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Judging Judgment: Assessing the Competence of Mental Patients to Refuse Treatment

GRANT H. MORRIS*

I. REFUSING TREATMENT: DUE PROCESS CONSIDERATIONS

In the interface of psychiatry and law, no issue has generated more controversy than the claim by involuntarily confined mental patients of a right to refuse psychotropic medication. The debate was fueled by

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1. See, e.g., Jonathan Brant, Pennhurst, Romeo, and Rogers: The Burger Court and Mental Health Law Reform Litigation, 4 J. LEGAL MED. 323, 345 (1983) ("The question of whether patients have a right to refuse treatment is probably the most controversial issue in forensic psychiatry today."); William M. Brooks, A Comparison of a Mentally Ill Individual's Right to Refuse Medication Under the United States and the New York Constitutions, 8 TOURO L. REV. 1, 1 (1991) ("The right of a mentally ill and involuntarily hospitalized individual to refuse medication prescribed by a psychiatrist has divided the legal and psychiatric professions more than any other recent issue."); Bruce J. Winick, New Directions in the Right to Refuse Mental Health Treatment: The Implications of Riggins v. Nevada, 2 WM. & MARY BILL OF RTS. J. 205, 206 (1993) ("[T]he issues surrounding the availability and dimensions of such a right remain mired in controversy.").

2. In legislation, court decisions, and legal scholarship, the words "psychotropic," "antipsychotic," and "neuroleptic" are often used indiscriminately to refer to medication prescribed to treat people with major mental disorders. The words, however, are not synonymous. "Psychotropic" is derived from two root words, "psycho-" meaning the mind or mental processes, and "-tropic" meaning changing or directing. Thus,
two early, and often-cited, articles—one asserting that the right to refuse psychiatric treatments is necessary to inhibit a "therapeutic orgy," the other asserting that patients who are allowed to refuse needed medication are permitted to "rot with their rights on."

Psychotropic medications include all chemical agents that act on and affect the mind. Robert J. Waldinger, Fundamentals of Psychiatry 396 (1986). Antipsychotic medications, also known as neuroleptic medications or major tranquilizers, are one type of psychotropic medication and are used to treat thought disorders such as schizophrenia. Other psychotropic medications include antidepressants and mood stabilizers. These drugs are used to treat mood disorders. Id. at 397-98. Lithium, for example, is used to treat manic-depressive illness, and is classified as a mood stabilizer. Id. at 434; see Brief for the American Psychiatric Association and the Washington State Psychiatric Association as Amici Curiae at 2-3 n.1, Washington v. Harper, 494 U.S. 210 (1990) (No. 88-599). Because the claim of a right to refuse treatment applies to involuntary mental patients with either thought or mood disorders, I have used the broader word "psychotropic" in this article.


In one article, Appelbaum and Gutheil criticize a judge for using "[s]uch loaded terms as 'involuntary mind control' to describe the effect of antipsychotic medications." Appelbaum & Gutheil, The Boston Hospital Case, supra at 721. The authors assert that psychiatrists administer drugs not to control minds but to restore them to the patients' control. Id. Ironically, for those who critique the inappropriate use of language by others, use of the word "rotting" seems most inapt. The bodies of people with schizophrenia or other nonorganic mental disorder do not undergo any rotting or decay even if they never receive the benefit of psychotropic medication. Even if "rotting" is given a broader definition to refer to untreated people "wasting away" while confined indefinitely in mental hospitals, the word is inappropriate. Regardless of whether they accept or refuse treatment, mentally disordered persons can only be involuntarily committed so long as their mental conditions meet the jurisdiction's involuntary commitment criteria. Often doctors discharge patients who are found competent to refuse treatment.
Although the rhetoric of subsequent publications is somewhat less polemic, legal and psychiatric commentators remain intensely interested in the subject. One author divided the voluminous scholarship into three categories, the first focusing on theoretical justifications for the right, the second on psychiatric objections to the right, and the third

6. But see Barry B. Perlman, Letter to the Editor, 38 Hosp. & Community Psychiatry 673 (1987). Dr. Perlman, Director of Psychiatry at St. Joseph's Medical Center in Yonkers, New York, asserted that the right to refuse treatment creates an "unworkable situation." To pressure the legislature to remedy the problem, Dr. Perlman recommended that hospital staff members be encouraged to bring criminal charges against mental patients who cannot be medicated legally but who commit assaults. Dr. Berman cautioned, however, that prosecution of mental patients "would have to be carefully explained to the public as acts on behalf of the proper treatment of patients, lest a backlash against caregivers occur." Id.


on empirical studies of results occurring when the right was implement­ed. He characterized the proliferation of scholarship in these categories as the emergence of “cottage industries.”

After a twenty-year debate, survival of the right to refuse treatment seems assured. Alan Stone, M.D., noted Harvard psychiatrist and former President of the American Psychiatric Association, found that the legal justifications for the right to refuse treatment were so “clear and


12. Perlin, supra note 7, at 957.
compelling that he urged his psychiatrist colleagues to accept the right's existence. Dr. Stone conceded that a mentally disordered person's refusal of psychotropic medication is merely one example of refusal of medical treatment by any ill person. In a treatment refusal situation, the doctrine of informed consent restricts the state's authority to intrude on the individual's autonomy. Only when the individual, whether from mental disorder or other cause, is unable to make competent decisions, may another's judgment be substituted. Although autonomous decisionmaking is negated by incompetence, incompetence is not established solely by proof of mental disorder or proof that treatment is clinically indicated.

Dr. Stone, however, would structure the civil commitment decision to deny the right to refuse treatment to those most in need of it. Dr. Stone has proposed, and the American Psychiatric Association has endorsed his proposal, that civil commitment be conditioned on a finding of incompetence to make treatment decisions. Under the proposal, competent mentally disordered people will be neither civilly committed nor involuntarily treated, but civilly committed people will be subject to involuntary treatment. The right to refuse treatment survives, but it is not a right enjoyed by involuntarily confined mental patients. For them, the right will be restored only when they are released from confinement.

14. Id. at 360.
15. Id. at 359.
16. See Alan A. Stone, Foreword to CHARLES W. LIDZ ET AL., INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY at xi (1984). Stone noted that the doctrine of informed consent is supported by both a deontological and a utilitarian justification, i.e., the value of individual autonomy and protection against iatrogenic harm. Only a utilitarian objection can be offered against it, i.e., that informed consent will not work. Stone questioned whether the claim that "doctor knows best" can be elevated to a deontological principle that warrants opposition to the doctrine.
17. See Winick, On Autonomy, supra note 9. Legal doctrine, political theory, and principles of psychological well-being support the value of autonomy. Id. at 1772.
19. Id.
20. ALAN A. STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION 68 (1975); Stone, supra note 13, at 361; see also Loren H. Roth, A Commitment Law for Patients, Doctors, and Lawyers, 136 AM. J. PSYCHIATRY 1121 (1979).
Dr. Stone’s proposal has been severely criticized. The proposal forces a decision that may be premature. At the time of the initial civil commitment hearing, information on the proposed patient’s competence to make treatment decisions may not be available. The proposed patient’s mental disorder may not have been finally diagnosed and a treatment plan may not have been developed. How can a proposed patient’s competence to make an informed decision be measured when the treatment has not been prescribed and the risks, benefits, and alternative treatments have not been explained? Additionally, the proposal has been criticized for eliminating any meaningful opportunity for an involuntary mental patient to challenge the doctor’s treatment decisions. Loss of the right to refuse treatment seems particularly inappropriate for a patient who was unable to make reasoned treatment decisions when initially confined but who has regained competence during the period of involuntary commitment.

If incompetence to make treatment decisions is a prerequisite for civil commitment, the judge or administrative officer conducting the civil commitment hearing is unlikely to make a careful assessment of the proposed patient’s competence. If the other criteria for civil commitment have been proven, i.e., the person is mentally disordered and either dangerous or unable to provide for basic personal needs, a pro forma finding of incompetence is likely if such finding is necessary to place the person in a structured environment.

Fortunately, few states have adopted Dr. Stone’s proposal. Most

22. Cichon, supra note 9, at 389.
23. The 1847 Code of Ethics of the American Medical Association included a statement of “Obligations of Patients to Their Physicians.” Loren H. Roth, The Right to Refuse Psychiatric Treatment: Law and Medicine at the Interface, 35 EMORY L.J. 139, 143 (1986) (quoting AM. MEDICAL ASS’N CODE OF MEDICAL ETHICS, ch. 1, art. 1, § 2, reprinted in PERCIVAL’S MEDICAL ETHICS 218 (Leake ed. 1927)). The code provided that “[t]he obedience of a patient to the prescriptions of his physician should be prompt and implicit. He should never permit his own crude opinions as to their fitness, to influence his attention to them.” Id.
24. Cichon, supra note 9, at 388.
25. Id.
26. In Kansas, a “mentally ill person” is subject to civil commitment. Included within the definition of “mentally ill person” is a requirement that the individual “lacks capacity to make an informed decision concerning treatment.” KAN. STAT. ANN. § 59-2902(h)(2) (Supp. 1993). That term is further defined as an inability “despite conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment, or [as an inability] to engage in a rational decision-making process regarding hospitalization or treatment, as evidenced by [an] inability to weigh the possible risks and benefits.” Id. § 59-2902(e). Although another statute declares that “a person shall not lose rights as a citizen, property rights or legal capacity by reason of being a patient,” that statement is specifically subject to limitations imposed by other statutes. Id. § 59-2930 (1983). Another statute authorizes medications to be
states do not presume or require incompetence as a criterion for civil commitment. The mentally disordered person's dangerousness to self or others, or inability to provide for basic necessities, justifies a

administered over a patient's objection. See id. § 59-2928(b) (Supp. 1993).

In Delaware, a "mentally ill person" subject to civil commitment is defined as one who is "unable to make responsible decisions with respect to his hospitalization." DEL. CODE ANN. tit. 16, § 5001(1) (1983). Other Delaware statutes, however, do not specify whether this inability is determinative of incompetency to refuse treatment.

In Iowa, Michigan, and South Carolina, civil commitment requires a finding that the proposed patient be unable to make responsible decisions regarding treatment (Iowa and South Carolina) or the need for treatment (Michigan). IOWA CODE ANN. § 229.1(14) (West 1994); MICH. COMP. LAWS ANN. § 330.1401(c) (West 1992); S.C. CODE ANN. § 44-17-580 (Law. Co-op. 1985). In each of these states, however, another statute specifically declares that civil commitment does not raise a presumption of incompetency. IOWA CODE ANN. § 229.27(1) (West 1994); MICH. COMP. LAWS ANN. § 330.1489(1) (West 1992); S.C. CODE ANN. § 44-17-580 (Law. Co-op. 1985). These conflicting statutes do not appear to resolve the question of whether the civil commitment decision constitutes an adjudication of the patient's incompetence to refuse treatment.

In New Mexico, incompetence to make a treatment decision is not a criterion for civil commitment. However, if the civil commitment criteria are present, the committing court is required to consider and decide whether the patient is capable of informed consent. N.M. STAT. ANN. § 43-1-11(D) (Michie 1993). Thus, some New Mexico civil committees may be competent to make treatment decisions. See id. § 43-1-5. A treatment guardian may be appointed for those who are not. Id. § 43-1-15(B). The court specifies a period of time, up to a maximum of one year, during which the treatment guardian exercises his or her powers. Id. § 43-1-15(C).

Similarly, in Idaho, incompetence to make a treatment decision is not a criterion for civil commitment. However, a statute requires the order of commitment to "state whether the proposed patient lacks capacity to make informed decisions about treatment." IDAHO CODE § 66-329(m) (Supp. 1994). Thus, some Idaho civil committees may be competent to make treatment decisions. In Bradshaw v. State, 120 Idaho 429, 433-34, 816 P.2d 986, 990-91 (1991), the Idaho Supreme Court required the committing court to consider evidence of incapacity to make treatment decisions separately from evidence of civil committability and required that a finding of incapacity be supported by clear and convincing evidence.

27. See Blackburn, supra note 3, at 472 n.88, for statutes declaring that civil commitment neither raises a presumption of, nor constitutes a finding of, the patient's incompetence. See also Cichon, supra note 9, at 350 n.435, for court decisions separating the commitment and competence issues. In fact, as of 1985, only eight states even allowed civil commitment and competency to be determined in the same proceeding. SAMUEL J. BRAKEL ET AL. THE MENTALLY DISABLED AND THE LAW 374 n.35, 405-07 (3d ed. 1985).

Psychiatrists have strongly supported law reform efforts to assure that civil commitment does not automatically deprive patients of their right to vote, to enter into contracts, to marry, or to drive automobiles. Stone, supra note 13, at 359. Apparently, however, psychiatrists draw the line at patients' decisionmaking authority to refuse treatment.
deprivation of liberty, but without a separate determination of incompetence, does not justify a deprivation of the patient's right to refuse treatment or other rights.

Although most states have recognized the right of competent, though involuntarily committed, patients to refuse treatment, they have divided almost equally on the question of procedural protections necessary to enforce that right. When a mental patient refuses treatment, does due process require that his or her competence to make that judgment be assessed in a formal hearing before a judge or other law-trained decisionmaker or is an informal assessment by a staff psychiatrist or hospital committee sufficient?

In cases on related issues involving mentally disordered persons, the United States Supreme Court held that an informal, medical decisionmaker model satisfies the due process requirement. In Parham v. J.R., decided in 1979, the Supreme Court acknowledged that children have a substantial liberty interest in avoiding unnecessary confinement for treatment. Nevertheless, the Court ruled that parents retain plenary authority to obtain treatment for their children in a mental health facility subject to a physician's independent examination and medical decision. Because the commitment decision was deemed "essentially medical in character," due process did not require the state to provide either a preadmission or a postadmission adversarial hearing before a law-trained judicial or administrative officer.

Arguably, the Parham precedent is not directly applicable to the right to refuse treatment issue. Children, because of their youth and immaturity, are subject to the substitute decisionmaking of their parents and physicians; competent adults, even if involuntarily confined, should not be. A decision to override a competent person's refusal of treatment is not essentially medical in character. From their medical expertise, doctors know the risks and benefits of, and the alternatives to, treatments they are prescribing. The doctrine of informed consent requires them to provide this information to their patients. However, as the California

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28. To determine whether an involuntarily committed mental patient's treatment refusal will be upheld, 14 states use a medical decisionmaker model and 18 states use a judicial decisionmaker model. Blackburn, supra note 3, at 479 & n.101, 493 & n.147.
30. Id. at 604.
31. Id. at 609.
Supreme Court noted, "The weighing of these risks against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgment reserved to the patient alone." 33

In Youngberg v. Romeo, decided in 1982, the United States Supreme Court acknowledged that involuntarily committed mentally retarded persons have liberty interests in freedom and safety from restraint and that the state must provide minimally adequate or reasonable training to assure that those interests are protected. 34 In determining whether the state has adequately protected the confined person’s rights, the Court merely required that judgment be exercised by a qualified professional. 35

In Youngberg, the Court focused primarily on the extent of the state’s affirmative obligation to provide habilitation services—a "right to treatment" issue. The Court also deferred to professional judgment on the question of whether physical restraints should be imposed in individual cases—a "right to refuse treatment" issue. The Youngberg Court, however, did not fully consider the right to refuse treatment issue. 36 Romeo was a profoundly retarded person with the mental capacity of an eighteen-month old child. 37 Obviously he lacked the mental capacity necessary to make treatment decisions. The Court did not discuss or decide whether a competent patient can refuse treatment that is deemed appropriate in the judgment of a professional.

Two weeks after announcing Youngberg, the Court vacated the judgment of a circuit court of appeals that had recognized the right of involuntarily confined mental patients to refuse psychotropic medication. The Court remanded the case for further consideration in light of Youngberg. 38 By implication, the Court was suggesting that deference

35. Id. at 321-22.
36. In Cruzan v. Director, Missouri Dep’t of Health, 497 U.S. 261 (1990), the Supreme Court acknowledged: "Youngberg . . . did not deal with decisions to administer or withhold medical treatment." Id. at 280.
37. Youngberg, 457 U.S. at 309.
to professional judgment might also be a usable standard in right to refuse treatment cases.  

In 1990, for the first time, the Supreme Court directly considered whether competent mental patients have a right to refuse treatment and, if so, who determines their competence. In *Washington v. Harper*, the Court found that a prison inmate possesses a significant liberty interest in avoiding the unwanted administration of psychotropic medication. The Court, however, rejected the prisoner’s contention that this liberty interest prevents the state from overriding his treatment refusal decision without a judicial finding of his incompetence. The Court upheld a prison regulation that authorized the involuntary administration of psychotropic medication upon a treating psychiatrist’s determination that the prisoner was both mentally disordered and dangerous to either himself or others. The Court read into the regulation a requirement that the treatment ordered be in the prisoner’s medical interest. In the Court’s judgment, the state’s interest in prison safety and security warranted involuntary treatment without a full court hearing. If a prison regulation is reasonably related to legitimate penological interests, it will be upheld even if a more rigorous standard of review would ordinarily be required to measure the alleged infringement of a fundamental constitutional right.

39. On remand, the Third Circuit Court of Appeals applied the *Youngberg* professional judgment standard. Rennie v. Klein, 720 F.2d 266 (3d Cir. 1983) (en banc). The *Rennie* court expressed its belief that the *Youngberg* Court had declined to limit the state’s authority by requiring that the treatment ordered be the least intrusive of the patient’s liberty. *Id.* at 268. For a critique of the professional judgment standard, especially in right to refuse treatment situations in which the individual is asserting a negative right against invasive state action, see Susan Stefan, *Leaving Civil Rights to the “Experts”: From Deference to Abdication Under the Professional Judgment Standard*, 102 YALE L.J. 639 (1992); see also Cichon, supra note 9, at 376-405.


41. *Id.* at 222, 228.

42. *Id.* at 227. The prison regulation also authorized the involuntary administration of psychotropic medication on prisoners who were both mentally disordered and gravely disabled. *Id.* at 215. In a subsequent opinion, Justice Kennedy, author of the majority opinion in *Harper*, clarified that *Harper* addressed only the situation in which involuntary medication is administered to a prisoner “to insure that the incarcerated person ceased to be a physical danger to himself or others.” Riggins v. Nevada, 112 S. Ct. 1810, 1818 (1992) (Kennedy, J., concurring).

43. *Harper*, 494 U.S. at 227. In a concurring and dissenting opinion, three justices noted that the state’s policy did not require a determination that involuntary treatment would advance the prisoner’s medical interest. *Id.* at 244 (Stevens, J., concurring and dissenting). Thus, in their judgment the policy inappropriately “sacrifices the inmate’s substantive liberty interest to refuse psychotropic drugs, regardless of his medical interests, to institutional and administrative concerns.” *Id.* at 245-46.

44. *Id.* at 223. The Court noted: “There are few cases in which the State’s interest in combating the danger posed by a person to both himself and others is greater
Because a state can claim no legitimate penological interest in the confinement and treatment of noncriminals, the *Harper* decision appears applicable only to mentally ill prisoners. However, could the state’s interest in the safety and security of its mental treatment facilities support the involuntary treatment of dangerous civilly committed patients who pose a danger to themselves or other patients? *Harper* provides no definitive answer. 46

After disposing of the prisoner’s substantive claim, the Court addressed the adequacy of the prison regulation’s procedural protections. The regulation provided for a prisoner-initiated hearing to review the treating psychiatrist’s decision. A committee consisting of a psychiatrist, a psychologist, and the facility’s associate superintendent conducts the hearing. No committee member can be involved in the prisoner’s current treatment or diagnosis. If the committee determines that the prisoner suffers from a mental disorder and is dangerous, the prisoner may be medicated involuntarily. 47 The Supreme Court upheld this regulation as satisfying procedural due process requirements. 48

than in a prison environment . . . .” *Id.* at 225.

45. The prison regulation used definitions of “mental disorder,” “gravely disabled,” and “likelihood of serious harm” that were identical to the definitions used in the state’s civil commitment statute. *Id.* at 215 n.3. Do these similarities suggest that the adoption of the same regulation for civilly committed patients would satisfy minimum federal constitutional requirements?

46. Less than a year later, however, the Court hinted that *Harper* might be applicable to a treatment refusal situation that did not involve prison security. Perry v. Louisiana, 498 U.S. 38 (1990) (per curiam). In *Perry*, the Court vacated a Louisiana trial court decision ordering a death row inmate to be treated involuntarily with psychotropic medication to restore him to competency to be executed. The Supreme Court ordered a reconsideration in light of *Harper*. *Id.*. Although Perry was a prisoner, there was no proof that without medication he was dangerous to himself or others. Was the Court suggesting that mentally disordered prisoners cannot be treated involuntarily if they are not dangerous? Was the Court suggesting that dangerousness is not the only justification for treatment of mentally disordered prisoners? On remand, the trial court reinstated its order, but, on appeal, the Louisiana Supreme Court reversed in part, distinguishing *Harper*. State v. Perry, 610 So. 2d 746, 747, 751-55 (La. 1992). The Louisiana Supreme Court found that the involuntary administration of psychotropic medication for the purpose of restoring competence for execution “does not constitute medical treatment but forms part of the capital punishment sought to be executed by the state.” *Id.* at 753. Under the Louisiana Constitution, such a practice violates the right to privacy and constitutes cruel, excessive, and unusual punishment. *Id.* at 747.


48. *Id.* at 231-35.
The Court suggested two reasons why the state may defer to the judgment of an internal professional review committee. First, the Court noted that the intentions (i.e., judgments) of a mentally disordered person are difficult to assess and are changeable. Those intentions can be better determined by frequent and ongoing clinical observations of mental health professionals than by a judge in a single judicial hearing. The Court’s assertion is most curious. Under the procedure approved by the Court, the internal review committee is not required to hold multiple hearings at which the prisoner’s intentions are discerned. In fact, under the Court’s ruling, the prisoner’s judgment, whether competent or incompetent, is irrelevant.

Second, the Court was concerned with the costs of a judicial hearing. Financial resources and staff time would be diverted from patient care. The Court cited studies indicating that patient refusals of psychotropic medications are upheld infrequently, whether the decisionmaker is a judge or a mental health professional, internal or external to the facility. Thus, because the regulation approved in Harper requires the hearing committee to review the treating staff’s medical decisions regarding the type and dosage of medication, the state could legitimately conclude that an administrative review using medical decisionmakers would be more effective than a judicial review. The Court ignored studies cited in amicus curiae briefs demonstrating that a judicial review model that provides therapeutic benefits to patients could be implemented without seriously burdening the mental health system.

49. Id. at 231.
50. Id. at 231-32.
51. Id. at 232.
52. Id. at 234 n.13.
53. Id. at 233.
54. Brief of the National Association of Protection and Advocacy Systems et al. as Amici Curiae at 24-27, Washington v. Harper, 494 U.S. 210 (1990) (No. 88-599) (Judicial oversight increased the doctor’s attention to medication side effects and increased the doctor’s willingness to accommodate patient needs. An effective therapeutic alliance resulted in therapeutic benefit. Patients who refused treatment were not adversely affected by any delay from scheduling a competency hearing. They did not become violent and disruptive.).
55. Brief for the Mental Health Legal Advisors Committee of the Massachusetts Supreme Judicial Court et al. as Amici Curiae at 16-18, Washington v. Harper, 494 U.S. 210 (1990) (No. 88-599) (In Massachusetts, using a judicial review model, patients who refused treatment were not hospitalized for longer periods than similarly situated patients who accepted treatment. Accidents and injuries to patients and staff did not increase. Use of restraints to control violent and destructive behavior did not increase. Because hearings were conducted at the mental health facilities, staff time spent away from the facilities was small and document preparation time was minimized.).

For a critique of Harper, see Cichon, supra note 9, at 409-16.
Federal courts, often relying on Parham, Youngberg, and Harper, have upheld statutes and regulations that use a mental health professional decisionmaker model to review mental patient treatment refusals. Nevertheless, the Harper Court insisted on procedural protections to insure that the treating professional’s decision to medicate involuntarily is neither arbitrary nor erroneous. Therefore, the Court is unlikely to uphold the involuntary medication of patients on the unreviewed judgment of the treating professional.

Recently, the Supreme Court signaled a new direction in its right to refuse treatment decisionmaking. In Riggins v. Nevada, a criminal defendant who had been found mentally competent to stand trial moved unsuccessfully for an order suspending the administration of psychotropic medication during his trial. The Supreme Court reversed the defendant’s conviction because the trial court, in denying the defendant’s motion, had not acknowledged the defendant’s liberty interest in freedom from unwanted medication. The trial court did not make any finding that medication was necessary to accomplish an essential state interest. By allowing the state to medicate the defendant over his objection in the absence of such a finding, the trial court may have


57. Harper, 494 U.S. at 228.


59. Id. at 138. On remand, the Nevada Supreme Court ordered Riggins retried without the involuntary administration of psychotropic medication unless, following the cessation of all such medications, the trial court makes the findings required by the United States Supreme Court. Riggins v. State, 860 P.2d 705, 705-06 (Nev. 1993).
violated the defendant’s right to a fair trial. Harper’s twin requirements of overriding justification and medical appropriateness, which allow the forced medication of convicted prisoners, are also required for criminal defendants. In fact, because criminal defendants are not confined in prison unless and until they are convicted, due process may require more deference to their liberty interest than is required for prison inmates.

The Riggins’ majority did not delineate with finality the substantive standards that govern the forced medication of criminal defendants. The majority did, however, suggest a standard that “certainly would satisfy due process.” Due process would be satisfied if the trial court finds that the compelled treatment is “medically appropriate and, considering less intrusive alternatives, essential for the sake of [the defendant’s] own safety or the safety of others.” Additionally, due process might be satisfied if the compelled treatment is medically appropriate and an adjudication of guilt or innocence cannot be obtained by using less intrusive means.

60. Id. The Court noted that the side effects of the psychotropic medication may have impacted the defendant’s “outward appearance, the content of his testimony on direct or cross examination, his ability to follow the proceedings, or the substance of his communication with counsel.” Id.
61. Id. at 135.
62. Only sentence-serving prisoners are in “the unique circumstances of penal confinement.” Id. at 134.
63. One federal district court has already construed Riggins to require more than Harper. In Woodland v. Angus, 820 F. Supp. 1497 (D. Utah 1993), the plaintiff, who was charged with murder, was found mentally incompetent to stand trial. Such a finding, however, was held not to include an adjudication of the defendant’s incompetence to make treatment decisions. Id. at 1502. In a separate proceeding, the court determined that the plaintiff was also incompetent to make treatment decisions. Id. at 1504. In deciding whether to permit forced medication to restore the defendant’s competence to stand trial, the court rejected Harper’s reduced standard of review. Id. at 1509. Citing Riggins, the court required proof of a compelling state interest to outweigh the plaintiff’s liberty interest. Id. at 1510. The plaintiff’s liberty interest is not outweighed in the absence of proof that forced medication will render him competent to stand trial. Id. at 1512. The state’s parens patriae authority does not justify its decision to administer psychotropic medication merely by showing that such medication is in the plaintiff’s medical interest. The plaintiff’s liberty interest is protected through the appointment of a guardian who considers the incompetent individual’s values and preferences in deciding whether to consent to treatment. Id. at 1517.
64. Riggins, 504 U.S. at 136. In his dissenting opinion, Justice Thomas asserted that the Riggins’ majority “appears to adopt a standard of strict scrutiny.” Id. at 156 (Thomas, J., dissenting). The majority denied the assertion. Id. at 136.
65. Id. at 135.
66. Id.
67. However, because Riggins did not claim a right to discontinue psychotropic medication if its administration was necessary to continue his competence to stand trial, the Court specifically refused to consider whether he, or any competent criminal defendant, had such a right. Id. Justice Kennedy, author of the majority’s Harper decision,
By focusing the trial court's attention on alternatives to involuntary treatment that are less intrusive to the individual's liberty, *Riggins* departs from previous Supreme Court decisions. In *Harper*, the Court imposed no requirement that the state's asserted interest in maintaining prison safety be measured against less intrusive alternatives to involuntary treatment. Similarly, in *Youngberg*, the Court imposed no requirement that the exercise of professional judgment be tempered by a consideration of alternatives that are less intrusive than medically appropriate, but involuntary, treatment. Most importantly, the *Riggins* standard, as worded, requires the consideration of less intrusive alternatives, not of the mental health professional's analysis of the medical appropriateness of the proposed treatment, but rather, of the state's claimed justification for overriding the individual's treatment refusal. The question of whether the forced administration of psychotropic medication is necessary to accomplish an essential state policy is not within the expertise of mental health professionals. It is a question for the courts to address.68 The *Riggins* majority even suggested that in deciding individual cases, the trial court should require that the substantive standard for involuntary treatment be proven by clear and convincing evidence.69

Neither *Harper* nor *Riggins* involved treatment refusals by civilly committed patients, and the Supreme Court has not determined the standard applicable to that context. Civilly committed patients may be entitled to greater due process protection than are either prison inmates.

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68. Although noting that *Riggins* specifically required the trial court to make the necessary findings in the criminal trial context, one commentator questioned whether a judicial model would also be required in other right to refuse treatment contexts. In the criminal trial context, the trial judge is already involved and making decisions. Thus, an administrative decisionmaker is unnecessary to decide the treatment refusal issue. Winick, *supra* note 1, at 220 n.104. However, the consideration of less restrictive alternatives, imposed by the *Riggins* standard, is addressed to the state's justification for compelled treatment, not to the medical appropriateness of that treatment. As such, it is an issue that is more suited to judicial, rather than to clinical, decisionmaking.

69. Immediately after presenting a substantive standard for judging the forced administration of psychotropic medication, the Court noted that due process requires clear and convincing evidence to establish the criteria for civil commitment. *Riggins*, 504 U.S. at 135 (citing *Addington v. Texas*, 441 U.S. 418 (1979)).
The state cannot claim that forced treatment of civilly committed patients without any court hearing is necessary to maintain prison safety and security. Unlike the prison inmate in *Harper*, civilly committed patients are not subject to punishment in a prison. The state cannot claim that forced treatment of civilly committed patients without any court hearing is necessary to determine their guilt or innocence. Unlike the criminal defendant in *Riggins*, civilly committed patients are not on trial.

Mentally disordered persons who are incapable of living in society or are dangerous to themselves or others are subject to civil commitment. The state's legitimate interest in protecting them, and in protecting others from them, is satisfied by the confinement itself—without coercing treatment. Although the state does have a legitimate interest in protecting other patients and staff from dangerous mental patients, the danger is far less in a mental hospital than it is in a prison. At most, all that is needed is authority to medicate temporarily when emergencies arise. In nonemergency situations, greater deference to the civilly committed patient's liberty interest in refusing treatment seems appropriate.

It remains to be seen whether, following *Riggins*, the Supreme Court will require an expanded due process model for civilly committed patients, or whether, consistent with *Youngberg* and *Harper*, a limited due process model will be held to suffice. Regardless of how the issue is resolved, the Court will only be deciding the minimum required by the United States Constitution. As the Supreme Court noted in a treatment refusal case, states may recognize substantive liberty interests that are more extensive than those protected by the Constitution. Those state-created liberty interests are protected by the federal Due Process Clause. A state may also confer procedural protections beyond those

70. One author has suggested that treatment refusal cases can be divided into three categories. Under *Harper*, prison inmates are subject to a reasonableness standard of review. Under *Riggins*, pretrial detainees are subject to a higher standard of review, requiring that the forced administration of psychotropic medication be the least intrusive measure to accomplish a compelling state objective. Civilly committed patients are "entitled to the most exacting standard of review." Cichon, *supra* note 9, at 419.

71. See Winick, *supra* note 1, at 228-29. Winick notes that, unlike prisons, mental hospitals have professional and support staff trained in dealing with problems of potential violence. Hospitals are also able to deal with violence using alternative approaches such as segregation, physical restraints, psychotherapy, and behavior therapy. *Id.* at 229.

72. *Id.* at 229.


minimally required by the United States Constitution. If the state does so, the minimal requirements of the Constitution do not control. Many state courts have relied upon liberty interests derived from state constitutions, statutes, and the common-law doctrine of informed consent to mandate judicial findings of incompetence before treatment refusal decisions of civilly-committed patients can be overridden. Occasion-
ally, a state court has expressly refused to be bound by an existing federal court decision offering less protection to civilly committed patients.78

Numerous empirical studies have been conducted in states that use a law-trained decisionmaker model. The studies, and their results, are remarkably alike. Typically, the researchers are psychiatrists or other mental health professionals. They report that in an overwhelming number of cases, the decisionmaker found the patient incompetent, overriding his or her treatment refusal.79 The researchers then assess

appoint a guardian to make an informed judgment for the patient.; Henderson v. Yocum, 11 Mental & Physical Disability L. Rep. (ABA) 327 (S.D. Cir. Ct. 1987) (By statute and by constitution, involuntarily committed mental patients have a right to refuse psychotropic medication in nonemergency situations. To override a treatment refusal, a court must review the patient’s competence. If the patient is found incompetent, the court must balance the patient’s right to refuse against competing state interests and also assure that the proposed treatment is provided in the least restrictive way.), aff'd, 438 N.W.2d 225 (S.D. 1989) (mem.); State ex rel. Jones v. Gerhardstein, 141 Wis. 2d 710, 734-39, 416 N.W.2d 883, 893-95 (1987) (Because precommitment detainees have a statutory right to refuse psychotropic medication, the equal protection clauses of the state and federal constitutions are violated by statutes that allow other involuntarily committed individuals to be treated over their objection in nonemergency situations. Because a court review of competence is required before a precommitment detainee may be involuntarily treated, a similar review is also required for other involuntarily admitted individuals.).

In related contexts, courts have mandated judicial hearings of patients’ competence before involuntary treatment is authorized. See, e.g., Keyheau v. Rushen, 178 Cal. App. 3d 526, 541, 223 Cal. Rptr. 746, 755-56 (1986) (Under the statutes, state prisoners are entitled to a judicial determination of their competency to refuse treatment before they can be subjected to long-term involuntary psychotropic medication.); People v. Gilliland, 769 P.2d 477, 483 (Colo. 1989) (Involuntarily committed insanity acquittees have a right to refuse psychotropic medication. To override their treatment refusals, a court must make the same findings that are required to override treatment refusals of civilly committed patients.); Gundy v. Pauley, 619 S.W.2d 730, 731-32 (Ky. Ct. App. 1981) (In the absence of an emergency, the constitution—not further defined as state or federal—requires a judicial declaration of incompetence before an involuntarily committed patient can be compelled to undergo electroconvulsive therapy.); Williams v. Wilzack, 319 Md. 485, 510, 573 A.2d 809, 821 (1990) (A state statute authorizing the involuntary medication of insanity acquittees without any judicial review was held to violate procedural due process under state and federal constitutions. In the absence of a valid statute, common law principles applied. Those principles prohibit nonconsensual administration of medication on mentally competent adults under nonemergency circumstances.; In re Guardianship of Roe, 383 Mass. 415, 417, 421 N.E.2d 40, 42 (1981) (In the absence of an emergency, psychotropic medication may be administered forcibly to a noninstitutionalized ward only when ordered by a judge.).


79. See, e.g., Binder & McNiel, supra note 11, at 353 (A study of 444 patients admitted to a 16-bed locked unit in a university psychiatric hospital revealed that 32 competency hearings were conducted during a 17-month period. Only four patients, i.e., 12.5%, were found competent.); Ciccone et al., supra note 11, at 211-12 (A study of a
the costs involved in holding these hearings and usually express their opinion that an alternative, less expensive, model is warranted. In a

107-bed psychiatric service in a private university hospital and an 850-bed state-operated psychiatric hospital revealed that 16 competency hearings were conducted during a one-year period. Only three patients, i.e., 18.8%, were found competent; Cournos et al., supra note 11, at 852-53 (A study of a 1200-bed adult state mental hospital revealed that 21 competency hearings were conducted during a one-year period. Only three patients, i.e., 14.3%, were found competent;); DeLand & Borenstein, supra note 11, at 39-41 (A study of a state forensic hospital with an average census of 200 to 250 patients revealed that 15 competency hearings were conducted during a one-year period. Not one of the 15, i.e., 0%, was found competent;); Farnsworth, supra note 11, at 35-37 (A study of a state security hospital with 153 patients revealed that 16 competency hearings were conducted during a two-year period. Only one patient, i.e., 6.3%, was found competent;); Hoge et al., supra note 11, at 950, 952 (A study of 1434 patients admitted to four acute inpatient units in state-operated mental health facilities revealed that 19 competency hearings were conducted during a six-month period. Not one of the 19, i.e., 0%, was found competent;); Steven K. Hoge et al., The Right to Refuse Treatment Under Rogers v. Commissioner: Preliminary Empirical Findings and Comparisons, 15 BULL. AM. ACAD. PSYCHIATRY & L. 163, 164-65 (1987) (A study of all 350 competency hearings conducted in Massachusetts during a 17-month period revealed that only 12 patients, i.e., 3.4%, were found competent;); Miller et al., supra note 11, at 110-11, 115 (Of the 272 patients who were either confined in a maximum security state forensic facility at the time the competency hearing requirement was implemented or who were admitted to that facility within six months, 39 competency hearings were conducted. Not one of the 39, i.e., 0%, was found competent;); Sauvayre, supra note 11, at 222-23 (A study of all patient refusals resulting in court hearings at a maximum security forensic hospital revealed that 40 competency hearings were conducted on 33 patients during a two-year period. In only eight cases, i.e., 20% of the hearings, were patients found competent;); Schouten & Gutheil, supra note 11, at 1348-49 (A study of all 2216 competency hearings conducted in Massachusetts during an 18-month period revealed that only 21 patients, i.e., 0.9%, were found competent;); Jorge Veliz & William S. James, Medicine Court: Rogers in Practice, 144 AM. J. PSYCHIATRY 62, 63-64 (1987) (A study of a strict-security facility for criminally insane men revealed that 39 competency hearings were conducted during a one-year period. Only four patients, i.e., 10.3%, were found competent;); Zito, New York Under Rivers, supra note 11, at 905-06 (A study of all New York state adult psychiatric and forensic facilities revealed that for the 49,408 patients admitted, 358 competency hearings were conducted during a one-year period. Only 32 patients, i.e., 8.9%, were found competent;); Zito, One Year Under Rivers, supra note 11, at 297-98, 300 (A study of a large state psychiatric facility revealed that for the 2328 patients in residence at the start of the study or admitted during the study, 15 competency hearings were conducted during a one-year period. Only two patients, i.e., 13.3%, were found competent;).

In jurisdictions that use a medical decisionmaker review model, most refusals of treatment are overridden and most patients are treated involuntarily. See Paul S. Appelbaum & Steven K. Hoge, The Right to Refuse Treatment: What the Research Reveals, 4 BEHAVIORAL SCI. & L. 279, 288-90 (1986) (discussing studies).
few studies, the researchers state the doctors’ reasons for recommending treatment over their patients’ objections and/or the patients’ reasons they are found competent to refuse treatment. Additionally, in some situations, doctors may not even contest a patient’s medication refusal if they believe the patient will be found competent at a hearing.; Ciccone et al., supra note 11, at 210-11 (Court hearings required an average of 31 days to resolve at the private hospital and 68 days to resolve at the public hospital. The legal expense to the private hospital is over $2000 per hearing. Two clinicians and an ethicist, who reviewed patient charts at the public hospital, found no patients who benefited from the hearing requirement.; Cournos et al., supra note 11, at 855 (Court hearings are costly and require staff time. Judges almost always defer to physicians to make treatment decisions.; DeLand & Borenstein, supra note 11, at 41 (Each competency hearing required approximately six hours of a psychiatrist’s time, and each psychiatrist interviewed expressed the belief that the physician-patient relationship was adversely affected by the hearing process.; Farnsworth, supra note 11, at 38-41 (Judicial review significantly delayed the beginning of treatment for patients found incompetent—an average of 80 additional days. The financial impact of holding patients for 80 days without treatment is enormous.; Hoge et al., supra note 11, at 955-56 (Delay in preparing petitions and awaiting judicial hearings prolonged hospitalization, increased patient morbidity, increased the number of patient assaults and disruption of the therapeutic milieu, and diverted clinical staff time.; Hoge et al., supra note 79, at 168 (The cost of 350 hearings was estimated at $1 million including the time of the judge, lawyers, and doctors.; Miller et al., supra note 11, at 115-17 (Costs of hearings include delays in treatment and staff time required for hearings. The willingness of courts to accept telephone testimony eliminated staff travel time and time waiting in court for the case to be called.; Schouten & Gutheil, supra note 11, at 1349-51 (In fiscal year 1985, the legislature appropriated $364,000 and in fiscal year 1986, the legislature appropriated an additional $824,000 to fund the personnel costs of conducting hearings. Noneconomic costs include damage to the therapeutic relationship and the suffering of patients when treatment is delayed. Delays of 8 to 10 weeks were common.; Veliz & James, supra note 79, at 63-66 (Court hearings are extremely time-consuming and cumbersome. The waiting period between petitioning for a hearing and the hearing itself averaged 4.5 months. Each hearing requires an enormous investment of professional time.; Zito, New York Under Rivers, supra note 11, at 907-08 (The court-review procedure reduces the likelihood of achieving the clinical goal of compliance with psychotropic medication regimens. Court hearings are inefficient; the delay in scheduling and holding hearings averaged slightly more than one month. When patients were found incompetent, courts simply agreed with requested medication orders, failing to tailor therapy narrowly to individual patients’ clinical needs.; Zito, One Year Under Rivers, supra note 11, at 300 (The median time from a request for a court hearing to a court decision was 35 days.).

81. See, e.g., Cournos et al., supra note 11, at 855-54 (The primary reasons for requesting treatment were severe mental illness with regression in 33% of the cases, severe mental illness without regression in 29% of the cases, and serious untreated medical illness in 10% of the cases.; DeLand & Borenstein, supra note 11, at 41 (Psychiatrists testified that patients were incompetent because the patients denied their illnesses, were unable to recognize the benefits of the medication or the dangers of refusing treatment, or were so delusional and disorganized that they could not make rational judgments about the medication.; Hoge et al., supra note 11, at 951 (When asked to identify patients’ reasons for refusing medication, physicians identified psychotic or idiosyncratic reasons in 49% of the cases; transference problems, anger toward the clinician, or other interpersonal issues in 11% of the cases; and side effects of medication in 7% of the cases.; Veliz & James, supra note 79, at 64 (Psychiatrists testified that patients lacked competence for the following reasons: the patient is not rational because of his mental illness, the patient becomes psychotic and violent when
for refusing treatment.\textsuperscript{82} In these studies, the researchers either report their own assessment of patient reasons for refusal,\textsuperscript{83} or fail to identify he does not take medication, the patient does not acknowledge his mental illness, or the patient does not understand the benefits of medication.); Zito, \textit{One Year Under Rivers}, \textit{supra} note 11, at 299 (Psychiatrists requesting competency hearings targeted the following symptoms for treatment with medication: violence/assaultiveness in 40\% of the cases; refusal to eat in 20\% of the cases; schizophrenic symptoms such as delusions, hallucinations, and disordered thinking in 10\% of the cases; refusal of medical treatment in 10\% of the cases; and depression/suicide risk in 10\% of the cases.).

82. \textit{See, e.g.}, Hoge et al., \textit{supra} note 11, at 951 (After interviewing patients who refused medication, researchers characterized patients' reasons as follows: 35\% refused because of side effects from the medication, 30\% refused for reasons that overtly reflected psychotic or idiosyncratic thought processes, 21\% denied being mentally ill, and 12\% claimed the medication was ineffective.); Miller et al., \textit{supra} note 11, at 111 (Of 91 patients who refused medication, the reasons for refusal included denial of illness in 69.2\% of the cases, assertion of legal rights in 26.4\% of the cases, complaints about side effects in 15.4\% of the cases, use of medication refusal as a bargaining tool with staff over other issues in 7.7\% of the cases, too disorganized to refuse or consent in 3.3\% of the cases, assertion that medication had not helped in the past in 1.1\% of the cases, and assertion that patient didn't want the medication in 1.1\% of the cases.); Zito, \textit{One Year Under Rivers}, \textit{supra} note 11, at 299-300 (As recorded by the treating psychiatrists, patients refused treatment for the following reasons: paranoid belief that the medication was poisonous in 35\% of the cases; denial of the need for medication and the belief that they were not mentally ill in 25\% of the cases; side effects from previous administration of medication such as acute dystonic reaction, dry mouth, and sleeplessness in 10\% of the cases; unconfirmed religious restrictions in 10\% of the cases; no reason offered in 15\% of the cases.). \textit{See also} Schwartz et al., \textit{supra} note 11, at 1050, 1052 (During a four-month study period, researchers identified 25 patients on two inpatient psychiatric units of a university-affiliated hospital who had been involuntarily treated in a medical emergency or as a result of a court order. At discharge, 24 of these patients were asked why they had refused treatment. Patients denied the need for medication in 33.3\% of the cases, were severely confused or exhibited psychotic ideation in 29.2\% of the cases, expressed concerns about side effects in 20.8\% of the cases, and gave no reason or did not know in 16.7\% of the cases.).

Some researchers have studied reasons for patients' refusal of psychotropic medication unrelated to whether the refusals resulted in court hearings of the patients' competence or other reviews of their decisions. \textit{See, e.g.}, Appelbaum \& Gutheil, \textit{"Rotting With Their Rights On"}, \textit{supra} note 5, at 310-11; Appelbaum \& Hoge, \textit{supra} note 79, at 284-86 (discussing studies).

83. \textit{See, e.g.}, Hoge et al., \textit{supra} note 11, at 950 (Researchers interviewed patients.); Schwartz et al., \textit{supra} note 11, at 1052 (Researchers interviewed patients.); Zito, \textit{One Year Under Rivers}, \textit{supra} note 11, at 299-300 (Treating psychiatrists recorded patients' reasons for refusing treatment. Researchers then classified the reasons as meritorious or nonmeritorious. Although illness-based reasons were considered nonmeritorious, a self-reported depression was categorized as meritorious. Unconfirmed religious restrictions were categorized as nonmeritorious.).
the source of the stated reasons.  

When researchers characterize patients' reasons, biased reporting is a significant possibility.

Since 1990, I have served as a law-trained decisionmaker in hearings to determine mental patients' competence to refuse psychotropic medication. Each hearing was electronically recorded, and I wrote a case report within a few hours after each hearing was completed. A case report contains: statistical data on the patient; summaries of the facility representative's testimony, the cross-examination by the public defender, and the patient's testimony; my decision and the reasons for my decision; and any additional observations that I considered noteworthy. This article reports on, and analyzes, my experience. Thus, unlike other empirical studies, this article focuses on the evidence presented in each hearing, the judgment of the decisionmaker, and the decisionmaker's perspective on the process itself.

In Part II, I discuss the California court decision imposing a judicial hearing requirement, San Diego Superior Court rules implementing the decision, and legislation codifying the hearing requirement but modifying procedural safeguards. In Part III, I present and analyze data on the competency cases I decided, focusing on factors that may have affected my decisionmaking. I also compare my hearing results with those of other decisionmakers. I discuss attitudinal problems of treating physicians in relating to patients as autonomous human beings, in understanding and accepting the legal requirement of informed consent, and in cooperating with and participating in the competency hearing process. Generally, these problems are not statistically quantifiable. However, they do impact the hearings by altering the evidence available to the decisionmaker. In my judgment, they also support a policy judgment requiring that competency hearings be conducted by law-trained decisionmakers. In Part IV, I suggest how this model may be implemented without undue cost or burden. I caution, however, that although these hearings will provide due process for patients who participate in them, they will provide only the illusion of due process for patients who do not. Appropriate measures are needed to assure that consent obtained from competent patients is truly voluntary and informed.

84. See Miller et al., supra note 11, at 111. The authors merely state the reasons for patients' refusals without attributing any source of those reasons. Some of the reasons presented, however, suggest that the source was not the patients themselves, but the assessment of patients' reasons by either the treating physicians or the researchers. For example, some patients were reported to use a "medication refusal as a bargaining tool with staff over issues unrelated to medication." Id. Other patients were characterized as "too disorganized to be considered competent to refuse or consent." Id.

85. Appelbaum & Hoge, supra note 79, at 285.
II. **RIESE V. ST. MARY'S HOSPITAL AND MEDICAL CENTER.**\(^{86}\) **THE CASE AND ITS CONSEQUENCES**

In June, 1985, Eleanor Riese entered St. Mary’s Hospital as a voluntary patient. Prior to this admission, she had been treated for chronic schizophrenia with Mellaril\(^{87}\), a psychotropic medication. As a result of that earlier treatment, her bladder had been severely damaged.\(^{88}\) Nevertheless, the treating doctor prescribed Mellaril\(^{87}\), and she consented to its use. Although she complained of dizziness and dry mouth and stated that she was receiving too much medication, the dosage was not reduced. When she protested and refused medication, she was forcibly injected and committed as an involuntary patient.\(^{89}\)

Ms. Riese brought a class action on behalf of patients involuntarily committed under California’s seventy-two-hour treatment and evaluation detention\(^{90}\) or its fourteen-day intensive treatment certification.\(^{91}\) She sought a court order requiring that patients’ informed consent be obtained before psychotropic mediation can be administered.\(^{92}\)

Although plaintiffs lost at the trial level, the California Court of Appeal reversed, upholding the patients’ right to exercise informed consent in nonemergency situations.\(^{93}\) The court began its analysis by discussing the benefits and detriments of psychotropic medication. The court acknowledged that psychotropic medications “are the principal and single most effective treatment” for acute psychosis.\(^{94}\) Properly used, the primary effect of psychotropic medications is a normalizing one,
alleviating symptoms by restoring the brain's chemical balance. The medications do not brainwash the patient by creating new thoughts or ideas or by permanently inhibiting thought generation. Nevertheless, these powerful drugs act upon thought processes and are in that sense "mind altering." Further, psychotropic medications are not always used properly. Abuses have been documented, especially in understaffed and underfunded public mental hospitals. Psychotropic medications also produce adverse side effects, which the court characterized as "equally well recognized" as "their universally accepted benefits." Many of these side effects are reversible when the medication is terminated or given at a reduced dosage, but one, tardive dyskinesia, is an irreversible neurological disorder. In its most progressed state, tardive dyskinesia interferes with all of the patient's motor activity.

Turning to the plaintiffs' claim, the court discussed and relied upon numerous statutory provisions to support the requirement of informed consent by involuntarily committed mental patients. Although the court withheld judgment on whether constitutional bases also support informed consent in this context, it noted that the right of persons not adjudicated incompetent to give or withhold consent to medical


96.  Riese, 209 Cal. App. 3d at 1311, 271 Cal. Rptr. at 203. Winick has argued that because psychotropic medications directly affect mental processes and intellectual functioning, their proposed administration over a patient's objection demands first amendment scrutiny. Winick, A First Amendment Perspective, supra note 9, at 69-80; Bruce J. Winick, The Right to Refuse Psychotropic Medication: Current State of the Law and Beyond, in A.B.A. Comm'n on Mentally Disabled, supra note 8, at 7, 9-12. Winick has asserted that the label "side effects" is misleading and denigrates the impact of these undesirable consequences on patients. "Although these side effects are unintended, they are intrinsic to the drugs' benevolent properties and should not be trivialized, particularly since patients frequently experience them to be distressing enough to outweigh the drugs' positive clinical effects." Winick, A First Amendment Perspective, supra note 9, at 70.

99.  Riese, 209 Cal. App. 3d at 1311-12, 271 Cal. Rptr. at 203-04. Tardive dyskinesia is "manifested by involuntary, rhythmic and grotesque movements of the face, mouth, tongue, jaw and extremities." Id. at 1311, 271 Cal. Rptr. at 203. Although the condition generally occurs after prolonged treatment with psychotropic medication, it can occasionally occur after only brief treatment. Id. at 1312, 271 Cal. Rptr. at 204. For a discussion of the temporary and permanent side effects of psychotropic medication, see Cichon, supra note 9, at 297-310, and sources discussed therein.

102.  Id.
treatment\textsuperscript{103} is protected both by the common law and by the constitu­tional right to privacy.\textsuperscript{104} California courts uphold decisions by competent adults to refuse life-sustaining treatment.\textsuperscript{105} Logically, they cannot reject non-life threatening medication-refusal decisions by competent mental patients.

If incompetence to make treatment decisions is a prerequisite for involuntary commitment, and if the incompetence adjudication is subsumed in the commitment decision, then involuntarily committed mental patients would not enjoy a right to refuse treatment.\textsuperscript{106} California statutes, however, do not so provide. Typically, the involuntary commitment process originates without any judicial oversight. A seventy-two-hour evaluation and treatment detention merely requires a probable cause belief by a peace officer or evaluation facility staff member that the person detained is, as result of mental disorder, either a danger to others, to himself or herself, or gravely disabled.\textsuperscript{107}

Following a seventy-two-hour detention, the patient can be detained for fourteen days on an intensive treatment certification signed by a treating physician.\textsuperscript{108} An administrative hearing, conducted by a court-appointed commissioner, referee, or certification review hearing officer, is statutorily mandated during that fourteen-day period.\textsuperscript{109} The decisionmaker determines whether probable cause exists to believe that the commitment criteria are established but does not determine whether

\textsuperscript{103} Because treatment with psychotropic medication profoundly affects mind and body in both intended and unintended ways, the court declared that the right to refuse psychotropic medication "clearly falls within the recognized right to refuse medical treatment." \textit{Id.} at 1318, 271 Cal. Rptr. at 208.

\textsuperscript{104} \textit{Id.} at 1317-18, 271 Cal. Rptr. at 207-08.

\textsuperscript{105} \textit{Id.} at 1317-18, 271 Cal. Rptr. at 208 (discussing Bartling v. Superior Court, 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220, 225 (1984)).

\textsuperscript{106} \textit{See supra} text accompanying notes 20-27.

\textsuperscript{107} \texttt{CAL. WELF. \\& INST. CODE § 5150} (West 1984). "Gravely disabled" is defined as "[a] condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter." \textit{Id.} § 5008(h)(l)(A) (West Supp. 1995).

\textsuperscript{108} \textit{Id.} § 5250 (West Supp. 1995). A person who has been evaluated under a 72-hour detention may be certified for 14 days of intensive treatment if the professional staff of the evaluating facility has found that the person is, as a result of mental disorder, either a danger to others, to himself or herself, or gravely disabled. \textit{Id.}

\textsuperscript{109} \textit{Id.} §§ 5254-5256.8. The hearing is conducted within four days of the beginning of the intensive treatment certification. \textit{Id.} § 5256.
the person certified is competent to refuse treatment. Even if a mental health conservatorship is subsequently established for a gravely disabled patient, the conservatorship does not, of itself, constitute an adjudication of incompetence. A conservatee can be compelled to accept treatment to alleviate the condition of grave disability only if the conservatorship court authorizes the conservator to order such treatment. Although the statute does not specifically require an adjudication of incompetence before the conservatee loses the right to refuse treatment, the Riese court noted that the conservatorship court must make the “appropriate findings” before authorizing the conservator to act as a surrogate decisionmaker.

The Riese court cited five statutes that confirm the involuntarily committed patient’s status as presumptively competent to give or withhold informed consent. A statute that defines informed consent and prohibits coercion by physicians in obtaining consent also provides that a confined person is not to be deemed incapable of refusing treatment solely because he or she was diagnosed as mentally Disorders. Another statute declares: “No person may be presumed to be incompetent because he or she has been evaluated or treated for mental disorder . . . regardless of whether such evaluation or treatment was voluntarily or involuntarily received.” Three other statutes identify the extent to which rights enjoyed by nonpatients are retained by involuntarily committed patients. One declares that mentally disordered persons “have the same legal rights and responsibilities guaranteed all


111. For a critique of California mental health conservatorship law and the process by which conservatorships are established, see Grant H. Morris, Conservatorship for the “Gravely Disabled”: California’s Nondeclaration of Nonindependence, 15 SAN DIEGO L. REV. 201 (1978).


113. CAL. WELF. & INST. CODE § 5358(b) (West Supp. 1995).

114. Riese, 209 Cal. App. 3d at 1313, 271 Cal. Rptr. at 204.

115. Id. at 1313-17, 271 Cal. Rptr. at 205-07.

116. CAL. WELF. & INST. CODE § 5326.5(d) (West 1984). Although the decision in Riese was unanimous, one justice wrote a concurring opinion to express his belief that this statute should serve as the sole basis for the court’s decision. A discussion of other statutes was said to be scholarly and interesting but unnecessary to the decision and to the narrow statutory basis upon which it rests. Riese, 209 Cal. App. 3d at 1324-25, 271 Cal. Rptr. at 213 (Benson, J., concurring).

other persons by the Federal Constitution and laws, and the Constitution and laws of the State of California unless specifically limited by federal or state law or regulations.\textsuperscript{118} The other two declare that involuntarily committed patients shall retain all rights\textsuperscript{119} and shall not forfeit any rights\textsuperscript{120} unless specifically stated to the contrary in the statutes. The court rejected the hospital’s argument that the legislature’s failure to articulate an explicit right to refuse psychotropic medication was intended to exclude such right: “[T]hroughout the statutory scheme the Legislature repeatedly admonishes that the failure . . . to explicitly confer a particular right upon mentally [disordered] persons cannot provide a basis upon which to deny it.”\textsuperscript{121}

The court also rejected the hospital’s argument that if the right to refuse treatment exists, the court’s role is merely to assure that professional judgment has been exercised in the decision to medicate patients.\textsuperscript{122} Rather, the \textit{Riese} court declared that the role of the court is to determine whether the patient is competent to refuse medication despite his or her mental disorder. Quoting the New York Court of Appeals, the \textit{Riese} court asserted that the determination of competence to refuse medication “is uniquely a judicial, not a medical function.”\textsuperscript{123}

California statutes provide for an evidentiary hearing whenever a mental patient’s competence to consent to convulsive therapy is in question.\textsuperscript{124} Appellate courts interpreting those statutes require that the patient’s incapacity be established by clear and convincing evidence.\textsuperscript{125} The \textit{Riese} court held that the statutory provisions governing the determination of the patient’s competence to consent to convulsive therapeu

\begin{itemize}
\item \textsuperscript{118} \textit{Id.} § 5325.1.
\item \textsuperscript{119} \textit{Id.} § 5327.
\item \textsuperscript{120} \textit{Id.} § 5005.
\item \textsuperscript{121} \textit{Riese v. St. Mary’s Hosp. \& Medical Ctr.}, 209 Cal. App. 3d 1303, 1316-17, 271 Cal. Rptr. 199, 207 (1987) (republished opinion).
\item \textsuperscript{122} \textit{Id.} at 1320-21, 271 Cal. Rptr. at 210.
\item \textsuperscript{123} \textit{Id.} at 1321, 271 Cal. Rptr. at 210 (quoting \textit{Rivers v. Katz}, 67 N.Y.2d 485, 496, 495 N.E.2d 337, 343, 504 N.Y.S.2d 74, 80 (1986)).
\item \textsuperscript{124} \textit{CAL. WELF. \& INST. CODE} § 5326.7 (West 1984).
\item \textsuperscript{125} \textit{Conservatorship of Waltz}, 180 Cal. App. 3d 722, 733, 227 Cal. Rptr. 436, 442 (1986); \textit{Lillian F. v. Superior Court}, 160 Cal. App. 3d 314, 324, 206 Cal. Rptr. 603, 609 (1984). In \textit{Lillian F.}, the court noted that although the state has an interest in insuring appropriate treatment for those who are incapable of understanding its benefit, “[i]t has an equal interest in insuring that such a serious and intrusive procedure is not forced on a [patient] who does not want it and who is simply in disagreement with his [or her] physicians.” \textit{Lillian F.}, 160 Cal. App. 3d at 323, 206 Cal. Rptr. at 608.
\end{itemize}
therapy were equally appropriate to a determination of the patient’s competence to refuse psychotropic medication. Specifically, the Riese court imposed a requirement that the patient’s incapacity to refuse medication be established by proof that is clear and convincing.

Borrowing liberally from a text for psychiatrists prepared by Thomas G. Gutheil, M.D., and Paul Appelbaum, M.D., the Riese court identified three factors that judges should consider in assessing the competence of a patient’s medication refusal. First, the judge should consider “whether the patient is aware of his or her situation.” The court offered one example of such awareness: If the judge believes that the patient is psychotic, does the patient acknowledge the psychosis? The court’s singular example seems unfortunate. Doctors often assume that patients who do not acknowledge their disorder are unable to appreciate the benefits of medication to treat that disorder and are, therefore, incompe-

127. *Id.*
130. *Id.*
Although denial of mental disorder may be a factor in assessing a person’s awareness of the situation, it is certainly not the exclusive measure. Even if a person denies having a mental disorder, he or she is aware of the situation if the person knows that he or she is involuntarily confined in a mental hospital, that the doctors have diagnosed the person as having a mental disorder, that the doctors have prescribed psychotropic medication to treat the disorder, that the doctors believe the medication will benefit the person by relieving symptoms, and that the person is refusing the medication because of concern about medication side effects that have been previously experienced.

Second, the judge should consider “whether the patient is able to understand the benefits and the risks of, as well as the alternatives to, the proposed intervention.” Here, too, the Riese court gave an example. Even if the patient is acutely psychotic, the patient should understand that dystonic reactions are a risk, that resolution of the psychotic episode is a benefit, and that psychotherapy, milieu therapy and possibly electroconvulsive therapy are alternatives. This example, suggested by Drs. Gutheil and Appelbaum, appears helpful. Nevertheless, one can question whether treating physicians even consider the suggested alternative therapies as viable substitutes for psychotropic medication. The Riese court admitted, for example, that electroconvulsive therapy is almost never prescribed during the seventy-two-hour and fourteen-day treatment periods.

Third, the judge should assess the patient’s ability “to understand and to knowingly and intelligently evaluate the information required to be given patients whose informed consent is sought (§ 5326.2) and otherwise participate in the treatment decision by means of rational thought processes.” The court cited with approval a suggestion offered by Drs. Gutheil and Appelbaum that the patient should be assumed to be utilizing rational thought processes in the absence of

131. GUTHEIL & APPELBAUM, supra note 128, at 219 (“Patients who are required to make a decision about psychiatric treatment but who deny the existence of a psychotic state or of their severe depression cannot be considered to be competent to decide about means of ameliorating their condition.”).
132. Riese, 209 Cal. App. 3d at 1322, 271 Cal. Rptr. at 211.
133. Id. at 1322-23, 271 Cal. Rptr. at 211-12.
134. GUTHEIL & APPELBAUM, supra note 128, at 219.
136. Id. at 1323, 271 Cal. Rptr. at 212.
proof clearly linking delusional or hallucinatory perceptions to the individual's ultimate decision.\textsuperscript{137}

An assessment of a patient's ability to understand information begins with the information that the patient has been given. Although the \textit{Riese} court did not itself discuss what information must be provided, it incorporated, by specific reference, California Welfare and Institutions Code section 5326.2. That statute itemizes information that must be given to the patient in a clear and explicit manner in order to obtain a voluntary informed consent. Among the required disclosures are: (1) the nature and seriousness of the patient's mental disorder that serves as a reason for treatment; (2) the nature of the proposed treatment, including probable frequency and duration; (3) the degree and duration of improvement or remission anticipated with or without such treatment; (4) the nature, degree, duration, and the probability of side effects and significant risks of the proposed treatment and how and to what extent they may be controlled, if at all;\textsuperscript{138} (5) the reasonable alternative treatments, and why the physician is recommending this particular treatment; and (6) that the patient has the right to accept or refuse the proposed treatment, and that if the patient consents, he or she has the right to revoke the consent for any reason and at any time prior to or between treatments.\textsuperscript{139}

After discussing the competency assessment factors, the \textit{Riese} court considered the results of the adjudicatory process. If the patient is found competent to give informed consent and refuses to do so, the patient may not be medicated involuntarily.\textsuperscript{140} If the patient is found incompetent to give informed consent, and the patient is being detained on a seventy-two-hour or fourteen-day treatment hold, the patient may be required to accept psychotropic medication that has been medically prescribed.\textsuperscript{141} The doctor is empowered to impose treatment without

\textsuperscript{137} Id. (citing GUTHEIL & APPELBAUM, \textit{supra} note 128, at 220).

\textsuperscript{138} Because tardive dyskinesia is a known, significant side effect of psychotropic medication, its risk must be disclosed. The statutory requirement precludes the suggestion of Drs. Gutheil and Appelbaum that information about tardive dyskinesia should be withheld by doctors until the acute episode of their patients' mental disorders has been resolved. \textit{See} GUTHEIL & APPELBAUM, \textit{supra} note 128, at 219.

\textsuperscript{139} CAL. WELF. & INST. CODE § 5326.2 (West 1984). This statute was enacted in 1976 as one of several statutes designed to place limitations on the use of psychosurgery and convulsive therapies. Act of Sept. 20, 1976, ch. 1109, § 3.5, 1976 Cal. Stat. 4992, 4994-95. Thus, the statute contains some disclosure requirements that are particularly applicable to those treatments. For example, disclosure is required of: (1) the probability and duration of memory loss, including its irreversibility, and (2) the division of opinion that exists regarding the efficacy of the proposed treatment. \textit{Id}.

\textsuperscript{140} \textit{Riese}, 209 Cal. App. 3d at 1323, 271 Cal. Rptr. at 212.

\textsuperscript{141} Id.
obtaining the approval of a court, guardian, or other surrogate decisionmaker. If the incompetent patient has been placed on a mental health conservatorship in which the conservator may authorize the patient’s confinement and treatment for renewable periods of one year, \(^{142}\) consent must be obtained from the patient’s conservator. \(^{143}\) The court noted that surrogate decisionmakers should attempt to ascertain the choice the patient would have made if the patient were competent, \(^{144}\) and if it is not possible to do so, the surrogate should be guided in the decision by the patient’s best interests. \(^{145}\)

The *Riese* court’s refusal to require a surrogate decisionmaker for incompetent patients on seventy-two-hour or fourteen-day treatment holds is surprising. In other states, courts have required not only a judicial determination of the patient’s competence, but also, a judge’s \(^{146}\) or guardian’s approval \(^{147}\) before treatment may be imposed.

144. *Id.* (quoting Barber v. Superior Court, 147 Cal. App. 3d 1006, 1021, 195 Cal. Rptr. 484, 493 (1983)). For example, the patient’s concerns about medication side effects may have been expressed before the patient became incompetent:
145. *Id.*
146. *See, e.g.*, People v. Medina, 705 P.2d 961, 973-74 (Colo. 1985) (“If the court is convinced of the patient’s mental incompetency, it must then determine whether the proposed treatment is necessary either to prevent a significant and likely long-term deterioration in the patient’s mental condition or to prevent the likelihood of the patient causing serious harm to himself or others in the institution.”) If less intrusive alternatives to psychotropic medication are available, nonconsensual treatment should be denied.); *In re Boyd*, 403 A.2d 744, 750 (D.C. 1979) (“The court, as surrogate for the incompetent, is to determine as best it can what choice that individual, if competent, would make with respect to medical procedures.”); Rogers v. Commissioner of Dep’t of Mental Health, 390 Mass. 489, 504, 458 N.E.2d 308, 318 (1983) (“We conclude that, if a patient is declared incompetent, a court must make the original substituted judgment treatment decision and should approve a substituted judgment treatment plan. . . . The judge may delegate to a guardian the power to monitor the treatment process to ensure that the substituted judgment treatment plan is followed.”); Rivers v. Katz, 67 N.Y.2d 485, 497-98, 495 N.E.2d 337, 344, 504 N.Y.S.2d 74, 81 (1986) (“If . . . the court concludes that the patient lacks the capacity to determine the course of his own treatment, the court must determine whether the proposed treatment is narrowly tailored to give substantive effect to the patient’s liberty interest, taking into consideration all relevant circumstances, including the patient’s best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments.”).

Research discloses, however, that judges who find patients incompetent almost always find that they would choose to accept medication if they were competent to decide. Veliz & James, *supra* note 79, at 64. The substituted judgment requirement has not been an effective barrier to coerced treatment of incompetent patients.
on an incompetent patient. Those courts have not distinguished between incompetent patients on short-term treatment holds and those on longer-term or indefinite treatment holds. To support the requirement of judicial determinations of competence, the *Riese* court noted that “the forcible administration of powerful mind altering drugs ... involves moral and ethical considerations not solely within the purview of the medical profession.” Nevertheless, the *Riese* court was unwilling to consider whether those moral and ethical considerations are equally applicable to medication decisions for incompetent patients and should also require court oversight. Without extensive discussion, the *Riese* court merely instructed competency court judges not to decide medical questions, such as whether the prescribed medication was really needed or was the least drastic therapy available. As previously discussed, the Supreme Court's decision in *Riggins* may well necessitate judicial consideration of less intrusive alternatives to psychotropic medication for all mental patients, whether competent or incompetent.

In 1988, the California Supreme Court granted review of the *Riese* court of appeal decision. A year later, the California Supreme Court dismissed the review, remanded the case, and ordered the court of appeal decision published. The court of appeal decision was republished in 1990.

In response to the *Riese* decision, courts throughout California began conducting competency hearings. On March 1, 1990, the San Diego County Superior Court promulgated court rules establishing procedures to implement the *Riese* hearing requirements. The court rules
require competency hearings for treatment-refusing patients who are detained on seventy-two-hour holds, fourteen-day holds, and temporary conservatorships. The decision to include persons on temporary conservatorships is warranted. In establishing a temporary conservatorship, the court determines whether the patient is able to provide for food, clothing, and shelter, not whether the patient is competent to refuse medication. Additionally, temporary conservatorships are established upon the ex parte judgment of the court. No adversarial hearing is conducted on any issue. A separate Riese hearing is needed to provide temporary conservatees with their day in court on the treatment competency issue.

The court rules require competency hearings for patients in public and private hospitals. This clarification seems appropriate. Although the Riese defendant was a private facility, the Riese court did not specifically limit its decision to patients in private facilities. As authority for its decision, the court relied upon statutes that were equally applicable to patients in private and public facilities.

In Riese, the court required a judicial determination of the patient’s incompetence before psychotropic medication can be administered without informed consent. Riese, however, involved patients in nonemergency situations. A California statute authorizes the denial of a patient’s rights “for good cause” and requires the Director of Mental Health to “adopt regulations specifying the conditions under which [a patient’s rights] may be denied.” The regulation promulgated pursuant to that statute permits the physician to take appropriate action in an emergency—including the administration of antipsychotic medication. The regulation narrowly defines the situations in which

156. Id. R. 2.124.
158. Id. § 5352.1. A temporary conservatorship expires when the court conducts a hearing on the conservatorship petition or after 30 days if a conservatorship hearing has not been conducted prior to that time. If the proposed conservatee demands a court or jury trial on the issue of grave disability, the temporary conservatorship may be extended until the issue is decided, but not longer than six months. Id.
159. SAN DIEGO SUPER. CT. R. 2.124.
162. CAL. CODE REGS. tit. 9, § 853 (1995). If psychotropic medication is administered in an emergency, its administration is limited to “that which is required to
a *Riese* hearing is not required: "An emergency exists when there is a sudden marked change in the patient’s condition so that action is immediately necessary for the preservation of the life or the prevention of serious bodily harm to the patient or others, and it is impracticable to first obtain consent." The term “antipsychotic medication” is defined broadly to include all psychotropic medication used to treat either psychotic or nonpsychotic symptoms of any serious mental disorder. The court rules repeat those definitions and interpret *Riese* to impose a judicial hearing requirement only in nonemergency situations.

The court rules provide for the treating physician to initiate the hearing process by petitioning the court for a judicial determination of the patient’s capacity to give or withhold informed consent. Whenever possible, the hearing is calendared within two court days. Under the rules, the superior court appoints court commissioners who act as judges pro tempem to conduct the evidentiary hearings. At each hearing, a request is made to the parties to stipulate to the court commissioner’s designation as judge pro tempem for all *Riese* hearing purposes. If the parties stipulate, then the court commissioner is empowered to make all findings, conclusions, decisions, and orders in the matter. If the parties do not stipulate, the hearing is set before the superior court judge, who calendars the hearing within one court day of the originally set date, whenever possible.
The policy of using court commissioners as judges in *Riese* hearings is meritorious. It responds to the problem of delay frequently associated with the requirement of judicial hearings. When court commissioners are used, treatment refusal cases do not have to be calendared onto already busy superior court dockets. Patients do not have to be transported to and from court. Doctors do not have to waste valuable time waiting for the case to be called. Hearings can be held within two court days of their request. The hearings can be, and are required by the rules to be, held at the mental health facility where the patient is being detained. Because court commissioners decide the matter at the conclusion of the hearing, treatment can be initiated immediately for those patients found incompetent. Thus, the use of court commissioners assures that the judicial system is not unduly burdened, that hearings are conducted without significant interruption in the daily routine of doctors or patients, and that cases can be decided and decisions implemented quickly.

The California Constitution empowers the legislature to provide for trial courts to appoint "commissioners to perform subordinate judicial duties." The legislature authorized court commissioners to serve as temporary judges when they are appointed for that purpose and "when otherwise qualified so to act." Court commissioners are required by statute to be citizens of the United States and residents of California. Courts may also impose a requirement that persons appointed as commissioners be lawyers who have been admitted to practice in the state for a period of at least five years.

In San Diego County, most of the court commissioners who conduct administrative hearings to determine whether probable cause exists to detain mental patients for fourteen days are not lawyers. Typically, their professional backgrounds are in various clinical disciplines including social work, rehabilitation counseling, and criminal justice administra-

170. See supra note 80.
171. SAN DIEGO SUPER. CT. R. 2.135. The rule requires hearings to be held in surroundings that allow for quietness and a reasonable degree of confidentiality. Id.
172. Id. R. 2.141.
173. CAL. CONST. art. VI, § 22.
175. CAL. GOV'T CODE § 70142 (West 1976).
Are these court commissioners eligible to serve as temporary judges in competency hearings?

The *Riese* court required a judicial, not an administrative, determination of the patient’s competence. The decisionmaker must decide whether clear and convincing evidence establishes the patient’s incapacity, not merely whether probable cause exists to believe so. To carefully weigh the evidence in a *Riese* case, a legal education is a necessary prerequisite. While not all court commissioners need be lawyers, only those court commissioners who are lawyers are qualified to act as temporary judges. In San Diego County, the eight court commissioners appointed as temporary judges in competency hearings were attorneys.

Ordinarily, court commissioners report their findings to the court which approves, rejects, or modifies them or conducts a hearing on exceptions. If the parties stipulate that the court commissioner may act as a temporary judge, however, the court commissioner is empowered to make a final determination of the case without any action or oversight by the court that appointed the commissioner. The request for the parties’ stipulation, required by the court rules, confirms the “lawyers only” qualification for competency hearings. The California Constitution authorizes parties to stipulate to the trial and final determination of a matter “by a temporary judge who is a member of the State Bar.”

The Public Defender represents the patient in the *Riese* hearing, unless the patient retains his or her own attorney.

176. Morris, supra note 110, at 335.
178. *Id.* at 1322, 271 Cal. Rptr. at 211.
179. See *People v. Tijerina*, 1 Cal. 3d 41, 49, 459 P.2d 680, 685, 81 Cal. Rptr. 264, 269 (1969) (A court commissioner may not “act as a temporary judge if he is not otherwise qualified so to act.”).
180. Ironically, five of the eight were engaged in the private practice of law while serving as court commissioners, in apparent violation of CAL. GOV’T CODE § 70142 (West 1976). At the time these individuals were appointed as court commissioners, the superior court knew of their qualifications and understood that they intended to continue their private practices while serving as court commissioners on an infrequent, as needed, basis. The statutory prohibition may have been intended to preclude only full-time commissioners from engaging in law practice, although the statute is not so limited in its wording.
182. CAL. CONST. art. VI, § 21. Ironically, one individual appointed as a court commissioner/judge pro tem was not a member of the California Bar, although he was a member of a bar in another state. The court knew of his qualifications at the time he was appointed.
183. SAN DIEGO SUPER. CT. RS. 2.129, 2.133.
mental health facility may be, but are not required to be, formally represented by counsel. At the hearing, a facility representative presents the petition and declaration, and any oral or documented evidence. The facility representative must be a psychiatrist, psychologist, registered nurse, or social worker with at least a masters' degree. The court rules do not require the treating physician to testify, but they caution that the physician's absence may result in insufficient evidence to support a finding of the patient's mental incapacity. The rules provide for the patient's right to be present at the hearing and, through counsel, to present evidence and to cross-examine witnesses. The patient may, however, choose not to attend the hearing.

The court rules repeat Riese's placement of a clear-and-convincing-evidence burden on the facility and restate the three factors identified in Riese as the focus of a competency assessment. In an apparent misreading of the first factor, however, the court rule directs the decisionmaker to consider the narrow issue of the patient's awareness of his or her mental condition, not the broader issue of the patient's awareness of his or her situation.

In addition to considering the evidence at the hearing, the judge is authorized by the court rules to consider the patient's relevant medical records. At the conclusion of the hearing, the judge is required to make a determination of the patient's capacity to give or withhold informed consent. The rules provide for confidentiality of the proceedings and records of the proceedings.

In 1991, the California Legislature enacted statutes that codify, with some significant modifications, Riese's competency hearing require-
The legislation declares that involuntarily committed mental patients have a right to refuse psychotropic medication. Medication may be administered, however, to patients who do not exercise their right following disclosure of the right and of statutorily mandated information about the probable effects and possible side effects of the medication. Although the legislation assures patients that they will receive information that will support their decision to refuse medication, for those patients who do not refuse, the legislation eliminates their right to exercise informed consent. Nonprotesting patients may be treated with psychotropic medication without giving a competent consent. The *Riese* court’s reliance on a statutory basis to support an informed consent requirement is undermined by the 1991 legislation. Whether constitutional guarantees of due process and equal protection will assure nonprotesting patients of no lesser informed consent right than other people remains undetermined.

The legislation specifically provides that in an emergency, a protesting patient may be treated with antipsychotic medication that is necessary to treat the emergency condition. The legislature narrowly defined “emergency” and broadly defined “antipsychotic medication.”

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195. The statute specifically includes persons detained for: 72 hours of evaluation and treatment without any court order pursuant to CAL. WELF. & INST. CODE § 5150 (West 1984), 14 days of intensive treatment pursuant to CAL. WELF. & INST. CODE § 5250 (West Supp. 1995), an additional 14 days of intensive treatment as an imminently suicidal person pursuant to CAL. WELF. & INST. CODE § 5260 (West 1984), or an additional 30 days of intensive treatment as a gravely disabled person pursuant to CAL. WELF. & INST. CODE § 5270.15 (West Supp. 1995). Ironically, the statute contains no reference to patients who are involuntarily committed for 72 hours of evaluation and treatment by court order pursuant to CAL. WELF. & INST. CODE § 5206 (West 1984) or patients who have been placed on a temporary conservatorship and are involuntarily committed for up to 30 days by their temporary conservator pursuant to CAL. WELF. & INST. CODE § 5353 (West 1984). The failure to include patients in these two categories is unwarranted. Patients in both categories are involuntarily committed without any hearing on the treatment competence issue. See supra text accompanying notes 156-58.

196. CAL. WELF. & INST. CODE § 5325.2 (West Supp. 1995). The right to refuse medication is not absolute; it is subject to statutory limitations. Id.

197. Id. §§ 5152(c), 5213(b).

198. Id. § 5332(a).


201. Id. § 5008(m). Unlike CAL. CODE REGS. tit. 9, § 853 (1995), however, the statute does not impose a requirement that the necessity for immediate action be the result of a sudden marked change in the patient’s condition. See supra text accompany--
adopting definitions previously promulgated in the California Code of Regulations. When no emergency exists, medication may be administered to a protesting patient only if the treatment staff determines that alternatives to involuntary medication are unlikely to meet the treatment needs of the patient and the patient’s incapacity to refuse treatment has been determined in a hearing. Throughout the legislation, the hearings are referred to as “capacity” hearings.

The hearing process is initiated by a petition filed with the superior court. The facility requesting the hearing is required to provide a written notice of its petition to the patient and a mental health professional is required to inform the person of his or her capacity hearing rights. The legislation calls for capacity hearings to be held within twenty-four hours of the petition’s filing whenever possible. Hearings can be postponed for twenty-four hours if any party needs additional time to prepare. Hearings may also be postponed for an additional twenty-four hours in cases of hardship but must be held within seventy-two hours of the petition’s filing.

By statute, capacity hearings may be conducted by a superior court judge or a court-appointed commissioner, referee, or hearing officer. The superior court appoints commissioners, referees, and hearing officers from a list of attorneys unanimously approved by the local mental health director, the county public defender, and the county counsel or district

ing note 163.
204. CAL. WELF. & INST. CODE § 5332(b) (West Supp. 1995).
205. Id. §§ 5332-5334, 5336.
206. Id. § 5333(b).
207. Id.
208. Id. § 5333(c). The mental health professional is also required to answer any questions or concerns of the patient. Id.
209. Id. § 5334(a). The statute does not define “hardship” but authorizes the county mental health director and the presiding judge of the superior court to develop a local policy regarding the scheduling of hearings. Id.
210. Id.
211. Id. § 5334(c).
attorney. Persons appointed as hearing officers are required to receive training on capacity hearings issues.

Capacity hearings are no longer judicial hearings; they are administrative hearings. Although hearing officers must be lawyers, they serve as administrative decisionmakers not judicial decisionmakers. The patient is no longer entitled to representation by an attorney; he or she may be represented by a patients' rights advocate. Qualifications for individuals serving as patients' rights advocates are not specified in either the California statutes or the California Administrative Code. Many patients' rights advocates are not attorneys.

California courts have not been called upon to determine whether an administrative capacity hearing satisfies constitutional requirements of due process. The requirement that hearing officers be attorneys and that appeals of hearing officer decisions be subject to de novo review by the superior court enhances the likelihood that the statute will be upheld if challenged.

The statute requires that capacity hearings be conducted at the mental health facility where the patient is being detained. The use of hearing officers facilitates this requirement. At the conclusion of the hearing, the decisionmaker is obligated to announce his or her decision, and as soon as practicable, to provide a written notification of the decision, including a statement of the evidence relied upon and the reasons for the decision. A determination of incapacity to refuse treatment remains in effect only for the duration of the seventy-two-hour

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212. *Id.* Employees of a county mental health program or mental treatment facility are not eligible to serve as hearing officers. *Id.*

213. *Id.*

214. *Id.* § 5333(a). The statute provides the patient with a right to representation by either a patients' rights advocate or legal counsel. *Id.*

215. The California Administrative Code identifies a "Patients' Advocate" as "the person in a local mental health program delegated the responsibility for ensuring that mentally disabled persons in facilities . . . are afforded their statutory and constitutional rights." CAL. CODE REGS. tit. 9, § 863(b) (1995).

216. See, e.g., Morris, supra note 110, at 326. In San Diego County certification review hearings, three of the five patients' advocates who assisted patients were not law trained.

217. CAL. WELF. & INST. CODE § 5334(f) (West Supp. 1995). The person who is the subject of the capacity hearing is entitled to appeal the decision. *Id.* § 5334(e)(1). The person who petitioned for a capacity hearing may request the district attorney or county counsel to appeal the hearing decision. *Id.* § 5334(e)(2). The court of appeal hears appeals of superior court decisions; the superior court hears appeals of hearing officer decisions. *Id.* § 5334(e)(1-2).

218. *Id.* § 5334(b).

219. *Id.* § 5334(d). The written notification is submitted to the superior court and provided to the person who is the subject of the capacity hearing, the person's counsel or advocate, and the director of the facility. *Id.*
or fourteen-day detention, or both, unless the patient’s capacity to refuse treatment has been restored prior to that time.220

The capacity hearing legislation is silent on two important issues. First, the statutes establish no standard for measuring a patient’s capacity to refuse treatment. Second, the statutes establish no burden of proof in capacity hearings. In the absence of a legislative decision to the contrary, the three capacity assessment factors identified in Riese should continue to be applied.221 Similarly, in the absence of a legislative decision to the contrary, the clear-and-convincing evidence burden announced in Riese should continue to be applied.222 The 1991 legislation made some significant modifications to the Riese capacity hearing requirement. To the extent Riese was not modified, however, it remains the applicable law.

The San Diego County Superior Court did not amend its court rules to implement the statutory modifications. However, nine attorneys were appointed as mental health hearing officers, replacing the court commissioners who acted as judges pro tem.223 Because these hearing officers do not serve as temporary judges, the parties are not asked to stipulate to their designation. Hearing officers continue to impose a clear-and-convincing-evidence burden on the facility and to use the three competency assessment factors identified in Riese and repeated in the

220. Id. § 5336. The statute specifically refers to “the detention period described in Section 5150 or 5250.” This period is 72 hours for persons detained for evaluation and treatment without any court order (id. § 5150 (West 1984)) and 14 days for persons certified for intensive treatment (id. § 5250 (West Supp. 1995)). Imminently suicidal persons certified for an additional 14 days (id. § 5260 (West 1984)) and gravely disabled persons certified for an additional 30 days (id. § 5270.15 (West Supp. 1995)) are also entitled to capacity hearings. Id. § 5332(b); see discussion supra note 195. Inexplicably, the statute fails to prescribe how long incapacity determinations remain in effect for these patients.


222. Riese, 209 Cal. App. 3d at 1322, 271 Cal. Rptr. at 211; see supra text accompanying note 127.

223. Of the eight persons appointed in 1990 as court commissioners, five were appointed in 1991 as mental health hearing officers. Two court commissioners chose not to continue serving, and one did not receive the unanimous approval of the local mental health director, the county public defender, and county counsel required for appointment as a hearing officer. Four attorneys who had not served as court commissioners were also appointed as mental health hearing officers, bringing the total to nine. Telephone Interview with William D. Miller, Director, Office of Counselor in Mental Health, San Diego County Superior Court (1992).
court rules. Although, by statute, patients are only entitled to representa-
tion by either a patient’s rights advocate or an attorney, in San
Diego County patients continue to be represented by public defender
attorneys.

III. ONE DECISIONMAKER’S EXPERIENCE: STATISTICAL DATA AND
COMMENTARY

In this portion of the article, I present and analyze data on the capacity
hearings I conducted over a three-year period. From May 1990 through
December 1991, I served as a court commissioner acting as a judge pro
tem. During this time, forty-three hearings were calendared, of which
thirty-three were heard and decided on the merits. Throughout the
tables, I refer to these hearings as Group A. In January 1992, I began
serving as a mental health hearing officer. From January 1992 through
June 1993, thirty-four hearings were calendared of which thirty-three
were heard and decided on the merits. Throughout the tables, I refer to
these hearings as Group B. Thus, for each table, data are provided on
an equal number of hearings conducted under the court rules implemen-
ting the Riese decision and under the statutes enacted subsequently. Data
are also presented on the combined Groups A and B.

TABLE 1
RESULTS OF HEARINGS

<table>
<thead>
<tr>
<th></th>
<th>Group A</th>
<th>Group B</th>
<th>A &amp; B Comb’d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of hearings</td>
<td>43</td>
<td>34</td>
<td>77</td>
</tr>
<tr>
<td>calendared</td>
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</tr>
<tr>
<td>Number of hearings</td>
<td>33</td>
<td>33</td>
<td>66</td>
</tr>
<tr>
<td>decided on the merits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of patients</td>
<td>18</td>
<td>9</td>
<td>27</td>
</tr>
<tr>
<td>found competent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of patients</td>
<td>54.5</td>
<td>27.2</td>
<td>40.9</td>
</tr>
<tr>
<td>found competent</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

As reported in TABLE 1, I found 54.5 percent of Group A patients
competent as compared with 27.2 percent of Group B patients. Several

factors may account for this disparity. First, in each hearing that I conducted, the facility was represented by a psychiatrist, psychologist, nurse, or social worker. None of these individuals was trained in law or had the assistance of an attorney during the hearing. In contrast, the patient was represented by an attorney from the public defender's office in each hearing. These attorneys focused my attention on the narrow competency issue that was to be determined.

With experience, facility representatives have acquired an adequate ability to present evidence of the patient's incompetence. However, in the first few months in which hearings were conducted, facility representatives often were confused by the competency criteria. For example, in the very first case I heard, the psychiatrist's testimony focused on the patient's inability to provide food, clothing, and shelter. Obviously, she did not understand that the issue of grave disability is decided in a certification review hearing and not a capacity hearing. The psychiatrist admitted in her written declaration that the patient was able to understand the risks and benefits of medication and to understand and evaluate information rationally regarding the proposed treatment and alternatives to that treatment. The psychiatrist's sole basis for asserting the patient's incapacity was the patient's unwillingness to acknowledge his mental disorder. Without this acknowledgement, the psychiatrist believed that the patient could not appreciate the benefits of the proposed medication. On cross-examination, the psychiatrist admitted that the patient had suffered adverse effects from a previous administration of the same medication and that the patient's reason for refusing this medication was rational. I found this patient competent.

Second, in my opinion, the Group B patients were more seriously mentally disordered than were the Group A patients. As the recession struck California in 1992 and 1993, severe budgetary constraints were placed on public mental health programs. In the San Diego County Psychiatric Hospital, three of the four inpatient units were closed. Only the most seriously ill patients were accepted; patients who refused treatment were often released. Additionally, as doctors became more familiar with capacity hearings issues, I believe they became more selective in the cases for which they would seek a finding of incapacity. Over time, doctors developed alternative strategies to avoid capacity hearings. These strategies range from negotiating acceptable medication options with the patient to coercing treatment without informing the
patient of medication risks and without petitioning for a capacity hearing.

Third, in Group A, ten of the calendared hearings were not heard. Of this number, five involved patients who either refused to stipulate to my designation as temporary judge or who refused to be represented by the public defender.\(^{225}\) Although I did not conduct evidentiary hearings in these cases,\(^ {226}\) I believe that most of these patients would have been found incompetent. For example, one patient who refused to stipulate to my designation as temporary judge expressed the belief that no one should be able to judge his competence. Despite repeated attempts to explain that if I did not hear the matter it would be calendared for a hearing by a superior court judge, the patient remained adamant in his refusal. People who are unduly suspicious of their appointed attorney or the court commissioner are often equally suspicious of the psychiatrist assigned by the hospital as their doctor. They are unlikely to weigh rationally the doctor's explanation of the medicine's benefits. In contrast, because hearing officers do not serve as temporary judges, no request for stipulation was made in Group B hearings. In Group B, only one calendared hearing was not conducted. In that case, the doctor withdrew the petition because the patient began taking medication voluntarily before the hearing could be conducted.

Fourth, two patients in Group A and ten patients in Group B refused to attend the capacity hearing. Additionally, two Group B patients continually interrupted the facility representative's testimony, and the hearings had to be completed outside of their presence. In one Group B hearing, the patient attended but remained mute throughout. When patients choose not to participate in hearings, they forfeit the opportunity to present direct evidence to support a finding of competence. Often these same patients are unwilling to cooperate with their counsel. Without such cooperation, the facility representative’s testimony is rarely refuted by effective cross-examination.

\(^{225}\) In five other Group A cases that were calendared, evidentiary hearings were not conducted for the following reasons: (1) the petition was withdrawn because the patient was taking medication voluntarily; (2) the patient was a voluntary patient and could not be treated involuntarily; (3) the doctor had not completed the declaration of the treating physician giving the patient notice of the facts upon which he concluded that the patient was not competent to make treatment decisions, and the doctor did not attend the hearing; (4) no facility representative was present at the hearing; and (5) neither the patient nor his attorney was present at the hearing.

\(^{226}\) Patients who refused the services of the public defender usually demanded to be represented by private counsel. These patients, however, had not engaged private counsel to represent them. Because capacity hearings are conducted so quickly after the petition is filed, I granted the patients a delay to enable them to contact private attorneys. I did not inquire into the patients' financial ability to pay for these services.
In only one case did I find a nonattending patient competent, and that case occurred in Group A. The psychiatrist testified that the patient was mentally ill and delusional. The psychiatrist admitted, however, that he had no specific evidence on whether the patient refused medication for an irrational reason. The psychiatrist admitted: "We can't assess his mind. We can't get him to discuss his reasons for refusing medications." When the psychiatrist attempted to encourage the patient to accept medication by informing him that the medication would enable the patient to obtain release faster, the patient responded by stating that he would wait out the detention period. I found that the facility had not proven by clear and convincing evidence that the patient's medication refusal was the result of an irrational reasoning process. In the thirteen Group B cases involving patients who either did not attend their hearings, were disruptive, or remained mute, the facility representatives presented sufficient evidence of the patients' judgmental incapacity to satisfy the burden of proof.

Although I believe that the above-stated reasons, whether individually or in combination, account for the disparity in Group A and Group B decisions, other factors are worth considering. Perhaps I was simply inconsistent in my decisionmaking. Despite my familiarity with mental health law issues and despite my ten-years' experience as a certification

227. At the time Group A hearings were conducted, a party who was dissatisfied with a hearing result could obtain a rehearing before the same court commissioner who made the original decision. Policy adopted by the Honorable Michael D. Wellington, San Diego County Superior Court, 1991. Under the legislation governing Group B hearings, a dissatisfied party could appeal the hearing officer's decision and receive a hearing de novo before a superior court judge. CAL. WELF. & INST. CODE § 5334(e)-(f) (West Supp. 1995). I considered whether the difference in this procedure may have been a significant factor accounting for the decisionmaking disparity and concluded that it was not. I am aware of no Group A or Group B hearing in which a patient found incompetent sought either a rehearing or a hearing de novo. However, in three Group A hearings in which I found a patient competent, the facility requested a rehearing. In the tables, each rehearing is counted as a separate hearing. In a rehearing, the decisionmaker considers whether a change in the patient's mental condition since the last hearing warrants a different result. The decisionmaker does not consider either previously introduced evidence or new evidence of the patient's condition at the time of the original hearing. Despite the limited nature of the inquiry, in two of the three rehearings, the facility was able to convince me that the patient's mental condition had deteriorated since the last hearing and that the patient was no longer competent. In only one rehearing did I continue to find the patient competent. Thus, the requirement for Group A hearings that rehearings be conducted before the same commissioner who found the patient competent originally was not a factor increasing significantly the number of decisions in which a patient was found competent.
review hearing officer,228 I found decisionmaking in many capacity hearings to be extremely difficult. Testimony was not merely conflicting; it was dissatisfying. Psychiatrists often assumed that patients’ unwillingness to acknowledge their mental disorder was all that was needed to establish their incompetence. Many psychiatrists did not provide patients with needed information on medication side effects229 or respect patients’ expressed concerns about side effects.230 To these psychiatrists, side effects were merely an annoyance but not a legitimate reason for rejecting the anticipated benefits of the proposed therapy. Patients often assumed that refusal of medication because of a previous experience with medication side effects was all that was needed to establish their competence. Many refusing patients did not consider their doctors’ explanations of the benefits anticipated from the proposed medication. To these patients, any improvement in mental condition could not possibly outweigh the discomfort of medication side effects. These cases were not neat little packages for decisionmakers to unwrap at their leisure. Nevertheless, I attempted in good faith to decide the cases fairly and consistently. Perhaps this report will provide some insight as to my success or failure in doing so.

In evaluating my performance as a decisionmaker, one may wish to compare my hearing results with those of other decisionmakers. Surprisingly, statewide data on capacity hearings have not been gathered or analyzed by the California Department of Mental Health or anyone else.231 Some data, however, are available on the San Diego County experience. At infrequent meetings of court commissioners and hearing officers with the superior court mental health judge, statistics on capacity hearing results were occasionally provided by the Office of Counselor in Mental Health.232 Although no comprehensive statistics are avail-

228. See Morris, supra note 110.
229. See infra text accompanying TABLE 8.
230. See infra text accompanying TABLE 7.
231. In fact, in response to my inquiry, Lori Chin, a Research Analyst in the Performance Outcome Reporting Section of the California Department of Mental Health, informed me on August 8, 1994, that she had never heard of the Riese case or legislation requiring capacity hearings. Ironically, the legislation imposes a duty on the California Department of Mental Health to prepare a report to the legislature before January 1, 1994, summarizing information on the role of patients’ rights advocates and the number of advocates needed for adequate representation of patients in capacity hearings. Act of Oct. 7, 1991, ch. 181, § 8, 1991 Cal. Stat. The report has not yet been prepared.
232. Copies of all San Diego County capacity hearings results are on file with the author. Upon reviewing my case summaries, I discovered that some of my hearings had been reported erroneously in the statistical reports provided by the San Diego Superior Court’s Office of Counselor in Mental Health. For example, some cases that I did not decide on the merits were reported as decisions of incompetence. I do not know whether data from other court commissioners or hearing officers contain similar mistakes.
able for the twenty-month period during which I gathered data on my Group A patients, the available statistics suggest that San Diego County court commissioners were finding patients competent in approximately one of five cases at a time that I was finding patients competent in approximately one of two cases. Although I have no complete explanation for this disparity, I can identify one contributing factor. Although Riese hearings were assigned to court commissioners on a rotating basis, one court commissioner agreed to serve whenever other court commissioners were not available. He heard a disproportionately large number of cases. For example, between April and November 1990, this individual heard forty-five cases while all other court commissioners combined heard fifty-seven cases. In the forty-five hearings, the individual found only one patient (2.2%) competent. The remaining court commissioners found nineteen patients (33.3%)
competent. The individual was not appointed as a hearing officer when the capacity hearing legislation was implemented in January 1992.

Although no comprehensive statistics are available for the eighteen-month period during which I gathered data on my Group B patients, the available statistics suggest that San Diego County hearing officers were finding patients competent in just under one of four cases at a time that I was finding patients competent in just over one of four cases.\(^\text{235}\) Although I did not consciously revise my decisionmaking principles, my Group B findings are far more consistent with the findings of other decisionmakers than were my Group A findings.

The decisions of other hearing officers were influenced by the factors identified above that influenced my decisions. However, although these factors reduced significantly the percent of patients I found competent, the percent increased slightly for other hearing officers. This anomaly may be explainable by the absence of one conservative decisionmaker who heard numerous cases as a court commissioner at the time my Group A cases were decided, but who did not serve as a hearing officer at the time my Group B cases were decided. If his decisions were excluded, the findings of competence for other decisionmakers would have diminished from one of three (in the Group A time frame) to one of four (in the Group B time frame).

San Diego County court commissioners and hearing officers have consistently found patients competent at rates that are higher than reported in empirical studies of law-trained decisionmaker models utilized in other states.\(^\text{236}\) When physician findings of patient incompetence are not upheld in 20 to 25% of the hearings, one can assert that a law-trained decisionmaker model is needed to assure that treatment refusal decisions of competent patients are acknowledged.\(^\text{237}\)

\(^{235}\) Hearing officers conducted 146 hearings on the merits during the 10-month period of January through October 1992 and found 28 patients (21.2%) competent. OFFICE OF COUNSELOR IN MENTAL HEALTH, SAN DIEGO SUPER. CT., RIESE HEARINGS STATISTICAL REPORT [hereinafter RIESE HEARINGS STATISTICAL REPORT #4] (undated) (on file with author as report #4). During this period, I conducted 12 hearings on the merits and found three patients (25.0%) competent.

During the eight-month period of January through August 1993, hearing officers conducted 159 hearings on the merits and found 37 patients (23.3%) competent. OFFICE OF COUNSELOR IN MENTAL HEALTH, SAN DIEGO SUPER. CT., RIESE HEARINGS STATISTICAL REPORT [hereinafter RIESE HEARINGS STATISTICAL REPORT #5] (undated) (on file with author as report #5). During this period, I conducted 17 hearings on the merits and found four patients (23.5%) competent. Two of the 17 were conducted after the Group B patient class had been completed. Both of those patients were found incompetent.

\(^{236}\) See supra note 79.

\(^{237}\) But cf. Appelbaum & Schwartz, supra note 10, at 465 (asserting that the hearing process is substantially ineffective if doctors are not motivated to alter their
### Table 2A

**Average Age of Patients (in Years)**

<table>
<thead>
<tr>
<th>Average Age</th>
<th>Group A (N=31)</th>
<th>Group B (N=25)</th>
<th>A &amp; B Comb'd (N=56)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>44.5</td>
<td>42.6</td>
<td>43.7</td>
</tr>
<tr>
<td>Patients found competent</td>
<td>41.3</td>
<td>48</td>
<td>43</td>
</tr>
</tbody>
</table>

### Table 2B

**Age of Patients in Hearings on Merits**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Group A (N=33)</th>
<th>Group B (N=33)</th>
<th>A &amp; B Comb'd (N=66)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent</td>
<td>Percent</td>
<td>Percent</td>
</tr>
<tr>
<td>21-30</td>
<td>9 (27.3)</td>
<td>8 (24.2)</td>
<td>17 (25.8)</td>
</tr>
<tr>
<td>31-40</td>
<td>5 (15.2)</td>
<td>4 (12.1)</td>
<td>9 (13.6)</td>
</tr>
<tr>
<td>41-50</td>
<td>4 (12.1)</td>
<td>4 (12.1)</td>
<td>8 (12.1)</td>
</tr>
<tr>
<td>51-60</td>
<td>5 (15.2)</td>
<td>4 (12.1)</td>
<td>9 (13.6)</td>
</tr>
<tr>
<td>61-70</td>
<td>5 (15.2)</td>
<td>3 (9.1)</td>
<td>8 (12.1)</td>
</tr>
<tr>
<td>71-80</td>
<td>3 (9.1)</td>
<td>2 (6.1)</td>
<td>5 (7.6)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2 (6.1)</td>
<td>8 (24.2)</td>
<td>10 (15.2)</td>
</tr>
</tbody>
</table>

**Age of Patients Found Competent**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Group A (N=9)</th>
<th>Group B (N=8)</th>
<th>A &amp; B Comb'd (N=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent</td>
<td>Percent</td>
<td>Percent</td>
</tr>
<tr>
<td>21-30</td>
<td>5 (55.6)</td>
<td>1 (12.5)</td>
<td>6 (35.3)</td>
</tr>
<tr>
<td>31-40</td>
<td>3 (60.0)</td>
<td>1 (25.0)</td>
<td>4 (44.4)</td>
</tr>
<tr>
<td>41-50</td>
<td>4 (100.0)</td>
<td>2 (50.0)</td>
<td>6 (75.0)</td>
</tr>
<tr>
<td>51-60</td>
<td>2 (40.0)</td>
<td>1 (25.0)</td>
<td>3 (33.3)</td>
</tr>
<tr>
<td>61-70</td>
<td>2 (40.0)</td>
<td>0 (0.0)</td>
<td>2 (25.0)</td>
</tr>
<tr>
<td>71-80</td>
<td>1 (33.3)</td>
<td>1 (50.0)</td>
<td>2 (40.0)</td>
</tr>
<tr>
<td>Unknown</td>
<td>1 (50.0)</td>
<td>3 (37.5)</td>
<td>4 (40.0)</td>
</tr>
</tbody>
</table>

Assessments of patients' competence by adverse judgments that continue to be large in number.)
Data on patient ages are reported in TABLES 2A and 2B. The average age of all patients on whom information was obtained did not differ significantly between Group A and Group B patients. Group B patients found competent were only slightly older than Group A patients. TABLE 2B identifies patient ages in ten-year increments. In both Group A and Group B, approximately twice as many patients were in the twenty-one through thirty age group than any other age group, and I heard similar numbers of Group A and Group B cases for patients in higher age groups. Although the numbers of patients found competent in each age group is too small to permit a statistically significant comparison, age did not appear to be a contributing factor in my Group A or Group B decisionmaking. Even elderly patients in the seventy-one through eighty age group were found competent at a rate comparable to patients in other age groups.

**TABLE 3**

**TYPE OF FACILITY**

<table>
<thead>
<tr>
<th></th>
<th>Group A</th>
<th>Percent</th>
<th>Group B</th>
<th>Percent</th>
<th>A &amp; B Comb'd</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public facilities</td>
<td>20</td>
<td>60.6</td>
<td>17</td>
<td>51.5</td>
<td>37</td>
<td>56.1</td>
</tr>
<tr>
<td>Private facilities</td>
<td>13</td>
<td>39.4</td>
<td>16</td>
<td>48.5</td>
<td>29</td>
<td>43.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Group A</th>
<th>Percent</th>
<th>Group B</th>
<th>Percent</th>
<th>A &amp; B Comb'd</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public facilities</td>
<td>12 (N=20)</td>
<td>60.0</td>
<td>3 (N=17)</td>
<td>17.6</td>
<td>15 (N=37)</td>
<td>40.5</td>
</tr>
<tr>
<td>Private facilities</td>
<td>6 (N=13)</td>
<td>46.2</td>
<td>6 (N=16)</td>
<td>37.5</td>
<td>12 (N=29)</td>
<td>41.4</td>
</tr>
</tbody>
</table>

Data on the type of facility in which I conducted hearings are presented in TABLE 3. I conducted somewhat more hearings in public facilities than in private facilities. I was interested in determining
whether the type of facility affected my decisionmaking. In Group A and Group B hearings combined, I found patients competent at almost an identical rate regardless of facility type. The percentage of all patients found competent declined from Group A to Group B. The decline, however, was far more severe for hearings conducted at public facilities (from 60.0% to 17.6%) than private facilities (from 46.2% to 37.5%). I do not believe the disparity is a result of any bias on my part against patients in public facilities. Rather, as explained above, Group B patients in public mental health facilities were more seriously ill than either Group B patients in private facilities or Group A patients in either type of facility.

### Table 4

**Professional Qualifications of Facility Representatives**

<table>
<thead>
<tr>
<th></th>
<th>Group A</th>
<th>Percent</th>
<th>Group B</th>
<th>Percent</th>
<th>A &amp; B Comb'd</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>22</td>
<td>66.7</td>
<td>18</td>
<td>54.5</td>
<td>40</td>
<td>60.6</td>
</tr>
<tr>
<td>All Others</td>
<td>11</td>
<td>33.3</td>
<td>15</td>
<td>45.5</td>
<td>26</td>
<td>39.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Group A</th>
<th>Percent</th>
<th>Group B</th>
<th>Percent</th>
<th>A &amp; B Comb'd</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>12 (N=22)</td>
<td>54.5</td>
<td>5 (N=18)</td>
<td>27.8</td>
<td>17 (N=40)</td>
<td>42.5</td>
</tr>
<tr>
<td>All Others</td>
<td>6 (N=11)</td>
<td>54.5</td>
<td>4 (N=15)</td>
<td>26.7</td>
<td>10 (N=26)</td>
<td>38.5</td>
</tr>
</tbody>
</table>

Treating psychiatrists diagnose patients; prescribe medication; inform patients of medication benefits, risks, and alternatives; assess patients’ competence; and petition for a hearing. They are the best source of evidence to support findings of incompetence. As mentioned above, the San Diego County Superior Court rules warn facilities that the failure of the psychiatrist to testify may result in insufficient evidence to support a finding of the patient’s mental incapacity.  

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238. See *supra* text accompanying note 186.
As reported in TABLE 4, the patient’s treating psychiatrist served as the facility representative in over half the Group A and Group B hearings. I was interested in determining whether, in the hearings I conducted, the failure of the treating psychiatrist to testify affected the hearing’s result. The data reveal that psychiatrists and nonpsychiatrists were equally adept at proving the patient’s incompetence. When the treating psychiatrist does not testify, the court requires the psychiatrist to submit a written declaration summarizing his or her assessment of the patient’s competence. The declaration is admitted into evidence and the nonpsychiatrist facility representative merely offers additional testimony to support the psychiatrist’s declaration. Apparently, this procedure is working satisfactorily to assure that the facility’s case is adequately presented.

TABLE 5A lists the psychiatric diagnoses for Group A and Group B patients. Although most patients were diagnosed with one mental disorder, two Group A and three Group B patients received dual diagnoses. In my sample population, I heard 29 cases (43.9%) involving patients diagnosed with mood disorders (bipolar disorder and depressive disorder) and 27 cases (40.9%) diagnosed with thought disorders (schizophrenia and other psychotic disorder). The most common mental disorder was bipolar disorder, diagnosed in nineteen of the sixty-six patients (28.8%). Bipolar disorder is a mood disorder characterized by the occurrence of one or more manic episodes or both manic and depressive episodes. The second most common mental disorder was schizophrenia, diagnosed in fifteen of the sixty-six patients (22.7%). Schizophrenia is a psychotic disorder. Additionally, twelve patients (18.2%) were diagnosed with psychotic disorders other than schizophrenia. Psychotic disorders are thought disorders characterized

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240. In Group A, one patient was diagnosed with psychotic disorder—NOS (i.e., not otherwise specified) and mental retardation; another patient was diagnosed with schizoaffective disorder and mixed substance abuse. In Group B, one patient was diagnosed with schizophrenia and Alzheimer’s dementia; a second patient was diagnosed with schizophrenia, paranoid type, and polydrug abuse; a third patient was diagnosed with depression and dementia.

241. DSM-IV, supra note 239, at 350.
### TABLE 5A
#### DIAGNOSIS OF PATIENTS IN HEARINGS ON THE MERITS

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Group A (N=33)</th>
<th>Percent</th>
<th>Group B (N=33)</th>
<th>Percent</th>
<th>A &amp; B Comb'd (N=66)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar disorder (including diagnosis of bipolar affective disorder-manic)</td>
<td>13</td>
<td>39.4</td>
<td>6</td>
<td>18.2</td>
<td>19</td>
<td>28.8</td>
</tr>
<tr>
<td>Schizophrenia (including diagnosis of schizophrenia-paranoid)</td>
<td>4</td>
<td>12.1</td>
<td>11</td>
<td>33.3</td>
<td>15</td>
<td>22.7</td>
</tr>
<tr>
<td>Psychotic Disorder (including diagnoses of psychotic disorder not otherwise specified and atypical psychosis)</td>
<td>3</td>
<td>9.1</td>
<td>9</td>
<td>27.3</td>
<td>12</td>
<td>18.2</td>
</tr>
<tr>
<td>Depressive disorder (including diagnosis of major depression)</td>
<td>5</td>
<td>15.2</td>
<td>5</td>
<td>15.2</td>
<td>10</td>
<td>15.2</td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td>7</td>
<td>21.2</td>
<td>0</td>
<td>0.0</td>
<td>7</td>
<td>10.6</td>
</tr>
<tr>
<td>Organic disorder (including diagnoses of organic brain syndrome, organic delusional disorder, organic mood disorder)</td>
<td>1</td>
<td>3.0</td>
<td>2</td>
<td>6.1</td>
<td>3</td>
<td>4.5</td>
</tr>
<tr>
<td>Dementia (including diagnosis of Alzheimer’s dementia)</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
<td>6.1</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td>Psychoactive Substance Use Disorder (including diagnoses of mixed substance abuse and polydrug abuse)</td>
<td>1</td>
<td>3.0</td>
<td>1</td>
<td>3.0</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td>Mental Retardation</td>
<td>1</td>
<td>3.0</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>35</strong></td>
<td><strong>106.1</strong></td>
<td><strong>36</strong></td>
<td><strong>109.1</strong></td>
<td><strong>71</strong></td>
<td><strong>107.4</strong></td>
</tr>
</tbody>
</table>
by the presence of psychotic symptoms\textsuperscript{242} such as delusions,\textsuperscript{243} hallucinations,\textsuperscript{244} or disorganized speech.\textsuperscript{245}

I was interested in discovering whether the most frequently diagnosed disorders were similar for each Group, and if not, whether the differences might have contributed to the disparity in hearing results. The data reveal a sharp contrast. Mood disorders were far more prevalent in Group A, accounting for eighteen of the thirty-three cases (54.5\%) as compared with only eleven Group B cases (33.3\%). Thought disorders were far more prevalent in Group B, accounting for twenty cases (60.6\%) as compared with only seven Group A cases (21.2\%).

Psychiatrists have noted that law-trained decisionmakers generally conceptualize competence as a cognitive capacity.\textsuperscript{246} Therefore, patients with thought disorders who are suffering from delusions, hallucinations, and disorganized speech, are more likely to be found incompetent than patients with mood disorders. Patients with mood disorders may be found competent if they are capable of coherent speech and able to articulate rational objections to medication. Psychiatrists, however, have asserted that patients who have an intellectual understanding of a medication's risks and benefits may, nevertheless, be incompetent if their mood disorder causes them to become unduly concerned about risks or unable to appreciate the benefits.\textsuperscript{247} For example, people with bipolar disorder who are experiencing a manic episode may feel an inflated sense of self esteem or grandiosity. They may engage excessively in pleasurable activities despite the high potential for painful consequences.\textsuperscript{248} In their euphoric state, they may deny the existence

\textsuperscript{242} Id. at 273.
\textsuperscript{243} “Delusions . . . are erroneous beliefs that usually involve a misinterpretation of perceptions or experiences.” Id. at 275.
\textsuperscript{244} “Hallucinations . . . may occur in any sensory modality . . . but auditory hallucinations are by far the most common and characteristic of schizophrenia. Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the person's own thoughts.” Id. at 275.
\textsuperscript{245} Disorganized thinking may be the single most important feature of schizophrenia. Because inferences about thought are based primarily on an individual’s speech, disorganized speech was emphasized in the definition of schizophrenia. Id. at 276. Other criteria for schizophrenia include grossly disordered behavior and negative symptoms, such as affective flattening, alogia, and avolition. Id.
\textsuperscript{247} Harold J. Bursztajn, Beyond Cognition: The Role of Disordered Affective States in Impairing Competence to Consent to Treatment, 19 BULL. AM. ACAD. PSYCHIATRY & L. 383, 384 (1991).
\textsuperscript{248} DSM-IV, supra note 239, at 332.
of a mental disorder or the potential benefit from treatment. A study comparing thirty treatment-refusing patients with thirty treatment-consenting patients revealed a significant diagnostic difference between the two groups: nine of the twelve diagnosed with bipolar disorder (75%) refused medication; twenty-two of the thirty-two diagnosed with schizophrenia (68.8%) consented.

Because a person’s mood may influence the weighing of risks and benefits, mood disturbances are an appropriate component of a competence assessment. However, in considering a patient’s mood, decisionmakers should not equate a diagnosis of bipolar disorder or other mood disorder with incompetence, just as they should not equate a diagnosis of schizophrenia or any other disorder with incompetence. Proof of mental disorder, whether acknowledged by the patient or not, is only one factor in establishing a patient’s incompetence. The question to be determined is whether the patient is competent to refuse medication despite his or her mental disorder.

Thus, as reported in Table 5B, of the twenty-nine cases I heard involving patients diagnosed with mood disorders, twelve were found competent (41.4%). Of the twenty-seven cases I heard involving patients diagnosed with thought disorders, nine were found competent (33.3%). Although thought disordered patients were found incompetent at a higher rate than were mood disordered patients, diagnosis alone was not determinative. Some thought disordered patients were found competent, some were not. Some mood disordered patients were found competent, some were not.

249. Appelbaum & Hoge, supra note 79, at 283 (Studies have suggested that patients experiencing the pleasurable state of grandiosity may reject medication because they are reluctant to part with feelings of superiority.); Gutheil & Bursztajn, supra note 246, at 1021 (Patients in a manic state may deny the possibility that treatment may benefit them.); Paul Rodenhauser, Treatment Refusal in a Forensic Hospital: Ill-Use of the Lasting Light, 12 BULL. AM. ACAD. PSYCHIATRY & L. 59, 61 (1984) (Among forensic patients studied, the leading causes of medication refusal were grandiosity and denial of mental disorder.).


<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Group A %</th>
<th>Group B %</th>
<th>A &amp; B Comb'd %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar disorder (including diagnosis of bipolar affective disorder-manic)</td>
<td>53.8</td>
<td>33.3</td>
<td>47.4</td>
</tr>
<tr>
<td>Schizophrenia (including diagnosis of schizophrenia-paranoid)</td>
<td>50.0</td>
<td>18.2</td>
<td>26.7</td>
</tr>
<tr>
<td>Psychotic disorder (including diagnoses of psychotic disorder not otherwise specified and atypical psychosis)</td>
<td>33.3</td>
<td>44.4</td>
<td>41.7</td>
</tr>
<tr>
<td>Depressive disorder (including diagnosis of major depression)</td>
<td>60.0</td>
<td>0.0</td>
<td>30.0</td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td>57.1</td>
<td>0.0</td>
<td>57.1</td>
</tr>
<tr>
<td>Organic disorder (including diagnoses of organic brain syndrome, organic delusional disorder, and organic mood disorder)</td>
<td>100.0</td>
<td>50.0</td>
<td>66.7</td>
</tr>
<tr>
<td>Dementia (including diagnosis of Alzheimer's dementia)</td>
<td>0.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Psychoactive Substance Use Disorder (including diagnoses of mixed substance abuse and polydrug abuse)</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>54.3</td>
<td>33.3</td>
<td>43.7</td>
</tr>
</tbody>
</table>
TABLE 5B supports my assertion that Group B patients were more seriously disordered than were Group A patients. In virtually every diagnostic category, the percent of patients found competent declined from Group A to Group B. The percent of patients found competent when diagnosed with schizophrenia or other psychotic disorder declined from 42.8% in Group A to 30.0% in Group B. The percent of patients found competent when diagnosed with bipolar disorder or depressive disorder declined from 55.6% in Group A to 18.2% in Group B.

Although mood disorder diagnoses predominated in Group A patients and thought disorder diagnoses predominated in Group B patients, my assertion that Group B patients were more seriously disordered is not based on a belief that thought disorders are more serious disorders than mood disorders. I note, for example, that a person suffering from major depressive disorder—a common mood disorder—may lose interest in nearly all activity, feel worthless, and have recurrent thoughts of death.252 Approximately 15% of people with severe cases of major depressive disorder commit suicide.253

TABLE 6 summarizes the evidence introduced by facility representatives to support their assertions that patients were incompetent to make medication decisions. The most frequently cited reason, mentioned in over 90% of Group A and Group B cases, was the patient’s refusal to acknowledge his or her mental disorder. The almost universal reliance on this reason is not surprising. To assist in the implementation of capacity hearings, the San Diego County Superior Court approved a “script” that was used by court commissioners who acted as temporary judges and is currently used by mental health hearing officers. The script contains a series of questions designed to elicit relevant testimony from facility representatives. Because the Riese case identifies the patient’s willingness to acknowledge mental disorder as a competence assessment factor,254 the treating psychiatrist is asked: “Does the patient believe that he or she suffers from a mental disorder?” When the treating psychiatrist does not serve as the facility representative, the physician’s declaration containing a written response to the same question is introduced into evidence.

252. DSM-IV, supra note 239, at 327, 339.
253. Id. at 340.
<table>
<thead>
<tr>
<th>Reasons Given to Support Determination of Incapacity</th>
<th>Group A (N=33)</th>
<th>Group B (N=33)</th>
<th>A &amp; B Comb’d (N=66)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Patient does not acknowledge his or her mental disorder.</td>
<td>32 97.0</td>
<td>30 90.9</td>
<td>62 93.9</td>
</tr>
<tr>
<td>B Patient is psychotic, delusional, etc.</td>
<td>20 60.6</td>
<td>22 66.7</td>
<td>42 63.6</td>
</tr>
<tr>
<td>C Patient will not listen to explanation of risks and benefits.</td>
<td>8 24.2</td>
<td>13 39.4</td>
<td>21 31.8</td>
</tr>
<tr>
<td>D Patient is dangerous to self or others.</td>
<td>12 36.4</td>
<td>7 21.2</td>
<td>19 28.8</td>
</tr>
<tr>
<td>E Patient is paranoid or suffers from paranoia.</td>
<td>7 21.2</td>
<td>12 36.4</td>
<td>19 28.8</td>
</tr>
<tr>
<td>F Patient is mute or unresponsive.</td>
<td>7 21.2</td>
<td>9 27.3</td>
<td>16 24.2</td>
</tr>
<tr>
<td>G Patient’s condition has not improved or will not improve without medication.</td>
<td>2 6.1</td>
<td>8 24.2</td>
<td>10 15.2</td>
</tr>
<tr>
<td>H Patient refuses food.</td>
<td>3 9.1</td>
<td>3 9.1</td>
<td>6 9.1</td>
</tr>
<tr>
<td>I Patient’s claim of allergic reaction or side effects to medication is not substantiated.</td>
<td>3 9.1</td>
<td>2 6.1</td>
<td>5 7.6</td>
</tr>
<tr>
<td>J Patient’s intellectual function is impaired.</td>
<td>2 6.1</td>
<td>1 3.0</td>
<td>3 4.5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>96</strong></td>
<td><strong>107</strong></td>
<td><strong>203</strong></td>
</tr>
</tbody>
</table>
Even if psychiatrists were not specifically questioned about the issue, a patient's refusal to acknowledge mental disorder would remain a popular reason to support a determination of incompetence. A competent decision on whether to accept or reject treatment requires a weighing of the anticipated benefits as well as the possible risks and alternatives of that treatment. Patients who believe that they have no mental disorder are unlikely to value the therapeutic effects of a medication to treat a mental disorder.

In over 60% of Group A and Group B cases, the psychiatrist testified (either in person or by written declaration) that the patient was psychotic or delusional. Because psychotic individuals are, by definition, grossly impaired in reality testing, their ability to assess rationally the risks and benefits of proposed medication is questionable. Psychotic symptoms include delusions and hallucinations. Thus, for example, a patient with a delusional belief that the doctor wishes to harm him or her may believe that the proposed medication is poison. A medication refusal for this reason would be irrational.

In TABLE 6, evidence that the patient is paranoid or suffers from paranoia is categorized as a separate reason. Although, properly used, the words "paranoid" or "paranoia" imply the presence of delusions or hallucinations, sometimes these words are used inappropriately to suggest suspiciousness. Because suspiciousness may be rationally based, it is not an appropriate symptom of psychosis. In fourteen of the nineteen cases in which the psychiatrist testified that the patient was paranoid or suffers from paranoia, the psychiatrist also testified that the patient was psychotic or delusional. When the two reasons are combined, but not double-counted, the data reveal that in twenty-two Group A cases (66.7%) and twenty-five Group B cases (75.8%),

255. DSM-IV, supra note 239, at 273.
256. Id.; see supra notes 243-44.
257. The essential feature of schizophrenia, paranoid type, "is the presence of prominent delusions or auditory hallucinations in the context of a relative preservation of cognitive functioning and affect." DSM-IV, supra note 239, at 287. The essential feature of delusional disorder "is the presence of one or more nonbizarre delusions that persist for at least 1 month . . ." Id. at 296. In the previous edition of the Diagnostic and Statistical Manual, delusional disorder was named delusional (paranoid) disorder. AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-III-R) 199-203 (3d ed. rev. 1987).
Facility representatives offered an average of three reasons to support a determination of incapacity. The two most frequently cited reasons were the patient’s refusal to acknowledge mental disorder and the patient’s psychosis or delusions. No other single reason was offered in more than one-third of the combined Group A and Group B cases. Nevertheless, there were some differences between the two groups in the use of various reasons. For example, evidence that the patient was dangerous was introduced more frequently in Group A hearings than in Group B hearings. Perhaps as psychiatrists became more familiar with the criteria used to determine competence, they realized that evidence of the patient’s dangerousness is irrelevant to the assessment of competence.

Evidence that the patient was paranoid and evidence that the patient would not listen to an explanation of risks and benefits was introduced more frequently in Group B hearings than in Group A hearings. The two reasons compliment each other. A person who is preoccupied by paranoid delusions may not be willing to listen to the doctor’s explanation of medication risks and benefits. The more frequent use of these reasons in Group B hearings may indicate that the Group B patients were more seriously mentally disordered than the Group A patients.

Evidence that the patient’s condition had not improved without medication or that it would not improve without medication was also introduced more frequently in Group B hearings than in Group A hearings. I can only speculate why this occurred. Perhaps the reason was offered to suggest that the patient was seriously mentally disordered and that alternatives to the proposed medication did not exist. Perhaps the reason was offered to suggest that the psychiatrist was willing to accept the patient’s medication refusal if improvement in the patient’s mental condition could occur without medication. If, however, psychiatrists were more willing to defer to their patients’ treatment refusal decisions, the number of hearings should have decreased. It did not. The number of San Diego County hearings conducted during the Group A time period averaged less than thirteen per month.260 When

258. Evidence of either psychotic symptoms or paranoia was introduced in 47 Group A and Group B cases combined (71.2%).
259. In four cases, the psychiatrist gave only one reason to support a finding of incapacity. Refusal to acknowledge mental disorder was the reason given in three of the four cases.
260. From April 1990 through March 1991, 155 hearings were conducted on the merits, an average of 12.9 per month. PATIENT ADVOCACY PROGRAM, RIESE REPORT, supra note 233. From July 1990 through June 1991, 146 hearings were conducted on
### Table 7

**Patients’ Evidence**

<table>
<thead>
<tr>
<th>Reasons Given For Refusing Medication</th>
<th>Group A (N=33)</th>
<th>Percent</th>
<th>Group B (N=33)</th>
<th>Percent</th>
<th>A &amp; B Comb’d (N=66)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1 Patient experienced side effects from previous administration of medication.</td>
<td>23</td>
<td>69.7</td>
<td>17</td>
<td>51.5</td>
<td>40</td>
<td>60.6</td>
</tr>
<tr>
<td>B1 Patient says he or she doesn’t need or doesn’t want the medication.</td>
<td>9</td>
<td>27.3</td>
<td>12</td>
<td>36.4</td>
<td>21</td>
<td>31.8</td>
</tr>
<tr>
<td>C1 Patient does not trust or is angry at the psychiatrist.</td>
<td>6</td>
<td>18.2</td>
<td>14</td>
<td>42.4</td>
<td>20</td>
<td>30.3</td>
</tr>
<tr>
<td>D1 Patient denies having a mental disorder.</td>
<td>7</td>
<td>21.2</td>
<td>12</td>
<td>36.4</td>
<td>19</td>
<td>28.8</td>
</tr>
<tr>
<td>E1 Patient claims the medication has not helped in the past or will not help now.</td>
<td>6</td>
<td>18.2</td>
<td>8</td>
<td>24.2</td>
<td>14</td>
<td>21.2</td>
</tr>
<tr>
<td>F1 Patient expresses concern about possible side effects.</td>
<td>7</td>
<td>21.2</td>
<td>6</td>
<td>18.2</td>
<td>13</td>
<td>19.7</td>
</tr>
<tr>
<td>G1 Patient asserts risks and benefits of proposed medication have not been explained.</td>
<td>5</td>
<td>15.2</td>
<td>5</td>
<td>15.2</td>
<td>10</td>
<td>15.2</td>
</tr>
<tr>
<td>H1 Patient asserts that he or she is being detained illegally, or that he or she has a legal right to refuse treatment.</td>
<td>4</td>
<td>12.1</td>
<td>6</td>
<td>18.2</td>
<td>10</td>
<td>15.2</td>
</tr>
<tr>
<td>I1 Patient’s lifestyle or religious belief is to reject all medicines.</td>
<td>6</td>
<td>18.2</td>
<td>2</td>
<td>6.1</td>
<td>8</td>
<td>12.1</td>
</tr>
<tr>
<td>J1 Patient says he or she doesn’t care whether he or she gets well or not.</td>
<td>1</td>
<td>3.0</td>
<td>1</td>
<td>3.0</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>74</strong></td>
<td><strong>83</strong></td>
<td><strong>157</strong></td>
<td><strong>157</strong></td>
<td><strong>157</strong></td>
<td><strong>157</strong></td>
</tr>
</tbody>
</table>

the merits, an average of 12.2 per month. *RIESE HEARINGS STATISTICAL REPORT #3*, *supra* note 233.
Group B hearings were conducted, the number of hearings rose to 14.6 per month from January through October 1992 and to 19.9 per month from January through August 1993.  

TABLE 7 summarizes the evidence introduced by patients to support their assertions that their medication refusal decisions were competently made. In most cases, the table reflects the testimony of patients in their hearings. Although the testifying psychiatrist is asked what information was given to the patient on medication risks, benefits, and alternatives and what did the patient say or do in response, the best source of evidence on reasons for a patient’s treatment refusal is the testimony of the patient himself or herself. In the two Group A and thirteen Group B hearings in which the patient did not participate, the table reflects the psychiatrist’s answer.

The most frequently cited reason for medication refusal, mentioned in almost 70% of Group A cases and over 50% of Group B cases, was side effects experienced from previous administration of medication. Patient concern about potential medication side effects was categorized as a separate reason. In nine of the thirteen cases in which patients testified that they were concerned about potential side effects, they also testified that they had previously experienced medication side effects. When the two reasons are combined, but not double-counted, the data reveal that in twenty-six Group A cases (78.8%) and eighteen Group B cases (54.5%), evidence was introduced that the patient either experienced side effects previously or was concerned about potential side effects.

Psychotropic medications are powerful drugs that may produce temporary and permanent side effects that are discomforting, painful, and...
disabling, and even deadly. Although competent decisionmaking should also weigh the potential benefits of the proposed medication, a patient’s concern about side effects, particularly if those side effects have been experienced previously, may be a rational basis to support a medication refusal.

In each hearing, the psychiatrist is asked whether the patient objected to the use of psychotropic medication because of side effects from prior treatment. In many cases, the psychiatrist reported no such patient objection. In subsequent testimony, however, the patient often stated that he or she refused medication because of previous experiences with side effects. The underreporting of patient concern about side effects is not unique to the psychiatrists who testified in the hearings that I conducted. In a study of mental patients admitted to four acute inpatient units in Massachusetts mental health facilities, the researchers compared the reasons given by patients for refusing medication with their doctors’ perceptions of those reasons. The single most frequently cited reason for medication refusal was side effects, mentioned by 35% of the patients. Physicians, however, identified patient concern about side effects in only 7% of the cases.
In the hearings I conducted, there were other obvious inconsistencies in the evidence. As one such example, in more than 90% of the cases, psychiatrists reported that patients did not acknowledge their mental disorder. However, in fewer than 30% of the cases, patients testified that they refused medication because they had no mental disorder. As another example, psychiatrists responding to a standard question uniformly testified that they informed or attempted to inform the patient of the potential risks and benefits of, and alternatives to, the proposed medication. Nevertheless, in 15.2% of the cases, patients testified that they refused medication because they had not been so informed. Other patients testified that they had not been informed but did not base their refusal on the lack of information. Often, these patients experienced side effects previously and were aware of at least some of the medication risks. Although their medication refusal was based on their prior experience, they were entitled to the full explanation of medication benefits, side effects, and alternatives. Granted, in some cases, an individual may be too confused to remember that he or she heard a psychiatrist’s explanation. Nevertheless, the frequent patient complaint that no explanation was given is highly disturbing.

In the Massachusetts study, researchers reported that patients and their doctors agreed only 37% of the time on reasons for medication refusal. The researchers, including Drs. Appelbaum, Gutheil, and other noted psychiatrists, concluded: “The frequent failure of psychiatrists to recognize patients’ reasons for refusing suggests a lack of communication between them about the basis for refusal . . . ” At a minimum, hearing officers should be skeptical of psychiatrists’ reports of their patients’ reasons for refusing medication.

Patients offered an average of two reasons to explain why they refused medication. However, no single reason other than previous experience with medication side effects was offered in more than one-third of the combined Group A and Group B cases. Nevertheless, there were some differences between the two groups in the use of various reasons. For example, evidence that the patient rejected medication because of a religious belief or a lifestyle choice was introduced more frequently in Group A hearings than in Group B hearings. Such evidence may

269. Id.
270. Id.
271. In a related context, Drs. Appelbaum and Hoge noted that when researchers offer their own opinions as to why patients refuse medication, the possibility of researcher bias is significant. Appelbaum & Hoge, supra note 79, at 285.
272. In 13 cases, the patient gave only one reason for refusing medication. Previous experience with medication side effects was the reason given in eight of the 13 cases.
support a finding of competence. In one of the first appellate cases recognizing the right to refuse psychotropic medication, the Second Circuit held that a practicing Christian Scientist, whose religious beliefs predated any mental disorder and who had not been adjudicated incompetent, stated a claim for damages resulting from forced medication in violation of her constitutional right to religious freedom.\(^{273}\) Over the years, the right to refuse psychotropic medication has evolved to protect the competent decisionmaking of patients who also refuse medication for nonreligious reasons, including a lifestyle choice to reject any medical treatment. An individual’s decision to forego medication and to substitute natural treatments—herbs, vitamins, or even fresh air—is not *a fortiori* irrational simply because it deviates from the norm. In a free society, an individual’s idiosyncratic or eccentric beliefs must be respected even if society views them as strange.

In more Group B than Group A cases, the patient either denied having a mental disorder or testified that he or she did not trust or was angry at the psychiatrist. On their face, these reasons do not seem to support the patient’s position. In fact, their more frequent use in Group B hearings may suggest that the Group B patients suffered from more serious mental disorders than Group A patients. After all, when a psychiatrist, whose training and expertise is in diagnosing mental disorder, has diagnosed a mental disorder, is the patient’s denial worthy of consideration? When a psychiatrist, whose training and expertise is in treating mental disorder, prescribes a psychotropic medication to improve the patient’s condition, is the patient’s hostility toward the psychiatrist justifiable? Surprisingly, the answer to both questions may be “yes.”

Previously, I suggested that hearing officers should consider whether a patient’s seemingly rational objections to medication were so influenced by a mood disorder that the patient’s judgment was irrational.\(^{274}\) Similarly, a hearing officer should consider whether a patient’s seemingly irrational objections to medication were, in fact, rationally based. For example, does the patient who appears to deny a mental disorder acknowledge a problem in nonmedical terms? Is the patient denying mental disorder in order to maintain control over his or her life and to avoid being thrust into the dependent role of a mental patient?

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274. *See supra* text accompanying notes 247-51.
Is the denial an attempt to avoid a catch-22 situation, i.e., by admitting mental disorder the patient strengthens the psychiatrist’s assertion that medication is the appropriate remedy? Is the patient’s hostility toward the psychiatrist a rational reaction either to the patient’s involuntary detention or to the lack of communication between the psychiatrist and the patient?

Through cross-reference with TABLES 6 and 7, TABLE 8 identifies the evidence introduced to support the parties’ positions in each hearing. Although this evidence was categorized for purposes of tabular presentation, the evidence introduced in each case was distinct. Although certain types of reasons were more influential than others, I did not decide individual cases by focusing on the types of reasons presented. Rather, I considered the evidence that was introduced in each case, the credibility of witnesses, and the oral arguments of both sides. Each case was unique.

**TABLE 8**

**SUMMARY OF EVIDENCE INTRODUCED, DECISIONS MADE, AND RATIONALE FOR EACH DECISION**

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Facility’s Evidence (From Table 6)</th>
<th>Patient’s Evidence (From Table 7)</th>
<th>Decision and Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1-43</td>
<td></td>
<td></td>
<td>GROUP A</td>
</tr>
<tr>
<td>1</td>
<td>A, B</td>
<td>A₁, C₁</td>
<td><strong>Competent.</strong> Although the patient was unwilling to acknowledge that he suffered from a mental illness, the psychiatrist admitted that the patient was cognitively able to understand the risks and benefits of medication and to evaluate them rationally. In his testimony, the patient complained of a side effect (sleeplessness) which ceased when the medication was discontinued.</td>
</tr>
<tr>
<td>2</td>
<td>A, I</td>
<td>A₁, H₁</td>
<td><strong>Competent.</strong> Although the patient claimed to be someone other than the person who was lawfully committed to the facility, nevertheless, the patient’s refusal of medication was based on concern about possible side effects from the proposed medication. Because she previously experienced side effects, the patient’s concern seemed rational.</td>
</tr>
<tr>
<td>Case No.</td>
<td>Facility’s Evidence (From Table 6)</td>
<td>Patient’s Evidence (From Table 7)</td>
<td>Decision and Rationale</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------</td>
<td>----------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>3</td>
<td>A, B</td>
<td>B₁, C₁, J₁</td>
<td>Incompetent. The patient stated that the doctors were practicing witchcraft and didn’t trust any of them. The patient also believed the medicine was poison. The patient did not indicate that he was refusing medication because of concern about side effects. (Rehearing of case #1).</td>
</tr>
<tr>
<td>4</td>
<td>A, G, I</td>
<td>A₁, H₁</td>
<td>Competent. The patient’s condition had not deteriorated since the last hearing. She based her refusal primarily on side effects that she had suffered previously and could suffer if medication was administered. These side effects have been documented. (Rehearing of case #2).</td>
</tr>
<tr>
<td>5</td>
<td>A, B, D</td>
<td>A₁, D₁, E₁, H₁</td>
<td>Incompetent. The patient did not acknowledge suffering from a mental disorder, although he made statements in the hearing that indicated he was psychotic. In explaining why he refused medication, the patient simply asserted his right to dissent but gave no rational basis for his dissent. He did not express a concern about side effects until he was prompted to do so by the public defender.</td>
</tr>
<tr>
<td>7</td>
<td>A, E, H</td>
<td>A₁</td>
<td>Incompetent. This profoundly dehydrated and malnourished patient could not give a rational explanation for why he refused food. Although he had experienced side effects from previous medications and expressed concern about side effects as his reason for refusing medication, I concluded that he had not considered rationally the anticipated benefits of the medication.</td>
</tr>
<tr>
<td>Case No.</td>
<td>Facility’s Evidence (From Table 6)</td>
<td>Patient’s Evidence (From Table 7)</td>
<td>Decision and Rationale</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------</td>
<td>-----------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>8</td>
<td>B, F, H</td>
<td>A₁, C₁</td>
<td>Competent. The patient articulated rational concerns about side effects she had experienced. She also expressed a willingness to continue taking medications if not on an empty stomach. Although the psychiatrist stated that the patient might not take the medication, the question to be decided is whether she is competent to make a judgment regarding medication, not whether her judgment is to accept the medication.</td>
</tr>
<tr>
<td>10</td>
<td>A, D</td>
<td>A₁, B₁, I₁</td>
<td>Competent. The patient experienced side effects previously and thus had a rational reason for refusing. Additionally, the patient expressed a sincere belief in homeopathy and rejects all medicine.</td>
</tr>
<tr>
<td>17</td>
<td>A, B</td>
<td>A₁, D₁</td>
<td>Incompetent. Although the patient’s refusal was based in part on side effects of previous administration, patient’s irrational concern that others were trying to poison him so affected his judgment that he could not make a rational decision.</td>
</tr>
<tr>
<td>18</td>
<td>A, D, F</td>
<td>A₁, G₁</td>
<td>Competent. The patient rationally refused medication because of side effects he was suffering. The patient was willing to consider taking other medication that might not have same effect.</td>
</tr>
<tr>
<td>19</td>
<td>A, B</td>
<td>A₁, F₁</td>
<td>Competent. The patient acknowledged his mental disorder. The patient expressed a willingness to take medications, despite his concern about side effects, to avoid being placed in restraint and seclusion. This decision seems rationally based.</td>
</tr>
<tr>
<td>Case No.</td>
<td>Facility’s Evidence (From Table 6)</td>
<td>Patient’s Evidence (From Table 7)</td>
<td>Decision and Rationale</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------------------</td>
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</tr>
<tr>
<td>20</td>
<td>A, C, D, F</td>
<td>A, B, D, F</td>
<td>Incompetent. Although the patient expressed some concerns about side effects, the primary reason she refused was her belief she was not mentally ill. Her testimony, however, led me to conclude she was mentally ill.</td>
</tr>
<tr>
<td>21</td>
<td>A, B, D, G, J</td>
<td>A</td>
<td>Competent. The patient was in contact with reality and gave a rational reason—experiencing side effects—for refusing. He expressed a willingness to take medications because he realizes he’s &quot;a confused human being.&quot;</td>
</tr>
<tr>
<td>22</td>
<td>A, B, F</td>
<td></td>
<td>Incompetent. The patient was not able to communicate.</td>
</tr>
<tr>
<td>23</td>
<td>A, B, C, D, E</td>
<td>A, B, D, C</td>
<td>Competent. Two days before the hearing, the patient was medicated intramuscularly on an emergency basis when he acted violently toward a staff member. At the hearing, the patient was sedated and in good contact with reality. He gave a rational reason for refusing medication—various side effects. Nevertheless, he expressed a willingness to take lithium, which he previously refused.</td>
</tr>
<tr>
<td>24</td>
<td>A, C, H</td>
<td>A</td>
<td>Competent. The patient acknowledged her mental disorder. The patient had a rational reason—side effects—for refusing. The patient was willing to take some psychotropic medication.</td>
</tr>
<tr>
<td>25</td>
<td>A, B</td>
<td>A, D, I</td>
<td>Incompetent. The patient denied being mentally ill but admitted having &quot;an environmentally ill personality.&quot; She did not consider the potential benefits from medication but refused it because it tasted bad and because it might affect her unborn fetus. The patient, however, was not pregnant. The patient’s reasoning was not rational.</td>
</tr>
<tr>
<td>Case No.</td>
<td>Facility’s Evidence (From Table 6)</td>
<td>Patient’s Evidence (From Table 7)</td>
<td>Decision and Rationale</td>
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</tr>
<tr>
<td>26</td>
<td>A, B, C, F</td>
<td>A₁</td>
<td>Incompetent. The patient did not attend the hearing. The patient’s attorney merely speculated that the patient’s refusal was based on concern about side effects mentioned in the patient’s chart.</td>
</tr>
<tr>
<td>27</td>
<td>A, B, C</td>
<td>A₁, E₁</td>
<td>Incompetent. The patient was extremely depressed. Although her answers sounded rational, she did not appear to be making a risk/benefit assessment and was not refusing medication due to side effects she had experienced previously. Rather, her feeling of hopelessness—i.e., that the medication won’t do any good—led her to refuse.</td>
</tr>
<tr>
<td>28</td>
<td>A, D</td>
<td>A₁, B₁, E₁</td>
<td>Competent. The patient acknowledged having a mental disorder, was able to articulate the benefits that the psychiatrist believed would result from the medication, and articulated rational concerns about side effects he had experienced and the lack of positive results from prior administration of psychotropic medication.</td>
</tr>
<tr>
<td>29</td>
<td>A, D, J</td>
<td>C₁, D₁</td>
<td>Incompetent. Evidence of violent outbursts by the patient indicated his failure to understand how the medicine would benefit him by reducing agitation. The patient appeared confused at the hearing. (Rehearing of case #28).</td>
</tr>
<tr>
<td>31</td>
<td>A, B, C</td>
<td></td>
<td>Incompetent. The patient interrupted the facility representative’s testimony several times. When the patient was called to testify, however, she became upset and left the hearing. No reason was given for refusing medications.</td>
</tr>
<tr>
<td>32</td>
<td>A, D, I</td>
<td>A₁, F₁, G₁</td>
<td>Competent. The patient expressed rational concerns about side effects he had suffered and side effects he had observed others suffering.</td>
</tr>
<tr>
<td>Case No.</td>
<td>Facility’s Evidence (From Table 6)</td>
<td>Patient’s Evidence (From Table 7)</td>
<td>Decision and Rationale</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>33</td>
<td>A, B, E</td>
<td>B₁, F₁, I₁</td>
<td><strong>Competent.</strong> The patient gave rational reasons for refusing medications: concern about how the medications would affect a thyroid condition that the patient had years ago and a lifestyle belief against taking any drugs.</td>
</tr>
<tr>
<td>34</td>
<td>A, B, C, D, E</td>
<td>A₁, G₁</td>
<td><strong>Incompetent.</strong> Although the patient expressed a rational concern about side effects, he did not acknowledge his mental disorder and did not understand what the psychiatrists were attempting to accomplish by treating him with medication. Although risks and benefits were explained to him, he was unwilling to consider the psychiatrist’s perspective before making a decision.</td>
</tr>
<tr>
<td>35</td>
<td>A, D</td>
<td>A₁, G₁</td>
<td><strong>Competent.</strong> The patient was depressed because he had tested HIV-positive. Nevertheless, his refusal of an antidepressant was rationally based and the facility representative so testified, contradicting the declaration of the treating psychiatrist.</td>
</tr>
<tr>
<td>36</td>
<td>A, B, E, F</td>
<td>A₁</td>
<td><strong>Incompetent.</strong> The patient did not testify coherently. Her statements shifted from one topic to another with no apparent connection. At one point, the patient became agitated at me and others for no apparent or expressed reason.</td>
</tr>
<tr>
<td>37</td>
<td>A, B, C, E</td>
<td>D₁, E₁, F₁, H₁</td>
<td><strong>Competent.</strong> The patient had both rational and irrational reasons for refusing. In part, he was concerned about side effects; in part, he believed he was not mentally ill.</td>
</tr>
<tr>
<td>38</td>
<td>A, B</td>
<td>B₁, C₁, D₁</td>
<td><strong>Competent.</strong> Although the psychiatrist expressed an opinion that the patient was mentally ill and delusional, he offered no evidence that the patient’s reason for refusing medication was irrational. The patient did not attend the hearing.</td>
</tr>
<tr>
<td>Case No.</td>
<td>Facility's Evidence</td>
<td>Patient's Evidence</td>
<td>Decision and Rationale</td>
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<tr>
<td></td>
<td>(From Table 6)</td>
<td>(From Table 7)</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>A, B</td>
<td>B₁, I₁</td>
<td>Incompetent. Throughout the hearing, the patient was extremely agitated and distraught. She continually interrupted the psychiatrist's presentation. When given an opportunity to speak, she gave no rational reason for refusing medication.</td>
</tr>
<tr>
<td>41</td>
<td>A, B D G₁, I₁</td>
<td>A₁, E₁, I₁</td>
<td>Competent. The patient was knowledgeable about, and expressed a sincere belief in, the Christian Science religion. Additionally, the patient experienced side effects from the medication previously administered to her.</td>
</tr>
<tr>
<td>42</td>
<td>A, E F</td>
<td></td>
<td>Competent. A court interpreter spoke to the patient in her native Philippine dialect—Llocano. Her answers were rational and coherent. She showed no signs of depression or muteness. She expressed a willingness to take psychotropic medication.</td>
</tr>
<tr>
<td>43</td>
<td>A</td>
<td>B₁, E₁, F₁</td>
<td>Incompetent. Although the patient articulated a rational concern for refusing medication—her daughter experienced side effects from the same medication—I did not believe she adequately considered its possible benefit. She did not believe she was mentally ill and did not understand how the medication would help her condition. She was unable to focus on a single topic for any length of time.</td>
</tr>
</tbody>
</table>
**GROUP B**

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Facility’s Evidence (From Table 6)</th>
<th>Patient’s Evidence (From Table 7)</th>
<th>Decision and Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>44</td>
<td>A, C, E</td>
<td>B₁, C₁, E₁</td>
<td><strong>Incompetent.</strong> The patient did not state a rational reason for why she refused an injectable or liquid form of medication but was willing to accept medication in pill form. At the hearing, she expressed no concern about side effects, although in cross-examination of the psychiatrist, the patient’s attorney established that she had suffered anticholinergic side effects caused by the medication.</td>
</tr>
<tr>
<td>45</td>
<td>A, B, C, E</td>
<td>C₁, D₁, F₁, H₁</td>
<td><strong>Incompetent.</strong> The patient denied being mentally ill but gave lengthy, and sometimes incoherent, answers to questions. The patient’s unwillingness to discuss the psychiatrist’s information on the effects of medication, or consequences to her if she refused to take it, suggested that her thought process was irrational.</td>
</tr>
<tr>
<td>46</td>
<td>A, B, C, D</td>
<td>A₁, B₁, C₁, D₁, E₁, G₁</td>
<td><strong>Incompetent.</strong> The patient repeatedly interrupted the hearing with verbal abuse toward the psychiatrist. Ultimately the hearing was conducted outside the patient’s presence. The evidence established that the patient was incapable of listening to information and evaluating it rationally. The patient would not consider the medication’s benefits.</td>
</tr>
<tr>
<td>47</td>
<td>A</td>
<td>A₁, B₁, E₁</td>
<td><strong>Competent.</strong> The patient had rational reasons for refusing medications. The patient expressed concern about side effects she had suffered when she took medication voluntarily earlier, during this detention. Additionally, she claimed medication had not helped her sort out her thoughts. The patient was knowledgeable about medications and their effects.</td>
</tr>
<tr>
<td>Case No.</td>
<td>Facility’s Evidence (From Table 6)</td>
<td>Patient’s Evidence (From Table 7)</td>
<td>Decision and Rationale</td>
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</tr>
<tr>
<td>48</td>
<td>A</td>
<td>A₁, E₁</td>
<td><strong>Competent.</strong> The patient gave rational responses to questions. He previously experienced side effects of medications and based his refusal on concerns about side effects. He was willing to take some medications but not the specific psychotropic medications that were being proposed.</td>
</tr>
<tr>
<td>49</td>
<td>A, B, C, E, G</td>
<td>A₁, C₁, D₁, H₁</td>
<td><strong>Incompetent.</strong> The patient continually interrupted the hearing claiming everyone was violating his rights. The patient did not trust the psychiatrist and would not consider potential benefits of the medication. Although he expressed a concern about side effects, I was not convinced that he was refusing medication because of this concern.</td>
</tr>
<tr>
<td>50</td>
<td>A, B, C, H₁</td>
<td>C₁, D₁, H₁</td>
<td><strong>Incompetent.</strong> The patient denied any mental illness despite the psychiatrist’s evidence to the contrary. The patient’s conduct at the hearing and testimony also confirmed her disordered condition. She also asserted that it was unlawful for the psychiatrist to treat her. She was unable to evaluate risks and benefits rationally.</td>
</tr>
<tr>
<td>51</td>
<td>C, F</td>
<td>C₁</td>
<td><strong>Incompetent.</strong> The patient did not attend the hearing. The evidence established that she refused medication but gave no reason for doing so. She did not listen to explanations about risks and benefits. She exhibited extreme behavioral disorganization in the hospital.</td>
</tr>
<tr>
<td>52</td>
<td>A, E, J</td>
<td>C₁, D₁, G₁</td>
<td><strong>Incompetent.</strong> The patient did not attend the hearing. The patient denied being mentally ill, despite strong evidence to the contrary. The psychiatrist stated that without treatment, the patient would be placed in a locked skilled nursing facility. With treatment, she may be able to return home. The patient was unable or unwilling to consider this benefit of medication.</td>
</tr>
<tr>
<td>Case No.</td>
<td>Facility’s Evidence (From Table 6)</td>
<td>Patient’s Evidence (From Table 7)</td>
<td>Decision and Rationale</td>
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</tr>
<tr>
<td>54</td>
<td>A, B, D, I</td>
<td>A₁</td>
<td><strong>Incompetent.</strong> Although the patient expressed some concern about side effects, the claimed side effect was not one that the proposed medication produces. In response to questions, the patient talked on, rather incoherently, about other matters. Despite strong evidence of mental illness and inappropriate behavior, the patient did not acknowledge any mental problem.</td>
</tr>
<tr>
<td>55</td>
<td>A, B, C, D, E</td>
<td>B₁, C₁, D₁</td>
<td><strong>Incompetent.</strong> The patient did not attend the hearing. The psychiatrist reported that the patient would not listen to information about risks and benefits, was isolative and hostile, and denied mental illness.</td>
</tr>
<tr>
<td>56</td>
<td>A, B</td>
<td>A₁, F₁, G₁</td>
<td><strong>Competent.</strong> Although the patient was manic and highly verbal, she had experienced incontinence from previous doses of medication that she accepted during this hospitalization. Her concern about side effects appeared rational.</td>
</tr>
<tr>
<td>57</td>
<td>A, B, C, D, E, I</td>
<td>A₁₁, E₁</td>
<td><strong>Incompetent.</strong> Although the patient expressed concern about weight gain from medication, this side effect does not occur from the medicine prescribed. Additionally, the patient’s concern about this side effect did not seem genuine. Finally, even if the patient’s concern was genuine, the patient did not appreciate how dangerous and assaultive he was without medication. He was not rationally considering the benefits as well as the risks.</td>
</tr>
<tr>
<td>Case No.</td>
<td>Facility’s Evidence (From Table 6)</td>
<td>Patient’s Evidence (From Table 7)</td>
<td>Decision and Rationale</td>
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<tr>
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</tr>
<tr>
<td>58</td>
<td>F</td>
<td>A₁</td>
<td>Incompetent. Although the patient expressed concern about stomachaches from large dosages of medication, he was unwilling to consider small dosages even though they did not upset his stomach. The patient was unwilling to acknowledge that his mental condition had improved from medication that he took sporadically while in the hospital.</td>
</tr>
<tr>
<td>59</td>
<td>A, G</td>
<td>B₁, I₁</td>
<td>Incompetent. The patient refused medication, asserting that food and vitamins were sufficient. The psychiatrist’s testimony indicated the patient was severely depressed and in a state of denial. The patient did not adequately consider the benefits of mediation and was not particularly concerned about the risks.</td>
</tr>
<tr>
<td>60</td>
<td>A, F</td>
<td>J₁</td>
<td>Incompetent. According to the psychiatrist, the patient expressed no complaints or concerns about medication. At the hearing, the patient merely asserted that the medication was not the right medication or insufficient in amount, and that it didn’t make any difference if he took it or not. He gave no explanation for rejecting medication.</td>
</tr>
<tr>
<td>61</td>
<td>A, B, C, E</td>
<td>G₁</td>
<td>Competent. The patient was not fluent in English. I believe this language difficulty, not her mental disorder, created a lack of understanding about the psychiatrist’s explanation of risks and benefits. The patient did not believe the medication was poison and expressed a willingness to follow the advice of her own (nonhospital) doctor. Her thought process appeared rational.</td>
</tr>
<tr>
<td>Case No.</td>
<td>Facility’s Evidence (From Table 6)</td>
<td>Patient’s Evidence (From Table 7)</td>
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</tr>
<tr>
<td>62</td>
<td>A, B, D, E</td>
<td>A₁, B₁, E₁</td>
<td>Competent. The patient spoke rationally about his concerns that the medication affected him adversely. Although the patient did not fully appreciate his mental disorder or the benefits of the medication, his opinion of how the medication affected his thinking was entitled to deference.</td>
</tr>
<tr>
<td>63</td>
<td>A, B, E, F, G</td>
<td>C₁, D₁</td>
<td>Incompetent. The patient was unwilling to speak with the public defender or to attend the hearing. The facility representative reported that the patient was out of touch with reality and responded to information on risks and benefits by claiming there was a plot against her. The patient voiced no concerns regarding side effects. No contradictory evidence was offered.</td>
</tr>
<tr>
<td>64</td>
<td>A, B</td>
<td>A₁, E₁, F₁</td>
<td>Incompetent. Although the patient had experienced side effects from the medication, she had no insight or appreciation of her current mental condition. She lacked appreciation of the benefits of the medication—to alleviate psychotic symptoms that she demonstrated at the hearing.</td>
</tr>
<tr>
<td>65</td>
<td>A, B, F, H</td>
<td>B₁</td>
<td>Incompetent. The patient did not attend the hearing. Uncontradicted evidence was presented that the patient had been mute for one and one-half weeks and refused food, fluids, medications, and medical testing procedures. Her behavior indicated a suicidal intent caused by her major depression.</td>
</tr>
<tr>
<td>66</td>
<td>A, B, C, E, H</td>
<td>A₁, F₁</td>
<td>Competent. Although the evidence clearly established that the patient was severely mentally disordered, he made a rational complaint about the extrapyramidal side effects he was suffering. Sincere concerns about side effects was his sole basis for refusing medication.</td>
</tr>
<tr>
<td>Case No.</td>
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</tr>
<tr>
<td>67</td>
<td>A, B, G</td>
<td>A₁, B₁, C₁, D₁, E₁, F₁, H₁</td>
<td>Competent. Although the evidence convinced me that the patient’s problem was probably mental, not physical, and the patient did not appreciate this possibility, nevertheless, the patient suffered a bad side effect from haloperidol and did not want another dose of this drug. In addition to this rational reason for refusing, the patient also relied on a finding of competence that was made at a hearing two days earlier.</td>
</tr>
<tr>
<td>68</td>
<td>A, C, G</td>
<td>D₁, H₁</td>
<td>Incompetent. The patient did not attend the hearing. The psychiatrist’s testimony established the patient would not listen to an explanation of risks and benefits because he did not believe he was mentally ill. The patient merely redirected the conversation to his legal status and asserted that he should not be confined in the hospital. He appeared unable to understand the benefits of medication.</td>
</tr>
<tr>
<td>69</td>
<td>A, B, E</td>
<td>C₁, D₁, H₁</td>
<td>Incompetent. The patient interrupted the hearing on several occasions with angry and delusional outbursts. It became necessary to complete the hearing out of his presence. The psychiatrist’s unrefuted testimony established that the patient suffered from delusions and was hostile. Because of his suspiciousness that hospital staff desired to hurt him, he was unable to evaluate the benefits of the proposed medication.</td>
</tr>
<tr>
<td>70</td>
<td>D, F, H</td>
<td>A₁</td>
<td>Incompetent. Although the patient attended the hearing, he remained mute throughout and did not respond to questions as to why he refused treatment. The psychiatrist’s unrefuted testimony established that the patient suffered from a major mental disorder that impaired his ability to understand risks and benefits of medication. The patient refused to decide whether to accept medication because he was afraid to make a mistake.</td>
</tr>
</tbody>
</table>
### Case Facility’s Patient’s Evidence Decision and Rationale

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Facility’s Evidence (From Table 6)</th>
<th>Patient’s Evidence (From Table 7)</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>71</td>
<td>A, B, G</td>
<td>B₁, C₁, D₁</td>
<td>Incompetent. The patient did not attend the hearing. Uncontroverted testimony was presented by the facility representative that the patient was suffering from a major mental disorder and a major physical disease but denied these illnesses and denied the need for any medication to assist her. The evidence established the patient’s psychotic thought process.</td>
</tr>
<tr>
<td>72</td>
<td>A, B, F</td>
<td>B₁</td>
<td>Incompetent. The patient did not respond rationally to questions. When asked why she was opposed to taking medication, she stated: “Because it creates an illusion and that’s Walt Disney.” When asked what medications she had taken in the past, she stated: “Reality.”</td>
</tr>
<tr>
<td>73</td>
<td>A, B, C, G</td>
<td>A₁, C₁, D₁</td>
<td>Incompetent. Although the patient previously experienced side effects from medication and expressed an unwillingness to take it again because of those side effects, the patient’s main reason for refusal was a belief that she was not mentally ill. She seemed clearly delusional, expressing a belief that she was royalty and that people were living within her. Her mental disorder prevented her from rationally considering potential benefits of the medication.</td>
</tr>
<tr>
<td>74</td>
<td>A, B, D, F, G</td>
<td>A₁, C₁</td>
<td>Incompetent. The patient gave inconsistent answers to questions and did not seem to have any appreciation for possible benefits of medication. He stated that the psychiatrists wanted to give him medication because they are psychotic.</td>
</tr>
</tbody>
</table>

421
<table>
<thead>
<tr>
<th>Case No.</th>
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</thead>
<tbody>
<tr>
<td>75</td>
<td>A, B, F</td>
<td>B₁, G₁, I₁</td>
<td><strong>Competent.</strong> Although the psychiatrist's declaration described the patient as unable to communicate, at the hearing the patient testified in a mostly coherent fashion. Even prior to his hospitalization, the patient had a history of refusing medications of any kind. Further, the psychiatrist's declaration did not clearly indicate that the patient had been informed of risks and benefits of the proposed medication.</td>
</tr>
<tr>
<td>76</td>
<td>A, B, C</td>
<td>A₁, B₁</td>
<td><strong>Incompetent.</strong> The patient did not attend the hearing. Although the patient was reported to have suffered side effects from a previous administration of the proposed medication, he had not articulated a reason for refusing other than that he didn't want it. Unrefuted evidence was presented that the patient was confused and disoriented.</td>
</tr>
<tr>
<td>77</td>
<td>A, E</td>
<td>A₁, F₁</td>
<td><strong>Competent.</strong> The patient gave rational reasons for refusing medication. She suffered side effects from a previous administration of the proposed medication. Through her professional training, she understood the effects of psychotropic medications. She believed that a close family member was over-medicated when treated for the same mental disorder. The patient was able to articulate why the psychiatrist wanted her to take the medication—to help alleviate her mental disorder.</td>
</tr>
</tbody>
</table>
In Table 8, I report my decision in each hearing conducted on the merits and summarize my reasons for each decision. My decisionmaking was guided by several principles. First, my objective was to assess the patient’s competence to perform the narrow task of deciding whether to accept or refuse psychotropic medication. Evidence of general incompetence, although relevant, was not determinative of this issue. For example, a psychiatrist’s testimony that the patient was psychotic or paranoid, or that the patient’s intellectual function was impaired, did not, by itself, establish the patient’s incapacity to make medication decisions. Similarly, evidence of specific incompetence on other matters, although relevant, was not determinative of medication refusal competence. For example, a psychiatrist’s testimony that the patient was dangerous or refused to eat did not, by itself, establish the patient’s incapacity to make medication decisions.

Second, I evaluated the patient’s reasons for refusing medication and whether those reasons were rationally based. Generally, I regarded patients’ concerns about side effects to be rational. However, there were exceptions. For example, in one hearing, the patient testified that she was pregnant and refused medication because of her concern about the effects of the medication on her unborn fetus. However, the facility representative introduced conclusive medical proof that the patient was not pregnant. I found that the patient’s reasoning was irrational.

Third, I evaluated the patient’s assessment of the medication’s potential benefits and whether that assessment was rationally based. Patients who did not acknowledge any mental disorder often did not acknowledge any medication benefits. Such denial is evidence of decisional incompetence, but it is not necessarily conclusive. When asked to do so, patients could often explain what they perceived were the psychiatrists’ reasons for prescribing the medication. Sometimes

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275. In Table 8, the cases are numbered one through 77, in the order they were calendared for hearing. Sixty-six cases were heard on the merits. Cases that were not heard on the merits were omitted from the table.

276. Because I assessed the patient’s competence in each hearing, I was particularly interested in, and often influenced by, the patient’s testimony. Thus, the reasons explaining my decisions reflect my evaluation of that testimony. In every hearing in which the patient testified, I asked questions of the patient. These questions helped resolve differences in the testimony introduced by the psychiatrist and the patient.
these explanations demonstrated that the patient had identified and rationally considered the medication’s therapeutic potential but had refused treatment because medication side effects were of greater concern.\textsuperscript{277}

Fourth, in accordance with \textit{Riese}, I imposed on the facility the burden of proving the patient’s incapacity by clear and convincing evidence.\textsuperscript{278} As expressed by the California Court of Appeal in a case involving a mental patient’s capacity to give or withhold informed consent to electroconvulsive treatment, this burden requires proof that leaves no substantial doubt, i.e., proof that is “sufficiently strong to command the unhesitating assent of every reasonable mind.”\textsuperscript{279} If a patient’s incapacity could not be proven with such certainty, I found the patient competent even though his or her incompetence was more probable than not.

Although my decisionmaking principles are easy to state, their application to specific cases was far more difficult. One recurring fact situation involved patients who offered both rational and irrational reasons for refusing medication. Typically, the patient would deny any mental disorder despite the psychiatrist’s overwhelming proof that mental disorder existed. The denial of mental disorder led the patient to disclaim any benefit from medication that would treat the disorder. Although the patient’s reasoning could be labeled irrational, the patient also offered rational reasons. Typically, the patient had experienced side effects from previous administration of medication and refused medication in order to avoid a reoccurrence.

The California Court of Appeal considered the problem in a closely related context. In \textit{Conservatorship of Waltz},\textsuperscript{280} the patient became agitated and psychotic when doctors attempted to discuss electroconvul- 

\begin{footnotes}
\item[277] Sometimes I tested the patient’s preference for avoiding side effects by suggesting that the patient might be detained for a longer period of time if he or she refused medication that the psychiatrist believed was needed to improve the patient’s mental condition. Invariably, patients expressed a willingness to endure extended commitment as preferable to medication side effects.

In some hearings, the psychiatrist testified that he or she would order the patient released if the patient was found competent. When such testimony was introduced, I did not suggest to the patient that a medication refusal might lengthen the patient’s detention.


\end{footnotes}
sive therapy with him. He would not listen to their explanations. However, in his nonpsychotic moments, including during his testimony, he understood that electroconvulsive therapy could cause memory loss and could kill him. The court, characterizing the patient's fears as both psychotic and rational, found the patient competent to make the treatment decision.

Waltz suggests that a patient's rational fears of side effects outweigh psychotic or irrational fears. In Waltz, however, the patient acknowledged that he suffered from a mental disorder and he was willing to take psychotropic medication to treat it. The disagreement between psychiatrist and patient as to the best course of treatment did not establish the patient's inability to make an informed judgment. If, however, a patient does not acknowledge mental disorder or any potential benefit from medication, should the patient's rational concern about side effects trump the patient's inability to weigh medication risks and benefits rationally? California court decisions provide no definitive answer.

Riese imposes on hearing officers the obligation to assess the patient's ability to understand risks and benefits of, and alternatives to, the proposed medication. Riese also imposes on the hearing officer the obligation to assess the patient's ability to understand and evaluate the information about those risks, benefits, and alternatives that is required to be given to the patient. Often it was not possible to make those assessments. In many cases, psychiatrists had not provided patients with the required information.

When psychiatrists were asked whether they informed patients of the potential risks and benefits of, and alternatives to, the proposed

281. Id. at 729, 227 Cal. Rptr. at 440.
282. Id. at 731, 227 Cal. Rptr. at 441.
283. Id.
284. Id. at 734, 227 Cal. Rptr. at 443-45. The court reversed the trial court judgment that found the patient incapable of giving informed consent to electroconvulsive therapy.
285. Id. at 731, 227 Cal. Rptr. at 441.
286. Id. at 734, 227 Cal. Rptr. at 443-45.
287. Id.
289. Id. at 1323, 271 Cal. Rptr. at 212; see supra text accompanying notes 136-39.
treatment, they answered affirmatively. But when they were then asked what they informed patients, frequently their answers did not support their claims of disclosure. In many hearings, psychiatrists testified that they informed patients only about medication benefits. For example, in one case, the psychiatrist testified that he told the patient "that haloperidol would help reduce her feelings of anxiety and would reduce some or all of her hostility." In another case, the psychiatrist testified that he informed the patient that "she would feel less agitated and that her thinking would improve if she agreed to medications." In another case, the psychiatrist simply stated: "I informed the patient that medication would be necessary to help her with her distress and encouraged her to take it."

Even when psychiatrists did discuss risks, they did not divulge "all information relevant to a meaningful decisional process"—the test of disclosure imposed by the California Supreme Court. To obtain a patient's informed consent, that test requires the psychiatrist to divulge all risks that are material to the patient's decision. Sometimes psychiatrists spoke about risks in general terms, informing patients that any medication can have detrimental as well as beneficial effects. Of

290. Sometimes, a psychiatrist testified that he or she attempted to inform the patient but the patient would not listen to the psychiatrist’s explanation.

291. For example, in one hearing the psychiatrist testified that the prescribed medication was relatively new and that side effects had not been summarized for psychiatrists’ use with patients. He produced the manufacturer's lengthy list of contraindications and side effects to demonstrate the difficulty of informing patients of all risks. However, he did not testify that he informed the patient of any risks.

292. For example, in one hearing the psychiatrist testified (in a written declaration) that he informed the patient "that haloperidol would help reduce her anxiety and paranoid feelings and would reduce some or all of her hostility." In another hearing, the psychiatrist testified (in a written declaration) that the patient "would feel calmer, less agitated, thinking would improve if she agreed to medications." In a third hearing, the psychiatrist testified (in a written declaration) that he informed the patient that "medicine might stop voices and paranoid thinking." In these written declarations, the psychiatrists did not assert that they informed patients about either medication risks or alternatives to medication. The psychiatrists did not attend the hearings, and the written declarations were the only evidence introduced that emanated from the treating psychiatrists.

293. Cobbs v. Grant, 8 Cal. 3d 229, 242, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 513 (1972).

294. The California Supreme Court summarized the physician’s disclosure duty as follows:

In sum, the patient's right of self-decision is the measure of the physician’s duty to reveal. That right can be effectively exercised only if the patient possesses adequate information to enable an intelligent choice. The scope of the physician’s communications to the patient, then, must be measured by the patient's need, and that need is whatever information is material to the decision. Thus the test for determining whether a potential peril must be divulged is its materiality to the patient's decision.

Id. at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515.
course, the psychiatrists asserted that the medication was prescribed for its beneficial effects. At other times, psychiatrists discussed some side effects but not others. Typically, the psychiatrist would inform the patient of non-neurological side effects such as sedation or anticholinergic side effects, i.e., dry mouth, blurred vision, urinary retention, and constipation, but would omit any discussion of neurological side effects such as dystonia, Parkinsonism, akathisia, akinesia, and tardive dyskinesia. Obviously, if the risk of non-neurological side effects is material to a patient’s decision, the risk of neurological side effects is likely to be more so.

When psychiatrists disclosed the risk of neurological side effects, they usually sugar-coated the information. For example, psychiatrists testified that they prescribed Cogentin to alleviate extrapyramidal side effects. They failed to mention that Cogentin may intensify mental symptoms and can even precipitate a toxic psychosis. Cogentin may aggravate symptoms of tardive dyskinesia. Cogentin may also cause tachycardia (rapid heart beat), hyperthermia, and other anticholinergic side effects. It is not a magic pill devoid of risks. And yet, psychiatrists rarely disclosed them. When psychiatrists informed patients about tardive dyskinesia, they mentioned that patients might experience uncontrollable movements but failed to disclose the irreversible nature of the side effect. Additionally, psychiatrists reassured patients by saying that tardive dyskinesia typically develops only after a lengthy course of treatment with psychotropic medication. They failed to disclose that in some cases, tardive dyskinesia develops after only a brief course of treatment.

295. I deliberately chose the word “sugar-coated.” In one hearing, in response to my question: “Did you treat the patient with antipsychotic medication during this admission?,” the psychiatrist testified: “No and yes. I managed to sweet talk him into taking Navane a couple of times—three days in a row.” Navane is the Roerig Division (of Pfizer Incorporated) brand of thiothixene hydrochloride. PHYSICIANS’ DESK REFERENCE, supra note 87, at 2093.
296. Cogentin is the Merck & Company brand of benztropine mesylate. Id. at 1512.
297. Id.
298. Id.
299. Id. at 1512-13.
300. See, e.g., George Gardos & Jonathan O. Cole, Overview: Public Health Issues in Tardive Dyskinesia, 137 AM. J. PSYCHIATRY 776, 777 (1980) (Some patients developed tardive dyskinesia after only a few months of medication exposure.); C. Thomas Gualtieri et al., Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic
Sometimes psychiatrists testified that they used a written advisement to inform patients about medication side effects. Typically, those so-called consent forms contained no information about risks but merely asserted that the prescribing physician had provided information about medication risks and benefits. Often those forms were used ritualistically to substitute for the process of obtaining informed consent rather than as evidence that informed consent was, in fact, obtained. A patient’s signature on such a form did not, in and of itself, provide adequate proof that the required information was disclosed and that the patient’s acquiescence was uncoerced.

Information about side effects was usually inadequate; but information about alternatives to medication was usually nonexistent. A biological approach—medication—was the therapy of choice, and it was the only choice. Other treatment modalities, including psychodynamic therapy, group therapy, marital and family therapy, and even milieu therapy, were not discussed. Although some psychiatrists and other mental health professionals might view these therapies as appropriate for some medication-protesting patients, the psychiatrists who testified in the hearings I conducted did not. Although some patients might have been receptive to treatment with these alternative therapies, they were not given that choice.

Some treating psychiatrists were rigid even in their choice of medication. For example, even if a patient complained of extrapyramidal symptoms from Prolixin®, the psychiatrist would continue to prescribe that medication instead of another phenothiazine, such as Mellaril®, which is less likely to cause extrapyramidal side effects, although more likely to cause anticholinergic side effects. If the

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Treatment, 14 J. PSYCHIATRY & L. 187, 201, 204 (1987) (Some patients on low-to-moderate doses of psychotropic medication experienced severe tardive dyskinesia after only a few weeks or months of treatment).

301. BARBARA A. WEINER & ROBERT M. WETTSTEIN, LEGAL ISSUES IN MENTAL HEALTH CARE 139 (1993).


303. Prolixin® is the Apothecon (a Bristol-Myers Squibb Company) brand of fluenazine hydrochloride. PHYSICIANS’ DESK REFERENCE, supra note 87, at 526.

304. Prolixin® is a high-potency medication that has primarily extrapyramidal side effects. Mellaril® is a low-potency medication that has primarily anticholinergic and sedating side effects. WALDINGER, supra note 2, at 418-19.

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therapeutic benefits of two medications are similar, shouldn’t the patient be given the choice of which side effects he or she is willing to endure to achieve that benefit?

The failure of psychiatrists to inform patients adequately of medication risks and alternatives was not limited to a few isolated incidents. It was pervasive. Although, surely, some psychiatrists made the required disclosures, those psychiatrists were the exception, not the rule. 305

Even Dr. Stone admits that typically the treatment decision is a fait accompli before the patient is given much information. The patient is simply pressured to conform promptly to that fait accompli. 306

How can the decisionmaker assess the patient’s competence when the psychiatrist has failed to provide the patient with required information about risks and alternatives to the proposed medication? One obvious answer is to find the patient competent. Even Dr. Appelbaum concedes that when patients are uninformed or inadequately informed, an assessment of their decisionmaking ability is almost always impossible. 307

When the psychiatrist’s breach of the information disclosure requirement renders an assessment of the patient’s competence impossible, the facility has not sustained its burden of proving the patient’s incompetence by clear and convincing evidence. The insufficiency of the evidence warrants a finding that the patient is competent. A finding of competence is also warranted to penalize inappropriate psychiatrist behavior and to induce future compliance with the disclosure obligation. 308

Nevertheless, in some cases, despite the psychiatrist’s failure

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305. In one hearing, the patient complained of side effects he experienced from Haldol®. The psychiatrist responded by expressing a willingness to prescribe Prolixin® or some other antipsychotic medication that might not produce the same side effects. The patient agreed to try the new medication. I found the patient competent, and the patient accepted the alternative medication.

306. Stone, supra note 16, at xii. A researcher in Ohio found that many patients remember what they are told about medications that were prescribed for them, but they were told very little. Typically, the only side effects mentioned were nausea and drowsiness. Lisa A. Callahan, Changing Mental Health Law: Butting Heads with a Billygoat, 4 BEHAVIORAL SCI. & L. 305, 314 (1986); see also Hargreaves et al., supra note 11, at 191 (Fewer than six of the 51 patients interviewed were able to state the benefits and risks of the prescribed medication.).

307. Appelbaum & Grisso, supra note 128, at 1637.

308. California statutes require that patients detained on 72-hour holds be informed of medication benefits, risks, and alternatives. These statutes specifically preclude release of patients for failure to provide the required information. CAL. WELF. & INST. CODE §§ 5152(c), 5213(b) (West Supp. 1995). Nevertheless, psychotropic medication
to provide required information, the available evidence clearly established the patient’s incompetence, and I so held. A hearing officer’s function is to determine the patient’s competence to refuse treatment, not to exact punishment for a psychiatrist’s transgression.

Undoubtedly, my consideration of evidence and my decisionmaking were influenced by the widespread nondisclosure practice. For example, in over 30% of the combined Group A and Group B cases, the patient testified that he or she did not trust, or was angry at, the psychiatrist. Typically, the psychiatrist testified that such hostility was due to paranoia—a symptom of the patient’s mental disorder. Before accepting such explanation, however, I attempted to determine whether the hostility was attributable to the psychiatrist’s refusal to involve the patient in the process of treatment decisionmaking. Was the patient’s hostility a rational response to the psychiatrist’s failure to provide information about medication risks and to address the patient’s concerns about those risks?

Similarly, when patients refused medication because they had previously experienced medication side effects, I was sympathetic to their concern. For example, during one hearing, the patient described and then demonstrated a dystonic reaction that he had suffered from medication. He was terrified by the experience. The patient’s concern was genuine and was based in reality. If he had been fully informed of other potential side effects, he probably would have been even more reluctant to accept medication. Although the patient had not considered the potential benefits of medication, I concluded that even if he had rationally considered them, he would not have changed his mind. Under such circumstances, I found the patient competent.

A patient’s prior experience with medication side effects or the failure of the psychiatrist to disclose other side effects did not always outweigh the patient’s failure to consider medication benefits. For example, in one case, the patient testified that he suffered side effects—“shaky nervousness,” dry mouth, and muscle stiffness—when previously treated with psychotropic medication. He refused medication now because he did not wish to suffer those side effects again. However, the patient had stopped eating, was suffering severe malnutrition, and was profoundly dehydrated. He claimed that he did not eat only because he lacked an appetite. Medication was prescribed to relieve the patient’s psychosis so that he would start eating and drinking. In this case, I found the patient

may only be administered to medication-refusing patients if they are found mentally incapable of refusing that treatment. Id. § 5332(b).

309. See supra note 264 (describing dystonic reaction).
incompetent. The patient's failure to consider how medication might benefit him could have disastrous consequences. Not only would his mental condition continue unimproved, but his physical condition would continue to deteriorate dangerously. Under such circumstances, the patient's failure to weigh medication benefits against medication risks was irrational.

IV. CONCLUSION: ASSURING COMPETENT PATIENTS THEIR RIGHT TO REFUSE TREATMENT

To implement the Riese decision in San Diego County, lawyers were appointed as temporary judges to conduct competency hearings. The legislature converted those judicial hearings into administrative capacity hearings but continued to require that the hearing officers be law trained. Hearings have been conducted, and are being conducted today, without significant problems or costs. Hearings are conducted within forty-eight hours of their request. The facility is represented by the treating psychiatrist or, if that individual is not available, by another treatment staff person who introduces into evidence the treating psychiatrist's declaration. The patient is represented by the public defender or the patient advocate. A typical hearing is completed within thirty to forty minutes, and, at the hearing's conclusion, the hearing officer announces a decision and reasons for the decision. Patients found incompetent can be treated without further delay. Although hearings are performed expeditiously, they are not performed perfunctorily. During a three-year period, law-trained decisionmakers in San Diego County found patients competent in 20 to 25% of the hearings.

Efficiency is but one consideration. More importantly, law-trained decisionmakers are needed to assure due process. Doctors are trained to diagnose and treat illness. When they assess a patient's capacity to refuse medication, they are unduly influenced by their own assessment of the medication's anticipated benefit to the patient they are treating.310 For this reason, they are not suited to serve as impartial judges of the patient's competence. Even Dr. Appelbaum admitted, "When physicians act as judges, they still tend to think like physicians."311

310. Zito et al., supra note 250, at 826.
311. Appelbaum, supra note 10, at 417; see also Hargreaves et al., supra note 11, at 191-92. When independent psychiatrists reviewed medication refusal decisions, they
My experience as a hearing officer confirms Dr. Appelbaum’s observation. Most psychiatrists equated incompetence with either their finding of mental disorder or the patient’s unwillingness to acknowledge mental disorder. When psychiatrists made a professional judgment that a medication was medically appropriate to treat the patient’s disorder, they often viewed any patient objections as irrational. They failed to consider whether the patient had made a rational assessment of risks, benefits, and alternatives, and to decide the patient’s competence using those criteria. Psychiatrists not only performed as biased judges, they practiced bias in relating to their patients. When psychiatrists withheld or otherwise manipulated information about risks and alternatives, they undermined their patients’ abilities to make competent decisions.312

The legislature has imposed on psychiatrists the duty to disclose to their patients the risks and benefits of, and alternatives to, psychotropic medications they prescribe.313 Psychiatrists must not be allowed to ignore or circumvent their disclosure obligation. The requirement of informed consent is not an interference with medical practice; it is a prerequisite to it. A law-trained decisionmaker can, and should, demand that the patient be provided with adequate information. When such information has not been provided, law-trained decisionmakers can, and in appropriate cases should, find that the evidence is insufficient to prove the patient’s incompetence.

The problem of information nondisclosure is not resolved, however, by the use of law-trained decisionmakers in capacity hearings. Those hearings are conducted only for patients who adamantly refuse treatment. Such patients are few in number. In San Diego County, during the

approved the administration of medication in 98.9% of the cases. Id. at 192. “The reviews did not reduce the average dose of antipsychotic medication received by involuntary patients, did not make it easier for patients to successfully refuse medication, and did not seem to be visible to patients as a new right or an improvement in their situation.” Id. at 191.

312. John S. Carroll, Consent to Mental Health Treatment: A Theoretical Analysis of Coercion, Freedom, and Control, 9 BEHAVIORAL SCI. & L. 129, 132 (1991); see also Roth, supra note 23, at 143 (“Information is given to patients largely to achieve their compliance, not to involve the patient in decision making.”). To make a competent decision, a patient must analyze relevant information in terms of his or her own knowledge, beliefs, and goals. Carroll, supra at 132.

313. CAL. WELF. & INST. CODE §§ 5152(c), 5213(b) (West Supp. 1995). These statutes require that risks and benefits of, and alternatives to, proposed medication be disclosed to involuntary mental patients during the initial 72-hour detention period. See also id. § 5332(a). In addition to requiring disclosure of information about risks, benefits, and alternatives, this statute requires disclosure of the patient’s right to refuse medication. See also id. § 5326.2 (West 1984) (listing the information that must be provided patients to obtain their informed consent); see supra text accompanying notes 138-39.
twelve-month period of July 1990 through June 1991, 4,077 patients were detained on seventy-two-hour holds and 1,904 patients were detained on fourteen-day holds. 314 During that twelve-month period, only 146 capacity hearings were conducted on the merits.315 The overwhelming number of patients either consented or did not object to treatment. Who demanded that psychiatrists meet their information disclosure obligation to these patients? There was no one. What safeguards assured that patient decisions accepting treatment were voluntary, informed, and competent? There were none.

The information disclosure requirement can be strengthened through litigation, legislation, and administrative regulation. For example: (1) Instead of allowing treatment to proceed on nonobjecting patients, written, informed consent should be required from any patient before treatment can be administered. Currently, voluntary mental patients must give such consent.316 Why should competent involuntary mental patients receive any less protection? (2) The forms used to document a patient’s consent are often inadequate. They merely state that the psychiatrist has disclosed required information. Those forms should be modified to require the psychiatrist to record the information that was actually disclosed. (3) When a psychiatrist medicates an objecting patient in an emergency, he or she should be required to justify the decision by documenting the specific facts that, in the psychiatrist’s judgment, warranted the coerced treatment. (4) The Patients’ Advocate, acting as the person responsible for ensuring that mental patients are afforded their rights, should be required to monitor the informed consent process, to investigate individual patient complaints of abuse, and to compel appropriate corrective actions.317

The coerced treatment of competent mental patients will not be eliminated solely by changes in laws or rules. What is needed is a change in attitude. Psychiatrists do not treat mental disorders; they treat

314. PERFORMANCE OUTCOME AND REPORTING SECTION, CALIFORNIA DEP’T OF MENTAL HEALTH, REPORT NO. 93-02, SUMMARY OF IN VOLUNTARY DETENTIONS IN COUNTY DESIGNATED FACILITIES AND STATE HOSPITALS FOR THE MENTALLY DISABLED, FISCAL YEAR 1990-91 (1993). Statewide, 78,548 adults (plus 5,717 children) were detained on 72-hour holds, and 33,266 patients were detained on 14-day holds during the July 1990 through June 1991 period.

315. RIESE HEARINGS STATISTICAL REPORT #3, supra note 233. Statewide data on capacity hearings is not available. See supra text accompanying notes 231-32.


317. Id. §§ 863(b), 863.1(a), 863.2(4)-(5).
people with mental disorders. Those people are entitled to make their own decisions. When patients refuse treatment, psychiatrists must resist the urge to pressure them into complying “for their own good.” Medical paternalism—doctor knows best—must be replaced by acceptance of patient autonomy—patient knows best. As Dr. Stone warned, the unwillingness of psychiatrists to accept “informed consent is symptomatic of a more serious disorder in the healing relationship.”

Grudging acceptance of patient autonomy is not enough. Psychiatrists should not merely defer to competent decisions of their patients, they should actively promote competent decisionmaking by their patients. Psychiatrists do so when they fully disclose information on the risks of, and alternatives to, the medication they prescribe. Patient empowerment is not only socially desirable, it is therapeutically desirable as well. Patient choice increases the patient’s satisfaction and confidence in the treatment process. Patient choice promotes the patient’s trust of, and confidence in, the therapist. A therapeutic alliance can not be achieved by forcing therapeutic compliance.

An American Psychiatric Association resource document, approved by the Association’s Board of Trustees, urges psychiatrists, as a matter of good medical practice, “to maximize the patient’s participation in the treatment decisionmaking process; and, if the patient registers objections, to try to understand the basis for these objections and take them into account in formulating a treatment plan.” If patient participation becomes the standard of medical practice, informed consent will no longer be a burden that the law imposes on psychiatrists, but rather, an

318. The American Psychiatric Association has cautioned that the classification of mental disorders does not classify people but only the disorders that people have. Thus, for example, a person with schizophrenia should not be referred to as “a schizophrenic.”


322. See Winick, A Therapeutic Jurisprudence Analysis, supra note 321, at 100-11 (discussing psychological research).

323. See id. at 111-16.

324. AMERICAN PSYCHIATRIC ASSOCIATION, RIGHT TO REFUSE MEDICATION RESOURCE DOCUMENT 3 (1989). Although the Resource Document was approved by the Board of Trustees, it does not represent official policy of the American Psychiatric Association.
opportunity for a true therapeutic alliance that psychiatrists willingly offer their patients.