,” or “neurotic.”\textsuperscript{136} They should not be used in combination with, or within two weeks following, the administration of tricyclic antidepressants because of severe adverse reactions which may result in death.\textsuperscript{137}

C. Schizophrenia

Schizophrenia is a disorder manifested in pathological disturbances of thought, mood, and behavior.\textsuperscript{138} Among the symptoms associated with

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  \item Hematologic reactions such as bone marrow depression and agranulocytosis also occur. \textsuperscript{128} PHYSICIAN’S DESK REFERENCE, supra note 102, at 1016-17. See text accompanying notes 180-82 infra.
  \item Tricyclic antidepressants lower the convulsive threshold, increasing the possibility of seizures. Other neurological reactions may be numbness, tingling, and extrapyramidal side effects (see text accompanying notes 163-68 infra). Therapeutic doses have produced palpitations, tachycardia and orthostatic hypotension (reduced blood pressure), abnormalities in the electrocardiogram and arrhythmias, myocardial damage, congestive heart failure, and death. Melmon & Morrelli, supra note 101, at 856; PHYSICIAN’S DESK REFERENCE, supra note 102, at 1016.
  \item “The incidence of adverse drug reaction steadily increases with age. Beyond 60 years of age, there is a progressive reduction of tissue mass, as well as renal, hepatic, and cardiovascular function.” Melmon & Morrelli, supra note 101, at 63.
  \item Electroconvulsive therapy (ECT), also known as electroshock therapy, has been described as “a technique by which a current of from 70 to 130 volts of electricity is permitted to flow through the patient’s brain, causing a convulsion equivalent to an epileptic seizure.” New York City Health and Hosp. Corp. v. Stein, 70 Misc. 2d 944, 946-47, 335 N.Y.S.2d 461, 463-64 (Sup. Ct. 1972). For the involutional melancholia form of psychotic depression, ECT is the treatment of choice. A. BECK, supra note 108, at 363.
  \item The American Psychiatric Association has defined schizophrenia as follows: a group of disorders manifested by characteristic disturbances of thinking, mood and behavior. Disturbances in thinking are marked by alterations of concept formation which may lead to misinterpretation of reality and sometimes to delusions and hallucinations, which frequently appear psychologically self-protective. Corollary mood
acute schizophrenia are unrealistic thinking, severe anxiety, excessive suspiciousness, perplexity or confusion, social withdrawal, auditory hallucinations, blunted affect, overactivity, feeling of impending doom, and generalized motor inhibition. Manifestations of schizophrenia may also be very subtle, so that some persons who have the illness may be considered to be only eccentric. The functioning of chronic schizophrenics is often severely impaired, and many are unable to deal with the stresses of everyday life. Ten percent of all schizophrenics need prolonged custodial care, and less than fifteen percent of individuals who are so seriously affected as to require prolonged hospitalization ever function normally. Schizophrenia is the most prevalent disorder in the mental health system, accounting for nearly half of all patients.

Schizophrenia is treated with antipsychotic or psychotropic medication. The most widely used of the antipsychotic drugs are the phenothia-
zine derivatives.\textsuperscript{147} Other antipsychotic medications in use are the butyrophenones, the thioxanthenes, loxapine, and molindone.\textsuperscript{148} Most of these drugs are equally efficacious,\textsuperscript{149} but vary in potency.\textsuperscript{150} Individual patients respond differently to different medications, and a wide range of possible therapeutic doses of antipsychotic drugs is available.\textsuperscript{151}

Antipsychotic medications work by affecting the function of the neurotransmitters in the brain.\textsuperscript{152} They are used both to ameliorate the acute symptoms of schizophrenia and on a long-term, maintenance basis to prevent the symptoms' return.\textsuperscript{154} Some schizophrenics, however, receive no benefit from antipsychotic medication,\textsuperscript{155} and others may do as well or better without drug treatment.\textsuperscript{156} In addition, while psychotropic drugs have a

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  \item \textsuperscript{147} Melmon & Morrelli, \textit{supra} note 101, at 857-58; Lipton & Burnett, \textit{supra} note 18, at 322, 325.
  \item \textsuperscript{148} See Melmon & Morrelli, \textit{supra} note 101, at 857, 859; Lipton & Burnett, \textit{supra} note 18, at 325-27.
  \item \textsuperscript{149} Physician D, \textit{supra} note 112; Mellmon & Morrelli, \textit{supra} note 101, at 857-62; Lipton & Burnett, \textit{supra} note 18, at 327.
  \item \textsuperscript{150} For example, 2 mg. of Haldol (haloperidol) have the same antipsychotic effect as 100 mg. of Thorazine (chlorpromazine). The antipsychotic drugs also vary in their sedative effect, the less potent having a greater sedative effect than the more potent. Physician D, \textit{supra} note 112; Lipton & Burnett, \textit{supra} note 18, at 329.
  \item \textsuperscript{151} Melmon & Morrelli, \textit{supra} note 101, at 862; Lipton & Burnett, \textit{supra} note 18, at 331.
  \item \textsuperscript{152} Melmon & Morrelli, \textit{supra} note 101, at 895; \textit{Physician's Desk Reference}, \textit{supra} note 102, at 673; Lipton & Burnett, \textit{supra} note 18, at 323.
  \item \textsuperscript{153} Melmon & Morrelli, \textit{supra} note 101, at 862; Lipton & Burnett, \textit{supra} note 18, at 331. Among the symptoms which antipsychotic medications relieve are thought disturbance, paranoid symptoms, delusions, social withdrawal, loss of self-care, anxiety, and agitation. Melmon & Morrelli, \textit{supra} note 101, at 862; Schwartz, \textit{supra} note 66, at 812. Combativeness disappears, and patients become relaxed and cooperative. DuBose, \textit{supra} note 53, at 1194; Schwartz, \textit{supra} note 66, at 813.
  \item \textsuperscript{154} Melmon & Morrelli, \textit{supra} note 101, at 862-63; Lipton & Burnett, \textit{supra} note 18, at 333. The use of antipsychotic medication on a maintenance basis resembles the use of insulin by diabetics or the use of antihypertensive medication by persons with high blood pressure. Treatment is considered to be indefinite and uninterrupted, although the dosage may vary and be considerably reduced during the length of the treatment. A sizeable number of readmissions to hospitals have been traced to the reappearance of symptoms caused by the patient's stopping the use of medication. Melmon & Morrelli, \textit{supra} note 101, at 862-63. See also Opler, \textit{Tardive Dyskinesia and Institutional Practice: Current Issues and Guidelines}, 31 HOSPITAL & COMMUNITY PSYCH. 239 (1980).
  \item \textsuperscript{155} As many as 20 to 25\% of schizophrenics may receive no benefit from antipsychotic medication. Physician D, \textit{supra} note 112; See Crane, \textit{Clinical Psychopharmacology in its 20th Year, 181 SCIENCE} 124 (1973); Van Putten, \textit{Why Do Schizophrenic Patients Refuse to Take Their Drugs?}, 31 ARCHIVES GENERAL PSYCH. 67 (1974) [hereinafter cited as Van Putten]; Van Putten & May, \textit{Subjective Response as a Predictor of Outcome in Pharmacotherapy}, 35 ARCHIVES GENERAL PSYCH. 477 (1978) [hereinafter cited as Van Putten & May].

As many as 30\% of psychotic patients spontaneouly remit within a few days in an appropriate milieu. Lipton & Burnett, \textit{supra} note 18, at 330.
\end{itemize}
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wide therapeutic index and consequently a great margin of safety, they are responsible for a number of side effects, one of which may be permanent.

When patients are first treated with antipsychotic medication, they may experience any of several short-term side effects, including drowsiness, dry mouth, dizziness, nausea, and blurred vision. These usually last no more than two weeks. Patients may also experience confusion and lethargy.

A second category of side effects is the extrapyramidal or neuromuscular syndromes resulting from the drug's effects on the central nervous system. One extrapyramidal effect is Parkinsonism, the symptoms of which include coarse tremor, shuffling gait, drooling, and rigidity. Extrapyramidal side effects also include dystonias—uncoordinated body spasms, including spasm of neck muscles, rigidity of the back muscles, swallowing difficulties, and protrusion of the tongue. Another extrapyramidal effect is akathisia—motor restlessness characterized by feelings of not being able to calm oneself ranging from inner disquiet to inability to sit or lie quietly to insomnia. Anti-Parkinsonism (anticholinergic) drugs used to counteract extrapyramidal side effects may produce blurred vision, dry mouth, nausea, and nervousness.

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157. The therapeutic index indicates the range between a therapeutic dose and a toxic dose of medication. The greater the therapeutic index, the safer the drug and the lower its potential toxicity at therapeutic doses. See Melmon & Morrelli, supra note 101, at 73, 79-80; Lipton & Burnett, supra note 18, at 336.

158. Melmon & Morrelli, supra note 101, at 862.

159. See Lipton & Burnett, supra note 18, at 337, for a listing of the nature and frequency of adverse reactions to various types of antipsychotic medications.

160. PHYSICIAN'S DESK REFERENCE, supra note 102, at 1634; Lipton & Burnett, supra note 18, at 338; DuBose, supra note 53, at 1203.

161. DuBose, supra note 53, at 1203.

162. Interview with Physician E. Physician E is the staff psychiatrist in charge of a division of a large residential treatment center. The patients on his ward are acutely mentally ill. He has encountered some patients who have refused medication, but his policy is to wait and try to talk the patients into taking medication voluntarily. He has not gone to court. The patients on his ward remain a maximum of three weeks; if they still need treatment they are transferred to another ward.

163. DuBose, supra note 53, at 1203. Both the amelioration of symptoms of psychosis and the extrapyramidal side effects result from the same pharmacologic action on the postsynaptic dopamine receptors. The drugs' blockade of receptors in the mesolimbic dopaminergic system produces the antipsychotic properties and the blockade of receptors in the striatonigral dopaminergic system is followed by the extrapyramidal symptoms. Melmon & Morrelli, supra note 101, at 860. Approximately 30% of patients on sedative phenothiazines or thioxanthenes and more than 50% of patients on other antipsychotic medications will suffer from extrapyramidal syndromes. Lipton & Burnett, supra note 18, at 336, 338.

164. Melmon & Morrelli, supra note 101, at 893; PHYSICIAN'S DESK REFERENCE, supra note 102, at 1634; DuBose, supra note 53, at 1203; Plotkin, supra note 71, at 475. Other symptoms of Parkinsonism include pinrolling motion, plastic rigidity, or "cog wheeling," characterized by stiffness of the skeletal muscles interrupted by lapses at the rate of three to seven cycles per second; akinesia, which involves difficulty in initiating movements or modifying ongoing motor activity; and mask-like face. Melmon & Morrelli, supra note 101, at 893; Plotkin, supra note 71, at 475.

165. PHYSICIAN'S DESK REFERENCE, supra note 102, at 1634; DuBose, supra note 53, at 1203.

166. Physician D, supra note 112; MEDICAL DICTIONARY, supra note 113, at 50.

167. Melmon & Morrelli, supra note 101, at 863. One anti-Parkinsonism drug commonly used is Cogentin. PHYSICIAN'S DESK REFERENCE, supra note 102, at 1149.

168. Melmon & Morrelli, supra note 101, at 864; PHYSICIAN'S DESK REFERENCE, supra note
A serious and possibly permanent side effect of antipsychotic medications is tardive dyskinesia. This syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (including protrusion of the tongue, puffing of the cheeks, puckering of the mouth, and chewing movements), and involuntary movements of the extremities. Most, if not all, cases of tardive dyskinesia are preceded by the Parkinsonism syndrome. Ironically, however, the anticholinergic medications used to counteract Parkinsonism and other extrapyramidal side effects are not only ineffective against tardive dyskinesia, but often unmask latent dyskinesias and may exacerbate existing ones. In addition, though the long-term use of high dosage antipsychotic medications is the cause of tardive dyskinesia, paradoxically, the symptoms are often not observed until drug usage is discontinued. Because sudden withdrawal of antipsychotic medications may bring out latent syndromes, the most effective treatment to ameliorate the symptoms of tardive dyskinesia is to increase the present dosage or to readminister antipsychotic medication.

Although recent research has indicated that lecithin may be used to ameliorate the symptoms of tardive dyskinesia, at present, no reliably effective treatment has been developed. Other serious side effects of antipsychotic medications include skin and eye changes, liver damage, and agranulocytosis. The skin may become sensitive to sunlight and turn gray, blue, or purple upon exposure to the sun.

Anticholinergic drugs may produce mental confusion and excitement with large doses. Mental symptoms may be intensified and visual hallucinations may occur. The actual cause is not known. It has been suggested that antipsychotic drugs cause hypersensitivity of, or damage to, receptors or neurons in the striatonigral dopaminergic system in the brain. The risk of tardive dyskinesia increases with age and length of use of medication. More women than men are likely to develop the syndrome. Fine vermicular (wormlike) movements of the tongue may be an early sign of the onset of the syndrome. These movements may also involve the diaphragm, esophagus, and trunk. One recommended course of treatment at present is to eliminate or reduce anticholinergic medication as soon as possible and to reduce the dose of antipsychotic medication slowly, trying to strike a balance between improvement in the psychosis and amelioration of the abnormal movements. Some patients may do as well without medication, and withdrawal of medication in some cases has lead to reversal of the symptoms of tardive dyskinesia and often complete remission.
Fine particles may appear in the lens and cornea of the eye. Pigmentary retinopathy, characterized by diminution of visual acuity, brownish coloring of vision, and impairment of night vision may also occur. Fatty changes in the liver may result in chronic jaundice. Agranulocytosis, which involves a precipitate disappearance of white blood cells, is potentially fatal because of the risk of immediate infection. It is most often associated with the administration of drugs in high dosages. This side effect is now less common, at least in part, because of increased usage of lower dosage, higher potency drugs, from the use of which it is virtually unknown. Finally, there have been reports of sudden, unexplained deaths of hospitalized psychotic patients receiving antipsychotic medications, but at present there is insufficient evidence to establish a relationship between the deaths and the administration of psychotropic medication.

D. Schizoaffective disorder

Schizoaffective disorder is characterized by a mixture of schizophrenic symptoms and altered affect, either depression or excitement. If depression is the affect presented, the disorder is not easily distinguished from psychotic depression. If the patient is excited, the disorder resembles the manic phase of manic-depressive disorders. Chlorpromazine is more effective for highly agitated schizoaffective patients, and lithium carbonate and chlorpromazine are equally effective for mildly agitated patients.

E. Misdiagnosis and drug treatment

A number of studies have shown that the diagnostic reliability of psychiatric disorders is poor. One commentator concluded that while the
reliability of the diagnoses of organic disorders is fairly high, the reliability of diagnoses of functional disorders is only about fifty percent.\textsuperscript{189} Contributing to the problems of diagnosing mental illness are the facts that symptoms overlap between diagnostic categories, discrimination among diagnostic categories is unclear, and within each category a wide variety of symptoms exists. The manic phase of manic-depressive disorder resembles some forms of schizophrenia,\textsuperscript{190} while the depressive phase is at first often indistinguishable from depression.\textsuperscript{191} Although the manic patient may respond to antipsychotic medications typically prescribed for schizophrenia, better long-term control of the manic phase results from treatment with lithium.\textsuperscript{192} Persons diagnosed as having schizoaffective disorder may in fact have manic-depressive illness.\textsuperscript{193} Depression may be masked with the patient having no complaints of feeling sad or "blue."\textsuperscript{194} A large number of patients do not fit neatly into any diagnostic niche.\textsuperscript{195} As a result of the diagnostic complexities, there is some feeling that the current proclivity is to make too rapid diagnoses followed by too narrowly derived treatment decisions, particularly regarding drug therapy.\textsuperscript{196}

The problem of misdiagnosis is compounded by the fact that drugs may bring out undesired symptoms. Antidepressants can exacerbate psychoses\textsuperscript{197} and activate latent schizophrenia symptoms.\textsuperscript{198} If antidepressant medication is given to manic-depressive patients, it may cause symptoms of the manic phase to occur.\textsuperscript{199} If phenothiazines, the most frequently used class of antipsychotic medication, are given to nonpsychotic patients, dysphoria results.\textsuperscript{200} Dysphoria is characterized by disquiet, restlessness, and malaise.\textsuperscript{201} Misdiagnosis is particularly critical in the elderly,\textsuperscript{202} who often have...
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paradoxic reactions to medications; for example, sedatives may produce agitation. Considering the variety of potential side effects of medications used in the treatment of mental illness and the possibility of misdiagnosis, refusal of medication by mental patients may be founded on very objective bases.

III. COLORADO STATUTE AND REGULATIONS ON CARE AND TREATMENT OF THE MENTALLY ILL

The Colorado statute regulating the care and treatment of the mentally ill has codified much of the case law regarding patients' rights. The purposes underlying the statute are:

(a) To secure for each person who may be mentally ill such care and treatment as will be suited to the needs of the person and to insure that such care and treatment are skillfully and humanely administered;
(b) To deprive a person of his liberty for purposes of treatment or care only when less restrictive alternatives are unavailable and only when his safety or the safety of others is endangered;
(c) To provide the fullest possible measure of privacy, dignity, and other secure treatment and care for mental illness;
(d) To encourage the use of voluntary rather than coercive measures to secure treatment and care for mental illness.

The statute provides that a person may be detained on an emergency basis for evaluation or treatment or certified for care and treatment only if he or she is an imminent danger to himself or herself or others, or is gravely disabled. A person is gravely disabled if "as a result of mental illness, he is unable to take care of his basic personal needs or is making irrational or grossly irresponsible decisions concerning his person and lacks the capacity to understand this is so."

A person can be detained for evaluation and treatment on an emergency basis for only seventy-two hours. If at the end of that period the person still meets the criteria for certification, he may be certified by court order for short-term treatment of no longer than three months' duration. The certification and requests for treatment on an outpatient basis must be

203. Melmon & Morrelli, supra note 101, at 870.
204. See text accompanying notes 275-85 infra.
207. Id. § 27-10-105(1)(a) (Supp. 1979).
208. Id. § 27-10-102(5) (Supp. 1979). A person taken into custody on an emergency basis cannot be detained in a jail, lock up, or other place used for the confinement of persons charged or convicted of penal offenses unless no other place or confinement for treatment and evaluation is available. In that event, a person may be held for only 24 hours and must be held separately from persons charged with or convicted of penal offenses. Id. § 27-10-105(1.1) (Supp. 1979).
209. Id. § 27-10-105(1) (Supp. 1979).
reviewed by a court if at any time during the three-month period the patient
or his attorney so petitions the court.\textsuperscript{211} At the end of three months, the
certification may be extended by court order for an additional three months
if the person's condition so warrants.\textsuperscript{212}

In the event the person is still an imminent danger to himself or others
or gravely disabled and has received short-term treatment for five consecu-
tive months, he may be certified for long-term treatment for a period of no
longer than six months.\textsuperscript{213} A hearing on long-term certification before either
the court or a jury is mandatory if requested by the patient or his attor-
ney.\textsuperscript{214} Long-term certifications may be extended for consecutive periods of
up to six months each thereafter.\textsuperscript{215} Both short- and long-term certifications
must be terminated as soon as the professional in charge of the patient's
treatment determines that the patient has received sufficient benefit from
such treatment to warrant release.\textsuperscript{216}

Persons detained for evaluation or treatment have a right to receive
medical and psychiatric care and treatment suited to meet their individual
needs in the least restrictive environment possible.\textsuperscript{217} They may petition the
court for a less restrictive setting within or without the treatment facility,
and if they are receiving no treatment, they may petition the court for re-
lease.\textsuperscript{218} Consent must be given for specific therapies and major medical
treatment in the nature of surgery.\textsuperscript{219} Specific therapies for which consent
must be given are surgery, electroshock treatment,\textsuperscript{220} and the use of psychi-
atric drugs in extraordinarily large doses.\textsuperscript{221} The consent to their adminis-
tration must be informed,\textsuperscript{222} freely given, in writing, and signed by the

\begin{itemize}
  \item 211. \textit{Id.} § 27-10-107(6) (Supp. 1979). The hearing must be held within ten days of the
court's receipt of the petition. \textit{Id.} An attorney must be appointed for every person certified for
  \item 212. \textit{Id.} § 27-10-108 (1973). At the request of the patient or his attorney, a hearing is also
mandatory for extension of certification. \textit{Id.}
  \item 214. \textit{Id.} § 27-10-109(3) (1973). Requests for jury trials must be filed with the court within
ten days after the receipt of the petition by the patient or his attorney. \textit{Id.}
  \item 215. \textit{Id.} § 27-10-109(5) (Supp. 1979). Hearings are again mandatory, if requested.
  \item 216. \textit{Id.} § 27-10-110 (Supp. 1979). The professional person must notify the court within five
days of such termination.
  \item 217. \textit{Id.} § 27-10-116(1)(a) (Supp. 1979). \textit{See} Department of Institutions, Care and Treat-
[hereinafter cited as 1978 Regulations]. "[T]he patient shall enjoy the maximum amount of
freedom consistent with his/her clinical needs. . . ." \textit{Id.}
Stat. §§ 27-10-117, -119, -120 (1973), regarding rights and privileges of patients while they are
committed to institutions.
  \item 220. \textit{See note 133, supra.}
  \item 221. 1978 Regulations, \textit{supra} note 217, § VII.A.
  \item 222. An informed consent must be preceded by the following:
    \begin{enumerate}
      \item A fair explanation of the proposed specific therapy, including identification of its
experimental elements, if any;
      \item the probable consequences if the treatment is not permitted to proceed;
      \item the availability of appropriate alternative treatment, if any;
      \item an offer to answer any inquiries concerning the specific therapy;
      \item an instruction that the patient or other person giving consent is free to withdraw
his/her consent and discontinue therapy at any time.
    \end{enumerate}
patient or his or her legal guardian.\textsuperscript{223}

On July 30, 1979, the Department of Institutions adopted regulations on the right to refuse medication.\textsuperscript{224} Where prescription medications are to be a part of the treatment program, the patient or his legal guardian must be informed of the reasons for prescribing the medication, the probable consequences of not taking the medication, the expected benefits of the medication, the common side effects associated with its use, if any, and the major risks, if any.\textsuperscript{225} The physician must make a reasonable attempt to obtain voluntary acceptance of the medication by the patient and must be available to answer inquiries regarding the medication. In addition, the patient must be informed that he may withdraw agreement to take the medication at any time. If after this procedure the patient refuses to accept medication, then appropriate treatment alternatives must be presented to the patient.\textsuperscript{226}

Under nonemergency conditions, the 1979 regulations provided that if the patient refused medication, and the physician concluded that medication was essential for the patient’s treatment, a review hearing was to be conducted by the facility’s medical director or his designee.\textsuperscript{227} The review hearing amounted to a quasi-judicial proceeding in which the patient’s attorney could be present; the patient could present evidence, question witnesses, and have a physician testify on his own behalf; and written findings and conclusions were to be issued by the presiding physician.\textsuperscript{228} The procedure was followed reluctantly, if at all, for several reasons. Physicians, believing their job was to treat patients, did not want to be placed in the role of a judge.\textsuperscript{229} One facility, which hired an outside psychiatrist to preside over medication hearings, found this method unsatisfactory because of the costs involved in paying the psychiatrist and providing space and staff for him. In addition, attorneys raised the issue of a possible conflict of interest because the psychiatrist was paid by the institution attempting to medicate their clients involuntarily.\textsuperscript{230} This review procedure was overturned by the Colorado Supreme Court in the \textit{Goedcke} decision,\textsuperscript{231} which ruled that a patient had the right to refuse medication in nonemergency situations unless a competent tribunal first finds that the patient’s illness “has so impaired his judgment that he is incapable of participating in decisions affecting his health.”\textsuperscript{232}

Following the \textit{Goedcke} decision, the Division of Mental Health Advisory

\begin{itemize}
\item \textsuperscript{223} Id. § VII.B.1.
\item \textsuperscript{224} 1979 Regulations, \textit{supra} note 7, § VIII.
\item \textsuperscript{225} Id. § VIII.A.1.
\item \textsuperscript{226} Id. §§ VIII.A.2. to -. 5.
\item \textsuperscript{227} Id. § VIII.B.2.a.ii. Prior to the issuance of these regulations, the decision to medicate in spite of the patient’s refusal was made upon consultation with other physicians. Physician B, \textit{supra} note 47; Interview with Physician G. Physician G is a psychiatrist who is the medical director of a large residential treatment center. He has served in this capacity throughout the time that the Colorado regulations regarding the right to refuse treatment have been in effect.
\item \textsuperscript{228} 1979 Regulations, \textit{supra} note 7, § VIII.B.2.a.ii.
\item \textsuperscript{229} Physician B, \textit{supra} note 47; Physician C, \textit{supra} note 104.
\item \textsuperscript{230} Physician A, \textit{supra} note 8.
\item \textsuperscript{231} Goedcke v. State, 603 P.2d 123 (Colo. 1979).
\item \textsuperscript{232} Id. at 125.
\end{itemize}
Board for Service Standards and Regulations proposed new regulations which were adopted on July 16, 1980, after public hearings and numerous meetings. All references to administration of medication over the objections of the patient in nonemergency situations were deleted. Under the current regulations, medication may be administered over the objection of a patient only if an emergency exists. Such an emergency exists only if one of the three conditions set forth in the regulations is met:

i. The patient is determined to be in imminent danger of hurting herself/himself or others as evidenced by symptoms which have in the past reliably predicted imminent dangerousness in the particular patient or by a recent overt act, including but not limited to a credible threat of bodily harm, an assault on another person, or self-destructive behavior.

ii. The patient's life is in imminent danger due to toxicity arising from the patient’s use or abuse of another medication, drug, or other substance.

iii. The patient’s life is in imminent danger because of a severely debilitated condition.

The patient’s condition is to be evaluated every twenty-four hours to determine if the emergency condition still exists. If the attending physician determines that the emergency condition continues and that medication is indicated beyond seventy-two hours, the facility must request a court hearing for an order to administer the medication, and the physician must obtain a concurring consultation with another physician. Medication cannot be administered over a patient’s lack of consent for longer than ten days without a court order. The patient must be notified promptly of the right to contact an attorney or a court of competent jurisdiction. The treating facility must help the patient contact the attorney or the court if necessary to effectively exercise these rights.

IV. THE IMPACT OF THE RIGHT TO REFUSE MEDICATION

The refusal of medication has affected the mental health treatment system in many ways. A very direct effect has been apparent on the wards in residential treatment centers. One aim of inpatient treatment is to structure...

234. Department of Institutions, Care and Treatment of Mentally Ill, Rules and Regulations, 2 C.C.R. 502-1 (effective July 16, 1980) [hereinafter referred to as 1980 Regulations].
235. Id. § VIII.B.1.A.
236. 1979 Regulations, supra note 7, § VIII.B.1.b.
237. Id. § VIII.B.1.a.
238. 1980 Regulations, supra note 234, § VIII.B.1.c. 1. The 1979 regulations had provided that medication could be administered on an emergency basis for only 72 hours. 1979 Regulations, supra note 7, § VIII.B.1.d.
239. 1980 Regulations, supra note 234, § VIII.B.1.c. If the consultation cannot be obtained within the initial 72 hours of involuntary administration of medication, no medication can be administered until a concurring consultation is documented in the patient's chart. Id.
240. Id. § VIII.B.1.d.
241. Id. § VIII.B.2.
242. Id.
the patient's environment so that it will be as constructive a force as possible toward the achievement of treatment objectives. The therapeutic milieu is disrupted in several ways by patients who refuse medication. First, the outward refusal of medication undermines the good will of other patients on the ward. Not only do refusing patients try to convince other patients not to take their medications, but the mere fact of their refusal is sometimes contagious.

Patients refusing medications may become disruptive, out of control, or violent. Their disturbances may make it impossible to treat others. In addition, when violence and other uncontrollable behavior occurs on the

244. Attorney A, supra note 197. See Ford, supra note 38, at 337.
246. Interview with Psychiatric Nurse A. Psychiatric Nurse A has a master's degree in psychiatric nursing. She is the head nurse and administrator of the psychiatric ward of a private hospital. The ward has a capacity of up to 33 patients, both neurotic and psychotic, with both functional and organic illnesses. The average length of stay is two weeks. About an eighth of the patients are involuntary and paid for by the state on a contract basis with a mental health center. This hospital has for some time been keeping detailed documentation of side effects and has closely monitored the use of medication.
247. Id.; Physician B, supra note 47; Physician G, supra note 227; Interview with Attorney C; Interview with Psychiatric Nurse B.
248. Interview with Attorney C. Attorney C specializes in mental health law. His clients come primarily through court appointments. He has participated in four medication hearings, and serves both on the Mental Disabilities Committee of the Colorado Bar Association and on the Advisory Committee on Rules and Regulations, Division of Mental Health, Department of Institutions.

Psychiatric Nurse B has earned a Ph.D. in psychiatric nursing, has taught that subject, and has worked in the mental health systems of three states. She is the director of nursing at a residential treatment hospital which has a capacity of 70 inpatients.

An extreme example of the chaos that can result from the refusal of treatment was summarized in a brief prepared by the Massachusetts Psychiatric Society in response to a temporary restraining order allowing patients in a state hospital to refuse treatment. Statements in quotation marks are taken from hospital records:

"Tension seems to fill the air at the Austin Unit twenty-four hours a day." One wing has been destroyed by fire, set by a patient. One female patient attempted to burn a staff member, to choke a patient, and to strangle herself with a ripped dress. She smashed a window, threatened to kill several staff members, attacked, kicked, and spat at them. At another time she was "screaming, threatening, deluded, beat staff, grabs them, incited another disturbed patient to violence by inviting him to her bed and defying staff to deal with him. This other patient becomes so threatening that the night staff sent Dr. G. a letter signed by all informing him that they would not and could not work under these conditions."

Another female Austin Unit patient punched a social worker and several patients, cut herself with fliptops, and "gouged her face with her fingernails until she bled; this continued almost daily through the month of June." A schizophrenic male patient who has refused medication since the grant of the restraining order has had sexual intercourse with at least three different patients who are either retarded or are severely and chronically regressed. He has also broken a window, kicked a patient, and grabbed and threatened two female staff members. The incidence of assaultive behavior by Austin patients has also increased as the administration of medication has declined in deference to their wishes.

Patients in the May Unit have experienced similar problems. One woman, while refusing medication, became psychotic and left the hospital in anger, lived on a doorstep without changing her clothes for two weeks, and was twice returned to the hospital by police, and twice set herself on fire in her room. In the May, as in Austin Unit, "since the issuance of the temporary restraining order, tensions, threats, agitation and acts of violence have increased."

Quoted in Stone, Legal and Ethical Developments, in DISORDERS OF SCHIZOPHRENIC SYNDROME 571 (1979).

248. Stone, supra note 247, at 566.
ward, patients become fearful, not only for their own safety but for their own self-control.249 In general, most patients do not want to be crazy or violent; they want to be stopped before they get out of control. Indeed, one major purpose of the therapeutic milieu is to provide structure and set limits in order to help patients master their own impulsive behavior.250

The relationships between patient and staff are also negatively affected by out of control behavior resulting from a patient's refusal of medication. Threats and violence are often directed at the staff.251 The staff in response becomes fearful and angry, not only because they may be physically injured and other patients endangered, but also because they are now much more limited in their ability to deal with such out of control behavior as a result of the new regulations regarding the right to refuse medication.252 There is uncertainty as to when the emergency use of medication is allowed.253 It is presently used only when a life-threatening situation arises and only after violent behavior occurs.254 The use of restraints and seclusion, the abolition of which has been advocated for some time, is now often the only method of dealing with out of control behavior.255 For some patients, whose out of con-

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249. Physician B, supra note 47; Psychiatric Nurse A, supra note 246.
251. Id; Psychiatric Nurse B, supra note 247.
253. There are mixed feelings among mental health professionals about whether the 1980 regulations have clarified some of the confusion which existed both immediately after the implementation of the 1979 regulations and after the Goedecke decision. Some feel that the new regulations have made working conditions easier. Physician B, supra note 47; Physician C, supra note 104; Psychiatric Nurse A, supra note 246; Interview with Attorney D. Others feel the situation is more confused. Physician D, supra note 112; Psychiatric Nurse B, supra note 247.

Attorney D is an assistant county attorney responsible for mental health law, who works with a community mental health center. Attorney D has participated in fifteen medication hearings.


Example 1: A patient with a history of aggressive behavior, who had refused medication, became increasingly agitated. Because of this and other behaviors, the staff knew that he would become violent. The hospital, however, had a policy of not administering medication against a patient's wishes unless there was a life-threatening emergency or the patient had demonstrated through a recent act that he was dangerous to himself or others. As his condition deteriorated, he was placed in seclusion. Some time later the staff heard a crash, and two members went to the room in which the patient had been placed. The patient had tried to break a window by throwing a chair through it. The patient then bashed one of the mental health workers and threw the other across the room. The situation then was determined to be dangerous enough for the administration of medication. Psychiatric Nurse A, supra note 246.

Example 2: A woman who suffered from chronic schizophrenia, and who had been in and out of the hospital many times, refused to take medication. Part of her behavior pattern was throwing chairs. The hospital's policy was to administer medication against a patient's wishes only if a life-threatening emergency arose. The woman had never hit another person with the chairs she threw, so the situation was determined by the staff not to be life-threatening. After she refused medication for a period of time and continued to throw chairs, her throwing arm was placed in a restraint. Her condition eventually settled down to the point where she no longer threw chairs, and the restraint was removed. She then began to remove her clothing wherever she happened to be and would not keep it on. Her condition was not considered serious enough to petition the court for a medication order. Physician D, supra note 112.

255. Physician B, supra note 47; Attorney A, supra note 197; Psychiatric Nurse B, supra note 247.

Example 3: A large male, who was clearly out of control and potentially dangerous, was brought to the psychiatric ward of a hospital from the emergency room. He refused to take medication. The hospital's policy was to medicate only in a life-threatening emergency. The
trol behavior can be compared to a child acting out to get attention, the stopping of their actions by the use of physical restraint can have a salutary effect, not only to prevent physical injury, but to help them to regain control. The increased use of restraints and seclusion, however, is considered by many to be a step backward in the treatment of mental illness.

The dynamics of the patient-staff relationship is also affected in other ways. First, when assaultive behavior occurs, the staff has a tendency to isolate the patient. This may, in turn, provoke more acting-out behavior on the part of the patient, which may result in more isolation on the part of the staff, thus impeding therapeutic progress. Second, disruptive patients require an inordinate amount of staff time, resulting in less time available for nondisruptive patients. Third, part of the structure of the therapeutic milieu is derived from the authority of the therapist. When this authority and its attendant limit-setting ability are undermined, the structure is greatly weakened, contributing to increased anxiety on the part of other patients.

Example 4: A young woman who was retarded was placed in a residential treatment center through a community health center. She was paranoid and psychotic, but was not dangerous. She refused to take medication. She repeatedly ran away from the hospital and continued to refuse medication. She was first placed in leg shackles, but managed to leave the hospital. Eventually, she was kept strapped to a chair. Interview with Psychiatric Nurse C. Psychiatric Nurse C has a master's degree and has worked in several states. She is the head of the inpatient team at a community mental health center. The team is in charge of patients both at a small residential treatment unit and at a state psychiatric hospital.

State regulations provide that restraint and seclusion may be used only in an emergency when a professional person determines that the patient is in imminent danger of hurting himself or herself or others and treatment of the condition is possible only with the use of restraints or seclusion. They may be used only when less restrictive means cannot produce the control necessary to prevent harm to the patient or others, and only such restraint or seclusion as is reasonably necessary may be used. The patient may be secluded or restrained for no more than four hours, unless upon examination by a professional person, an express order is given for a longer period of restraint. The patient must be observed not less than every fifteen minutes during the period of restraint or seclusion. Finally, there must be an examination of the patient and new authorization for seclusion every 24 hours. 1978 Regulations, supra note 217, § II.E. See Brakel & Rock, supra note 11, at 158-61.

Hearings on the right to refuse treatment are not limited to the right to refuse medication. A hearing was held in which two psychiatrists testified that the extended use of four-point restraints was the most appropriate treatment for a patient who did not respond to medication. The patient had refused the use of physical restraints. Interview with Judge A. Judge A is a district court judge who presides over a civil division. He hears most of the mental health cases in his district, and has presided over some fifteen medication hearings. Physician B, supra note 47; Attorney A, supra note 197; Psychiatric Nurse A, supra note 246; Psychiatric Nurse B, supra note 247; Brakel & Rock, supra note 11, at 158-61.

One physician stated that he felt the use of physical restraints was inhumane. Physician D, supra note 112. Another physician felt that in some cases the use of medical restraint through medication was less intrusive than the use of physical restraint. He cited the example of a very fearful and paranoid patient, among whose delusions were that someone was out to kill him. He had refused medication and was strapped in a chair. Being placed in restraints aroused in him abject terror, for he felt he was trapped and defenseless against his imagined enemy. Physician F, supra note 184.

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Patients refuse medication for three primary reasons. The first is because of their illness. They may be paranoid and suspect that the medication is poison or ascribe some secret and unfriendly meaning to the therapeutic maneuvers of the therapist. The patient’s belief that he or she is not ill is prominent in psychosis. Mental illness is stigmatizing, and patients who do not want to be labeled mentally ill may refuse the medication which would force them to admit that they are ill. Manic patients and grandiose schizophrenics are often very euphoric or ecstatic and refuse medication because they do not want the elation they feel to be dispelled. Dysphoric or depressed patients are less likely to refuse; however, some depressed patients who are suicidal and want to die will refuse treatment because medication will enable them to live and other depressed patients may feel they are not worthy of treatment. Patients may not want to be treated because they are unwilling to surrender the positive, defensive adaptations of their illness. They may not want to reestablish contact with reality because they fear some intolerable condition which exists in reality. Improvement in the patient’s mental illness might lead to reality, thus forcing the patient to confront it. One physician estimated that nine out of ten patients who refuse medication do so because of their illness.

A second reason for drug refusal relates to the patient-therapist relationship. There may be tension in the relationship, excessive passivity on the
part of the therapist, or lack of feedback from the therapist.\textsuperscript{273} There may
be negativistic or other power struggles going on between the patient and the
physician or staff.\textsuperscript{274}

Drug side effects constitute a third reason for refusal of medication.\textsuperscript{275}
Some patients refuse medication because of dysphoric response.\textsuperscript{276} One
study found that an early dysphoric response indicates that the medication
will have no long-term beneficial effect.\textsuperscript{277} Such physiologic responses as
sedative or extrapyramidal side effects may produce panic reactions and fur-
ther psychotic deterioration. In addition, the extrapyramidal side effects
may often be very stressful.\textsuperscript{278} "[M]ost drug reluctant patients find life with
chronic EPI [extrapyramidal side effects] unbearable."\textsuperscript{279} One study found a
strong correlation between hostile, paranoid schizophrenia, extrapyramidal
side effects, and drug reluctance.\textsuperscript{280}

Patients who refuse medication may not do so consistently. Some pa-
tients may refuse medication one day and accept it the next.\textsuperscript{281} Others refuse
medication infrequently with no apparent pattern.\textsuperscript{282} Some refuse medica-
tion as a habitual response to stress, but usually resume taking medication at

\begin{verbatim}
273. Appelbaum & Gutheil, supra note 261, at 341.
274. Id. at 340; Physician G, supra note 227; Psychiatric Nurse A, supra note 246; Van Put-
ten, supra note 155, at 68.
Example 6: A large man, who had been in and out of hospitals many times over a period of
years, refused medication because he said it would make him seem unfriendly, would inhibit
him, and would make him unable to talk as well. In addition, he had suffered some muscle
paralysis seven years earlier for two weeks, the only time he had experienced that side effect.
He was dangerous and potentially violent. During a court hearing, he testified only as to the poten-
tial side effects and recognized none of the benefits. Medication was ordered. Attorney D, supra
note 253.

Example 7: A 67-year-old depressed woman, who refused medication periodically during
her hospitalization, stated that she believed the staff was giving her incorrect medication, the
effect of which was making her confused. In fact, blood tests indicated that the amount of
antidepressants in her system was at a very toxic level. Appelbaum & Gutheil, supra note 261, at
242-43. See also text accompanying notes 127-31 supra.
276. Appelbaum & Gutheil, supra note 261, at 243; Van Putten, supra note 155, at 68; Van
Putten & May, supra note 155, at 479. Patients may complain that they feel miserable. See text
accompanying notes 200-01 supra.
277. Van Putten & May, supra note 155, at 480.
278. Van Putten, supra note 155, at 68.
279. Id. at 70.
Example 8: A woman, so uncommunicative as to be almost mute, was a patient in a hospi-
tal which has a very coercive atmosphere (patients are routinely placed in restraints upon their
arrival). She refused to take medication, and also would not sign a release to obtain background
information. Whenever the subject of medication or the reason for her hospitalization was dis-
cussed she would become totally unresponsive. The attorney appointed to represent her noticed
movements of her lips and tongue, indicating the possibility of tardive dyskinesia. The doctors
had done no testing for tardive dyskinesia and had not mentioned the syndrome or the lip and
tongue movements in their report to the court hearing a petition for medication. Her attorney
revealed the existence of the tongue and lip movements on cross examination. The court or-
dered medication, but stayed the implementation of the order for two weeks so that an in-
dependent examination could be made to evaluate the possible presence of tardive dyskinesia.
Attorney C, supra note 247. See text accompanying notes 169-75 supra.
280. Van Putten, supra note 155, at 70.
282. Appelbaum & Gutheil, supra note 261, at 342.
\end{verbatim}
some time shortly after refusal. It has been found that in these situations, the patient's overall treatment has not been impaired and some positive advantages have resulted. The group of patients about whom there is most concern is comprised of those who refuse medications over a substantial period of time in a manner which significantly interferes with the hospital's ability to treat them. These patients' situations bring out the essential conflict between the right to refuse treatment and the philosophy of mental health treatment today: These patients have a right to treatment, indeed the statute mandates their treatment, but if they refuse treatment as is their right, they cannot be treated. This dilemma applies particularly to nonviolent, passive refusers, the persons described as "harmlessly crazy, but suffering greatly." Unless after a time of attempted persuasion they voluntarily take medication, these persons will remain unmedicated. Their condition may stabilize, but for some, unless they receive medication to help clear their thinking, no therapeutic progress can be made. There is nothing in the statute or regulations that mandates against petitions for medication being brought on their behalf. If their illness makes them incapable of participating in decisions affecting their health, they meet the Goedecke criterion to have a competent tribunal decide whether or not they can be medicated. Petitions for nonemergency medication are not being brought, however. Instead there is a tendency to drop patients' certifications as soon as their conditions become stabilized and return them to the community. They are simply not being treated.

Although some mentally ill persons may remit spontaneously without medication, many cannot begin to function effectively without drug therapy; and they need more than medication to help them live in society. They

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283. This response has been described as the dynamic equivalent of a child going on a hunger strike to evoke certain responses from its mother. Id. at 344.
284. Id. at 345. See text accompanying notes 314-16 infra.
285. Appelbaum & Gutheil, supra note 261, at 343-44.
286. "In situations of this type . . . the right to and the right to refuse treatment are essentially antithetical rights because to enforce one is to fully destroy the other." Schoenfeld, Recent Developments in the Law Concerning the Mentally Ill—"A Cornerstone Laid in Mud," 9 U. Tol. L. Rev. 1, 16 (1977).
287. "The fact is that the great majority of hospitalized mental patients are too passive, too silent, too fearful, too withdrawn [to be dangerous]." Deutsch, Statement, supra note 1, at 43. 
Example 9: A young woman in her 20's was extremely withdrawn and frightened. She was not dangerous but spent the day walking aimlessly clinging to a stuffed rabbit. She refused medication, and came under no criteria upon which medication could be administered without her consent. Her condition gradually deteriorated. Psychiatric Nurse A, supra note 246.
288. Physician E, supra note 162.

Example 10: A critically ill schizophrenic woman lived in a closet for the first six weeks of her hospitalization. She would not bathe or eat except in the closet in the middle of the night. Because she did not come under the emergency rules—she was no danger to herself or others—medication could not be given without her consent. The psychiatrist eventually established an alliance with her so that she voluntarily took medication. Within two weeks she was out of the closet and began to function normally. Meanwhile, her hospitalization had cost $100 per day plus the cost of the doctor. Psychiatric Nurse B, supra note 247.
291. One authority has estimated that as many as 30% of psychotic patients will spontaneously remit within a few days in an appropriate milieu. Lipton & Burnett, supra note 18, at 330.
need, at a minimum, social support if not social therapy, but they cannot benefit from social therapy unless they receive medication.\textsuperscript{292} It is the ethical duty of the medical profession to treat, but because therapists cannot treat in this situation, they feel helpless and frustrated.\textsuperscript{293} Even though a violent patient may present more risk to the therapist, at least something can be done under the emergency regulations.

Mental health professionals define emergency in a much narrower sense than the regulations seem to allow. Some mental health facilities will administer medication on an emergency basis only if a life-threatening situation arises.\textsuperscript{294} Others will administer medication only after assaultive behavior has occurred.\textsuperscript{295} The regulations, however, allow administration of medication if "the patient is determined to be in imminent danger of hurting herself/himself or others as evidenced by symptoms which have in the past reliably predicted imminent dangerousness on the part of the patient."\textsuperscript{296} At only one institution are medications being given under the emergency regulations before assaultive or violent behavior occurs. In that instance, medications are administered only if the present pattern of behavior, as clearly documented in the past, has predictably indicated future aggression or violence.\textsuperscript{297} There has been a tendency to "save" the seventy-two hour emergency medication until the condition of the patient deteriorates to the point where he is totally out of control.\textsuperscript{298} In addition, mental health professionals in the Denver metropolitan area are acting in the belief that there is only one emergency medication period allowed per patient. At the Colorado State Hospital in Pueblo, however, emergency medications are used whenever they are needed—if a patient is medicated, becomes better, and some time later again meets the criteria for emergency medication, it will again be used.\textsuperscript{299}

Some mental health professionals consider the ten-day limitation on the emergency administration of medication without a court hearing\textsuperscript{300} to be totally arbitrary and unrelated to good medical practice. The ten-day limitation in the 1980 regulations, however, is a considerable improvement over the seventy-two hours allowed by the original 1979 regulations.\textsuperscript{301} The re-

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\textsuperscript{292} Attorney A, supra note 197.
\textsuperscript{293} Physician B, supra note 47; Physician G, supra note 227; Ford, supra note 38, at 333; Redlich & Mollica, supra note 289, at 132.
\textsuperscript{294} Physician B, supra note 47; Psychiatric Nurse B, supra note 247; Warner & Yeager, supra note 156, at 3.
\textsuperscript{295} Physician D, supra note 112; Psychiatric Nurse A, supra note 246; Psychiatric Nurse B, supra note 247.
\textsuperscript{296} 1980 Regulations, supra note 234, § VIII.B.1.b.i.
\textsuperscript{297} Psychiatric Nurse A, supra note 246.
\textsuperscript{298} Physician B, supra note 47; Physician G, supra note 227; Psychiatric Nurse A, supra note 246.
\textsuperscript{299} Physician F, supra note 184; Interview with Attorney E. Attorney E is an assistant county attorney responsible for mental health litigation in his county. He has filed six petitions for medication. One petition has been heard. Four are awaiting hearings on motions to dismiss, and one will be heard shortly.
\textsuperscript{300} Physician D, supra note 112.
\textsuperscript{301} Physician B, supra note 47; Psychiatric Nurse A, supra note 246. In discussing the 72-hour limitation on medication, one physician drew a parallel to the administration of medication for strep throat: After the patient takes the medication for 72 hours, the symptoms of strep
quest for a court hearing must still be made within seventy-two hours after the initial emergency administration of medication to a nonconsenting patient if the physician believes medication will be necessary beyond seventy-two hours. The ten-day limitation merely allows continuation of the medication for more than seventy-two hours pending the court hearing.\textsuperscript{302} The extended time period, however, at least gives mental health professionals more ability to work with the patient therapeutically.\textsuperscript{303} Some nonconsenting patients given medication on an emergency basis have become calmer and more amenable to treatment and have continued taking medications voluntarily before the expiration of the ten days, thus obviating the need for a court hearing.\textsuperscript{304}

Two categories of patients are potential candidates for medication hearings: nonconsenting patients who need emergency treatment for more than seventy-two hours and persons who refuse medication but who do not meet the criteria for administration of medication on an emergency basis. The criteria used by mental health professionals to evaluate those patients for whom court-ordered medication will be requested are even more stringent than the criteria for emergency medication. As a consequence, petitions are being filed for only the most seriously ill or dangerous patients.\textsuperscript{305}

The process of going to court to obtain medication may have a detrimental effect on the treatment of mental illness because of the delays in obtaining a court hearing. As long as two or three weeks have elapsed from the filing of the petition for medication until the date of the hearing.\textsuperscript{306} If a hearing cannot be set within ten days of the first administration of medication on an emergency basis, the medication must be discontinued at the expiration of the ten-day limit until a court order is obtained. The patient's condition may begin to deteriorate upon withdrawal. The judicial process may also have a detrimental effect; if motions to dismiss are filed, they must first be ruled upon before the hearing on the petition for medication takes place.\textsuperscript{307} The additional delay may have a further negative effect on the

\textsuperscript{302} 1980 Regulations, supra note 234, § B.1.c.
\textsuperscript{303} Psychiatric Nurse A, supra note 246.
\textsuperscript{304} Physician C, supra note 104; Psychiatric Nurse A, supra note 246.
\textsuperscript{305} Physician D, supra note 112; Physician G, supra note 227. Doctors may bring petitions for involuntary medication for only those patients whose cases they believe they can win. If the doctors feel a medication order will not be granted, they will not file a petition. Physician A, supra note 8; Attorney D, supra note 253.
\textsuperscript{306} Physician D, supra note 112; Attorney D, supra note 253. In one court, there has been an average of seven days between the time a petition is filed and the time a hearing is held. Recently, the time has been shortened. Attorney D, supra note 253. In another court, although there were delays at first in scheduling a hearing on medication petitions, the court is attempting to hear them as soon as possible, and the delays have been shortened. Interview with Judge C. Judge C is a probate judge and handles all mental health cases for the judicial district in which his court is located. He has heard a dozen medication hearings.
\textsuperscript{307} One commentator suggested that "unnecessary delays [sic] in terminating psychotic episodes is tantamount to 'playing with fire.'" Forced Drug Medication, supra note 71, at 118 n.98.

Example 17: A woman for whom a petition for medication had been filed submitted a motion to dismiss. Between the filing of the motion and the hearing, the woman walked away from the institution in which she was being treated. She went to her home, saw four photo-
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An additional consequence of going to court is the submission of the physician-patient relationship to the adversarial process, which many physicians feel is detrimental to the physician-patient relationship and impairs the treatment of mental illness. Many patients who refuse medication are distrustful to begin with, and the adversarial process increases this distrust, thus impeding the establishment of the mutual trust necessary for a therapeutic alliance. Having the court make the decision may diminish the patient's respect for the physician's judgment and reduce his or her authority.

Positive effects may also result from both the attempt to persuade the patient to voluntarily accept the medication and the process of going to court. By discussing court procedures with the patient, the physician can improve the patient's understanding of that procedure. Throughout the discussions, time is being spent with the patient which may lead toward the building of a positive relationship and therapeutic alliance, with the eventual development of mutual trust necessary for long-term success in mental health treatment. The patient's role in the treatment decision is likely to lead to an increased sense of self worth and power.

Example 12: A woman, who had many previous hospital admissions, refused medication. During previous admissions, she had compensated immediately upon taking medication. She was overtly psychotic and refused to eat. Among her delusions was that she had to purify her system by drinking salt water. She had been confined for a year without medication and had been through three jury trials, on the issue of certification, two of which had ended in mistrials. Because persons can be medicated involuntarily only if they are certified for treatment, she had not been medicated on an emergency basis. If she had been placed on medication, it is very likely in the light of her previous history that she would have been released from the hospital in a very short time. Physician F, supra note 184.

Example 13: A man, who was certified but was being treated as an outpatient, suffered
reached prior to a court hearing. Even if medication is ordered against the patient’s wishes, he may accept the decision in a positive way if he feels he received a fair hearing.\footnote{317}

The relative infrequency of medication hearings in Colorado to date may have been influenced by nonmedical factors as well. Physicians are reluctant to go to court.\footnote{318} They are busy and resent taking the time to go to court.\footnote{319} Many do not feel comfortable in a courtroom with its adversarial setting and are intimidated by judges and the judicial system.\footnote{320} They do not like to have their expertise challenged in court.\footnote{321} Furthermore, they resent “courtroom therapy” and do not trust judges to make what they consider medical decisions. Judges are also uncomfortable making decisions impinging upon medical treatment;\footnote{322} however, they understand clearly that it is not their function as judge to make treatment decisions.\footnote{323} The impact of these nonmedical factors may have diminished during the year that the Colorado regulations regarding the right to refuse medication have been in effect. Doctors and judges are becoming more experienced and comfortable with medication hearings.\footnote{324} In addition, some doctors are attempting to establish new dialogues and closer relationships with courts to facilitate the process of going to court for medication hearings.\footnote{325}

In the court hearing, the petitioner for medication bears the initial burden of showing that the Goedecke criteria for court-ordered medication exists.\footnote{326} The Goedecke decision provides that the petitioner must first prove from a severe mental illness that led him to be highly agitated, irrational, violent, and a serious danger to others. If he took medication, he was able to lead a fairly active life as an outpatient. He believed he suffered from no mental illness and refused to take medication. He had suffered some side effects five years prior to the hearing, but had experienced none recently. He based his refusal of medication on the belief that if he were placed on drug treatment he would have to tell potential employers and would not be able to get a job. If he was not medicated, he would have to be institutionalized. The judge ruled against involuntary medication because the patient had demonstrated a capacity to make a rational decision regarding treatment. He gave the man a choice, either remain unmedicated and be placed in an institution or voluntarily accept medication and continue to be treated as an outpatient. The man chose medication.

Judge A, supra note 256; Warner & Yeager, supra note 156, at 8-9.

\footnote{317} Attorney A, supra note 197.

\footnote{318} Physician B, supra note 47; Physician D, supra note 112; Physician G, supra note 227; Psychiatric Nurse B, supra note 247; Redlich & Mollica, supra note 289, at 130.

\footnote{319} Attorney D, supra note 253. One physician described going to court as an “incredible problem,” stating that it takes one-half day or longer; and in addition to the physician and patient, two other staff persons have to go to court. Physician D, supra note 112. See also Stone, The Myth of Advocacy, 30 HOSPITAL AND COMMUNITY PSYCH. 819, 822 (1979).

\footnote{320} Physician B, supra note 47; Physician G, supra note 227.

\footnote{321} Judge A, supra note 256; Attorney D, supra note 253.

\footnote{322} Judge C, supra note 306. One judge felt that if doctors are doing their job to treat their patients according to their best medical judgment, they should not be afraid to go to court. Id.

\footnote{323} Judge A, supra note 256; Judge C, supra note 306.

\footnote{324} Judge A, supra note 256; Attorney D, supra note 253.

\footnote{325} Judge A, supra note 256; Physician B, supra note 47.

\footnote{326} This article covers only the treatment of mental illness in the civil system and not the treatment of forensic patients who have been committed through the criminal system. Upon the implementation of the regulations regarding the right to refuse medication, there was confusion as to the refusal of medication by forensic patients, particularly as to which courts had jurisdiction over involuntary medication of forensic patients. For a time, medication hearings for forensic patients were held in a civil division. Interview with Judge B; Physician F, supra note 184; Attorney E, supra note 299. The issue was brought to a head when a petition was filed regarding the refusal of medication by a very difficult forensic patient, who was serving a life
that the patient is not capable of making decisions affecting his or her health.\textsuperscript{327} The petitioner must then show that the inability to make the decision is due to impaired judgment resulting from the patient’s illness.\textsuperscript{328} In addition to the \textit{Goedcke} criteria, evidence must also be presented that the regulations regarding the attempt to obtain voluntary consent have been complied with in detail.\textsuperscript{329} The petitioner must further establish that the medication for which an order is sought is part of a rational treatment plan.\textsuperscript{330} Among the considerations in evaluating the propriety of the treatment plan are whether the program of medication is designed to alleviate the immediate symptoms of the illness, whether the medication is to be used on a maintenance basis for an indefinite length of time, and whether the medication will have to be continued in the community on an outpatient basis.\textsuperscript{331} The presence or absence of side effects is also important to the decision.\textsuperscript{332}

If the treatment plan appears to be appropriate, then the burden shifts to the patient to show why the treatment plan, including medication, is not suitable. It is presumed that a rational person would accept an appropriate treatment plan. In order to prove he is competent to make the treatment decision, the patient cannot give a mere recital of possible side effects, but must demonstrate that he is aware of the potential benefits of the medication.\textsuperscript{333} If the patient can look only to the disadvantages of the treatment and not recognize any of the advantages, he is unable to make a competent decision.\textsuperscript{334} In one court’s experience, most patients have not understood the potential positive effects of the medication, and medication has been ordered in nine out of ten hearings.\textsuperscript{335}

sentence, but who also had had a long history of mental illness. He suffered from tardive dyskinesia and had marked physical symptoms. It was decided that his petition should be filed by the Attorney General’s office in the criminal division of the district court in which he was tried and sentenced. This policy remains in effect today. Judge B; Physician F, \textit{supra} note 184.

Judge B is probate judge in a Colorado district court. A large residential treatment center is in his district.

\textsuperscript{327} \textit{Goedcke} v. State, 603 P.2d 123, 125 (Colo. 1979).
\textsuperscript{328} \textit{Id.}
\textsuperscript{329} Physician D, \textit{supra} note 112.
\textsuperscript{330} Attorney D, \textit{supra} note 253.
\textsuperscript{331} One judge commented that he was more apt to medicate on a short-term basis and less apt to order medication on a long-term basis or if the medication would have to be continued in the community. Judge C, \textit{supra} note 306.
\textsuperscript{332} Judge A, \textit{supra} note 256; Judge B, \textit{supra} note 326; Judge C, \textit{supra} note 306. Side effects were very clearly present in most of the patients appearing for medication hearings in one court.

Judge B, \textit{supra} note 326.

One commentator has questioned the ability of judges to rule in the area of mental health treatment. “[J]udges who presumably lack specialized medical and psychiatric training can hardly be expected to rule swiftly and correctly upon the appropriateness of treatments given to the mentally ill. There are certainly no ‘specific, judicially ascertainable and manageable standards’ for measuring the adequacy or appropriateness of treatment.” Schoenfeld, \textit{supra} note 286, at 19.

\textsuperscript{333} Attorney D, \textit{supra} note 253.
\textsuperscript{334} \textit{Id.}
\textsuperscript{335} Judge B, \textit{supra} note 326. Adverse consequences can result from the denial of involuntary medication by the court. One woman became violent in the hospital two days after the court denied medication. Physician D, \textit{supra} note 112. Another chronic schizophrenic was gravely disabled and could not function on his own. The patient refused medication, but had committed no recent overt act. An order for medication was denied, and because the hospital
Medication may be ordered for the length of the period of the certification, or its use may be limited to a relatively short period of time pending review by the court. In one instance, medication was ordered, but the implementation of the order was delayed until the physician could obtain more history about the patient.

If the treating facility or physician does not petition for a medication hearing or the court upholds the patient's refusal, the right to refuse medication may have further consequences for the patient, the mental health professionals, the mental health treatment system, and the community at large. The length of hospitalization of mentally ill persons who refuse medication is increased. The average hospital stay is only ten days when medication is accepted, but if the patient refuses medication, he may be hospitalized thirty days or longer while his condition settles down to the point where he can be released. If the condition deteriorates, or at least does not improve, he may be hospitalized with relatively little treatment for a very long time.

He may, in effect, be warehoused. Some hospitals have waiting lists, and other persons who need the institution's care may be unable to receive it. In addition, the cost of treating the patient is greatly increased in proportion to the length of stay. Patients who refuse medication not only are a burden to society so far as the expense of hospitalization, but they also impose substantial economic costs on society because they are nonproductive. With medication, however, it is likely they can become contributing members of society. A further adverse effect is that physicians may leave staff positions at hospitals because of the impediments to effective treatment of patients caused by the right to refuse treatment. Staff turnover is detrimental to an institution's patients, and especially to those who need long-term, intensive therapy.

If the patient refuses medication but his condition nevertheless im-

could not treat the patient without medication, the certification was terminated. The patient's brother was forced to take the patient unwillingly. Physician F, supra note 184.

336. Judge A, supra note 256; Judge B, supra note 326; Judge C, supra note 306. One patient who had side effects resulting from prolonged use of antipsychotic medication believed they resulted from malaria, which the patient did not have. Judge A, supra note 256.

337. Judge C, supra note 306.

338. Id. See Example 8, supra note 279.

339. Since the introduction of psychotropic drugs, the length of hospitalization for psychotic episodes has been reduced by two-thirds. Lipon & Burnett, supra note 18, at 323.


342. Judge C, supra note 306; Physician G, supra note 227; Attorney D, supra note 253; Psychiatric Nurse C, supra note 255. Because of the waiting list, this institution no longer will accept patients on an emergency basis. Patients who need immediate treatment are often forced to return to their families, who initially brought them in for treatment because of their deteriorated condition, or must stay in jail until beds become available. Psychiatric Nurse C, supra note 255.

343. See Example 5, supra note 261.

344. D. Rubin, supra note 264, at 10; Stone, supra note 247, at 267.

345. Physician B, supra note 47; Physician G, supra note 227; Psychiatric Nurse A, supra note 246; Psychiatric Nurse B, supra note 247.

346. Physician B, supra note 47.
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proves, he may be released. The release of stabilized patients without therapeutic treatment may have several negative ramifications. One consequence of the release of essentially untreated individuals into society is an acceleration of the "revolving door" phenomenon. Chronic patients who take medication when hospitalized become stable and functional and return to the community. After some time in the community, many feel they no longer need medication and stop taking it.\textsuperscript{347} Their condition deteriorates to the point where they have to be rehospitalized, and the cycle begins again.\textsuperscript{348} The numbers of patients being released into the community without medication will become part of this phenomenon, but their condition is likely to deteriorate more rapidly, thus speeding up the cycle.\textsuperscript{349}

Another consequence of releasing untreated but stabilized persons into the community is that a number may end up in the ghettos of mentally ill persons which have resulted from deinstitutionalization.\textsuperscript{350} Many mentally ill persons who are released into the community have little ability to look after themselves, limited coping capacities, and no friends or relatives with whom to live.\textsuperscript{351} Communities are unwilling to have group homes and halfway houses for the deinstitutionalized mentally ill in residential neighborhoods.\textsuperscript{352} Nursing homes and boarding homes are closing.\textsuperscript{353} While the need for more community mental health services increases, community resources are diminishing as citizens are increasingly reluctant to pay increased taxes to fund these services.\textsuperscript{354} The right to refuse medication will contribute to this dilemma, as even more persons will be requiring support from already overtaxed and underfunded community mental health centers.\textsuperscript{355}

\textsuperscript{347} Studies have shown that between one-quarter and one-half of patients stop taking required medication after several months. A. Beck, supra note 108, at 371; Lipton & Burnett, supra note 18, at 334. In addition, 25-30\% of outpatients receiving active medications drop out of treatment. A. Beck, supra note 108, at 357. Up to 70\% of patients who have had at least one acute schizophrenic episode will relapse within three months to a year after they stop taking medication. Lipton & Burnett, supra note 18, at 334, 337.

\textsuperscript{348} Saphire, supra note 15, at 249; Interview with Mental Health Worker A. Mental Health Worker A is the team leader of an after-care treatment team associated with a residential treatment center. She has a master’s degree and has worked in the field of mental health for more than ten years. The team has 245 clients, in nursing homes, halfway houses, supervised apartments, and family settings.

\textsuperscript{349} Physician A, supra note 8. See DuBose, supra note 53, at 1206-08.

\textsuperscript{350} Mental Health Worker A, supra note 348; Mechanic, supra note 11, at 272. It has been estimated that of patients hospitalized for an acute episode of schizophrenia, 60\% will be socially recovered five years later, 30\% will show some psychopathology but will live in the community, and the remaining 10\% will be rehospitalized. Lipton & Burnett, supra note 18, at 323.

\textsuperscript{351} Bellak, supra note 53, at 5. The lack of community support often leads to exacerbation of symptoms. Mechanic, supra note 11, at 53.

\textsuperscript{352} D. Rubin, supra note 264, at 93, 104. This feeling has contributed in large measure to the enactment of zoning restrictions against group homes. Id. at 93.

\textsuperscript{353} Physician B, supra note 47; Mental Health Worker A, supra note 348.

\textsuperscript{354} Physician E, supra note 162.

\textsuperscript{355} Stone, supra note 11, at 291.

"There is no question that the current cure provided to chronic patients in the community, whether deinstitutionalized or never admitted, is inadequate." Talbott, Care of the Chronically Mentally Ill—Still a National Disgrace, 136 Am. J. Psych. 688 (1979).

What . . . is happening . . . is that the right to treatment, coupled with other developments, is leading to an abdication of responsibility for the treatment of the chronically mentally ill in America. The civil libertarian strategy . . . has been a
Unmedicated persons released into the community may be caught between the criminal and mental health systems. Even if they are not dangerous, their behavior is often not within the tolerance of society. They may end up in the criminal system for acts that are annoying or fall within such criminal classifications as trespass, disturbance, or harassment. They often end up in jail where the conditions may be far worse than in the old mental hospitals and where there is no treatment available. These marginal members of society are not wanted in the criminal system. They may be placed on probation on the condition they receive mental health treatment, but often do not cooperate.

The mentally ill population of the jails throughout Colorado is increasing.


357. Physician A, supra note 8; Warner, supra note 356, at 4. People feel burdened by having people around whose behavior might be classed as peculiar, and the behavior of the mentally ill often has a negative effect on those around them. D. Rubin, supra note 264, at 104; Bellak, supra note 53, at 7; Stone, supra note 247, at 566.

Ralph Goedecke, whose case established the right to refuse treatment in Colorado, spent several months in jail in 1980 as a result of behavior which might have been eliminated had he not refused medication. Physician A, supra note 8.

358. Attorney A, supra note 197; Attorney D, supra note 253. "Many mentally ill persons... have particular difficulty in accepting responsibility for their own actions and in conforming their behavior within socially prescribed bounds." Cameron, supra note 243, at 726.

There is... between madness and badness a large gray area which, depending on cultural values and administrative practice, might be labelled as criminal or mental. The major legal difficulty... is that in the gray area it might be possible to confine someone simply by changing his label to conform to whichever allows the easier route to confinement.

A. Stone, supra note 55, at 6.

359. Warner & Yeager, supra note 156, at 5; Warner, supra note 356, at 4. In a large city jail, "[one schizophrenic, for example, was found to be locked in a darkened linen closet which served, so the staff said, as a 'secure room.' Such abuses of the mentally ill in U.S. jails are not uncommon." Warner & Yeager, supra note 156, at 5.

360. Attorney B, supra note 202; Attorney D, supra note 253. It has been estimated that as many as eight percent of jail inmates are functionally psychotic. Warner, supra note 356. In addition, because of the lack of beds for treatment of the mentally ill on an emergency basis, persons may spend up to five days in jail awaiting placement. Psychiatric Nurse C, supra note 255.

361. Physician E, supra note 162.

362. Example 14:

A young man held in the county jail on misdemeanor charges was evaluated by a mental health center staff as suffering from schizophrenia. His charges were dropped and he was transferred to a psychiatric hospital for treatment but refused medication. Drug-free treatment in a residential program in the community was attempted as soon as the patient was thought to be sufficiently cooperative, but he soon eloped, committed another crime, and returned to jail. The criminal court judge, with some anger at the mental health system, held the young man in jail pending transfer to the forensic unit of the state hospital for evaluation of his competency to stand trial.

Warner & Yeager, supra note 156, at 4.

For borderline mentally ill persons who refuse to cooperate with treatment efforts and repeatedly are picked up for minor offenses, the criminal system may have a therapeutic effect in that they may be forced to accept responsibility for their actions. Mental illness is often used as an excuse by such persons for their actions. Psychiatric Nurse C, supra note 255.
ing. This same pattern was observed in California shortly after the Lant-erman-Petris-Short Act of 1968 became effective. This law embodied stricter criteria for hospitalization, emphasized community treatment, and included the right to refuse treatment. After its enactment the use of civil commitment drastically declined while the number of criminal commitments due to findings of incompetency to stand trial dramatically increased. In addition, a study of patients before and after the right to refuse medication was implemented in California showed a significant increase in the number of patients jailed after being able to refuse treatment. Another study of 500 previously hospitalized patients who were arrested showed that their offenses generally derived from acute psychotic processes or from the poor judgment and impulsive behavior characteristic of mental illness. 

Finally, potentially dangerous individuals are being released into the community as a result of the right to refuse treatment. Dangerousness is very hard to predict. In fact, studies have demonstrated a marked tendency toward overprediction. Other studies have concluded that mentally ill persons are generally no more dangerous than other members of society; however, as more untreated mentally ill persons are released into society, the number of persons who are mentally ill and may commit violent crimes increases proportionately. Persons who are dangerous are rational most of the time; their violent acts are often the result of diminished impulse control. What will trigger a violent reaction in any individual cannot be predicted with any accuracy.

366. Id. at 12.
367. A. Stone, supra note 55, at 25-40; Cocozza & Steadman, supra note 58, at 1085; Ennis & Litwack, supra note 188, at 711; Griffith & Griffith, supra note 58, at 257; Monahan, supra note 58, at 201; Peszko, Is Dangerousness an Issue for Physicians in Emergency Commitments?, 132 AM. J. PSYCH. 825, 826 (1975); Shah, supra note 58, at 504; Shah, Some Interactions of Law and Mental Health in the Handling of Social Deviance, 23 CATH. U.L. REV. 674, 705 (1974).
368. DuBose, supra note 53, at 1210; Shah, supra note 58, at 503; Zitrin, Crime and Violence Among Mental Patients, 133 AM. J. PSYCH. 142, 147 (1976). One study found that a prediction of dangerousness in the context of civil commitment was related to the length of the term for which commitment was sought. Monahan, supra note 58, at 200.
369. Sosowsky, supra note 58, at 40.
371. It is fairly easy to predict that violent behavior will occur within a short period of time, for example, 72 hours, but it is very difficult to predict violence on a long-term basis. Physician C, supra note 104. There is a certain group of patients with a previous history of committing dangerous acts that one could predict would be possibly dangerous in the future. A. Stone, supra note 55, at 33. However, it is too often forgotten that dangerousness is an attribute not only of persons but of situations and environmental factors; more correctly, dangerousness should be regarded as an outcome of the interaction of these various factors.

This point, that of “interaction” between personal characteristics and situations, cannot be stressed strongly enough.
The treatment of mental illness has progressed within the past twenty years from primarily institutional care to community-based treatment combined with short-term hospitalization. This has been made possible in large measure by the use of medication to treat mental illness. In addition, mental patients have acquired a number of rights which have freed them from the barren existence of confinement in an institution. Mentally ill persons in Colorado have a recognized right to refuse medication, under which medication cannot be administered without their consent unless an emergency situation exists or a court order is obtained. The exercise of this right to refuse medication seems to be changing the direction of the treatment of mental illness.

First, doctors are going to court only in very limited circumstances to obtain orders for medication for the most seriously ill or dangerous patients. As a consequence, many mental patients who might benefit from drug therapy are not receiving any medication. Second, patients who could be productive with the use of medication become a burden on society, both in terms of the increased length of hospitalization required to stabilize their condition and because they are likely to be unproductive upon their release. Third, mentally ill persons are increasingly being placed in the criminal system, which does not want them and which provides no treatment for them. Fourth, the mental health treatment system is being forced to regress, with the increased use of restraints and seclusion, the inability to return patients to society as soon as possible, and the increase in long-term hospitalization.

Several alternatives exist for unmedicated patients. They may improve without medication, or they may continue to be hospitalized and remain essentially untreatable—in effect, warehoused—while their condition deteriorates. Their condition may stabilize to the point where they may be released into the community. Possibly, they will be able to function well in the community, or they may fall among the marginal members of society caught between the mental health and the criminal justice systems. Alternatively they may simply exist in the ghettos of deinstitutionalized mental patients in rundown urban areas. If their behavior becomes out of control in the hospital, they may be forcibly medicated under emergency procedures or placed in restraints or in seclusion. If they become out of control in the community, they are likely to end up in jail.

Their refusal of medication is often justified in light of the many side effects of drugs used in the treatment of mental illness. The question then becomes whether the unwanted side effects are more burdensome to the patients than being restrained, being jailed, or living a marginal existence in society.

The Colorado requirement that a court order be obtained before medication can be administered involuntarily has placed burdens on both the courts and the mental health facilities. Three alternatives to court hearings on the issue of medication have been adopted by courts in other states which have recognized the right to refuse medication. The first, which has been
adopted in Massachusetts and Oklahoma provides for the appointment of a guardian if it is determined in a court hearing that the patient is incapable of making informed decisions regarding treatment. Initially, this solution presents some of the same problems as the Colorado approach—for example, the difficulty in getting into court within a short period of time and the reluctance of physicians to go to court. An additional difficulty would be the availability of a pool of guardians who would be able to be appointed to serve both in an immediate crisis and over the term of treatment. It is very likely that there would not be enough persons willing to serve in this capacity. The guardian approach, however, would relieve the courts from successive court hearings in the event additional decisions would have to be made regarding the patient’s refusal of medication.

Another alternative is the solution utilized in the Utah case of Colyer v. District Court, in which it was held that before a mentally ill person can be involuntarily hospitalized, the court must find that the person is unable to make a rational decision as to the need for treatment. This requirement was subsequently codified, and the state must now prove beyond a reasonable doubt that the patient “lacks the ability to engage in a rational decision-making process regarding the acceptance of mental treatment as demonstrated by the evidence of inability to weigh the possible costs and benefits of treatment.” Once a person is hospitalized, all treatment decisions would be made by the institution and treating physician, and a consultation would not be necessary. A drawback to this solution is the fact that mentally ill persons are not necessarily incompetent to make treatment decisions, although they may meet other criteria for involuntary hospitalization.

The final alternative for allowing the use of medication to treat a mentally ill person who has refused such treatment has been adopted in the states of New Jersey and Ohio. In New Jersey, Rennie v. Klein dictated that the review be conducted by a psychiatrist outside the hospital:

The court . . . finds that independent review by psychiatrists,

375. Id.
378. Id.
379. UTAH CODE ANN. § 64-7-36(10)(c) (Supp. 1979). In addition to the determination of the patient’s inability to make rational decisions regarding mental treatment, the court must also find beyond a reasonable doubt that the patient has a mental illness, that because of the illness the patient poses an immediate danger of physical injury to others or self (including the inability to provide the basic necessities of life), that there is no appropriate less restrictive alternative to court-ordered hospitalization, and that the hospital or mental health facility in which the individual is to be hospitalized can provide the individual with treatment that is adequate and appropriate to the individual’s conditions and needs. Id. § 64-7-36(10)(a), (b), (d), (e).
rather than by judges, lawyers or laypersons, would provide the most accurate analyses of patient interests. Review within the profession would also create far less resentment among physicians and staff whose decisions are questioned. . . . Informal inquiries would be superior to formal procedures because the latter would require more time and resources and often be more disruptive of patient-doctor relations, but would not significantly decrease the risk of erroneous determinations.384

It has been suggested that the "competent tribunal" required by Goedecke385 does not necessarily mean a court of law, but could be a review panel.386 The United States Supreme Court held in Parham v. J.R.387 that "[d]ue process has never been thought to require that the neutral and detached trier of fact be law trained or a judicial or administrative officer. . . . Surely, this is the case as to medical decisions, for 'neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments.'"388 It is important, however, that the person reviewing requests for medication be truly independent; that is, be compensated by someone other than the institution whose petition for medication is being reviewed.

The court in Rennie v. Klein proposed a balancing test to evaluate whether the patient's refusal of medication will prevail. The four elements of the test are "(1) [the patient's] physical threat to [other] patients and staff at the institution; (2) the patient's capacity to decide on his particular treatment; (3) whether any less restrictive treatments exist; and (4) the risk of permanent side effects from the proposed treatment."389 This solution would appear to provide a much better method of meeting the needs of the patients, the doctors and hospital staff, the institutions, and society than the present requirement in Colorado that a court order must be obtained to administer medication on an involuntary basis.

Slightly more than a year has passed since the right to refuse medication was recognized in Colorado. Its effect has been to turn the treatment of mental illness in a regressive direction, while at the same time giving mental patients the right to be free of very uncomfortable side effects of medication if they so choose. Many issues have been raised about the direction in which the mental health treatment system is going. A balance will have to be achieved between the needs of the patients, the needs of society, and the goals of mental health treatment if progress is going to continue to be made in the treatment of mental illness.

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386. Attorney D, supra note 253.
388. Id. at 607.