Involuntary Patients' Right to Refuse Medication: Impact of the *Riese* Decision on a California Inpatient Unit

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On June 22, 1989, the California Supreme Court allowed the Appellate Court decision in the right to refuse treatment case, *Riese v. St. Mary's Hospital* to stand. The court ruled that absent a judicial determination of incompetence, antipsychotic drugs cannot be administered to involuntarily committed mental patients in non-emergency situations without their informed consent. Much concern was expressed by the California Psychiatric Association and the California Alliance for the Mentally Ill about the decision's negative impact on patient care. In this paper, the authors review the decision, elucidate the anticipated concerns about the impact of the decision, and then describe the decision's actual impact on an acute inpatient unit in California. The authors report that *Riese* hearings were held on 7 percent of admissions to their locked inpatient facility. Only 1 percent of the patients were found to be competent to refuse medications. The authors give clinical examples of patients who were affected by the *Riese* decision and review the benefits and risks of this decision from the perspective of actual clinical practice.

On June 22, 1989, the California Supreme Court allowed the Appellate Court decision in the right to refuse treatment case, *Riese v. St. Mary's Hospital*[1] to stand. Much concern was expressed by the California Psychiatric Association and the California Alliance for the Mentally Ill about the decision's negative impact on patient care. In this report, we will review the decision, elucidate the concerns, and then describe the decision's actual impact on an acute inpatient unit in California.

The Decision Appellant Riese had a history of chronic schizophrenia and one hospitalization in 1968. She was treated with Mellaril from 1969 to 1981 and did not need to be rehospitalized during that time. In 1981, she developed bladder problems associated with Mellaril and her medication was changed. She was rehospitalized in 1981 and 1982, and placed back on Mellaril. In 1984, she was placed on Moban and then decom-

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pensated. She was rehospitalized as a voluntary patient at St. Mary's Hospital in San Francisco on June 12, 1985, and signed an informed consent for antipsychotic medications. She was given Mellaril, then Moban, then Navane, and then Mellaril again. She complained of dizziness and dry mouth from the Mellaril and refused further medication. Subsequently, she became agitated and was forcibly injected. She then was made an involuntary patient on the basis of being violent and psychotic. She was switched back to Navane and given medications intramuscularly when she refused them orally. She complained that the Navane had adverse physical effects and agreed to take Mellaril. She was subsequently placed on a conservatorship and discharged to a board and care home. However, she needed readmission, and orders were written for intramuscular injections if she refused oral medications.

The court ruled that absent a judicial determination of incompetence, antipsychotic drugs cannot be administered to involuntarily committed mental patients in nonemergency situations without their informed consent. Furthermore, competence to consent to drug treatment was defined by three factors: (1) whether patients are aware of their situation; (2) whether patients are able to understand the benefits, the risks, and the alternatives to the proposed medication; and (3) whether patients are able to understand and evaluate information given to them for informed consent. The court stated that, in the absence of a clear link between an individual's delusions or hallucinations and his or her decision about taking medication, it should be assumed that the patient is utilizing rational thought.

Thus, the *Riese* decision gave involuntarily hospitalized patients the right to refuse medications except on an emergency basis. If patients refuse medication, they remain hospitalized on the involuntary civil commitment without medication until such time that there can be a judicial review. In our hospital, the review takes place twice a week.

Concerns of the California Psychiatric Association (CPA) In July 1989, the CPA sent a letter to California psychiatrists describing the *Riese* decision. The concern of the CPA was that California psychiatrists would no longer have the authority to treat acutely disturbed inpatients. There was also concern that patients would receive little more than preventive detention and that public beds, already in short supply, would be filled with patients who could not be safely released or referred to other facilities.[2]

Concerns of the California Alliance for the Mentally Ill (CAMI) CAMI was concerned that patients who were involuntarily detained would be denied immediate medication. They pointed out that, under the *Riese* decision, treatment would be postponed at a patient's request until a judiciary hearing could be held.[3]

Thus, the concerns of both the CPA and the CAMI were that patients would have to suffer a delay in getting treatment because of a delay in having judicial hearings after admission or would

be denied treatment altogether because they would be considered competent although psychotic. This latter concern is similar to the arguments made in other right to refuse treatment cases, i.e., that, in the interest of civil liberties, patients would be allowed to "rot with their rights on."

Impact of Decision on Our Inpatient Unit Our inpatient service is a 16-bed locked unit in a university psychiatric hospital. The average length of stay is 17 days, and over 90 percent of the patients are admitted on emergency civil commitments ("72-hour holds") as a danger to themselves, a danger to others, and/or gravely disabled (unable to provide food, shelter, or clothing for themselves).

During the first 17 months after the *Riese* decision was put into effect, there were 444 admissions to the unit. *Riese* hearings were held on 32 patients (7 percent). During the 32 hearings, four patients (1 percent of all admissions) were found to be competent, and 28 were deemed incompetent to refuse medications.

These figures imply that the *Riese* decision had little impact on clinical decision-making, i.e., that most patients agreed to take medications and did not need *Riese* hearings; or if they had *Riese* hearings, they were found incompetent and subsequently were treated appropriately with medications. However, these figures represent an underestimation of the impact of the *Riese* decision on the inpatient unit. For many cases, there was discussion in the treatment team meeting that the patient needed but refused medication. Nevertheless, because of experience with prior *Riese* hearings, the staff felt confident that the patient would be judged competent at the hearing. In those cases, staff did not contest the patients' medication refusal and a hearing was not held because it was considered to be a waste of time.

Clinical Examples

Pairings of Different Findings in Probable Cause (for Commitment) and* Riese *Hearings (for Competency) In our hospital, the "probable cause hearings" to determine whether there is probable cause to involuntarily commit patients for an additional 14 days of treatment, after their 72-hour hold expires, are held twice a week. The *Riese* hearings are done on the same days. In practice, patients would first have a probable cause hearing. If they were released, there was no need for a *Riese* hearing. Only if the patient were civilly committed by the commissioner were the *Riese* hearings held. Thus, some patients were released although we felt they should be both committed and medicated. In other situations, the patients were civilly committed in the probable cause hearing and judged incompetent in the *Riese* hearing. Some patients, however, were civilly committed but were then considered competent to refuse medication. Examples of each will be given.

Mr. A. was considered by the staff to be a danger to others and gravely disabled. He was also thought to be incompetent to refuse medications, but he was released at his probable cause hearing and never had a *Riese* hearing.

Mr. A is a 41-year-old divorced man with a two-year history of bipolar affective disorder.

He was picked up by the police for confusion, disorientation, and drinking out of flower vases. He was belligerent and said that he would put bazookas around his son's elementary school to defend his son from evil. Mr. A agreed to take lithium but refused all neuroleptics. He blamed his previous treatment with haloperidol for the fact that he had signed papers allowing his wife to have custody of their children. He felt that this decision had been caused exclusively by taking haloperidol. In the probable cause hearing, the commissioner ruled that he did not meet the criteria for commitment as either a danger to others or gravely disabled. Mr. A left the hospital against medical advice. Four days later, there was an article about Mr. A in the local newspapers. The article stated, "An angry motorist deliberately slammed into six cars on the [highway]. . . . He was angry because his wife was awarded custody of his son and wouldn't allow him to visit."

Ms. B was considered by the staff to be gravely disabled and incompetent. She was deemed holdable at her probable cause hearing and incompetent at her *Riese* hearing.

Ms. B is a 65-year-old woman with paranoid schizophrenia for 25 years. She was admitted because she had stopped her neuroleptics three months prior to admission and subsequently had become agitated and delusional about the people in her Board and Care Home. She felt that the food was poisoned, and she howled at night like a wolf. The Board and Care operator told her that she could no longer remain in the Board and Care Home. In the hospital, Ms. B refused to take fluphenazine because it was "made by aliens from outer space." She denied mental illness and said that the Marine Corps told her she doesn't need medication. At her probable cause hearing, the commissioner decided that Ms. B met the criteria for grave disability and gave the hospital the authority to continue to hospitalize her. At her *Riese* hearing, the commissioner judged that she was incompetent, and we were authorized to give her medications. After two weeks of treatment with neuroleptics, Ms. B became much less delusional and was returned to her Board and Care Home.

At her probable cause hearing, Ms. C was committed as gravely disabled. However, at her *Riese* hearing, she was deemed competent to refuse medications.

Ms. C is a 49-year-old woman who was admitted because she threatened to chop up her boyfriend with a machete. She was agitated and irritable and was noted to have looseness of associations. She was judged by the commissioner to be gravely disabled because she did not have a home to which she could return. She refused lithium or low dose neuroleptics because, she said, she had seen other patients on medications and they looked like "zombies." She was judged competent to refuse medications. She was kept in the hospital for a brief period and then was released. The staff felt that she had received very little treatment and that her prognosis was terrible.

Inappropriate or Incomplete Treatment

Some patients received inappropriate or incomplete treatment as a result of the *Riese* decision.

Ms. D is a 40-year-old single women with graduate degrees and a diagnosis of schizoaffective disorder. She had three hospitalizations in the last six months precipitated by noncompliance with her medication regimen. She was grandiose and stated that she had European royal blood. She believed that a man whom she had not seen for 10 years was in love with her and wanted to marry her. She was assaultive to her elderly parents and had auditory hallucinations. The patient agreed to take "Prolixin" up to 20 mg but refused to take "fluphenazine." The staff wanted to treat her with lithium, carbamazepine, or clonazepam but the patient refused. She also refused to take more than 20 mg of "Prolixin," although the staff felt that she had an inadequate response to this dose of medication. A *Riese* hearing was held because the staff wanted to institute one of these alternative treatments to improve her prognosis. Ms. D. was judged competent to refuse these alternatives because she was

agreeing to some medications (i.e., the Prolixin up to 20 mg) that could be used for treatment of her disorder.

Similarly, Ms. E is a 30-year-old married woman who has a diagnosis of schizoaffective disorder. She was delusional about her grandmother and husband trying to torture her. She was also labile and irritable. She agreed to take neuroleptics but refused to consider lithium treatment. She was considered competent at her *Riese* hearing since she agreed to take some medication. Ms. E was discharged to outpatient follow-up, but needed to be readmitted six months later. This time she was admitted after keeping a knife under her pillow and threatening her family. She agreed to lithium treatment and did much better than in her prior admission with decreased delusions and paranoia.

Uninformed Assent We had several patients who gave uninformed assent rather than informed consent for medication. In San Francisco County, the *Riese* decision is interpreted so that only patients who refuse medication are entitled to a *Riese* hearing. In deciding how to institute the *Riese* decision, a meeting was held involving the public defenders and the city attorney. It was decided that the *Riese* decision could be interpreted in two ways. One way was as a decision related to informed consent, and the other way was as a right to refuse treatment case. It was decided that the *Riese* decision would be interpreted as a right to refuse treatment decision and, thus, would protect people who refused treatment. This interpretation was also made for practical reasons, i.e., to keep the number of hearings down because of limited resources and also because the assumption was made that patients who agreed to medication but did not know what they were signing would most probably be deemed incompetent at the *Riese* hearings anyway (personal communication from the San Francisco public defender's office mental health division, January 10, 1991).

Two examples of patients who gave uninformed assent but were not given *Riese* hearings are:

Mr. F is a 66-year-old man with a history of alcoholism and dementia. He was picked up by the police after eating out of a can of cat food. He was unkempt, inarticulate, oriented to person but not to place or time, and very agitated, including banging on the walls. He "agreed" to take low-dose neuroleptics that were used to control his agitation.

Ms. G is a 70-year-old woman who was admitted after she attacked her developmentally disabled daughter. Her diagnosis was dementia with delusional features. She was oriented only to person and was assaultive, threatening, and delusional. She "agreed" to take neuroleptics.

Fluctuating Competence Some patients had fluctuating competence. These patients were difficult to manage because, at times of competence and agreement to take medications, a *Riese* hearing was unnecessary. However, at other times, the patient seemed incompetent and needed a hearing.

Ms. H is a 42-year-old married woman who lived with her husband and teenage daughter. Her diagnosis is schizoaffective disorder exacerbated by her increased alcohol consumption. Before admission, she left the gas on in her home and had pressured, loud speech. She was paranoid and internally preoccupied. On admission, she refused a physical exam. The following day, she agreed to a partial physical exam, but refused to have her blood drawn. At times she would allow vital signs to be taken, but at other times she would refuse. She verbally agreed to take fluphenazine by mouth, but then refused fluphenazine decanoate, saying that she had recently received an injection. Her family and her outpatient therapist stated

emphatically that she had never received an injection. She refused to discuss her medications with her doctor or the reason for her opposition. The commissioner judged her incompetent during the *Riese* hearing, since she appeared incompetent at that point in time. However, at other points in time, e.g., when she appeared cooperative with treatment, she probably would have been judged to be competent.

Discussion

The *Riese v. St. Mary's Hospital* decision is an attempt by the court to protect patients' rights. Those concerned about the decision feared that patients would be confined in hospitals without appropriate treatment. Our experience suggests that the decision did not lead to a significant protection of patients' rights. Nor did it expand significantly the number of patients hospitalized without treatment.

Most of the involuntary patients on our unit either agreed to take medications, met the criteria for emergency treatment, or had a *Riese* hearing and were judged incompetent to refuse medications. This is similar to studies[5,6] from Massachusetts where the *Rogers v. Commissioner*[7] decision attempts to protect patients' right to refuse medications. As in Massachusetts, only a minority of our patients (7 percent) refused antipsychotic medications and needed a judicial review. Only 1 percent of our patients were judged competent to refuse medications.

Our experience is that patients were not left to "rot with their rights on." This was partially because hearings were held twice a week and paired with the "probable cause hearings" for continued involuntary commitment. The hearings took place often enough so that patients were not left unmedicated for extended periods. The pairing with the involuntary hospitalization hearings meant that, in most cases, a patient met the criteria for involuntary hospitalization and was incompetent, or did not meet the criteria for involuntary hospitalization and was released from the hospital so that the issue of competency was irrelevant because the patient was no longer our patient. Anticipated problems were actually realized in only a few cases, i.e., some patients were committed for involuntary hospitalization but were then found competent to refuse medication and thus could not be medicated.

However, the issue of judicial review for competency to consent to medications did lead to unforseen problems. One problem was related to the fact that the court wound up making decisions about type of treatment, which sometimes led to inappropriate or incomplete treatment (e.g., is lithium really necessary for this patient?). In addition, the interpretation of the *Riese v. St. Mary's* decision in San Francisco does not adequately deal with the issue of "assent" by probably incompetent patients or by patients with fluctuating competence. This leaves the clinician in the position of giving medication to patients who do not understand the risks and benefits. This uncomfortable experience has been described by prior authors commenting on the Massachusetts experience.[8] This category of assents has also been rejected by the Supreme Court in the *Zinermon*

v. Burch decision;[9] yet, in at least our county in California, assenters are not entitled to *Riese* hearings.

When decisions are made by legislators and judges about issues related to the right to refuse treatment and informed consent, many mental health professionals are concerned that the decisions do not take into account the realities of severe mental illness and the benefits of antipsychotic medication. In addition, it is often difficult to predict the impact of a judicial decision on the treatment of severely disturbed patients, e.g., on an inpatient unit that treats these patients. It is hoped that this article will convey the clinical experience of treating severely disturbed patients on an inpatient unit after the institution of the *Riese* decision.

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