

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

ELEANOR RIESE, et al.,

No. S004002

Appellants,

vs.

ST. MARY'S HOSPITAL AND
MEDICAL CENTER,

Respondent.

BRIEF OF AMERICAN PSYCHOLOGICAL ASSOCIATION AND
THE CALIFORNIA PSYCHOLOGICAL ASSOCIATION
AS AMICUS CURIAE
IN SUPPORT OF THE POSITION OF APPELLANTS

After Decision of the Court of Appeal for the First
Appellate District, Division Two--No. A034048

After Judgment of the Superior Court of the State of
California, City and County of San Francisco--No. 81488

Honorable Raymond D. Williamson, Jr., Judge

Donald N. Bersoff
Donald B. Verrilli, Jr.
Jenner & Block
21 Dupont Circle, NW
Washington, DC 20036
(202) 223-4400
Attorneys for Amicus Curiae
American Psychological Association

Michele H. Licht
Licht & Bloom
15260 Ventura Boulevard, Suite 670
Sherman Oaks, California 91403
(818) 905-0819
Attorneys for Amicus Curiae
California State Psychological
Association

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INTEREST OF AMICI

The interests of amici, American Psychological Association and California Psychological Association, are set forth in their Application for Leave to File a Brief Amicus Curiae in Support of Appellant.

STATEMENT OF ISSUE PRESENTED

This case squarely presents the issue whether statutory, common law, and constitutional principles prohibit a hospital -- in the absence of an emergency -- from forcibly administering antipsychotic drugs to competent persons who have been involuntarily committed for treatment of mental illness.

SUMMARY OF ARGUMENT

Antipsychotic drugs^{1/} can benefit some persons suffering from mental illness, but also pose the risk of severe, and occasionally fatal, side effects for many patients.

^{1/} Three groups of drugs are principally used to treat patients with mental disorders: (1) sedative agents; (2) antidepressants; and (3) psychotropic agents. The first group is normally prescribed for neurotic disorders; the second group for depressive disorders; and the third group for psychotic disorders, especially schizophrenia. Psychotropic simply means "exerting an effect on the mind." Dorland's Pocket Medical Dictionary. The types of psychotropic drugs at issue in this case are known as "antipsychotic" or "neuroleptic" drugs. Common antipsychotic drugs include Thorazine (chlorpromazine), Stelazine (trifluoperazine), Trilafon (perphenazine), Mellaril (thioridazine), Prolixin (fluphenazine), Navine (thiothexen), and Haldol (haloperidol). This brief refers to this class of medications as "psychotropic" or "antipsychotic" drugs.

Notwithstanding a strong interest in preserving appropriate professional discretion in treating mental illness, amici do not endorse the the proposition that mental health professionals should have unbridled discretion to administer antipsychotic drugs against the will of involuntary committed, but competent, patients. Antipsychotic drugs are so intrusive, so risky, and so powerful in their "mind altering" effect, that a patient's competent decision to refuse the drugs must be respected. Statutory, common law, and constitutional principles -- recognizing the extreme intrusion upon physical and mental integrity and the serious risks imposed by administration of antipsychotic drugs -- absolutely prohibit the forcible administration of such drugs to an involuntarily committed patient unless: (i) an emergency exists; or (ii) the patient is incompetent to make treatment decisions.^{2/}

^{2/} Neither is present in this case. Eleanor Riese is a person suffering from chronic schizophrenia who, although involuntarily committed by her treating physician, has never been found incompetent to make basic treatment decisions. She has long suffered from mental illness, and has been treated with the antipsychotic drug Mellaril since 1969. During the episode of mental illness that led to the involuntary medication at issue, Riese was first admitted to St. Mary's hospital as a voluntary patient, and initially consented to treatment with Mellaril and Cogentin, another antipsychotic drug. Riese first refused treatment when the treating physician, after trying at least two other antipsychotic drugs, increased the dosage of Mellaril. Riese objected precisely because she was suffering uncomfortable side effects. Her refusals to accept medication prompted her treating physician to seek transformation of
(Footnote Continued)

Mental health professionals uniformly acknowledge the intrusiveness and risks associated with antipsychotic drugs. Short-term side effects include mask-like face, stiffness, shuffling gait, muscle spasms, irregular flexing, and uncontrollable writhing motions. The most serious long-term side effect associated with antipsychotic drugs is tardive dyskinesia, a potentially devastating condition that, in severe cases, results in gross, incapacitating disfiguring movements. Tardive dyskinesia cannot be cured, often cannot even be ameliorated, and can be a permanent condition. Antipsychotic drugs can also cause neuroleptic malignant syndrome, a condition that can be lethal. (Point I.A). And antipsychotic drugs affect the mind as well as the body; they are literally "mind altering," and can precipitate docility or interfere with learning and communication. (Point I.B.) Because antipsychotic drugs pose these risks, mental health professionals often seek to make use of a range of alternative treatments and therapies in treating even serious mental illnesses -- and typically administer antipsychotic drugs with great caution. (Point I.C)

(Footnote Continued)

her status to "involuntary commitment" under section 5250 of the Welfare and Institutions Code. After involuntary commitment, Riese was forcibly medicated, and suffered from swollen feet, urinary problems, shaking, memory loss and seizures. Riese v. St. Mary's Hospital and Medical Center, 196 Cal. App. 3d 1388, 1393-1395, __ Cal. Rptr. __, __ (1987).

As the Court of Appeal correctly found, the Lanterman-Petris-Short Act ("LPS") prohibits treating facilities from forcibly administering antipsychotic drugs against the will of patients involuntarily committed under the authority of sections 5150 and 5250 of the Act. Properly understood, LPS grants patients this right to refuse treatment. But whether or not LPS directly grants the right to refuse treatment, patients involuntarily committed under sections 5150 and 5250 retain their right, grounded in the common law and the Constitution of this State, to refuse antipsychotic medication. As amici will show, the common law and the California Constitution specifically protect the right of a competent person to refuse medical treatment, including treatment with antipsychotic drugs. (Point II.A) Numerous provisions of LPS preserve the common law and constitutional rights of involuntarily committed patients unless any such right is specifically denied in LPS. See sections 5005, 5325.1, and 5327. No provision of LPS specifically denies to involuntarily committed persons the right to refuse antipsychotic drugs. Accordingly, LPS cannot be construed to authorize forced medication with antipsychotic drugs absent an emergency or a finding of incompetence, neither of which is implicit in involuntary commitment under sections 5150 or 5250. Indeed, a recent study of patients involuntarily committed under these sections concluded that "it is possible to secure informed consent prior to the administration of antipsychotic medication." Ghannam & Gresham, Informed

Consent to Receive Antipsychotic Medication in Involuntarily Detained Psychiatric Patients, at 2-3 (Exhibit 2 hereto); see also summary entitled A Preliminary Exploration of Informed Consent in Involuntarily Detained Patients, The California Psychologist (Sept. 1988) (in publication) (exhibit 1 hereto). (Point II.B)

Because state law principles resolve the present case in favor of respondent, this Court need not reach the issue whether the Fourteenth Amendment to the United States Constitution also grants a right to refuse antipsychotic medication absent an emergency or a finding of incompetence. In any event, persons have a Fourteenth Amendment right to refuse unwanted treatment with antipsychotic drugs. (Point III.A) This right extends to involuntarily committed patients, and is not limited by the "professional judgment" standard imposed by the United States Supreme Court in Youngberg v. Romeo, 457 U.S. 307 (1982). The constitutional interests at stake in this case differ from that of Youngberg in two crucial respects. First, unlike Youngberg, the issue in this case is whether an individual's competent decision to refuse unwanted medical treatment may be overridden by a hospital official seeking to act in the medically-indicated "best interest" of the individual. Second, the risks associated with antipsychotic drugs far outweigh any risks posed to the patient in Youngberg. At issue in Youngberg was the propriety of short-term physical restraint that would have no lasting consequences; antipsychotic

drugs, in contrast, can cause irreversible debilitating side effects, and -- on occasion -- death. The Court of Appeal in this case correctly held that granting such discretion to override individual treatment decisions affords treating officials too much power to intrude upon individual autonomy and personal security. (Point III.B) And even if a patient has been adjudged incompetent, the Constitution prohibits the forcible administration of antipsychotic drugs unless the patient would have consented to treatment if competent. This "substituted judgment" approach "commends itself simply because of its straightforward respect for the integrity and autonomy of the individual." Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 751, 370 N.E.2d 417, 431 (1977). (Point III.C)

Furthermore, adequate protection of the patient's rights under both state and federal law requires the procedural safeguard of a judicial determination of competency. These decisions are fundamentally legal -- and not medical -- in nature, and cannot safely be left to the judgment of the treating physician, however well-intentioned that physician might be. (Point IV)

ARGUMENT

I. ANTIPSYCHOTIC DRUGS ARE BENEFICIAL FOR MANY PATIENTS, BUT THEY ALSO CAUSE SUBSTANTIAL PHYSICAL SIDE EFFECTS, SEVERELY AFFECT MENTAL PROCESSES, AND ARE UNNECESSARY WHEN EFFECTIVE ALTERNATIVE TREATMENTS ARE AVAILABLE.

A. Antipsychotic Drugs Cause Substantial Physical Side Effects.

In urging that a patient's competent choice to refuse antipsychotic drugs must be respected, amici intend no denigration of these medications. When efficacious, antipsychotic drugs reduce the delusions, hallucinations, and thought disorders associated with the most severe psychiatric illness -- the psychoses. See Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337, 339 n.1 (1986) (medical usefulness stems from "ability to influence thought patterns so as to eliminate psychotic symptoms"). For many patients, these drugs provide significant benefits and are considered the treatment of choice. See, e.g., Cole & Davis, Clinical Efficacy of the Phenothiazines as Antipsychotic Drugs, in Public Health Service, Psychopharmacology: A Review of Progress 1957-1967, 1057 (1968) at 1057-1063; Davis, Overview: Maintenance Therapy in Psychiatry: I. Schizophrenia, 132 Am. J. Psychiatry 1237 (1975); National Institute of Mental Health Psychopharmacology Service Center Collaborative Study Group, Phenothiazine Treatment in Acute Schizophrenia, 10 Arch. Gen. Psychiatry 246 (1964); Hogarty, et al., Drug and Sociotherapy in the Aftercare of Schizophrenic Patients, 31 Arch. Gen. Psychiatry 603 (1974). Courts have consistently recognized that "[p]sychotropic

drugs are considered more effective than any other form of treatment in reducing thought disorder in schizophrenics." In re Boyd, 403 A.2d 744, 752, n.13 D.C.C.A. 1979). See also, e.g., Davis v. Hubbard, 506 F. Supp. 915, 927 (N.D. Ohio 1980).

Recognition of these potential benefits should not, however, obscure the risks posed by this form of treatment. Antipsychotic drugs cause a wide range of unwanted and often unpredictable physical and mental side effects that can be serious -- and occasionally fatal. Because side effects occur in a high percentage of medicated patients, and serious side effects occur in significant numbers, the use of antipsychotic drugs is generally recognized as a "high-risk treatment." In re Guardianship of Richard Roe, III, 421 N.E.2d 40, 54 (Mass. 1981). See also Bee v. Greaves, 744 F.2d 1387, 1390-1391 (10th Cir. 1984), cert. denied, 469 U.S. 1214 (1985); Jarvis v. Levine, 418 N.W.2d 139 (Minn. S. Ct. 1988).^{3/}

^{3/} Among the many cases concluding that antipsychotic drugs are high risk treatment: Mills v. Rogers, 457 U.S. 291, 293 n.1 (1982); Rogers v. Okin, 634 F.2d 650, 653 & n.1 (1st Cir. 1980), vacated sub nom. Mills v. Rogers, 457 U.S. 291 (1982); Davis v. Hubbard, 506 F. Supp. 915, 927-29 (N.D. Ohio 1980); Bee v. Greaves, 744 F.2d 1387, 1390-91, 1394 (10th Cir. 1984), cert. denied, 105 S. Ct. 1187 (1985); People v. Medina, 705 P.2d at 969-970, n.4 (Colo. 1985); and Opinion of the Justices, 465 A.2d 484, 488 (N.H. 1983). See Scott v. Plante, 532 F.2d 939, 945 n.8 (3d Cir. 1976) (describing side effects).

Petitioner's assertions that "antipsychotic medications are safe" and have "no lethal overdose risk," Petitioner's Brief on the Merits at 4, 6, are incorrect and irresponsible. The professional literature documenting the harmful physical side effects of antipsychotic drugs is current, balanced, and comprehensive. See, e.g., Ananth, Edelmuth & Dargan, Meige's Syndrome Associated With Neuroleptic Treatment, 145 Am J. Psychiatry 513 (1988); Gardos, Cole, Salomon & Schniebolk, Clinical Forms of Severe Tardive Dyskinesia, 144 Am. J. Psychiatry 895 (1987); A. Schatzberg & J. Cole, Manual of Clinical Psychopharmacology 99 (1986); Hollister, Antipsychotics and Antimanic Drugs, in Review of General Psychiatry 596 (H. Goldman ed. 1984). This literature documents serious, debilitating unwanted effects, including -- on occasion -- death. Pope, Keck & McElroy, Frequency of Presentation of Neuroleptic Malignant Syndrome in a Large Psychiatric Hospital, 143 Am. J. Psychiatry 1227 (1986).

Several common side effects caused by antipsychotic drugs are: parkinsonian syndrome, which is characterized by mask-like face, drooping, stiffness and rigidity, shuffling gait, and tremors; akathesia, which is characterized by strong subjective feelings of distress and an often irresistible need to be in constant motion; and dystonic reactions, which include muscle spasms, irregular flexing, writhing or grimacing movements, and protrusion of the tongue. See generally Hollister, Antipsychotics and

Antimanic Drugs, in Review of General Psychiatry 596

(Goldman, ed. 1984).^{4/}

Courts have consistently acknowledged that anti-psychotic drugs produce these side effects. See, e.g., Mills v. Rogers, 457 U.S. 291, 293 n.1 (1982); Bee v. Greaves, 744 F.2d at 1390-1391; Davis v. Hubbard, 506 F. Supp. 915 (N.D. Ohio 1980); Rivers v. Katz, 495 N.E. at 339 n.1; In re Boyd, 403 A.2d 744 (D.C.C.A. 1979). In Boyd, the D.C. Court of Appeals also noted nonmuscular side effects that regularly result from psychotropic drugs, including drowsiness, dizziness, blurred vision, dry mouth and throat, "torn up" stomach, low blood pressure, skin rashes, constipation, and loss of sexual desire. 403 A.2d at 752 n.13.

4/ Meige's Syndrome and Neuroleptic Malignant Syndrome are two other important and more recently identified side effects that must be encompassed in any evaluation of the overall risks of antipsychotic drugs. Meige's syndrome results in uncontrollable contractions of eye muscles; it often severely constricts vision and makes many day-to-day activities impossible. Ananth, Edelmuth & Dargan, Meige's Syndrome Associated With Neuroleptic Treatment, 145 Am. J. Psychiatry 513 (1988). Neuroleptic malignant syndrome is "a continuous spectrum of physiologic reactions," including elevated temperature and blood pressure, incontinence, and extrapyramidal symptoms, "that in some patients takes a severe, potentially lethal form." Addonizio, Susman & Roth, Symptoms of Neuroleptic Malignant Syndrome in 82 Consecutive Inpatients, 143 Am. J. Psychiatry 1587, 1588 (1986); see also Pope, Keck & McElroy, Frequency of Presentation of Neuroleptic Malignant Syndrome in a Large Psychiatric Hospital, 143 Am. J. Psychiatry 1227 (1986).

The physical side effects described above, all of which occur in short-term use, are both frightening and serious. The most frequent debilitating effect associated with these drugs -- and one of the most serious -- is tardive dyskinesia,^{5/} see A. Schatzberg & J. Cole, Manual of Clinical Psychopharmacology 99 (1986), which is "emerging as one of the dreaded diseases in psychiatry." Gardos, Cole, Salomon & Schniebolk, Clinical Forms of Severe Tardive Dyskinesia, 144 Am. J. Psychiatry 895 (1987). The New York Court of Appeals in Rivers v. Katz described this condition as "potentially devastating," 495 N.E.2d at 339 n.1, and many other courts have recognized its potential severity. See In re Boyd, 403 A.2d at 752 n.13; People v. Medina, 705 P.2d at 968 n.3. See generally H. Kaplan & B. Sadock, Modern Synopsis of Comprehensive Textbook of Psychiatry/III 943, 956-961 (1976).

Standard reference manuals make clear that "the severity of tardive dyskinesia ranges from minimal tongue restlessness and finger movements to gross, incapacitating disfiguring movements." A. Schatzberg & J. Cole, Manual of Clinical Psychopharmacology 99 (1986) (emphasis added). In some cases, "self-care, feeding and swallowing, as well as

^{5/} While neuroleptic malignant syndrome, unlike tardive dyskinesia, often causes death (see note 4, *supra*), it does not occur with as much frequency as tardive dyskinesia and is a more recently discovered phenomenon.

vocationally important dexterity, can be impaired; severe cases, while infrequent, can be as disabling as Huntington's disease." Baldessarini, Clinical and Epidemiological Aspects of Tardive Dyskinesia, 4 J. Clinical Psychiatry 8 (1985). Clinical studies have reported cases of tardive dyskinesia so severe as to "interfere[] even with eating and drinking" or to "prevent driving and reading." Gardos, Cole, Salomon & Schniebolz, Clinical Forms of Severe Tardive Dyskinesia, 144 Am. J. Psychiatry at 897. One clinical report of the death of a patient with tardive dyskinesia, noting that "the potential for serious motor disability is generally underestimated," reported that persistent retching, vomiting, weight loss and dehydration can occur, with respiratory or gastrointestinal involvement. Lazarus & Toglia, Fatal Myoglobinuria Renal Failure in a Patient with Tardive Dyskinesia, 35 Neurology 1055, 1057 (1985).

Estimates of the rate at which tardive dyskinesia afflicts patients medicated with antipsychotic drugs have been steadily rising. A study published in 1981 pointed out that the "reported prevalence [of tardive dyskinesia] among neuroleptic-treated psychiatric inpatients has been progressively rising and has reached 25% during the past five years." Jeste & Wyatt, Changing Epidemiology of Tardive Dyskinesia: An Overview, 138 Am. J. Psychiatry 297 (1981). A more recent study noted that "prevalence rates . . . grow year by year." Gualtieri, Sprague, and Cole, Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic

Treatment, 14 J. Psychiatry and Law at 206. These increases may be due in part to substantial advancement in defining the criteria for a diagnosis of tardive dyskinesia. See Schooler & Kane, Research diagnoses for tardive dyskinesia (RD-TD), 39 Arch. Gen. Psychiatry 486 (1982).^{6/} Earlier studies probably underestimated the prevalence of tardive dyskinesia for two reasons: (i) antipsychotic drugs can mask symptoms even as the drugs cause tardive dyskinesia, see Gualtieri, Sprague & Cole, Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic Treatment, 14 J. Psychiatry and Law at 199; and (ii) clinicians often fail to diagnose the symptoms, see Weiden, Hass, Mattson & Frances, Clinical Nonrecognition of Neuroleptic-Induced Movement Disorders: A Cautionary Study, 144 Am. J. Psychiatry 1148, 1153 (1987) (noting "an alarming rate" of underdiagnosis).^{7/}

6/ The wide range of percentages noted particularly in the earlier studies is attributable in large part to the lack of "established or universally accepted criteria for the diagnosis" of tardive dyskinesia. Kane & Smith, supra, at 473. In addition, "many other neuromedical disorders produce a similar clinical picture," and prevalence and incidence vary markedly depending on the "symptom severity" required by the researcher to identify a "case." Id. Because substantial progress has been made in defining diagnostic criteria, more recent studies measure the prevalence or incidence of tardive dyskinesia with greater precision than had previously been attained.

7/ Studies suggest a similar underdiagnosis of Neuroleptic Malignant Syndrome, another side effect of antipsychotic drugs. One study noted that "neuroleptic malignant syndrome may afflict a larger number of cases than is generally suspected. . . . [E]ven a conservative estimate would place
(Footnote Continued)

The best current estimates of prevalence rates are in the range of 20 to 60 percent. See, e.g., Hollister, Antipsychotics and Antimanic Drugs, in Review of General Psychiatry at 596 ("20-40% of chronically treated patients"); A. Schatzberg & J. Cole, Manual of Clinical Psychopharmacology at 99 (rates in chronically institutionalized patients "on the order of 50-60 percent"). Some studies report consistently high rates. For example, two prevalence studies indicate that the condition affects 50% to 56% of chronically hospitalized schizophrenics,^{8/} and a

(Footnote Continued)

the annual prevalence of neuroleptic malignant syndrome in the United States in the thousands of cases, a significant number of which may have fatal consequences." Pope, Keck & McElroy, Frequency of Presentation of Neuroleptic Malignant Syndrome in a Large Psychiatric Hospital, 143 Am. J. Psychiatry at 1232.

8/ Gardos & Cole, Drug Variables in the Etiology of Tardive Dyskinesia, 1 Prog. Neuro-Psychopharm. 147-54 (1977); Jus, et al., Epidemiology of Tardive Dyskinesia, Part 1, 37 Dis. Nerv. Syst. 210-14 (1976). Prevalence studies compare the number of patients treated with antipsychotic drugs in a hospital population who have developed tardive dyskinesia with the total number of patients treated with antipsychotic drugs in the hospital population at that time. Because patients who do have tardive dyskinesia may be more likely to remain hospitalized than those who do not develop the condition, and patients free of tardive dyskinesia may be more likely to have been discharged, these studies are primarily valuable for determining the likelihood that long-term hospitalized patients, or long-term users of the drugs, will develop the disease. Prevalence studies may overestimate the risk that a newly admitted patient with no history of antipsychotic medication will develop tardive dyskinesia.

Incidence studies measure how many patients out of ever 100 patients treated will develop tardive dyskinesia within
(Footnote Continued)

third prevalence study indicates that the condition affects 41% of all outpatients. Asnis, et al., A Survey of Tardive Dyskinesia in Psychiatric Outpatients, 134 Am. J. Psychiatry 1367-1370 (1970). The magnitude of the public health issue implicit in these percentages emerges fully when it is recognized that about 3 million Americans are currently medicated with antipsychotic drugs, and that 945,000 new patients receive the drugs each year. Gualtieri, Sprague, and Cole, Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic Treatment, 14 J. Psychiatry and Law 187, 204 (1986).

Unlike effects such as akathisia, parkinsonian syndrome, and dystonic reactions, which can subside when

(Footnote Continued)

a given time period. The incidence of tardive dyskinesia increases with cumulative exposure to antipsychotic drugs. See Physicians Desk Reference 1988 at 1238. A major on-going study of the incidence of tardive dyskinesia has reported that the "overall TD [tardive dyskinesia] incidence . . . is 18.5% . . . following four years of cumulative exposure." Kane, et al., Integrating Incidence and Prevalence of Tardive Dyskinesia, 22 Psychopharmacology Bull. 253, 254 (1986) (this study also reported that the "incidence of TD which persists for at least 3 months is 13% . . . at 4 years and 29% . . . at 8 years." Id.) See generally Kane, et al., Incidence of Tardive Dyskinesia: Five Year Data From A Prospective Study, 20 Psychopharmacology Bull. 39 (1984); American Psychiatric Association Task Force Report #18, Tardive Dyskinesia, at 57 (estimating incidence of 10-40% in patients receiving long-term treatment).

Prevalence studies provide the more appropriate figures for estimating the risks of developing tardive dyskinesia for the class of persons that includes Ms. Reise -- those with long-term exposure to antipsychotic drugs.

antipsychotic drugs are discontinued, tardive dyskinesia often persists long after treatment and can be irreversible. See Gaultieri, Sprague & Cole, Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic Treatment, 14 J. Psychiatry and Law at 198; Gardos, Cole & Tarsy, Withdrawal Symptoms Associated With Antipsychotic Drugs, 135 Am. J. Psychiatry 1321 (1978). Reference works acknowledge that "[t]here is no effective or standard treatment for tardive dyskinesia." A. Schatzberg & J. Cole, Manual of Clinical Psychopharmacology at 100.

Accurate predictions as to who will develop the condition are not yet possible. Id. at 99. Thus, it cannot be predicted with any certainty whether a particular patient will benefit from antipsychotic drugs and experience no adverse side effects, will benefit but experience adverse side effects, will not benefit but will not experience adverse side effects, or will not benefit but will experience adverse side effects. In short, "there is no way to avoid tardive dyskinesia except to avoid using antipsychotics." Id. at 100. See also Ayd, Pre-treatment Prediction of Responsiveness to Chlorpromazine: Is it Possible, 10 Int'l Drug Therapy Newsletter 4 (1975).

Respondent hospital seeks to minimize the significance of these risks by suggesting that they arise only from long-term use of antipsychotic medications, not from use in short-term crisis intervention authorized by sections 5150 and 5250. But this claim rests on a false premise. As the

facts of the present case amply demonstrate, many persons forcibly medicated under the authority of sections 5150 and 5250 have long histories of treatment with antipsychotic drugs. Indeed, involuntary commitment under these sections may well have been precipitated by a patient's discontinuance of antipsychotic drugs, and discontinuance may well have been the result of the onset of tardive dyskinesia or other debilitating side effects. Also, many patients are the subjects of repeated, short-term hospitalizations during which they receive antipsychotic medication. For both these groups of patients, forced administration may bring on or exacerbate the serious side effects amici have outlined. In any event, side effects associated with even short-term use, such as akithesia, can be serious and disabling. Other side effects -- such as Miege's syndrome and neuroleptic malignant syndrome, and occasionally tardive dyskinesia -- can result from short-term exposure. Forced administration of antipsychotic drugs under sections 5150 and 5250 thus poses serious health risks.

B. Antipsychotic Drugs Can Severely Affect Mental Processes.

Antipsychotic drugs also powerfully influence mental functioning. They are, quite literally, "mind altering." See Mills v. Rogers, 457 U.S. at 293 n.1. As the Supreme Judicial Court of Massachusetts observed, these drugs have a "profound effect . . . on the thought process of an individual." Roe III, 421 N.E. at 53.

Although antipsychotic drugs may be "mind altering" in a potentially beneficial sense, they also often diminish the mentally ill person's ability to concentrate, to learn, and to communicate. Studies indicate that, at upper levels of prescribed doses, antipsychotic drugs interfere with patients' abilities to concentrate, learn, and react to stimuli by reducing attention span and increasing reaction time. Spohn, Coyne, Lacoursiere, Mazur & Hayes, Relation of Neuroleptic Dose and Tardive Dyskinesia to Attention, Information-Processing, and Psychophysiology in Medicated Schizophrenics, 42 Arch. Gen. Psychiatry 849 (1985). The Physician's Desk Reference specifically warns that various antipsychotic drugs can impair mental alertness. E.g., Physicians Desk Reference 1779 (1987) (mellaril); id. at 1191 (haldol); id. at 1932 (thorazine). One documented effect of antipsychotic drugs is akinesia, a condition in which the patient loses energy and interest in his or her surroundings, and often complains of feeling "dead inside."

Thus, although the administration of antipsychotic drugs should not be considered "thought control" in the sense of facilitating indoctrination or purging particular ideas and values from the minds of the medicated, these drugs can adversely affect mental processes by precipitating docility and diminishing a patient's ability and inclination to interact with environmental stimuli. Recognition of these mental effects has consistently led courts to conclude that antipsychotic drugs implicate First Amendment interests

by intruding upon a patient's ability to form and communicate ideas. E.g., Bee v. Greaves, 744 F.2d at 1394; Davis v. Hubbard, 506 F. Supp. at 927-929. Furthermore, the issue of forced medication will arise not only in cases of patients who are profoundly disturbed in all aspects of mental functioning, but also in cases of patients who may be delusional in some aspect but mentally sound in others. In such cases, forced administration of antipsychotic drugs precludes a patient's ability to opt for preservation of the "normal" aspects of mental functioning by foregoing the medication.

C. Antipsychotic Drugs Are Not The Only Effective Treatment For Severe Mental Illness, And The Forced Administration of These Drugs Is Particularly Disfavored.

Because antipsychotic drugs carry serious risks of powerful and debilitating unwanted effects, these drugs are not always used to treat serious mental illness. Respondent is simply wrong in asserting that "antipsychotic medications are . . . the only effective treatment for . . . patients who comprise the population involuntarily hospitalized under . . . Sections 5150 and 5250." Petitioner's Brief on Merits at 4; see also id. at 7. In fact, a recent study of involuntary commitments at one California hospital found that fewer than half the patients admitted involuntarily for short-term treatment in the period under study were medicated with antipsychotic drugs. Ghannam & Gresham, Informed

Consent to Receive Antipsychotic Medication in Involuntarily Detained Psychiatric Patients, Exhibit 2. Treatment with antipsychotic drugs is merely one part of the total treatment regime provided by hospitalization.

In an effort to preserve unbridled discretion for hospital staff, petitioner's argument ignores the substantial benefits that may be achieved, even in initial stabilization of an episode of acute mental illness, without antipsychotic drugs. Hospitalization is a form of treatment in itself; the limits, controls, and structure provided to the patient through hospitalization have considerable therapeutic benefit. And mental health professionals have available many alternative treatments to stabilize patients with acute conditions. Seclusion or restraint with cold, wet sheet packs can provide an effective means of managing some acute episodes of psychosis. These options are often more humane than forced medication; patients treated in this way often, upon recovery, state that the seclusion or restraint ameliorated their anxieties by restoring a sense of safety and control to their environment. Psychotherapy is also an option that is effective in the treatment of psychosis. See B. Karon & G. VandenBos, Psychotherapy of Schizophrenia: The Treatment of Choice (1981); Karon & VandenBos, Cost/Benefit Analysis for Schizophrenic Patients Treated by Psychologists, Psychiatric Psychotherapists, and Medication (without psychotherapy), 7 Professional

Psychology 107 (1976). LPS specifically contemplates the use of these options. See sections 5008(a), (d) & (e).

Conversely, forced administration of antipsychotic drugs can itself cause psychological harm. Forced injection is, as the facts of this case demonstrate, often an intrusive and degrading process in which the patient is either threatened with force or physically restrained prior to injection in the buttocks. Involuntary oral administration often involves forcibly placing medication in the mouth of the patient, and using threats or coercion to force the patient to swallow the drugs. Application of intrusive force in this way can undermine establishment of a therapeutic alliance, an essential relationship of trust, between the patient and the treating professionals, and thereby impede the possibility of successful long-term treatment. See Brief Amicus Curiae of American Orthopsychiatric Association. If a mental health professional is pursuing a sound treatment program, the decision to administer antipsychotic drugs is far from routine or automatic, and the decision to administer medication forcibly, if ever appropriate, must be a last resort preceded by assiduous efforts to obtain the consent and cooperation of the patient under treatment. Antipsychotic drugs are properly considered a component of treatment, not a substitute for treatment. But with unbri-
dled discretion to medicate patients forcibly, psychiatrists and other physicians unknowledgeable about a wide range of

effective treatment alternatives will be without incentive to explore these less intrusive, less risky alternatives.

II. AN INVOLUNTARY PATIENT'S RIGHT TO REFUSE ANTIPSYCHOTIC DRUGS GUARANTEED BY STATUTE, COMMON LAW, AND THE CALIFORNIA CONSTITUTION.

The decision whether to accept antipsychotic medication can be gravely difficult and troubling for the patient. The decision goes to the core of a person's sense of security and bodily integrity, and is entitled to respect and legal protection even if it differs from the one recommended by a treating mental health professional. The threat to personal security and bodily integrity is exacerbated because it is virtually impossible to predict whether the drugs will cause adverse side effects.

For these reasons, as the Court of Appeal held, California law protects the right of an involuntarily committed patient to refuse the administration of antipsychotic drugs, absent an emergency or a finding of incompetence to make treatment decisions. See LPS sections 5001 et seq. (all statutory cites are to the provisions of LPS contained in the Code of Welfare and Institutions).

By its terms, LPS neither explicitly grants nor withholds the right to refuse antipsychotic medication in cases of commitment under sections 5150 and 5250. Relying on this silence, respondent hospital argues that the statutory authorization of involuntary commitment for "treatment" in sections 5150 and 5250 necessarily grants to the hospital by

implication the power to administer any medically indicated treatment despite patient objections. Although involuntary commitment for seventy-two hours under section 5150 or for 14 days under section 5250 necessarily restricts a patient's liberty to some extent, commitment does not implicitly deprive an individual of the right to refuse antipsychotic medication. To the contrary, the weight of the evidence in the statutory text points toward the opposite conclusion.

A primary motive for passage of LPS was protection of the rights of persons suffering from mental illness. The Court of Appeals noted the Legislature's predominant concern that "'far too frequently, recipients of mental health services are deprived of the protection of the law and their rights are disregarded or abused . . . in the course of obtaining treatment for their disability.'" 178 Cal. App. 3d at 1400 n.8 (quoting legislative history) (emphasis omitted). Section 5325.1 provides, for example, that involuntary patients have statutory rights to "to dignity, privacy, and humane care," and to treatment "provided in ways that are least restrictive of the personal liberty of the individual."

Numerous provisions of LPS specifically cabin the discretion of treating mental health professionals and preserve the rights of patients to influence the course of their treatment. Crucially, LPS specifically requires that patients committed under sections 5150 and 5250 be given information about the possible benefits and side effects of

proposed treatment with antipsychotic drugs, and about available alternative therapies. See sections 5152(c) & 5213(b). The obvious intent of these sections is to protect the right of persons committed under sections 5150 and 5250 to make an informed choice respecting administration of antipsychotic drugs; these provisions are premised on the existence of such a right, and would be superfluous without it. Thus, as the Court of Appeal correctly concluded, LPS itself should be interpreted to grant a right to refuse treatment. This interpretation accords with the legislative intent underlying LPS, and best advances the statutory purposes of protecting the rights and respecting the dignity of the mentally ill.

But even if LPS did not itself grant a right to refuse unwanted treatment with antipsychotic drugs, involuntarily committed patients would nonetheless retain a right to refuse. As amici will show, the common law and the California Constitution specifically protect the right of a competent person to refuse medical treatment, including treatment with antipsychotic drugs. Numerous provisions of LPS unequivocally preserve this common law and constitutional right. See sections 5005, 5325.1, and 5327.

A. Common Law Informed Consent And The California Constitution Guarantee The Right To Refuse Treatment With Antipsychotic Drugs.

In Cobbs v. Grant, 8 Cal. 3d 229 (1972), 104 Cal. Rptr.

505, this Court unequivocally held that competent patients may not be forced to undergo medical treatment without their informed consent:

Preliminarily we employ several postulates. The first is that patients are generally persons unlearned in the medical sciences and therefore, except in rare cases, courts may safely assume the knowledge of patient and physician are not in parity. The second is that a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to subject to lawful medical treatment. The third is that the patient's consent to treatment, to be effective, must be an informed consent. And the fourth is that the patient, being unlearned in medical sciences, has an abject dependence upon which he relies during the decisional process, thus raising an obligation in the physician that transcends arm's-length transactions.

8 Cal. 3d at 242. Leaving medical decisions to the discretion of the treating physician, the Court went on to hold, "is irreconcilable with the basic right of the patient to make the ultimate decision regarding the course of treatment to which he knowledgeably consents to be subjected." Id. at 243. Accordingly, competent patients -- those of "sound mind" in the legal meaning of the term -- are entitled to be informed about the nature and risks of proposed treatment, and retain ultimate authority to decide whether to proceed.

The high courts of many states have universally held that common law informed consent encompasses the right of a competent patient to refuse antipsychotic drugs, even if the patient has been involuntarily committed. In Rivers v.

Katz, the New York Court of Appeals established a coextensive common law and state constitutional right to refuse antipsychotic medication. The court recognized that under our fundamental "notions of individual autonomy and free choice . . . it is the individual who must have the final say in respect to decisions regarding his medical treatment." 498 N.E.2d 337, 341. The Colorado Supreme Court has twice recently found such rights under common law, as to these drugs both for competent and incompetent mentally ill persons. See Goedecke v. State Dept. of Institutions, 603 P.2d 123 (Colo. 1979) and People v. Medina. In Goedecke, the Court stated:

The courts of this state have long acknowledged the physician's obligation to obtain the patient's informed consent not only for surgery, but also for treatment with drugs having possible harmful side effects. As Justice Cardoza declared in Schloendorff v. Society of New York Hospitals, 211 N.Y. 125, 105 N.E. 92, 93 (1914), "every human being of adult years and sound mind has a right to determine what shall be done with his own body." The above cited statutory provisions [authorizing involuntary commitment for mental health care and treatment] recognize that mental and emotional illnesses are not crimes and that hospitalization for their treatment is not to be confused with incarceration for punishment. It would be inconsistent with the statutes' spirit and purpose to insist that a patient's common law right to decline medical treatment is abrogated by short-term certification alone.

198 Col. at 411, 603 P.2d at 125. And Medina extended this

common law right to incompetent mentally ill persons in nonemergency situations. 705 P.2d at 968.

Other courts have reached the same conclusions under similar circumstances. In Clites v. Iowa, 322 N.W.2d at 917 (Iowa App. 1982), where a plaintiff afflicted with tardive dyskinesia "became aggressive and self-abusive [and] began uncontrolled movements of his arms and legs . . ." (322 N.W.2d at 923) as a result of the involuntary administration of antipsychotic medications, the court affirmed an award of \$760,165 for denial of plaintiff's right to informed consent.

In Guardianship of Roe, the Massachusetts Supreme Court, in finding a right in a mentally ill person to refuse treatment with antipsychotic drugs, relied in part on the common law right of every person "of adult years and sound mind . . . to determine what shall be done with his own body." 421 N.E.2d at 581, n.9 (quotation omitted). And a later decision of the Massachusetts Supreme Judicial Court, recognized "in the law of the commonwealth, as elsewhere, that a person has a strong interest in being free from nonconsensual invasion of his bodily integrity. . . . In short, the law recognizes the individual interest in preserving the 'inviolability of his person.'" Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417, 424 (1977) (citations omitted).

The reasoning of these many state court decisions provides persuasive authority for recognizing that common

law informed consent encompasses the right to refuse unwanted treatment with antipsychotic drugs. Appellant Riese thus should be found entitled to informed consent under the doctrine announced in Cobbs v. Grant.

The right to refuse treatment is protected by the California Constitution. The Constitution's explicit right of privacy encompasses the right "to give or withhold informed consent with respect to proposed medical treatment." Foy v. Greenblott, 141 Cal. App. 3d 1, 11 (1983). Furthermore, because antipsychotic drugs have powerful mind altering effects, treatment with these drugs "can itself invade the constitutional right of privacy." Lillian F. v. Superior Court, 160 Cal. App. 3d 314 (1984). See Long Beach City Employees Assoc. v. City of Long Beach, 41 Cal.3d 937, 943 (1986) (privacy right protects "fundamental and compelling interest" in "our thoughts, our emotions, our expressions, our personalities" (emphasis in original). See also Brief of Respondent at 26-35.

B. The Common Law and Constitutional Right To Refuse Medication May Not Be Overcome Absent an Emergency or a Finding of Incompetence, Neither of Which is Present in this Case.

Amici acknowledge that an involuntarily committed patient's right to refuse antipsychotic medication is not absolute. But this right may not be overcome absent either (i) an emergency or (ii) a finding that the patient is incompetent to make treatment decisions.

Forcible medication is legitimate interest in an emergency -- that is, when a patient is actively dangerous to herself or others, or who poses an immediate and substantial threat of becoming violent. Under these circumstances, the state's police power interest in preserving order and protecting patients and staff within the institution will be sufficient to override the patient's refusal of antipsychotic drugs if -- but only if -- other less intrusive approaches would be ineffective in preventing violent behavior. See C.C.R., Tit. 9, § 853.

Forcible medication may also be appropriate -- in some instances -- when an objecting patient has been found incompetent to make treatment decisions. Common law informed consent, and the state constitutional privacy provision, protect the right of a person of sound mind to make informed choices about medical treatment. A person found incompetent to make treatment decisions does not fall within the scope of the state law protections. For these patients, as amici will show, a refusal of antipsychotic drugs should be respected only if it can be determined that the patient, if competent, would have refused the medication. See Point III.C infra.

The present case falls within neither exception. There is no dispute that the commitment of Riese did not involve an emergency situation permitting forced medication. Nor does commitment under sections 5150 and 5250 demonstrate incompetence to make treatment decisions. The New York

Court of Appeals explained the basis for the distinction between commitment and incompetency in Rivers v. Katz:

[T]he nearly unanimous modern trend in the courts, and among psychiatric and legal commentators is to recognize that there is no significant relationship between the need for hospitalization of mentally ill patients and their ability to make treatment decisions. Indeed there is considerable authority within the psychiatric community that from a medical point of view no relationship necessarily exists between the need for commitment and the capacity to make treatment decisions . . . since the presence of mental illness does not ipso facto warrant a finding of incompetency.

495 N.E.2d at 342. Accord Brooks, The Constitutional Right to Refuse Antipsychotic Medications, 8 Bull. of Am. Academy of Psychiatry & L. 179, 191 (1980).

There is also now an almost universal legislative recognition of the separation between determinations of the need for involuntary hospitalization and incompetency. As a major study published in 1968 noted:

The trend in legislation during the last fifteen years has been toward a complete separation of hospitalization and incompetency. This trend appears to be a reflection of the belief held by an increasing number in both the medical and legal professions that there is no necessary relationship between a person's need to be cared for in a mental hospital and his capacity to handle his own affairs.

Allen, Ferster & Weihofen, Mental Impairment and Legal Incompetency 49-50 (1968) (footnotes omitted). "Today, virtually every state has an explicit provision to the effect that institutionalization does not affect competency

or even create a presumption of incompetency." Brakel, Parry & Weiner, The Mentally Disabled and the Law 71, 184-185, 405-407 (3d ed. 1985). See also, e.g., Cal. Welfare & Institutions Code §§ 5326.5, 5331, 5357, and 5358.

This conclusion, that commitment and incompetence are not equivalent, is supported by numerous studies showing that people like Eleanor Riese are capable of informed consent to antipsychotic drugs. The recent study using patients involuntarily committed for short-term treatment in a San Francisco crisis clinic, mentioned supra, thus concluded that: "patients are often able to provide information as to what is possible and what is not possible. . . . [T]his study indicates that it may also be possible for involuntary patients to do the same and thus to be involved in an important and significant part of their treatment which has, under most circumstances been denied them." Ghannam & Gresham, Informed Consent to Receive Antipsychotic Medication in Involuntarily Detained Psychiatric Patients, Exhibit 2 at 10. Further, 53% of the medicated patients during a fifteen day period gave informed consent prior to receiving any medications. Of those patients drugged without informed consent, all but one were found to meet emergency criteria. Within 72 hours of admission, 73% of this latter group were able to give informed consent after the emergency was over. Id. at 7-9.

C. LPS Explicitly Protects The Common Law And Constitutional Right To Refuse Treatment.

In LPS, the legislature made absolutely clear that persons committed for evaluation and treatment retain all rights not specifically denied them by statute. Section 5005 states that "[u]nless specifically stated, a person [detained under] the provisions of this part shall not forfeit any legal right or suffer legal disability by reason of the provisions of this part." Section 5325.1 explicitly guarantees persons with mental illness "the same legal rights and responsibilities guaranteed all other persons by the . . . Constitution and laws of the State of California unless specifically limited by federal or state law or regulations." And section 5327 provides further that "[e]very person involuntarily detained . . . shall retain all rights not specifically denied him under this part." No provision of LPS specifically denies to involuntarily committed persons the right to refuse antipsychotic drugs. Absent any specific denial of the right to refuse, the unambiguous legislative directives in sections 5005, 5325.1 and 5327 require that involuntarily committed patients retain the common law and constitutional right to refuse treatment with antipsychotic drugs. Because the mere fact of involuntary commitment does not establish an emergency or incompetence, and nothing in LPS specifically deprives involuntarily committed patients of the right to refuse

antipsychotic medications, respondent Riese retains the right to refuse.

Respect for the careful balance struck in LPS requires affirmance of the Court of Appeal. Although petitioner invokes judicial restraint as a reason for overturning the decision below, it is petitioner's position that would require this Court to engage in substantial lawmaking in derogation of the legislative command that patients retain all rights not specifically limited in LPS. Petitioner asks this Court to ignore that intentional legislative limitation on the permissible interpretation of LPS, and to render a judgment in accord with petitioner's view of sound mental health policy. Should petitioner believe that a patient's right to refuse medication impedes the efficacy of treatment under sections 5150 and 5250, the legislature -- and not this Court -- is the proper forum for readjusting the balance struck in LPS between patient rights and professional discretion. LPS on its face precludes this Court from rewriting the statute in the way that petitioner urges.

III. A HOSPITALIZED PATIENT HAS A FEDERAL CONSTITUTIONAL RIGHT TO REFUSE ANTIPSYCHOTIC DRUGS UNLESS THE PATIENT HAS BEEN FOUND INCOMPETENT TO MAKE TREATMENT DECISIONS OR IS IMMINENTLY DANGEROUS TO SELF OR OTHERS.

Because LPS, the common law, and the California Constitution all protect the right to refuse antipsychotic medication, this Court can -- and should -- resolve the present case without considering federal constitutional issues.

Ashwander v. Tennessee Valley Authority, 297 U.S. 288,

346-348 (1936) (Brandeis, J., concurring). Should this Court decide to reach the federal constitutional issues, however, the result would be the same as that dictated under California law. Amici will demonstrate that the involuntarily committed retain a right under the Fourteenth Amendment to refuse antipsychotic medication.

A. The Federal Constitution Protects An Individual's Right To Refuse Antipsychotic Medication.

The U.S. Supreme Court has repeatedly held that "[a]mong the historic liberties protected by the Due Process Clause is the 'right to be free from . . . unjustified intrusions on personal security.'" Vitek v. Jones, 445 U.S. 480, 492 (1980) (quoting Ingraham v. Wright, 430 U.S. 651, 673 (1977)). The individual's firmly embedded common law "right to determine what shall be done with his body," Schloendorff v. Society of New York Hospitals, 211 N.Y. 125, 129, 105 N.E. 92 (1914) (Cardozo, J.), is without question one of the "personal rights that can be deemed fundamental or implicit in the concept of ordered liberty" and is therefore protected by the Due Process Clause. See Palko v. Connecticut, 302 U.S. 319, 325 (1937) (Cardozo, J.) (internal quotation omitted). This right to personal security and bodily integrity, the Supreme Court has made clear, encompasses a fundamental interest "in independence in making certain kinds of important decisions" about what will be done to one's body and mind. Whalen v. Roe, 429 U.S. 589, 599-600 (1977). See generally Superintendent of Belchertown

State School v. Saikewicz, 373 Mass. 728, 742, 370 N.E.2d 417, 426 (1977).

The forced administration of antipsychotic drugs to a person competent to refuse such treatment intrudes upon not only these interests in personal security and bodily integrity, but also upon the sanctity of the mental process. See Point I supra. An individual's right to refuse antipsychotic drugs is accordingly protected by the United States Constitution. See generally Brooks, The Constitutional Right to Refuse Antipsychotic Medications, 8 Bull. Am. Acad. Psychiatry & Law 179 (1980). In Mills v. Rogers, 457 U.S. 291 (1982), the Supreme Court, though remanding for a determination whether state law provided a right to refuse antipsychotic medication, proceeded on the assumption that the Due Process Clauses of the federal Constitution encompasses such a right:

As do the parties, we assume for purposes of this discussion that involuntarily committed mental patients do retain liberty interest protected directly by the Constitution, cf. O'Connor v. Donaldson, 422 U.S. 563, and that these interests are implicated by the involuntary administration of psychotropic drugs.

Id. at 299, n.16. The Court's reliance on O'Connor v. Donaldson is significant. There the Court unanimously held that an individual retained liberty interests that were protected by the federal Constitution even after the individual was involuntarily committed by court order to a state

mental hospital, and even though the individual had been found incompetent. 422 U.S. at 566 n.2.

Similarly, in Winston v. Lee, the Supreme Court specifically refused to permit surgery upon a criminal defendant to remove a bullet that would have provided probative evidence of the defendant's guilt because that surgery would have constituted an "extensive intrusion on . . . personal privacy and bodily integrity." 470 U.S. 753, 764 (1985). Although the case arose under the Fourth Amendment, the analysis in Winston vindicated personal rights virtually identical to those at stake in the present case. In finding the proposed surgery to be too severe an infringement of personal security and bodily integrity to be permitted under any circumstances, the Court acknowledged that forcing a defendant to undergo a serious nonconsensual medical procedure "involves a virtually total divestment of . . . ordinary control." Id. at 765. The existence of conflicting scientific evidence about the risks and intrusiveness of the proposed surgery did not alter the Court's judgment. To contrary, the Court held, "the very uncertainty militates against" forcing the defendant to undergo the operation.

Every lower court that has ruled on the issue in the past decade has reached the conclusion that the right to refuse antipsychotic drugs is a substantive liberty interest protected by the federal Constitution -- although courts have differed in demarking where the right must yield to a compelling governmental interest. See, e.g., Project

Release v. Prevost, 722 F.2d 960, 979 (2d Cir. 1983). Some have based their conclusion on the constitutional right to form and express ideas, others on the constitutional right to privacy, to personal integrity, to personal security, or to substantive due process. That other courts have not agreed on a single rationale for the right is not an argument against recognition by this Court. To the contrary, the breadth of constitutionally protected interests those courts have cited demonstrates that forcible administration of antipsychotic drugs implicates a panoply of fundamental liberty interests. But regardless of the specific source of the right, those courts have all held that involuntarily hospitalized mental patients have a constitutionally protected right to refuse antipsychotic drugs that must be respected by the government.^{9/}

^{9/} In addition to the district court and circuit opinions in Mills v. Rogers, both of which found a federal constitutional right to refuse antipsychotic drugs (see Rogers v. Okin, 478 F. Supp. 1342 (D. Mass. 1979), Rogers v. Okin, 738 F.2d 1 (1st Cir. 1984) (on remand)), see Winters v. Miller, 446 F.2d 65 (2d Cir.), cert. denied, 404 U.S. 985 (1971); Davis v. Hubbard, 506 F. Supp. 915 (N.D. Ohio 1980); Rennie v. Klein, 653 F.2d 836 (3d Cir. 1981) (en banc) cert. granted and judgment vacated and remanded, 485 U.S. 1119 (1982), on remand, 720 F.2d 266 (3d Cir. 1983); In Re K.K.B., 606 P.2d 747 (Okla. 1980); Johnson v. Silvers, 742 F.2d 823 (4th Cir. 1984); and Rogers v. Commissioner of Mental Health, 390 Mass. 489, 458 N.E.2d 308 (1983). See also Project Release v. Prevost, 722 F.2d 960 (2d Cir. 1983), and Anderson v. Arizona, 663 P.2d 570 (Ct. App. Ariz. 1982), both of which hold that patients have a right to refuse antipsychotic drugs and appear to ground that right in both the federal Constitution and state law. And see, (Footnote Continued)

B. Absent An Emergency, A Competent Person Has An Absolute Right to Refuse Antipsychotic Medication Even If That Person Has Been Involuntarily Hospitalized For Treatment of Mental Illness.

Of course, recognition of a patient's right to refuse treatment with antipsychotic drugs does not mean that the right is absolute. Determining its appropriate scope requires a weighing of "the individual's interest in liberty against the State's asserted right for restraining individual liberty." Youngberg v. Romeo, 457 U.S. at 320. As amici noted, see Point II.B supra, forced administration of antipsychotic drugs is appropriate in an emergency or when

(Footnote Continued)

Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973) (mental patients have a constitutional right to refuse the drug apomorphine); Scott v. Plante, 532 F.2d 939 (3d Cir. 1976) (complaint alleging forced administration of psychotropic drugs states a claim under the federal Constitution); Bee v. Greaves, 744 F.2d 1387 (10th Cir. 1984), cert. denied, 105 S. Ct. 1187 (1985) (pre-trial detainees have a constitutional right to refuse psychotropic drugs); Osgood v. District of Columbia, 567 F. Supp. 1026 (D.D.C. 1983) (former mental patient has a constitutional right, in jail, to refuse psychotropic drugs); and Mackey v. Procunier, 477 F.2d 877 (9th Cir. 1973) (complaint alleging forcible administration of the drug succinylcholine to a prisoner in a state mental facility states a claim under the federal Constitution). Furthermore, although sympathetic to a federal constitutional right many other courts have found it unnecessary to reach that question and have ruled, instead, that involuntarily hospitalized mental patients have a common law right, a state statutory right, or a state constitutional right to refuse psychotropic drugs. E.g., Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337 (1986); Goedcke v. State Dep't of Institutions, 603 P.2d 123 (Colo. 1979); People v. Medina, 705 P.2d 961 (Colo. 1985) (en banc); Opinion of the Justices, 465 A.2d 484 (N.H. 1983).

it is determined that an incompetent patient would not have refused the drugs if competent.

The particular constitutional balance struck in Youngberg, however, is of little utility in resolving the present case because Youngberg did not involve the individual interest at stake here -- the right to refuse unwanted medical treatment. In Youngberg itself the Court held that a profoundly mentally retarded patient in a state hospital had an individual liberty interest in safe conditions, freedom from unnecessary restraint, and adequate training, but that this interest could be adequately protected by a legal standard that "professional judgment was in fact exercised" in deciding upon the extent of restraint imposed or of training given. Id. at 321-324. Youngberg does not, however, stand for the proposition that government may override an individual's decision to refuse medical treatment whenever the treatment appears medically indicated in the exercise of "professional judgment." Although the government has an interest in the health and well-being of its citizens, this interest has never been held to be sufficient in itself to override a competent individual's right to accept or refuse medically indicated treatment. Were the medical treatment at issue an intrusive and risky procedure such as bypass surgery, a mastectomy, or dialysis, it is inconceivable that the Constitution would be held to permit the federal government to force a competent adult to undergo such treatment against his or her will -- even if

professionals considered the treatment to be in the best medical interest of the patient. Because antipsychotic drugs are similarly intrusive and pose the risk of similarly severe unwanted effects, a competent decision to refuse these drugs must likewise receive constitutional protection.

The patient in Youngberg was a profoundly mentally retarded individual who was utterly unable to care for himself and functioned at the level of an eighteen month-old baby. The patient was not competent to make treatment decisions, and had never in his life been competent to make treatment decisions. He claimed a constitutional entitlement to certain adequate levels of treatment and standards of care, and not a right to have any choice to refuse treatment respected. In Youngberg, therefore, the government had an obvious interest in caring for a hospitalized individual who was incapable of caring for himself in any way, and the individual was not even seeking to assert any liberty interest in making his own competent decisions about treatment. Given that the individual's constitutional claim was at bottom one for medically adequate conditions and care in Youngberg, the Court struck the balance between the patient's claim of entitlement and the government's interests by applying the "professional judgment" standard.

Unlike the patient in Youngberg, appellant Riese is asserting a right to have her decision not to endure the risks and side effects of antipsychotic drugs respected. In general, a competent adult may not constitutionally be

forced by government to submit to unwanted, intrusive medical procedures that entail significant risks. The right at stake in this case is not the right to be free from "arbitrary" administration of antipsychotic drugs. Rather, it is the right of a competent adult to make medical treatment decisions when proposed treatment poses serious risks. Forced administration of antipsychotic drugs is constitutionally permissible only if something about Ms. Riese's particular character or circumstances provides the Hospital with a compelling justification for overriding her decision to refuse unwanted medical treatment.

No such justification exists under the circumstances of this case. The mere fact of involuntary commitment does not justify a decision to override an individual's liberty interest in being free of unwanted, risky treatment with antipsychotic drugs. As amici have shown, involuntary commitment is not equivalent to a finding of incompetence to make treatment decisions. Because respondent Riese has not been found incompetent to make treatment decisions, only one conceivable basis thus exists for justifying a decision to override Ms. Riese's right to refuse medication with antipsychotic drugs: the government's parens patriae interest in caring for her because she is unable to make treatment decisions for her. This purported justification does not provide a sufficient compelling reason for

overriding the right to refuse antipsychotic medication in this case.^{10/}

^{10/} No other conceivable government interest would be adequate to justify the intrusion. The state's interest in saving life is not implicated here because antipsychotic drugs do not save or prolong life. The state's interest in improving the health of the public does not outweigh the patient's constitutionally protected interests. Although the Supreme Court held, in Jacobson v. Massachusetts, 197 U.S. 11 (1905), that the state's interest in compulsory vaccination outweighed the individual's right to bodily integrity, the balance of governmental and individual interests is far different in the case of antipsychotic drugs. First, the state's interest in administering antipsychotic drugs in the hope that they will help individuals is not as compelling as its interest in administering vaccinations to prevent highly predictable and life-threatening epidemics. Second, far more than vaccinations, antipsychotic drugs dramatically affect the body and mind of the individual and have dangerous and often permanent side effects. (See Point I, supra.) Third, vaccinations are highly effective, but as noted in Point I, antipsychotic drugs may not benefit a given patient. Fourth, although there are no realistic alternatives to vaccinations, other treatment methods (such as group or individual psychotherapy and certain forms of properly developed behavior modification) that are less physically intrusive than antipsychotic drugs may be effective for at least some patients. Nor is the interest in institutional efficiency sufficient. Any governmental institution might function more efficiently and effectively if individual freedom could be curtailed. But our constitutional system of government is based on the premise that individual freedom should be protected even at the expense of some loss of governmental efficiency and order. In any event, the threat to these interests is not severe. See Point III infra.

Finally, recognition of the right of competent patients to refuse antipsychotic medication is wholly consistent with the government's interest in furthering professional ethics. Among treating professionals, it is an almost universally accepted principle that patients must give informed consent before they are subject to medical treatment. See National Comm'n for Protection of Human Subjects of Biomedical and Behavioral Research, Research Involving Those

(Footnote Continued)

C. Absent An Emergency, Antipsychotic Drugs May Be Administered Over The Objections Of An Incompetent Patient Only After A Substituted Judgment Has Been Made.

Amici will also demonstrate that the opinion below in this case was incorrect in holding that persons adjudged incompetent do not retain the right to refuse antipsychotic medication if, in the judgment of a substitute decisionmaker, the patient would have decided to refuse the drugs when competent. Respect for the autonomy and dignity of the incompetent requires adoption of the substituted judgment approach for cases in which a person adjudged incompetent refuses treatment with antipsychotic medication. Under that standard, the decisionmaker does not look to the best interests of the patient in an objective sense, but instead must ask what the patient, subjectively, would consider in his or her best interest if competent to decide.

(Footnote Continued)
Institutionalized As Mentally Infirm (5-3)-(5-6) (H.E.W. Pub. No. 78-0007, 1978) (Nat'l Comm'n). The underlying legal and ethical premise of the informed consent doctrine is the notion of "thorough-going self determination."
Natanson v. Kline, 186 Kan. 393, 406, 350 P.2d 1093, 1104 (1960). See American Psychological Association, Ethical Principles of Psychologists, 36 Am. Psychologist 633, at 633, 636 (1981) (psychologists strive to protect fundamental human rights, they fully inform clients of the purpose and nature of treatment, and they recognize that clients "have freedom of choice with regard to participation").

The rationale for substituted judgment was well expressed by the Massachusetts Supreme Judicial Court:

The 'best interests' of an incompetent person are not necessarily served by imposing on such persons results not mandated as to competent persons similarly situated. It does not advance the interest of the State or the ward to treat the ward as a person of lesser status or dignity than others. . . . To presume that the incompetent person must always be subjected to what many rational and intelligent persons may decline is to downgrade the status of the incompetent person by placing a lesser value on his intrinsic human worth and vitality.

Superintendent of Belchertown State School v. Saikewicz, 403 A.2d at 750 (citation omitted). Similarly, in Rivers v. Katz, the New York Court of Appeals explained that "the right extends equally to mentally ill persons who are not to be treated as persons of lesser status or dignity because of their illness." 495 N.E.2d at 341. See also People v. Medina, 705 P.2d at 971 ("The disruption of bodily integrity is no less real in the case of an incompetent patient; more, for that matter are the risks from the antipsychotic medication any less for a patient who is unable to give an informed consent").

This approach may raise difficult questions in some cases. For example, although it would be permissible to administer antipsychotic drugs to an incompetent patient who, if competent, would consent, is forced drugging permissible when, despite a good faith effort, it is impossible to determine what the incompetent patient would do if

competent? In amicus' view, it would be permissible to administer antipsychotic drugs in that circumstance if certain additional standards were satisfied. A recent thoughtful opinion of the Supreme Court of Colorado, en banc, summarizes the standards amici would consider appropriate for determining whether to medicate an incompetent patient when it cannot be determined what the patient would decide if competent:

We are satisfied that the interest of both the patient and the state will be adequately served if the physician or professional person desiring to administer antipsychotic medication satisfies the court by clear and convincing evidence of the following four propositions: (1) that the patient is incompetent to effectively participate in the treatment decision; (2) that treatment by antipsychotic medication is necessary to prevent a significant and likely long-term deterioration in the patient's mental condition or to prevent the likelihood of the patient's causing serious harm to himself or others in the institution; (3) that a less intrusive treatment alternative is not available; and (4) that the patient's need for treatment by antipsychotic medication is sufficiently compelling to override any bona fide and legitimate interest of the patient in refusing treatment.

People v. Medina, 705 P.2d at 973.^{11/}

^{11/} A patient who refuses antipsychotic medication does not go without treatment. There are a variety of alternative less intrusive, but potentially effective, interventions with severely mentally ill patients. See Point I.C supra.

IV. JUDICIAL DETERMINATIONS OF COMPETENCY AND SUBSTITUTED JUDGMENT ARE CONSTITUTIONALLY REQUIRED TO PROTECT AN INDIVIDUAL'S RIGHT TO REFUSE ANTIPSYCHOTIC DRUGS.

To ensure that a person's substantive rights to refuse antipsychotic drugs are adequately protected, the determination of competency and -- in the case of an incompetent person -- the substituted judgment determination must be made by a court. These issues are essentially legal in nature. Courts have traditionally been considered the appropriate forum for resolving issues of competency or danger to self or others, Rivers v. Katz, 495 N.E.2d at 343 ("[s]uch a determination is uniquely a judicial, not a medical function"), and there is no persuasive reason why courts should not resolve those same issues in the context of forced medication. For example, in People v. Medina, the Supreme Court of Colorado, en banc, held that a court must conduct the substituted judgment evaluation because the issues to be resolved are primarily legal in nature:

Although the decision to forcibly medicate a patient with antipsychotic drugs undoubtedly involves an aspect of professional medical judgment in connection with psychiatric diagnosis and treatment alternatives, the fact remains that the decision itself directly implicates the patient's legal interests in personal autonomy and bodily integrity.

705 P.2d at 969. Accord Rivers v. Katz, 67 N.Y.2d 485, N.E.2d 337 (1986); Rogers v. Commissioner of Mental Health, 390 Mass. 489, 458 N.E.2d 308 (Mass. 1983); In re K.K.B., 609 P.2d 747 (Okla. 1980).

Leaving competency and substituted judgment determinations to hospital personnel creates a significant risk that, simply because a professional believes the patient has made the "wrong" decision, the professional will conclude that the patient is incapable of rational thought. Hospital personnel are simply not in the position to make the kind of neutral and detached judgment necessary to respect the patient's rights. Indeed, that is precisely what happened in the present case. It is because of the dangers posed by such well-intentioned but potentially biased judgments that "[u]nder our Constitution there is no procedural right more fundamental than the right of the citizen, except in the extraordinary circumstances, to tell his side of the story to an impartial tribunal." Winters v. Miller, 446 F.2d 65, 71 (2d Cir.), cert. denied, 404 U.S. 985 (1971).

Requiring judicial competency and substituted judgment determinations will not unduly burden governmental interests in institutional efficiency and treatment. Because the vast majority of patients who are prescribed antipsychotic drugs willingly take them, judicial process would be required only for that small minority of persons who object to treatment with psychotropic drugs. The example of the Rogers' case is instructive. In a more than two-year period after the district court issued its injunction generally prohibiting forced administration of antipsychotic drugs in nonemergency situations, a witness for the state was able to identify only 12 patients out of approximately 1,000 who refused such

drugs. And most of them changed their minds within a few days and agreed to take the drugs. Rogers v. Okin, 484 F. Supp. at 1369. Also, the evidence suggests that recognizing a right to refuse antipsychotic drugs has not interfered with the operation of institutions or with treatment programs. In New Jersey, for example, a state institution operated for a year under a court order enforcing patients' right to refuse antipsychotic drugs. The hospital staff experienced little disruption in treating patients. In fact, substantial savings in medication costs were realized, fewer side effects occurred, and most significantly, "treatment itself . . . improved . . . [without] substantial additional burdens . . . placed on treatment personnel." Brooks, The Constitutional Right to Refuse Antipsychotic Medications, 8 Bull. Am. Acad. Psychiatry & L. 179, 213 (1980). See also Appelbaum & Gutheil, Drug Refusal: A Study of Psychiatric Inpatients, 137 Am. J. Psychiatry 340, 345 (1980). And one study in the District of Columbia found that only 2.4 percent of committed mental patients refused treatment with antipsychotic drugs. Keisling, Characteristics and Outcome of Patients Who Refuse Medication, 34 Hosp. Community Psychiatry 847 (1983).

CONCLUSION

For all the foregoing reasons, and for the reasons stated in the decision of the Court of Appeal below, the judgment below should be upheld, except for the determination that substituted judgment is not required on behalf of people adjudicated incompetent, which should be reversed.

Respectfully submitted,

DONALD N. BERSOFF
DONALD B. VERRILLI, Jr.
Jenner & Block
21 Dupont Circle
Washington, D.C. 20036
(202) 223-4400

MICHELE H. LICHT
LICHT & BLOOM
Suite 670
15260 Ventura Boulevard
Sherman Oaks, California 91403
(818) 905-0819

EXHIBITS

A Preliminary Exploration of Informed Consent in
Involuntarily Detained Patients

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Gail L. Gresham, R.N., M.S., J.D., and
Jess H. Ghannam, Ph.D.

Mount Zion Hospital and Medical Center
San Francisco, California
and
University of California, San Francisco
School of Medicine and Nursing
San Francisco, California

* * *

In mid-June 1985 a petition was filed in the Superior Court of the City and County of San Francisco on behalf of a group of individuals who had been detained involuntarily in psychiatric treatment facilities and required to take medication in the absence of their informed consent. These individuals, the petitioner-patients, asked the court for a judicial determination requiring that informed consent be obtained prior to the administration of medication and in the absence of an emergency.

The Superior Court, in a December 6, 1985, decision, held that the nonemergency administration of antipsychotic medication in the absence of informed consent was not a violation of the individual's constitutional right to have such consent secured. Specifically, the court stated that "petitioners have made no showing of a right to give or withhold consent . . . furthermore, present California law deals with this subject matter, specifically providing for the right to informed consent for voluntary patients, only, thus excluding other groups and classes. Such distinction is not constitutionally infirm."^{1/}

The California law which the court referred to was Title IX, California Code of Regulations (formerly referred to as the California Administrative Code), Section 850,^{2/} which provides

that every person admitted as a voluntary patient to a facility for psychiatric evaluation and treatment has the right to refuse the administration of antipsychotic medication.^{3/} Antipsychotic medication has been defined as any drug customarily used for the treatment of symptoms of psychosis and other mental and emotional disorders.^{4/}

Emergency situations, thus far, have provided the only significant exception to this rule regarding the voluntary patients' right to refuse antipsychotic medication. The limits of this exception are defined and restricted to those circumstances where there is a "sudden marked change in the patient's condition which necessitates immediate action in order to preserve the life of, or to prevent serious bodily harm to, the patient or others."^{5/} It must, likewise, in these situations, be impracticable to first obtain the consent of the patient.

Following the order and judgment from the Superior Court, the petitioner-patients noticed an appeal. The appellate court was requested by the now appellant-patients to reverse the decision of the Superior Court and "confirm that in the absence of an emergency involuntarily institutionalized mentally ill persons have the right to refuse antipsychotic medications."^{6/}

In December 1987 the First District Court of Appeal returned a favorable decision on behalf of that class of persons who had been involuntarily detained and medicated without their consent in the absence of an emergency. The appellate court determined, essentially, that involuntary detention does not divest the individual patient of the right to refuse antipsychotic medication.^{7/}

As a response to the appellate decision, an urban community psychiatric crisis clinic in Northern California developed a policy which became effective the latter part of December 1987. The policy required that all patients involuntarily detained for evaluation and treatment pursuant to

California Welfare and Institutions Code Section 5150~~2~~ had the right to give or withhold consent for antipsychotic medication in the absence of an emergency.

Subsequent to this and upon learning that the decision of the appellate court had been stayed pending review by the California Supreme Court, an internal decision was made at the facility to continue the then-existing policy with one exception. The exception was that involuntarily detained patients could be medicated in the absence of both an informed consent or the existence of an emergency if all efforts had been exhausted to first obtain consent prior to initial administration of medication and the existence of an emergency had been ruled out.

An internal audit was initiated to determine the effects of the revised policy. A protocol was also developed which would provide information regarding demographic characteristics and the existence of informed consent. Informed consent was operationally defined as the presence of the patient's signature on a medication consent form ordinarily used for voluntary patients.

A sample selected from a two week (15 day) period in 1987, before the policy was initiated, was used as the comparison group. A sample from the same period in 1988 was used as the target group. The only difference between the two groups was the imposition, in the 1988 sample, of a policy requiring that involuntarily detained patients be offered the opportunity to give informed consent prior to administration of medication. In the 1987 sample, 69 involuntarily detained patients were evaluated and 37 were medicated. In the 1988 sample, 70 involuntarily detained patients were evaluated and 34 were medicated. The samples did not differ statistically in age, sex, ethnicity, 5150 criteria, diagnosis or disposition.

Informed consent was obtained in 53% of the 1988 sample prior to the administration of antipsychotic medication. Of the patients who did not give informed consent prior to administration, 44% met the emergency criteria for the administration of antipsychotic medication under Section 853 as defined above. Only one patient (3%) was medicated in the absence of both informed consent and emergency criteria.

* * *

Notes

- 1/ Order and Judgment Denying Petition for Writ of Mandate (Joint Appendix, Vol. X, at 95), Riese v. St. Mary's Hospital and Medical Center (1987) 196 Cal.App.3d 1388.
- 2/ Cal. Code of Regs., tit. 9, § 850.
- 3/ Id.
- 4/ Id. at 856.
- 5/ Id. at 853.
- 6/ Appellant's Opening Brief at 49, Riese v. St. Mary's Hospital and Medical Center, 196 Cal.App.3d 1388.
- 7/ "We hold that appellants have statutory rights to exercise informed consent to the use of antipsychotic drugs in nonemergency situations absent a judicial determination of their incapacity to make treatment decisions, and do not reach the constitutional issues." 196 Cal.App.3d at 1393.
- 8/ Welf. & Inst. Code § 5150 (Supp. 1985).

cih/96/mdm

Informed Consent to Receive Antipsychotic Medication in Involuntarily
Detained Psychiatric Patients

Jess H. Ghannam, PhD¹, and Gail L. Gresham, RN, MS, JD

Department of Psychiatry
Mount Zion Hospital and Medical Center
San Francisco, California

&

University of California San Francisco
School of Medicine and Nursing
San Francisco, California

Running head: Informed consent in involuntary patients

¹ Address requests for reprints to Dr. Ghannam, CCSSF, Department of Psychiatry, Mount Zion Hospital and Medical Center, 2330 Post Street, San Francisco, California 94115

Abstract

Securing informed consent from psychiatric patients receiving antipsychotic medication has become an important consideration in the overall treatment of mental disorders. Legal and clinical commentators have argued for and against the right of involuntarily detained patients to accept or refuse this mode of treatment. We were interested in determining if it was possible to obtain informed consent in a group of involuntarily detained patients presenting to a community crisis service. Two samples of patients were compared before and after a policy was instituted requiring that such consent be obtained. The two groups did not differ statistically in age, gender, ethnicity, diagnosis, grounds for involuntary detention, or disposition. Although the two groups did not differ on these variables, 53% of the patients in the second sample gave informed consent prior to the initial administration of antipsychotic medication. Forty-four percent of the remaining patients met emergency criteria and were medicated in the absence of consent. Only one patient was medicated in the absence of either informed consent or emergency criteria. Our findings suggest that it is

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possible to secure informed consent to receive antipsychotic medication from patients who are involuntarily detained.

Key words: informed consent, involuntary detention, antipsychotic medication

Securing informed consent from psychiatric patients receiving antipsychotic medication has become an important consideration in the treatment of mental disorders (1-6). In one of the few studies in this area, Appelbaum and Gutheil (7) reported that permitting limited refusal of antipsychotic medication in hospitalized psychotic patients was "generally innocuous" and that therapeutic gains were not always precluded by medication refusals. Zito, Routt, Mitchell, and Roerig (8) reported that psychotic patients who refuse medication were no more assaultive or combative than a matched group of consenters.

In legal forums, the right of involuntarily detained patients to refuse antipsychotic medication was generally not considered prior to 1978 (9). Federal district court decisions in 1978 and 1979, however, provided involuntarily detained patients with qualified rights to refuse antipsychotic medication (10,11). Brooks (12) reports that many state courts, guided by the federal decisions, have also considered the right of refusal in this group of patients.

Despite continued judicial and clinical interest in the area of informed consent, to our knowledge there have been no empirical investigations assessing the outcome of providing involuntarily detained patients with

the opportunity to give or refuse informed consent prior to the administration of antipsychotic medication. This study was designed to evaluate the extent to which this group of patients could give informed consent prior to administration. A comparison of two samples was used: one prior to a policy requiring informed consent, another group after the policy was initiated.

Method

Sample

All patients in the study were admitted to an urban crisis service designated by the county to receive involuntarily detained patients for evaluation and treatment (13). The samples were selected from a fifteen day period in 1987 and the same period in 1988. During the 1987 time period, 69 involuntary patients were admitted and 37 were medicated. None of the patients in this sample were afforded the opportunity to accept or refuse medication. During the same period in 1988, 70 involuntary patients were admitted and 34 were medicated. In the absence of emergency criteria (14), each of these patients was afforded the opportunity of accepting or refusing medication.

The 1987 sample was selected for purposes of determining if the two

samples were demographically and diagnostically similar. The mean age of the two samples was 38.5 (S.D. 12.91) and 36.0 (S.D. 11.77) years, respectively. The mean length of stay on the crisis unit was 10.2 (S.D. 7.44) and 17.5 (S.D. 15.95) hours, respectively. Tables 1 and 2 present the demographic and diagnostic profile of the two samples.

Procedure

The clinical records of both samples were examined retrospectively. Patients not receiving antipsychotic medication were not included in the final analysis. Antipsychotic medication in this study was defined as any drug customarily used to treat the symptoms of psychosis and other mental and emotional disorders (15). The remaining 71 records were divided between two reviewers and pertinent data was extracted. Reliability and agreement issues were minimal because the data were categorical, concrete, and did not require interpretation or inference. Three charts from each reviewer were randomly selected for purposes of cross-checking and complete agreement was found.

The only difference between the two samples concerned the imposition of a policy in the 1988 sample requiring informed consent. Patients in the 1988 sample receiving antipsychotic medication were given the opportunity

of accepting or refusing the medicine prior to administration. Those patients accepting medication were asked to sign a standard consent form created originally for use by voluntary patients.

The data were analyzed using CRUNCH, an interactive statistical software package. Categorical data were analyzed using chi-square tests. Two-tailed independent sample t-tests were used for the continuous data (i.e., age and length of stay).

Results

There were no statistical differences between the groups in age, gender, ethnicity, diagnosis, grounds for involuntary detention, or disposition (see Table 3). The only difference between the two samples that achieved statistical significance was the length of stay on the crisis unit. Sample II patients tended to remain for longer periods of time (17.53 hours versus 10.24 hours, respectively). Although the mean difference in length of stay was significant at the $p.02$ level, the variances were also significantly different ($p<.05$), suggesting that the mean difference should be interpreted with caution.

Fifty-three percent ($N=18$) of the patients in Sample II gave informed consent prior to the administration of antipsychotic medication as

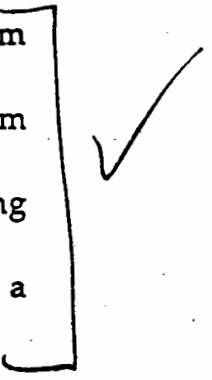
evidenced by their signatures on a standard consent form. Forty-four percent (N=15) of the patients met emergency criteria and were medicated in the absence of prior consent. Three percent (N=1) of the sample neither gave informed consent nor met emergency criteria.

Discussion

There are several possible methodological limitations to the current study. First, the retrospective nature of the data base and use of chart-based information that cannot be independently confirmed needs to be considered. Secondly, although the two groups did not differ on important demographic and diagnostic variables, caution should be taken regarding inferences to larger populations given that the samples were drawn from limited time periods. Lastly, the measure of informed consent consisted of the presence of the patient's signature on a standard consent form. The extent to which the patients understood or appreciated the meaning or the significance of the consent form was not assessed. This was not the purpose of the present study.

Despite these limitations, the results suggest that it is possible to secure informed consent prior to the administration of antipsychotic medication in a population of patients who are involuntarily detained during an

emergency psychiatric admission. Fifty-three percent of the Sample II patients were able, while being detained, to give informed consent. By providing these patients with the opportunity to receive informed consent, we were able to enlist their participation in that aspect of the treatment process which involved the administration of medication. As Appelbaum and Gutheil have suggested (16), some therapeutic benefit may result from the mutual participation of providers and patients in the process of securing informed consent. Our data suggest that this may be possible even in a group of involuntarily detained patients.



Another finding of interest emerged in the group of fifteen patients that did not sign consent forms prior to administration of medication. Seventy three percent (N=11) of the patients in this group received medication information and signed consent forms after administration. That is, eleven of the fifteen patients who were not initially provided with the opportunity to give or refuse informed consent were able to give informed consent within 72 hours of admission. This suggests that a group of patients initially meeting emergency criteria may later be able to give informed consent to receive medication and thus participate in this aspect of the treatment process.

Important questions arise with respect to the one patient who was medicated in the absence of either informed consent or emergency criteria. If the refusal was the product of an existing mental disorder, it could be reasoned that the patient lacked the capacity to make the decision to refuse. If the refusal was not the product of the mental disorder and no emergency existed, current practice in most clinical settings would allow the administration of medication in any case. This area would benefit from further investigation and analysis.

As psychiatry and law continue to move toward some equilibrium, we believe it is important to test empirically, operationally define, and integrate the often opposing and divergent views in a manner which reflects clinical practices and realities. In this regard, we believe that patients are often able to provide information as to what is possible and what is not possible. In much the same way that it was once believed that voluntary psychiatric patients were incapable of providing informed consent to accept or refuse antipsychotic medication, this study indicates that it may also be possible for involuntary patients to do the same and thus to be involved in an important and significant part of their treatment which has, under most circumstances, been denied them.²

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Table 1. Demographic characteristics of Sample I and Sample II

	Sample I (N=37)		Sample II (N=34)	
	N	%	N	%
Male	23	63	24	70
Female	14	37	10	30
Ethnicity				
Caucasian	22	60	21	61
Black	11	30	11	32
Asian	4	10	2	7
Involuntary Criteria*				
Danger: self	23	40	18	37
Danger: others	17	30	18	37
Grave disability	17	30	12	26

* includes listing of patients in more than one category

Table 2. DSM III Axis I diagnoses of Sample I and Sample II

	Sample I (N=37)		Sample II (N=34)	
	N	%	N	%
Psychotic Disorders	22	59	18	53
Mood Disorders	12	32	11	32
Adjustment Dis.	1	3	4	12
Anxiety Disorders	1	3	0	0
Organic Mental Dis.	1	3	1	3

Table 3. Significance levels for variables between Sample I and Sample II

Variable	df	p value	Statistical test
Age	69	.44	Independent sample T-test
Length of stay	69	.02*	Independent sample T-test
Gender	1	.62	Chi-square test
Ethnicity	2	.71	Chi-square test
Involuntary criteria	2	.59	Chi-square test
Diagnosis	4	.51	Chi-square test
Disposition	4	.43	Chi-square test

* F-test of equal variances rejected at the $p < .05$ level