IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

ELEANOR RIESE, et al.,

Appellants,

vs.

ST. MARY'S HOSPITAL AND MEDICAL CENTER,

Respondent.

No. S004002

BRIEF OF THE CALIFORNIA NETWORK OF MENTAL HEALTH CLIENTS, THE NATIONAL ALLIANCE OF MENTAL PATIENTS, AND MENTAL HEALTH CONSUMER CONCERNS AS AMICI CURIAE IN SUPPORT OF APPELLANTS, ELEANOR RIESE, ET AL.

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

After Judgment of the Superior Court of the State of California, City and County of San Francisco--No. 841488

Honorable Raymond D. Williamson, Jr., Judge

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STATEMENT OF INTEREST

The California Network of Mental Health Clients (the Network) is a statewide, non-profit, self-help network comprised entirely of people who have had personal, first-hand experience as patients in the mental health system. Most of its members have experienced the personal effects of psychotropic drugs. Some members have chosen to take these drugs and some have not, although it is a principle of the Network that to do so is a personal decision left up to the individual. The Network has offered technical assistance and training for the development of many effective, self-help alternatives to traditional psychiatric treatments throughout the state. They have also created a Public Policy Program by which they educate the government, the public, and other mental health constituency groups about the interests and concerns of mental health clients.

The National Alliance of Mental Patients (NAMP) is a nation-wide, non-profit self-help organization run by and for people who have personal experience as patients in psychiatric hospitals. One of its goals is to further the development of user-controlled alternatives to the traditional mental heatlh treatment system including peer support groups, drop-in centers, and independent housing. Many of NAMP's efforts are geared toward fighting the discrimination often experienced by patients and former patients within the mental health system.

Mental Health Consumer Concerns (MHCC) is a consumer-run, non-profit corporation which provides advocacy services and training to clients, educates the public and mental health professionals, and fosters self-help alternative programs in the

northern California area. One of its programs has been entiled "Striving to Instill Greater Mutual Awareness" (STIGMA) by which they have tried to alert the public to the many false, stigmatizing attitudes and beliefs towards mentally disabled people that are often held by the public and are perpetuated by the media. MHCC also contracts with Contra Costa County to provide state-mandated patients rights advocacy services to mental health clients. See Calif. Welf. & Inst. Code Sections 5500 et seq.

INTRODUCTORY STATEMENT

Mental Health clients are uniquely and painfully aware of the widespread distrust and discrimination that awaits any person who has been unfortuante enough to suffer the effects of involuntary treament. This discrimination effects every area of their lives including housing, employment and education. Perhaps nowhere is the stigma felt more keenly than on the wards of mental hospitals where clients often experience the most fundamental affronts to their dignity. Not only are they frequently deprived of choices that many of us take for granted, but they are treated as if they are not even capable of knowing what can help them or what can harm them. LPS was enacted to combat the notion that one leaves these fundamental rights and choices at the door of the psychiatric ward.

Eleanor Riese and other mental health clients do not, as St. Mary's Hospital and Medical Center ("St. Mary's" or "Hospital") suggests, "invite this court to create a medical battle where none exists." (Petitioner's Brief on Merits, p. 11.) There is no medical debate over the probability of substantial

risks that await any person who is given antipsychotic drugs, whether they be given short-term, cumulatively through repetitive hosptializations, or through long-term hospitalizations or outpatient treatment. But more importantly, Eleanor Riese and other mental health clients would like this Court to recognize that regardless of medical opinion, the right to give informed consent is not within the province of the medical professional, but is a distinct function "reserved to the patient alone". Cobbs v. Grant, (1972) 8 Cal.3d 229, 243. "It is the patient, not the professional, who must cope with being transformed into a grimacing puppet. If, indeed, the tradeoff is reasonable, it is the patient who must make the choice." (Statement of Judi Chamberlin, Doudera & Swazey, "Refusing Treatment in Mental Health Institutions--Values in Conflict," at 165, American Society of Law & Medicine, AUPHU Press, (1982).)

I. THE LPS ACT SCRUPULOUSLY PROTECTS THE DIGNITY AND PRIVACY RIGHTS OF HOSPITALIZED PSYCHIATRIC PATIENTS BY UPHOLDING THEIR FUNDAMENTAL RIGHTS OF INFORMED CONSENT.

In one of the statements of legislative intent contained within the LPS Act itself, the Legislature listed as one of the paramount rights of mental patients the "right to dignity, privacy, and humane care." Cal. Welf & Inst. Code Section 5325.1 (b).[1] Moreover, it is well established under California constitutional and common law that the right to weigh the risks and benefits of a medical treatment and the right to consent to that treatment belongs to the patient and not to the doctor. In

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[1]All statutory references are to the Welfare and Institutions Code unless otherwise indicated.

the landmark case of Cobbs v. Grant (1972) 8 Cal. 3d 229, this Court concluded "The weighing of these risks [of treament] against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgement reserved to the patient alone." Id., at 243. Likewise, in Bouvia v. Superior Court (1986) 179 Cal.App.3d 1127, the Court recently noted:

> The right to refuse treatment is basic and fundamental. It is recognized as a part of the right of privacy protected by both the state and federal constitutions. Its exercise requires no one's approval. It is not merely one vote subject to being overridden by medical opinion.

Id. at 1137. (Citations omitted).

Similarly, in Bartling v. Superior Court (1984) 163 Cal.App.3d 186, the court stated:

> The right of a competent adult patient to refuse medical treatment has its origins in the constitutional right of privacy. This right is specifically guaranteed by the California Constitution (art. I, Section 1).... The constitutional right of privacy guarantees to the individual the freedom to choose to reject, or refuse to consent to, intrusions of his bodily integrity.... [I]f the right of the patient to self-determination as to his own medical treatment is to have any meaning at all, it must be paramount to the interests of the patient's hospital and doctors.

Id. at 195 (emphasis added).

The Court of of Appeal below correctly recognized the importance of protecting the fundamental autonomy rights of patients:

> Unless the incompetence of a person refusing drug treatment has been judicially established, "it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is

> accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires."

196 Cal.App.3d at 1409, quoting Rivers v. Katz (N.Y.1986) 495 N.E.2d 337, 341.

Numerous other courts which have recognized the right to refuse psychiatric drugs stressed the patient's right to decide as fundamental to their conclusions. For example, the Wisconsin Supreme Court noted:

> The whole purpose of the development of the law outside the field of mental competency has been to recognize that the patient through informed consent makes the choices of bodily treatment. Medical doctors advise the patient on available courses of treatment, but it is the patient who ultimately consents to the treatment. As long as a person is competent to make such choices which do not affect others, then that individual should be allowed to decide whether to receive such a drastic form of treatment.

State ex rel. Jones v. Gerhardstein (Wis. 1987) 416 N.W.2d 883, 895.

Similarly, the Oklahoma Supreme Court has noted:

> It is also difficult for any person, even a doctor, to balance for another the possibility of a cure of his schizophrenia with the risks of permanent disability in the form of tardive dyskinesia. Whether the potential benefits are worth the risks is a uniquely personal decision which, in the absense of a strong state interest, should be free from state coercion...If the law recognizes the right of an individual to make decisions about her life out of respect for the dignity and autonomy of the individual, that interest is no less significant when the individual is mentally or physically ill. Because the patient will be the one to suffer the consequences she must have the power to make the decision.

In re K.K.B (Okla. 1980) 609 P.2d 747, 750-52 (emphasis added).

And, the Minnesota Supreme Court recently stated:

> Indeed, the final decision to accept or reject a

> proposed medical procedure and its attendant risks is ultimately not a medical decision, but a personal choice. (Emphasis in orignial) ...It is a doctor's obligation to explain to the patient the diagnosis and proposed method of treatment. The informed patient then decides whether to consent to the treatment in whole or in part. The doctor may recommend, but does not dictate the final decision.
>
> ...To deny mentally ill individuals the opportuntity to exercise that right is to deprive them of basic human dignity by denying their personal autonomy.

Jarvis v. Levine (Minn. 1988) 418 N.W.2d 139, 148 (footnote ommitted, emphasis added.)

"The principle which supports the doctrine of informed consent is that only the patient has the right to weigh the risks attending the particular treatment and decide for himself what course of action is best suited for him." Davis v. Hubbard (N.D. Ohio 1980) 506 F. Supp. 915, 932 (footnote omitted). The Davis court continued as follows:

> The very foundation of the doctrine [of informed consent] is every man's right to forego treatment or even cure if it entails what for him are intolerable consequences of risks, however warped or perverted his sense of values may be in the eyes of the medical profession, or even of the community, so long as any distortion falls short of what the law regards as incompetency. Individual freedom here is guaranteed only if people are given the right to make choices which would generally be regarded as foolish.

Id., quoting 2 F. Harper & F. James. Jr., The Law of Torts 61 (1968 Supp.) (emphasis in original).

Several distinguished commentators in this area have also recognized that "[u]nless patients are viewed as having the right to say no, as well as yes, and even yes with conditions, much of the rationale for informed consent evaporates." Applebaum, Lidz & Meisel, Informed Consent: Legal Theory and Clinical Practice

(1987) at 190. "Whether or not the trade-off between treatments--or between the choice of treatment and no treatment--is roughly equivelant in medical terms, however, our society has given competent patients the right to make that choice." Id., at 195.

The only exception to this principle is that in a bonafide emergency, consent by the patient is implied, not given. "Of course the general rule requires consent of the patient, but consent may be implied...by an emergency." Preston v. Hubbell (1948) 87 Cal.App.2d 53; see also Wheeler v. Barker (1949) 92 Cal.App.2d 776, 785; Cobbs v. Grant, 8 Cal. 3d at 243.

Even when a patient is incompetent, due to minority or disability, the right to give consent to medical treatment is not a medical decision, but a personal one to be rendered by a properly authorized substitute decision maker. Cobbs v. Grant, 8 Cal.3d at 244; see also Conservatorship of Valerie N. (1985) 40 Cal.3d 143; Foy v. Greenblott (1983) 141 Cal.App.3d 1; Conservatorship of Drabieck (1988) ____Cal.App.3d, 88 C.D.O.S. 2411, review denied July 28, 1988; 58 Ops.Cal.Atty.Gen. 849 (1975).

The Legislature has prohibited the application of a different set of standards for physicians when they are treating persons with mental disabilities. St. Mary's would like this court to adopt the unprecedented position that competence is of no importance whatsoever, and that competent people can be forcibly drugged in nonemergencies without any judicial review. Such an interpretation of the LPS Act undermines the official statement of legislative intent which guarantees to patients the

same legal rights and responsibilities under federal and state constitutions and laws as any other person. See Section 5325.1.

The Legistature also mandated that "... treatment should be provided in ways that are least restrictive of the personal liberty of the individual." (Section 5325.1 (a), emphasis added.) It would be ludicrous to suggest that the nonemergency forced injection of Thorazine (while five staff members wrestled her to the floor,) was less restrictive to the personal liberty, privacy and dignity of Eleanor Riese than would have been a respectful inquiry into her concerns and opinions about her treatment.

II. THE DRAFTERS OF THE LPS ACT NEVER ENVISIONED THE WHOLESALE USE OF FORCED MEDICATION AS THE PRIMARY MODE OF "TREATMENT" FOR PERSONS ON 72 HOUR AND 14 DAY HOLDS.

St. Mary's, characterizing antipsychotic drugs as the only appropriate treament for most patients on 72 hour and 14 day holds, maintains that when the legislature authorized short-term involuntary detention, that it also intended to give to doctors the unmitigated authority to force unwanted medications upon their patients. The authors of the LPS Act never envisioned that such wholesale usage of psychotropic drugs would result from the passage of the Act. In fact, the drafters of LPS were outspokenly critical of such practice. In the principle background document underlying the passage of the Act it was found that two-thirds of the patients in California mental hospitals were treated with psychotropic drugs, a practice criticized as excessive. The Dilemma of Mental Commitments in California, Subcommittee on Mental Health Services, Assembly Interim Committee on Ways and Means (1967) (hereinafter "Subcommittee Report") at 67.) A report

by the California Medical Association, cited with approval in the Subcommittee Report stated: "There seemed to be excessive over-reliance on drug therapy which represents to us an attitude of benign restrictiveness and lack of patient orientation." (Id.) The Subcommittee also soundly criticized the overreliance on medication, instead emphasising the need for individualized treatment:

> Another treatment problem stems from the fact that the "mentally ill" concept has apparently produced a mental health system which provides highly traditional medical types of service which do not focus on the non-medical problems that may be at the root of the disturbed person's difficulties. This is a particularly serious issue since most of the patients are from very low socio-economic groups and often have many nonpsycho-logical, physical, employment, housing and other practical problems....Physicians, judges, nurses psychiatric technicians, and social workers appear to be guided by the psychiatric medical model and a limited notion of 'treatment."

Subcommittee Report at 75.[2]

The drafters of the Act envisioned a diverse range of voluntary services to be made available to patients. See Subcommittee Report at 84-86. In enacting LPS, the Legislature mandated that this broad range of services be offered and made available to persons under 72 hour and 14-day holds. See Section 5008 (a),(c),(d),(e). Thus, St. Mary's position that all patients on short-term holds must be drugged is in stark contrast to the clear legislative intent and mandate to provide individualized

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[2]In fact, ten years after the passage of the LPS act, the Assembly Office of Research ("AOR") published a report that found that the medical profession had still shown a strong reluctance to acknowledge the adverse effects of psychotropic drugs. "The Use and Misuse of Psychiatric Drugs in California's Mental Health Programs," AOR No. 31, at 17 (1977) (Hereinafter, " Assembly Report.")

treatment services.

III. ARGUMENTS OF TREATMENT "EFFICACY" ARE INSUFFICIENT TO JUSTIFY THE FORCED DRUGGING OF MENTAL HEALTH CLIENTS.

St. Mary's relies primarily upon arguments of treatment "efficacy" to justify the involuntary administration of antipsychotic drugs on psychiatric patients. This limited approach reflects a total misunderstanding of the nature and importance of the therapeutic alliance.

As the Colorado Supreme Court has noted, "because the therapeutic value of antipsychotic medication depends upon the existence of a trusting relationship between the patient and the psychiatrist the patient's willingness to submit to the medication can only be viewed as a vital component of any effective treatment program." People v. Medina, (Colo. 1985) 705 P.2d 961 n.6, citing Davis v. Hubbard, 506 F.Supp. at 936. Requiring the physician to explain the proposed treatment to the patient and to listen to the patient's reasons for not wanting to take the proposed medication is likely to enhance communication between the two and improve doctor's practices in prescribing medications. See Diamond, Drugs and Quality of Life: The Patient's Point of View, 46 J. Clinical Psychiatry 29 (1985).

Moreover, as the Wisconsin Supreme Court recently noted, "all professional literature indicates that obtaining prior informed consent makes treatment using psychotropic drugs more effective and rapid than when they are forced on an individual." Wisconsin ex rel. Jones v. Gerhardstein, 416 N.W.2d at 890. Other courts have recognized that "involuntary treatment is much less effective than the same treatment voluntarily received," Rennie

v. Klein, 462 F.Supp. at 1144, and that "it is more likely that a patient will consent to desirable treatment when consulted before action is taken, and when he feels he has some real control over his fate, than when he feels totally at the mercy of the hospital doctors." Id. at 1144-45. In fact, a recent study commissioned by the California Department of Mental Health shows that many individuals actually flee the system and avoid receiving mental health services due to fears that involuntary treatment may result if they seek such services. (Campbell & Schraiber, The Well-Being Project Draft Report, California Department of Mental Health, Office of Prevention, p. 18 (1987).)

There is an inherent conflict of interest for a doctor who is prescribing a treatment to be the party who consents to the treatment, especially where, as here, the doctor also has the power to involuntarily confine the person.[3]

Moreover, the psychiatric profession has shown itself to be poorly suited to weigh the benefits and the risks for the patients. As the Assembly Office of Research noted:

> The adverse reactions that psychiatrists frequently consider mild are often extremely distressing to the patient. While some of these adverse reactions are easily controlled, the drugs used to control them have their own adverse reactions. Psychiatrists often state that since shcizophrenia is such a severe disease, the frequently occurring adverse reactions

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[3]As the Court of Appeal has noted: "There are sound reasons why the treating physician's assessment of his patient's competency ... may not always be objective." Aden v. Younger, (1976) 57 Cal.App.3d 662, 683.) A number of other courts have also recognized that psychiatrists have competing interests which argue against their being given the sole authority for making treatment decisions as urged by St. Mary's. See e.g., In re Mental Commitment of M.P. (Ind. 1987) ____ N.E.2d 645, 647; Rogers v. Comm'r of the Dep't of Mental Health (Mass. 1983) 458 N.E. 2d 308, 317-18 & 19.

> are a small price to pay. Such an assessment is reasonable only on two conditions; first, that the informed patient and not the psychiatrist make the decision on respective costs and benefits...[T]he second condition is that prescribing practices be rational....

Assembly Report at 16.

It is also firmly established that there is a high degree of error in psychiatric diagnoses. See e.g., Conservatorship of Roulet (1979) 23 Cal.3d 219, 230; In re Roger S. (1977) 19 Cal.3d 921, 929; O'Connor v. Donaldson, (1975) 422 U.S. 563, 579, 584 (Burger, C.J., concurring); Doe V. Gallinot (C.D. Cal. 1979) 486 F.Supp. 983, 992; Ennis & Litwak, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom (1974) 62 Cal.L.Rev. 693, 699-708. Furthermore, evidence suggests that significant numbers of mental health clients who are held on 14 day involuntary holds do not even meet the commitment criteria. A recent study by a California Certification Reveiw hearing offices (See Welf. & Inst. Code Sections 5256 et seq.) revealed that 37.1% of all hearings conducted by San Diego County hearing officers resulted in findings that probable cause did not exist to justify involuntary commitment. See Morris, Civil Commitment Decisionmaking: A Report on One Decisionmaker's Experience, 61 So.Cal.L.Rev. 291, 331 (1988).

St. Mary's mischaracterizes the thrust of Eleanor Riese's argument as stating that notwithstanding the efficacy of medications, the drugs are potentially damaging. (Petitioner's Brief on the Merits, p. 8.) More accurately, the main thrust of her argument is that beneficial or not, harmful or not, she, and only she was in the position to weigh the benefits and the risks.

Ms. Riese demostrated her ability to make this kind of analysis by reporting her preference for one medication over another, reporting symptoms of the drugs being given her by the Hospital, and by attempting to have input into the proper dosage. The legislature never intended that capable, competent individuals would have no choice in what happens to their bodies or their minds.

In fact, St. Mary's makes no claim that it even attempted to negotiate with Ms. Riese or respect her evident ability to participate in treatment decisions. Hospital simply asserts that they did not have to.

St. Mary's claim that most patients' refusal to take a medication is symptomatic of the very condition that led to the involuntary commitment in the first place is wholly unsupported.[4] It is this very approach of lumping people together that results in the stripping away of the dignity of mental health clients and offends the principles of individualization and voluntarilness which are at the heart of LPS. As one former patient observed:

> Some patients consider themselves to be in emotional distress; others are reasonably satisfied with their lives. Once subjected to "treatment," however, both groups are required to see themselves as "sick" and

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[4]Contrary to St. Mary's claims (see Petitioner's Brief on Merits at 29-30, 37), many of the class members, like Eleanor Riese, refuse medications for valid reasons which are not the result of delusional behavior. As stated by the highest court in New York, mental illness "often stikes only limilted areas of functioning, leaving other areas unimpaired, and consequently ...many mentally ill persons retain the capacity to function in a competent manner." Rivers, v. Katz, 495 N.E.2d at 342 (citations omitted). See also, Davis v. Hubbard, 506 F.Supp. at 927 [roughly 85% of patients are capable of rationally deciding whether to consent to the use of psychotropic drugs]; Rogers v. Comm'r, 458 N.E.2d at 313 [a person may be competent to make some decisions, but not others].

> "treatment" as helpful. Patients who persist in calling mental hosptials prisons and the people who work in them jailors are commonly considered by mental health professionals to be displaying "symptoms" requiring further "treatment."

Statement of Judi Chamberlin, Doudera & Swazey, supra, at 165.

IV. THE CONDITIONS LEADING TO INVOLUNTARY COMMITMENT UNDER SECTIONS 5150 AND 5250 DO DO NOT EQUAL THE TYPE OF EMERGENCY REQUIRED TO OVERRIDE A PATIENT'S RIGHT TO INFORMED CONSENT.

Mental health clients are not detained because they are incapable of making their own treatment decisions or because there is an emergency justifying forced drugging. See Calif. Code of Regulations, Title 9, Section 853. The fact that a person may be unable to meet their basic needs for food, clothing or shelter, or that they may be suicidal, does not alone justify nonemergency forced drugging. In recognition of this fact, numerous courts have formulated narrowly tailored emergency exceptions to the requirement of informed consent which are similar to that adopted by the Court of Appeal below. See e.g., Rivers v. Katz, 495 N.E. 2d at 343; Rogers v. Comm'r, 458 N.E. 2d at 321-22; Gerhardstein, 416 N.W. 2d at 894; Opinion of the Justices, 465 A. 2d at 489. "Given the alternatives available in non-emergencies, subjecting a patient to the humiliation of being disrobed and then injected with drugs powerful enough to immobilize both body and mine is totally unreasonable by any standard." Rogers v. Okin (D.Mass.1979) 478 F. Supp. 1342, 1369, aff'd in part, rev'd in part (1st Cir. 1980) 634 F.2d 650, vacated & remanded sub. nom. Mills v. Rogers (1982) 457 U.S. 291.

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V. PSYCHOTROPIC DRUGS OFTEN IMPAIR RATHER THAN FACILITATE A PATIENT'S ABILITY TO FUNCTION INDEPENDENTLY.

A recent article describes the experience of a medical student who received only 1 milligram of halperidol (haldol) intramuscularly as a volunteer in a research study:

> The student developed what he described as a "slowly increasing anxiety" which focused on the idea that he "could not possibly sit still" for the rest of the experiment.
>
> "I could not concentrate." he said. "As soon as I could move, I fould myself pacing up and down the lab, shaking and wringing my hands. When I stopped moving, the anxiety increased."
>
> The akathesia resolved approximately 17 hours after the haloperidol was administered. The student reported that it had been an extremely dysphoric experience characterized by the "sense of a foreign influence" forcing him to move.

Friedman, et al., Akathisia: The Syndrome of Motor Restlessness, 35 Family Physician 145, 146 (Feb. 1987).

The description of the subjective distressing experience of the medical student above is completely consistent with the experience of many of the Network's members and others who are or have been exposed to these drugs. In one of the few studies documenting the validity of the subjective complaints of mental health clients, respondents complained that the medication:

> "keeps me closed in, It puts me in another state of mind ... makes me feel spacey." Another subject said the drug "intensifies my fears." Other dysphoric responses included: "It (the drug) takes me away from my normal state of mind," "slows my thinking," "makes me panic" ... "My whole body feels sike a physical prison."

Van Putten, et al., Response to Antipsychotic Medication: The Doctor's and the Consumer's View, 141 Am. J. Psychiatry 16-17 (1984).

A similar report of some of the disturbing effects of psychotropic drugs was noted by the Colorado Supreme Court:

> Indeed, Goedecke's reason for refusing prolixin treatment was that he had previously been treated with the drug and had experienced some of its short-term adverse side effects, including passing out, falling down, loss of breath, stiff tongue, disordered thinking and a feeling like being "half dead."

Goedecke v. State Dept of Institutions (Colo. 1979) (en banc) 603 P.2d 123, 124.

One former patient described her subjective experience of Thorazine the following way:

> I am taken into a room where I am forced down to the bed and given an injection of Thorazine; it makes me limp and weak inside.... My nerves are cut...I have lost interest in the world. People who will not open their eyes to me ask me to see, yet keep me captive.... The denigration is absolute. I am given the words "flat affect" because I withold from them, my captors, my friendship.

Anonymous, Assembly Report at 126.

After noting that "the psychiatric profession has not been very sensitive to patient's subjective responses to antipsychotic medication[,]" Van Putten, et al., supra, 141 Am J.Psychiatry at 16, Van Putten concluded as follows:

> [It] would be well to pay more attention to the consumer's subjective response to antipsychotic drugs. The patient's subjective response should not be dismissed as an aberration of a sick mind."

Id., at 18 (emphasis added).

Another recent study indicated that though the anti-psychotic agents may have been successful in treating some symptoms of psychosis, they have been less successful in ameliorating negative symptoms associated with the disease

itself:

> In fact, there is some evidence that neuroleptic medication produces or enhances negative symptoms (Andreason 1985; Carpenter et al. 1985.) Patients in whom hallucinations and delusions have been satisfactorily treated often remain socially withdrawn and avolutional with blunted effect. Such deficit states have consequences for the patient's social adjustment since they are directly related to the patient's ability to display the affect and drive necessary to engage in social interactions and perform instrumental role behaviors. The exacerbation of deficit states has implications not only for social adjustment but for the family's response to the patient.

Kreisman, et al., "Family Attitudes and Patient Social Adjustment in a Longitudinal Study of Outpatient Schizophrenics Receiving Low-Dose Neuroleptics: The Family's View," PSYCHIATRY, Vol. 51, (February 1988.)

In short, psychotropic drugs, even when prescribed carefully and monitored diligently by the psychiatric professional, can have destructive impact not only on the lives of their patients, but upon those of their families as well. Physicians, no matter how well-intentioned, are simply not in the position to render unscrutinized judgements concerning the benefits and risks of psychiatric treatment for their patients.

CONCLUSION

There is no medical debate over the fact that psychotropic drugs pose a serious threat to the health and safety of patients who are treated with these drugs. Whether or not these potential risks are outweighed by possible benefits is not a medical decision, but one to be rendered by the person who must live with the effects of such treatment. LPS upholds the constitutional and common law rights of competent adults to give informed consent to

treatment in nonemergency situations. Eleanor Riese attempted to exercise these rights, and to have input into medical decisions. St. Mary's Hospital acted without authority when it forced psychotropic drugs upon her without her input and without her consent. The decision of the Court of Appeal should be upheld.

DATED: August 16, 1988

Respectfully submitted,

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