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PSYCHIATRIC PATIENTS' RIGHT TO REFUSE PSYCHOTROPIC MEDICATION:
TREATMENT OR CONTROL?

The Ohio State University

Ph.D. 1983

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PSYCHIATRIC PATIENTS' RIGHT TO REFUSE PSYCHOTROPIC MEDICATION: TREATMENT OR CONTROL?

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy in the Graduate School of The Ohio State University

By
Lisa A. Callahan, B.S., M.A.

*****

The Ohio State University
1983

Reading Committee:
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Dr. Dennis R. Longmire
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My work is dedicated to my mother, father, and grandmother.
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they are, is an inspiration.

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TABLE OF CONTENTS

Acknowledgements........................................ iii
Vita.......................................................... v
List of Tables............................................... ix
List of Figures............................................... x

Chapter                                                                 Page

ONE. INTRODUCTION AND FOCUS OF RESEARCH..... 1
   Purpose of Study................................. 4
   Pragmatic Results of Research..... 7

TWO. FROM MADNESS TO MENTAL ILLNESS....... 8
   Ancient and Premodern Societies... 11
   The Middle Ages to Modern
   Societies............................................. 15
   France.............................................. 15
   England.......................................... 21
   United States.................................... 27
   Summary............................................. 36

THREE. SOCIAL REACTIONS TO MENTAL ILLNESS:
   TREATMENT OR CONTROL?....................... 39
   Treatment of the Mentally Ill..... 41
      The Progressive Era
      (1900-1950)................................. 41
      From Custody to Therapy
      (1930-1950)................................. 50
      The Introduction of
      Medications................................. 52
      Chemical Therapy: Ethical and
      Philosophical Queries.................... 59
   The Critics of Psychiatry............. 65
   Conclusions.................................... 74
FOUR. CHANGING MENTAL HEALTH LAW: BUTTING HEADS WITH A BILLYGOAT

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prisoners' Rights Movement</td>
<td>76</td>
</tr>
<tr>
<td>The Emergence of Patients' Rights: A Threat to Psychiatric Autonomy</td>
<td>80</td>
</tr>
<tr>
<td>The Right to Treatment</td>
<td>81</td>
</tr>
<tr>
<td>Refusing Psychotropic Medication: The New Quagmire of Patients' Rights</td>
<td>85</td>
</tr>
<tr>
<td>Clinical Issues</td>
<td>92</td>
</tr>
<tr>
<td>Changing Mental Health Policy: Legal and Administrative Frameworks</td>
<td>95</td>
</tr>
</tbody>
</table>

FIVE. RESEARCH GOALS, DESIGN, AND METHODOLOGY

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals of the Research</td>
<td>101</td>
</tr>
<tr>
<td>Method of Initiation</td>
<td>103</td>
</tr>
<tr>
<td>Interpretation Issues</td>
<td>103</td>
</tr>
<tr>
<td>Implementation of the Right to Refuse Medication</td>
<td>105</td>
</tr>
<tr>
<td>Impact of Refusals</td>
<td>107</td>
</tr>
<tr>
<td>Research Design</td>
<td>109</td>
</tr>
<tr>
<td>Populations</td>
<td>109</td>
</tr>
<tr>
<td>Implementing and Impact Behaviors</td>
<td>114</td>
</tr>
<tr>
<td>Methodology</td>
<td>115</td>
</tr>
<tr>
<td>National Mail Survey</td>
<td>116</td>
</tr>
<tr>
<td>Site Visits</td>
<td>117</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>120</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Right to refuse medication: national summary</td>
<td>129</td>
</tr>
<tr>
<td>2.</td>
<td>Right to refuse medication: status by state</td>
<td>132</td>
</tr>
<tr>
<td>3.</td>
<td>Year of formal recognition of the right to refuse medication</td>
<td>135</td>
</tr>
<tr>
<td>4.</td>
<td>Interpreting population for the right to refuse medication: national summary</td>
<td>136</td>
</tr>
<tr>
<td>5.</td>
<td>Method of initiation and implementation by state</td>
<td>138</td>
</tr>
<tr>
<td>6.</td>
<td>States with litigation pending on the right to refuse medication</td>
<td>141</td>
</tr>
<tr>
<td>7.</td>
<td>Method of informing patients of the right to refuse medication</td>
<td>143</td>
</tr>
<tr>
<td>8.</td>
<td>When patients are informed of the right to refuse medication</td>
<td>144</td>
</tr>
<tr>
<td>9.</td>
<td>Conditions under which a medication refusal can be overridden</td>
<td>146</td>
</tr>
<tr>
<td>10.</td>
<td>Who can override a patient's refusal in an emergency</td>
<td>147</td>
</tr>
<tr>
<td>11.</td>
<td>Who can override a patient's refusal in a non-emergency</td>
<td>149</td>
</tr>
<tr>
<td>12.</td>
<td>Refusal of other treatments in all states</td>
<td>150</td>
</tr>
</tbody>
</table>
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Research Model</td>
<td>110</td>
</tr>
</tbody>
</table>
CHAPTER ONE

INTRODUCTION AND FOCUS OF RESEARCH

During the 1970's courts and legislatures responded officially through litigation and statute to psychiatric patients' complaints that state mental institutions are, at best, warehouses for society's "mentally ill" citizens. Wyatt v. Stickney (1972) is the first federal court decision which clearly and specifically identifies maltreatment and mistreatment in a state mental hospital (Bryce Hospital in Tuscaloosa, Alabama). The court states that in order to involuntarily confine a citizen for purposes of therapy, treatments must be available (Wyatt, 1972). Further, the court outlines conditions for compliance and penalties for noncompliance with the decision. Wyatt is the beginning of a rather prolonged engagement between state mental health officials and the federal courts.

Specific issues raised in the "right to treatment" decisions include the unavailability of humane treatment as described in the plaintiffs' post-trial brief from Davis v. Baylor (Ohio, N.D.:117):
If Lima State Hospital is to truly function as a psychiatric facility it must change its present prison-like dehumanizing atmosphere which overemphasizes security and locked custodial care. Instead it should emphasize evaluation of each individual's unique problems and needs with humane care and effective treatment to restore him to his optimal level of functioning in the community.

Emerging from the humane treatment issue is a recognition of the overuse of available treatments including electroconvulsive therapy (ECT), aversive therapy, psychosurgery, and psychotropic medications. Courts and legislatures have responded to complaints of excessive use of ECT, aversive therapy, and psychosurgery in a fairly uniform manner (Kaimowitz v. Michigan, 1973; Mackey v. Procunier, 1979; Knecht v. Gillman, 1979). Either extensive safeguards or outright prohibition of use in state mental health facilities has led to a relative absence of these three forms of psychiatric treatment (Stone, 1975). The specific interest of this study is on the fourth modality — the use of psychotropic medications as treatment of mentally ill persons.

The theme of mental health litigation today is whether psychiatric patients may refuse prescribed psychotropic medications. (For a discussion of medications, see Chapter Three.) In state mental facilities the primary form of treatment is psychotropic medication; nearly all persons in
state facilities are "on" at least one psychotropic drug. When asked to speculate what proportion of patients at any given time are taking psychotropic medications, mental health staff place the figure at 90 to 100 percent of patients.2 Justifications for the domination of this mode of therapy range from economics to effectiveness. Because legal prescribing of drugs is the responsibility/right of medical doctors (or other specially-trained individuals), contemporary treatment of persons identified as being "mentally ill" falls within the purview of medicine.

Although it may appear paradoxical for the courts to permit treatment in the earlier decisions and now to order refusal of treatment, there is growing evidence that medications are unnecessarily, excessively, and extensively prescribed for the treatment of mental disorders. A further indication to the courts for a need in overview of this form of treatment is research which shows that some people develop negative side effects from a number of psychotropic medications. Sometimes these side effects are physically and mentally debilitating, and they can be irreversible.

The current philosophy of the courts is not to simply let patients remain untreated. As with other forms of intrusive treatments, psychotropic medications must be carefully prescribed for purposes of treatment, not for maintenance and control. Assuming that most patients are
competent to participate in treatment decisions, the courts have established that consent to medicate must be obtained.

It is enough to observe that the power to control men's minds is wholly inconsistent not only with the philosophy of the first amendment but with virtually any concept of liberty . . . indeed, the State's power to control the minds of its subjects is the hallmark of those totalitarian ideologies we profess to hate . . . (Davis v. Hubbard, 1980:933).

Purpose of the Study

At the core of this study is how we as a society can insure a humane treatment environment for mentally ill people. The state has taken the responsibility to care for and provide a treatment environment for indigent mentally ill individuals. The medical profession has emerged as the technical experts of treatment. The state has defaulted on its promise of care by severely underfunding and understaffing these facilities. The medical profession has neglected its professional commitment to treat by allowing abuse of medically-specific modes of therapy to occur. These two problems are exemplified below using Ohio, circa 1970 and 1980, as the state setting:

Seven out of the twenty-one state hospitals do not have a Board certified psychiatrist; two do not have a psychiatrist who might be Board eligible. Seven hospitals do not have a doctoral level psychologist. Twenty-five percent of the social work staff in mental hospitals have Masters degrees while approximately 95% of those employed in the community supported clinics have
Masters degrees. Nurse coverage for 24 hours a day is possible in only one of the state hospitals. None of the state hospitals in Ohio have sufficient activities or therapy personnel. Only seven hospitals have qualified supervisory activities, therapists, or occupational therapists (1971 Citizens Task Force, cited in Plaintiffs' Post-Trial Brief, Davis v. Baylor, N.D.:115).

Psychotropic drugs are not only overprescribed, they are also freely prescribed. They are prescribed by both licensed and unlicensed physicians. Both licensed and unlicensed physicians regularly prescribe drugs for any patient in the institution without regard to whether he is personally assigned to the patient or whether he has even seen the patient. It is not unusual for attendants to recommend a certain dosage or increased dosage. Such recommendations are often accepted by the physician without having examined the patient (Davis v. Hubbard, 1980:926).

Grounded in a sociohistorical analysis of mental illness, this research discusses the current status of the newly-defined psychiatric patient right to refuse psychotropic medications. Also included is a sociolegal examination of how administrators have responded to the courts' decisions and an evaluation of staff reactions to the conceptualization and implementation of the right to refuse psychotropic medications.

Chapters Two and Three provide the sociological and historical foundations for this study. Chapter Two, "From Madness to Mental Illness," specifically examines the changing conceptualization of mental disorders. Included in this discussion is a brief social history of the mad,
the emergence of a psychological definition of madness, and the resultant medicalization of madness to be redefined as mental illness. This movement into the medical approach to mental disorders has a significant impact for social reactions to the mentally ill. Chapter Three, "Social Reactions to Mental Illness: Treatment or Control?", presents the major arguments supporting and refuting the medical treatment of the mentally ill. Also discussed in this chapter are the medications used in the treatment of mental illness, their effects, and their side effects.

The thesis that psychiatric treatment is actually control has placed psychiatry and the forms of psychiatric treatment into the realm of legal scrutiny. Where the courts have left treatment issues to the physicians, the courts have retained jurisdiction over deciding who can be denied liberty. Recognizing that detainment for treatment in a mental hospital can often lead to the loss of basic human and civil rights, the courts have recognized mental patients as a minority group whose rights need to be both articulated and protected.

Most of the bellwether litigation and legislation on patients' rights has occurred within the last decade. Chapter Four, "Changing Mental Health Law--Butting Heads With a Billygoat," examines the methods of initiating and implementing changes in mental health law. Rather than take a "hands off" approach to patients' rights, the courts
continue to take an aggressive stand on this issue. Although not the only way of changing law, the court is a public, powerful, and official change agency. The courts have the power to order compliance from the executive and legislative branches of government. Further examined in this context is the psychiatric patient as a litigant who simultaneously is defined as needing psychiatric treatment. The possibilities for a nexus between law and psychiatry are addressed.

The research design and methodologies utilized in collecting data for the research are discussed in detail in Chapter Five. Chapter Six presents the findings of the study and a discussion of the results. Conclusions are given in Chapter Seven.

**Pragmatic Results of Research**

The pragmatic results of this research are likely to be twofold. First, a recommendation will be made to the Ohio Department of Mental Health (ODMH) on how to approach the issue of psychiatric patients' right to refuse psychotropic medications. Included in this recommendation will be structural as well as theoretical components. A comprehensive study prior to major mental health policy changes is a benefit which ODMH can use to their advantage.

The national scope of this research provides the basis for the second practical application of the study, a
state-by-state comparison of policies. Information on the different right to refuse policies, the variations in interpretation, implementation, and impact could be of benefit to all states. The willingness of the lower federal courts to continue to review cases on this issue underlines the urgent need for a systematic, well-researched approach to psychiatric patients' right to refuse psychotropic medication.
CHAPTER TWO
FROM MADNESS TO MENTAL ILLNESS

History and literature are laced with anecdotes and descriptions of madmen and madwomen. Greek, Roman, and Christian history as well as works of art and literature discuss or describe individuals suffering from some type of mental disorder. The mentally disordered individual has not always been considered "mentally ill," having a "disease of the mind" and in need of official attention. From ancient times (700 B.C.) through the late Middle Ages, mentally deranged individuals were left in the community as long as they caused no major disturbance. Responsibility for care rested with the family. However, as early as 1326 confinement in hospitals was available in Germany for acutely disturbed people who could afford to pay for care (Rosen, 1968).

It was not until what Foucault (1973) refers to as the "great confinement" in 1656 that reactions to the mad became public and, somewhat accidentally, that the responsibility for their care fell to physicians. Shortly after its opening in 1656, the Hopital General of Paris
housed 6,000 persons or one percent of the population of Paris (Foucault, 1973:45). During the 12th century in Europe institutions were constructed to confine lepers. England and Scotland built 220 leper houses for 1.5 million inhabitants (Foucault, 1973:4). As leprosy disappeared, the institutions gradually emptied only to be filled with the poor, the criminal, and the mentally deranged.

Much has been written about the history of mental illness. Philosophers (Foucault, 1973; 1976), historians (Rothman, 1971; 1980), and social scientists (Perrucci, 1974; Rosen, 1968; Scull, 1981) among others have approached the study of madness from different yet complementary perspectives. To achieve an encompassing vision of the history of madness, no one account is sufficient. This chapter represents a synthesis of the major themes developed in these works: how historically mentally disturbed individuals have been identified, ignored, accommodated, reacted to, and controlled. Special attention is given to the writings of Foucault (1973), Rosen (1968), and Scull (1981), three efforts which provide detailed histories and thorough analyses of the study of mental illness.

This discussion begins with ancient societies, moves through Europe from the late Middle Ages to the 19th Century, and concludes with a discussion of the modern
(20th century) roots of psychiatry. How the mad have been reacted to historically provides an understanding of how today's societies react to the mentally ill. Especially significant is the emergence of a profession, psychiatry, to treat these people. Because the overarching focus of this study is on attempts to create a humane environment for the mentally ill, particular attention is given to the first confinement movement and the birth of the asylum.

Ancient and Premodern Societies

Passages from the Old Testament establish that the ancient Hebrews and their neighbors recognized mental disorders. The sketchy history of this time describes kings and subjects at times pretending to be mad. David, in seeking refuge in the city of Goliath, pretended to be a madman to avoid punishment (Rosen, 1968:21). An unusual amount of information exists about Saul, the first king of ancient Israel. His overzealous desire to destroy his enemies led to the "suspicion and hostility which he developed to a pathological degree ... . Saul became moody and depressed, a condition which apparently recurred more frequently as he proved increasingly unable to cope with his difficulties" (Rosen, 1968:25-27). While we retrospectively label Saul's behaviors as pathological, his actions were explained as prophetic. Rosen (1968) describes possession and trances of the prophets, the
observable symptoms of which are strikingly similar to neuroses and psychoses ranging from feelings of detachment to seizures, hallucinations, and voices. These states were accepted by the public as much value was placed on the prophets' visions of the future. These prophets were not referred to as deranged unless they contradicted prevailing religious and political views, thus becoming a threat to public order.

Scholars of ancient history are able to establish that during this period, mental disorders were associated with some causal factors such as aging. Distinctions were made between the acute and the chronic, the dangerous and the harmless. The lower class, non-dangerous or homeless lunatics were permitted to be in the community while the more well-to-do families confined their family members at home. A mentally disordered person who was a potential danger to self or others was often confined, restrained, and placed in the stocks. During this period (500 B.C.-A.D. 200) all mentally deranged and insane individuals were considered incompetent and not legally responsible for their actions; the court could appoint a guardian (Rosen, 1968). It is certain that during this time in ancient history, communities identified and reacted negatively to people whose behaviors fell outside tolerable boundaries. Care for these deviant individuals was the responsibility of the community and the family.
Greek mythology includes stories of gods spreading mental derangement in societies as punishment. Failure to worship Dionysus (god of an orgiastic religion and of wine) brought madness to subjects. Ritual human sacrifices were performed to please Dionysus; accounts exist of the god as "frenzied or raving, that is, in a state of ecstatic excitement" (Rosen, 1968:79). The gods of the underworld, Hermes and Hecate, were thought to cast spells of madness on the Greek citizens. Rosen (1968) gives extensive accounts of how the mentally disordered were often linked to the supernatural world. Often these deranged persons were thought to be divine, sacred, and prophetic.

During the ancient Greek and Roman periods, reactions to the mad combined fear, contempt, and a little compassion. The belief in some divine source of madness gave comfort to few individuals. The mad were avoided. By the 5th century B.C. beliefs about the causes of mental illness began to include medical explanations. Because of the changing attitude from divine to evil intervention and the emerging medical perspective, the mentally deranged individuals were often the target of attack (Rosen, 1968).

Medical doctors during this time allegedly rejected the supernatural causes of madness and adhered to physiologic explanations. The human was thought to be composed of four organically-produced humours: blood, phlegm, and yellow and black bile. When an organ was
subjected to internal or external stresses, an imbalance would occur, producing an excess of humour or disease. Diseases of the mind, particularly melancholia, were caused by an excess of black bile (Rosen, 1968). These medical explanations for madness were not necessarily far removed and contrary to the prevailing community attitude that madness was caused by divine intervention. The external factors which bring an excess of black bile could include supernatural forces.

In general, reactions to the mad among ancient Greeks and Romans were to protect person and property. As with ancient Hebrews, non-violent madmen and madwomen were tolerated in the community. Also similar to the Hebrew law of incompetence and irresponsibility of the insane, Roman law prohibited the mad from making contracts, marrying, and acquiring or disposing of property. In both ancient periods of history, protection and treatment of the mad were based upon social class. Those who were monied sought the help of a doctor in treating madness and hired an attendant to protect the mad individual from harm. Families with little economic means often sought divine relief in treating insanity (Rosen, 1968).

Early societies knew madness. What history reveals for us is that insanity was often associated with religion. The prophets and the gods were possibly identified as mad; supernatural beings caused madness. Treatment for the mad
was generally rooted in religious beliefs. Reactions to individuals seen as insane were a mixture of acceptance and deference. Some raving prophets were awarded "god" status, and some lunatics were stoned to death. The religious battle between good and evil raged with regard to the mentally deranged.

The Middle Ages to Modern Societies

Throughout the Middle Ages (6th to 13th century) and the Renaissance (14th to mid-17th century), the mad were allowed the freedom to remain among members of society. Reactions to the mad paralleled those taken during ancient societies. Deranged (non-dangerous) persons were left in the community or with family. Madness was talked about and often romanticized in the literature, particularly by Shakespeare. The classical era, the age of reason, ended the historically undaunted attitude toward the mad.

France. During the mid-17th century in France, the great confinement began. The hospital (modeled after the Hopital General, circa 1656) was a "quasi-absolute sovereignty, jurisdiction without appeal, a writ of execution against which nothing can prevail--the Hopital General is a strange power that the King establishes between the police and the courts, at the limits of law: a third order of repression" (Foucault, 1973:40). Within the century all of the King's jurisdictions were to have an
institution, administered by the best families and served by a medical doctor. Often these facilities were only slightly reorganized leper houses; the inhabitants were equally as curious to the eyes of the group.

The purpose for the confinement of thousands of individuals was not for medical treatment as only ten percent of the arrests for the Hopital General were for insanity (Foucault, 1973:65). According to Foucault (1973) the mass confinement was an extension of the laws already enacted which prohibited begging and unemployment; these laws were not directed specifically to the mad. Also during this time economic crises were all of Europe. Idleness was condemned; the confined would work for the government for no wages.

During the classical age, work became equated with virtue, and those who did not work were considered immoral. Places of confinement forced regular, strict labor on the interned. Foucault (1973:63) states that "'confinement' conceals both a metaphysics of government and a politics of religion." The Protestant work ethic became entrenched in the administrative philosophy in the governmental houses of confinement. Poverty was linked to unemployment, unemployment to idleness, and idleness to immorality. Because of their inability to secure regular work (as today), some mad persons came to the attention of the police authorities. They were confined and then often
unable to perform work responsibilities in the institution, especially when compared with their "simply" poor coinhabitants. The confined insane became doubly repressed and twice as immoral.

The confinement era was not humanistic in motivation. Reason dominated thought and philosophy. Unreasonable individuals became targets of scandal, hidden from public view, and denied liberty. They were, however, displayed like animals; the dangerous were generally chained to the walls and to beds (Foucault, 1973). The mad became beasts. "For classicism, madness in its ultimate form is man in immediate relation to his animality, without reference, without any recourse" (Foucault, 1973:74). Treatment for these "beasts" was discipline and brutality. What constituted madness was being explored.

Until the beginning of the 17th century, the four humours (sometimes referred to as "animal impulses") accounted for melancholia and mania. The qualities of each humour, coldness, hotness, dryness, and wetness, could enter into conflict with the temperament of an individual, causing a mad experience. Where melancholia was a preoccupation with reflection and a fixation on one idea, mania was an overactive imagination and a deformation of all concepts and ideas. Melancholia was accompanied by fear and sadness while with mania came impudence and fury. The qualities or essences for the two diseases varied;
melancholia was humid, heavy, and cold, and mania was parched, hot, and subject to sudden bursts of energy or violence. Although these explanations disappeared during the 18th century, the perceptions of and resulting treatments for melancholia and mania remained based in these early images (Foucault, 1973).

Hypochondria and hysteria joined the class of mental diseases late in the classical period. Medical explanations for these two new diseases were not as easily reached as for melancholia and mania which had totally organic causes. An evolution of medical thought occurred from explaining mental illness in terms of the spreading of essences to more specifically locating some mental diseases in, for example, the nervous system (Foucault, 1973). Of course, this shift in explanation was possible only with increasing knowledge about human physiology. The roles and functions of the nervous system were considered to include sensibility and irritability, sensation and movement. It was in these "diseases of the nerves" and the "hysterias" that psychiatry was born (Foucault, 1973).

Treatment for madness in the classical period reflected both the prevailing moral and medical views. According to Foucault (1973:159-177), early therapies could be grouped into four categories:
1) "Consolidation"--Because madness reflected weakness and irritability, substances that promote feelings and a proper gravity were prescribed. Direct absorption of iron filings was recommended.

2) "Purification"--Clogging of the blood caused madness. Ingestion or external application of corrosive agents such as soap, vinegar, or scabies helped to break down the black bile.

3) "Immersion"--The notions of absolution and rebirth were tied to hydrotherapy. Cold water cools the hot frenzy of the maniac, and hot water warmed the coldness of the melancholic. At the end of the 17th century, water therapy dominated the treatments for madness.

4) "Regulation of movement"--Madness involved irregular irritation of the nerves or the body; therefore, mobility was regulated. The rotary machine was one treatment mechanism that regulated internal movement.

In addition to these bases for treatment, the mad were "awakened" to their illness, establishing responsibility and creating guilt for being unable to adapt to the stresses of daily existence. In the mental institution, so strictly regimented and governed by morality, madness was unable to prevail. Guilt was the foundation for psychological treatment (Foucault, 1973). Of significant implication for modern psychiatry is "the reduction of the classical experience of unreason to a strictly moral perception of madness, which would secretly serve as a nucleus for all the concepts that the nineteenth century would subsequently vindicate as scientific, positive, and
experimental" (Foucault, 1973:197).

The massive confinement of the 17th century, primarily based upon poverty, gave way to confinement based upon either dangerousness or madness. The criminals, not the self-proclaimed humanitarians, were the first to complain about their being housed with the insane. The "mere" criminals disliked the disruptiveness of the insane and resented their mutual confinement. The insane were removed from the jails, and this further separation of the mad from society gave birth to the retreat or the asylum (Foucault, 1973).

Four characteristics are peculiar to the asylum experience: silence, recognition, perpetual judgment, and medical staffing. The last factor is the most significant for modern psychiatry and madness. Insanity and medicine became inseparable compatriots of the experience of madness. By the end of the 18th century, a medical certificate was necessary to institutionalize the mad; each confined person had to be visited by a medical doctor. Treatment was not so much medical, but rather the asylum doctor was seen as a "wise man," as a father. The metaphor of the family in the institution rendered not an understanding of mental illness, but rather a domination of the mad. The deranged were treated as children, incompetent yet paradoxically responsible. Many of the treatments developed during the earlier part of the century
now became punishments. The purification ritual of the shower was used to punish those who would not admit to (recognize, awaken to) their madness. Punishment would stop with the creation and admission of remorse.

No longer were the deranged responsible for the causes of their madness, yet they were required to take moral responsibility for their disruption of society. Treatments included rituals of social existence such as "tea parties" during which the patients would be required to follow proper etiquette. Awkwardness or social errors were regarded as failures and one, though not the only, justification for further confinement. Madness became associated with social failure. "The science of mental disease, as it would develop in the asylum, would always be only of the order of observation and classification" (Foucault, 1973:250). Patients knew that they were being observed. To be liberated (cured) of their madness, patients had to admit to their madness, take responsibility, behave "socially," and feel guilty.

England. Prior to the 19th century in England, men of medicine had little interest in men of madness. Doctors administered to the body; clergy administered to the mind or the "soul." When King George III (1760-1820) developed mania, a power struggle between the clergy and the physicians began. The opportunity to administer to King George's disorder was an impetus to separate the
treatment of the mad from the church. If doctors could transform madness to mental illness, they would be professionally responsible for treatment. The functions of the mind became conceptually distinct from the brain. The brain, as an organ of the body, was the source of most mental disease according to the physicians. After all, since the body, not the mind, becomes diseased, physicians were responsible for the treatent of mental disorders (Scull, 1981). The treatment for insanity became the domain of physicians. The social location of this treatment was in institutions. However, conditions of the institutions began to deteriorate, causing enough public concern to force parliamentary investigations.

Despite the 1815 and 1816 Parliamentary investigations into conditions and treatment within public and private institutions, and despite the discovery of abuse by medical personnel, the goal of the committees appeared to be quality of care, not the removal of the medical persons. Provision of no medical treatment was in itself seen by the committees as neglect. There was a commonly-held belief that physical ailments such as a brain lesion always accompanied mental ailments (Bynum, 1981). Bynum (1981:50) describes that although there was little empirical support for the popular brain lesion explanation for madness, three factors led to an acceptance by physicians that insanity was physiological: (1) "the conflation of the concepts of
mind and soul"; (2) "the inheritance of physical explanations from antiquity"; and (3) "the lay threat to medical control of the insane implicit in the milieu of moral therapy and early 19th century institutional reform."

Physicians obviously were successful in convincing the public that they could cure a large proportion of the mentally ill, particularly with early diagnoses. By the mid-19th century, lay reformers were content to allow doctors to maintain their reign in the institutions.

The administration of asylums centered around the virtues of work, routine, and discipline. During the Victorian period (1830-1900), the state assumed the responsibility for the care of the insane. In addition to the use of former leper hospitals to house the mad, institutions were constructed specifically to house the insane. The madhouse had become the asylum, a place of treatment; the mental hospital was created, and the mad became a patient (Scull, 1981). What emerged was a queer combination of medical treatment and moral therapy (Bynum, 1981).

Phrenology is today regarded as a non-science. It holds, however, some important historical keys for the development of psychiatry from 1820 to 1840. It was embraced by most 19th century British "alienists" (psychiatrists) because of its comprehensive yet simple explanation of human behavior. It was a flexible and
Franz J. Gall (1758-1828) is often considered the "father" of phrenology. Cooter (1981:70-72) argues that Gall was successful in convincing most of his medical colleagues of the accuracy of the first three tenets of phrenology: (1) The brain was the organ of the mind; (2) the brain was a collection of organs; and (3) each part of the brain could modify, to some degree depending on its development, a moral quality or intellectual faculty. The fourth of Gall's principles of phrenology, and no doubt the source of "the bumps on the head" description of the science, gave rise to controversy and its eventual demise: "since the cranium was ossified over the shape of the brain, one's organology could be determined by an external examination of the skull . . . " (Cooter, 1981:71-72). Moral treatments disguised as medical treatments could be utilized to suppress the disturbed organs. Mental health resulted from the exercise of mental organs. Idleness or over-activity of the brain was a precursor to insanity. Moral virtues such as chastity, sobriety, and moderation were prescribed as conducive to good mental health. Individualized treatments (case studies) began since no two people have similar cranial structures. Further, the phrenologists explained that prevention of insanity was finally possible (Cooter, 1981).

The phrenologists' reliance on anecdotal rather than
empirical evidence helped to lead psychiatry into the developing area of neuropathology, a purely physiological science. This emphasis on physical treatment led to a decline of moral therapy. Phrenology had provided a foundation for moral treatment within the realm of medicine. With the tenets of phrenology losing credibility, moral treatment became unnecessary (Cooter, 1981). The importance of phrenology in the development of psychiatry is described below by Cooter (1981:87):

Phrenology's place then in nineteenth-century psychiatry is perhaps best described as an agent that motivated and rationalized institutional arrangements and clinical procedures and provided a framework for and direction to its scientific evolution. Phrenology's influence upon psychiatry can be seen in hindsight as important chiefly in relating function to structure; showing the importance of environment in causing and for curing insanity and for the improvement of the race (in pre-Darwinian context); forcing insanity to be seen as a disease of the brain and thus bringing psychiatry into the realm of general clinical medicine as well as refusing the amount of emotional involvement with patients whose conditions could now be seen as physically based; and, finally, in giving the first impetus to individual therapy prior to psychoanalysis.

Toward the end of the 19th century, British psychiatrists rejected psychological explanations for mental illness and embraced the medical perspective. Physical health and mental health were seen as coexisting, reaching equilibrium in the "healthy" person. The mental health sphere was not self-determined (as was the physical
sphere), but rather subject to morbid states of the nervous system and the brain. Therefore, diseased physical processes caused "abnormal" mental processes. Because of the morbidity of essential mental functioning, mental health could not be restored by rational, psychological treatments. The purpose of treatments for mental disease were to achieve ideal physiological conditions so that the body could return to a perfect instrument of rational will (Clark, 1981).

The prevailing medical view of mental disorders throughout Victorian England affected psychological treatments in the practice of psychiatry in three general ways: (1) it required scientific rationales for psychological treatments; (2) it restricted psychological treatments to diagnosis; and (3) it asserted that conditions for psychological intervention were themselves disorders (Clark, 1981).

Clark (1981) illustrates the above points with hypnosis, a treatment that was utilized during the 19th century. For hypnosis to be an acceptable treatment, it had to fit into the dominant scientific philosophy; the prescribed treatment had to "cure" the mental disease. Some practitioners of hypnosis created scandalous controversy and became associated with quackery and non-naturalism. Mental symptoms manifested in behaviors were accepted for diagnosis and classification only.
Observable behaviors were symptoms, not causes of defective physiological processes. Symptoms, thus, became external to the objective, scientific pursuit of psychiatry. They became either prognostic or diagnostic tools for determining the ultimate (physiological) cause of mental illness. For some psychological treatments to be effective, particular symptoms were often required. For example, obedience and suggestibility, considered indicators of mental illness, were necessary for hypnosis to work. Some naturalists argued that using treatments which required symptoms of mental disorder precluded efficacy or a cure. As long as the symptoms continued, the treatment could continue. Because mental disorders were viewed as a departure from a healthy physiological state, most legitimate treatments in the late 19th century were physical. Any therapies which took for granted "the morbid subjectivity and moral depravity of the mentally disordered" were outside the purview of "legitimate medicine" (Clark, 1981:301).

United States. During the Jacksonian period in the United States of America, a social revolution occurred. In colonial times, institutions were the places of last resort. After 1820 institutions were erected as places of first resort, as the preferred solution for social problems such as insanity, delinquency, crime, and poverty. Rothman (1971) describes the Jacksonian era as "the age of the
asylum." Insanity was more a social than a medical problem, caused by the increasing complexity of life in the United States. The movement was not a benevolent escape for the mad, but an attempt to master madness and force it into conformity. "The well-ordered asylum would exemplify the proper principles of social organization and thus insure the safety of the republic and promote its glory" (Rothman, 1971:xxix).

The etiology of insanity in colonial America was simple; insanity was God's will. The insane were the responsibility of the family and community. Poverty and insanity were not social "problems" but social "responsibilities." The etiology determined or justified the reaction to the insane. Borrowing from the French Enlightenment and in the wake of the American Revolution, there emerged a growing recognition that insanity was becoming a social problem. Searches for non-divine causes for insanity began.

Pre-Civil War (1861) practitioners concurred that insanity was caused by a diseased brain. Neurologists claimed that lesions on the brain caused insanity. Medical superintendents acknowledged that organic problems were a likely cause of mental illness. However, the primary cause of the organic problems were the nature of social life in the United States. A New York physician in 1845 listed the following multiple causes of mental disease among his 551
patients: ill health (104), religious anxiety (77),
disappointed ambition (44), loss of property (28),
excessive study (25), blows on the head (8), political
excitement (5), and going into cold water (1) (Rothman,
1971:111).

One major source of insanity was within the family.
Excesses of ambition, zeal, and achievement present in
society were nurtured and encouraged in the family.
Medical superintendents thought the family was the ultimate
environment that perpetuated social disorganization, thus,
insanity. With the etiology of mental illness located
within the social (dis-)order, medical superintendents
sought an institutional organization which approximated a
well-ordered society (Rothman, 1971). The asylum was born
in the United States.

The physical construction of the asylums was greatly
influenced by the medical superintendents. Unlike England
and France, the U.S. did not have preexisting institutions
which were converted from leper hospitals to mad and poor
houses. Asylum construction began early in the 19th
century in the eastern states. Prior to 1810, these
private institutions cared for fewer than 500 patients who
were generally wealthy (Rothman, 1971). During the 1830's
the industrialized and the agricultural areas of New York,
Massachusetts, Vermont, Ohio, Tennessee, and Georgia all
constructed institutions for the insane. Twenty-eight of
the 33 states had public institutions by 1860 (Rothman, 1971:130).

Projections of extraordinary cure rates fueled the movement to build the asylums. Some doctors boasted 100 percent curability of mental illnesses. There existed competition among medical superintendents to release very high cure rates, and reformers wanted America to lead the western world. Mental health was restored because of the institution itself; health was not necessarily restored by medical treatment. As with their French and British counterparts, American asylums were routinized, well-organized, and moral places to cure the mentally ill. Administrative and architectural issues dominated the agenda for the first years of the Association of Medical Superintendents. Organized in 1844, this professional group was comprised exclusively of heads of asylums. Their perspective remained narrow even when faced with revolutionary ideas in the last decades of the 19th century (Rothman, 1971). The ideas which dominated these early associations are an integral part of the legacy of the American asylum.

The American asylum program had three goals: (1) the prompt separation of the patient from the community; (2) the separation of the asylum from the community; and (3) as the core of moral treatment, the asylum was to be "well-ordered" (Rothman, 1971). Humane yet firm, treatment
in the asylum included the severing of family ties; this, of course, was consistent with the prevailing etiology. Visits and correspondence by friends and family were discouraged by the physician and by the physical isolation of the institution. Politically, the further from urban areas the asylums were constructed, the more favorable the response. Not only were there no neighbors to complain, but rural land was relatively inexpensive. To allay suspicion and fear by the community and family, tours of the asylums were encouraged. The administration attempted to impress upon those touring, however, that any interaction with patients would result in a setback for the patient (Rothman, 1971).

Confinement was the cure. Life within the institution consisted of work, daily manual labor. Public asylums were particularly anxious to utilize patient labor. Competition for funds and collegial respect made administrators eager to have the insane maintain, without wages, the physical operations of the asylum. Although the overarching philosophy was for efficient benign treatment through work and discipline, and despite the opposition to harsh punishment, the institutional structure and organization made living the philosophy less than a reality. There were too few staff to personally attend the insane; therefore, mechanical restraints became necessary for control. Violent and noisy patients were not physically separated
from less disruptive patients. There was little, if any, classification of patients. Attempts to classify were usually simply good intentions. By the end of the 1840's, conditions in the American asylums had deteriorated (Rothman, 1971). More discipline was required. Rothman (1971:154) states:

Thus the insane asylum, like other corrective institutions in the Jacksonian period, represented both an attempt to compensate for public disorder in a particular setting and to demonstrate the correct rules of social organization. Medical superintendents designed their institutions with eighteenth-century virtues in mind. They would teach discipline, a sense of limits, and a satisfaction with one's position, and in this way enable patients to withstand the tension and the fluidity of Jacksonian society. The psychiatrists, like contemporary penologists, conceived of proper individual behavior and social relationships only in terms of a personal respect for authority and tradition and an acceptance of one's station in the ranks of society. . . . Regimentation, punctuality, and precision became the asylum's basic traits. . . . It was, in essence, an institution -- at its best uniform, rigid, and regular. This was the new world offered the insane.

The special qualities of the asylum were lost by the 1850's. Moral treatment gave way to custody. A failure of reform and "cure" did not cause a demise of the institutional system for the deviant. Public policy continued to focus on the insane asylum. The optimistic promises were broken, but the institutions endured. The most obvious indication of a shift from treatment to
custody was the overcrowding. The use of mechanical restraints and harsh punishments were no longer exceptional. The social disorganization outside the walls now existed inside the asylums. Ready to criticize the "confinement as cure" position were the neurologists. As before, their physiological explanations for insanity were rejected. Medical superintendents, although increasingly pessimistic about environmental manipulation as a cure, were still unwilling to support the neurologists' purely medical etiology of insanity. Legislative appropriation of maintenance funds continued, but economic crises, especially inflation, made the costs of running institutions fall outside the available funds. Not only were staff reduced in number, but the position of superintendent became a political plum (Rothman, 1971).

Reform was undermined by the economic conditions and by the superintendents' unwillingness or inability to control the composition of the patient population. When the asylums were designed and constructed, the medical superintendent expected a mixture of patients. They ended up with "the manic, furiously insane, and worse yet, the chronic, with no prospect of meaningful improvement" (Rothman, 1971:271). Moral virtues of discipline, cleanliness, and silence were not familiar or applicable to these patients. State commitment regulations took the control of intake away from the hospital administrators.
In Massachusetts, for example, the legislature prioritized admissions to the Worcester hospital. First to be admitted were the violently insane; thus, the jails were relieved of their insane inmates. Next, the indigent insane were to be admitted; the poorhouses were relieved of their insane residents. Of last priority were the non-violent, non-indigent insane. As a result, Worcester's initial population was comprised of 50 percent jail and poorhouse transfers and 33 percent chronics who had already been confined for up to thirty years. Sixty-five percent of the total population was perceived as violent (Rothman, 1971:272). Between the 1840's and the Civil War, hospitals such as Worcester saw some improvements in the conditions and in the patients. This reform was short-lived (Rothman, 1971).

The chronically mentally ill filled the institutions in the years following the Civil War. Superintendents were faced with the dilemma of discharging these "incurables" to a rather bleak, deprived existence in the community or keeping them, admitting to the failure of the asylum to cure insanity. The choice for most hospital directors was to keep the chronic patients. Midway through the 19th century estimates for recovery had dropped to approximately 25 percent. The custody role of the institutions was rationalized so that it became a disservice to the chronic patient to be discharged into the community where care and
services were unavailable. Not only were public institutions unwilling to exclude chronic patients, but private hospitals as well admitted nearly any patient; those who paid, stayed. As guidelines which restricted the population composition were ignored, treatment became custody (Rothman, 1971).

Reforms were suggested to alleviate the "chronics'" domination of the public (and private) hospitals. The American Medical Association recommended the construction of separate facilities for acute and chronic patients. Asylum directors opposed this policy, stating that exclusively chronic institutions would deteriorate into the worst possible places. Medical superintendents were justifying their endurance on the cleanliness of the institutions when compared with the poorhouses and jails and on their caring for the chronically mentally ill. Little mention was made of curing insanity. Rather than establish a separate mental institutional system, officials deferred to the opinion of the superintendents. After all, the mental institutions had become a convenient place to confine lower class and foreign-born patients (Rothman, 1971).

By the middle of the 19th century, immigrants made up a disproportionate number of patients in both public and private hospitals. Eastern institutions in particular were heavily endowed with foreign born patients. As expected,
nearly all of the patients at the New York City Lunatic Asylum were immigrants, primarily Irish. In 1861, in Ohio at Longview Asylum, 67 percent of the patients were foreigners (Rothman, 1971:283). In addition to housing primarily immigrants, institutions saw an influx of indigent patients. The Central Ohio Lunatic Asylum would admit only the indigent insane in 1852. Custodial care became further rationalized by medical superintendents and accepted by the public. There was a (perpetuation of the belief) that the insane, especially the manic patient, was subject to sudden, unpredictable violence. The public embraced the mental institution as an acceptable means of mollifying the potential threat posed by the insane. It was commonly believed that the immigrants and lower class bred violence and insanity. The institutions became the dumping grounds for society's undesirables (Rothman, 1971). The reform ideology of the early 19th century asylum movement that stressed isolation for the patients' benefit took a peculiar turn. Institutions and the mentally ill needed to be isolated to protect society.

Summary

The mad became bad. The bad became ill. This transformation is not simply semantic but rather represents a number of changes in Europe and in the United States. In general, three major factors are greatly influential in the
identification of the mad as a population in need of official response: the great confinement(s), the French Enlightenment, and the emergence of medicine as a positivistic science.

Foucault (1973), Scull (1981), and Rothman (1971) provide detailed descriptions of confinement movements in England, France, and the United States respectively. In England and France, the poor were selected for confinement, and in the United States the poor and the immigrants were confined. A potentially threatening class of people were identified and conveniently confined. Neither Foucault nor Rothman argue that these confinement movements were humanitarian in motivation. Goals of treatment and curability were *ex post facto* rationalizations.

Philosophical influences of the French Enlightenment affected society's reactions to the mad. Increased secularization of thought forced pursuits into etiology of madness. Prior to the Enlightenment, madness was seen as exclusively divine punishment. Responsibility for care rested with the family and community as God's will was simply accepted. During the Enlightenment, however, human thought became volitional. People were rational beings, and madness was a breach of rationality. Separate facilities were constructed to master madness, to harness irrationality. Routine, orderliness, silence, discipline, and other Victorian virtues dominated the formal and
informal organization of the 19th century European and American insane asylums. Confinement in a well-ordered institution would cure insanity.

A final major impact on the 19th century development of psychiatry was the growth of scientific knowledge in medicine. Phrenology allowed treatment to coexist with physiological therapies. Compared with today's medical practices, the 19th century practices appear relatively barbaric. Yet toward the end of the century, the neuropathologists challenged the non-treatment orientation of the asylum. They argued that insane asylums should become teaching and research hospitals with a commitment to curing mental illness. These confrontations were not realized in the late 19th and early 20th centuries. Medical superintendents, who clung to the environmental causes of insanity, stood their ground. The asylum endured.
CHAPTER THREE

SOCIAL REACTIONS TO MENTAL ILLNESS: TREATMENT OR CONTROL?

At the beginning of the 20th century, mental illness was treated in the asylum. With the exception of a few experimental drugs, therapy was undirected and noncurative; treatment was nihilistic. The prospects for curing mental illness were grim. Medical superintendents of state insane asylums were politically powerful and had a corner on the treatment market. If patients' basic needs of food, clothing, and shelter were met, the state had fulfilled its responsibility to the indigent insane population. The asylums well-served the economic, political, and social needs of the time.

Winslade (1981) and Rothman (1980) argue that a few decades into the 20th century, notions of reform and alternatives to the asylum system emerged. Horror stories of the asylum became public knowledge, arousing some interest in etiological research and in searching for non-institutional methods of curing insanity. Leaders in this movement were the neuropathologists. What resulted was a forerunner of today's community mental health and
acute diagnostic centers and a continued burgeoning of the asylum population. Both Winslade (1981) and Rothman (1980) identify the years from 1870 to 1930 as (a continuation of) the "custodial" period in American psychiatry. The years from 1930 to 1950 are referred to as the "therapeutic" period by Winslade (1981) and as the "progressive" period by Rothman (1980). Winslade (1981) further identifies the period between 1950 and the present as the "health systems" period.

Throughout American psychiatry until the 1950's, physicians of one persuasion or another dominated the area of mental health. As the field of medicine increased in sophistication so, too, did the treatments. The therapeutic nihilism of early 20th century psychiatry gave way to some psychological and psychosocial treatments as well as to limited drug therapy; the case study approach to treatment began. Prior to World War II, psychologists were few and far between. Stresses associated with "battle" became an impetus for the growth of the profession of psychology. The midpoint of the 20th century played host to a number of changes in the internal and external climate of the asylums.

Some students of mental illness recognize 1950 as the turning point of modern psychiatry. Drug therapy as a major form of treatment emerged in 1950's with the
marketing of Thorazine. There were movements to empty out the asylums. "Deinstitutionalization" and "community mental health" entered the vocabulary of professionals and laypersons alike. Critics among the ranks of psychiatrists issued sweeping condemnations of the very foundations of psychiatry from diagnosis to treatment (Szasz, 1956; 1960; 1965). Social scientists of the interactionist perspective criticized psychiatry and the detrimental effects of labeling some as mentally ill (Goffman, 1961). Attention became focused on the mental health system. When lawyers became activists in mental health law in the early 1970's, patients' rights were formally recognized.

This chapter examines psychiatry and the treatment of mental disorders in the United States from the turn of the century to the present. Specific attention is given to the institutional climate and treatment of mental illness, focusing particularly on psychotropic medications. Also discussed are the criticisms of psychiatric treatments or the "control" of mental disorders and the emergence of a mental patients' rights movement.

Treatment of the Mentally Ill

The Progressive Era (1900-1950). Progressives believed that non-institutional programs could coexist with institutions. Rather than replace institutions, reform programs became supplements to institutions. Instead of
decreasing the number of mentally ill within the state system, community programs extended the "net" of treatment. In the case of institutional treatment, Progressives of the early 1900's did not advocate tearing down the asylum walls. The Progressive or reformist itinerary had three paths: (1) individualized history, (2) construction of new facilities as alternatives to asylums, and (3) education of the public to prevent mental illness. Their goal was to reduce the incidence of insanity by branching out beyond the asylums and into the community (Rothman, 1980).

On the 50th anniversary of the American Medical Superintendents Association in an address to the members, S. Weir Mitchell, a neurologist and critic of the asylum system, attacked the entire state asylum system. According to Mitchell, the asylum had lost any legitimate reason for existence. The medical profession had learned nothing about insanity in the decades since the building of the asylums. Medical superintendents had failed at both cure and custody (Rothman, 1980). Mitchell, a physician, was analyzing the role of the asylum from its explicit purposes, custody and cure. The convenience of controlling a perceived dangerous class (the poor immigrants), the economic value of the institutions, and the political power of the superintendents were factors extraneous to his criticisms. In short, he, too, acknowledged these functions of the asylums.
A further indictment of the treatment for the insane was an ex-patient's autobiography (Beers, 1917). The author described the patients' perspective on insanity as well as the brutality of the attendants. Because the medical superintendents were aware of the abuse and allowed it to continue, the author held them directly responsible for the conditions in the asylums (Rothman, 1980). The asylum system and the hospital directors came under professional and public attack.

Individualized treatment or a "life chart" was essential to determining the causes of mental illness (as well as other forms of deviant behavior). Progressive psychiatrists such as Adolf Meyer thought etiology could be found in the facts of the case. Insanity was "maladaptation" to life circumstances. To discover each patient's unique diagnosis and prescribed treatment, psychiatrists had to go into the "field." Early intervention would preclude the development of serious disorders. The Progressives were committed to "civic medicine" as Meyer referred to this new practice. All components of the community were potentially important factors in the detection and prevention of mental illness. Activities that had been called "immoral" were referred to as "unhealthy." Sexual promiscuity led to syphilitic infections which caused the softening of the brain, an incurable disease called paresis. Continued use of alcohol, opium, morphine, and cocaine weakened mental
powers, causing insanity. Meyer's civic medicine offered such grand promises that it had to be transformed from ideas into programs. The psychopathic hospital and post institutional programs were the answer (Rothman, 1980).

By design, the psychopathic hospital included an outpatient clinic which was convenient, did not carry the asylum stigma, helped more people early in their disorder, and produced high cure rates. Additionally, a short-term inpatient unit was included. The function of the inpatient unit was research and teaching. Lastly, the psychopathic hospital performed diagnostic and referral services for a wide variety of community organizations. Regardless of contradictory interests, professional people supported the concept. Curable patients were candidates for another Progressive program -- after-care. The goals of after-care were independence and adjustment to the community. A "friendly visitor" would periodically follow-up the patients, noting progress or recommending readmission to the asylum. The friendly visitor became the professional social worker (Rothman, 1980).

Education of the public to the perils of mental illness was the third major task for the Progressives. The National Committee for Mental Hygiene (NCMH) performed the role of dissemination of information. In New York City the NCMH distributed pamphlets entitled, "Why Should Anyone Go Insane?" Their campaign included exposing the public to
the high costs of institutionalization, the benefits of early detection, and the virtues of leading a healthy life. Included in their overall campaign was reform of the asylums (Rothman, 1980).

The Progressives did not advocate destruction of the asylum system. The community system intended to deal exclusively with curable or acute incidences of mental illness. The state insane asylums were necessary to care for the incurable chronic patients. The reformist rhetoric, which at first appeared to be a threat to the medical superintendents, was welcomed by the hospital directors. The asylums were needed to confine the chronic and violent patients. Not only was custody expected as every other treatment was exhausted at the community level, but the physical isolation of the patients and the facilities was desirable. The asylum back wards which gave some impetus to the Progressive movement were now anticipated and a legitimate condition in the asylum.

The Progressive dreams of the psychopathic hospital remained just that, dreams. Only a few psychopathic hospitals were ever constructed, and those became simply the front door to the state asylums. These progressive facilities became a convenient path to custodial care. The ultimate purpose of the psychopathic hospital may have been a further legitimating force for the state asylum. If a patient was in the community hospital and the physician
recommended a transfer to the state hospital, it appeared that the alternatives had been exhausted. Along with the patients from the hospital came a name change for the state asylum. A number of institutions changed their name to "state hospital"; attendants became nurses. Like the state asylums, the state hospitals received a large proportion of chronic patients who often never left the hospital. Custody still prevailed (Rothman, 1980).

Treatment in the state hospital usually began with an extensive individual intake record, a successful input from the reformists. Patient behavior was then observed on the ward with little attention ever again being given to the case history. Patients were assigned to a ward based upon their early behaviors. Charting decreased in frequency the longer the patient stayed. Although some experiments with drugs were undertaken with the state insane population, the major treatment was labeled as occupational therapy but was actually institutional peonage. The inmate patients were necessary for the maintenance of the hospitals. In addition to labor, Greenblatt (1978:102) describes the available therapies:

"Seclusion": Many dangerous, impulsive, disruptive, and belligerent patients were incarcerated in locked rooms or cells with little or no furniture. Interruptions of the tedium were only for feeding, toileting, perhaps for a physical examination or for medication.
"Forced Tube-Feeding": Patients who manifested hostility, fears, and disorganization by refusing to eat were forcibly restrained and tube-fed. This severe and destructive indignity was compounded by the danger of aspiratation pneumonia whenever the fatty, viscous tube feeding mixture spilled into the respiratory tract of the struggling patient.

"Chemical restraint": Heavy doses of medication, usually administered parenterally, were given to disturbed patients who, it was thought, could not otherwise be controlled.

"Continuous tubs": Agitated, depressed patients were soaked for long hours in tubs of water, heated to body temperature. Not a few such patients attempted to drown themselves.

"Physical restraints": Patients labelled 'destructive' were spread-eagled on a bed, and thongs attached to hands and feet were tied to the bedposts.

"Wet-sheet packs": Patients were wrapped in wet sheets to reduce body movements and to quiet agitation. The risk of hypothermia and death was significant.

The patient population was chronic. "Call a facility a hospital, use the rhetoric of the mental hygiene movement, but ultimately know that the institution was in the asylum business" (Rothman, 1980:349). The character of the asylum had not changed. Prior to World War II, approximately 40 percent of the asylum population was over 50 years of age; the "senile, syphilitic, and alcoholic" patients made up 13 percent of the population while the schizophrenic patients accounted for 45 percent. Evidence that once one was committed to a state hospital, the stay would more than likely be long is that one third of the
patients had been in the hospital for more than ten years. The patients in the state hospitals apparently had few options. In 1920, foreign born individuals made up 14.5 percent of the U.S. population; however, they accounted for 30 percent of the institutional population. Most patients were indigent (Rothman, 1980:350). Admissions continued to increase, and the discharge rates were low. The national figures for 1922 and 1939 show the number of admissions to state hospitals increasing from 64,000 to 108,000, and the daily patient census increased from 230,000 to 440,000 with no new asylum construction. It seems obvious to state that most hospitals operated over capacity. Staffing was also a major problem in the state hospitals. The doctor to patient ratio from 1900 to 1940 was 1:250. Turnover was rapid among professionals and attendants alike. Working conditions were dangerous and thankless. Abuse was rampant, and much went undetected or overlooked, but occasionally attendants were dismissed for brutality (Rothman, 1980).

The air of hopelessness that pervaded the state hospitals, together with their difficult patients, short-handed and badly trained staff, overcrowded wards, and ineffective treatments, meant that institutional life would be in a very real way, dangerous. This kind of care, however well-intentioned, generated abuse. . . . Given the primitive techniques available to physicians [as those described above], it is not clear how and where one draws the line between good faith (albeit crude) treatment and outright punishment. . . . hours in restraint . . . frequent use of
seculsion . . . transfers to violent wards . . . "occupational therapy" . . . probably served the institution more than they benefited the patient, and may have been actually injurious (Rothman, 1980:360).

Programs of the Progressive movement met resistance from the administrators of the state asylums. The patients who were best qualified to enter into "family living" or boarding arrangements were often the best workers in the institutions. Their labor was necessary to the institution. Although possibly more cost effective in the long run, community alternatives such as the boarding program were not financially supported by the state legislatures. The funding would have to be assumed by the hospitals, a very unlikely prospect. Parole of mental patients was also proposed by the mental hygienists. Again, this program interfered with the running of the hospitals. Those patients ready for release were usually the better workers. As with the boarding and parole programs, outpatient services were undercut by the asylum directors and the community. Already scarce resources would have to be shared, and the community did not want insane people in their neighborhoods. Programs which would have helped to ease the overcrowded conditions and financial strains were capped by the medical superintendents because of the needs of the institution (Rothman, 1980).
The asylums survived the Progressive and reform movements. Medical superintendents cited their function in the community as "taking care of the 'social waste'" (Rothman, 1980:374). Few people were eager to assume this gruesome task. The population of the U.S. had increased 2.6 times from 1880 to 1940 while the state hospital population had increased 12.6 times. The rates of commitment increased from 159 to 332 per 100,000 (general population). In 1946, the admission population was, in a word, chronic: 28 percent senile, 19 percent schizophrenic (yet accounted for more than 50 percent of the resident population), 6 percent syphilitic, and 4 percent alcoholic. In New York in 1947, 27 percent of the hospital population had been confined for more than fifteen years (Rothman, 1980:374). The function and role of the state hospital in 20th century America was defined.

From Custody to Therapy (1930-1950). Changes in treatment modalities and personnel within the institutions began in the period which Winslade (1981) calls the "therapeutic period" from 1930 to 1950. Electro shock for the depressed, insulin shock for schizophrenics, and lobotomies for the hopelessly anxious appeared in the 1930's. Finally the "incurables" could be helped. In addition to these intervention techniques, the influx of central European psychoanalysts brought psychoanalysis to the mentally ill. Not only were there changes in the
therapies available in the mental hospitals, but social scientists who did research in the hospitals placed emphasis on the mental health community or milieu. Causes of mental illness were biological, physical, psychological, and social. Psychologists, nurses, and social workers joined the psychiatrists in the newly-founded optimism in the treatment of the mentally ill.

The mental health professional explosion occurred in the years following World War II. Psychoanalysis had proven to be successful with troops in the battlefield. Psychiatrists not only provided one million men with psychiatric excuses for not being drafted, but they sent home two million men with psychiatric discharges (Winslade, 1981). Clinical psychology assumed the professional responsibility for psychoanalysis with neurotic patients, leaving the psychotic institutionalized patients the responsibility of the psychiatrists. Because the United States citizenry was having (and is still having) a "love affair" with science and technology, the scientific intervention techniques utilized by psychiatrists were welcomed. The psychiatrists also enjoyed considerable political support with the creation of the National Institute of Health (NIH), the National Institute of Mental Health (NIMH), and the Veterans Adminstration (VA), all of which supported research in the area of psychiatry (Winslade, 1981).
The philosophical mood of this period was pragmatic and positivistic; treatments had to be scientific, show results, and be the responsibility of a scientist, the psychiatrist. Not only did scientists know what was fact, but they could determine what was best. The role of the patient in this new approach to treatment was cooperation with the psychiatrist. It was believed that patients could reach their maximum functioning level as long as they had "insight" into their illness and recognized that the treatment was in their "best interests." The psychiatrists expected the patients to simply comply with their prescribed therapies. "If the patient cooperated by accepting transference, dependence, and therapeutic authority, there was the prospect of being successfully or fully analyzed" (Winslade, 1981:45). There was a major snag in the understanding that psychoanalysis was the preferred treatment for many of the mentally ill; it was expensive and its results amorphous, read -- unscientific.

The Introduction of Medications. Since the 1950's drug therapy has emerged as the dominant treatment for mental illness. One result has been a marked decline in the resident population in state mental hospitals. The community mental health movement of the 1960's has not reached expected goals within projected costs. However, there exists a push for the "least restrictive alternative" which is generally seen as non-institutional. Patients,
therefore, are released into the community more quickly because of both psychotropic drugs and fiscal pressures. Despite the fact that the resident population of state hospitals has significantly declined since the 1950's, the first time admission and readmission rates have steadily increased (Greenblatt, 1978).

Within the state hospital system, the conflict between liberation (from mental illness) and cost effectiveness has clouded the discussion of whether alternative therapies such as psychoanalysis and behavior modification or drugs are in the "best interests" of the patients. Many clinicians argue that drugs make patients more open to other forms of therapy, but whether these other therapies exist in state hospitals is yet another side to that issue. That drugs often reduce psychotic symptoms and allow for a rapid release from the institution is part of the cost effectiveness argument, while the long term psychological costs to the patient are not articulated in the cost effectiveness perspective. Further, quick inexpensive solutions to human problems are attractive to the American population (Winslade, 1981). A balance between liberation and cost effectiveness appears to be possible when looking at short range goals of state psychiatric care of the mentally ill. However, long range release from mental illness and psychological costs associated with "quickie" solutions do not weigh so favorably for drug therapy.
Psychopharmacology is particularly attractive to psychiatrists. Not only does the primary treatment for mental illness remain within (or return to) the professional expertise of physicians, but by relying on drugs, psychiatry is in the mainstream of medicine and science. Because drugs can be used to quickly control patients, their use is consistent with persisting views of mental illness -- that it needs to be dominated or controlled. Psychiatric treatment during this "health systems" period is aimed at relief of symptoms, often through medications, not at the curing of mental illness. There is some professional interest in etiology of mental illness, but because of multiple diagnoses, treatments are usually a combination of drugs and group, occupational, and milieu therapy (Winslade, 1981).

"There are no harmless medications" appears to be a harmless enough statement. This statement when referring to psychotropic drugs, however, often elicits the retort that "even penicillin can kill." That is begging the question. The point is that the purpose of all medications is to alter body chemistry. Eric Martin (1978:1) argues that ". . . safe and effective drug therapy demands profound knowledge of every drug product being prescribed, thorough patient analysis, and adequate patient education." Martin continues, "If these three essentials are observed, most drug-related malpractice litigation can be avoided"
Although psychiatrists are involved in little malpractice litigation, a 1981 case in Iowa (Clites v. Iowa) held the facility and physicians liable for negligence in prescribing of medications and for failure to obtain informed consent (Klein and Glover, 1983). Drug treatment to be therapeutic must fit the diagnosis, be appropriate and available for the patient, prescribed with clear directions and full awareness of hazards, be of high quality, and involve attentive and complete follow-up evaluation (Martin, 1978).

All medications produce side effects, some desirable and some undesirable. Psychotropic drugs can produce the adverse reactions listed in the Physicians Desk Reference which range from nausea to death. The less severe reactions occur more frequently, and the more severe less often. The most disturbing side effects of psychotropic drugs are the extrapyramidal symptoms (EPS). A large percent of patients who receive psychotropics develop one or more of these sometimes bizarre symptoms. It is unknown what causes differential development of EPS; each patient seems to have his or her own level of drug susceptibility. The classes of drugs most often associated with EPS are the phenothiazines or neuroleptics (Thorazine, Prolixin, Trilafon, Mellaril, and Stelazine), butyrophenones (Haldol), and thiozanthenes (Navane) (Greenblatt, et.al., 1970). (For a more complete list of
medications, see Appendix A.)

Most phenothiazine-induced disorders are reversible and fall into three broad categories: dystonic reactions, akathisia, and parkinsonian reactions. Greenblatt et al. (1970:93) list the symptoms of each:

"Dystonic reactions"
1. dystonias—exaggerated posturing of the head, neck, or jaw: neck twisting, torticollis; spasms of muscles of lips, tongue, face, or throat; tongue protrusion or curling, facial grimaces, and distortions, difficulty in speech and swallowing; hyperextension of neck and trunk: opisthotonus (arching of back); oculogyric crisis (fixed upward gaze).
2. dyskinesias—clonic involuntary contractions of muscle groups: facial tics and twitches, chewing movements, lip smacking, blinking, aimless movements of tongue, shoulder shrugging, pedaling movements of legs.

"Akathisia"
Inability to sit still, intolerance of inactivity, continuous agitation and restless movement, rocking and shifting of weight while standing, shifting of legs and tapping of feet while sitting.

"Parkinsonian reactions"
1. akinesia—rigidity and immobility, stiffness and slowness of voluntary movement, mask-like immobility of facies, stooped posture, shuffling, festinating gait, slow monotonous speech.
2. tremor—regular rhythmic oscillations of extremities, especially hands and fingers; pill-rolling movements of fingers.

EPS can generally be alleviated by lowering the dose or discontinuing the medication. Because of the therapeutic costs involved in discontinuing drug treatment, a synthetic antispasmodic parasympatholytic
(antiparkinsonian) agent is prescribed. Most patients experience only partial relief of EPS (Greenblatt et. al., 1970). These antispasmodics themselves can produce central nervous system toxicity, constipation, dryness of the mouth, and blurred vision. Two additional alternatives exist, the use of a tricyclic antidepressant which can be useful in the treatment of parkinsonianism or the use of thioridazine (Mellaril) which has both antipsychotic efficacy and lower incidence of EPS (Greenblatt et. al., 1970).

The most disturbing and controversial adverse reaction to psychotropic medication is the irreversible side effect, tardive dyskinesia:

Lingual-facial hyperkinesias: smacking of the lips, sucking movements, chewing movements, rolling and protrusion of the tongue, blinking, grotesque grimaces, and spastic facial distortions; choreoathetoid movements of extremities: clonic jerking of fingers, ankles, and toes; and tonic contractions of neck and back muscles (Greenblatt et. al., 1970:96).

Tardive dyskinesia occurs insidiously, often taking a couple of years of drug therapy before the symptoms are noticed. However, onset can be almost immediate. The disorder is unrelated to the specific drug used (among the phenothiazines), dosage, treatment schedule, or existence of reversible EPS (Greenblatt et. al., 1970). In fact parkinsonianism and tardive dyskinesia seem to have a
reciprocal relationship (Baldessarini and Tarsy, 1978). Often tardive dyskinesia symptoms appear only after the psychotropic drug is discontinued or the dose lowered. "Tardive dyskinesias are not alleviated by antiparkinsonian medication, and indeed are often made worse by it" (Greenblatt et.al., 1970:96). Who is most susceptible has not been established either clinically or neuropathologically. Some critics argue that tardive dyskinesia is not irreversible and is simply the lingering effects of the phenothiazines in the body. The physical manifestations of this disorder whether irreversible or simply lingering can cause embarrassment to the patient, the family, and the treating physician (Greenblatt et.al., 1970).

It is well-established that tardive dyskinesia is drug-induced. It was thought at one time that schizophrenics were more susceptible. However, schizophrenics not treated with drugs do not develop the disorder. Although the disorder has been reported more often in schizophrenics, this is (probably) the result of prolonged treatment with neuroleptics. Additionally, non-psychotic patients (e.g. personality disorders) treated with neuroleptics have developed tardive dyskinesia (Greenblatt et.al., 1970).

Baldessarini and Tarsy (1978:999) stress the importance of preventing tardive dyskinesia. They state,
"Long-term neuroleptic therapy in the management of psychoneurosis, anxiety state, personality disorders, depression, and mania, or chronic pain syndromes, for example, should be discouraged" (1978:999). As with early intervention in psychosis leading to a more favorable prognosis, early recognition of tardive dyskinesia suggests a better recovery. The American Psychiatric Association makes the following recommendations: minimum effective doses, avoidance of polypharmacy, reduction in use of antiparkinsonian agents, discussion of hazards with patients and family, examination and re-evaluation of the patients regularly, ideally stopping drug treatment with the first indication of tardive dyskinesia, and treating tardive dyskinesia with benign agents as long as possible (Mental Disability Law Reporter, 1980).

Chemical Therapy: Ethical and Philosophical Queries

It is clear that psychotropic medications temporarily or permanently affect the human body. What is less clear is how these drugs affect the body and, equally importantly to some critics, how psychotropic medications affect the mind. Although it is difficult to place aside the pragmatic issue of short term cost-effectiveness, ethical and philosophical issues need to be addressed. Emerging in part from the growing evidence of irreversibility of adverse side effects, there is an increased interest in
medical ethics. The ethical questions such as short and long range efficacy of psychotropic drugs can be discussed with the philosophical questions.

The history of political philosophy is rich with attempts to understand the delicate relationship between liberty and authority. Physical and psychological medical interventions are examined within this dichotomy of person and society. It is argued that liberty, or freedom from external coercion, is intimately connected to the spirit of human existence, but that no right to liberty is so great that absolute freedom is expected (Beauchamp and Walters, 1982). There are many principles upon which the state or some other political or social authority may justify the subrogation of individual autonomy. Beauchamp and Walters (1982:37) recognize four "liberty-limiting principles" in the body of philosophical discussion of this issue:

1. "The Harm Principle" - A person is justifiably restricted to prevent harm to others;
2. "The Principle of Paternalism" - A person is justifiably restricted to prevent harm to self;
3. "The Principle of Legal Moralism" - A person's liberty is justifiably restricted to prevent that person's immoral behavior; and
4. "The Offense Principle" - A person's liberty is justifiably restricted to prevent offense to other caused by that person.

The literature discussing psychiatric treatment and prevention in the mental health area does not rely so
heavily upon the principals of "legal moralism" or "offense." Instead, social control of both physical and mental illness draws directly from the principle of "harm" and "paternalism." Both Thomas Hobbes (1962) and John Stuart Mill (1977) agree that the only condition under which the state is justified in limiting the liberty of individuals to control the functions of their bodies is based upon the harm principle.

Subjects have liberty to defend their own bodies, even against them that lawfully invade them . . . When therefore our refusal to obey, frustrates the end for which the sovereignty was ordained; then there is no liberty to refuse: otherwise there is (Hobbes, 1962:164-5).

One very simple principle is, that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can rightfully be exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant (Mill, 1977:186).

The decision by authorities to focus some official response (to punish or to treat) toward an individual's body is just, according to the harm principle, for purposes of control or avoidance of behavior dangerous to others. When official reactions focus upon the control of self-destructive behavior, paternalism prevails and is unjust according to the arguments of Hobbes and Mill.
The issue of paternalism becomes more difficult, however, when the individual is perceived as being incompetent to make decisions for himself or herself. Some (Appelbaum, et al., 1981; Roth et al., 1982) argue that many forms of psychosis render the "victim" incompetent to make informed decisions concerning treatment. Until approximately the 1950's, all mental patients were presumed to be incompetent to make most decisions (Winslade, 1981). The philosophy of both clinicians and the judiciary began to evolve throughout the 1960's and 1970's to accept that some patients are competent to decide in his or her own best interests. The current position of the courts as expressed in Rennie v. Klein (1979), however, is that all patients are presumed to be competent and that incompetency must be determined judicially or quasijudicially.

Parens patriae (paternalism) is not a new concept. Its application to mental health and criminal justice is historically documented (Kittrie, 1971; Platt, 1969; Schurr, 1973). The practice of the sovereign as parent to the insane is evident to a limited degree in 14th century England. Guardianship laws (which even predate European societies) required that the crown take the responsibility for the insane; this practice was imported to the United States through our system of Common Law. As protective functions of the state increased, the "welfare state"
emerged (Kittrie, 1971). Only recently has the authority of our "kindly parent" been challenged by its beneficiaries. Rather than simply be protective, the state became the "therapeutic state." Social problems such as mental illness, poverty, delinquency, and crime had to be prevented (Kittrie, 1971).

The therapeutic state is not just a new name for the welfare state. Science, not faith, is the foundation for the therapeutic state; with the help of science, agents of the state know what is best. With moral problems becoming medical problems, imposed and experimental intervention for the good of society was possible. The parens patriae power within the welfare state justified the compulsory treatment of the therapeutic state. The distinction between voluntary versus involuntary treatment became blurred (Kittrie, 1971). Kittrie (1971:41) argues that "the state's therapeutic function is often authoritarian and may be exercised on a deviant [an insane] individual for the asserted public interest with little or no consideration of his own choice." The therapeutic state is not only a benevolent parent but an authoritarian parent as well.

Control by authorities acting in the best interest of an individual or class forces to the forefront arguments of a balancing of interests: the individual versus the state. Winslade (1981) refers to this in the mental health context
as person-oriented versus social-oriented treatments. Dworkin (1977) argues that in all cases the agent exercising authority over the individual must assume the burden of proof that individual liberties are in need of control. Some argue that institutionalization itself, whether voluntary or involuntary, is evidence enough for having the authority to act in the best interests of the person. When asked if patients should be required to accept treatment, state mental health staff often respond, "If they didn't need treatment, they certainly wouldn't be here." Because the principle of paternalism requires restriction to prevent harm to self, harm must be extended to include "psychological harm" for the non-suicidal, non-dangerous person. Paternalism as the basis for forcing treatment requires a broadening of the traditional definitions of harm to include amorphous claims such as "mental deterioration" and "psychiatric emergency."

The conflict between individual autonomy and state authority over mental patients gained national attention as early as 1845 with the case of Josiah Oakes (Tancredi et al., 1975). Oakes requested to be released from confinement, asserting that he had been committed without justification. The Massachusetts Supreme Court denied his request, holding that "the confinement of a mentally ill patient should continue as long as it is required for the patient's own safety or for that of others and that this is
the 'proper limitation'" (Tancredi et.al., 1975:11). Kittrie (1971) argues that the Oakes case is not a therapeutic justification for confinement as the decision falls within the guidelines of paternalism and prevention of harm to others. It must be recognized, nevertheless, that decisions such as this corresponded with an expansion of the commitment laws, justifying commitment based solely on the need for treatment (Tancredi et.al., 1975). In the Oakes case, both the principle of harm to others and a "restrictive" interpretation of paternalism were used to justify the state's control over the psychiatric patient. The law in this context was not concerned with Oakes' rights. Instead, of primary concern was the state's power to regulate behaviors under the authority of prevention of harm to self and others. This generous "net" of control gave considerable power to the medical psychiatric profession.

The Critics of Psychiatry

Criticisms of psychiatry range from the institutional treatment of the mentally ill (Goffman, 1961; Perrucci, 1974) to the utilization of the medical model (Foucault, 1976; Tancredi et.al., 1975) to questions concerning the definition of madness as an illness (Hills, 1980; Scheff, 1975; Szasz, 1974). Goffman's classic work Asylums (1961) describes in fascinating detail life in the mental hospital
66

as a total institution. Goffman (1961:5-6) states:

[Whereas] a basic social arrangement in modern society is that the individual tends to sleep, play, and work in different places, with different co-participants, under different authorities, and without an over-all rational plan. The central feature of total institutions can be described as a breakdown of the barriers ordinarily separating these three spheres of life.

According to Goffman (1961), the characteristics of total institutions are: (1) life in the institution is conducted in the same place under the same authority; (2) all activities are executed among a large group of the same people; (3) all activities are tightly scheduled with formal and explicit rules; and (4) all of the activities are planned to meet the official goals of the institution. People in a total institution are carefully watched, making certain that there are complying with the rules and regulations. The managers and the managed are both structurally (bureaucratically) and social psychologically distant. Descriptions of the asylums in the 19th and 20th centuries provided earlier in this chapter and in Chapter Two provide the foundation for an understanding of the mental hospital as a total institution.

Perrucci (1974) expands Goffman's analysis to include the continuous attempt to destroy the pre-institutionalized sense of self since, it is claimed, it was that characteristic which brought the patients to the
institution. Perrucci describes patient adaptation to the often contradictory norms present in the mental hospital. Patients can withdraw or flee the situation. These patients neither initiate nor respond to interaction with patients and staff. Accommodation is conforming both to staff and patient expectations. A patient who accommodates is often viewed as the "perfect patient." The conversion adaptation occurs when patients develop a strong identification with the staff. These patients often provide a source of conflict among the staff in that they are useful (gopher) but encroach upon the distance characteristic between staff and patients. Lastly, patients can become resistant. Resistant patients are not necessarily disruptive or noncompliant with rules. These patients recognize the barriers between staff and patient but recognize the need to "play their game" to be released.

Both Goffman and Perrucci observed staff and patient relationships in a mental institution, the former in the mid-1950's and the latter in the early 1970's. Although their statements and conclusions are not necessarily in and of themselves critical of psychiatry, their rich descriptions of the patients, the staff, and the facilities can lead to a rather morbid and pessimistic view of the state treatment of mental illness in the United States. It requires for some a "wild stretch of the imagination" to conclude that conditions and treatment has improved
significantly in this century.

Research by Dinitz et al. (1967) and Townsend (1978) help to affirm, in part, Goffman and Perruci's implications that institutionalization of the mentally ill can negatively affect psychiatric outcomes and actual progress. Dinitz et al. (1967) found the schizophrenics treated at home had significantly better outcomes when matched with controls treated in the hospital. Townsend (1978) found that playing the game in American institutions can lead to earlier releases. Rebellious patients often find their behaviors incorporated into both their diagnosis and treatment. Staff often state, "Patients need to learn that compliance with treatment leads to a more rapid release."

The psychiatric perspective applies the medical model in the study and treatment of mental disorders. Although European psychiatrists adhere more fully to physiological explanations than do American psychiatrists, the mental disorder as mental illness perspective dominates the field (Townsend, 1978). Symptoms of mental illness are ordered into diagnostic categories and used for prediction and control of the mental illness. Common causal factors can be genetic, biochemical, psychological, or environmental. These factors are then utilized to reach a greater understanding of the etiology, diagnosis, and treatment of the illness. The focus of the psychiatric or medical model is the individual, not social reactions to the individual
(Horwitz, 1982).

Foucault (1976) argues that "pathologies of the mind" being methodologically and conceptually parallel to "pathologies of the body" is purely mythical. He asserts that, unlike other areas of medicine, psychiatry cannot adapt abstractions of part-to-whole in explaining causality of a disorder. For example, a physical ailment can be more fully understood in the larger context of the whole physical body. Mental disorders, however, cannot be analyzed from afar in relation to the whole mind. The physiological limits are more definitive than mental boundaries. The physiological effects of treatments for mental illness such as lobotomies, ECT, aversive shock, and psychotropic medications are presented much more clearly than are the psychological effects. There exists, states Foucault (1976), some scientific or measurable notion of normal and pathological states of the body. Except in extreme cases, mental disorder (or mental order) is not so dichotomous. Foucault's (1976) final criticism of the medical model applied to mental pathologies is the importance of the patient's environment in the disorder. Although physical ailments can be environmentally induced, the patient can be entirely removed and returned to a "healthy" whole. The mental patient cannot be totally removed from his or her psychological environment.
In much the same spirit as Foucault, Tancredi et al. (1975) challenge the appropriateness of the medical model for the evaluation and treatment of behavior problems. Recognizing that many psychiatric symptoms are universal and not simply characteristic of the mentally ill, the authors state that the presence of symptoms is a necessary but not sufficient reason for seeking psychiatric treatment. Further, they argue, nonorganic psychiatric illnesses cannot be determined by standard, objective physical diagnostic tests. There is considerable discrepancy among psychiatrists as to what constitutes mental illness and what are the best treatments. The choices of appropriate treatment are not so narrowly defined and consistent in psychiatry as in physical ailments.

Critical of the unscientific methodology, Scheff (1975:7) argues that "there has been no scientific verification of the cause, course, site of pathology, uniform and invariant signs and symptoms, and treatment of choice for almost all the conventional, 'functional' diagnostic categories. Psychiatric knowledge in these matters rests almost entirely on unsystematic clinical impressions and professional lore." Hills (1980), too, is critical of the medical model and definitions of mental illness. He asserts that "this medical perspective tends to locate the source of a person's troubles—as well as the
place of treatment— in the individual rather than in the structural flaws of the society or in the patient's immediate social environment" (1980:120). Scheff (1975) argues that the ideological atmosphere of mental illness is value-laden and deeply entrenched in white middle class Western society and a defense of the social order.

Townsend (1978) found significant variation between American and German mental health professionals with regard to concepts of mental illness. The American public and mental health profession, when compared with their German counterparts, are more likely to assign environmental causes to mental disorders. This is, in part, a reflection of the American emphasis of self-reliance, independence, and personal achievement; these qualities are within the control of the American individual. In Germany, disorders that are environmentally induced are seen as transitory and curable, while those that are incurable are inherited or endogenous. You are released from the institution when you are cured. In the United States, it is believed that release from an institution depends upon conforming behavior, not on any somatic qualities.

Szasz (1974) presents a much more critical analysis of mental illness itself. He states that modern psychiatry began by redefining disease through the creation of new categories based upon behaviors, not upon organic anomalies. Szasz argues that mental illness is
"manufactured" apart from any empirical evidence, implying that the standards and methods used by psychiatrists are not scientific. Szasz and others argue that the medicalization of human problems leads to a scientific and deterministic approach to the entire social response to mental disorders. Szasz (1972) describes the identification of two diseases in 1851 by Dr. Samuel Cartwright, the chairman of a Louisiana Medical Association. "Drapetomania" is "the escaping of the Negro slave from his white master" and "dysaesthesia Aethiopis" is "the Negro's neglecting his work or refusing to work altogether." Szasz considers the definition of these two diseases by Cartwright as an example of medical authorities invoking power to (further) dehumanize a certain class of people. Cartwright's language, states Szasz, is similar to that used today by mental health professionals to justify forced control or treatment of the mentally ill.

In response to the perceived domination of the labeling or societal reaction perspective of mental illness advanced by Scheff (1966) and Goffman (1961), Gove (1982) argues that the psychiatric perspective of mental illness is the only position that competes with labeling. He adds that the empirical evidence disputes labeling theory in favor of psychiatric tenets. Sedgwick (1982) refers to the works of Szasz and Goffman (among others) as representative of "antipsychiatry," or the position that psychiatric
subject matter is socially constructed and improper. He suggests that Goffman's *Asylums* (1961) presents the "strong" antipsychiatry position that mental illness is primarily a power relationship and less attributable to some individual characteristic. The weaker version of antipsychiatry combines labeling with other theoretical perspectives to present mental illness and institutions as variable, not as fixed and even fatalistic as Sedgwick describes Goffman's observations and conclusions. Sedgwick argues that Szasz's strong antipsychiatry position is different from others in that Szasz's sharp criticisms of psychiatry and psychotherapy have not waned. The relatively new critique of medicine in general may place an already tenuous branch of medicine, psychiatry, into a wider target of attack.

Offered as support to Gove's assertion that mental illness is not predominantly the result of labeling is Klerman's (1982) discussion of the "psychiatric revolution." Medical research, particularly in psychopharmacology, genetics, and psychopathology, has led to a better understanding of psychiatric disorders. Central to this "revolution" is the development of psychotropic drugs to treat mental illness and, more recently, the inclusion of psychiatric (not most psychological) treatments in third party insurance coverage.
Conclusions

In the tradition of Kuhn's (1970) analysis of scientific revolutions, an examination of the historical evolution of treatments used with the mentally ill, culminating with the introduction of psychotropics as the treatment of choice does not necessarily lead to a conclusion of a scientific (medical) revolution. The major focus of mental health treatment, at least as it is practiced in state institutions, is clearly control. The potential crisis represented by the encroachment of non-medical professionals into the treatment of mental illness following World War II was quickly put to rest with the discovery of chemical therapy and the restrictions limiting prescription writing privileges to medical doctors. Mental illness was already seen as probably incurable and controllable only by whatever means were available. Historically, the available means have ranged from chains to psychotropic medications. Few clinicians argue that psychotropic medications cure mental illness; drugs control the symptoms. This perspective was echoed continuously by professionals when asked, "What do psychotropic medications do to the mental illness?" Controlling symptoms of mental illness is not inconsistent with enduring psychiatric philosophy. States Kuhn (1970:84-5):
The transition from a paradigm in crisis to a new one from which a new tradition of normal science can emerge is far from a cumulative process, one achieved by an articulation or extension of the old paradigm. Rather it is a reconstruction of the field from new fundamentals, a reconstruction that changes some of the field's most elementary theoretical generalizations as well as many of its paradigm methods and applications. During the transition period there will be a large but never complete overlap between the problems that can be solved by the old and by the new paradigm. But there will also be a decisive difference in the modes of solution. When the transition is complete, the profession will have changed its view of the field, its methods, and its goal.

The introduction of psychotropic medications may represent a revolution in medical technology. They do not, however, constitute a scientific revolution in psychiatry. It is true that the practice of psychiatry in the United States has itself changed throughout history. What is yet clearer is that neither general medicine nor psychiatry has contributed to improved conditions within state mental hospitals. The profession most responsible for changing the conditions of institutions is the legal profession.
Mental patients' rights emerged at a time in American history when many citizens were arguing for greater civil rights and liberties. The prisoners' rights movement of the 1960's was, by the nature of the conditions and confinement, a natural forerunner for a patients' rights movement. In fact, some of the major litigation involved patients who had been charged with a felony but were confined in state mental institutions as with both of the Davis (1974; 1980) decisions in Ohio. Litigation in the criminal justice arena did not generalize to the mental health system. It did, however, lay the legal foundation for much of the patients' rights cases.

Prisoners' Rights Movement. There is abundant literature analyzing and debating the merits of the medical model of corrections in penal environments (American Friends Service Committee, 1971; Fogel, 1975; Pepinsky, 1980). The consensus of these works is that, for better or worse, there is no longer any firm commitment to the provision of therapeutic treatment for law violators.
serving criminal sentences in the United States. Some have argued that the current "anti-rehabilitation" sentiment dominating criminal justice policy making is in part the product of the increasingly litigious nature of the prison population (Huff, 1977; Irwin, 1980; Jacobs, 1977; Sullivan and Tifft, 1975). In short, when the Federal courts began to disregard their "hands-off" policy with respect to the prison conditions and the rights of prisoners, the climate of correctional institutions began to turn from therapeutic to adversarial (Fogel, 1975). The prison administrator in this context needs more legal training than bureaucratic savvy, and the inmate population has progressed through a series of transformations, nicely captured in Fogel's (1975:110) phrase "From Patient to Plaintiff - From the Couch to the Bench."

The legal status of the prisoner has changed since the Ruffin decision in 1871 where a prisoner was by law a "slave of the state." Gradually rights have been clarified in the courts. Prior to the 1960's most prisoners were given standing only in extreme cases of cruelty or gross denial of rights. The most notable early decision in the area of prisoners' rights is the "doctrine of retained rights." In Coffin (1944:445) the judge held, "A prisoner retains all the rights of an ordinary citizen except those expressly, or by necessary implication, taken from him by
law." The decision places the burden of proof on the state, opening up a new area of arbitration and making the courts more accessible to prisoners. The court in Powell (1949) articulated the first "hands off" doctrine, deferring to the judgment and discretion of the prison administrator. But as the political organization of prison administration changed from local to state authority, the warden's autonomy became threatened by the courts.

The once-secure (from the courts and public) warden's fortress became open to the public in the 1960's. The treatment model confronted the custody model. Incidents within the institutions were brought to the attention of not only the already-interested prison reformers; the general public became informed of prison conditions. Litigation of prisoners' rights became popular among reform-oriented attorneys. The courts began to grant standing to prisoners who were leveling grievances against the custody staff. The areas of litigation included in the prisoners' rights movement are summarized by Fogel (1975): challenges to the conditions of confinement, first amendment issues, mail and media, due process, and access to the court and legal materials. The intrusion of the legal system into prisons leads to some administrative problems. By giving standing to inmates, the court challenges administrative authority. Implicitly or explicitly, the courts can hold that the administration and
guards are no longer trustworthy. Guards, the primary disciplinarians, complain that new court-imposed procedures are inconsistent with the necessary measures needed to punish inmates (Irwin, 1980).

While the analysis of the rise and fall of the "medical model" in penal institutions has been rather detailed (Dinitz, 1978; Tittle, 1978), there is little direct discussion of similar trends in non-criminal social control institutions. Instead, much recent attention has been given to the apparent proliferation of the "medical model" in the social reaction to various forms of deviance including hyperkinesis (Conrad, 1975; Lennard, 1971), child abuse (Conrad and Schneider, 1980; Pfohl, 1977), alcoholism (Levine, 1978), and mental illness (Foucault, 1976; Horwitz, 1982; Scheff, 1975). Little discussion is directed toward the possibility that the patterns influencing the demise of rehabilitation in penal environments may also be at work influencing the "treatment" environment of social welfare agencies, alcohol rehabilitation centers, and private and public health care facilities.

This chapter focuses upon the relatively recent invasion of the psychiatric profession's autonomy by the legal profession, demonstrating that while much deviance has been thrust under the penumbra of the medical profession, this "medicalization" syndrome has recently
been confronted with an equally powerful "legalization" movement. Reasons for this legalization syndrome, the resultant implications for the delivery of psychiatric services, and the legal and administrative methods for changing mental health law are analyzed and discussed.

The Emergence of Patients' Rights: A Threat to Psychiatric Autonomy

The history of psychiatry reveals that until recently there was little judicial or legal oversight of the practice of psychiatry. Ennis (1978) argues that for the majority of the 20th century, federal judges maintained a "hands-off" policy toward the psychiatric profession, allowing virtually uncontrolled discretion in the selection and administration of treatment for mental patients. Winslade (1980:38) supports this argument and further states that prior to the 1930's, the primary right afforded to the mentally ill was "the right to custody; to be taken care of and controlled." Because of the growing belief that effective therapeutic processes require negotiation and neutrality (Ennis, 1978) and the concomitant realization that by the mid-20th century America's public psychiatric institutions had become warehouses where people were incarcerated for extensive periods of time (Grob, 1966; Rosenberg, 1981; Rothman, 1971), a judicially supported patient rights movement emerged.
The Right to Treatment. The earliest cases brought by or on behalf of mental patients addressed the necessity of treatment and the professional wisdom of the psychiatrists in determining proper treatment. In Whitree v. State (New York, 1965) a patient was awarded damages for not receiving medications while in the mental hospital. The patient refused the drugs, and the physicians did not administer them. The court held, however, that the doctors should have administered the medications over the objections; the psychiatrists have a "duty to treat."

Valid involuntary hospitalization and professional determination were sufficient grounds to administer ECT over the objections of a patient in Campbell v. Glenwood Hills Hospital, Inc. (Minnesota, 1966). As in Whitree, the court held that the doctors would have been at fault had they not treated over the patient's objections. In Rouse v. Cameron (Washington, D.C., 1966) the court avoided the issue of whether involuntarily confined patients have a constitutional right to receive treatment. Instead, the court held that the patient did have the right to treatment, but the decision was based upon existing statutes. In 1971 the New York court held in Winters v. Miller that involuntary commitment does not necessarily lead to involuntary treatment; the treatment in this case was medication. The right to be free from medication during the appeal of an involuntary commitment
and the standards of involuntary commitment were established in Lessard v. Schmidt (Wisconsin, 1972). The right to refuse ECT even when a parent has given consent was upheld in Stein v. NYC Health and Hospitals Corp. (1972).

The most often cited landmark case with regard to patients' right to treatment is Wyatt v. Stickney (Alabama, 1972). Since the decision in Wyatt was the result of a ("sweetheart") class action suit brought on behalf of all patients involuntarily committed to the Alabama Department of Mental Health, the constitutional right to access adequate treatment for patients became the standard in that state and soon generalized to all state mental health facilities throughout the nation. The court defined minimum constitutional standards for psychiatric treatment within state institutions in three areas: "(1) a humane psychological and physical environment; (2) qualified staff in numbers sufficient to administer adequate treatment; and (3) individualized treatment plans" (Krantz, 1976:176). It is ironic that the landmark right to treatment case, Wyatt, is also the foundation for the right to refuse treatment litigation.

The Wyatt court also established the patients' right to refuse lobotomies, ECT, aversive therapy, and other experimental treatments. Proper informed consent was broadened to include not just the physician and patient
interaction, but the patient could request consultation with counsel or any other person before consent was considered "informed." Wyatt is the beginning of the legal threat to the professional autonomy of psychiatrists.

The Wyatt decision is cited as a precedent in Davis v. Watkins (Ohio, 1974) wherein patients institutionalized at the Lima State Hospital in Ohio were identified as having an implicit right to receive treatment during their confinement. The court was quite specific in Davis to articulate the thesis that mental patients have a constitutional right to receive treatment under "the least restrictive conditions necessary to achieve the purpose of their commitment . . . ." The realization that some therapeutic techniques produce extreme discomfort and often irreversible effects on the physical and mental condition of patients led the court to conclude in Davis that while mental patients have a right to be treated, they also have an equally significant right not to be subjected to overly intrusive treatment.

This same logic has resulted in the specific recognition that patients may not be forced to succumb to aversive therapy, psycho-surgery, and experimental treatments. In Kaimowitz v. Department of Mental Hygiene (Michigan, 1973), the court discussed the conditions necessary for consent to be informed. The patient must have the capacity to consent, be informed of
the risks and benefits of the treatment, and give consent voluntarily. In *Kaimowitz*, an involuntarily committed patient could not, by nature of his confinement, give voluntary consent to experimental psychosurgery. The use of aversive conditioning as behavior modification with involuntarily confined patients was found to be cruel and unusual punishment in *Knecht v. Gillman* (Iowa, 1973).

The standard of the "least restrictive alternative" for mental patients was set forth in *Welsch v. Likens* (Minnesota, 1974). Not only did the court find a constitutional right to treatment, but under the Due Process Clause, they charged state officials with the responsibility for developing community-based facilities for civilly committed patients. In *O'Connor v. Donaldson* (Florida, 1975) the U.S. Supreme Court held that it is unconstitutional to confine a non-dangerous person without providing treatment if the individual is able to survive outside the institution.

With the exception of the right to refuse medication (which is addressed later in this chapter), patients' rights are well-defined through statute, case law, administrative rule, and/or departmental policy. Six areas of patients' rights are described by Weiner (1981:68-9) as the right to "treatment, communicate, read hospital record, confidentiality, knowingly participate in treatment decisions, and be free from restraints and seclusion."
Limitations and restrictions are placed on each of these areas. Discretion is often given to the general institutional staff, not exclusively to the treating physician. Whether patients are aware of their rights and whether their rights are actually extended to them varies considerably with regard to the patient, the staff, the institution, and the state.

Refusing Psychotropic Medication: The New Quagmire of Patients' Rights

The technical foundation upon which the right to refuse treatment is based is the doctrine of "informed consent." While the medical model of mental illness invokes a strong professional commitment to the provision of treatment to ailing patients, treatment is only legitimate in instances where the patient or a legally appointed guardian has given consent (Foster, 1978; Katz, 1981). For consent to be valid, it is assumed that the patient is competent and knowledgeable and that there is no coercion involved in the consent-giving process (Rosenberg, 1981). If a competent, rational mental patient refuses to consent to a prescribed treatment routine, under the medical profession's doctrine of informed consent, the psychiatrist is ethically and legally obligated to withhold the specific treatment (Stone, 1981).
In most jurisdictions treatment techniques such as psychosurgery, ECT, and aversive therapy have all but disappeared in public psychiatric facilities (Stone, 1975). Two factors have primarily influenced this trend: the litigation which limits the use of the treatments and the proliferation of psychotropic medications. With treatment today usually involving some form of chemotherapy which can be administered rather easily on an outpatient basis or from a community mental health center, the population of mental hospitals has declined. Scull (1977:79) documents this trend in both the United States and in England and Wales. Scull argues that community treatment of the mentally ill with psychoactive drugs is a "technological fix" and that these "decarcerated" individuals have traded their confinement in a mental hospital for a "chemical straitjacket." Some students of mental illness identify chemical interventions as being even more intrusive than previous treatment practices. The basis of this criticism is founded on the argument that since chemical intervention into the minds of patients appears to be so much less severe than surgery, for example, the professional, constitutional, ethical, and moral standards used to scrutinize chemical treatment strategies may be lessened. In fact these critics argue that "mind altering" drugs such as those used in chemical treatment programs are a more insidious threat to human liberty and dignity because they
alter the very ability of the patient to exercise free and reasoned judgment about his or her life (Conrad and Schneider, 1980; Hills, 1980). Further, because of the tremendous numbers of people receiving psychotropic medications both in and out of institutions, the scope of the "problem" is great.

The first case to grant the right to refuse medication to involuntarily confined patients was Rennie v. Klein (New Jersey, 1979). This class action suit brought in New Jersey has come to be known as "the procedural due process and independent psychiatrist decision." The federal District Court established the following provisions as necessary to insure that patients' rights are being respected: (1) a system of informed consent forms must be signed before the administration of drugs; (2) the establishment of patient advocates within the hospital to independently review findings of incompetence to consent to treatment and to serve as counsel to patients; and (3) an independent psychiatrist to review all cases of forced medication to ascertain if the patients' rights were honored and to hold informal hearings with witnesses and cross-examinations. In 1982 Rennie was remanded by the U.S. Supreme Court for the District Court's reconsideration because of their (Supreme Court's) decision in Youngberg v. Romeo (1982) which gives more professional discretion to the psychiatrists. It is still undecided. Although
Youngberg deals with providing treatment to mentally retarded individuals and is not a right to refuse case, the U.S. Supreme Court's decision to give deference to the professional wisdom of psychiatrists helps to define the current Court's philosophy.

The case which raised tremendous hopes among patient advocates and patients, elicited fear in mental health professionals, yet left everyone in a state of confusion was Rogers v. Okin (Massachusetts, 1980) (also known as Mills v. Rogers in later decisions). At District and Circuit Court levels, all psychiatric inpatients were granted the right to refuse non-emergency treatment including antipsychotic drugs. Three distinctive issues emerge from this decision. First, psychiatric inpatients are presumed to be competent and capable of accepting or rejecting psychotropic medication. For those patients who are incompetent, a court-appointed guardian must make the decision. Second, the state has the power to override the patients' right to refuse medication in an emergency. Initially in Rogers the court narrowly defined "emergency" as a situation which poses a risk of substantial harm to the patient or to others. On appeal, the court broadened the definition to include situations that were not necessarily defined as imminently physically dangerous but gave discretion to the physician to define an emergency. Finally, the right to refuse psychotropic medication is a
basic constitutional right derived from the right to privacy. The Rogers decisions are referred to as the "judicial review" standards for the right to refuse medications since that state requires the court to override refusals.

During the summer of 1982, it appeared that the U.S. Supreme Court, in reviewing Rogers, would make a decision on psychiatric patients' right to refuse psychotropic medication. The Court did not make a decision in Rogers but, instead, returned the resolution of the right to refuse controversy back to the state and lower federal courts. The Massachusetts Supreme Court in the interim ruled on another right to refuse case, In re Richard Roe III (Massachusetts, 1981). The state court upheld Roe's right to refuse medication, reducing "the power of a guardian to compel an outpatient to take psychotropic medication" (Appelbaum, 1983). Many read the Massachusetts Supreme Court's decision as setting a state-law foundation for the right to refuse. If state law exists on an issue, the U.S. Supreme Court will often remand a case for reconsideration. Rather than set definitive guidelines by ruling in the Rogers case, the U.S. Supreme Court, in light of Roe, implied that states should independently pursue right to refuse policies. Because the Massachusetts Supreme Court had made a ruling on the right to refuse issue generally, the U.S.
Supreme Court remanded Rogers for further consideration.

In an effort to clarify the conditions under which the patients' right to refuse psychotropic medication can be overridden by the state, legislative activity throughout the U.S. has produced varied statutory guidelines. In A.E. and R.R. v. Mitchell (Utah, 1980) the Utah Supreme Court upheld statutory law which equates civil commitment with incompetency and establishes that incompetency precludes the right to refuse medication. There is currently litigation in Oregon which challenges the vagueness of that state's right to refuse treatment statute.

Litigation such as Davis v. Hubbard (Ohio, 1980) also addresses the right to refuse psychotropic treatment and offers guidelines for its implementation in a specific institution, Lima State Hospital. The 1980 Davis decision which is based on Rennie and Rogers establishes the patients' right to refuse psychotropic medication under the Fourteenth Amendment of the U.S. Constitution. This right is not presented in absolute terms, but rather allows for it to be overridden in emergency situations. Patients have the right to the opinion of an outside independent psychiatrist on their treatment refusal, and all refusals are "heard" by the clinical director.

Together Rennie, Rogers, and Davis place drastic limits on the professional expertise of the
treating psychiatrists. Rather than give any clear indication of future decisions, the Court ruled in Youngberg v. Romeo (1982) that the professional judgment of the psychiatrist is presumed to be valid unless it represents a substantial departure from standard medical practice. The Court does not close the door on patients' right litigation, but it invokes the "federalism" argument as a justification for deferring to the states' policies. If patients can establish substantial departure from acceptable treatment or violation of explicit policies, the issue of adequate treatment and the right to refuse treatment is yet ripe.

Both the legislative and case law approaches to patient rights represent legal intrusion into the medical profession. Stone (1981) outlines the legal history of medical treatment generally, and indicates that traditionally psychiatric patients have been exempt from legal safeguards under both common tort law and criminal law. He argues, however, that it is politically and clinically unadvisable to treat mental patients against their will. Stone (1981) raises the issue that refusing treatment is in effect a rejection of parens patriae. Furthermore, a dangerous, civilly committed person who refuses treatment and who is nevertheless confined is being detained for preventive measures, a practice which the courts have traditionally considered unacceptable. The
philosophical justification for preventive detention is "police power" of the state. The literature indicates the problems of predicting dangerousness (Cocozza and Steadman, 1978; Monahan, 1975; Pfohl, 1978). The balancing of interests between the state and the individual, even when considering the controversy surrounding prediction, weighs in favor of the state's power to protect, regardless of whether or not treatment is received.

Clinical Issues. Although the right of psychiatric patients to refuse treatment is in the process of being generalized throughout the United States, some argue that this movement may be severely undermining the treatment climate in the nation's mental health facilities. Clearly, a patient population with the power to refuse a physician's prescribed treatment plan is not going to be acceptable to the medical profession. This reaction is even more likely in instances where the illness being treated is of a psychiatric or emotional origin. The right to refuse treatment, as noted above, requires an informed, rational decision maker. The psychotic patient does not possess, by definition, the necessary rationality to make such decisions (Appelbaum and Gutheil, 1980b).

While Appelbaum and Gutheil (1980a) refer to the right to refuse treatment as the "right to rot," they concede that psychiatrists may have to recognize limits on treating patients who refuse therapy. The results from a study
conducted by Appelbaum and Gutheil (1980b) on patients' right to refuse medication indicate that the limited refusal itself is probably not therapeutic, but the negotiations which occur throughout this process may show beneficial effects. Behaviorists describe this negotiating process as "countercontrol" and assert that patients who exercise this right are demonstrating positive behavioral changes (Salzinger, 1981). Social and cultural differences exist surrounding the taking of medication (Amarasingham, 1980). Both compliance with and refusal of psychiatric treatment occur within an entire context of treatment. Amarasingham states that medication is a social message that carries significant symbolic meaning for the patient. For many patients, complying with or refusing treatment is the only opportunity for the exercise of autonomy. What may appear to the treating psychiatrist to be irrational or confrontational behavior may be better understood in the social and cultural context.

Appelbaum and Gutheil (1982) discuss the therapeutic problems which may arise from approaching a medication refusal as a legal issue. They identify two erroneous assumptions made by some clinicians: that there is nothing clinically to be learned from understanding a patient's refusal of treatment and that refusals are always a direct result of the patient's mental illness. They suggest that treatment refusals should be considered as any behavior
which occurs in the therapeutic context. There exist many factors which may affect the refusal of treatment, and Appelbaum and Gutheil (1982) discuss some of these issues. Some patients' refusals are based in real concerns about the treatment, particularly about adverse side effects. They assert that it is a mistake to overemphasize and underemphasize this issue. The second possible basis for treatment refusal is rooted in the relationship between the patient and the psychiatrist. Although the psychological variation of this problem is vast, if a "therapeutic alliance" is never established or is damaged, refusals of treatment may result. Another factor which may affect refusals is the idiosyncratic meaning of treatment for the patient. Appelbaum and Gutheil (1982) argue that psychiatrists are often to blame by failing to explain to their patients the nature of the medications. That the clinician and patient do not always agree on the gains of treatment and the risks of illness is another potential source for refusals. Lastly, third parties can significantly influence a patient's refusal of (or compliance with) medication. These influences can range from denial of the illness to religious rejection of treatment. The authors recommend that rather than immediately override a patient's refusal, attempts should be made to identify the factors underlying the refusal and to resolve the problems outside of the legal framework.
Changing Mental Health Policy: Legal and Administrative Frameworks

Most of the attention in the literature on the right to refuse medication focus on the judicial model of changing policy. Much speculation transpired prior to the Supreme Court's remanding of Rogers v. Okin. The major question which emerged from the speculations was, "What will the impact of a right to refuse policy be on staff and patients?" The major criticism was that the courts were "practicing medicine from the bench." Most of the impact questions and criticisms center on judicial decisions. Although these cases receive much public and professional attention, state mental health officials as well have changed mental health policy on the right to refuse medication. There exist, therefore, two broad categories of methods to change mental health policy -- legal and administrative. Within the legal framework are judicial decisions, statutes, and attorney general opinions, and within the administrative framework are administrative rules and departmental policies.

Assessments of the impact of change in mental health policy has singularly focused on the impact of judicial decisions and occasionally on statutes. Baum (1977) argues that studies on judicial impact have narrowly-selected decisions, relying on major U.S. Supreme Court decisions. Further, most students of the judicial process utilize a
"compliance model" with the research question being "Have the policy makers complied with Supreme Court decisions?"

This perspective has three major weaknesses according to Baum (1977): first, it oversimplifies the decisions into an obedience-disobedience dichotomy; second, it excludes the study of decisional trends; and third, it poses definitional problems for policies which are not inconsistent with but evade a court ruling. Baum suggests that a process-oriented implementation model replace the compliance model, in part because the former stresses the role of (lower court) judges and administrators as policy makers and their responses to decisions.

Implementation is defined by Baum (1977:130) as "the relevant actions and inactions of public officials who have responsibility to achieve objectives contained in previously enacted policies." By analyzing only judicial implementation, students of the judicial process often conclude that impediments to implementation rest within the judicial process. According to Baum (1977), similar problems occur in legal and administrative arenas. By expanding beyond the limits of judicial impact studies, more effective information on administrative and legal policy implementation can be attained.

Carter (1977) proposes three categories of indicators of policy effectiveness: technical competence, effective information processing, and political acceptability.
Technical competence requires that the members of the policy-making institution (PMI) be familiar with the scope and language of the problem and that they be the best possible institution to approach the problem. The second category of indicators, effective information processing, requires that the PMI have access to reliable information to develop the policy and that the PMI be structured to reformulate the policies as information is gained from implementation efforts. Timing of information processing is of crucial importance to effective policy making. The final group of indicators, political acceptability, mandates that the public recognize the existence of the problem and agree that the particular PMI is the appropriate institution to respond to the problem, both of which are necessary for political accountability and institutional survival (Carter, 1977).

Although mandated by federal statutes and litigation, quality assurance programs are forms of administrative policies which affect state mental health services. For state departments of mental health to receive third party reimbursement (e.g. Medicare, Medicaid, and private insurance) for care of the institutionalized mentally ill patients, the institutions (or specific units) must meet certain minimal standards established by federal law (Lalonde, 1982).

Quality assurance is the guarantee that particular
standards of care are being met in the delivery of mental health services. Quality assurance also helps to detect problems and errors in treatment; two important issues included in quality assurance are admissions and extended stay review. Although quality assurance began as a rather vague philosophical position that patients should receive "quality" care, specific programs and sets of guidelines have emerged at state and federal levels. Examples of quality assurance programs whose standards are often goals for institutional care are Professional Standards Review Organizations (PSROs), the Joint Commissions on Accreditation of Hospitals (JCAH), and the Accreditation Council for Psychiatric Facilities (AC/PF). The specific criteria for these three programs will not be discussed in detail but under the rubric of quality assurance.

State departments of mental health often have their own quality assurance guidelines which may or may not meet federal standards. These state policies may be initiated judicially or statutorily, but the specific policy and changes incorporated into the policy are usually accomplished at the departmental level. Particular hospitals within a state may have more rigid quality assurance guidelines, but, in general, public mental hospitals must meet the minimal state requirements.

Because of the controversy surrounding the issue of psychotropic medications in state mental institutions, some
states have developed policies to control or monitor the prescription of these drugs. For example, some states require explicit documentation and peer review for the administration of more than one major psychotropic drug to a patient. Further, dosage limitations of one medication have been established in some states.

Baum (1977) and Carter (1977) provide criticisms of the studies and literature on policy making. Their recommendations for the direction of policy-making research provide the foundation for an expansion of the mental health policy-making institutions under study to include legal as well as administrative bodies. The research discussed in the following three chapters adopts this broader definition of policy-making institutions. Chapter Five describes the background of the research, the research design, the model, and the methodology utilized in the research process. Chapter Six is the presentation and discussion of the areas of analysis, the research findings, and the conclusions from the research. Chapter Seven is a discussion of the research implications and some possible explanations for the findings and conclusions.
CHAPTER FIVE

RESEARCH GOALS, DESIGN, AND METHODOLOGY

The state of Ohio does not formally recognize psychiatric patients' right to refuse psychotropic medication. Only in Lima State Hospital may patients refuse medication, and that right was granted in a federal district court decision, Davis v. Hubbard (1980). In reviewing the cases described in Chapter Four, Ohio mental health officials in 1982 began to realize the need for the development of a state-wide policy on the right to refuse medication. Because little if any guidance was given by the U.S. Supreme Court in Rogers, the Office of Program Evaluation and Research (OPER) of the Ohio Department of Mental Health (ODMH) sponsored this research project to determine what the other states have done in response to this trend, and what the impact of the right to refuse medication has been.

Whether analyzing legal or administrative policies, the psychiatric patients' right to refuse psychotropic medication is not consistent across jurisdictions. Because the U.S. Supreme Court has for now deferred to lower
federal courts and to state officials in determining appropriate procedures surrounding the right to refuse psychotropic medication, several critical issues need to be addressed so that state mental health administrators can effectively and constitutionally implement these procedures. The areas of apparent inconsistency which need clarification include the method of initiation of the right to refuse medication, the interpretation of the policy in each state, the implementation process, and the impact of the right to refuse medication. An examination of each of these and other issues and the specific problems associated with them is discussed in the "Goals" section of this chapter.

The overarching problem associated with the right to refuse psychotropic medication is summarized by federal circuit Judge Coffin in Rogers v. Okin (1980), "Under what conditions may state officials forcibly administer antipsychotic drugs to mental health patients without violating the 14th Amendment?" The court raises the question, but the answer can only be discovered through careful analysis of each state's policies and procedures.

**Goals of the Research**

The operative assumption of this research is that the procedures utilized to implement the right to refuse
psychotropic medication vary widely by jurisdiction and hospital. Considerable variation exists both among states and within states. The review of cases and literature suggests major differences between states, even among states which have had major federal litigation. However, the nature and the direction of variance has been yet undetermined. Until this research, the most current state-by-state comparison of patients' rights (National Association of State Mental Health Program Directors, 1979) identified thirteen states which statutorily guaranteed the right to refuse psychotropic medication; there is no mention of other policies which may have existed. Not only is this 1979 survey out of date, but it does not provide necessary information regarding the specific issues of the right to refuse psychotropic medication.

The present research examines the issues surrounding the right to refuse psychotropic medication through a nationwide survey of state mental health officials and attorneys general. In addition, an intensive investigation and analysis of procedures being used in states bordering Ohio was undertaken to focus upon the issues of initiation, interpretation, implementation, and impact of the right to refuse medication. The objectives of both the nationwide survey and the bordering states analysis are as follows: to provide detailed descriptive information regarding the status of the right to refuse psychotropic medication on a
national level; to identify variations in interpretation styles, to whom the right extends, and how patients are informed of the right; and to assess what, if any, impact the right to refuse has had on staff practices and whether or not interpretation can be identified as directly influencing implementation and impact. As an additional contribution, our results should help inform ODMH on how "best" to approach a right to refuse medication policy on a statewide level.

Method of Initiation. Within the context of psychiatric patients' right to refuse medication, most of the 50 states and the District of Columbia (hereinafter referred to as "51 states") have responded in one or more ways -- litigation, statute, attorney general opinion, administrative rule, or departmental policy. Many states have used a combination of methods for initiation and implementation. Often the legal methods of initiation -- litigation, statute, and attorney general opinion -- require an administrative method to implement the policy. How each of the 51 states states have approached the right to refuse medication is examined.

Interpretation Issues. There is some consensus that competent psychiatric patients have the right to refuse psychotropic medication. What is unclear, however, is what constitutes competence and who makes this determination. For example, a patient who refuses
treatment may, for this reason, be evaluated as incompetent and lacking "insight" into his or her illness. Further, some policies require that a judge determine competence. Competence to participate in treatment decisions is not necessarily equatable with competence to execute a will, to vote, to marry, or to dispose of property. Competence to participate in decisions may vary during the time of confinement. There also exists some question as to how commitment status affects competence and whether competence should be determined legally or medically.

There is much inconsistency in the literature on how commitment affects the right to refuse medication. In Roe, outpatients were given the right to refuse, and in Rogers, Rennie, and Davis involuntary patients were given a "qualified" right to refuse medication. What remains unclear is whether voluntary patients may refuse medication. If one of the requirements for voluntary admission is signing a consent to treatment form, then voluntary patients do not have the right to be treated and the right to refuse medication. Additionally, can the refusal of medication be used as a criterion for involuntary commitment. The states also vary on which patient groups are included in the right to refuse medication. This research focuses on how the issues of competency and commitment have been interpreted in each state.
Implementation of the Right to Refuse Medication.

A policy may exist which grants psychiatric patients the right to refuse medication, but if the policy is not effectively implemented, the right is simply a "paper victory." It is important to determine which state mental health officials have the responsibility to implement the policy and if it is actually being implemented. Because the implementation procedures exist is not a guarantee that the right to refuse medication has been effectively implemented. Of further importance is the implementation process itself and any problems or other factors which have emerged from this process. This research analyzes the organizational implementation problems including staff recommendations for changes. In addition, an assessment is made to determine if the policy has been effectively implemented. Rather than ask the question, "Can patients refuse medication?", which is a rewording of, "Does the right to refuse medication exist?", the essential question is, "May psychiatric patients refuse medication?"

If patients are informed of their rights, ideally they will be able to exercise those they choose to exercise. How and when patients are informed of their rights is a frequently-raised question. Patients may never be informed; they may be informed only at admission; they may be informed in language they cannot understand; or
they may be informed in an on-going effort by a staff member (or attorney, family member, etc.). There may or may not be an attempt made to help patients comprehend the rights they do have. If patients are informed of their rights, they may or may not exercise them. If patients are not informed or not meaningfully informed, they cannot exercise these rights. Therefore, it is an important component of this research to determine the nature of patient education on their rights, specifically the right to refuse psychotropic medication.

The recent court decisions discussed in Chapter Four require or suggest that there exist some procedural guarantee or review process for patients' right to refuse medication. Some states mandate a judicial hearing if medication is refused while other states allow the medical director to serve as the "judge" in determining if the refusal is to be upheld. Some states utilize an outside consulting psychiatrist to guarantee "fairness" and yet other states have no procedural guarantees at all. Still other states have intrahospital review panels ranging from interdisciplinary groups to a panel of psychiatrists. Without actually deciding, the U.S. Supreme Court sent a message to the states that some form of review of refusals should be guaranteed. Whether the procedure is within the judicial or medical framework is left to the states and federal district courts to decide. This research
determines how the states guarantee the right to refuse medication to their psychiatric patients.

Because the right to refuse medication exists only in "non-emergency" situations, it is important to establish the conditions under which the right to refuse psychotropic medication can be overridden. Of further importance is who has the responsibility to override this right in both emergencies and non-emergencies and what procedures are necessary to override the right to refuse medication. The literature suggests that, depending on jurisdiction, either institutional or non-institutional officials are charged with the responsibility to override the right. Procedures for implementing overrides as well exist either internal or external to the institution. The research identifies who is responsible for overriding medication refusals and what procedures are involved in overrides.

**Impact of Refusals.** Patients exercising the right to refuse medication can affect the institutional organization in a number of ways. For example, administrative and managerial alterations may be necessary to accommodate procedural implementation of this policy. Furthermore, staff workload may be affected. Clinical services will also be affected by patients' refusals of medication. Staff may find it necessary to rely upon treatment alternatives, the efficiency of which is low. The climate of the institution may also be affected.
Whether or not the institutional environment becomes more aggressive, hostile, or dangerous is an important consideration. Another important factor on the impact of medication refusals is how the refusal affects that patient and the other patients. For example, the length of stay for the patient who remains medication free may be affected. Further, patients on the ward may be affected by the refusal. The present research analyzes the impact of the right to refuse psychotropic medication on the institutional organization of mental health facilities within each state and how patients can be affected by medication refusals.

To date, only one study has been conducted which examines the frequency with which patients exercise their right to refuse psychotropic medication (Appelbaum and Gutheil, 1980a). The findings indicate that refusals of medication are a common experience, but that refusals do not seriously impair patient care. This research is only minimally applicable to the present research in that Appelbaum and Gutheil focus only on a three-month period within a community mental health center. It is still unknown how frequently committed psychiatric patients refuse medication. The present research attempts to assess the frequency of medication refusals and how the population of patients who refuse medication differs from the general patient population.
Research Design

In researching the impact of a legal or administrative policy, problems arise. Some difficulties include lack of a general conceptual framework; for example, what standards should be used in defining impact, compliance, or evasion? Further, impact analyses have included information from an array of political officials ranging from judges to legislators, making comparisons and generalizations difficult. In an effort to organize research and theory in the area of impact analysis, Johnson (1977) has proposed a model or framework in which the two major components are populations and behaviors within each population. This model is presented in Figure 1 and is utilized in the research so that information obtained from states where right to refuse medication policies are dissimilar can be compared. Additionally, the officials and attorneys surveyed and interviewed in each state differ in their position within the mental health hierarchy. Therefore, information gained from each individual can be conceptualized within the model and compared.

Populations. The model presented in Figure 1 identifies five populations and the major categories of behaviors for each. With regard to psychiatric patients' right to refuse psychotropic medication, the policy makers are the state and federal courts including the U.S.
Figure 1. Research Model
Supreme Court. Although the U.S. Supreme Court did not issue guidelines for the right to refuse medication, they recognized the ripeness of the issue by agreeing to hear Rogers v. Okin, Rennie v. Klein, and Youngberg v. Romeo, and they granted standing to the patients, acknowledging the importance of the right to refuse medication to these individual patients or groups of patients. The lower court decisions and the message from the U.S. Supreme Court are thus communicated to the interpreting and implementing populations.

The officials charged with interpreting the meaning of the general right to refuse policy are, in this model, the interpreting population. They are responsible for refining the policy and making it applicable to their state. The interpreting population establishes rules for questions not raised in the original decision and executes the decision. For example, the patients in Rogers, Rennie, and Hubbard were all involuntarily committed; they have the right to refuse medication. The interpreting population is left with determining how the decision applies to voluntary patients. The courts have also stated that all patients are presumed competent without stating how competence must be decided and how competence affects the right to refuse medication. The right to refuse medication can be overridden in an emergency, but the interpreting population is left with
defining what is an emergency and who can override. This population may include lower courts, attorneys general, directors, commissioners, chief administrators of mental health, and official legal counsel.

The implementing population consists of those individuals who are directly accountable to the interpreting population. Included in this population are division chiefs, institutional directors, and institutional staff. This population applies the policy's "system rules" to persons within their authority. Often the original policy and subsequent interpretations are intended to establish boundaries on the behaviors of the implementing population. Right to refuse medication policies generally describe the limits of behaviors for hospital staff. It is the implementing population which has the most direct contact with the consumer (patient) population.

A second component of the implementing population is the group of lawyers, for example, who are involved in mental health law though not employed by the departments. This subpopulation of mental health legal specialists can insist that the implementing population within the institutions follow appropriate procedures. If their work is not accepted by the interpreting population, however, their actions are often futile.

Those individuals for whom policies are set forth are the consumer population. Usually this group consists of
people whose rights are being somehow violated by governmental actions. State mental patients are the consumer population for the right to refuse psychotropic medication. The implementing population within the state institutions is the governmental group whose actions are being limited by the policy. They must implement the policy so that the patients can "consume" or exercise their right to refuse medication if they choose to do so. As part of the entire system being analyzed, the patient/consumer population can comply or fail to comply. The patient compliance behavior is that they can exercise the right to refuse medication as long as they are within the official guidelines set forth by the interpreting population. If a dangerously acting out person refuses medication, his or her behavior is not compliant with the policy if emergencies are exempt from this right and the behavior is an emergency.

The secondary population is indirectly affected by the right to refuse medication policy and its implementation. Often their response is some form of feedback directed toward one of the other four populations. Within the secondary population are three subpopulations. The governmental attentive public includes legislators or other officials who have direct, legitimate authority and are in a position to support or sanction the policy, the policy makers, and the interpreting and implementing
populations. The nongovernmental attentive public is aware of, though not directly involved in, the political or policy-making process. The group may include relatives of consumers (patients), politically-active individuals (patient advocates), and the media. A last subpopulation is the general public, those people who are not members of the consumer group or any of the other two subpopulations.

Johnson (1977) asserts that the subdivision of populations is primarily functional. Although particular individuals may at times be members of different populations, this distinction is important when considering the influence among populations and when comparing the relative impact of actors in the process.

**Implementing and Impact Behaviors.** Johnson (1977) argues that acceptance or rejection of a policy is the first stage of the decision-making process for each population. The populations' understanding of the policy and their perceived requirements must be ascertained before a researcher can explain other responses. Rather than attempt to assess attitudes toward a policy or the policy makers, a researcher can observe subsystem adjustments. A subsystem adjustment according to Johnson (1977:113) is "a change in the normative and organizational structure of the population." The normative structure involves both formal and informal norms and rules such as formal procedures and/or patterns of behavior. Organizational changes could
include additions of new functions or new sections to a department. The ways in which the interpreting and implementing populations have responded to the right to refuse medication policies supplies valuable information on their attitude toward both the policy and the policy makers.

Compliance and feedback behavior comprise the behavioral aspects of impact of the right to refuse policies. Compliance is "that behavior directed toward the [patient] populations in accordance with the policy or the interpretation and implementation of the policy" (Johnson, 1977:113). Feedback is directed to the superior or secondary populations. Feedback in this model means that populations may intentionally or unintentionally influence others in the political process (Johnson, 1977). While Johnson (1977) argues that each of the components of the model are significant and in need of analysis in all policy impact studies, this research directly surveys and interviews the interpreting and implementing populations. The consumer population will be interviewed in future research.

Methodology

This research consists of two interdependent phases: a national mail survey of state mental health officials and interviews and site visits with mental health staff in nine
institutions in five states. Although the data gained from the two phases are cumulative, they are presented as distinct in this section. In Chapter Six, the presentation of findings, the interdependence and cumulative nature of the knowledge becomes clear.

National Mail Survey. This stage of the research involved a mail questionnaire (See Appendix B) to mental health directors or commissioners, mental health attorneys, chiefs of mental health research and program evaluation, and attorneys general in all 51 states. The questionnaires were mailed and returned in self-addressed stamped envelopes provided with the questionnaires. The sample was selected based upon the assumption that these officials would comprise the interpreting population. Further, these officials would have knowledge of a right to refuse policy if one exists and to which categories of patients the right extends.

The purpose of the mail survey was to assess the status of the right to refuse psychotropic medication in all 51 states. Until this research there was no state by state comparision of this right. The survey included questions within the following areas:

1. Current status of the right to refuse policy;
2. which patients have the right;
3. year of recognition;
4. method of initiation and implementation;
5. litigation pending;
6. how patients are informed;
7. procedural guarantees;
8. procedural overrides; and
9. right to refuse other treatments.

Respondents of the mail survey were asked to identify individuals within their states who have knowledge of the issues involved in the patients' right to refuse psychotropic medication. These people were contacted by telephone to assure reliability of the mail responses and to clarify any further questions the researchers had from the survey.

In those states which do not recognize the right to refuse medication, the survey included the question of whether or not the issue has been raised and who initiated the issue. Respondents in these states were also asked if patients could refuse other treatments.

Site Visits. To acquire more detailed information about the implementation and impact of patients' right to refuse psychotropic medication, nine institutions in five states were visited. The first criterion for state site visit selection was that a right to refuse policy existed. The second selection criterion was a pragmatic one -- the states had to be in reasonable proximity to Ohio. Third, there had to be some variation in the right to refuse policies. The states included in the site visits were Minnesota, Indiana, Kentucky, West Virginia, and Michigan.
Only one hospital in Minnesota had implemented the policy, so only that institution was visited. In each of the four other states, the hospitals included in the site visits were selected by the director or commissioner of mental health in each state. These officials were asked to choose two institutions in which the populations were demographically diverse. For example, it was requested that one hospital draw from a rural catchment area and one from an urban area. The state official made initial contact with each superintendent, and then the researchers arranged the dates of the visits and the people to be interviewed. (For a list of the institutions visited and the positions of the people interviewed, see Appendix C.)

The interviews with the implementing population were in Dexter's (1970:5) terminology "elite" interviews, requiring nonstandardized treatment:

(1) stressing the interviewee's definition of the situation; (2) encouraging the interviewee to structure the account of the situation; and (3) letting the interviewee introduce to a considerable extent his notions of what he regards as relevant, instead of relying upon the investigator's notions of relevance.

Dexter (1970) suggests that elite interviews be used in conjunction with another source of data and also when the interviewers have considerable knowledge of the subject. This style of interview was appropriate in the research because of the background information already
obtained in an extensive literature review, preliminary interviews, and in the national survey findings.

The framework for the interviews (See Appendix D) allowed for general information gathering as well as responses to the following questions:

1. Why is the right to refuse medication an issue?
2. Are patients now overmedicated or undermedicated?
3. How might problems with medication be resolved without resorting to right to refuse policies?
4. How was the staff informed of the new policy?
5. What were staff reactions?
6. What were staff anticipations?
7. How are patients informed?
8. Have there been any changes in your professional practice?
9. Have there been any changes in record keeping?
10. Have there been any changes in interactions with patients?
11. Have there been any changes in interactions among staff?
12. Have there been any changes in patient behavior?
13. What is the frequency of refusals?
14. Who refuses?
15. What do you do when a patient refuses?
16. How might the implementation process be improved?

Each interviewee did not answer every question. In some cases, the interviewee was not familiar with the necessary information to adequately respond. These questions became the interview guidelines, and attempts were made to focus on particularly relevant topics with each interviewee.
Data Analysis. The data collected from the national survey area analyzed and presented in Chapter Six. The data are of such a nature that simple frequency distributions provide the most information. Because the information from the site visit interviews is primarily descriptive, the constant comparative method of qualitative analysis is utilized. Glaser (1964) argues that this procedure is designed to generate theory which is close to the data. It is not a methodology which tests theories already in existence, rather it yields grounded theory or theory discovered from the data (Glaser and Strauss, 1967). The role of theory in sociology is to "provide clear enough categories and hypotheses so that crucial ones can be verified in present and future research . . . " (Glaser and Strauss, 1967:3). The alleged controversy between quantitative and qualitative methodologists is instead a clash between theory verification and theory generation. Because of the lack of theory building in the area of policy implementation, the methodologies used in this research are the most appropriate and produce the most informative and generalizable findings and conclusions.
CHAPTER SIX

RESEARCH FINDINGS: INITIATION, INTERPRETATION, IMPLEMENTATION, AND IMPACT OF PSYCHIATRIC PATIENTS' RIGHT TO REFUSE PSYCHOTROPIC MEDICATION

Few recent mental health issues have generated as much controversy among clinical professionals and attorneys as psychiatric patients' right to refuse treatment. Central to this controversy are philosophical discussions and medico-legal arguments about whether or not patients should participate in treatment decisions and what impact this may have on treatment. The focus of this research is the initiation, interpretation, implementation, and impact of psychiatric patients' right to refuse psychotropic medication. These four issues are studied from two major sources of primary data: a national mail survey and face-to-face interviews with mental health professionals and staff in nine psychiatric institutions in five states.

Initiation of the right to refuse medication is placed within the larger context of individual civil rights litigation on the right to treatment. These cases are discussed in detail in Chapter Four and will, therefore, not be further described here. Also instrumental in the
initiation of the right to refuse medication was the recognition that some patients were being overmedicated or "zonked" for purposes of control. Initiation of the right to refuse medication was discussed in the site visit interviews by asking respondents, "Why is the right to refuse medication an issue today?"

This chapter also includes an analysis of whether or not state mental health authorities have formally responded to the right to refuse trend set forth by the courts. The interpreting population of the right to refuse policy varies among the states. Also included in this chapter is a presentation of who are the interpreting populations within each state. Data used for the examination of interpretation issues are taken from the national survey.

The implementation and impact of the right to refuse medication are studied from the site visit interview data. The mental health professionals and staff comprise the implementing population in each state. Two important issues discussed are "Has the right to refuse medication policy been implemented as it was interpreted?" and "How has the implementation of this right impacted the treatment of patients and the delivery of treatment?" The questions discussed in the methodology section of Chapter Five describe the interpretation and implementation issues.
Initiation: Psychiatrists' Responses

Site Visit Interviews. During the site visit interviews, psychiatrists and physicians were asked why the right to refuse medication is an issue. The responses were generally consistent, falling into two broad categories: a general concern for human rights and the increased litigiousness of the United States society. Some of the psychiatrists appeared accepting of these two factors which affect the practice of psychiatry. Examples of psychiatrists' responses to the patients' rights movement are as follows:

"This state has a long history of human rights attention . . . [there is a] general attentiveness to the need to protect patients' rights."

"Medications are intrusive. The right to refuse is not necessarily a purely medical issue but involves cultural changes and represents a social statement."

"[The right to refuse] resulted from a product of the times as lawyers got involved in prisons and socio-economic groups . . . now everybody has rights."

"As a country we are concerned with rights. We are in a period of consumer advocacy."

"Psychiatric patients became recognized as a minority group whose rights have been abused and ignored in the past. Thus, the general civil rights movement naturally focuses on them."

There is a history of abuse in psychiatry which is recognized by some of the psychiatrist/physician
respondents as one of the specific motivating factors behind patients' right to refuse medication. Additionally, the side effects of the drugs became pronounced along with the realization (or perhaps admission) that drugs were being used for purposes other than treatment. For example:

"There were abuses but more out of lack of information rather than neglect."

"Tendency for [the] benefits and abuses of drugs to become public."

"Patients were forced into treatment more for punishment than therapy."

"Medications were given for convenience of the staff."

"Side effects of drugs became known. We had people here who were purple due to drugs." (nurse)

"... ineffective diagnostic practices resulted in [the] wrong treatment."

Only a limited number of psychiatrists were unaware of the right to refuse medication as a national issue. For example, when questioned about the issue, one psychiatrist responded, "Is it a national issue?" Further, not all psychiatrists and physicians interviewed appeared tolerant of the patients' rights movement and the right to refuse medication as illustrated by the following responses to the question "Why is the right to refuse medication an issue?" Although these statements represent an unaccepting
position, they do fall into the two general categories of responses.

"The reform movement is by 'cause celebres' and is out of ignorance of the mental health professions and of mental illness. Since the 1960's we have seen people riding off in all directions to correct abuses that don't really exist."

"The public has the misimpression of the state hospital as a snakepit."

"Lawyers' involvement [in patients' rights] was motivated by money not patients' well-being."

"[Patients' rights were initiated by] agitation among minority group members who claimed that their rights were being violated . . . complaints which were ill-founded and clearly the people initiating them were not aware of what was really going on . . . ACLU-types."

"Public defenders think they win if they get the patients off medications."

"Most advocates for change pick up on a subject that looks good and advocate. [There is] little concern for possible harm they might cause, and this is the case with the right to refuse."

Psychiatrists and physicians were generally aware of the national scope of the right to refuse medication issue. Whether they accept or reject the patients' rights movement in general and the medication issue specifically is an individual question. Although the nature of the data does not lend itself to counting how many psychiatrists and physicians accept or reject the right to refuse medication, or to measuring to what degree they accept or reject patients' rights, most psychiatrists and physicians
interviewed do recognize and at least tolerate the existence of psychiatric patients' right to refuse medication. Of additional importance is that many of the interviewees identified a history of abuses in psychiatry and placed the patients' rights movement in the larger social context of individual rights, not simply as a reaction against psychiatry.

**Interpretation: A National Survey**

Forty-five states (88.24%) recognize a "qualified" right to refuse psychotropic medication. A "qualified" right refers to the fact that the policies include some conditions under which patients do not have the right to refuse and/or limits the patients to whom the right applies. The court decisions do not grant to patients the absolute right to refuse medication. And the court decisions do not specify all of the patient groups who can refuse medication. The states are left with the responsibility of interpreting these decisions. No state gives all patients the right to refuse medication without conditions for overriding the refusal. A patient's refusal cannot be overridden in only one state. This policy, however, limits the right to competent patients.

Qualifications or restrictions on the right to refuse medication are often based upon either competency or commitment. Some states allow a guardian to refuse for an
incompetent patient. In states which responded that a guardian could refuse for an incompetent patient, that state appears in the results as allowing incompetent patients to refuse medication. Guardianship is another important legal and therapeutic issue with regard to patients' rights generally, but an analysis of it is beyond the limits of this research. In states which allow patients to refuse only on religious grounds, provided their religion is not a product of psychosis, that state is identified as having no right to refuse medication policy. Further, when there are special groups of patients who are not yet part of the general patient population (e.g. those awaiting hearing), and if the policies are different for the special classes of patients, the present results are based upon the policies applying to the general patient population. If these limitations were not placed on the research findings, the data would not be comparable among states. One further qualification placed on this right in all but one state is that patients cannot refuse medication in emergency situations. The definitions of emergency vary across jurisdictions, but the most common definition is "danger to self or others." All states include at least the dangerousness stipulation and may also include "psychiatric emergencies" wherein a patient's psychiatric condition is threatened. Variations in "how" and "when" it is possible to override refusals is also discussed in this
Of the 45 states which recognize a qualified right to refuse medication, 25 (55.56%) generalize this right to all adult psychiatric patients being treated in state mental institutions. Table 1 presents the national summary of how many states have/do not have a right to refuse policy and which patients may refuse.

In those states where the right to refuse medication is qualified by more than the presence of an emergency, the standards used to determine which patients can refuse medication often center around competency and commitment status. Competency is the more critical issue as all but one of these 20 states restrict the right to refuse to competent patients. In ten states all competent patients may refuse medication, and in nine states only competent voluntary patients can refuse. In only one state is commitment status the sole criterion used to qualify this right.

Because every state in the United States now requires "dangerousness" as one criterion for involuntary commitment, controversy emerges as to how an involuntarily committed patient can refuse medication since "emergency" conditions would allegedly always be present. This argument is simplistic in that it makes two assumptions, one which places total faith in the legal model and one which places no faith in the treatment or medical model.
### TABLE 1
Right to refuse medication: national summary

<table>
<thead>
<tr>
<th>REFUSAL POLICY</th>
<th># OF STATES</th>
<th>PERCENT</th>
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<tbody>
<tr>
<td>No Right to Refuse</td>
<td>6</td>
<td>11.76</td>
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<tr>
<td>Voluntary/Competent Patients</td>
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<tr>
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<td>19.61</td>
</tr>
<tr>
<td>All Patients</td>
<td>25</td>
<td>49.02</td>
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</tbody>
</table>

Total                                             | 51          | 100.00  |
Although designed to guarantee due process, jury by peers, and representation by an attorney, commitment proceedings often do not approach this idealized model. There is much deference from the court to psychiatric opinion, and psychiatrists frequently are not present during the hearing for questions and cross-examination. And although dangerousness must be established, what constitutes dangerousness is far from clear. Is a "street person" who is unable or unwilling to seek traditional shelter and work dangerous? The concept of dangerousness has been broadened in practice in many jurisdictions to include what were once paternalistic criteria. Further, without a commitment hearing, a patient cannot be legally dangerous. So if a dangerous person agrees to sign voluntary admission forms, that patient is legally, but not necessarily psychiatrically, different from the involuntary patients.

The second assumption made is that throughout the hospitalization and treatment process, the "dangerous" patient continues to be considered dangerous. Dangerousness is perceived as being a dichotomy, not a continuum. The day before release the patient is still as dangerous as when committed, but on the date of release, dangerousness magically vanishes. Because dangerousness can only be imperfectly predicted, it is a faulty foundation as a criterion of commitment and a restriction on rights.
A state-by-state description of the status of the right to refuse medication is presented in Table 2. When contradictions existed among respondents, clarification was achieved by either telephoning the respondents or by further analysis of secondary sources. When combining the mail responses and the telephone interviews which also were utilized to gain more information, there were 125 respondents.

According to the findings of the national survey, the right to refuse medication has received formal attention only recently. Data are available indicating when the policy was initiated and formalized in 43 of the 45 states which do have a policy. It was not until 1978, the time when the right to refuse medication litigation was gaining national attention, that half (51.2%) of the states which do now recognize the right formally did so. Table 3 presents a national summary of the year of formal recognition of the right to refuse medication.

In each state the interpreting population is responsible for taking the general policy set forth by the initiating population, the courts, and developing a policy. The data from the national survey presented in Table 4 show that the most common singular right to refuse policy is initiated by statute (13.3%, n=6). Most states (66.7%, n=30) have utilized two or more methods of initiation, while only 15 states (33.3%) have utilized only one method.
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<th>VOL/COMP/INCOMP</th>
<th>VOL/INVOL/COMP</th>
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Year of formal recognition of the right to refuse medication

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*Total does not equal 100% due to rounding error.
TABLE 4

Interpreting populations for the right to refuse medication: national summary

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Of those states which have a right to refuse policy, most (62.2%, n=28) have a statute which addresses this right. When comparing the legal with the administrative approaches to the right to refuse medication, there are a total of 54 (57.5%) legal policies and 40 (42.5%) administrative policies. When only one method of interpretation is used, there is only one more legal (n=8) than administrative policy (n=7). Table 5 presents a state-by-state description of the interpreting populations for the right to refuse psychotropic medication.

In the six states which do not recognize psychiatric patients' right to refuse psychotropic medication, the issue has been raised in three of them. In one state the right was raised through litigation, in another by administrative rule, and in the third by way of an attorney general's opinion. In the remaining three states, the right to refuse medication issue has not been raised.

Although most states have policies concerning psychiatric patients' right to refuse medication, the policies are not necessarily going to remain unchallenged. There are currently sixteen states which have litigation pending specifically on this issue, and in only one of these states is the right not recognized. Table 6 lists the states which have litigation pending. The litigation issues range from vagueness of an existing right to refuse statute (e.g. Oregon) to the initial recognition of the
## TABLE 5

Method of initiation and implementation by state

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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Vermont</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Jersey</td>
<td>Wisconsin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
right in a state (e.g., Ohio). Many states (n=20) are carefully observing the litigation activity in other states before reassessing their policies. The reluctance of the U. S. Supreme Court to set a specific policy on the right to refuse medication issue while at the same time agreeing that it is a "ripe" issue leads to the projection that there will continue to be litigation at all levels on this issue.

For patients to be aware of their rights and to be able to exercise these rights, they must be informed. The national survey identifies how patients are (supposed to be) informed of their right to refuse psychotropic medication in 42 of the 45 states which have a policy. Table 7 presents the national summary. In most states (52.4%, n=22) patients are informed both verbally and in writing. Patients are informed in writing only in ten (23.8%) of the states and only verbally in seven (16.7%) states. In three states (7.1%) patients are not informed that they have the right to refuse psychotropic medication.

The point in their careers when patients are informed of their rights can be crucial to whether or not they choose to exercise their rights. Respondents to the national survey were asked at what point patients are informed of their right to refuse psychotropic medication in their state. Table 8 identifies the time during voluntary or involuntary commitment when patients are
### TABLE 7

Method of informing patients of the right to refuse medication

<table>
<thead>
<tr>
<th>METHOD</th>
<th># OF STATES</th>
<th>PERCENT (n=42)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written &amp; Verbal</td>
<td>22</td>
<td>52.4</td>
</tr>
<tr>
<td>Written</td>
<td>10</td>
<td>23.8</td>
</tr>
<tr>
<td>Verbal</td>
<td>7</td>
<td>16.7</td>
</tr>
<tr>
<td>Not informed</td>
<td>3</td>
<td>7.1</td>
</tr>
</tbody>
</table>
TABLE 8

When patients are informed of the right to refuse medication

<table>
<thead>
<tr>
<th>TIME</th>
<th># OF STATES</th>
<th>PERCENT (n=38)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission only</td>
<td>4</td>
<td>10.5</td>
</tr>
<tr>
<td>Admission</td>
<td>14</td>
<td>36.8</td>
</tr>
<tr>
<td>Within 72 hours</td>
<td>13</td>
<td>34.2</td>
</tr>
<tr>
<td>Upon request</td>
<td>23</td>
<td>60.5</td>
</tr>
<tr>
<td>When treatment changed</td>
<td>14</td>
<td>36.8</td>
</tr>
<tr>
<td>Never</td>
<td>1</td>
<td>2.6</td>
</tr>
<tr>
<td>Other times</td>
<td>11</td>
<td>29.0</td>
</tr>
</tbody>
</table>
informed of this right in 38 states. In many states patients are informed of their rights at more than one time. However, in four states patients are informed of their rights only at the time of admission. In addition to the three states which are identified in Table 7 as not informing patients of their right to refuse medication, another state's respondents admitted that although patients are supposed to be informed, they are not.

In two states, a patient's right to refuse medication can be overridden at any time. In all but one of the states which have a right to refuse policy, a refusal can be overridden in an emergency (97.7%, n=44). A refusal can be overridden only in an emergency in nine states (21%), while a refusal can be overridden in emergencies as well as in other situations in 31 states (72.1%). It is unknown when a refusal can be overridden in two states which do have a policy. Therefore, Table 9 represents the findings for 43 of these 45 states. In the two states which allow a refusal to be overridden at any time, an internal review committee is responsible for the override in one state and an outside psychiatrist in the other.

Who has the responsibility for overriding the right to refuse medication in emergency situations is presented in Table 10. In the 42 states where a refusal can be overridden, the treating psychiatrist can override the right in 36 of the states (85.7%). In the six remaining
### TABLE 9

Conditions under which a medication refusal can be overridden

<table>
<thead>
<tr>
<th>TIME</th>
<th># OF STATES</th>
<th>PERCENT (n=45)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>1</td>
<td>2.3</td>
</tr>
<tr>
<td>Anytime</td>
<td>4</td>
<td>4.7</td>
</tr>
<tr>
<td>Emergency only</td>
<td>9</td>
<td>21.0</td>
</tr>
<tr>
<td>Emergency &amp; Other</td>
<td>31</td>
<td>72.1</td>
</tr>
<tr>
<td>INDIVIDUAL</td>
<td># OF STATES</td>
<td>PERCENT (n=42)</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Treating M.D.</td>
<td>36</td>
<td>85.7</td>
</tr>
<tr>
<td>Outside M.D.</td>
<td>7</td>
<td>16.7</td>
</tr>
<tr>
<td>Internal review</td>
<td>5</td>
<td>12.0</td>
</tr>
<tr>
<td>External review</td>
<td>3</td>
<td>7.1</td>
</tr>
<tr>
<td>Court</td>
<td>11</td>
<td>26.2</td>
</tr>
<tr>
<td>Nursing staff</td>
<td>2</td>
<td>4.8</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>31.0</td>
</tr>
</tbody>
</table>
states, the court may override in emergencies in two of the states, the nursing staff in one, and a combination of clinical persons in the other three states. In non-emergency situations, a refusal can be overridden in 33 states (76.7%). In most states (66.7%, n=22) the court is responsible for overriding a refusal in non-emergency situations. Table 11 presents the findings from the national survey of who may override a patient's refusal when the conditions do not involve an emergency.

Respondents to the national survey were also asked to identify what treatments, in addition to psychotropic medication, patients may refuse. The data represent information from 47 of the states and are presented in Table 12. In all states patients may refuse aversive therapy, ECT, psychosurgery, and experimental treatments. In addition, some of these treatments are unavailable in a number of states.
<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th># OF STATES</th>
<th>PERCENT (n=33)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treating M.D.</td>
<td>7</td>
<td>21.2</td>
</tr>
<tr>
<td>Outside M.D.</td>
<td>4</td>
<td>12.1</td>
</tr>
<tr>
<td>Internal review</td>
<td>7</td>
<td>21.2</td>
</tr>
<tr>
<td>External review</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>Court</td>
<td>22</td>
<td>66.7</td>
</tr>
<tr>
<td>Nursing staff</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>33.3</td>
</tr>
</tbody>
</table>
### Table 12

Refusal of other treatments in all states

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Pts. May Refuse</th>
<th>Treatment Not Available</th>
<th>Status Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aversive</td>
<td>35</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>ECT</td>
<td>44</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Psychosurgery</td>
<td>34</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>Behavior Mod.</td>
<td>31</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>31</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Experimental</td>
<td>45</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>
Implementation

The implementing population in each state is that group of individuals who are responsible for taking the right to refuse policy as it has been interpreted and putting it in place within the institution. In most hospitals the implementing population consists of the administrative, professional, and custodial staff. In two of the site visit institutions, an administrator was part of the interpreting population as well. Discuss in this chapter how this factor may affect both interpretation and implementation. This section consists of three subsections, the data for which came from the 191 site visit interviews: the general medication issue, the implementation, and the impact of the psychiatric patients' right to refuse psychotropic medication.

The Problem of Medication. Because of the history of medication abuse in psychiatry and the potential dangers of medications, personnel at all levels were asked during the interviews, "Are patients now being overmedicated or undermedicated?" No one said that patients were being routinely "zonked" or overmedicated. Perpetual problems that emerge are generally associated with a specific individual. A psychologist (Ph.D.) in one institution stated, "One doctor who is still here brought patients to convulsions regularly." When an individual becomes identified as regularly prescribing or distributing
medications outside of that hospital's norm, that person is usually dealt with in one of three ways: fired, pressured to resign, or forced to change. Patterns of "irresponsible" medication practices are generally not tolerated, but incidents of overmedication do exist. Apparently the biggest medication problem today in state institutions, according to staff, is not overprescription of one drug but the prescription of too many drugs, polypharmacy, and unnecessary medications.

Although in all of the nine institutions included in this study at least one person interviewed said there were instances of "zonking" patients, it is hardly a routine practice. The purpose for overmedicating is control of behavior. According to a psychologist/unit director, "Our doctor [on our unit] medicates a lot more than I'm comfortable with. He wants the patients to be mellow." Although not speaking directly to the issue of overmedication, the behavior control implications of a nurse's statement are implicit: "We don't often see patients who have gotten too much medication. Doctors are good at regulating doses according to aides' and nurses' requests." There is no implication here that nurses and aides are unaware of symptoms of psychosis; rather their charting and observations are predominantly of behaviors and the control of these behaviors. When overmedication does occur, most interviewees agreed that it was due to
doctors' ignorance of individual medication effects, not negligence. According to one pharmacist, "Doctors' knowledge of psychopharmacology varies. Some doctors overmedicate and some do polypharmacy."

The major medication problem described by all of the professionals and other staff interviewed is polypharmacy. This problem was identified at least once in every institution by staff ranging from psychiatrists to aides. The only documentation of this problem was by a consulting clinical pharmacist (Doctor of Pharmacy). He randomly selected 350 patients statewide and developed drug profiles for each. He found consistent errors of polypharmacy, although this state has guidelines for polypharmacy, and distribution errors. According to a psychiatrist, one reason for this problem is the extensive use of anti-parkinsonian drugs, sedatives, and PRN's.* Many of the professional staff are unaware of the sophisticated problems that may arise from drugs as exemplified by one nurse who stated, "Yes, we see lots of side effects, but other drugs help control them."

The unnecessary use of medications with patients is caused, in part, by the desire for a "quick fix" according to one psychiatrist/director and the assumption that medications are always the treatment of "choice" according to a number of non-medical staff. Some psychoses are not responsive to psychotropic medications. And these patients
(e.g. patients diagnosed as having personality disorders) can often be among the most disruptive. They are medicated only for control purposes. Some psychiatrists admit that patients are unnecessarily medicated for control purposes as in the following response: "At times medications are used for control purposes, but this is less probable now due to the possibility of pharmacy audits." This was a common statement by staff in the nine institutions when asked why patients are no longer overmedicated. The fear of lawsuits against psychiatrists seems to be a frequently-held reason for lower drug doses. Although these statements do not directly credit or blame the patients' right to refuse medication movement as the cause of more careful medication regimes, the fear of litigation, though the rarest of occurrences, is better than no accountability at all. As one social worker stated, "If you're doing your job well, why do you care if someone is taking a peek?"

There was general consensus among all persons interviewed that overmedication of one drug is no longer a major problem. There is also agreement that in the past it was a significant problem. The focal issue is polypharmacy or the use of drug combinations. The technical sophistication of psychopharmacology nearly makes it exceedingly difficult for a psychiatrist to be well-informed about all the medications available and
certainly abut the interactions of all these substances. There is a presumption across all staff, administrative, medical, psychological, social service, and custodial, that medication is the best treatment for patients in state mental institutions. Because of this underlying assumption, some patients are unnecessarily subjected to various combinations of drugs -- some antagonistic and many ill-advised. The issue prior of overmedication thus becomes one of quality control of medications.

Interviewees were asked how state mental health officials could resolve the medication problem. Their responses generally fall into the very broad category of funding. Proper management is possible with proper funding. Responses from two psychiatrists in different institutions place the abuses of medication outside of a right to refuse or legal context: "Medications were being abused, but abuse of medications is a separate issue from the rights' issue. It [abuse] shouldn't have been handled as a rights' issue" and "The primary abuse is neglect by the state to provide funding." Both imply that with the proper funding, state institutions could provide a higher quality of care including safe medication plans. Nearly all individuals interviewed stated that funding determines the quality of care. For example:

"Our capabilities are totally dependent on the whims of the legislature. Politics are involved
in psychiatric medicine." (nurse)

"Today's patient population has more personality disorders and probably needs more dynamic tic/y, more psychological approaches due to the nature of their illness. But money problems result in our having to push medicine. Even the DSM III takes a more psychopharmacological approach." (psychiatrist)

"The quality of dispensing medications is directly related to the money we have." (pharmacist)

Recommendations for improvements with the proper funding include:

"Past problems resulted from fewer professionals, nurses. Bring up the professional quality of the staff, and you increase the quality of care being given." (nurse)

"I have found that I can control almost all side effects by involving proper clinical counseling, attention to the patient, and making a more accurate diagnosis." (psychiatrist)

"If we get more people, the first thing I will do is start the unit dose system and develop a drug profile card for each patient." (pharmacist)

Only one person, a patient advocate, responded that the problem is not simply funding: "[We] need more extensive training and education of staff with regard to human rights and patients' rights." The role of an advocate or the court as a source of review within the mental health context and particularly for insuring patients' right to refuse medication was responded to in a variety of ways:
"Courts should order that a patient be treated at the time of commitment." (psychiatrist)

"[The legal advocates] and us are poles apart in what issues are relevant, but we understand that in their way they hope to change things for the better. But they are obnoxious. We all realize that major changes can come about by a legal model. But in this case patients are being used to win a legal battle." (nurse)

"Advocacy? I don't think they [patients] should be overmedicated, but lawyers don't know about treatment." (aide)

"A patient does need an advocate if he is going to be taken seriously. There is inevitably somebody of the staff who will take this role." (psychiatrist)

"Advocates would spend a lot of time on meaningless issues; they would be resented. If used, advocacy should be someone familiar with what a state hospital is." (aide)

"The public is generally unaware of how much internal scrutiny there is within the fraternity of doctors." (psychiatrist)

"Peer review doesn't have a very good history of providing effective scrutiny. If my peers are looking over my shoulder, I'll worry about clinical issues, but if a lawyer is looking, I'll be wary of legal issues." (psychiatrist)

Most persons who agreed that an advocate could be helpful stated specifically that "It shouldn't be a lawyer." There were strong statements that the advocate had to know what it is like to work in mental health. Some staff did argue that the advocate needed to be external to the staff, someone who could be a true advocate; this was a minority position. If a patient advocate was to be
forced on the institution, most staff said they would be more tolerant if a mental health professional assumed the role. In the one institution which had a lawyer-advocate, the staff tolerated the role while the administration accepted the role.

Nearly all of the staff interviewed evaluated the problem of medications, whether overmedication, polypharmacy, or unnecessary medication, as one of management and funding. With a few exceptions, the persons interviewed did not state that the medical model itself as a problem. The staff in state mental institutions are not willing to embrace a legal approach to advocacy or review.

An assistant attorney general for one department of mental health made the following statement and recommendation:

"Before I got involved, the medical professionals wanted to just let the courts and legal activists take charge and let the cases unfold in a legal way. I convinced them that the best way to go would be to not involve lawyers but instead to develop a policy that would satisfy the medical needs as well as the patient needs. In fact, I told them I could defend them better if they had a uniform, rational, and medically-sound policy."

The recommendation made by the attorney above is one which combines both a medical and legal approach, one which recognizes medical and legal needs of patients. It is not a "rights-based" approach or simply an "in the best interests of" approach, but an administrative attempt to
settle the medical-legal rift.

Whether a state has developed a policy from a legal or administrative approach, the policy has to be implemented to have any value to the consuming population, the patients. Five questions were raised specifically with regard to implementation of the right to refuse medication policy: "How was the staff informed, what were the staff reactions, what were the staff anticipations, how are patients informed, and what was the impact of the right to refuse medication policy?"

In two institutions a member of the administrative staff was involved in the interpretation and development of the right to refuse policy. The administrator of one hospital shared the drafts of the statute with the professional staff in the process of its development. He carried those comments back to the legislators responsible for drafting the statute. This was cited by many persons interviewed in that institution as being helpful. However, in another hospital in that same state, the head nurse said, "This was a critical problem. We were never really informed about the statute. No one really explained the law to us." The staff in this hospital stated that there was, as a result of no prior knowledge of the policy, a lot of fear and anxiety, or "treatment paralysis." There is some uncertainty how the staff were actually informed in the second hospital wherein the medical director played a
significant role in developing that state's policy. Although the staff now appears supportive of their medication review process, the unit directors agreed that they simply received a memo which informed them of the new policy.

Not all staff are aware that some patients can refuse medication as illustrated by a unit director's comment: "I don't think [this state] has a policy on the right to refuse medication, do they?" The staff in most of the hospitals were informally told notified of the right to refuse policy. The methods of informing staff varied from a memo on a bulletin board to "by word of mouth." No attendants stated that they were specifically and clearly informed of the policy or procedures. These individuals have the most frequent contact with the patients and do, in some states, distribute or participate in the distribution of medications. Additionally, the attendants as well as other staff expressed a lot of fear and confusion in anticipation of the implementation of the right to refuse medication policy.

Staff reactions to most right to refuse policies is expressed by one nurse: "Here they go making a law they don't have to work or live with." Some staff expressed concern that another regulating group (review process) was going to be scrutinizing their work. And, of course, there were concerns about encroachments on professional "turf"
and practicing medicine by committee. There were reactions such as "What about our rights?" and that allowing patients to refuse medication would open a "Pandora's Box" of problems. Confusion about what exactly the policy implementation would entail and how it would affect their work and the patients was coupled with frustration that their work was unappreciated. At the same time, many staff stated that patients should be allowed to express themselves. The reactions were generally that the right to refuse medication was unnecessary since they were doing their jobs anyway. One hospital administrator expressed the commonly-held assumption that commitment equates with dangerousness and, therefore, precludes refusals: "None of the staff seemed troubled by the right to refuse section of the [mental health] law because if a patient didn't need medications, they would probably not meet the criteria to be committed. Thus, this is really a moot issue."

The most common anticipation of the staff was that if patients could refuse medication, there would be chaos. The staff also feared that a large number of patients would refuse medication and become violent and/or disruptive on the ward. Because staff consistently stated that patients who are on medication stay for shorter periods of time, they anticipated that patients who remained medication free would stay longer. A psychologist expressed both the fear of unmedicated patients and the detrimental effects to the
patient: "I cringe at the thought of a patient population able to refuse medications. Most of these patients are in a state of horror in their illness and shouldn't be in this state if we can do something to stop it." Those professionals directly involved in the distribution of medication frequently expressed fear of legal scrutiny as illustrated by this nurse's statement: "The advocate as a lawyer creates fear. Now for the first time in my career, I've purchased malpractice insurance."

For patients to express their right to refuse medication, they must be told that they can. No one interviewed said that there is an on-going effort to assure that patients understand what their rights are, including the right to refuse medication. Frequently, people would say that if patients ask what their rights are, they are told. Patients are read and/or given a written copy of their rights, but most of the staff said that they do not go out of their way to help the patients understand. Even if patients are read their rights and given a copy, there is no assurance that they understand it. One psychologist stated, "I did a little study showing how out of sync the content forms were with the average literacy level of our patients, and some of the forms were modified. Very few patients are probably really informed about the right to refuse so that they understand it." In another state a nurse said, "[Informing patents of their rights is] really
not consistently done. If a patient asks us about it, we will tell them about the law and some of the short term side effects. If we get too detailed, too many would refuse." In yet another state, an attendant stated, "Patients are not told that they can petition the court to remain free from medications."

Disclosure of information to patients concerning the short and long term side effects of their medications is not routinely done. How much information is given to patients varies from doctor to doctor. Many staff stated that if patients were told of the side effects they would either develop psychosomatic side effects or refuse to take the medication altogether. Some doctors stated that they give full disclosure of the side effects while other doctors admitted that they do not inform the patients of long term permanent side effects until their patients begin to display symptoms. Often the potential side effects are presented in written form with little follow-up to ascertain the patients' comprehension. When questioned about their reluctance to disclose this information, some psychiatrists responded that psychosis is worse than tardive dyskinesia.
Impact

The impact of the implementation of psychiatric patients' right to refuse psychotropic medication was addressed in this research. Interviewees were asked to describe if and how the right has affected their professional practice, record keeping, interaction with patients, interaction among staff, patient behavior, frequency of refusals, who refuses, and what they as staff do when a patient refuses. Because of the anticipation, fear, and frustration described by staff in the previous section, it was anticipated that the right to refuse medication would have had a significant impact on hospital operations.

Most persons interviewed stated that the right to refuse medication has in some way affected their professional practice. As anticipated, not all interviewees felt that the impact was positive, but a considerable number of the individuals stated that the implementation of the right has been a positive one. There has been no actual documentation in the states as to the actual impact of the right to refuse medication. The data from the site visits reflect interviewee perceptions as conveyed to the researchers. Interviewee responses are anecdotal but elucidate the issue of how this right has affected the delivery of mental health services. The range of responses to the question of how the implementation of the
right to refuse medication has impacted professional practice are illustrated by the following:

"The quality of the hospital has improved since the patients' rights movement." (attendant)

"Two to three years ago this place was a snake pit. Now there is more treatment going on, less overmedication, better diagnosing, and more open to visits." (clinical pharmacist)

"Twenty years ago nurses gave patients their medications without question. It's different now because treatments have changed and because laws have passed which make patients more aware [of their rights]." (nurse)

"Before when a patient refused, we just took two or three people and held him down and injected. Now we can't do this unless the patient is dangerous or court ordered." (nurse)

"Unfortunately some very sick people have been put out on the streets due to changes." (administrator, non-clinical)

"Legal advocacy has paralyzed treatment." (psychiatrist)

"[The impact is a] deprivation of medical and psychiatric care." (psychiatrist)

A tangible effect of the right to refuse policies is usually an increase in documentation or record keeping as illustrated by this nurse's statement: "Now, more documentation is leading to better charting of patient behavior which leads to better identification of problems before they get out of hand. Also [this documentation] helps keep an eye on side effects." Although there is an increase in documentation, including signing an informed
consent document, a psychiatrist talked about the questionable usefulness of this: "A lot of this is a lawyer's game. We comply by getting the patient to sign. We know darn well the patient doesn't understand it, but they have to sign."

All of the clinical and custodial persons interviewed stated that they are spending more time talking with patients about their treatment, including medications. One advocate responded that the reverse is true. For example, the following responses were to the question, "How has the right to refuse medication affected staff interactions with patients?":

"Negotiation has increased the therapeutic nature of the hospital. There are better dynamics between the staff and patients." (psychiatrist)

"Attendants and nurses are now spending significant amounts of time negotiating and talking with patients. Also, there is more patient contact with the doctors." (nurse)

"Line staff have recognized the fact of working with patient behaviors. We realize we don't have to medicate to control people." (nurse)

"As a consequence of a successful refusal, staff becomes less involved with the patient . . . passive rejection." (legal advocate)

Staff interactions with one another have also been affected by the implementation of the right to refuse medication. This change is well-illustrated by a nurse who states, "Now the doctors are more responsive to nurses'
concerns. Part of this change is caused by the right to refuse. In the past we were little more than 'chambermaids' to the doctors."

There was anticipation by the staff before the implementation of the right to refuse medication that patient behavior would change dramatically, particularly that they would become violent and hostile. Also, the general consensus among the interviewees was that patients would stay in the hospital for longer periods of time if they were allowed to refuse medication. Few persons stated that patients have actually become more violent or hostile. The responses to the question, "How has patient behavior been affected by the right to refuse medication?" were varied. For example:

"We had a lot fewer problems when we could give patients a shot whenever we thought they needed one." (attendant)

"Now patients tell one another they don't have to take medications, creating an occasional disruption." (attendant)

"At one time, 40 percent of the patients on my unit were not on medications (not because they refused). All participated in other treatments with no problems." (psychologist/unit director)

"In spite of what everyone will tell you, patients are not time bombs, with or without medications." (chief psychologist)

Another anticipation among staff prior to the implementation of the right to refuse medication was that a
great many patients would refuse. This fear has not been realized. No interviewee stated that more than a "few" patients refuse their medication. It is not yet clear why patients do not refuse their medications, but some of the following responses describe the frequency of refusals and suggest possible reasons:

"Some patients have refused, but not to the degree we originally anticipated." (nurse)

"As chair of the patient grievance committee, no patients have raised the issue." (psychologist)

"There is a lot of resistance to medication, not outright refusals. We spend a lot of time negotiating the patient into [taking] medications." (nurse)

"Medication refusals are really not big deals. The critical one was the first case we took to court. We won and the frequency of refusals decreased following this." (review committee)

"We've got a lot of people here from the eastern part [of this state] who are afraid of us, that we're going to cut on their brain. If we explain our treatment to them (medication), they go along with little resistance." (psychologist)

"I think if involuntary patients know they could petition the court, there would be a lot more refusals." (attendant)

Many staff assert that certain types of patients refuse medication more frequently than others. This belief has not yet been documented. The question, "Who refuses?" was met with two general categories of responses: those patients who have had bad reactions to medications in the past or are experiencing them at the time, or those
patients whose refusals are a product of their mental illness. For example:

"Patients who have had dystonic reactions in the past." (nurse)

"Manics who like their mania." (nurse)

"Get a couple of antisocial personality patients on the unit and they pigeon-hole new patients into refusing by telling them they don't have to take medications. Sociopathic personality, paranoid patients who have been admitted on numerous occasions will often refuse specific medications and take the one they think makes them feel best." (nurse)

"Most refusals are not the product of a clear cognitive process but instead are related to a general behavioral pattern of manipulation." (psychologist)

One final impact question asked was, "What do you do when a patient refuses medication." The most common response was some form of negotiation with the patient; however, there were some clear indications that patients are coerced into taking their medications. The following responses illustrate both of these points:

"The best way [to respond] is to help the patient recognize their own symptoms and to recognize when they need it and when they don't." (social worker/unit director)

"[I] don't argue, don't force. After all the other medications have been given out, [I] go back and talk to the patient. [I] try to explain about the medications, tell them what they look like, how often they are to be taken, side effects that we need to be aware of, but not about the hairy tongue." (nurse)
"[I] chart the refusal, state that we need medications for management of the patient (not for treatment), thus we can force without a review or court." (nurse)

"I try to get someone else to get the patient to accept, go back 20 minutes later and try again. Go to the doctor if necessary, link taking medications to other privileges as part of the general treatment plan." (nurse)

"We have a behavior modification program underway. If a patient refuses medications, they lose points. If they object to side effects, we talk to the doctor. If they say it tastes bad, we give it to them anyway." (psychologist/program director)

The overall impact of the implementation of the right to refuse medication in state psychiatric hospitals has been positive, according to the staff. Very few patients actually refuse their medications, but their reasons for objecting can be legitimate (or non-psychotic). Aside from the increase in documentation, none of the anticipations or fears expressed prior to implementation have been realized according to the staff interviewed. There was no indication in any of the site visit institutions that the violence of patients has increased. Because the interpreting population in every state but one has given the power to the implementing population to override a medication refusal in an emergency, it is not surprising that there has not been an increase in violence.

There remains the question of whether or not patients are fully aware and informed that they may refuse
medication and if they would more often refuse medication if they were aware of their right. Later research will directly assess this issue in interviews with patients at Lima State Hospital in Ohio.
CHAPTER SEVEN

CONCLUSIONS

The questions of initiation, interpretation, implementation, and impact of psychiatric patients' right to refuse medication within state psychiatric institutions were addressed in this research. There exist are many interpretations of the general "right to refuse" issue set forth by the courts. Overall, most state policies provide all patients, regardless of competency and status of commitment, with the right to refuse psychotropic medications except in emergency situations.

Integral to the interpretation phase of the right to refuse medication is whether or not those states which have formally addressed the issue and developed a policy have incorporated the second major component of the policies encouraged by the courts, that of an administrative review as a procedural guarantee of the right to refuse medication. (The first component is that a policy exists at all.) In only two states visited is there an "administrative" review of medication refusals. In one of the two, the procedure involved a multidisciplinary review
of treatment, and in the other state, the procedure consisted of a review of medication refusals by three psychiatrists. In the remaining three states visited, it was the responsibility of the advocate or the clinical director to review refusals.

How the right to refuse policy has been implemented in the states varies greatly across jurisdictions included in the site visit phase of the research. The implementation style perceived by most staff as least "intrusive" was when at least some of the implementing staff was involved in the interpretation of the state's policy. In only two institutions (in different states) was this the case. In most of the states visited, no staff were involved in the policy formulation stage of the right to refuse medication issue. They were sometimes simply handed the policy and told to implement it. Often this was resented by those staff interviewed.

An important implementation question is whether the policy has been implemented as it was interpreted. One important factor which may help to answer this question is whether the patients are informed that they can refuse medication. The findings in this research strongly suggest that most patients are not informed in a meaningful way. For example, many staff stated that they read patients their rights, but there is no effort to guarantee that
patients understood the information. Patient knowledge of the right to refuse medication is really the key to the implementation; if patients do not refuse medication, the later implementation questions become moot.

In the cases where patients are aware that they can refuse medication and refuse to take their medications, staff were asked what they do in such instances. Official responses to these patients varies by and within the states. For example, if a patient refuses medications who cannot refuse, by the stated policy, the staff can respond differently than to a "legitimate" refuser. From the interviews with mental health staff, it was concluded that there has been an overall increase in persuasive techniques used by staff to convince all patients to take their medications. These staff suggested that their approach is, as a result of the medication refusal policies, more negotiative than in the past when they could force medications on any patient under their care. Coercive methods of medication compliance were frequently noted and do not indicate "effective" implementation of the policy.

Changes in professional practice noted by mental health staff interviewed provide one indicator of impact of the right to refuse medication. The positive impacts mentioned by the staff included an increased awareness of medication doses and side effects, an increase in documentation which assists in diagnosis and treatment, and
an increase in interaction with patients and other staff. Negative impacts included a form of "treatment paralysis," or a fear of forcing medications or any treatment in situations perceived by them to be dangerous. A few staff stated that there was an increase in injuries to staff and other patients, and that patients who have refused their medications sometimes become disruptive on the ward. Further, many staff mentioned the increase in time spent charting.

Factors Which Affect the Quality of Psychiatric Patients' Right to Refuse Psychotropic Medication: The Role of Social Distance

The concept of social distance is considered here to have two interrelated components: social-psychological distance and structural-bureaucratic distance. Although the present research does not "measure" these two factors, it is suggested that these two components are useful in approaching an explanation as to why there exists such considerable variation in the quality of the right to refuse medication from state to state, hospital to hospital, doctor to doctor, and patient to patient.

Social-psychological distance is the distance an individual perceives he or she has from another person. Socio-economic status and race are the clearest examples of attributes fostering social distance. In the case of mental illness, being institutionalized in a state mental
hospital is all too often an indicator of social class. The psychological partner to actual social distance is how one internalizes or perceives this social distance. For example, during the interviews with staff, one doctor and one attendant each referred to patients as "its." Further, being defined as "mentally ill" places one psychologically distant from many persons. An attendant (who had at one time been treated for a mental illness) in one hospital commented that the staff perpetuate the myth of mental illness that the general public has of the mad (Szasz, 1974). She stated that the staff often talk about the patient in his or her presence with total disregard of that patient (Goffman, 1961). Staff frequently stated that patients would be "off the wall" or "on the ceiling" without medications; these statements are not descriptive of psychiatric reality.

Included in the social-psychological component of distance as well are factors such as race, sex, age, and ethnicity (among others). It is proposed that the greater the perceived social-psychological distance both by the staff and the patients, the less the exercise of the right to refuse medication.

Structural-bureaucratic distance is more concrete than the social-psychological component, and to some degree, this factor was addressed in the research. Structural-bureaucratic distance is static and observable,
and the formal authority structure is fixed as well. Within the governmental bureaucracy of mental health, it is determined which agencies or divisions have authority over others. While some individuals, despite these boundaries, may have informal power, that is part of the social-psychological component. What is structurally, though not necessarily socially, clear is that the judicial and legislative branches of government have a great amount of legitimate authority over the mental health system (as part of the executive branch).

Within the context of psychiatric patients' right to refuse medication, the interpreting populations vary among the states, and these populations represent different levels within the structural hierarchy. It is proposed that the greater the structural-bureaucratic distance between the interpreting and implementing populations, the less the exercise of the right to refuse medication. When joined with the social-psychological component, this factor would account for the variation in the right to refuse medication policy implementation and impact.

Horwitz (1982) studied the relationship between patients and staff and the focus of the social control effort. The relationship can be either coercive or persuasive, and the focus of control can be either on conduct or personality. Below is a presentation of the possible variations:
Relationship between parties:

<table>
<thead>
<tr>
<th>Focus:</th>
<th>Coercive</th>
<th>Persuasive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct</td>
<td>Adjudicatory</td>
<td>Conciliatory</td>
</tr>
<tr>
<td>Personality</td>
<td>Indoctrinatory</td>
<td>Therapeutic</td>
</tr>
</tbody>
</table>

Horwitz (1982) states that when coercive attempts to change a person's conduct are imposed by a third party and are ultimately backed by coercive force, the result is adjudicatory social control. When attempts to change a person's conduct are persuasive, conciliatory social control results. Medication refusals can be resolved either by adjudicatory or conciliatory means; if a patient is involuntarily committed to an institution and ordered to be treated (with medication), that is adjudicatory. When mental health staff persuade a patient to take his or her medications, this is conciliatory social control. Treatments aimed at changing the conduct of a person, not the personality, cannot be therapeutic (or indoctrinatory). During this research, not one staff member interviewed stated the purpose of the medications were for anything other than control of disturbed behaviors (conduct). No one claimed that patients' personalities where changed by the medications. Horwitz (1982) continues and includes ECT, lobotomies, chains, and straitjackets as treatments aimed to control the conduct, not the alter
personalities of mental patients.

For a patient's mental status to be changed, he or she must participate in the treatment. Therapeutic social control (indoctrinatory social control will not be discussed) includes the manipulation of cultural symbols or language; therefore, the therapist and the patient must share a language. The patient must also believe in the efficacy of the technique for it to be therapeutic. Further, the therapist and patient must have a relationship based on trust. Coercive techniques of social control preclude the development of trust. Horwitz (1982) suggests that as cultural distance increases and social rank decreases, the patient is less likely to seek therapy voluntarily. He continues (1982:141), "Culturally distant and low ranking individuals are more likely to receive coercive control or to be neglected completely," and "The application of [therapy] is inversely related to the perceived severity of mental illness." Staff interviewed frequently stated, "These patients are the 'bottom of the barrel.'" Horwitz's (1982) propositions are consistent with those stated above with regard to social distance. The social-psychological variations among staff and patients alike account in part for the variation in the quality of the right within each hospital; the structural-bureaucratic component additionally must be studied.
The most structurally distant interpreting population is the legislature. This conclusion is derived from the recognition that statutes are usually, by their very nature, vague. By the time a bill becomes a law, it has gone through so many amendments, committees, and revisions that its original intent is frequently lost. In the states visited which do have the right to refuse medication by statute, the quality of the right observed was very low. Further, because of the courts' deference to the states, a state which has a statute is legally "safe," regardless of the way the right is implemented in the institutions. From a political perspective, legislators are susceptible to the whims of the constituents. The right to refuse medication issue is potentially volatile.

The second most distant population is the court. The formal bureaucratic hierarchy within the court system is, of course, important and relevant; the U.S. Supreme Court is more distant than the federal circuit courts and so forth. It should also be noted that the political vulnerability of judges declines with increased distance. Federal judges are not vulnerable whereas state judges may be. The court is considered structurally distant in part because of the time required to involve the court in the issue. Although the court can place an official within an institution to monitor the decision's implementation, the court's interests are often focused on the legal issues,
rather than on the therapeutic issues.

The third structurally distant population is the attorney general of each state. Because so few states utilized this method of interpretation, it will not be discussed in detail. Attorneys general are occasionally called upon to interpret legal questions for a department and to make recommendations. These opinions have a major legal impact. The three legal methods of interpretation -- statutory, litigation, and attorney general opinion -- are considered structurally and bureaucratically distant populations.

The methods of changing mental health law, administrative rule and departmental policy (administrative methods of interpretation), are structurally less distant than the legal methods. In the site visit state which interpreted psychiatric patients' right to refuse psychotropic medications by way of a departmental policy, the quality of the right was great in that it appeared that patients were able to refuse medication and to have their medication reviewed by an interdisciplinary panel. It must be stressed that the social-psychological factors are integral to this conclusion. The officials within the administrative and departmental segments of the mental health system are politically vulnerable, but the responsibility for changes is diffused and often the changes proceed without much public notice. (This is not
to say that political vulnerability is good or bad.) These
officials, too, are closer to the mental health system than
are the legislators, courts, or attorneys general, and they
are closer to the mental health staff. It is suggested
that right to refuse policies proposed at the administrative
and departmental level will be implemented more
effectively, and the quality of the right to refuse
medication will be greater.

Whether psychiatric patients may refuse psychotropic
medication is an issue different from whether they can
refuse medication. The existence of a formal policy does
not guarantee that patients will be able to remain
medication free if they choose to do so. Proponents of
this right often advocate either a purely medical or legal
approach to the issue. This research demonstrates that
neither model by itself addresses the full range of
questions raised by each position. The two are not
mutually exclusive.

As Horwitz (1982) states, punishment can be forced on
anyone, treatment cannot. If we are, as a society, going
to claim that medication is treatment, it must be
voluntarily accepted, not simply tolerated. It must be
accepted because both the therapist and the patient believe
that it is the most appropriate form of treatment, and that
it will benefit the patient. If these conditions are not
met, the medication is transformed into a method of conduct
control. The legal model of commitment and forced treatment may meet the demands of an adjudicatory model, but it is coercive. It should be the patient's choice. Judi Chamberlin (1982:168), a former mental patient, articulates the scope of psychiatric patients' right to refuse psychotropic medication as follows:

People who have undergone emotional crises are beginning to speak up about their own perceptions of mental health professionals and their "treatments," and, not surprisingly, these differ from what professionals have assured themselves and the public that patients think. Most mental health professionals consider themselves benevolent people and their patients as needy and helpless. Slavemasters thought the same about their relationship to their slaves; men have seen themselves as benefactors of women; white people saw themselves bringing "civilization" to people of color; people from developed nations have maintained these attitudes toward those they have called "primitive."

As members of these groups assert control over their own individual lives, and over their collective destinies, those whose power and control are threatened will object, will proclaim their own goodness and the dreadful results of the powerless obtaining power, and will sometimes fight to maintain control. The right to refuse "treatment" is one part of this vast process in which the goals are autonomy, freedom, and human dignity.
## APPENDIX A: LIST OF MEDICATIONS*

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phenothiazines:</strong></td>
<td></td>
</tr>
<tr>
<td>Acetophenazine</td>
<td>Tindal</td>
</tr>
<tr>
<td>Butaperazine</td>
<td>Repoise</td>
</tr>
<tr>
<td>Carphenazine</td>
<td>Proketazine</td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>Thorazine</td>
</tr>
<tr>
<td>Fluephenazine</td>
<td>Permitil, Prolixin</td>
</tr>
<tr>
<td>Perphenazine</td>
<td>Trilafon</td>
</tr>
<tr>
<td>Piperacetazine</td>
<td>Quide</td>
</tr>
<tr>
<td>Prochlorperazine</td>
<td>Compazine</td>
</tr>
<tr>
<td>Promazine</td>
<td>Sparine</td>
</tr>
<tr>
<td>Thiopropazate</td>
<td>Dartal</td>
</tr>
<tr>
<td>Thioridazine</td>
<td>Mellaril</td>
</tr>
<tr>
<td>Trifluoperazine</td>
<td>Stelazine</td>
</tr>
<tr>
<td>Trifluromazine</td>
<td>Vesprin</td>
</tr>
<tr>
<td><strong>Butyrophenones:</strong></td>
<td></td>
</tr>
<tr>
<td>Haloperidol</td>
<td>Haldol</td>
</tr>
<tr>
<td><strong>Thioxanthenes:</strong></td>
<td></td>
</tr>
<tr>
<td>Chlorprothixene</td>
<td>Taractan</td>
</tr>
<tr>
<td>Thiothixene</td>
<td>Navane</td>
</tr>
<tr>
<td><strong>6, 7, 5--Tricyclics:</strong></td>
<td></td>
</tr>
<tr>
<td>Amitriptyline</td>
<td>Elavil</td>
</tr>
<tr>
<td>Desipramine</td>
<td>Norpramin, Pertofrane</td>
</tr>
<tr>
<td>Doxepin</td>
<td>Sinequan</td>
</tr>
<tr>
<td>Imipramine</td>
<td>Tronfanil</td>
</tr>
<tr>
<td>Nortriptyline</td>
<td>Aventyl</td>
</tr>
<tr>
<td>Protriptyline</td>
<td>Vivactyl</td>
</tr>
</tbody>
</table>
Monoamine Osidase Inhibitors:

- Isocarboxazid
- Nialamide
- Phenelzine
- Tranylcypromine

Propanediols:

- Meprobamate
- Tybamate

Bensodiazepines:

- Chlordiazepoxide
- Diazepam
- Oxazepam

Other Structures:

- Hydroxyzine
- Lithium Carbonate

Antiparkinsonian Agents:

- Antihistamine
  - Orphenadrine
- Antihistamine & Anticholinergic
  - Diphenhydramine
  - Benztropine
  - Ethopropazine
- Anticholinergic
  - Procyclidine
  - Trihexyphenidyl
  - Biperiden
- Dopamine Agonist
  - Amantadine

*These lists were compiled from Hoffman (1981) and Martin (1980).
APPENDIX B: NATIONAL SURVEY INSTRUMENT

RIGHT TO REFUSE TREATMENT: A POLICY ANALYSIS

Sponsor: Ohio Department of Mental Health
Office of Program Evaluation & Research
Dee Roth, Chief

Research Team: Department of Sociology
The Ohio State University
Dennis R. Longmire, Ph.D.
Principal Investigator
Simon Dinitz, Ph.D.
Research Associate
Lisa A. Callahan
Graduate Research Associate

We want to obtain information about psychiatric patients' right to refuse psychotropic medication in the fifty states. This questionnaire has been mailed to all Commissioners, Attorneys General, Mental Health Attorneys, and Research Divisions. For the purposes of this study, "psychotropic medication" includes anti-psychotic drugs such as Thorazine, Mellaril, Prolixin, and Haldol, as well as anti-depressants and lithium. This questionnaire should take no longer than ten minutes to complete.

It is essential for us to have the following information for each respondent:

State ____________________________
Department ____________________________
Title of Respondent __________________
Address _______________________________
Phone Number ____________________________

Please answer the following questions. Additional comments and information beyond the limits of this survey are welcomed.
SECTION 1

1) Do psychiatric patients in your state have the right to refuse any one or more "psychotropic medications" listed above?  
   ___ yes (Please answer the following questions.)  
   ___ no (Please proceed directly to SECTION 2 below.)

2) Does this right apply to patients being treated in state, private, and/or community mental health facilities?  
   ___ state  
   ___ private  
   ___ community

3) Which of the following patient groups have the right to refuse psychotropic medication? (Please check all that apply.)

<table>
<thead>
<tr>
<th>CIVILLY COMMITTED</th>
<th>STATE</th>
<th>PRIVATE</th>
<th>COMMUNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>voluntary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>involuntary, non-criminal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>competent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>incompetent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>inpatient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>outpatient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>adult</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRIMINALLY COMMITTED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>penal transfers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>incompetent to stand trial</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>guilty but mentally ill</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>not guilty by reason of insanity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>special classification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e.g. sexual psychopath)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHERS (Specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4) Was your state's formal recognition of psychiatric patients' right to refuse psychotropic medication the result of any or all of the following? (Please check all that apply.)
   ___ statutory provision  
   ___ litigation  
   ___ administrative rule  
   ___ departmental policy  
   ___ attorney general opinion  
   ___ other (Specify)__________________________

5) Approximately when did your state formally recognize this right? Please list approximate year__________.

6) If possible, please provide us with copies of any existing documentation you have regarding the origin of this right (e.g. copies of statute, case citations, copies of administrative rules).
7) Is there any litigation pending in your state which addresses psychiatric patients' right to refuse psychotropic medication?  
   ___ yes (case citation____________________)  
   ___ no

8) Is there any litigation pending in other jurisdictions which may have an impact upon your state's policies regarding the right to refuse psychotropic medication?  
   ___ yes (case citations________________________________________)  
   ___ no

PLEASE PROCEED TO SECTION 3.

SECTION 2

1) Has the issue of psychiatric patients' right to refuse psychotropic medication been raised in your state?  
   ___ yes  
   ___ no (Please proceed directly to SECTION 5 below.)

2) Where was the recognition of this right initiated? (Please check all that apply.)  
   ___ statutory provisions  
   ___ litigation (case citations___________________________________)  
   ___ administrative rule  
   ___ departmental policy  
   ___ public interest groups  
   ___ media  
   ___ patient/client-initiated  
   ___ other (Specify)______________________________________________

3) Please provide us with copies of any existing documentation or commentary you have regarding the current status of this right.

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

PLEASE PROCEED TO SECTION 5.

SECTION 3

1) How are patients informed of the right to refuse psychotropic medication? (Please check all that apply.)  
   ___ in writing  
   ___ verbally

2) Please provide us with a copy of your informed consent statement and patient rights information given to patients/clients.
3) At what time(s) during their commitment are patients/clients informed of this right?
   ___ at admission only (within 24 hours)
   ___ within 72 hours of admission
   ___ upon patient/client request
   ___ every time their treatment plan/schedule is changed
   ___ never
   ___ other (Specify) _____________________________________________

4) Can the patients' right to refuse psychotropic medication be overridden?
   ___ yes (Please proceed to SECTION 4 below.)
   ___ no

5) Under what conditions can officials override the patients' right to refuse medication?
   ___ anytime
   ___ only in an emergency (Please define "emergency")
   ___ other (Specify)

6) Who has the authority to determine when the right to refuse can be overridden in non-emergency situations? (Please check all that apply.)
   ___ non applicable (right to refuse unavailable)
   ___ treating physician
   ___ outside consulting physician
   ___ internal review committee
   ___ external review committee
   ___ court
   ___ nursing staff
   ___ other (Specify)

7) Who has the authority to determine when the right to refuse can be overridden in emergency situations? (Please check all that apply.)
   ___ treating physician
   ___ outside consulting physician
   ___ internal review committee
   ___ external review committee
   ___ court
   ___ nursing staff
   ___ other (Specify)

8) Please briefly describe the standard process by which the patient right to refuse psychotropic medication is overridden.

9) Please include any documentation describing this process.

PLEASE PROCEED TO SECTION 4.
SECTION 4

1) Are you aware of any "in house" studies of psychiatric patients' right to refuse medication?
   yes
   no (Please proceed to SECTION 5.)

2) What issues are addressed in this study? (Please check all that apply.)
   ___ frequency of use
   ___ frequency of override
   ___ categories of patients using the right
   ___ impact on staff workload
   ___ impact on institutional climate (e.g. violence, discipline)
   ___ fiscal impact
   ___ other (Specify) ____________________________________________

3) Who should we contact to learn more about this research? (Please provide name, address, and phone number.) __________________________

PLEASE PROCEED TO SECTION 5.

SECTION 5

1) Do psychiatric patients in your state have the right to refuse any of the following? (Please check all that apply.)
   a) aversive therapy
      ___ yes, patients can refuse
      ___ no, patients cannot refuse
      ___ not available
   b) electro-convulsive therapy
      ___ yes, patients can refuse
      ___ no, patients cannot refuse
      ___ not available
   c) psychosurgery
      ___ yes, patients can refuse
      ___ no, patients cannot refuse
      ___ not available
   d) behavior modification
      ___ yes, patients can refuse
      ___ no, patients cannot refuse
      ___ not available
   e) psychotherapy
      ___ yes, patients can refuse
      ___ no, patients cannot refuse
      ___ not available
   f) experimental/research
      ___ yes, patients can refuse
      ___ no, patients cannot refuse
      ___ not available
   g) other (Specify) ____________________________________________
2) In addition to this questionnaire, we are going to be contacting several other persons within each state who have knowledge of the issues involved in the patients' right to refuse psychotropic medication (e.g. advocates, superintendents, lawyers, mental health administrators, etc.). Please provide us with any names, addresses, and phone numbers of individuals you recommend we contact.

THANK YOU FOR YOUR COOPERATION. PLEASE REMEMBER TO INCLUDE WITH YOUR COMPLETED QUESTIONNAIRE ANY SUPPORTING DOCUMENTATION.
APPENDIX C: SITE VISIT CODING FORM

Position:
Hospital:
Style of Implementation:

1. Why is the right to refuse medication an issue?
2. Are patients now overmedicated/undermedicated?
3. How might problems with medication be resolved without resorting to right to refuse policies?

4. Implementation Issues:
   a. How was the staff informed of new policy?
   b. What were staff reactions?
   c. What were staff anticipations?

5. Actual Impact of Right to Refuse Policy:
   a. Changes in professional practice.
   b. Changes in record keeping.
   c. Changes in interaction with patients.
   d. Changes in interaction with staff.
   e. Changes in patient behavior.
   f. Frequency of refusals.
   g. Who refuses.
   h. What do you do when a patient refuses?
6. Recommendations about how the process might be improved:

7. Other statements:
APPENDIX D: SITE VISIT HOSPITALS AND INTERVIEWS

Anoka State Hospital
(Anoka, Minnesota)

Medical Director, Psychiatrist
Chief Executive Officer
Assistant Administrator
2 Consulting Psychiatrists
2 Staff Psychiatrists
4 Community/Private Psychiatrists
Chief of Psychology/Director of Research (Ph.D.)
1 Utilization Review Technician
1 Quality Assurance Administrator
2 Program Chiefs
3 Discipline Chiefs (Social Work, Nursing, Psychology)
4 Unit Directors
Treatment Review Panel
8 Nurses (RN)
2 Doctors of Pharmacy
Commissioner of Public Welfare
Assistant Commissioner of Public Welfare
1 External Review Board Member
1 Attorney/Mental Health Advocate
1 Lobbyist for Mental Health Association
1 Assistant Attorney General
1 Patient Advocate (Attorney)
1 Judge
1 Law Clerk
Richmond State Hospital  
(Richmond, Indiana)

Superintendent
Assistant Superintendent, Programs (Ph.D.)
Assistant Superintendent, Medical (M.D.)
2 Physicians
Administrative Assistant to Superintendent (RN)
Utilization Review Coordinator (RN)
3 Nurses (RN)
4 Module Directors
1 Module Director/Social Worker
Rehabilitation Therapy Director
3 Attendants
1 Pharmacist

Madison State Hospital  
(Madison, Indiana)

Superintendent
Assistant Superintendent & Quality Assurance
Acting Medical Director (M.D.)
President of Medical Staff (M.D.)
1 Physician
2 Psychiatrists
Research Committee Chairperson (Ph.D.)
Psychology Director (Ph.D.)
Rehabilitation Director
Social Service Director
Nursing Supervisor (RN)
5 Nurses (RN)
4 Attendants
Admissions Clerk
Pharmacy Staff
1 Judge
Central State Hospital
(Louisville, Kentucky)

Director of Hospital
Director of Campus
Chief Psychologist (Ph.D.)
Clinical Director (Psychiatrist)
6 Physicians
5 Program Coordinators
Pastorial Counselor/Chairman of Patients Rights Committee
2 Nurses (RN)
Head Nurse (RN)
Quality Assurance Chairperson
Utilization Review Committee
Treatment Appropriateness Review Committee
3 Aides
Pharmacist

Eastern State Hospital
(Lexington, Kentucky)

Hospital Director (M.D.)
Director, Medical Services & Extended Care (M.D.)
Chief, Intensive Treatment Service (M.D.)
3 Staff Psychiatrists
Chief of Admissions (Staff Psychiatrist)
Program Director, Rehabilitation (Ph.D.)
Chairperson, Research & Human Subjects Committee (Ph.D.)
Treatment Review Committee Member (Ph.D.)
Quality Assurance Chairperson & Director of Social Work
Program Director, Rehabilitation
Program Director, Intensive Treatment Unit
Program Director, Chairman Patient Rights Committee
Supervisor Intensive Treatment Services (RN)
Supervisor Medical Service (RN)
2 Nurses (RN)
Director of Nursing
Treatment Review Committee
Utilization Review Committee
1 Pharmacist
3 Aides
Legal Coordinator
Utilization Review Coordinator
Huntington State Hospital
(Huntington, West Virginia)

Hospital Administrator
Clinical Director (M.D.)
Admitting Officer
1 Psychiatrist
2 Aides
2 Nurses (RN)
1 Patient Advocate
1 Master Social Worker
1 Pharmacist

Weston State Hospital
(Weston, West Virginia)

Assistant Administrator of Clinical Affairs
Director, Department of Psychology (Ph.D.)
ACSW-Director, Department of Social Work
Clinical Director (M.D.)
3 Physicians
Unit Director/Admissions Unit
Unit Director
Social Worker/Acting Unit Director
1 Patient Advocate
3 Nurses (RN)
4 Aides
1 Pharmacist
Kalamazoo State Hospital
(Kalamazoo, Michigan)

Medical Superintendent
Psychiatrist
Social Worker
Nurse (RN)
3 Aides
Director of Pharmacy
Utilization Review Chairperson
Rights Advisor
Psychologist (Ph.D.)

Detroit Psychiatric Institute
(Detroit, Michigan)

Hospital Director, Psychiatrist
Psychiatrist, Director of Adult Outpatient
Psychiatrist, Director of Adult Inpatient
Psychologist, Director of Psychology and Quality Assurance
MSW, Director of Social Services
2 Nurses (RN, LPN)
Pharmacist
1 Nurse (RN), 1 Aide, Child Unit
Consulting Doctor of Pharmacy
NOTES

1  For ease in discussion and presentation, the word "treatment" is used to refer to the action of dealing with a person in a specific manner, not necessarily implying any qualitative or quantitative changes in the person. Additionally, the utilization of medical terminology such as "patient" and "illness" as well as specific psychiatric diagnostic categories does not necessarily reflect an acceptance of the implied meanings. Again, the use of these words is for convenience, and an analysis of their semantic content is outside the parameters of this study.

2  Data for this research were collected from three primary sources: a nationwide mail survey of mental health officials, nationwide telephone interviews with "informants" in mental health, and 145 face-to-face interviews with mental health staff in nine public mental hospitals in five states. Chapter Six describes the methodology in detail.

3  A patient at Lima State Hospital is given credit for this analogy. As a new twist to the nationally-famous "pet therapy," a patient was found out in the courtyard, literally butting heads with a goat. Not only was this seen by this author as possibly an appropriate response to his hospitalization and treatment but as an appropriate analogy to changing the mental health system.

4  For example, Lady Macbeth from Macbeth and the main character in Ophelia, by W. Shakespeare (15th century); "Ship of Fools" by Hieronymus Bosch (15th century); and Don Quixote by S. Cervantes (16th century).

5  The rotary machine was a device to which a patient strapped and spun around at the desired speed, usually increased to a very rapid pace. The rhythm of the machine was then altered to further startle the melancholic.
This belief is still expressed by some people including psychiatrists. For example, one psychiatrist interviewed stated, "The quiet psychotic kills. Psychotics are responsible for most of the murders in society."

See Note 2.

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See Note 2.

Horwitz does not utilize Kittrie's definition of therapeutic as authoritarian.
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