

**REPORT TO THE TWENTY-THIRD LEGISLATURE
STATE OF HAWAII
2005**

PURSUANT TO

**H.C.R. NO. 156 H.D. 1, 2003-2004
REQUESTING THE DEPARTMENT OF HEALTH TO
CONVENE A WORKING GROUP TO EVALUATE AND RECOMMEND
POSSIBLE STATUTORY AND OTHER CHANGES TO
STREAMLINE AND EXPEDITE MENTAL HEALTH TREATMENT TO
PERSONS COMMITTED TO STATE-OPERATED OR -CONTRACTED FACILITIES**

**PREPARED BY
DEPARTMENT OF HEALTH
STATE OF HAWAII
JANUARY 2005**

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INTRODUCTION

This report was requested by the Hawaii State Legislature during the 2004 Regular Session through H.C.R. 156 H.D.1, "Requesting the Department of Health to convene a working group to evaluate and recommend possible statutory and other changes to streamline and expedite mental health treatment to persons committed to State-operated or -contracted facilities." A copy of H.C.R. 156 H.D.1 is included as Appendix A.

Specifically, the group was asked to evaluate alternatives and make recommendations to streamline and expedite the length of time it takes to obtain an Order to Treat (OTT); that is medical authorization to administer psychotropic medication involuntarily to persons civilly committed to a hospital pursuant to Hawaii Revised Statutes (HRS) Chapter 334 and persons committed to the custody of the Director of the Department of Health (DOH) pursuant to HRS Chapter 704; consider how the OTT could accompany a patient when he or she is committed to any State-operated or -controlled facility; and to report its findings and recommendations to the Legislature no later than 20 days prior to the convening of the Regular Session of 2005.

The group was to comprise, but was not limited to, representatives from the Judiciary, the DOH and staff from the Hawaii State Hospital (HSH), the Department of the Attorney General, the Hawaii Mental Health Association, the Hawaii Psychiatric Medical Association, the Hawaii Disability Rights Center, the National Alliance for the Mentally Ill, the Hawaii Government Employees Association and qualified mental health consumer advocates.

The DOH assembled a group of representatives from the Judiciary, the aforementioned agencies and two qualified mental health consumer advocates: David Alexander, Certified Peer Specialist and Facilitator for Building Recovery of Individual Dreams and Goals Through Education and Support (BRIDGES) and Bill Lennox, Director of the Office of Consumer Affairs, Adult Mental Health Division (AMHD), DOH. The Hawaii Nurses Association was also invited, but a representative was unable to participate. A complete list of work group participants is included as Appendix B (signatures on file at DOH).

Resource materials were distributed to all participants prior to the meetings to assure background information was shared. A copy of these materials is included as Appendix C. Additional materials were provided by participants during the meetings and are included as Appendix D.

Two all-day meetings of the group were held November 29 and 30, 2004, at the Manoa Innovation Center. A facilitated process, coordinated by a neutral party, was used to assure all parties could participate fully. On the first day, sixteen participants were in attendance. On the second day, fourteen participants were in attendance with the two representatives from the Judiciary unable to attend.

The following report is the result of the working group's (reference Appendix B) discussions and deliberations over the course of the two-day meeting. There was a clear consensus on three main points. First, that balancing the rights of individuals, the concern for public safety and the need for mental health treatment is paramount. Second, the status quo with regard to current OTT policies and procedures needs to be changed, and third, that Best Practices in the area of mental health treatment and mental health law currently exist in the United States and should be implemented in Hawaii. The group also agreed that a continued, deliberative process including all stakeholders is needed for effective reform.

Background on reform

Over the past several years, various reforms regarding involuntary treatment have been proposed. Recommendations generally focused on increasing the participation and decision making of family members and clinicians in the process.

One early proposal, put forth by the Hawaii Medical Association, would allow decisions regarding involuntary treatment to be made by the consumer, clinicians, and an administrative review panel with appeal to a judge. A clinical panel would make a determination about the need for treatment. If the consumer did not consent to this treatment, a second administrative review panel composed of family members, consumers and mental health professionals not associated with the treatment facility, would review the clinical panel's recommendations, issuing their own decision. If this second panel disagreed with the clinical panel's recommendation, a Judge would review both recommendations and render a decision.

A later proposal in 1999 (S.B. 1032 S.D.1 H.D.2 in 1999) that set a clearly defined statutory process for involuntary psychiatric treatment was passed, but vetoed by the Governor as the measure required an Attorney General to assist with each involuntary commitment and this was not considered a good use of that individual's time.

In 2004, the Hawaii Government Employees Association introduced H.B.2100 that proposed revisions to HRS to allow the DOH to establish an administrative process allowing involuntary medication of psychiatric patients institutionalized at the HSH to alleviate mental illness and restore competency.

Both H.B. 2100 and its companion bill, S.B. 2191, were held in committee, giving rise to H.C.R. 156 H.D.1 requesting the Department of Health to convene a working group to evaluate and recommend possible statutory and other changes to streamline and expedite mental health treatment.

RATIONALE

A need to better balance the rights of individuals, the concern for public safety and the need for mental health treatment when considering recommendations and alternatives to current OTT procedures was stated.

Hawaii's standards with regard to OTT are based on Federal constitutional law, and require "clear and convincing evidence" of three conditions before involuntary treatment can begin: first, the consumer is a danger to self and others; second, that treatment with medication is appropriate and; third, that less intrusive measures to forestall danger have been considered. Most of the group felt that clear and convincing evidence may be too high a test.

Current Hawaii law governing civil commitment (HRS Chapter 334) is weighted heavily toward individual rights and assuring due process. The conditions for involuntary treatment of individuals under this chapter are narrowly defined and limited. Definitions include: (1) That the person is mentally ill or suffering from substance abuse; (2) That the person is imminently dangerous to self or others, is gravely disabled or is obviously ill; and (3) That the person is in need or care or treatment, or both, and there is no suitable alternative available through existing facilities and programs which would be less restrictive than hospitalization. The treatment period is limited, i.e. 90 days at a time, with a procedure to extend at the end of this period.

Current law governing forensic commitment (HRS Chapter 704) is weighted more toward public safety and questions of personal responsibility at the time of a crime and an individual's fitness to participate in criminal proceedings. Involuntary treatment is based on one's dangerousness, not one's decisional capacity.

Involuntary psychiatric patients have the right to refuse treatment, including psychotropic medication, except when there is an OTT or in an "emergency." An "emergency" means an individual is "imminently dangerous" (likely to cause serious bodily harm to self and/or others) and/or they are "gravely disabled" or "obviously ill." The difficulty expressed with determination of "imminently dangerous" is that it may require / allow such discretion on the part of treatment staff that safety can be compromised. The problems with the terms "gravely disabled" and "obviously ill" are that they are not defined in statute and were not supported by the Judiciary in test cases.

The provisions of Chapters 334 and 704 rely on a judicial approach to assure the protection of individual rights and public safety. Such approaches weigh the individual's and the public's rights, but less the degree to which a person's psychiatric condition is known to be harmful to him/herself or to the public.

Medical practice continues to evolve, and much more is now known both about the damaging effects of untreated mental illness as well as about the clinical prediction of danger to others. Each patient's condition differs, presenting varying degrees of danger and degrees of competence for both the decision makers and the clinical staff who must try to render treatment.

Participants in the group urged greater consideration be given to the "right" of a consumer to receive the type of treatment they need and deserve to recover, and/or avoid further disability, in a timely manner. A need to protect consumers who are unable to care for themselves (unable to obtain food, shelter, and clothing) was asserted.

As recovery from mental illness is possible, appropriate treatment should be offered at the earliest opportunity, for the sake of the individual and their family and well as the larger community. As passionately stated by the representative from the National Alliance for the Mentally Ill, who is also the parent of a child with mental illness, *“Without timely and appropriate treatment people are in danger of losing their life, their self; all of their talents and capabilities, all their possibilities and dreams. Is condemning a seriously mentally ill person to homelessness or incarceration a protection of their ‘civil rights’?”*

Families who care for individuals suffering with mentally illness need support to obtain timely and appropriate treatment for their loved ones, especially when their family is in danger and becomes unable to care for their loved ones adequately.

Greater consideration also needs to be given to the “rights” of other patients and treatment staff to “be safe” and “feel safe”; to recover and work, respectively, in a therapeutic setting. When the level of dangerousness (“imminently dangerous to self or others) that a consumer needs to reach before an emergency arises and involuntary medication can be administered is excessively high, the safety of all individuals in the facility is compromised. As stated by a staff member at a facility, *“We are literally waiting for someone to get hurt, before we can move forward.”*

Current policies and procedures necessary to obtain an OTT in Hawaii make it a very difficult and protracted process, with negative consequences for stakeholders in the system.

These consequences include consumers, their family members and/or advocates not being able to access needed and appropriate mental health treatment in a timely manner, sometimes with negative effects on the future course of their illness; the continued loss of freedom by individuals who would have been discharged had they been treated; other patients and staff being assaulted by untreated patients who are waiting for an OTT; clinicians and treatment staff being constrained in their ability to provide best practices treatment; and, the waste of public funds.

For consumers involuntarily committed under HRS Chapter 334, two court hearings are generally necessary before needed and appropriate treatment can be received; one for involuntary commitment and another for involuntary medication. The limited 90-day commitment period is often insufficient to provide the type of treatment that supports recovery and though an extension to the 90-day period can be granted, the process associated with this can be protracted. Without timely and appropriate treatment, it is quite common for patients to psychiatrically deteriorate, suffer extended loss of freedom, and harm themselves and/or others.

Using HRS Chapter 704 also results in the inefficient use of resources. A consumer needs to go through three departments before being able to receive treatment. First, a consumer must be arrested and charged by public safety. Next, they go before the court for a forensic evaluation to determine whether they are able to proceed in court or are in need of treatment for fitness restoration. If it is determined that treatment is needed, but the consumer refuses, then the OTT process begins. Once the OTT is completed, the consumer undergoing fitness restoration can begin medication treatment. It was observed by some participants that patients in Community hospitals and at HSH may linger untreated for weeks or months without an OTT.

It was found among the group that as commitment is harder to obtain under HRS Chapter 334, procedures under HRS Chapter 704 seem to be preferred and more often used (Chapter 704 requires a lower standard of dangerousness for commitment.) Approximately 93% of HSH beds are occupied by those committed under HRS Chapter 704.

Clinicians, family members and advocates access HRS Chapter 704 to expedite needed relief and treatment, but in this process the behaviors of those with mental illness are “criminalized.” This perpetuates negative stereotypes and increases stigmatization of the mentally ill.

As the hospital to which a consumer is civilly committed bears legal and financial responsibility for that person, Community Hospitals are also reluctant to commit using HRS Chapter 334. Those committed using Chapter 704 become the responsibility of the HSH.

Our current law allows involuntary administration of medication without an OTT only in the case of an “emergency” and then, for only for 72 hours. It was highlighted that this is short-sighted and not conducive to effective treatment of mental illness. In fact, only the initial short-term effects of medication can be seen in this very brief period of time. What is being treated is agitation; only an acute symptom of mental illness, not the underlying, complex chemical imbalances. The administration of medication in this way can be a slippery slope to using medications as “chemical restraint” instead of treatment for persons suffering from mental illness.

Hospitalizations are prolonged by current processes, sometimes for months. The delays in obtaining an OTT cause an increase in the length of stay at facilities which increases costs and decreases the number of beds available to the community. The current costs of care for one consumer at the HSH is \$750/day; \$22,500/month; \$270,000/year. Given demand without broader systems change, the current number of inpatient beds in the State may be inadequate.

The group noted that while there exists in statute differences between procedures for civil and forensic commitment and OTT, *the diagnosis and need for treatment is the same for a given individual, regardless of how they are "processed" by the current system.*

Best Practices in the area of mental health treatment and mental health law currently exist in the United States and should be adopted in Hawaii.

Long stigmatized, those with mental illness in the past were warehoused in back wards of facilities, with little hope for re-integration into society. They were thought to function best under conditions we know today to be severely limiting. Given improvements in treatment modalities and anti-psychotic medications (newer medications are less toxic and with more benign side effects), recovery from mental illness is possible and should be the goal of treatment efforts.

When we hospitalize an individual, but do not provide the best treatment available, we fail to support recovery. Current literature has shown that both functional and structural changes take place in the brain when individuals with certain psychoses are left untreated. Delays in treatment and insufficient treatment, therefore, can cause individuals to have less chance of recovery and be further disabled.

With regard to the capacity of a mentally ill person to give informed consent, it is now a generally accepted fact that an individual's lack of awareness of their illness is frequently a part of the disease process in Severe and Persistent Mental Illness. These individuals, while clearly needing care, may at times be unable to give truly informed consent.

We need to provide inpatient mental health treatment that shortens the stay necessary to improve the quality of life for consumers and opens more beds to address the current needs of our community.

ALTERNATIVES TO ORDERS TO TREAT

1. Accept a consumer's verbal consent to treatment, when witnessed and documented.
2. Put more “teeth” in Advance Directives (AD) and educate, promote and encourage their use. In making an AD, a consumer who is able to make decisions can provide written instruction or designate a proxy (i.e. Durable Power of Attorney) specifically with regard to the decision to allow administration of medication as part of mental health treatment. This should be stated in the AD and should be binding, so that a separate court hearing is not needed for an OTT. The treating clinician / mental health professional is held legally harmless if the AD is followed in a clinical situation requiring treatment. Recent amendments have begun to address some of these issues.
3. Use Substitute Decision Makers (SDM). People who lack capacity to give informed consent, do not have an AD, and have not designated a proxy may be given a SDM by the court. This surrogate is limited to making specific decisions with regard to treatment with psychotropic medications.
4. Use Guardians. While Guardianship may also be court ordered, this option takes a large amount of power and decision making away from a consumer, when all that is really needed is decision making power regarding the administration of medication.
5. Put more resources into providing appropriate treatment earlier.
 - a. Provide support to consumers by offering viable options through a Crisis Team, connecting high-risk consumers to Assertive Community Treatment teams, and using Peer Specialists to increase understanding of the value of medication and assist in consumer decision-making.
 - b. If a consumer has a family or a proxy, involve these individuals as much as possible, as early as possible, providing them with clear and helpful information.
6. Revise HRS Chapter 334 regarding Outpatient Commitment (Assisted Outpatient Treatment) to allow reasonable and appropriate medications to be administered involuntarily. The current involuntary outpatient treatment procedures require a non-compliant consumer to be hospitalized involuntarily.

While forming a therapeutic alliance between the clinician and consumer is always preferred, at times it is not feasible and involuntary treatment becomes necessary.

RECOMMENDATIONS TO STREAMLINE AND EXPEDITE ORDERS TO TREAT

1. Address dangerousness
 - a. Expedite clinical intake evaluations (especially for those who are dangerous) so patient can receive treatment sooner.
 - b. Allow use of standardized risk assessments by treatment staff to assist in determining "imminent danger" for purposes of involuntary medication in an "emergency."
 - c. Consider how emergency treatment might be continued, pending judicial review for an OTT, beyond 72 hours.
 - d. Concentrate efforts to streamline and expedite OTT's on patients who have refused medications.
2. Make procedural changes in District and Circuit court
 - a. Fast track those with Severe and Persist Mental Illness (recidivists) especially those with a history of danger.
 - b. Prioritize commitment and OTT cases in Circuit and District courts. Set a time frame (with target dates/times) for court turnaround.
 - c. Provide clinician (staffed or contracted by DOH) to conduct mental health evaluations at court. This person could also serve as a mental health liaison to the Circuit and District courts, conducting competency evaluations.
 - d. Hold weekly court with Family and District courts and the HSH electronically, especially for consumers from the neighbor islands who are confined at HSH.
3. Cooperate with the Judiciary's efforts to establish Mental Health Court
 - a. Provide access to Mental Health court at treatment facility, utilizing teleconferencing.
 - b. Establish Mental Health Courts on all islands to facilitate outpatient treatment and monitor consumer adherence to treatment plan.
 - c. Evaluate Mental Health Court to produce good data (funding via grant application.)
 - d. Assign specially trained probation officer for cases in Mental Health court, to track outpatient commitment cases and monitor adherence to the clinical treatment plan.
4. Develop/share resources and staffing
 - a. Speed processes where possible with use of technology.
 - b. Enable departments to share data. Work with the Department of Public Safety to share information on detainees for risk assessments and to evaluate the success of prevention efforts in decreasing recidivism.

- c. Increase number of prosecutors and public defenders.
 - d. Increase number of certified forensic examiners.
5. Revisions to H.R.S. Chapter 334
- a. Expand the definition of “dangerousness” to include the longer-term risks of dangerousness to self due to impairment by Severe Mental Illness. This would decrease the number of individuals currently committed under H.R.S. Chapter 704.
 - b. Specify definitions of "Gravely Disabled" and "Obviously Ill" according to current Best Practices and acceptable models from other states. This would include consideration of a pattern of deterioration, a high recidivism rate, and an inability to provide/obtain food, shelter and clothing.
6. Revisions to H.R.S. Chapter 704
- a. Require Mental Health Court in lieu of incarceration for certain cases.
 - b. Require 706-607's (civil commitment in lieu of prosecution or sentence) to participate in Mental Health Court post-discharge.
 - c. Revise HRS and Hawaii Administrative Rules (HAR) to allow OTT as part of the initial order for "detention, specific care and treatment."
 - d. Revise HAR 11-175-45 "...except as ordered by a court under Chapter 704 of the Hawaii Revised Statutes to receive [specific] care and treatment..."
7. Pass enabling legislation to amend the HRS and/or HAR to allow for creation of DOH treatment review panels including clinicians, attorneys, and patient advocates to:
- expedite OTT (especially recidivists) within 10 days from initial request,
 - continue emergency treatment until an OTT can be heard, with review and decision on continuation of emergency treatment made no later than 72 hours after initiation of such treatment, and
 - access health and criminal history data to complete the risk of dangerousness evaluation used to assist the panel with decision-making.
8. Develop a dedicated forensic hospital, in which specialists in forensic treatment provide care within a secure setting.

WAYS ORDERS TO TREAT CAN ACCOMPANY PATIENTS WHEN COMMITTED

1. Allow OTT / civil commitment be to the Director of the DOH, rather than the treatment facility.
2. Allow back- to-back hearings of both civil or forensic commitment and OTT.
3. Enable guardians to make decisions about hospitalization and administration of medication.

APPENDIX A
H.C.R. 156 H.D.1

OFFERED BY: _____

Report Title:

DOH; Mental Health Treatment; Working Group

HOUSE OF REPRESENTATIVES
TWENTY-SECOND LEGISLATURE,
2004

H.C.R. NO. 156
H.D. 1

STATE OF HAWAII

HOUSE CONCURRENT RESOLUTION

REQUESTING THE DEPARTMENT OF HEALTH TO CONVENE A WORKING GROUP TO EVALUATE AND RECOMMEND POSSIBLE STATUTORY AND OTHER CHANGES TO streamline and expedite MENTAL HEALTH TREATMENT TO persons COMMITTED TO STATE-OPERATED OR -CONTRACTED FACILITIES.

WHEREAS, persons may be committed involuntarily to a state psychiatric facility or to the custody of the Director of Health pursuant to the processes described in chapter 334, Hawaii Revised Statutes (HRS), involuntary civil commitment by family court, and the Hawaii Penal Code, chapter 704, HRS, commitment by criminal court; and

WHEREAS, neither the law governing civil commitment nor the commitment provisions of the Hawaii Penal Code allow the committing court to automatically authorize the involuntary administration of psychotropic medication, known as "involuntary medication," during the period of confinement; and

WHEREAS, Hawaii law recognizes several rights of recipients of mental health services, including the right to informed consent prior to commencement of any nonemergency treatment for mental illness; and

WHEREAS, the rights of psychiatric in-patients include refusal of treatment, except in emergency situations or where a court order exists; and

WHEREAS, defendants committed to state-contracted facilities may arrive without orders to administer medications that would ameliorate their mental illness; and

WHEREAS, obtaining a court order to administer involuntary medication can take several months to obtain, inasmuch as the process is governed by legal precedents that require protection of the patient's rights and welfare; and

WHEREAS, the delay in administering medication may lead to the further deterioration of these patients, and greater risk to other patients and staff because of assaults by these patients; now, therefore,

BE IT RESOLVED by the House of Representatives of the Twenty-second Legislature of the State of Hawaii, Regular Session of 2004, the Senate concurring, that the Department of Health (DOH) is requested to convene a working group to evaluate alternatives and make recommendations to streamline and expedite the length of time it takes to obtain an order to treat defendants committed under chapter 334 or 704, HRS; and

BE IT FURTHER RESOLVED that the working group consider how the order to treat could accompany patients when they are committed to any state-operated or -contracted facility under chapter 334 or 704, HRS; and

BE IT FURTHER RESOLVED that the working group comprise but not be limited to representatives from:

(1) DOH, including staff from the Hawaii State Hospital;

(2) The Department of the Attorney General;

(3) The Judiciary;

(4) The Hawaii Mental Health Association;

(5) The Hawaii Psychiatric Medical Association;

(6) The Hawaii Disability Rights Center;

(7) The National Association of the Mentally Ill - Oahu;

(8) The Hawaii Government Employees Association; and

(9) Qualified mental health consumer advocates;

and

BE IT FURTHER RESOLVED that the working group, through DOH, is requested to report its findings and recommendations to the Legislature no later than 20 days prior to the convening of the Regular Session of 2005; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Director of Health, Attorney General, Chief Justice, President of the Hawaii Mental Health Association, President of the Hawaii Psychiatric Medical Association, President of the Hawaii Disability Rights Center, President of the National Association of the Mentally Ill, Hawaii Chapter, and Executive Director of the Hawaii Government Employees Association.

Report Title:

DOH; Mental Health Treatment; Working Group

APPENDIX B
LIST OF WORK GROUP PARTICIPANTS

H.C.R. No. 156 H.D. 1
Work Group
November 29 & 30, 2004

- (1) **The Department of Health, including staff from Hawaii State Hospital**
Alan Radke, M.D., Rupert Goetz, M.D., David Friar, M.D., Connie Ching, DON
Iqbal Ahmed, M.D., JABSOM/HSB Psychopharmacology Consultant, Michael
Wylie, Ph.D., Consulting Psychologist
- (2) **The Department of the Attorney General**
Martha Im, Esq.
- (3) **The Judiciary**
Honorable Colette Garibaldi, District Court
Dawn Nagatani, Law Clerk
- (4) **The Hawaii Mental Health Association**
Kenneth Wilson, Executive Director
- (5) **The Hawaii Psychiatric Medical Association**
Celia M. Ona, M.D., President
- (6) **The Hawaii Disability Rights Center**
Louis Erteschik, Esq.
- (7) **The National Alliance for the Mentally Ill - Oahu**
Jim Mahalke
- (8) **The Hawaii Government Employees Association**
Joan Takano
- (9) **Qualified mental health consumer advocates**
David Alexander, Certified Peer Specialist and Facilitator for BRIDGES
Bill Lennox, Director of the Office of consumer Affairs, AMHD, DOH

APPENDIX C
PARTICIPANT RESOURCE MATERIALS

OFFERED BY: _____

Report Title:

DOH; Mental Health Treatment; Working Group

HOUSE OF REPRESENTATIVES
TWENTY-SECOND LEGISLATURE,
2004

H.C.R. NO. 156
H.D. 1

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WHEREAS, the rights of psychiatric in-patients include refusal of treatment, except in emergency situations or where a court order exists; and

WHEREAS, defendants committed to state-contracted facilities may arrive without orders to administer medications that would ameliorate their mental illness; and

WHEREAS, obtaining a court order to administer involuntary medication can take several months to obtain, inasmuch as the process is governed by legal precedents that require protection of the patient's rights and welfare; and

WHEREAS, the delay in administering medication may lead to the further deterioration of these patients, and greater risk to other patients and staff because of assaults by these patients; now, therefore,

BE IT RESOLVED by the House of Representatives of the Twenty-second Legislature of the State of Hawaii, Regular Session of 2004, the Senate concurring, that the Department of Health (DOH) is requested to convene a working group to evaluate alternatives and make recommendations to streamline and expedite the length of time it takes to obtain an order to treat defendants committed under chapter 334 or 704, HRS; and

BE IT FURTHER RESOLVED that the working group consider how the order to treat could accompany patients when they are committed to any state-operated or -contracted facility under chapter 334 or 704, HRS; and

BE IT FURTHER RESOLVED that the working group comprise but not be limited to representatives from:

(1) DOH, including staff from the Hawaii State Hospital;

(2) The Department of the Attorney General;

(3) The Judiciary;

(4) The Hawaii Mental Health Association;

(5) The Hawaii Psychiatric Medical Association;

(6) The Hawaii Disability Rights Center;

(7) The National Association of the Mentally Ill - Oahu;

(8) The Hawaii Government Employees Association; and

(9) Qualified mental health consumer advocates;

and

BE IT FURTHER RESOLVED that the working group, through DOH, is requested to report its findings and recommendations to the Legislature no later than 20 days prior to the convening of the Regular Session of 2005; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Director of Health, Attorney General, Chief Justice, President of the Hawaii Mental Health Association, President of the Hawaii Psychiatric Medical Association, President of the Hawaii Disability Rights Center, President of the National Association of the Mentally Ill, Hawaii Chapter, and Executive Director of the Hawaii Government Employees Association.

Report Title:

DOH; Mental Health Treatment; Working Group

Report Title:

Advance Mental Health Care Directives

Description:

Recognizes, establishes, and sets forth an adult's and emancipated minor's rights to make enforceable advance mental health care directives. Repeals chapter 327F relating to medical treatment decisions of psychotic disorders. (CD1)

THE SENATE
TWENTY-SECOND LEGISLATURE,
2004
STATE OF HAWAII

S.B. NO. 1238
S.D. 2

H.D. 2

C.D. 1

A BILL FOR AN ACT

relating to mental health.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The purpose of this Act is to allow individuals to make known their preferences for their mental health care and treatment when they are able so that these preferences can guide care and treatment if the individual later loses the capacity to make such decisions due to a mental illness. This Act also allows individuals to appoint an agent and alternate agents to make mental health care decisions on behalf of the individual if the individual later loses the capacity to make such decisions due to a mental illness.

SECTION 2. The Hawaii Revised Statutes is amended by adding a new chapter to be appropriately designated and to read as follows:

"CHAPTER

ADVANCE MENTAL HEALTH CARE DIRECTIVES

§ -1 Purpose. The State finds that all competent persons have the fundamental right to control decisions relating to their own mental health care, including the decision to accept or refuse all types of mental health treatment. The rights of individuals shall be respected when they have lost the capacity to participate actively in decisions regarding themselves or their mental health care and treatment. The laws of the State of Hawaii shall recognize the right of persons eighteen years of age or older and emancipated minors to make a written advance mental health care directive expressing their preferences and instructions regarding mental health care and treatment, including the consent to, or refusal of, that care and treatment, and to designate an agent or alternate agents to make mental health care decisions on behalf of the individual, when that individual later loses the capacity to make those decisions due to a mental illness.

§ -2 Definitions. Whenever used in this chapter, unless the context otherwise requires:

"Advance mental health care directive" means a written document expressing preferences, instructions, or a power of attorney for mental health treatment.

"Agent" means a competent adult designated in a power of attorney contained in an advance mental health care directive to make a mental health care decision for the individual granting the power and includes all designated alternate agents.

"Best interests" means that the benefits to the principal resulting from a mental health treatment outweigh the burdens to the principal resulting from that treatment and includes:

(1) The effect of the mental health treatment on the physical, mental,

emotional, and cognitive functions of the principal;

(2) The degree of physical and mental pain or discomfort caused to the principal by the mental health treatment or the withholding or withdrawal of that treatment;

(3) The degree to which the principal's medical condition, the mental health treatment, or the withholding or withdrawal of mental health treatment, results in a severe and continuing impairment;

(4) The effect of the mental health treatment on the life expectancy of the principal;

(5) The prognosis of the principal for recovery or remission, with and without the mental health treatment;

(6) The risks, side effects, and benefits of the mental health treatment or the withholding of mental health treatment; and

(7) The religious beliefs and basic values of the principal receiving mental health treatment known to the agent, to the extent that these may assist the agent in determining benefits and burdens.

"Capacity" means a principal's ability to understand the significant benefits, risks, and alternatives to proposed mental health care or treatment and to make and communicate a mental health care decision.

"Competent adult" means an individual eighteen years of age or older who has the capacity to understand the significant benefits, risks, and alternatives to proposed mental health care or treatment and to make and communicate mental health care decisions.

"Emancipated minor" means an individual less than eighteen years of age who is deemed to be emancipated pursuant to section 577-25.

"Guardian" means a judicially appointed guardian or conservator having authority to make a mental health care decision for a principal, appointed under part 3 of article V of chapter 560.

"Health care institution" means an institution, facility, or agency licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business.

"Health care provider" means an individual licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession.

"Mental health care" means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a principal's mental condition, including:

- (1) Selection and discharge of health care providers and institutions;
- (2) Approval or disapproval of diagnostic tests, surgical procedures, and programs of medication; and
- (3) Approval or disapproval of electroconvulsive treatment.

"Mental health care decision" means a decision made by a principal or the principal's agent or guardian regarding the principal's mental health care or mental health treatment.

"Mental health treatment" means any form of treatment used for the treatment of mental illness, including but not limited to electroconvulsive treatment, the use of psychotropic medication, and admission to and retention in a health care facility for the care or treatment of mental illness.

"Physician" means an individual authorized to practice medicine under chapter 453 or osteopathy under chapter 460.

"Power of attorney" means the designation of an agent to make mental health care decisions for the principal granting the power.

"Primary physician" means a physician designated by a principal or the principal's agent or guardian to have primary responsibility for the principal's health care, including mental health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes the responsibility.

"Principal" means a competent adult or emancipated minor who has executed a written advance mental health care directive or power of attorney for mental health care.

"Psychologist" means an individual authorized to practice psychology under chapter 465.

"State" means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

"Supervising health care provider" means the primary physician or the physician's designee, or the health care provider or the provider's designee who has undertaken primary responsibility for a principal's health care, that includes mental health care.

§ -3 Advance mental health care directive; designation of agent. (a) A competent adult or emancipated minor may make a written advance mental health care directive declaring preferences or instructions regarding mental health treatment. The preferences or instructions may include consent to, or refusal of, mental health treatment. An advance mental health care directive may be a part of, or combined with, a written advance health care directive under chapter 327E.

(b) A principal, in a power of attorney contained in the written advance mental health care directive, may designate a competent adult to act as an agent to make any and all mental health care and mental health treatment decisions on behalf of the principal when the principal lacks capacity, unless otherwise specified or limited by the advance mental health care directive. A principal, in a power of attorney

contained in the written advance mental health care directive, may also designate competent adults to act as alternate agents, in the order so designated, if the original agent is unable or unwilling to act.

(c) A written advance mental health care directive may include the principal's nomination of a guardian of the person. The court shall make its appointment of a guardian of the person in accordance with the principal's most recent nomination in a valid and unrevoked advance mental health care directive, except for good cause shown.

(d) No individual shall be required to execute or refrain from executing an advance mental health care directive or power of attorney as a condition for insurance coverage, receiving mental or physical health services, receiving privileges while in a health care institution, or as a condition of discharge from a health care institution.

(e) An advance mental health care directive is valid and effective only if it is in writing, contains the date of its execution, is signed by the principal, and is witnessed in one of the following methods:

(1) Signed by at least two competent adults, except those as provided in subsection (f), each of whom shall attest that the principal is known to them, signed the advance mental health care directive in their presence, and appears to be of sound mind and not under duress, fraud, or undue influence; or

(2) Acknowledged before a notary public within this State.

(f) None of the following may serve as a witness to the signing of an advance mental health care directive:

(1) A health care provider, supervising health care provider, or an employee or relative of a health care provider or supervising health care provider;

(2) An owner, operator, or employee of a health care provider or health care

institution in which the principal is a patient or resident;

(3) A person related to the principal by blood, marriage, or adoption; or

(4) The agent or alternate agents.

(g) None of the following may serve as an agent or alternate agent under a designation in a power of attorney contained in an advance mental health care directive:

(1) A health care provider, supervising health care provider, or an employee of a health care provider or supervising health care provider, unless that person is related to the principal by blood, marriage, or adoption; or

(2) An owner, operator, or employee of a health care provider or health care institution in which the principal is a patient or resident, unless that person is related to the principal by blood, marriage, or adoption.

(h) An advance mental health care directive and power of attorney becomes effective when it is delivered to a health care provider, supervising health care provider, or health care institution and remains effective until revoked.

(i) An advance mental health care directive executed prior to the effective date of this chapter shall be valid for the purposes of this chapter if it complies substantially with this chapter or if it was executed in compliance with the laws of the state where it was executed.

§ -4 Revocation of advance mental health care directive.

(a) A principal who has capacity at the time may revoke all or part of an advance mental health care directive, including the designation of an agent or alternate agents, at any time and in any manner that communicates intent to revoke. The principal shall give notice of the revocation to a health care provider, supervising health care provider, health care institution, agent, or guardian.

(b) A health care provider, agent, or guardian who is informed of a revocation shall promptly communicate the fact and extent of the revocation to the supervising health care provider and to any health care institution in which the principal is a patient or resident.

(c) A revocation is effective when notice of the revocation is received by the supervising health care provider or health care institution. The supervising health care provider or health care institution shall promptly record the fact and extent of the revocation, including the date and time of the revocation, in the principal's medical record.

(d) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as agent, unless otherwise specified in the decree or in the advance mental health care directive.

(e) An advance mental health care directive that conflicts with an earlier advance mental health care directive revokes the earlier directive to the extent of the conflict.

§ -5 Authority and duty of agent; limitations on liability.

(a) The authority of an agent becomes effective only upon a determination that the principal lacks capacity and ceases to be effective upon a determination made under section - 7 that the principal has recovered capacity, unless otherwise specified in the advance mental health care directive.

(b) An agent has the authority to make any and all mental health care decisions on behalf of the principal while the principal lacks capacity, unless otherwise specified or limited in the advance mental health care directive.

(c) In exercising authority, an agent has a duty to act consistently with the provisions of the advance mental health care directive. An agent shall make all mental health care decisions in accordance with the principal's preferences or instructions expressed in the advance mental health care directive, if any, and the principal's other wishes to the extent known to the agent. If the principal's preferences, instructions, and wishes are not expressed or known, the agent shall make the decision in accordance with

the agent's good faith determination of the principal's best interests. In determining the principal's best interests, the agent shall consider the principal's personal values to the extent known to the agent.

(d) An agent has the same right as the principal to receive information regarding the proposed mental health treatment and to receive, review, and consent to disclosure of medical records relating to that treatment, unless limited by the advance mental health care directive or any federal law. This right of access and disclosure does not waive any evidentiary privilege.

(e) A mental health care decision made by an agent for a principal shall be effective without judicial approval.

(f) An agent is not, solely as a result of acting in that capacity, personally liable for the cost of treatment provided to the principal.

(g) An agent whose decisions regarding the principal are made in good faith, pursuant to the provisions of the advance mental health care directive, shall not be subject to criminal prosecution, civil liability, or professional disciplinary action with respect to those decisions.

§ -6 Withdrawal of agent; rescission of withdrawal. (a) An agent may withdraw by giving notice to the principal, if the principal has capacity at the time. If the principal lacks capacity, the agent may withdraw by giving notice to the supervising health care provider or health care institution. The supervising health care provider or health care institution shall promptly record the withdrawal, including the date and time of the withdrawal, in the principal's medical record.

(b) An individual who has withdrawn under subsection (a) may rescind the withdrawal by executing and dating a written acceptance of the designation as agent after the date of the withdrawal. An individual who rescinds a withdrawal shall give notice and a copy of the written acceptance to the principal, if the principal has capacity at the time. If the principal lacks capacity, the individual who rescinds a withdrawal shall give notice and a copy of the written acceptance to the supervising health care provider or health care institution. The supervising health care provider or health care institution shall

promptly record the rescission, including the date and time of the rescission, in the principal's medical record and make the written acceptance a part of the principal's medical record.

§ -7 Presumption of capacity; determination of lack of capacity; recovery of capacity. (a) A principal is presumed to have capacity to make mental health care decisions and to execute or revoke an advance mental health care directive or power of attorney designating an agent. Even if the principal has an advance mental health care directive, the principal has the right to make decisions regarding mental health care or mental health treatment, so long as the principal has capacity.

(b) The fact that a principal has executed an advance mental health care directive shall not create a presumption, nor constitute evidence or an indication, that the principal is mentally incompetent or lacks capacity.

(c) This chapter shall not create a presumption concerning the intention of an individual who has not executed or who has revoked an advance mental health care directive or power of attorney.

(d) For the purposes of this chapter, the determination that a principal lacks capacity shall be made by the supervising health care provider who is a physician and one other physician or licensed psychologist after both have conducted an examination of the principal. Upon examination and a joint determination that the principal lacks capacity, the supervising health care provider shall promptly note the determination in the principal's medical record, including the facts and professional opinions that form the basis of the determination, and shall promptly notify the agent that the principal lacks capacity and that the advance mental health care directive has been invoked.

(e) The determination that a principal has recovered capacity shall be made by the supervising health care provider who is a physician. The supervising health care provider shall promptly note the recovery of capacity in the principal's medical record, and shall promptly notify the agent that the principal has recovered capacity.

§ -8 Limitations on applicability of advance mental health care directive. (a) A supervising health care provider,

health care provider, or health care institution may subject the principal to mental health treatment in a manner contrary to the principal's preferences and instructions as expressed in an advance mental health care directive only:

(1) When a court order under part 3 of article V of chapter 560 contradicts the principal's preferences and instructions as expressed in the advance mental health care directive; or

(2) In cases of emergency when the principal poses an imminent threat to the safety of self or others.

(b) Neither an advance mental health care directive nor this chapter limits any authority either to take an individual into custody or to admit, retain, or treat an individual in a health care institution pursuant to part IV of chapter 334.

§ -9 Decisions by guardian. (a) A duly appointed guardian of the person of the principal shall comply with the principal's preferences or instructions expressed in the advance mental health care directive and shall not revoke the principal's advance mental health care directive, unless otherwise expressly authorized by a court of competent jurisdiction.

(b) Absent a court order to the contrary, a mental health care decision of an agent takes precedence over that of a guardian.

(c) A mental health care decision made by a guardian for the principal is effective without judicial approval, unless contrary to the principal's preferences or instructions expressed in the advance mental health care directive.

§ -10 Obligations of health care providers; limitations on liability. (a) The supervising health care provider, health care provider, or health care institution shall continue to obtain the principal's informed consent to all mental health treatment decisions when the principal has capacity to provide informed consent or refusal. Unless the

principal is deemed to lack capacity pursuant to this chapter, the instructions or decisions of the principal at the time of mental health treatment shall supersede the preferences or instructions expressed in the principal's advance mental health care directive.

(b) Upon being presented with an advance mental health care directive, the supervising health care provider or health care institution shall make the advance mental health care directive a part of the principal's medical record. When acting under the authority of an advance mental health care directive, the supervising health care provider, health care provider, or health care institution shall comply with it to the fullest extent possible, consistent with reasonable medical practice, the availability of treatments requested, and applicable law. In the event that one or more parts of the advance mental health care directive cannot be followed, all other parts of the advance mental health care directive shall nonetheless be followed.

(c) A supervising health care provider, health care provider, or health care institution may consider an advance mental health care directive to be valid and rely upon it in the absence of actual knowledge or notice of its revocation or invalidity.

(d) If the supervising health care provider or health care institution is unwilling at any time to comply with the advance mental health care directive or instructions of an agent, the supervising health care provider or health care institution may withdraw from providing mental health treatment consistent with the exercise of independent medical judgment. Upon withdrawal, the supervising health care provider or health care institution shall promptly notify the principal and agent and shall promptly record the notification in the principal's medical record.

(e) A physician or licensed psychologist, who in good faith determines that the principal has or lacks capacity in accordance with this chapter to decide whether to invoke an advance mental health care directive, is not subject to criminal prosecution, civil liability, or professional disciplinary action for making and acting upon that determination.

(f) In the absence of actual knowledge or notice of the revocation of an advance mental health care directive, the

supervising health care provider, health care provider, or health care institution shall not be subject to criminal prosecution, civil liability, or professional disciplinary action as a result of providing or withholding mental health treatment to a principal in accordance with this chapter or the advance mental health care directive, unless the absence of actual knowledge or notice resulted from the negligence of the supervising health care provider, health care provider, or health care institution.

(g) The supervising health care provider, health care provider, or health care institution who provides or withholds mental health treatment under this chapter or the advance mental health care directive shall not incur liability arising out of a claim to the extent that the claim is based upon lack of informed consent or authorization for the action.

(h) This section shall not be construed as affecting or limiting liability that arises out of a negligent act or omission in connection with the medical diagnosis, care, or mental health treatment of a principal under an advance mental health care directive or that arises out of any deviation from reasonable medical standards.

(i) This chapter does not authorize or require a supervising health care provider, health care provider, or health care institution to provide mental health treatment contrary to generally accepted health care standards applicable to the health care provider or institution.

§ -11 Statutory damages. (a) A supervising health care provider or health care institution that intentionally violates this chapter shall be liable to the principal or the principal's estate for damages of \$500 or actual damages resulting from the violation, whichever is greater, and reasonable attorney's fees. The damages payable in this section shall be in addition to any other damages permitted by law.

(b) A person who intentionally alters, conceals, obliterates, or falsifies an individual's advance mental health care directive or a revocation of an advance mental health care directive without the individual's consent, or who coerces or fraudulently induces an individual to give, revoke, or not to give an advance mental health care directive, shall be subject to liability to that individual

for damages of \$2,500 or actual damages resulting from the action, whichever is greater, and reasonable attorney's fees.

§ -12 Effect of copy. A copy of an advance mental health care directive, revocation of an advance mental health care directive, or designation, revocation, withdrawal, or rescission of withdrawal of an agent has the same effect as the original.

§ -13 Judicial relief. (a) On petition of a principal, the principal's agent or guardian, a health care provider, or a health care institution involved with the principal's care, any court of competent jurisdiction may enjoin or direct a mental health care decision or order other equitable relief. A proceeding under this section shall be governed by part 3 of article V of chapter 560.

(b) Any such petition filed shall include notice of the existence of an advance mental health care directive and a copy of the directive shall be provided to the court.

§ -14 Optional form. The following sample form may be used to create an advance mental health care directive. This sample form may be duplicated, or modified to suit the needs of the person. Any written document that contains the substance of the following information may be used in an advance mental health care directive:

"ADVANCE MENTAL HEALTH CARE DIRECTIVE

Explanation

You have the right to give instructions about your own mental health care. You also have the right to name someone else to make mental health treatment decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your health care providers. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a list of options you may designate as part of your mental health care and treatment. For ease of designating specific instructions, mark those options in Part 1.

Part 2 of this form is a power of attorney for mental health care. This lets you name another individual as your agent to make mental health treatment decisions for you, if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now, even though you are still capable of making your own decisions. You may name alternate agents to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a health care institution where you are receiving care.

You may allow your agent to make all mental health treatment decisions for you. However, if you wish to limit the authority of your agent, you may specify those limitations on the form. If you do not limit the authority of your agent, your agent will have the right to:

- (1) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a mental condition;
- (2) Select or discharge health care providers and institutions;
- (3) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication; and
- (4) Approve or disapprove of electroconvulsive treatment.

Part 3 of this form lets you give specific instructions about any aspect of your mental health care and treatment. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of medication and treatment. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 4 of this form must be completed in order to activate the advance mental health care directive. After completing this form, sign and date the form at the end and have the form witnessed by one or both of the two methods listed below. Give a copy of the signed and completed form to your physician, to any other health care providers you may have,

to any health care institution at which you are receiving care, and to any mental health care agents you have named. You should talk to the persons you have named as agents to make sure that they understand your wishes and are willing to take the responsibility.

You have the right to revoke this advance mental health care directive or replace this form at any time, unless otherwise specified in writing in the advance mental health care directive.

If you are in imminent danger of causing bodily harm to yourself or others, or have been involuntarily committed to a health care institution for mental health treatment, the advance mental health care directive will not apply.

PART 1

CHECKLIST OF MENTAL HEALTH CARE OPTIONS

NOTE TO PROVIDER: The following is a checklist of selections I have made regarding my mental health care and treatment. I include this statement to express my strong desire for you to acknowledge and abide by my rights, under state and federal laws, to influence decisions about the care I will receive.

(Declarant: Put a check mark in the left-hand column for each section you have completed.)

Designation of my mental health care agents(s).

Authority granted to my agent(s).

My preference for a court appointed guardian.

My preference of treating facility and alternatives to hospitalization.

My preferences about the physicians or other mental health care providers who will treat me if I am hospitalized.

My preferences regarding medications.

___ My preferences regarding electroconvulsive therapy (ECT or shock treatment).

___ My preferences regarding emergency interventions (seclusion, restraint, medications).

___ Consent for experimental drugs or treatments.

___ Who should be notified immediately of my admission to a facility.

___ Who should be prohibited from visiting me.

___ My preferences for care and temporary custody of my children or pets.

___ Other instructions about mental health care and treatment.

PART 2

DURABLE POWER OF ATTORNEY FOR MENTAL HEALTH TREATMENT DECISIONS

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make mental health care decisions for me:

(name of individual you choose as agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a mental health care decision for me, I designate as my first alternate agent:

(name of individual you choose as first alternate agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a mental health care decision for me, I designate as my second alternate agent:

(name of individual you choose as second alternate agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

(2) AGENT'S AUTHORITY: My agent is authorized to make all mental health care treatment decisions for me, including decisions to provide, withhold, or withdraw medication and treatment, and all other forms of mental health care, except as I state here:

(Add additional sheets if needed.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my supervising health care provider who is a physician and one other physician or licensed psychologist determine that I am unable to make my own mental health care decisions.

(4) AGENT'S OBLIGATION: My agent shall make mental health care decisions for me in accordance with this power of attorney for mental health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make mental health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of the person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 3

INSTRUCTIONS FOR MENTAL HEALTH CARE AND TREATMENT

If you are satisfied to allow your agent to determine what is best for you, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) My preference of treating facility and alternatives to hospitalization:

(7) My preferences about the physicians or other mental health care providers who will treat me if I am hospitalized:

(8) My preferences regarding medications:

(9) My preferences regarding electroconvulsive therapy (ECT or shock treatment):

(10) My preferences regarding emergency interventions (seclusion, restraint, medications):

(11) Consent for experimental drugs or treatments:

(12) Who should be notified immediately of my admission to a facility:

(13) Who should be prohibited from visiting me:

(14) My preferences for care and temporary custody of my children or pets:

(15) My preferences about revocation of my advance mental health care directive during a period of incapacity:

(16) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

(Add additional sheets if needed.)

PART 4

WITNESSES AND SIGNATURES

(17) EFFECT OF COPY: A copy of this form has the same effect as the original.

(18) SIGNATURES: Sign and date the form here:

(date) (sign your name)

(address) (print your name)

(city) (state)

(19) WITNESSES: This power of attorney will not be valid for making mental health care decisions unless it is either: (a) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (b) acknowledged before a notary public in the State.

AFFIRMATION OF WITNESSES

Witness 1

I declare under penalty of false swearing pursuant to section 710-1062, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility. I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

(date) (sign your name)

(address) (print your name)

(city) (state)

Witness 2

I declare under penalty of false swearing pursuant to section 710-1062, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility. I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

(date) (sign your name)

(address) (print your name)

(city) (state)

DECLARATION OF NOTARY

State of Hawaii

County of _____

On this _____ day of _____, in the year _____, before me, _____ (insert name of notary public) appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and

acknowledged that he or she executed it.

Notary Seal _____

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SECTION 3. Chapter 327F, Hawaii Revised Statutes, is repealed.

SECTION 4. If House Bill No. 2297 is passed by the legislature during this Regular Session of 2004, and becomes an Act whether before or after the effective date of this Act, then, effective January 1, 2005, subsection (b) of the new section 560:5-304 in section 1 of that Act shall be amended to read:

"(b) The petition shall set forth the petitioner's name, residence, current address if different, relationship to the respondent, and interest in the appointment and, to the extent known, state or contain the following with respect to the respondent and the relief requested:

(1) The respondent's name, age, principal residence, current street address, and, if different, the address of the dwelling in which it is proposed that the respondent will reside if the appointment is made;

(2) The name and address of the respondent's:

(A) Spouse or reciprocal beneficiary, or if the respondent has none, an adult with whom the respondent has resided for more than six months before the filing of the petition; and

(B) Adult children or, if the respondent has none, the respondent's parents and

adult siblings, or if the respondent has none, at least one of the adults nearest in kinship to the respondent who can be found;

(3) The name and address of any person responsible for care or custody of the respondent;

(4) The name and address of any legal representative of the respondent;

(5) The name and address of any person nominated as guardian by the respondent;

(6) The name and address of any agent appointed by the respondent under any medical directive, mental health care directive, or health care power of attorney, or, if none, any designated surrogate under section 327E-5(f);

(7) The name and address of any proposed guardian and the reason why the proposed guardian should be selected;

(8) The reason why guardianship is necessary, including a brief description of the nature and extent of the respondent's alleged incapacity;

(9) If an unlimited guardianship is requested, the reason why limited guardianship is inappropriate and, if a limited guardianship is requested, the powers to be granted to the limited guardian; and

(10) A general statement of the respondent's property with an estimate of its value, including any insurance or pension, and the source and amount of any other anticipated income or receipts."

SECTION 5. This Act shall take effect on its approval.

209 Cal. App. 3d 1303; 271 Cal. Rptr. 199; 1987 Cal. App. LEXIS 2430

ELEANOR RIESE et al., Plaintiffs and Appellants, v. ST. MARY'S HOSPITAL AND MEDICAL CENTER, Defendant and Respondent

No. A034048

Court of Appeal of California, First Appellate District, Division Two

209 Cal. App. 3d 1303; 271 Cal. Rptr. 199; 1987 Cal. App. LEXIS 2430

December 16, 1987

SUBSEQUENT HISTORY:

Review granted March 3, 1988. Review dismissed and opinion ordered published June 22, 1989.

PRIOR HISTORY:

Superior Court of the City and County of San Francisco, No. 841488, Raymond D. Williamson, Jr., Judge.

COUNSEL: Colette I. Hughes and Morton P. Cohen for Plaintiffs and Appellants.

Peter W. Davis, James M. Wood, Ezra Hendon and Crosby, Heafey, Roach & May for Defendant and Respondent.

J. Benedict Centifanti, James J. Preis, Michael L. Perlin and Peter Margulies as Amici Curiae.

JUDGES: Opinion by Kline, P. J., with Rouse and Benson, JJ., concurring. Separate concurring opinion by Benson, J.

OPINIONBY: KLINE

OPINION: This class action presents the question whether psychiatric patients involuntarily committed to mental health facilities under Welfare and Institutions Code sections 5150 and 5250 n1 may be forced to take antipsychotic drugs against their will in nonemergency n2 situations.

- - - - - Footnotes - - - - -

n1 All statutory references will be to the Welfare and Institutions Code unless otherwise indicated.

n2 "An emergency exists when there is a sudden marked changed 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." (Cal. Admin. Code, tit. 9, § 853.)

- - - - - End Footnotes- - - - -

Appellant Eleanor **Riese**, on behalf of the class of patients institutionalized under sections 5150 and 5250 and given antipsychotic drugs over their objection, brought a petition for writ of mandate seeking a determination that the patients' informed consent was required before such drugs could be administered. Appellants contend that California statutes, common law and constitutional guarantees of privacy and freedom of speech give them the right to refuse antipsychotic drugs.

(1a) We hold that appellants have statutory rights to exercise informed consent to the use of antipsychotic drugs in nonemergency situations absent a judicial determination of their incapacity to make treatment decisions, and do not reach the constitutional issues.

Statement of Facts

Appellant **Riese** has a history of chronic schizophrenia, apparently stemming from childhood meningitis. She was first hospitalized in 1968, at age 25. In 1969, an internist prescribed the antipsychotic drug Mellaril; appellant showed immediate improvement, moved into her own apartment and was not hospitalized for approximately 11 years. By 1981, however, appellant had developed bladder problems associated with long-term use of Mellaril. Her medication was changed but she decompensated to the point that she had to be hospitalized for two weeks in 1981. She was rehospitalized in 1982 and placed back on Mellaril on the theory that her bladder was already so damaged that more or less Mellaril would not affect its potential recovery. In 1984, appellant switched doctors and was placed on Moban, which did not help her symptoms. She then stopped seeing the doctor, decompensated and was hospitalized, the hospitalization from which the present litigation arose.

Appellant was admitted to respondent hospital as a voluntary patient on June 12, 1985, for an acute exacerbation of chronic schizophrenia. According to the report of the initial consultation, she had previously been treated with Mellaril but had not been taking the drug for five weeks. According to two psychiatrists who reviewed her records, appellant's failure to continue this medication was not the cause of the increasing agitation and anxiety, hallucinations and paranoid ideation that led to her hospitalization.

Upon admission, appellant signed a voluntary inpatient's consent form for antipsychotic medication, indicating that she had been informed of the nature of the drugs and their possible side effects and understood her right to refuse the drugs. The form specified the drugs Mellaril and Cogentin. On June 16, appellant consented to have her medication changed to Molindane (Moban). On June 17, the medication was changed to Navane, this time without execution of a consent form. On June 18, appellant was switched back to Mellaril, at an increased dosage. Appellant complained that Mellaril made her sleepy but agreed to take 100 milligrams 4 times a day. The next day she complained of dizziness

and dry mouth and insisted that the staff had given her too much medication. When appellant became more agitated and refused medication she was forcibly injected. n3

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n3 According to appellant's hospital records, she "cooperated [with the] injections although needed a show of force (5 staff members)." Appellant's declaration states that she was held down by several men who took down her underwear and injected her in the buttocks.

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At this point, on June 19, appellant was made an involuntary patient under Welfare and Institutions Code section 5250, on the ground that she refused medication and became violent, was unable to cooperate with treatment and was actively psychotic. Thereafter, appellant was apparently switched back to Navane and given medication intramuscularly when she refused to ingest it orally. Appellant complained that Navane had adverse physical effects (dermatitis and swelling of the ankles) and at one point agreed to take Mellaril in order to discontinue the Navane.

On June 26, 1985, it was recommended that a conservator be appointed for appellant, who was assertedly unable to provide for her own food, shelter and clothing and delusional about medication and therefore unable or unwilling to accept voluntary treatment. (§ 5352.) A temporary conservator was appointed on July 2 (§ 5352.1); a conservator was appointed subsequently on August 5, 1985. (§ 5350.) The court authorized the temporary conservator to place appellant for psychiatric treatment. (§§ 5353, 5358.)

On July 10, appellant was discharged to a board and care home, but she did not do well and was readmitted to the hospital on July 12. Her medication was changed to Serentil, with orders providing for intramuscular injections if she refused. Appellant continued to suffer from swollen feet, urinary problems, shaking, memory loss and seizures. While appellant attributes these problems to her use of medications, respondent contends that appellant was delusional about the medications.

Discussion

Antipsychotic Medications

Antipsychotic or, as they are sometimes called, psychotropic or neuroleptic drugs are "customarily used for the treatment of symptoms of psychoses and other severe mental and emotional disorders." (Cal. Admin. Code, tit. 9, § 856.) The drugs benefit many patients by minimizing or eliminating psychotic symptoms (*Keyhea v. Rushen* (1986) 178 Cal.App.3d 526, 531 [223 Cal.Rptr. 746] review den. July 10, 1986; Gelman, *Mental Hospital Drugs, Professionalism, and the Constitution* (1984) 72 Geo.L.J. 1725, 1741), although not all patients are helped by the drugs and some improve without them (Hollister, *Psychiatric Disorders* (1980) Principles and Practice of Clinical Pharmacology and

Therapeutics, p. 1076; Jennings & Schultz, *Psychopharmacologic Treatment of Schizophrenia: Developing a Dosing Strategy* (1986) 21 Hosp. Formul. 332), and there is no means to accurately predict how a patient will react to a particular drug. (Kemna, *Current Status of Institutionalized Mental Health Patients' Right to Refuse Psychotropic Drugs* (1985) 6 J. Legal Med. 107; Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment* (1977) 72 Nw.U.L.Rev. 461, 474-475.) The drugs are palliative rather than curative (Baldessarini, *Chemotherapy in Psychiatry: Principles and Practice* (rev. ed. 1985) 52; Hollister, *supra*, at p. 1076) and are most effective in the treatment of acute (short-term) rather than chronic (long-term) psychosis. (Baldessarini, *supra*, at pp. 52-53, 57; 87-88; Baldessarini & Lipinski, *Risks vs. Benefits of Antipsychotic Drugs* (1973) 289 New Eng. J. of Med., 427, 427-428; Kemna, *supra*, 6 J. Legal Med. at p. 110.) For acute cases, however, these drugs are the principal and single most effective treatment (Baldessarini & Lipinski, *supra*, at p. 427; Baldessarini, *supra*, at p. 87; Hollister, *supra*, at p. 1076), and "withholding of these medications within a period of weeks to a few months after recovery from an acute breakdown carries a serious risk of relapse." (Baldessarini & Lipinski, *supra*, at pp. 427-428.) Indeed, use of these drugs has greatly reduced the number of mentally ill requiring hospitalization, and the frequency and length of hospitalizations. (Hollister, *supra*, at p. 1058; Gelman, *supra*, at pp. 1725-1726, 1741; Brooks, *Law and Antipsychotic Medications* (1986) 4 Behavioral Sciences & The Law 247, 248-249.) It is believed that the positive effects of antipsychotic drugs are greatly lessened if the patient does not accept them willingly. (*Rennie v. Klein* (D.N.J. 1978) 462 F.Supp. 1131, 1141.)

Antipsychotic drugs have been described as normative in the sense that they "restore existing imbalance toward the balanced norm . . . [and] are generally incapable of creating thoughts, views[,] ideas or opinions *de novo*, or of permanently inhibiting the process of thought generation." (Appelbaum & Gutheil, "Rotting with their Rights On": *Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients* (1979) 7 Am.Acad.Psychiatry & L.Bull. 306, 308.) By the same token, they are by intention mind altering in that they act upon thought processes. (*Guardianship of Roe* (1981) 383 Mass. 415 [421 N.E.2d 40, 52-53]; *Rogers v. Okin* (D.Mass. 1979) 478 F.Supp. 1342, 1360 *affd.* in part, reversed in part (1st Cir. 1980) 634 F.2d 650, vacated *Mills v. Rogers* (1982) 457 U.S. 291 [73 L.Ed.2d 16, 102 S.Ct. 2442] on remand (1st Cir. 1984) 738 F.2d 1.) The drugs have been called "powerful enough to immobilize mind and body." (*Guardianship of Roe*, *supra*, 421 N.E.2d at p. 53.) They "'possess a remarkable potential for undermining individual will and self-direction, thereby producing a psychological state of unusual receptiveness to the directions of custodians.'" (*Keyhea v. Rushen*, *supra*, 178 Cal.App.3d at p. 531, quoting Gelman, *supra*, at p. 1751.) Abuses of psychotropic medications in understaffed and inadequately funded public mental hospitals have been documented. (See, e.g., *Davis v. Hubbard* (N.D.Ohio 1980) 506 F.Supp. 915, 926-927.)

In addition to their universally accepted benefits in the treatment of at least acute patients, antipsychotic drugs have equally well-recognized adverse side effects. These include sedation to the extent of interference with the ability to function normally; akathisia, an irresistible urge to move; pseudo-Parkinsonism (causing mask-like

facial expression, body rigidity, tremor, drooling, and a shuffling gait); blurred vision; dry mouth; dizziness or faintness; and low blood pressure. These effects are reversible upon termination or reduced dosage of the medication. On rare occasions, the drugs may cause sudden death. (*Keyhea v. Rushen*, *supra*, 178 Cal.App.3d at p. 531; *Davis v. Hubbard*, *supra*, 506 F.Supp. 915, 928; *Kemna*, *supra*, 6 J. Legal Med. at pp. 111-114.)

A potentially permanent side effect of antipsychotic medication is tardive dyskinesia, a neurological disorder manifested by involuntary, rhythmic and grotesque movements of the face, mouth, tongue, jaw and extremities. In its most progressive state, this condition interferes with all motor activity. (*Keyhea v. Rushen*, *supra*, 178 Cal.App.3d at p. 531; *Davis v. Hubbard*, *supra*, 506 F.Supp. at pp. 928-929; *Kemna*, *supra*, 6 J. Legal Med. at p. 113; see also, Taub, *Tardive Dyskinesia: Medical Facts and Legal Fictions* (1986) 30 St.Louis U.L.J. 833.) As tardive dyskinesia generally occurs after prolonged use of antipsychotic drugs (*Rogers v. Okin*, *supra*, 478 F.Supp. at p. 1360; *Baldessarini*, *supra*, at p. 75; Mills, Norquist, et al., *Consent and Liability with Neuroleptics: The Problem of Tardive Dyskinesia* (1986) 8 Intl.J.L. & Psychiatry 243, 246; Mann, et al., *Early Onset of Severe Dyskinesia Following Lithium-Haloperidol Treatment* (1983) 140 Am.J.Psychiatry 1385), respondent contends that it poses no risk to appellants, who are confined only on a short-term basis. It appears, however, both that the condition can occasionally occur after only brief treatment (Appleton, *Fourth Psychoactive Drug Usage Guide* (1982) 43 J.Clin.Psychiatry 12; Mann, et al., *supra*, 140 Am.J.Psychiatry at pp. 1385-1386), and that it may result from cumulative treatment (Kane, et al., *Integrating Incidence and Prevalence of Tardive Dyskinesia* (1986) 22 Psychopharmacology Bull. 254, 255), so that a patient subject to repeated hospitalizations might suffer incremental effects from short term drug treatment.

The Right to Refuse Antipsychotic Medication

The rights of involuntarily detained mentally disordered people in California are scrupulously protected by the Lanterman-Petris-Short Act. (§ 5000 et seq., hereinafter LPS; *Keyhea v. Rushen*, *supra*, 178 Cal.App.3d at p. 534.) (2) The act repealed the previously existing indeterminate civil commitment scheme; removed legal disabilities previously imposed upon those adjudicated to be mentally ill; and emphasized voluntary treatment, with periods of involuntary observation and crisis treatment for people unable to care for themselves or whose condition makes them a danger to themselves or others. (*Thorn v. Superior Court* (1970) 1 Cal.3d 666, 668 [83 Cal.Rptr. 600, 464 P.2d 56]; see § 5001.)

Under LPS, a person may be involuntarily detained in a mental health facility for 72 hours if a peace officer or one of certain specified professionals finds probable cause that the person is a danger to self or others or is "gravely disabled," that is, if he or she, as a result of a mental disorder, is unable to provide for basic personal needs for food, clothing or shelter. (§§ 5008, subd. (h)(1), 5150.) n4 The person may be certified for 14 days of intensive treatment if the professional staff of the facility determines that any of these conditions exist. (§ 5250.) n5 At this point, a conservator may be appointed if the person is judicially determined to be gravely disabled as a result of mental

disorder or impairment by chronic alcoholism. (§ 5350.)

(3) Appointment of a conservator under LPS, as under the Probate Code, does not involve an adjudication of incompetence (*Board of Regents v. Davis* (1975) 14 Cal.3d 33, 38-39, 43 [120 Cal.Rptr. 407, 533 P.2d 1047] on remand (1977) 74 Cal.App.3d 862 [141 Cal.Rptr. 670]; *Baber v. Napa State Hospital* (1984) 154 Cal.App.3d 514, 519 [201 Cal.Rptr. 432]; 58 Ops.Cal.Atty.Gen. 849 (1975)) or incapacity to make treatment decisions about one's own body. (60 Ops.Cal.Atty.Gen. 375, 376-378 (1977); 58 Ops.Cal.Atty.Gen. 849 (1977).) The conservatee retains the right to refuse medical treatment unless the court, after making appropriate findings, specifically denies the conservatee this right in its order and authorizes the conservator to make informed consent decisions. (*Keyhea v. Rushen, supra*, 178 Cal.App.3d at pp. 535-536.)

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n4 A person is also gravely disabled if he or she has been found mentally incompetent under section 1370 of the Penal Code, the indictment or information charges a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person, and has not been dismissed, and the person "as a result of mental disorder . . . is unable to understand the nature and purpose of the proceedings taken against him and to assist counsel in the conduct of his defense in a rational manner." (§ 5008 subd. (h)(2)(iii).)

n5 A person may be confined for an additional 14 days of intensive treatment if the person is suicidal (§ 5260), and for 180-day postcertification treatment periods if the person presents "a demonstrated danger of inflicting substantial physical harm upon others." (§§ 5300-5306.)

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A number of provisions of LPS delineate rights held by involuntary patients. Section 5325 requires that enumerated rights be prominently posted or otherwise brought to patients' attention; the most significant for purposes of this case are the right "[to] refuse convulsive treatment" (such as electroconvulsive and insulin coma treatment) (§ 5325, subd. (f)) and "[to] refuse psychosurgery." (§ 5325, subd. (g).) n6 Section 5325.1 generally states that "[persons] with mental illness have the same legal rights and responsibilities guaranteed all 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" and then sets out a nonexclusive list of rights including "[a] right to dignity, privacy, and humane care" (§ 5325.1, subd. (b)) and "[a] right to be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse, or neglect. Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the treatment program." (§ 5325.1, subd. (c); see, §§ 5005, 5327.) n7 Involuntary patients who are receiving medications as a result of their mental illness must be given, as soon as possible after detention, written and oral information about the probable effects and possible side effects of the

medication, and must be told the reason the medication is being given or recommended, the likelihood of improving or not improving without the medications, reasonable alternative treatments available, and information concerning the name, dosage and frequency of medication. (§ 5152, subd. (c).)

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n6 The full text of section 5325 is as follows: "Each person involuntarily detained for evaluation or treatment under provisions of this part, each person admitted as a voluntary patient for psychiatric evaluation or treatment to any health facility, as defined in Section 1250 of the Health and Safety Code, in which psychiatric evaluation or treatment is offered, and each mentally retarded person committed to a state hospital pursuant to Article 5 (commencing with Section 6500) of Chapter 2 of Part 2 of Division 6 shall have the following rights, a list of which shall be prominently posted in the predominant languages of the community and explained in a language or modality accessible to the patient in all facilities providing such services and otherwise brought to his or her attention by such additional means as the Director of Mental Health may designate by regulation: [para.] (a) To wear his or her own clothes; to keep and use his or her own personal possessions including his or her toilet articles; and to keep and be allowed to spend a reasonable sum of his or her own money for canteen expenses and small purchases. [para.] (b) To have access to individual storage space for his or her private use. [para.] (c) To see visitors each day. [para.] (d) To have reasonable access to telephones, both to make and receive confidential calls or to have such calls made for them. [para.] (e) To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence. [para.] (f) To refuse convulsive treatment including, but not limited to, any electroconvulsive treatment, any treatment of the mental condition which depends on the induction of a convulsion by any means, and insulin coma treatment. [para.] (g) To refuse psychosurgery. Psychosurgery is defined as those operations currently referred to as lobotomy, psychiatric surgery, and behavioral surgery and all other forms of brain surgery if the surgery is performed for the purpose of any of the following: [para.] (1) Modification or control of thoughts, feelings, actions, or behavior rather than the treatment of a known and diagnosed physical disease of the brain. [para.] (2) Modification of normal brain function or normal brain tissue in order to control thoughts, feelings, actions, or behavior. [para.] (3) Treatment of abnormal brain function or abnormal brain tissue in order to modify thoughts, feelings, actions or behavior when the abnormality is not an established cause for those thoughts, feelings, actions, or behavior. [para.] Psychosurgery does not include prefrontal sonic treatment wherein there is no destruction of brain tissue. The Director of Mental Health shall promulgate appropriate regulations to assure adequate protection of patients' rights in such treatment. [para.] (h) To see and receive the services of a patient advocate who has no direct or indirect clinical or administrative responsibility for the person receiving mental health services. [para.] (i) Other rights, as specified by regulation. [para.] Each patient shall also be given notification in a language or modality accessible to the patient of other constitutional and statutory rights which are found by the State Department of Mental Health to be frequently misunderstood, ignored, or

denied. [para.] Upon admission to a facility each patient shall immediately be given a copy of a State Department of Mental Health prepared patients' rights handbook. [para.] The State Department of Mental Health shall prepare and provide the forms specified in this section and in Section 5157. [para.] The rights specified in this section may not be waived by the person's parent, guardian, or conservator."

n7 Thus; for example, section 5325.1 provides in part as follows: "No otherwise qualified person by reason of having been involuntarily detained for evaluation or treatment under provisions of this part or having been admitted as a voluntary patient to any health facility, as defined in Section 1250 of the Health and Safety Code, in which psychiatric evaluation or treatment is offered shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity, which receives public funds. [para.] It is the intent of the legislature that persons with mental illness shall have rights including, but not limited to, the following: [para.] (a) A right to treatment services which promote the potential of the person to function independently. Treatment should be provided in ways that are least restrictive of the personal liberty of the individual. [para.] (b) A right to dignity, privacy, and humane care. [para.] (c) A right to be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse, or neglect. Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the treatment program. [para.] (d) A right to prompt medical care and treatment. [para.] (e) A right to religious freedom and practice. [para.] (f) A right to participate in appropriate programs of publicly supported education. [para.] (g) A right to social interaction and participation in community activities. [para.] (h) A right to physical exercise and recreational opportunities. [para.] (i) A right to be free from hazardous procedures."

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(4) It is one of the cardinal principles of LPS that mental patients may not be presumed incompetent solely because of their hospitalization. As stated in section 5331, "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." n8 Similarly, section 5326.5, subdivision (d), which is part of a section defining the written consent required in certain circumstances, reiterates the basic idea that: "[a] person confined shall not be deemed incapable of refusal [of proposed therapy] solely by virtue of being diagnosed as a mentally ill, disordered, abnormal, or mentally defective person." n9 Provisions such as section 5331 and subdivision (d) of section 5326.5 refer to a legal standard of competence and are in accord with other states' laws. (E.g., *Rivers v. Katz* (1986) 67 N.Y.2d 485 [504 N.Y.S.2d 74, 495 N.E.2d 337, 342]; *Goedecke v. State, Dept. of Institutions* (1979) 198 Colo. 407 [603 P.2d 123, 125]; *In re K.K.B.* (Okla. 1980) 609 P.2d 747, 749; *Rogers v. Com'r of Dept. of Mental Health* (1983) 390

Mass. 489 [458 N.E.2d 308, 314]; *Kemna, supra*, 6 J.Legal Med. at p. 117, fn. 75; *Plötkin, supra*, 72 Nw.U.L.Rev. at pp. 489, 490.)

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n8 Respondent argues that because section 5331 uses the past tense it "applies only to disabilities that arise after the patient's treatment has been completed and after he or she has been discharged." Therefore, respondent urges, the section implies a legislative intent to limit the rights of hospitalized patients. We reject this contorted construction. First of all, the legislative history of LPS makes it clear the Legislature intended to prohibit a presumption of incompetence both during and after hospitalization. (See, e.g., *The Dilemma of Mental Commitments in California: A Background Document*, Subcommittee on Mental Health Services, Assembly Interim Committee on Ways and Means (Nov. 1966), pp. 52-53; *The Mental Health Act of 1967*, Assembly Bill 1220, Summary of an Act to solve the dilemma of mental commitments in California (April 1967) p. 12). When in 1981 section 5325 was amended to expand the rights of persons involuntarily detained under LPS, the Legislature reiterated its concern that "far too frequently, recipients of mental health services are deprived of the protection of the law and their rights are disregarded or abused both *in the course of obtaining treatment for their disability* and the conduct of their lives in the community." (Stats. 1981, ch. 841, § 1, italics added.) The theory that section 5331 does not apply during hospitalization is also untenable because it rests upon an impermissible inference. As we later explain, persons with mental illness may not be denied rights available to others except on the basis of a specific statutory limitation. (See discussion, *post*, at pp. 1318-1319.) Section 5331 is bereft of any such limitation. Thus, respondent would have us employ a statute designed to expand rights to accomplish the opposite.

n9 An earlier version of section 5326.5 was declared unconstitutional in *Aden v. Younger* (1976) 57 Cal.App.3d 662, 686 [129 Cal.Rptr. 535], because it contained a penalty provision dependent on sections 5326.3 and 5326.4, which were found constitutionally infirm for a variety of reasons. (*Ibid.*) In 1976, shortly after *Aden v. Younger* issued, the Governor approved legislation amending section 5326.5 by deleting the penalty provision and adding, *inter alia*, the language now contained in subdivision (d), quoted in the text above.

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(1b) Respondent's claim that LPS affords appellants no right to refuse antipsychotic drugs emphasizes that such right is not listed in section 5325 along with the rights to refuse convulsive treatment and psychosurgery. Respondent additionally points out that the protection against abuses in prescribing and dispensing medication afforded by section 5325.1 implies that patients have no right to refuse medication given for proper reasons. Respondent also asserts that section 5152, subdivision (c), which requires that involuntary patients be given information concerning medication they receive without providing that they may refuse such medication, would be superfluous if a right to

informed consent existed and would have said so if it was intended to create such a right.

As indicated, the cornerstone of respondent's case is the fact that LPS does not explicitly grant appellants the right they claim. For example, after stressing that "[the] right to refuse antipsychotic medications absent a finding of incompetency is pointedly not included among the statutory rights given persons involuntarily committed under LPS," respondent argues that those provisions of LPS which confer *other* rights on such persons, such as the right to refuse "convulsive treatment" and "psychosurgery" (§ 5325, subds. (f) and (g)), "represent a classic illustration of the maxim of '*expressio unius est exclusio alterius* [*sic*],' under which in a comprehensive statutory scheme such as LPS 'there is an inference that all omissions should be understood as exclusions.'" (Citing 2A Sutherland, Statutory Construction (4th ed.), § 47.23, p. 194.)

(5) The maxim upon which respondent relies "'requires great caution in its application, and in all cases is applicable only under certain conditions.'" (2A Sutherland, Statutory Construction, *supra*, § 47.25, p. 209.) Moreover, the rule "can be overcome by a strong indication of legislative intent or policy." (*Id.*, § 47.23, p. 194.) As stated by our Supreme Court, "the inference embodied in the maxim *inclusio unius est exclusio alterius* is not to be drawn when to do so would frustrate a contrary expression of legislative will" (*Fields v. Eu* (1976) 18 Cal.3d 322, 332 [134 Cal.Rptr. 367, 556 P.2d 729]; accord, *Larcher v. Wanless* (1976) 18 Cal.3d 646, 658 [135 Cal.Rptr. 75, 557 P.2d 507].)

(1c) In this case, the treatment of a statutory omission as an exclusion would clearly frustrate a contrary expression of legislative purpose: throughout the statutory scheme the Legislature repeatedly admonishes that the failure of LPS to explicitly confer a particular right upon mentally ill persons cannot provide a basis upon which to deny it.

Section 5005 provides that " *Unless specifically stated*, a person [detained under] the provisions of this part shall not forfeit any legal right or suffer legal disability by reason of the provisions of this part." (Italics added.) Similarly, section 5325.1 commences with the definitive statement that "Persons with mental illness have the same legal rights and responsibilities guaranteed all 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*." (Italics added.) Finally, section 5327 specifies that "Every person involuntarily detained under provisions of this part . . . shall be entitled to all rights set forth in this part and *shall retain all rights not specifically denied him under this part*." (Italics added.)

The foregoing provisions were obviously calculated to prohibit the use of legislative silence as a basis upon which to deprive mentally ill persons not adjudicated incompetent of any right enjoyed by others. (6) It should be pointed out, in this connection, that the right of persons not adjudicated incompetent to give or withhold consent to medical treatment is protected by the common law of this state (*Cobbs v. Grant* (1972) 8 Cal.3d 229, 242-243 [104 Cal.Rptr. 505, 502 P.2d 1]; *Keyhea v. Rushen*, *supra*, 178 Cal.App.3d 526, 540; *Foy v. Greenblott* (1983) 141

Cal.App.3d 1, 11 [190 Cal.Rptr. 84]; *Bouvia v. Superior Court* (1986) 179 Cal.App.3d 1127, 1137-1138 [225 Cal.Rptr. 297] review den. June 5, 1986; *Barber v. Superior Court* (1983) 147 Cal.App.3d 1006, 1015 [195 Cal.Rptr. 484, 47 A.L.R.4th 1]) and by the constitutional right to privacy. (*Keyhea v. Rushen, supra*, 178 Cal.App.3d at p. 540; *Foy v. Greenblott, supra*, 141 Cal.App.3d at p. 11; *Bartling v. Superior Court* (1984) 163 Cal.App.3d 186, 195 [209 Cal.Rptr. 220] on remand *Bartling v. Glendale Adventist Medical Center* (1986) 184 Cal.App.3d 97 [228 Cal.Rptr. 847]; 58 Ops.Cal.Atty.Gen. 849, 850-852 (1975).) n10 This right to control "intrusions of [one's] bodily integrity" (*Bartling v. Superior Court, supra*, 163 Cal.App.3d at p. 195) extends so far as to protect the choice to refuse life-sustaining treatment. (*Bouvia v. Superior Court, supra*, 179 Cal.App.3d at p. 1137; *Bartling v. Superior Court, supra*, 163 Cal.App.3d at pp. 193-194; *Barber v. Superior Court, supra*, 147 Cal.App.3d at pp. 1015-1016.) (7) Treatment with antipsychotic drugs not only affects the patient's bodily integrity but the patient's mind, the "quintessential zone of human privacy." (*Long Beach City Employees Assn. v. City of Long Beach* (1986) 41 Cal.3d 937, 944 [227 Cal.Rptr. 90, 719 P.2d 660]; *Cutter v. Brownbridge* (1986) 183 Cal.App.3d 836, 842-843 [228 Cal.Rptr. 545].) n11 We have seen that such treatment has profound effects -- both intended and unintended -- on mind and body. The right to refuse treatment with these drugs clearly falls within the recognized right to refuse medical treatment. (See *Keyhea v. Rushen, supra*, 178 Cal.App.3d at p. 540.) Because this right is among those "guaranteed all other persons by the . . . Constitution and laws of the State of California" (§ 5325.1), it cannot be denied those confined under LPS absent a specific statutory limitation.

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n10 Although not mentioned by the cited cases, the California Supreme Court's decision in *People v. Privitera* (1979) 23 Cal.3d 697 [153 Cal.Rptr. 431, 591 P.2d 919, 5 A.L.R.4th 178], cert. den. *sub nom. Privitera v. California* (1979) 444 U.S. 949 [62 L.Ed.2d 318, 100 S.Ct. 419, 420], casts some doubt on whether the right to privacy encompasses decisions to refuse medical treatment. *Privitera* held that the right to privacy does not include decisions about medical treatment, specifically, the "right to obtain drugs of unproven efficacy." (Laetrile.) (*Id.*, at p. 702.) However, that case and others which rely upon its definition of the right of privacy concern state actions which limit access to desired but possibly harmful treatment (*id.*, at pp. 702-703; *Kate' School v. Department of Health* (1979) 94 Cal.App.3d 606, 621-622 [156 Cal.Rptr. 529]) or otherwise impinge upon the ability to obtain treatment (*People v. Younghanz* (1984) 156 Cal.App.3d 811, 815-816 [202 Cal.Rptr. 97]) or impose regulations on health care providers in the interest of public safety (*Wilson v. California Health Facilities Com.* (1980) 110 Cal.App.3d 317, 319, 321-322 [167 Cal.Rptr. 801] app. dismiss. 450 U.S. 1036 [68 L.Ed.2d 233, 101 S.Ct. 1751].) Such cases are quite different from the present one, where the state seeks to impose upon an unwilling patient a treatment having potentially harmful effects.

n11 The cited cases protect against intrusions into the mind by means

of lie detector tests (*Long Beach City Employees Assn. v. City of Long Beach, supra*) or therapists' disclosures (*Cutter v. Brownbridge, supra*). While the present case does not involve such forced revelations of the content of the mind, the changing of thoughts contested here is no less intrusive.

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(1d) We conclude that the failure of LPS to explicitly grant involuntary patients the right to refuse drug treatment, which respondent relies upon, cannot be deemed as significant as the failure of the statutory scheme to explicitly deny that right. As stated in *Rogers v. Com'r of Dept. of Mental Health, supra*, 458 N.E.2d 308, "[the] fact that [a statute] expressly authorizes patients to refuse psychosurgery and electroconvulsive treatment does not, as the defendants assert, exclude by implication the patients' rights to make treatment decisions as to antipsychotic drugs." (*Id.*, at p. 313.)

Moreover, as earlier explained, LPS is not silent on the question whether involuntary patients may be denied any right on the ground that they are of unsound mind. Section 5331 and section 5326.5, subdivision (d), prohibit the presumption of incompetence from the fact of an involuntary commitment. Other sections also indicate that involuntary commitment is not to be equated with incompetence to participate in treatment decisions. As previously noted, section 5325 gives involuntary patients the right to refuse convulsive treatment and psychosurgery. Psychosurgery may be performed on a patient, voluntary or involuntary, only in specified circumstances and only if the patient gives written informed consent. (§§ 5326.6, 5326.) Similarly, convulsive treatment may be administered to an involuntary patient under specified circumstances only if the patient gives written informed consent or is judicially determined not to have the capacity to give such consent and the consent is obtained from the patient's responsible relative, guardian or conservator. (§§ 5326.7, 5326.) n12 Thus, LPS recognizes that patients may be involuntarily committed yet nevertheless remain capable of giving informed consent. (See § 5326.15.) n13 Indeed, it is difficult to see the purpose of the recently adopted requirement that involuntary patients, including those detained under an emergency 72-hour commitment (§ 5152, subd. (c)), be given detailed information regarding medications and their side effects if these patients are necessarily incompetent to participate in treatment decisions and have absolutely no right to refuse the treatment prescribed.

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n12 Section 5326.15 concerns reporting requirements imposed upon any doctor or facility which administers convulsive treatments or psychosurgery. The section lists as one category "[involuntary] patients who gave informed consent" and as another "[involuntary] patients who were deemed incapable of giving informed consent and received convulsive treatment against their will." (§ 5326.15, subds. (a)(1) and (a)(2).)

n13 A confined person is considered incapable of written informed consent if the person "cannot understand, or knowingly and intelligently act upon" information enumerated in section 5326.2 concerning the reason for the treatment; nature of the procedures to be used; probable degree and duration of improvement or remission expected with or without the treatment; nature, degree, duration and probability of side effects and significant risks of the treatment commonly known to the medical profession, and how and to what extent they may be controlled; reasonable alternative treatments; and the right to refuse or consent to the treatment. (§ 5326.5, subd. (c).)

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The fact that voluntary patients are required to give informed consent to treatment with antipsychotic drugs is also significant. Patients who refuse drugs do so for a variety of reasons; while the majority are apparently delusional or the products of the mental illness, others are more rational. (Appelbaum & Hoge, *Empirical Research on the Effects of Legal Policy on the Right to Refuse Treatment*, in *The Right to Refuse Anti-Psychotic Medication* (ABA Com. on the Mentally Disabled 1986) 87, 91-92; Kemna, *supra*, 6 J.Legal Med. at pp. 115-116; Appelbaum & Gutheil, *supra*, 7 Am.Acad.Psychiatry & L.Bull. at pp. 311-315; Appelbaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients* (1980) 137 Am.J.Psychiatry 340, 344-345.) In one study, the only patients who refused treatment persistently (more than 24 hours) were judged to be delusional about the medication, suggesting that refusal is more a medical than a legal problem. (Appelbaum & Gutheil, *supra*, 7 Am.Acad.Psychiatry & L.Bull. at p. 313.) n14 Since "both psychosis and incompetence cut across lines of voluntariness" (*ibid.*), it is not status but competence which should determine a patient's ability to exercise the right to refuse medication.

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n14 Research indicates that the epidemic of refusals feared after early litigation of the right to refuse antipsychotic medication (e.g., *Rogers v. Okin, supra*, 478 F.Supp. 1342) has not materialized (Appelbaum & Hoge, *supra*, at p. 89) and that refusal has not led to increased accidents or injuries to patients or staff. (Schwartz, *Equal Protection in Medication Decisions: Informed Consent, Not Just the Right to Refuse*, in *The Right to Refuse Antipsychotic Medication* (ABA Com. on the Mentally Disabled (1986) pp. 74, 77; see also Gill, *Side Effects of a Right to Refuse Treatment Lawsuit: The Boston State Hospital Experience*, in Doudera and Swazey, *Refusing Treatment in Mental Health Institutions -- Values in Conflict* (1982) at p. 81.) While a substantial percentage of patients (20 to 50 percent) would refuse medication at some point in their hospitalization if permitted, few (1 to 5 percent, or 15 percent in 1 study) refuse consistently. (Appelbaum & Hoge, *supra*, at pp. 88-89; Appelbaum & Gutheil, *supra*, 137 Am.J. Psychiatry at p. 344; National Center for State Courts' *Guidelines for Involuntary Civil Commitment* (1986) 10 Ment. & Phys. Disability L.Rptr. 409, 458, fn. 5) and most accept medication again within 24 hours. (Appelbaum & Gutheil, *supra*, 7 Am.Acad. Psychiatry & L.Bull. at p. 313; Kemna, *supra*, 6 J.Legal Med. at p. 120.)

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Additionally, LPS provides that conservatees lose the right to refuse treatment only if a court order specifically gives the right to refuse or consent to treatment to the conservator. (§§ 5357, 5358, subd. (b), 5358.2; *Keyhea v. Rushen*, *supra*, 178 Cal.App.3d at pp. 535-536.) It would be anomalous to presume that patients who are not under conservatorship are less capable of making decisions about their treatment than those who are.

Reasonable minds can perhaps differ on the question whether involuntarily committed mental patients should be presumed incompetent to make treatment decisions. However, such a presumption was demonstrably thought unwise and prohibited by those who enacted LPS. Accordingly, we hold that, absent a judicial determination of incompetence, antipsychotic drugs cannot be administered to involuntarily committed mental patients in nonemergency situations without their informed consent.

The Role of the Court

Respondent urges that we adopt the federal approach to the problem of antipsychotic drug refusal in which the role of the court is merely to ensure that professional judgment has been exercised in the decision to medicate a patient. (*Johnson v. Silvers* (4th Cir. 1984) 742 F.2d 823, 825; *Project Release v. Prevost* (2d Cir. 1983) 722 F.2d 960, 979-981; *Rennie v. Klein*, *supra*, 720 F.2d 266, 269-270; *Stensvad v. Reivitz* (W.D.Wis. 1985) 601 F.Supp. 128, 131; *R.A.J. v. Miller* (N.D.Texas 1984) 590 F.Supp. 1319, 1321; *Sabo v. O'Bannon* (E.D.Pa. 1984) 586 F.Supp. 1132, 1140 disapproved on another point in *Blatz v. Shelley* (N.D.Ill. 1987) 661 F.Supp. 169, 178, fn. 36; *United States v. Leatherman* (D.C. Cir. 1983) 580 F.Supp. 977, 980 app. dismissed and case remanded (D.C. Cir. 1984) 729 F.2d 863). n15 Underlying this approach is the view that professionals are in a better position than courts to make treatment decisions and, therefore, that courts should defer to professional judgment rather than specifying which of several professionally acceptable choices should be made. (*Youngberg v. Romeo*, *supra*, 457 U.S. 319, 321-323 [73 L.Ed.2d 28, 39, 40-42].)

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n15 These cases follow *Youngberg v. Romeo* (1982) 457 U.S. 307, 311 [73 L.Ed.2d 28, 34, 102 S.Ct. 2452] on remand *sub nom. Romeo v. Youngberg* (3d Cir. 1982) 687 F.2d 33, which held that involuntarily committed psychiatric patients retain a constitutionally protected liberty interest in reasonably safe conditions of confinement, freedom from unreasonable bodily restraint, and such minimally adequate training as reasonably required by these interests. (*Id.*, at pp. 315-319 [73 L.Ed.2d at pp. 36-39].) These interests, however, are sufficiently protected if courts assure that professional judgment was in fact exercised. (*Id.*, at pp. 321-323 [73 L.Ed.2d at pp. 40-42].) Although *Youngberg* did not involve use of antipsychotic drugs, the cited cases take it to set the federal constitutional standard applicable to forcible use of "chemical restraints." (*Sabo v. O'Bannon*, *supra*, 586 F.Supp. 1132, 1140.)

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California is not bound to follow the federal standard. The United States Supreme Court has stated, in the context of the very issue before us, that state law may provide greater substantive and procedural rights than federal law and, if so, is determinative. (*Mills v. Rogers, supra*, 457 U.S. 291, 299-300 [73 L.Ed.2d 16, 22-24].) (8) LPS represents a considered decision of our Legislature to impose certain constraints upon the control that medical institutions and health care professionals may unilaterally exert over mental patients committed to their care.

The act accepts the proposition that, as stated by the highest court of New York, mental illness "often strikes only limited 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, supra*, 495 N.E.2d at p. 342; *Rogers v. Okin, supra*, 478 F.Supp. at p. 1361; *Davis v. Hubbard, supra*, 506 F.Supp. 915, 927 ["roughly 85% of the patients (of a state mental hospital) are capable of rationally deciding whether to consent to (use of psychotropic drugs)."]; Brooks, *The Constitutional Right to Refuse Antipsychotic Medications* (1980) 8 Bull. of Am.Acad.Psychiatry & L.Bull. 179, 191.) Consequently, the task for the court is simply to determine whether a patient refusing medication is competent to do so despite his or her mental illness. The determination of this capacity "is uniquely a judicial, not a medical function." (*Rivers v. Katz, supra*, 495 N.E.2d at p. 343.) As stated by an eminent psychiatrist, "Competence is not a clinical, medical, or psychiatric concept. It does not derive from our understanding of health, sickness, treatment, or persons as patients. Rather, it relates to the world of law, to society's interest in deciding whether an individual should have certain rights (and obligations) relating to person, property and relationships." (Michels, *Competence to Refuse Treatment*, in Doudera & Swazey, *Refusing Treatment in Mental Health Institutions -- Values in Conflict, supra*, at p. 115; accord, Gutheil & Appelbaum, *Clinical Handbook of Psychiatry and the Law* (1982) at p. 215.) Though judicial determinations of competency to give informed consent to proposed treatment are not easy, they are no more difficult than other types of competency assessments required to be made by trial courts under LPS (see, e.g., *Conservatorship of Waltz* (1986) 180 Cal.App.3d 722 [227 Cal.Rptr. 436]) and in other connections. (See, e.g., *People v. Burnett* (1987) 188 Cal.App.3d 1314 [234 Cal.Rptr. 67].) The task is facilitated by the increasing ability of mental health professionals to effectively assist in the forensic enterprise. (See, e.g., Gutheil & Bursztajn, *Clinicians' Guidelines for Assessing and Presenting Subtle Forms of Patient Incompetence in Legal Settings* (1986) 143 Am.J.Psychiatry 1020.)

(9) Provisions of LPS governing the determination required when a patient's capacity to consent to convulsive therapy is called into question seem to us equally appropriate when the question is capacity to consent to antipsychotic medication. LPS provides that there must be an evidentiary hearing directed to the question whether the patient is able to understand and knowingly and intelligently act upon information required to be given regarding the treatment. (§§ 5326.7, 5326.5;

Conservatorship of Waltz, supra, 180 Cal.App.3d 722, 729; *Lillian F. v. Superior Court* (1984) 160 Cal.App.3d 314, 320 [206 Cal.Rptr. 603]; *Conservatorship of Fadley* (1984) 159 Cal.App.3d 440, 446 [205 Cal.Rptr. 572].) The determination of incapacity must be made by clear and convincing evidence. (*Conservatorship of Waltz*, supra, at p. 733; *Lillian F. v. Superior Court*, supra, at p. 324.) The court is not to decide such medical questions as whether the proposed therapy is definitely needed or is the least drastic alternative available, but may consider such issues only as pertinent to assessment of the patient's ability to consent to the treatment. (*Conservatorship of Waltz*, supra, 180 Cal.App.3d at p. 728; *Conservatorship of Fadley*, supra, 159 Cal.App.3d at p. 446; see § 5326.7.) n16

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n16 Thus the procedure we specify is different from those required in other jurisdictions that have determined as a matter of state or constitutional law that involuntary patients may not be forced to take antipsychotic drugs in nonemergency situations absent judicial authorization. (*Rogers v. Com'r of Dept. of Mental Health*, supra, 458 N.E.2d at p. 314; *Goedecke v. State Dept. of Institutions*, supra, 603 P.2d at p. 125; *Rivers v. Katz*, supra, 495 N.E.2d at pp. 343-344; in re *K.K.B.*, supra, 609 P.2d at pp. 751-752; see also, *Opinion of the Justices* (1983) 123 N.H. 554 [465 A.2d 484, 489-490].) Courts in these states require some form of judicial determination as to treatment once a patient is found incompetent; the court must make either a "substituted judgment" determination, seeking to reach the conclusion the patient would have reached if competent (*Rogers v. Com'r of Dept. of Mental Health*, supra, at pp. 315-318; see also, *In re Boyd* (D.C.App. 1979) 403 A.2d 744, 750-751), or a form of "less intrusive alternative determination." (*Rivers v. Katz*, supra, 495 N.E.2d at p. 344; *People v. Medina* (Colo. 1985) 705 P.2d 961, 973.)

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(10)

Judicial determination of the specific competency to consent to drug treatment should focus primarily upon three factors: (a) whether the patient is aware of his or her situation (e.g., if the court is satisfied of the existence of psychosis, does the individual acknowledge that condition); (b) whether the patient is able to understand the benefits and the risks of, as well as the alternatives to, the proposed intervention (e.g., "an acutely psychotic patient should understand that psychotropic medication carries the risk of dystonic reactions [i.e., abnormal control and coordination of movement] . . . that the benefit is the probable resolution of the psychotic episode; and that alternatives include psychotherapy and milieu therapy, and possibly ECT, but that at least the two former alternatives carry a lower short-term success rate than does medication." (Gutheil & Appelbaum, *Clinical Handbook of Psychiatry and the Law*, supra, at p. 219)); and (c) whether the patient is able 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. With respect to this last consideration, it

has with reason been urged that "the appropriate test is a negative one: in the absence of a clear link between an individual's delusional or hallucinatory perceptions and his ultimate decision," it should be assumed "that he is utilizing rational modes of thought." (*Id.*, at p. 220.)

(11) If an involuntary patient is judicially determined to possess the capacity to give informed consent to the use of antipsychotic drugs and refuses to do so, the patient may not be required to undergo the treatment. If the patient is judicially determined incapable of giving informed consent, and if he or she is being detained for 72-hour treatment and evaluation under section 5150 or for not more than 14 days of intensive treatment under section 5250, the patient may thereupon be required to accept the drug treatment that has been medically prescribed. If confinement of a patient determined incapable of giving informed consent has been authorized for a period longer than 14 days, such consent must be obtained from the "responsible relative or the guardian or the conservator of the patient." (Cf. § 5326.7, subd. (g).) "[Any] surrogate . . . ought to be guided in his or her decisions first by his knowledge of the patient's own desires and feelings, to the extent that they were expressed before the patient became incompetent. [para.] If it is not possible to ascertain the choice the patient would have made, the surrogate ought to be guided in his decision by the patient's best interests." (*Barber v. Superior Court, supra*, 147 Cal.App.3d at p. 1021.) n17

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n17 The LPS provision requiring a surrogate to give informed consent to convulsive treatment when the patient is incompetent to do so (§ 5326.7) makes no exception, as we do, during the 72-hour and 14-day periods of initial confinement authorized by sections 5150 and 5250. The question whether the consent of a surrogate should be required during these brief periods (when it would often be difficult to identify, locate and adequately inform the appropriate surrogate) was not addressed in the statute because, unlike antipsychotic drugs, convulsive treatment is almost never prescribed at this time.

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Although available empirical evidence suggests that judicial intervention will not be required in the overwhelming number of cases in which an antipsychotic drug has been prescribed, because involuntarily committed mental patients usually do not object to such treatment (*Appelbaum & Hoge, Empirical Research on the Effects of Legal Policy on the Right to Refuse Treatment, supra*, at p. 89; *Courts' Guidelines for Involuntary Civil Commitment, supra*, 10 *Mental & Physical Disability L.Rep.* at p. 457; see also fn. 16), we are obliged to acknowledge that the interposition of the courts in the manner we prescribe will likely create some logistical problems and delay. However, neither this prospect, which can be contained by responsive trial courts, nor the likelihood that the courts will in most cases find the patient resisting drug treatment mentally incompetent to do so, warrant judicial retreat from the field, which would be impossible to reconcile with the legislative mandate.

The determination by a physician that an individual is mentally incompetent to refuse drug treatment cannot be exempted from judicial evaluation on the ground that the medical determination rests upon an unimpeachable scientific foundation. "[Because] of the imprecision of the criteria and difficulty inherent in any attempt to compass the human mind" (*People v. Burnett*, *supra*, 188 Cal.App.3d 1314, 1329, citing Gould, *The Mismeasure of Man* (1981)), determinations of mental competence simply cannot achieve scientific certainty. Moreover, the forcible administration of powerful mind-altering drugs also involves moral and ethical considerations not solely within the purview of the medical profession, and must be measured by the social consensus reflected in our laws. Exemption of these decisions from such external evaluation would invest physicians with a degree of power over others that cannot be squared with the intent of our Legislature and with the great value our society places on the autonomy of the individual. Such complete power also would not serve and might even be inimical to the genuine interests of the medical profession.

(12) 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." (*Rivers v. Katz*, *supra*, 495 N.E.2d at p. 341.) The Legislature has made it eminently clear that this right does not disappear upon involuntary commitment.

The judgment is reversed and the case remanded for proceedings consistent with the views expressed herein.

CONCURBY: BENSON

CONCUR: BENSON, J. I concur with the decision reached by my colleagues but do so solely on the basis that Welfare and Institutions Code section 5326.5, subdivision (d) directly and unequivocally addresses the issue raised on this appeal. It states: "A person confined shall not be deemed incapable of refusal [of proposed therapy] solely by virtue of being diagnosed as a mentally ill, disordered, abnormal, or mentally defective person." Subdivision (c) of that statute recognizes limitations on the right conferred by declaring that "[a] person confined shall be deemed incapable of written informed consent if such person cannot understand, or knowingly and intelligently act upon, the information specified in Section 5326.2." Thus the competence of the involuntarily confined patient to exercise informed consent must be determined in those nonemergency cases where antipsychotic medication is refused.

In my opinion, my colleagues' discussion of Welfare and Institutions Code sections 5005, 5152, subdivision (c); 5325, subdivision (f); 5325, subdivision (g); 5325.1, subdivisions (b) and (c); 5326, 5326.6, 5326.7, 5326.15, 5327, 5331, 5358, subdivision (b); and 5358.2 is unnecessary to the decision and, though scholarly and interesting, serves to obscure the narrow statutory basis which supports the decision we have reached.

I share my colleagues acknowledgment and concern that "the

interposition of the courts . . . will likely create some logistical problems and delay. . . ." While I am naturally concerned about the consequences of our decision on the already overburdened trial courts, my greater concern is directed toward the decision's impact upon the short-term crisis intervention program envisioned by the Lanterman-Petris-Short Act (LPS) and upon the medical professionals who must treat the patient who has been involuntarily confined because he or she is gravely disabled or a danger to self or others. The time a medical professional is required to devote going to, while at, and returning from a judicial hearing, is time lost from patient care. The longer an incompetent patient may lawfully reject antipsychotic medication which, in the judgment of medical professionals, may offer therapeutic benefit, the more tenuous the possibility for effective crisis management. The matter of developing procedures which are the least intrusive to the medical scheme envisioned by LPS should be, in my judgment, a matter of legislative priority.

**UNITED STATES COURT OF APPEALS
TENTH CIRCUIT**

<p>JAN E. JURASEK, Plaintiff-Appellant, v. UTAH STATE HOSPITAL; K.V. GREENWOOD, Adult II Psychiatrist; JOHN NILSEN, individually and as psychiatrist, Utah State Hospital; MARK PAYNE, individually and as Administrative Superintendent, Utah State Hospital; CRAIG HUMMEL, individually and as Clinical Director, Utah State Hospital; BRUCE A. GUERNSEY, individually and as psychiatrist, Utah State Hospital; and DR. JAMES HARDY, individually and as psychiatrist, Utah State Hospital, Defendants-Appellees. AMERICAN ORTHOPSYCHIATRIC ASSOCIATION ("AOA"), Amicus Curiae.</p>	<p style="text-align: center;">No. 97-4082</p>
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**Appeal from the United States District Court
for the District of Utah
(D.C. No. 91-CV-979)**

Linda V. Priebe, Brazelon Center for Mental Health Law, of Washington, D.C. (Erin Bradley Yeh, Disability Law Center, of Salt Lake City, Utah, with her on the brief), for the appellant.

Debra J. Moore, Assistant Utah Attorney General, of Salt Lake City, Utah, for the appellees.

John Townsend Rich and Jodi L. Short, Shea & Gardner, of Washington, D.C., on the brief for amicus curiae.

Before **BRISCOE, McWILLIAMS, and MURPHY**, Circuit Judges.

BRISCOE, Circuit Judge.

Jan Jurasek appeals the district court's entry of summary judgment in favor of defendants in this action brought under 42 U.S.C. § 1983. Jurasek, who was civilly committed and hospitalized for mental illness, claimed defendants violated his rights under the Due Process Clause of the Fourteenth Amendment and his rights of free expression under the First Amendment by forcibly medicating him with psychotropic drugs. We exercise jurisdiction pursuant to 28 U.S.C. § 1291 and affirm.

I.

Jurasek is a paranoid schizophrenic who was civilly committed to the Utah State Hospital on April 12, 1991. At the commitment hearing, a Utah state court determined (1) Jurasek suffered from a mental illness, (2) Jurasek posed an immediate physical danger to himself and others because of his mental illness, (3) Jurasek lacked the ability to engage in rational decision-making regarding the acceptance of mental treatment, (4) there was no appropriate less-restrictive alternative to a court order of commitment, and (5) the Hospital could provide Jurasek with adequate and appropriate treatment. Jurasek was examined by an independent psychiatrist prior to the commitment hearing and was represented by counsel at the hearing. The original commitment was slated to last six months. At the conclusion of the six months, a Utah state court reviewed Jurasek's commitment and, after finding the five requirements for civil commitment continued to exist, entered an order extending his commitment for an indeterminate period. Jurasek remains confined at the Hospital pursuant to this commitment order.

Jurasek has been treated with psychotropic drugs from the time he was first admitted to the Hospital. He has continuously objected to the treatment and it has been administered against his will. Since September 1991, the Hospital has had a series of policies which apply to patients who are involuntarily medicated. Under the current policy, patients can be forcibly injected with psychotropic drugs if the Hospital's involuntary medication hearing committee determines "the patient is, or will be, gravely disabled and in need of medication treatment or continuing medication treatment," or "without the medication treatment or continuing medication treatment, the [patient] poses or will pose, a likelihood of serious harm to himself/herself, others, or their property." Appellees' Br., Addendum C at § 6.9. This policy applies to all patients, including patients with legal guardians.

The involuntary medication hearing committee consists of a psychiatrist, a psychologist, and the hospital program administrator. None of the committee members are to be involved in the patient's treatment at the time the decision is made to forcibly medicate the patient; however, committee members "are not disqualified from sitting on the committee if they have treated or diagnosed the patient in the past." *Id.* at § 5.2. It is undisputed that none of the committee members involved in the multiple decisions to forcibly medicate Jurasek were part of his treatment team at the time of the decisions.

In September 1991, Jurasek filed the instant lawsuit in federal district court seeking injunctive relief and damages on the theory that his subjection to forced medication violated his Fourteenth Amendment due process and First Amendment free expression rights under the Constitution. Defendants responded they had not violated Jurasek's constitutional rights and, even if they had, the doctrine of qualified immunity absolved them of liability. In April 1997, the district court denied Jurasek's request for injunctive relief and granted defendants' motion for summary judgment.

II.

This court reviews a grant of summary judgment de novo, applying the same legal standard used by the district court. Sundance Assocs., Inc. v. Reno, 139 F.3d 804, 807 (10th Cir. 1998). Summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). "When applying this standard, we examine the factual record and reasonable inferences therefrom in the light most favorable to the party opposing summary judgment. If there is no genuine issue of material fact in dispute, then we next determine if the substantive law was correctly applied by the district court." Wolf v. Prudential Ins. Co., 50 F.3d 793, 796 (10th Cir. 1995) (internal citation and quotations omitted).

III.

It is well established that an individual has a liberty interest in "avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment." Washington v. Harper, 494 U.S. 210, 221-22 (1990); see Walters v. Western State Hosp., 864 F.2d 695, 698 (10th Cir. 1988). It is also well established that when an individual is confined in a state institution, individual liberties must be balanced against the interests of the institution in preventing the individual from harming himself or others residing or working in the institution. Harper, 494 U.S. at 222-23; Bee v. Greaves, 744 F.2d 1387, 1394 (10th Cir. 1984) (Bee D.)⁽¹⁾ In Harper, the Supreme Court applied this balancing test and concluded "the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will[] if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest." 494 U.S. at 227. The question presented in the instant case is different from that in Harper because Jurasek is not a prison inmate, but a civilly-committed patient who has been adjudicated incompetent. Further, Jurasek is medicated because he is "gravely disabled," while Harper was medicated because he was "dangerous to himself or others." Although the policy at issue in Harper also allowed the prison to medicate prisoners who were "gravely disabled," the Supreme Court did not pass on that part of the policy.

The parties agree Jurasek has a liberty interest in avoiding the unwanted administration of antipsychotic drugs. Presumably, they would also agree the state has a legitimate interest in the health and safety of its patients and employees. However, the parties disagree over

how to balance Jurasek's due process rights with the Hospital's interests in health and safety. We conclude the standards established in Harper for involuntarily medicating prisoners strike the appropriate balance. Accordingly, the Due Process Clause allows a state hospital to forcibly medicate a mentally ill patient who has been found incompetent to make medical decisions if the patient is dangerous to himself or others and the treatment is in the patient's medical interests.

Our conclusion is based on the fact that treatment with psychotropic drugs is not punishment. If such treatment was considered punitive, involuntarily-committed mental patients would undoubtedly be entitled to greater due process rights before being forcibly treated. See Youngberg v. Romeo, 457 U.S. 307, 321-22 (1982) ("Persons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish."). The lack of punishment in the context of forced medication, however, removes any need to provide involuntarily-committed patients with greater due process protection than prisoners. Moreover, unlike prisoners, involuntarily-committed patients have been adjudicated incompetent in a prior formal proceeding, thereby minimizing the potential for any abuse.

Our reasoning is further supported by the Supreme Court's application of the principles enunciated in Harper to a pretrial detainee who had been found incompetent to stand trial, but had not been civilly committed. See Riggins v. Nevada, 504 U.S. 127, 135 (1992). Like a mentally incompetent patient involuntarily committed at a mental health hospital, pretrial detainees have not been convicted of any crime. One could argue that because a pretrial detainee has not been convicted of a crime, he deserves greater due process protections than a prisoner. The Court, however, implicitly rejected this argument in Riggins by applying the Harper standards to an incompetent pretrial detainee. See also Morgan v. Rabun, 128 F.3d 694, 697 (8th Cir. 1997), cert. denied, 118 S. Ct. 1809 (1998) (applying Harper to forcibly medicate an insanity acquittee found incompetent and ordered committed to mental institution because "governmental interests in running a state mental hospital are similar in material aspects to that of running a prison"); Noble v. Schmitt, 87 F.3d 157, 161-62 (6th Cir. 1996) (applying Harper to involuntarily-committed mental patient's case without discussion of differences in status between a prisoner and a civilly-committed mental patient).

In deciding to forcibly medicate Jurasek, the Hospital committee determined Jurasek was "gravely disabled." The Hospital's medication policy defines a "gravely disabled" patient as one who:

suffers from a mental disorder such that he or she (a) is in danger of serious physical harm resulting from a failure to provide for his [or her] essential human needs of health or safety, or (b) manifests, or will manifest, severe deterioration in routine function evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety.

Appellees' Br., Addendum C at § 6.9.1. Jurasek argues this assessment did not justify the committee's decision because the Supreme Court has only authorized forced medication of a mentally ill patient when a hospital determines the individual "poses a 'likelihood of serious harm' to himself, others, or their property." Jurasek also contests the Hospital's reliance on the commitment court's decision that he posed an immediate danger of physical injury to himself and others, and challenges the committee's determination that treatment with psychotropic drugs is in his medical best interests. We consider each argument in turn.

Grave disability

In Harper, the Department of Corrections mental health policy permitted officials to forcibly treat prisoners with psychotropic drugs if the prison medical committee determined (1) the patient suffered from a mental disorder, (2) treatment was in the patient's medical interests, and (3) the patient either posed a "likelihood of serious harm" to himself, others, or their property, or suffered from a "grave disability." 494 U.S. at 215. Harper was medicated under the "likelihood of serious harm" prong of the policy. Thus, the Supreme Court did not specifically determine whether a confined individual found to suffer only from a "grave disability" may be forcibly medicated within the framework of the Fourteenth Amendment.

Nevertheless, the Court's subsequent discussion of the Harper requirements in Riggins sheds some light on this issue. In Riggins, the Court observed that "[u]nder Harper, forcing antipsychotic drugs on a convicted prisoner is impermissible absent a *finding of overriding justification* and a determination of medical appropriateness." 504 U.S. at 135 (emphasis added). The Court held due process requires the state to establish "treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, *essential for the sake of Riggins' own safety or the safety of others.*" Id. (emphasis added). These statements in Riggins suggest the Court believes a finding of "overriding justification" is more inclusive than the specifically listed criteria in the forced medication policy language at issue in Harper. An individual's classification as "gravely disabled," at least under the definition applied by the Hospital to Jurasek, provides a sufficiently overriding justification for involuntary medication.

Our next task is to examine the language of the Hospital's medication policy to determine whether it appropriately limits the circumstances in which a patient can be medicated against his will. A patient who is "in danger of serious physical harm," Policy § 6.9.1, is undoubtedly in need of treatment "for the sake of [his or her] own safety." See Riggins, 504 U.S. at 135. Moreover, a patient who is not receiving care "essential for his or her health or safety," Policy § 6.9.1, is, by definition, in need of treatment "for the sake of [his or her] own safety." See Riggins, 504 U.S. at 135. We thus conclude the Court's discussion in Riggins implicitly authorizes the forced medication of involuntarily-committed individuals designated as "gravely disabled" under the definition at issue here. The Hospital's actions are justified.⁽²⁾

Having determined Jurasek can be medicated pursuant to the "grave disability" prong of the Hospital's forced medication policy, we need not consider whether Jurasek's condition implicates the policy's "poses an immediate danger of physical injury to others or himself" component. We note, however, the commitment court's determination in 1991 that Jurasek "poses an immediate danger of physical injury to others or himself . . . if allowed to remain at liberty" is of dubious relevance to Jurasek's *current* dangerousness. See Davis v. Hubbard, 506 F. Supp. 915, 935 (N.D. Ohio 1980). A commitment court's determination is temporal. The court is required to determine whether an individual "poses an *immediate* danger of physical injury to others or himself." Utah Code Ann. § 62A-12-234(10)(b) (emphasis added). Thus, a hospital may not rely on a commitment court's determination unless such an assessment was made close in time to the hospital's decision to medicate.

Medical best interests

Jurasek next argues treatment with Haldol is not in his medical best interests. In early 1993, Hospital officials determined Jurasek's condition was not improving as well as they would have liked with treatment by Haldol and they began treating him with Prolixin. In April 1996, however, apparently dissatisfied with the Prolixin results, the Hospital discontinued the Prolixin treatment and resumed medicating Jurasek with Haldol. Once a patient objects to the forcible administration of antipsychotic medication, the state bears the burden of establishing the continued need and medical appropriateness of the treatment. See Riggins, 504 U.S. at 135.

The Hospital's involuntary medication hearing committee, comprised of psychologists and psychiatrists not involved in Jurasek's treatment, has consistently determined treatment with psychotropic drugs is in Jurasek's medical best interests. One of Jurasek's treating physicians also testified that Jurasek became increasingly agitated when the Hospital stopped treating him with psychotropic drugs. Another reported the medications Jurasek "is taking are not effective in curtailing his psychotic symptomatology; however they are decreasing somewhat the intensity of his symptoms." Record II, Doc. 137, Exh. I, at 3. The fact that a particular method of treatment fails to yield the type of results officials envisioned does not mean the treatment is inconsistent with the patient's medical best interests. In sum, the evidence in the record is uncontroverted that psychotropic drugs have been, at all times, at least partially beneficial in Jurasek's treatment.

Because Jurasek has been adjudicated gravely disabled and treatment with psychotropic drugs has been found to be in his medical best interests, the Hospital may treat him with psychotropic drugs without employing further substantive due process protections. Of course, the Hospital must afford him procedural due process before administering such treatment. In Harper, the Supreme Court found the hospital had provided the mentally ill prisoner with procedural due process by employing procedures substantially similar to those used here. 494 U.S. at 228-36. Both policies require a committee of independent medical personnel to examine whether the patient should be treated with psychotropic drugs, permit the patient to appeal the committee's decision to a hospital official, authorize the patient to be present at the hearing with an advisor, and allow the patient to

present evidence and cross-examine witnesses. Further, if the committee finds the patient should be medicated, the policies require that the committee support its decision with adequate documentation. In sum, we conclude the Hospital provided Jurasek with procedural due process.

IV.

Jurasek insists that, even if Harper applies, his due process rights were violated because he has not been determined incompetent to make medical decisions on his own behalf. Specifically, he argues his 1991 commitment hearing focused only on whether he should be involuntarily committed and he is entitled to a separate hearing to adjudicate his competency to make medical decisions. The Hospital claims the commitment court's finding that Jurasek "lacked the ability to engage in a rational decision making process regarding the acceptance of mental treatment" constitutes a finding that Jurasek is incompetent to make medical decisions on his own behalf. We agree with the Hospital's interpretation.

There could hardly be a clearer finding of Jurasek's inability to make medical decisions on his own behalf than that found by the commitment court. If Jurasek believes the commitment court's determination was wrong or is now obsolete because of changed circumstances, he can request a review hearing. See Utah Code Ann. §§ 62A-12-234(11)(c), 62A-12-242 (local mental health authority required to reexamine factual predicate for indeterminate commitment orders at six-month intervals). In fact, the record reveals Jurasek has exercised his right to reexamination at least once and that another state court judge determined he continued to satisfy the requirements for commitment listed in § 62A-12-234. See Record I, Doc. 136, Exh. E.⁽³⁾

V.

Jurasek further suggests Harper does not apply because he is entitled to the substituted judgment of a legal guardian. Judy Lord was appointed Jurasek's guardian in 1988. She instructed the Hospital to stop medicating Jurasek on January 27, 1994, and the Hospital initially complied. However, shortly thereafter, the Hospital revised its involuntary medication policy to permit the committee to override Lord's direction. Citing Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990), Jurasek argues a mentally ill person who is involuntarily committed under the Utah Mental Health Code has a right to have a legal guardian make medical decisions that are inconsistent with treatment determined appropriate by the hospital.

In Cruzan, the Court held that before allowing a guardian to withdraw hydration and nutrition from an incompetent person in such a way as to cause death, Missouri could constitutionally require clear and convincing evidence of the incompetent patient's wishes. The Court's decision assumed a competent person has a constitutional right to refuse lifesaving hydration and nutrition. More importantly for our purposes, the Court assumed the guardian had the right to make such a decision if "clear and convincing evidence" of the patient's wishes existed. Id. at 279-80. Jurasek argues Cruzan stands for

the proposition that an incompetent patient has an absolute right to a guardian's "substituted judgment."

Jurasek's reading of Cruzan is incorrect for two reasons. First, he ignores the fact that the Court merely *assumed for purposes of the opinion* that a guardian, in certain circumstances, has the right to discontinue lifesaving hydration and nutrition for his or her ward. Second, the gist of the court's ruling was even if the guardian had such a right, *that right could be outweighed by the state's interests in preserving life*, absent clear and convincing evidence that the ward's wishes are consistent with the guardian's intentions.

The Supreme Court in Harper specifically considered the issue of an incompetent person's entitlement to the substituted judgment of a guardian. Although the opinion is not clear as to whether Harper sought the substituted judgment of a legal guardian or a judicial officer, the Court unambiguously declared:

The alternative means proffered by respondent for accommodating his interest in rejecting the forced administration of antipsychotic drugs do not demonstrate the invalidity of the State's policy. Respondent's main contention is that, as a precondition to antipsychotic drug treatment, the State must find him incompetent, and then obtain court approval of the treatment using a "substituted judgment" standard. The suggested rule takes no account of the legitimate governmental interest in treating him where medically appropriate for the purpose of reducing the danger he poses. *A rule that is in no way responsive to the State's legitimate interests is not a proper accommodation, and can be rejected out of hand.*

494 U.S. at 226 (emphasis added).

Moreover, Jurasek has no absolute right to the "substituted judgment" of a guardian under Utah law. We acknowledge, of course, that a state may confer more comprehensive due process protections upon its citizens than does the federal government.

Where a State creates liberty interests broader than those protected directly by the Federal Constitution, the procedures mandated to protect the federal substantive interests . . . might fail to determine the actual procedural rights and duties of persons within the State. Because state-created liberty interests are entitled to the protection of the federal Due Process Clause, the full scope of a patient's due process rights may depend in part on the substantive liberty interests created by state as well as federal law. Moreover, a State may confer procedural protections of liberty interests that extend beyond those minimally required by the Constitution of the United States. If a State does so, the minimal requirements of the Federal Constitution would not be controlling, and would not need to be identified in order to determine the legal rights and duties of persons within that State.

Mills v. Rogers, 457 U.S. 291, 300 (1982) (internal citations omitted). The mere existence of a state regulatory scheme, however, does not mean the state has forged a liberty interest. Such regulations take on constitutional significance only if they employ

"explicitly mandatory language in connection with requiring specific substantive predicates." Hewitt v. Helms, 459 U.S. 460, 472 (1983).

The Utah guardianship statute provides that a guardian of an incapacitated person has only those "powers, rights, and duties respecting the ward granted in the order of appointment." Utah Code Ann. § 75-5-312(1).⁽⁴⁾ The Utah legislature has statutorily expressed its preference for limited guardianships. See id. § 75-5-304(2) (courts "shall prefer a limited guardianship and may only grant a full guardianship if no other alternative exists"). If an order of appointment is not limited, the state vests guardians with specific "powers and duties" subject to modification by order of the court. Id. § 75-5-312(2). Relevant here is the provision under which a "guardian may give any consents or approvals that may be necessary to enable the ward to receive medical or other professional care, counsel, treatment or service." Id. § 75-5-312(2)(c) (emphasis added).

Contrary to Jurasek's argument, this statute does not create a liberty interest. Its terms are entirely permissive in nature and do not *require* hospital officials to secure a guardian's consent or approval prior to administering medical treatment to an incompetent patient under their control. The Eighth Circuit, in fact, recently found discretionary language in a similar statute to be an insurmountable impediment to a plaintiff's state law-based due process claim. See Morgan, 128 F.3d at 698-99 (Missouri law providing mental facility "may authorize the medical and surgical treatment of a patient or resident . . . [u]pon consent of a parent or legal guardian" does not create federally protected liberty interest). Nor does the Hospital's Statement of Patient Rights or Involuntary Medication of Civilly-Committed Patients Policy contain any language mandating that the Hospital obtain the consent of Jurasek's guardian before forcibly medicating him with standard psychotropic drugs.⁽⁵⁾ Accordingly, we find the district court correctly rejected Jurasek's due process claim.

VI.

Based on the preceding analysis, we also agree with the district court that defendants are shielded from liability pursuant to the qualified immunity doctrine. Qualified immunity protects government officials "performing discretionary functions . . . from liability for civil damages insofar as their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known." Harlow v. Fitzgerald, 457 U.S. 800, 818 (1982). Thus, when a defendant asserts a qualified immunity defense, the plaintiff may proceed to trial only by demonstrating defendant's actions violated a constitutional or statutory right, and the constitutional or statutory right was clearly established at the time of the controverted conduct. Albright v. Rodriguez, 51 F.3d 1531, 1534 (10th Cir. 1995).

Our first task in evaluating a defendant's qualified immunity claim is to determine whether the plaintiff has alleged any constitutional or statutory violation. County of Sacramento v. Lewis, 118 S. Ct. 1708, 1714 n.5 (1998). Only if the plaintiff crosses this threshold do we examine "whether the right allegedly implicated was clearly established at the time of the events in question." Id. Having concluded defendants did not

contravene any of Jurasek's constitutional or statutory rights, we find defendants are entitled to qualified immunity.

VII.

We AFFIRM the district court's order granting summary judgment in favor of defendants.

FOOTNOTES

Click footnote number to return to corresponding location in the text.

¹In Bee I, we noted in the context of recognizing a plaintiff's liberty interests that the forcible administration of antipsychotic drugs "raises First Amendment concerns" as well because such drugs "have the capacity to severely and even permanently affect an individual's ability to think and communicate." 744 F.2d at 1394. Even if, as Jurasek claims, the forcible administration of antipsychotic drugs triggers First Amendment rights, such rights are subject to the same balancing test as liberty interests. Courts thus must determine whether the individual's rights are "outweighed by the demands of an organized society." Id.

²Jurasek's reliance on Woodland v. Angus, 820 F. Supp. 1497 (D. Utah 1993), is misplaced. In Woodland, the court determined the Hospital's December 1991 policy was unconstitutional because it did "not require a finding that [the patient] is dangerous to himself, other, or property." Id. at 1518. As explained above, under the current Hospital policy, a finding that a patient is "gravely disabled" *includes* a determination that the patient is "dangerous to himself;" therefore, the policy is constitutional under Harper.

³Jurasek contends "the periodic civil commitment review hearings in Utah are[] limited to evaluating whether the patient would constitute a danger if released." (Appellant's Br. at 27). This is an inaccurate statement of Utah law. See Utah Code Ann. § 62A-12-242 ("Any patient committed pursuant to Section 62A-12-234 is entitled to a reexamination of the order for commitment on the patient's own petition, or on that of the legal guardian, . . . to the district court of the county in which the patient resides or is detained."); see also Record I, Doc. 136, Exh. E (Jurasek's review hearing officer found all five conditions listed in § 62A-12-234 continued to exist).

⁴The order appointing Lord as guardian for Jurasek is not in the record. Lord testified she believed the guardianship order required her to act as a "go between" for Jurasek in his dealings with the Hospital. See Record VI at 6-7.

⁵The Statement of Patient Rights compels hospital officials to procure a guardian's consent only before having the patient participate in research projects, conducting surgical or hazardous assessment procedures, administering the patient with "unusual medications" or electroconvulsive therapy, using audiovisual equipment on the patient, and performing procedures for which consent is required by law. (Pl.'s Mot. for Partial Summ.)

SELL v. UNITED STATES

certiorari to the united states court of appeals for the eighth circuit

No. 02-5664. Argued March 3, 2003--Decided June 16, 2003

A Federal Magistrate Judge (Magistrate) initially found petitioner Sell, who has a long history of mental illness, incompetent to stand trial for fraud and released him on bail, but later revoked bail because Sell's condition had worsened. Sell subsequently asked the Magistrate to reconsider his competence to stand trial for fraud and attempted murder. The Magistrate had him examined at a United States Medical Center for Federal Prisoners (Medical Center). The Magistrate found him mentally incompetent to stand trial, and ordered his hospitalization to determine whether he would have the capacity to allow his trial to proceed. While there, Sell refused the staff's recommendation to take antipsychotic medication. Medical Center authorities decided to allow involuntary medication, which Sell challenged in court. The Magistrate authorized forced administration of antipsychotic drugs, finding that Sell was a danger to himself and others, that medication was the only way to render him less dangerous, that any serious side effects could be ameliorated, that the benefits to Sell outweighed the risks, and that the drugs were substantially likely to return him to competence. In affirming, the District Court found the Magistrate's dangerousness finding clearly erroneous but concluded that medication was the only viable hope of rendering Sell competent to stand trial and was necessary to serve the Government's interest in obtaining an adjudication of his guilt or innocence. The Eighth Circuit affirmed, focusing solely on the fraud charges, it found that the Government had an essential interest in bringing Sell to trial, that the treatment was medically appropriate, and that the medical evidence indicated a reasonable probability that Sell would fairly be able to participate in his trial.

Held:

1. The Eighth Circuit had jurisdiction to hear the appeal. The District Court's pretrial order was an appealable "collateral order" within the exceptions to the rule that only final judgments are appealable. The order conclusively determines the disputed question whether Sell has a legal right to avoid forced medication. *Coopers & Lybrand v. Livesay*, 437 U. S. 463, 468. It also resolves an important issue, for involuntary medical treatment raises questions of clear constitutional importance. *Ibid.* And the issue is effectively unreviewable on appeal from a final judgment. In fact, by the time of trial, Sell will have undergone forced medication--the very harm that he seeks to avoid and which cannot be undone by an acquittal. Pp. 7-9.

2. Under the framework of *Washington v. Harper*, 494 U. S. 210, and *Riggins v. Nevada*, 504 U. S. 127, the Constitution permits the Government involuntarily to administer antipsychotic drugs to render a mentally ill defendant incompetent to stand trial on serious criminal charges if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the trial's fairness, and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests. Pp. 10-16.

(a) This standard will permit forced medication solely for trial competence purposes in certain instances. These instances may be rare, because the standard says or fairly implies the following: First, a court must find that important governmental interests are at stake. The Government's interest in bringing to trial an individual accused of a serious crime is important. However, courts must consider each case's facts in evaluating this interest because circumstances may lessen its importance, e.g., a defendant's refusal to take drugs may mean lengthy confinement in a psychiatric institution, which would diminish the risks of freeing without punishment one who has committed a serious crime. In addition to its substantial interest in timely prosecution, the Government has a concomitant interest in assuring

defendant a fair trial. Second, the court must conclude that forced medication will *significantly further* those concomitant state interests. It must find that medication is substantially likely to render the defendant competent to stand trial and substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a defense. Third, the court must conclude that involuntary medication is *necessary* to further those interests and find that alternative, less intrusive treatments are unlikely to achieve substantially the same results. Fourth, the court must conclude that administering the drugs is *medically appropriate*. Pp. 10-14.

(b) The court applying these standards is trying to determine whether forced medication is necessary to serve the Government's interest in rendering the defendant competent to stand trial. If a court authorizes medication on an alternative ground, such as dangerousness, the need to consider authorization on trial competence grounds will disappear. There are often strong reasons for a court to consider alternative grounds first. For one thing, the inquiry into whether medication is permissible to render an individual nondangerous is usually more objective and more focused than the inquiry into whether medication is permissible to render a defendant competent. For another, courts have traditionally addressed involuntary medical treatment as a civil matter. If a court decides that medication cannot be authorized on alternative grounds, its findings will help to inform expert opinion and judicial decisionmaking in respect to whether to administer drugs for trial competence purposes. Pp. 14-16.

3. The Eighth Circuit erred in approving forced medication solely to render Sell competent to stand trial. Because that court and the District Court held the Magistrate's dangerousness finding clearly erroneous, this Court assumes that Sell was not dangerous. And on that hypothetical assumption, the Eighth Circuit erred in reaching its conclusion. For one thing, the Magistrate did not find forced medication legally justified on trial competence grounds alone. The experts at the Magistrate's hearing focused mainly on dangerousness. The failure to focus on trial competence would well have mattered, for this Court cannot tell whether the medication's side effects were likely to undermine the fairness of Sell's trial, a question not necessarily relevant when dangerousness is primarily at issue. Finally, the courts did not consider that Sell has been confined at the Medical Center for a long time, and that his refusal to be medicated might result in further lengthy confinement. Those factors, the first because a defendant may receive credit toward a sentence for time served and the second because it reduces the likelihood of the defendant's committing future crimes, moderate the importance of the governmental interest in prosecution. The Government may pursue its forced medication request on the grounds discussed in this Court's opinion but should do so based on current circumstances, since Sell's condition may have changed over time. Pp. 16-18.

82 F. 3d 560, vacated and remanded.

Breyer, J., delivered the opinion of the Court, in which *Rehnquist, C. J.*, and *Stevens, Kennedy, Souter, and Ginsburg, JJ.*, joined. *Scalia, J.*, filed a dissenting opinion, in which *O'Connor* and *Thomas, JJ.*, joined.

CHARLES THOMAS SELL, PETITIONER v. UNITED STATES

on writ of certiorari to the united states court of
appeals for the eighth circuit

[June 16, 2003]

Justice Breyer delivered the opinion of the Court.

The question presented is whether the Constitution permits the Government to administer antipsychotic drugs

voluntarily to a mentally ill criminal defendant--in order to render that defendant competent to stand trial for nonviolent, crimes. We conclude that the Constitution allows the Government to administer those drugs, even against the defendant's will, in limited circumstances, *i.e.*, upon satisfaction of conditions that we shall describe. Because the Court of Appeals did not find that the requisite circumstances existed in this case, we vacate its judgment.

I

A

Petitioner Charles Sell, once a practicing dentist, has a long and unfortunate history of mental illness. In September 1982, after telling doctors that the gold he used for fillings had been contaminated by communists, Sell was hospitalized, treated with antipsychotic medication, and subsequently discharged. App. 146. In June 1984, Sell told the police to say that a leopard was outside his office boarding a bus, and he then asked the police to shoot him. App. 148; Forensic Report, p. 1 (June 20, 1997). Sell was again hospitalized and subsequently released. On various occasions, he complained that public officials, for example, a State Governor and a police chief, were trying to kill him. *Id.*, at 4. In April 1997, he told law enforcement personnel that he "spoke to God last night," and that "God tells me every [Federal Bureau of Investigation] person I kill, a soul will be saved." *Id.*, at 1.

In May 1997, the Government charged Sell with submitting fictitious insurance claims for payment. See 18 U.S.C. §1035(a)(2). A Federal Magistrate Judge (Magistrate), after ordering a psychiatric examination, found Sell "competent," but noted that Sell might experience "a psychotic episode" in the future. App. 321. The judge released Sell on bail. A grand jury later produced a superseding indictment charging Sell and his wife with 56 counts of mail fraud, 5 counts of Medicaid fraud, and 1 count of money laundering. *Id.*, at 12-22.

In early 1998, the Government claimed that Sell had sought to intimidate a witness. The Magistrate held a revocation hearing. Sell's behavior at his initial appearance was, in the judge's words, "totally out of control," involving "screaming and shouting," the use of "personal insults" and "racial epithets," and spitting "in the judge's face." *Id.*, at 322. A psychiatrist reported that Sell could not sleep because he expected the FBI to "come busting through the door," and concluded that Sell's condition had worsened. *Ibid.* After considering that report and other testimony, the Magistrate revoked Sell's bail.

In April 1998, the grand jury issued a new indictment charging Sell with attempting to murder the FBI agent who had arrested him and a former employee who planned to testify against him in the fraud case. *Id.*, at 23-29. The attempted murder and fraud cases were joined for trial.

In early 1999, Sell asked the Magistrate to reconsider his competence to stand trial. The Magistrate sent Sell to the United States Medical Center for Federal Prisoners at Springfield, Missouri, for examination. Subsequently the Magistrate found that Sell was "mentally incompetent to stand trial." *Id.*, at 323. He ordered Sell to "be hospitalized for treatment" at the Medical Center for up to four months, "to determine whether there was a substantial probability that [Sell] would attain the capacity to allow his trial to proceed." *Ibid.*

Two months later, Medical Center staff recommended that Sell take antipsychotic medication. Sell refused. The staff sought permission to administer the medication against Sell's will. That effort is the subject of the present proceedings.

B

We here review the last of five hierarchically ordered lower court and Medical Center determinations. First, in early 1999, Medical Center staff sought permission from institutional authorities to administer antipsychotic drugs to Sell involuntarily. A reviewing psychiatrist held a hearing and considered Sell's prior history; Sell's current persecutory beliefs (for example, that Government officials were trying to suppress his knowledge about events in Waco, Texas); and Sell's mental state. The psychiatrist concluded that Sell was "mentally incompetent to stand trial." *Id.*, at 323. He recommended that Sell be hospitalized for up to four months, "to determine whether there was a substantial probability that [Sell] would attain the capacity to allow his trial to proceed." *Ibid.*

and had sent him to Alaska to silence him); staff medical opinions (for example, that "Sell's symptoms point to a diagnosis of Delusional Disorder but ... there well may be an underlying Schizophrenic Process"); staff medical concerns (for example, about "the persistence of Dr. Sell's belief that the Courts, FBI, and federal government officials are against him"); an outside medical expert's opinion (that Sell suffered only from delusional disorder and, from that expert's view, "medication rarely helps"); and Sell's own views, as well as those of other laypersons who testified in his favor (to the effect that he did not suffer from a serious mental illness). *Id.*, at 147-150.

The reviewing psychiatrist then authorized involuntary administration of the drugs, both (1) because Sell was "mentally ill and dangerous, and medication is necessary to treat the mental illness," and (2) so that Sell would "become competent for trial." *Id.*, at 145. The reviewing psychiatrist added that he considered Sell "dangerous only on threats and delusions if outside, but not necessarily in[side] prison" and that Sell was "[a]ble to function" in the "open population." *Id.*, at 144.

Second, the Medical Center administratively reviewed the determination of its reviewing psychiatrist. A Bellingham Prison official considered the evidence that had been presented at the initial hearing, referred to Sell's delusional differences of professional opinion as to proper classification and treatment, and concluded that antipsychotic medication represents the medical intervention "most likely" to "ameliorate" Sell's symptoms; that other "less restrictive interventions" are "unlikely" to work; and that Sell's "pervasive belief" that he was "being targeted for nefarious actions by various governmental . . . parties," along with the "current charges of conspiracy to commit murder," made Sell "a potential risk to the safety of one or more others in the community." *Id.*, at 154-155. The reviewing official "upheld" the "hearing officer's decision that [Sell] would benefit from the utilization of antipsychotic medication." *Id.*, at 157.

Third, in July 1999, Sell filed a court motion contesting the Medical Center's right involuntarily to administer antipsychotic drugs. In September 1999, the Federal Magistrate who had ordered Sell sent to the Medical Center for a hearing. The evidence introduced at the hearing for the most part replicated the evidence introduced at the administrative hearing, with two exceptions. First, the witnesses explored the question of the medication's effectiveness more thoroughly. Second, Medical Center doctors testified about an incident that took place at the Medical Center *after* the administrative proceedings were completed. In July 1999, Sell had approached one of the Medical Center's nurses, suggested that he was in love with her, criticized her for having nothing to do with him, and when told that his behavior was inappropriate, added "I can't help it." *Id.*, at 168-170, 325. He subsequently made similar remarks or acted in ways indicating that this kind of conduct would continue. The Medical Center doctors testified that, given Sell's prior behavior, diagnosis, and current beliefs, boundary-breaching incidents of this sort were not harmless and, when coupled with Sell's inability or unwillingness to desist, indicated that he was a safety risk within the institution. They added that he had been moved to a locked cell.

In August 2000, the Magistrate found that "the government has made a substantial and very strong showing that Sell is a danger to himself and others at the institution in which he is currently incarcerated"; that "the government has shown that anti-psychotic medication is the only way to render him less dangerous"; that newer drugs and/or other drugs will "ameliorat[e]" any "serious side effects"; that "the benefits to Dr. Sell . . . far outweigh any risks"; "there is a substantial probability that" the drugs will "retur[n]" Sell "to competency." *Id.*, at 333-334. The Magistrate concluded that "the government has shown in as strong a manner as possible, that anti-psychotic medications are the only way to render the defendant not dangerous and competent to stand trial." *Id.*, at 335. The Magistrate issued an order authorizing the involuntary administration of antipsychotic drugs to Sell, *id.*, at 331, but stayed that order to allow Sell to appeal the matter to the Federal District Court, *id.*, at 337.

Fourth, the District Court reviewed the record and, in April 2001, issued an opinion. The court addressed the Magistrate's finding "that defendant presents a danger to himself or others sufficient" to warrant involuntary administration of antipsychotic drugs. *Id.*, at 349. After noting that Sell subsequently had "been returned to a cell," the District Court held the Magistrate's "dangerousness" finding "clearly erroneous." *Id.*, at 349, and the court limited its determination to Sell's "dangerousness *at this time* to himself and to those around him *in his institutional context*." *Id.*, at 349 (emphasis in original).

Nonetheless, the District Court *affirmed* the Magistrate's order permitting Sell's involuntary medication. T

wrote that "anti-psychotic drugs are medically appropriate," that "they represent the only viable hope of rendering defendant competent to stand trial," and that "administration of such drugs appears necessary to serve the government's compelling interest in obtaining an adjudication of defendant's guilt or innocence of numerous and serious charges" (including fraud and attempted murder). *Id.*, at 354. The court added that it was "premature" to consider whether "the effects of medication might prejudice [Sell's] defense at trial." *Id.*, at 351, 352. The Government's motion was both appealed.

Fifth, in March 2002, a divided panel of the Court of Appeals affirmed the District Court's judgment. 282 F.3d 1038 (CA8). The majority affirmed the District Court's determination that Sell was not dangerous. The majority noted that according to the District Court, Sell's behavior at the Medical Center "amounted at most to an 'inappropriate and even infatuation' with a nurse." *Id.*, at 565. The Court of Appeals agreed, "[u]pon review," that "the evidence does not support a finding that Sell posed a danger to himself or others at the Medical Center." *Ibid.*

The Court of Appeals also affirmed the District Court's order requiring medication in order to render Sell competent to stand trial. Focusing solely on the serious fraud charges, the panel majority concluded that the "government's essential interest in bringing a defendant to trial." *Id.*, at 568. It added that the District Court "correctly concluded that there were no less intrusive means." *Ibid.* After reviewing the conflicting views of the experts, *id.*, at 568-571, the panel majority found antipsychotic drug treatment "medically appropriate" for Sell, *id.*, at 571. It added that the "medical evidence presented indicated a reasonable probability that Sell will fairly be able to participate in his trial." *Id.*, at 572. One member of the panel dissented primarily on the ground that the fraud and money laundering charges were "not serious enough to warrant the forced medication of the defendant." *Id.*, at 574 (opinion of Bye, J.).

We granted certiorari to determine whether the Eighth Circuit "erred in rejecting" Sell's argument that "allowing the government to administer antipsychotic medication against his will solely to render him competent to stand trial for non-violent offenses," Brief for Petitioner i, violated the Constitution--in effect by improperly depriving Sell of an important "liberty" that the Constitution guarantees, Amdt. 5.

II

We first examine whether the Eighth Circuit had jurisdiction to decide Sell's appeal. The District Court's judgment from which Sell had appealed, was a pretrial order. That judgment affirmed a Magistrate's order requiring Sell to involuntarily receive medication. The Magistrate entered that order pursuant to an earlier delegation from the District Court of legal authority to conduct pretrial proceedings. App. 340; see 28 U. S. C. §636(b)(1)(A). The order embodied legal conclusions related to the Medical Center's administrative efforts to medicate Sell; these efforts were a part of Sell's provisional commitment; and that provisional commitment took place pursuant to an earlier Magistrate's order seeking a medical determination about Sell's future competence to stand trial. Cf. *Riggins v. Nevada*, 504 U.S. 127 (1992) (reviewing, as part of criminal proceeding, trial court's denial of defendant's motion to discontinue medication); *Stack v. Boyle*, 342 U. S. 1, 6-7 (1951) (district court's denial of defendant's motion to reduce bail in criminal proceeding and is not reviewable in separate habeas action).

How was it possible for Sell to appeal from such an order? The law normally requires a defendant to wait until the end of the trial to obtain appellate review of a pretrial order. The relevant jurisdictional statute, 28 U. S. C. §1254, authorizes federal courts of appeals to review "final decisions of the district courts." (Emphasis added.) And the term "final decision" normally refers to a final judgment, such as a judgment of guilt, that terminates a criminal proceeding.

Nonetheless, there are exceptions to this rule. The Court has held that a preliminary or interim decision is appealable as a "collateral order" when it (1) "conclusively determine[s] the disputed question," (2) "resolve[s] an important issue completely separate from the merits of the action," and (3) is "effectively unreviewable on appeal until a final judgment." *Coopers & Lybrand v. Livesay*, 437 U. S. 463, 468 (1978). And this District Court order does appear to fall within the "collateral order" exception.

The order (1) "conclusively determine[s] the disputed question," namely, whether Sell has a legal right to

forced medication. *Ibid.* The order also (2) "resolve[s] an important issue," for, as this Court's cases make clear, involuntary medical treatment raises questions of clear constitutional importance. *Ibid.* See *Winston v. Lee*, 470 U.S. 753, 759 (1985) ("[a] compelled surgical intrusion into an individual's body . . . implicates expectations of privacy and security" of great magnitude); see also *Riggins*, *supra*, at 133-134; *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 286, 278-279 (1990); *Washington v. Harper*, 494 U.S. 210, 221-222 (1990). At the same time, the basic issue whether Sell must undergo medication against his will--is "completely separate from the merits of the action, whether Sell is guilty or innocent of the crimes charged. *Coopers & Lybrand*, 437 U.S., at 468. The issue is also separate as well from questions concerning trial procedures. Finally, the issue is (3) "effectively unreviewable on appeal from a final judgment." *Ibid.* By the time of trial Sell will have undergone forced medication--the very harm that he seeks to avoid. He cannot undo that harm even if he is acquitted. Indeed, if he is acquitted, there will be no appeal through which he might obtain review. Cf. *Stack*, *supra*, at 6-7 (permitting appeal of order setting high bail as a collateral order"). These considerations, particularly those involving the severity of the intrusion and corresponding importance of the constitutional issue, readily distinguish Sell's case from the examples raised by the dissent. *Id.* at 6 (opinion of *Scalia, J.*).

We add that the question presented here, whether Sell has a legal right to avoid forced medication, perhaps because medication may make a trial unfair, differs from the question whether forced medication *did* make a trial unfair. The first question focuses upon the right to avoid administration of the drugs. What may happen at trial is relevant, but only as a prediction. See *infra*, at 13. The second question focuses upon the right to a fair trial. It asks what *did* happen as a result of having administered the medication. An ordinary appeal comes too late for a court to enforce the first right; an ordinary appeal permits vindication of the second.

We conclude that the District Court order from which Sell appealed was an appealable "collateral order." The Eighth Circuit had jurisdiction to hear the appeal. And we consequently have jurisdiction to decide the question presented, whether involuntary medication violates Sell's constitutional rights.

III

We turn now to the basic question presented: Does forced administration of antipsychotic drugs to render a defendant incompetent to stand trial unconstitutionally deprive him of his "liberty" to reject medical treatment? U. S. Constitution, § 1 (Federal Government may not "depriv[e]" any person of "liberty . . . without due process of law"). Two prior precedents, *Harper*, *supra*, and *Riggins*, *supra*, set forth the framework for determining the legal answer.

In *Harper*, this Court recognized that an individual has a "significant" constitutionally protected "liberty interest in avoiding the unwanted administration of antipsychotic drugs." 494 U.S., at 221. The Court considered a state law authorizing forced administration of those drugs "to inmates who are . . . gravely disabled or represent a significant danger to themselves or others." *Id.*, at 226. The State had established "by a medical finding" that Harper, a mental hospital inmate, had "a mental disorder . . . which is likely to cause harm if not treated." *Id.*, at 222. The treatment decision had been made "by a psychiatrist," it had been approved by "a reviewing psychiatrist," and it "ordered medication only because that was "in the prisoner's medical interests, given the legitimate needs of his institution for confinement." *Ibid.*

The Court found that the State's interest in administering medication was "legitima[te]" and "importan[t]," 494 U.S. at 225; and it held that "the Due Process Clause permits the State to treat a prison inmate who has a serious mental disorder with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest." *Id.*, at 227. The Court concluded that, in the circumstances, the state law authorizing involuntary treatment amounted to a constitutionally permissible "accommodation between an inmate's liberty interest in avoiding the forced administration of antipsychotic drugs and the State's interests in providing appropriate medical treatment to reduce the danger that an inmate suffering from a serious mental disorder represents to himself or others." *Id.*, at 236.

In *Riggins*, the Court repeated that an individual has a constitutionally protected liberty "interest in avoiding the involuntary administration of antipsychotic drugs"--an interest that only an "essential" or "overriding" state interest can justify.

night overcome. 504 U. S., at 134, 135. The Court suggested that, in principle, forced medication in order to render a defendant competent to stand trial for murder was constitutionally permissible. The Court, citing *Harper*, noted that the State "would have satisfied due process if the prosecution had demonstrated . . . that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of *Riggins' own safety or the safety of others*." 504 U. S., at 135 (emphasis added). And it said that the State "[s]imilarly would have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins' guilt or innocence" of the murder charge "by using less intrusive means." Id., at 135 (emphasis added). Because the trial court had permitted forced medication of Riggins without taking account of his "liberty interest," with a consequent possibility of trial prejudice, the Court reversed Riggins' conviction and remanded for further proceedings. *Id.*, at 137-138. Justice Kennedy, concurring in the judgment, emphasized that antipsychotic drugs might have side effects that would interfere with the defendant's ability to receive a fair trial. *Id.*, at 140. Forced medication likely justified only where State shows drugs would not significantly affect defendant's "behavior and demeanor").

These two cases, *Harper* and *Riggins*, indicate that the Constitution permits the Government involuntarily to administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges in order to render the defendant competent to stand trial, but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial, and, taking account of less intrusive alternatives, is necessary to significantly to further important governmental trial-related interests.

This standard will permit involuntary administration of drugs solely for trial competence purposes in certain circumstances. But those instances may be rare. That is because the standard says or fairly implies the following:

First, a court must find that *important* governmental interests are at stake. The Government's interest in bringing to trial an individual accused of a serious crime is important. That is so whether the offense is a serious crime against a person or a serious crime against property. In both instances the Government seeks to protect through application of the criminal law the basic human need for security. See *Riggins, supra*, at 135-136 ("[P]ower to bring an accused to trial is fundamental to a scheme of 'ordered liberty' and prerequisite to social justice and peace" (quoting *Illinois v. Allen*, 397 U. S. 337, 347 (1970) (Brennan, J., concurring))).

Courts, however, must consider the facts of the individual case in evaluating the Government's interest in prosecution. Special circumstances may lessen the importance of that interest. The defendant's failure to take responsibility voluntarily, for example, may mean lengthy confinement in an institution for the mentally ill--and that would increase the risks that ordinarily attach to freeing without punishment one who has committed a serious crime. We do not suggest that civil commitment is a substitute for a criminal trial. The Government has a substantial interest in prosecution. And it may be difficult or impossible to try a defendant who regains competence after years of institutional commitment during which memories may fade and evidence may be lost. The potential for future confinement without does not totally undermine, the strength of the need for prosecution. The same is true of the possibility that the defendant has already been confined for a significant amount of time (for which he would receive credit toward the sentence ultimately imposed, see 18 U. S. C. §3585(b)). Moreover, the Government has a concomitant, constitutional essential interest in assuring that the defendant's trial is a fair one.

Second, the court must conclude that involuntary medication will *significantly further* those concomitant interests. It must find that administration of the drugs is substantially likely to render the defendant competent to stand trial. At the same time, it must find that administration of the drugs is substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense, thereby rendering the trial unfair. See *Riggins, supra*, at 142-145 (Kennedy, J., concurring in judgment).

Third, the court must conclude that involuntary medication is *necessary* to further those interests. The court must find that any alternative, less intrusive treatments are unlikely to achieve substantially the same results. Cf. Brief for American Psychological Association as *Amicus Curiae* 10-14 (nondrug therapies may be effective in restoring competence to psychotic defendants to competence); but cf. Brief for American Psychiatric Association et al. as *Amici Curiae* 10-14 (alternative treatments for psychosis commonly not as effective as medication). And the court must consider less intrusive means for administering the drugs, e.g., a court order to the defendant backed by the contempt power.

onsidering more intrusive methods.

Fourth, as we have said, the court must conclude that administration of the drugs is *medically appropriate* to the patient's best medical interest in light of his medical condition. The specific kinds of drugs at issue may vary elsewhere. Different kinds of antipsychotic drugs may produce different side effects and enjoy different levels of access.

We emphasize that the court applying these standards is seeking to determine whether involuntary administration of drugs is necessary significantly to further a particular governmental interest, namely, the interest in rendering a defendant *competent to stand trial*. A court need not consider whether to allow forced medication for that kind of purpose, if forced medication is warranted for a *different* purpose, such as the purposes set out in *Harper* relating to an individual's dangerousness, or purposes related to the individual's own interests where refusal to take drugs poses the individual's health gravely at risk. 494 U. S., at 225-226. There are often strong reasons for a court to determine whether administration of drugs can be justified on these alternative grounds *before* turning to the trial competence question.

For one thing, the inquiry into whether medication is permissible, say, to render an individual nondangerous is usually more "objective and manageable" than the inquiry into whether medication is permissible to render a defendant incompetent. *Riggins*, 504 U. S., at 140 (*Kennedy, J.*, concurring in judgment). The medical experts may find it difficult to provide an informed opinion about whether, given the risk of side effects, particular drugs are medically appropriate and necessary to control a patient's potentially dangerous behavior (or to avoid serious harm to the patient himself) and then to try to balance harms and benefits related to the more quintessentially legal questions of trial fairness and trial competence.

For another thing, courts typically address involuntary medical treatment as a civil matter, and justify it on alternative, *Harper*-type grounds. Every State provides avenues through which, for example, a doctor or institution may seek appointment of a guardian with the power to make a decision authorizing medication--when in the best interests of a patient who lacks the mental competence to make such a decision. *E.g.*, Ala. Code §§26-2A-102(a), 26-2A-106-2A-108 (Michie 1992); Alaska Stat. §§13.26.105(a), 13.26.116(b) (2002); Ariz. Rev. Stat. Ann. §§14-530-14-531 (West 1995); Ark. Code Ann. §§28-65-205, 28-65-301 (1987). And courts, in civil proceedings, may authorize involuntary medication where the patient's failure to accept treatment threatens injury to the patient or others. 48 CFR §549.43 (2002); cf. 18 U. S. C. §4246.

If a court authorizes medication on these alternative grounds, the need to consider authorization on trial competence grounds will likely disappear. Even if a court decides medication cannot be authorized on the alternative grounds underlying such a decision will help to inform expert opinion and judicial decisionmaking in respect of a request to administer drugs for trial competence purposes. At the least, they will facilitate direct medical and judicial focus upon such questions as: Why is it medically appropriate forcibly to administer antipsychotic drugs to a defendant who (1) is *not* dangerous and (2) *is* competent to make up his own mind about treatment? Can bringing an individual to trial *alone* justify in whole (or at least in significant part) administration of a drug that may have adverse side effects, including side effects that may to some extent impair a defense at trial? We consequently think that a court, asked to approve forced administration of drugs for purposes of rendering a defendant competent to stand trial, should ordinarily determine whether the Government seeks, or has first sought, permission for forced administration of drugs on these other *Harper*-type grounds; and, if not, why not.

When a court must nonetheless reach the trial competence question, the factors discussed above, *supra*, at 134-135, should help it make the ultimate constitutionally required judgment. Has the Government, in light of the efficiency of the side effects, the possible alternatives, and the medical appropriateness of a particular course of antipsychotic treatment, shown a need for that treatment sufficiently important to overcome the individual's protected interest in refusing it? See *Harper*, *supra*, at 221-223; *Riggins*, *supra*, at 134-135.

The Medical Center and the Magistrate in this case, applying standards roughly comparable to those set forth in *Harper*, approved forced medication substantially, if not primarily, upon grounds of Sell's dangerousness to himself and others. But the District Court and the Eighth Circuit took a different approach. The District Court found "clearly erroneous" the Magistrate's conclusion regarding dangerousness, and the Court of Appeals agreed. Both courts approved forced medication solely in order to render Sell competent to stand trial.

We shall assume that the Court of Appeals' conclusion about Sell's dangerousness was correct. But we make this assumption *only* because the Government did not contest, and the parties have not argued, that particular matter. If anything, the record before us, described in Part I, suggests the contrary.

The Court of Appeals apparently agreed with the District Court that "Sell's inappropriate behavior ... amounted most to an 'inappropriate familiarity and even infatuation' with a nurse." 282 F. 3d, at 565. That being so, it also held that "the evidence does not support a finding that Sell posed a danger to himself or others at the Medical Center." The Court of Appeals, however, did not discuss the potential differences (described by a psychiatrist testifying at the Magistrate's hearing) between ordinary "over-familiarity" and the same conduct engaged in persistently by a patient with Sell's behavioral history and mental illness. Nor did it explain why those differences should be minimized in light of the fact that the testifying psychiatrists concluded that Sell was dangerous, while Sell's own expert denied, notwithstanding his dangerousness, but the efficacy of the drugs proposed for treatment.

The District Court's opinion, while more thorough, places weight upon the Medical Center's decision, taken at the Magistrate's hearing, to return Sell to the general prison population. It does not explain whether that return reflected an improvement in Sell's condition or whether the Medical Center saw it as permanent rather than temporary. Cf. *Harper*, 494 U. S., at 227, and n. 10 (indicating that physical restraints and seclusion often not acceptable substitutes for medication).

Regardless, as we have said, we must assume that Sell was not dangerous. And on that hypothetical assumption, we find that the Court of Appeals was wrong to approve forced medication solely to render Sell competent to stand trial. For one thing, the Magistrate's opinion makes clear that he did *not* find forced medication legally justified on trial competence grounds alone. Rather, the Magistrate concluded that Sell *was* dangerous, and he wrote that forced medication was "the only way to render the defendant *not dangerous and* competent to stand trial." App. 335 (emphasis added).

Moreover, the record of the hearing before the Magistrate shows that the experts themselves focused mainly on the dangerousness issue. Consequently the experts did not pose important questions--questions, for example, about potential side effects and risks--the answers to which could have helped determine whether forced medication was warranted on trial competence grounds alone. Rather, the Medical Center's experts conceded that their proposed medications had "significant" side effects and that "there has to be a cost benefit analysis." *Id.*, at 185 (testimony of Dr. DeMier); *id.*, at 236 (testimony of Dr. Wolfson). And in making their "cost-benefit" judgments, they primarily took into account Sell's dangerousness, not the need to bring him to trial.

The failure to focus upon trial competence could well have mattered. Whether a particular drug will tend to impair the defendant, interfere with communication with counsel, prevent rapid reaction to trial developments, or diminish the defendant's ability to express emotions are matters important in determining the permissibility of medication to restore trial competence, *Riggins*, 504 U. S., at 142-145 (*Kennedy, J.*, concurring in judgment), but not necessarily relevant if dangerousness is primarily at issue. We cannot tell whether the side effects of antipsychotic medication were likely to undermine the fairness of a trial in Sell's case.

Finally, the lower courts did not consider that Sell has already been confined at the Medical Center for a long period of time, and that his refusal to take antipsychotic drugs might result in further lengthy confinement. There are two factors, the first because a defendant ordinarily receives credit toward a sentence for time served, 18 U. S. C. § 3605, and the second because it reduces the likelihood of the defendant's committing future crimes, moderate--though not eliminate--the importance of the governmental interest in prosecution. See *supra*, at 12-13.

V

For these reasons, we believe that the present orders authorizing forced administration of antipsychotic drugs cannot stand. The Government may pursue its request for forced medication on the grounds discussed in this opinion, including grounds related to the danger Sell poses to himself or others. Since Sell's medical condition may have changed over time, the Government should do so on the basis of current circumstances.

The judgment of the Eighth Circuit is vacated, and the case is remanded for further proceedings consistent with this opinion.

It is so

CHARLES THOMAS SELL, PETITIONER v. UNITED STATES

on writ of certiorari to the united states court of appeals for the eighth circuit

[June 16, 2003]

Justice Scalia, with whom Justice O'Connor and Justice Thomas join, dissenting.

The District Court never entered a final judgment in this case, which should have led the Court of Appeals to wonder whether it had any business entertaining petitioner's appeal. Instead, without so much as acknowledging that Congress has limited court-of-appeals jurisdiction to "appeals from all *final decisions* of the district courts of the United States," 28 U. S. C. §1291 (emphasis added), and appeals from certain specified interlocutory orders, §1292, the Court of Appeals proceeded to the merits of Sell's interlocutory appeal. 282 F. 3d 560 (2002). Petitioner's failure to discuss jurisdiction was attributable to the United States' refusal to contest the point there (as it has done here, see Brief for United States 10, n. 5), or to the panel's unexpressed agreement with the conclusion reached by other Courts of Appeals, that pretrial forced-medication orders are appealable under the "collateral order doctrine," e.g., *United States v. Morgan*, 193 F. 3d 252, 258-259 (CA4 1999); *United States v. Brandon*, 158 F. 3d 1051 (CA6 1998). But *this* Court's cases do not authorize appeal from the District Court's April 4, 2001, order because it was neither a "final decision" under §1291 nor part of the class of specified interlocutory orders in §1292. We therefore lack jurisdiction, and I would vacate the Court of Appeals' decision and remand with instructions to

I

After petitioner's indictment, a Magistrate Judge found that petitioner was incompetent to stand trial because he was unable to understand the nature and consequences of the proceedings against him and to assist in his defense as required by 18 U. S. C. §4241(d), the Magistrate Judge committed petitioner to the custody of the Attorney General, and petitioner was hospitalized to determine whether there was a substantial probability that in the foreseeable future he would attain the capacity to stand trial. On June 9, 1999, a reviewing psychiatrist determined, after a §549 administrative hearing¹, that petitioner should be required to take antipsychotic medication, finding the medication necessary to render petitioner competent for trial and medically appropriate to treat his mental illness. Petitioner's administrative appeal from that decision² was denied with a written statement of reasons.

At that point the Government possessed the requisite authority to administer forced medication. Petitioner responded, not by appealing to the courts the §549.43 administrative determination, see 5 U. S. C. §702, but by moving in the District Court overseeing his criminal prosecution for a *hearing* regarding the appropriateness of medication. A Magistrate Judge granted the motion and held a hearing. The Government then requested from the Magistrate Judge an order authorizing the involuntary medication of petitioner, which the Magistrate Judge entered. On April 4, 2001, the District Court affirmed this Magistrate Judge's order, and it is from *this* order that petitioner appealed to the Eighth Circuit.

II

A

Petitioner and the United States maintain that 28 U. S. C. §1291, which permits the courts of appeals to review "*final decisions* of the district courts of the United States" (emphasis added), allowed the Court of Appeals to review the District Court's April 4, 2001 order. We have described §1291, however, as a "final judgment rule," *Flanagan v. United States*, 465 U. S. 259, 263 (1984), which "[i]n a criminal case ... prohibits appellate review *until conviction and imposition of sentence*," *ibid.* (emphasis added). See also *Abney v. United States*, 431 U. S. 651, 656-657 (1977). The courts have invented⁴ a narrow exception to this statutory command: the so-called "collateral order" doctrine, which allows appeal of district court orders that (1) "conclusively determine the disputed question," (2) "resolve an important question completely separate from the merits of the action," and (3) are "effectively unreviewable on appeal from a final judgment." *Coopers & Lybrand v. Livesay*, 437 U. S. 463, 468 (1978). But the District Court's April 4, 2001, order fails to satisfy the third requirement of this test.

Our decision in *Riggins v. Nevada*, 504 U. S. 127 (1992), demonstrates that the District Court's April 4, 2001, order is reviewable on appeal from conviction and sentence. The defendant in *Riggins* had been involuntarily medicated while a pretrial detainee, and he argued, *on appeal from his murder conviction*, that the State of Nevada had contravened the substantive-due-process standards set forth in *Washington v. Harper*, 494 U. S. 210 (1990). Rather than holding that review of this claim was not possible on appeal from a criminal conviction, the *Riggins* Court held that forced medication of a criminal defendant that fails to comply with *Harper* creates an unacceptable risk of error and entitles the defendant to automatic vacatur of his conviction. 504 U. S., at 135-138. The Court is therefore wrong to say that "[a]n ordinary appeal comes too late for a defendant to enforce" this right, *ante*, at 9, and that review of any substantive-due-process challenge to the District Court's April 4, 2001, order must wait until after conviction and sentence have been imposed.⁵

It is true that, if petitioner must wait until final judgment to appeal, he will not receive the *type* of remedy he prefers—a predeprivation injunction rather than the postdeprivation vacatur of conviction provided by *Riggins*. The ground for interlocutory appeal is emphatically rejected by our cases. See, e.g., *Flanagan, supra* (disallowing interlocutory appeal of an order disqualifying defense counsel); *United States v. Hollywood Motor Car Co.*, 458 U. S. 263 (1982) (*per curiam*) (disallowing interlocutory appeal of an order denying motion to dismiss indictment on grounds of prosecutorial vindictiveness); *Carroll v. United States*, 354 U. S. 394 (1957) (disallowing interlocutory appeal of an order denying motion to suppress evidence).

We have until today interpreted the collateral-order exception to §1291 "with the *utmost strictness*" in criminal cases. *Midland Asphalt Corp. v. United States*, 489 U. S. 794, 799 (1989) (emphasis added). In the 54 years since we invented the exception, see *Cohen v. Beneficial Industrial Loan Corp.*, 337 U. S. 541 (1949), we have found only a few types of prejudgment orders in criminal cases appealable: denials of motions to reduce bail, *Stack v. Boyle*, 342 U. S. 100 (1951), denials of motions to dismiss on double-jeopardy grounds, *Abney, supra*, and denials of motions to discontinue under the Speech or Debate Clause, *Helstoski v. Meanor*, 442 U. S. 500 (1979). The first of these exceptions was justified on the ground that the denial of a motion to reduce bail becomes moot (and thus effectively unreviewable) on appeal from conviction. See *Flanagan, supra*, at 266. As *Riggins* demonstrates, that is not the case here. The interlocutory appeals in *Abney* and *Helstoski* were justified on the ground that it was appropriate to interrupt the

when the precise right asserted was the *right not to be tried*. See *Abney, supra*, at 660-661; *Helstonski, supra* at 108. Petitioner does not assert a right not to be tried, but a right not to be *medicated*.

B

Today's narrow holding will allow criminal defendants in petitioner's position to engage in opportunistic behavior. They can, for example, voluntarily take their medication until halfway through trial, then abruptly refuse and file an interlocutory appeal from the order that medication continue on a compulsory basis. This sort of concern about the disruption of criminal proceedings--strangely missing from the Court's discussion today--is what has led us to the narrow holding many times that we interpret the collateral-order exception narrowly in criminal cases. See *Midland Asphalt Corp. v. United States*, *supra*, at 799; *Flanagan*, 465 U. S., at 1064.

But the adverse effects of today's narrow holding are as nothing compared to the adverse effects of the new rule that underlies the holding. The Court's opinion announces that appellate jurisdiction is proper because review of conviction and sentence will come only after "Sell will have undergone forced medication--the very harm that the defendant seeks to avoid." *Ante*, at 9. This analysis effects a breathtaking expansion of appellate jurisdiction over interlocutory orders. If it is applied faithfully (and some appellate panels will be eager to apply it faithfully), any criminal defendant who asserts that a trial court order will, if implemented, cause an immediate violation of his constitutional (or perhaps statutory?) rights may immediately appeal. He is empowered to hold up the trial for months by claiming that a trial court order after final judgment "would come too late" to prevent the violation. A trial-court order requiring the defendant to wear an electronic bracelet could be attacked as an immediate infringement of the constitutional right to "bodily integrity." An order refusing to allow the defendant to wear a T-shirt that says "Black Power" in front of the jury could be attacked as an immediate violation of First Amendment rights; and an order compelling testimony could be attacked as an immediate denial of Fifth Amendment rights. All these orders would be immediately appealable. *Flanagan* and *Midland Asphalt*, which held that appellate review of orders that might infringe a defendant's constitutionally protected rights should await final judgment, are seemingly overruled. The narrow gate of entry to the collateral-order doctrine--previously reversible by only (1) orders unreviewable on appeal from judgment and (2) orders denying an asserted right to a fair trial--has been generously widened.

The Court dismisses these concerns in a single sentence immediately following its assertion that the order in *Sell* meets the three *Cohen*-exception requirements of (1) conclusively determining the disputed question (correctly), (2) resolving an important issue separate from the merits of the action (correct); and (3) being unreviewable on a collateral order that quite plainly is incorrect. That sentence reads as follows: "These considerations, particularly those involving the severity of the intrusion and corresponding importance of the constitutional issue, readily distinguish *Sell's* case from the examples raised by the dissent." *Ante*, at 9. That is a brand new consideration put forward in rebuttal, not discussed in the body of the Court's analysis, which relies on the ground that (contrary to my contention) this order is *not reviewable on appeal*. The Court's last-minute addition must mean that it is revising the *Cohen* test, to disallow review with the third requirement (unreviewable on appeal) *only when the important separate issue in question involves a 'severe intrusion' and hence an 'important constitutional issue.'* Of course I welcome this narrowing of a major doctrine--but I still would not favor the revision, not only because it is a novelty with no basis in our prior opinions but also because of the uncertainty, and the obvious opportunity for gamesmanship, that the revision-as-narrowing produces. If, however, I did make this more limited addition to the textually unsupported *Cohen* doctrine, I would at least do so in an undisguised fashion.

* * *

Petitioner could have obtained pre-trial review of the \$549.43 medication order by filing suit under the Administrative Procedure Act, 5 U. S. C. §551 *et. seq.*, or even by filing a *Bivens v. Six Unknown Fed. Narcotics Agents*, 403 U. S. 388 (1971), action, which is available to federal pretrial detainees challenging the conditions of confinement, see, e.g., *Lyons v. U. S. Marshals*, 840 F. 2d 202 (CA3 1987). In such a suit, he could have obtained

immediate appellate review of denial of relief.⁶ But if he chooses to challenge his forced medication in the context of a criminal trial, he must abide by the limitations attached to such a challenge--which prevent him from stopping proceedings in their tracks. Petitioner's mistaken litigation strategy, and this Court's desire to decide an interesting constitutional issue, do not justify a disregard of the limits that Congress has imposed on courts of appeals' (and their own) jurisdiction. We should vacate the judgment here, and remand the case to the Court of Appeals with instructions to dismiss.

FOOTNOTES

Footnote 1

28 CFR §549.43 (2002) provides the standards and procedures used to determine whether a person in the custody of the Attorney General may be involuntarily medicated. Before that can be done, a reviewing psychiatrist must determine that it is "necessary in order to attempt to make the inmate competent for trial or is necessary because the inmate is dangerous to self or others, is gravely disabled, or is unable to function in the open population of a mental health referral center or a regular prison," §549.43(a)(5).

Footnote 2

§549.43(a)(6) provides: "The inmate ... may submit an appeal to the institution mental health division administrator regarding the decision within 24 hours of the decision and ... the administrator shall review the decision within 24 hours of the inmate's appeal."

Footnote 3

It is not apparent why this order was necessary, since the Government had *already* received authorization to medicate petitioner pursuant to §549.43. If the Magistrate Judge had denied the Government's motion (or if this Court were to reverse the Magistrate Judge's order) the Bureau of Prisons' administrative decision ordering petitioner's forced medication would remain in place. Which is to suggest that, in addition to the jurisdictional defect of interlocutory review to which my opinion is addressed, there may be no jurisdiction because, at the time this suit was filed, petitioner failed to meet the "remediability" requirement of Article III standing. See *Steel Co. v. Citizens for Better Environment*, 523 U. S. 83 (1998). The Court of Appeals should address this jurisdictional issue on remand.

Footnote 4

I use the term "invented" advisedly. The statutory text provides no basis.

Footnote 5

To be sure, the order here is unreviewable after final judgment *if the defendant is acquitted*. But the "unreviewability" of our collateral-order doctrine--which, as it is framed, requires that the interlocutory order be "effectively unreviewable *on appeal from a final judgment*," *Coopers & Lybrand v. Livesay*, 437 U. S. 463, 468 (1978) (emphasis added)--is not satisfied by the possibility that the aggrieved party will have no occasion to appeal.

Footnote 6

<http://caselaw.lp.findlaw.com/scripts/printervfriendly.pl?page=us/000/02-5664.html>

Petitioner points out that there are disadvantages to such an approach--for example, lack of constitutional expertise of appointed counsel in a *Bivens* action. That does not entitle him or us to disregard the limits on appellate jurisdiction.

STATE OF HAWAII, Plaintiff-Appellee, v. WILLIAM KOTIS,
Defendant-Appellant

DIRECTOR OF HEALTH, DEPARTMENT OF HEALTH, STATE OF HAWAII,
Party In Interest-Appellee

NO. 18823

APPEAL FROM THE FIRST CIRCUIT COURT

(CR. NO. 92-2780)

JULY 13, 1999

IN THE SUPREME COURT OF THE STATE OF HAWAII

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STATE OF HAWAII, Plaintiff-Appellee, v. WILLIAM KOTIS,

Defendant-Appellant

DIRECTOR OF HEALTH, DEPARTMENT OF HEALTH, STATE OF HAWAII,

Party In Interest-Appellee

NO. 18823

APPEAL FROM THE FIRST CIRCUIT COURT

(CR. NO. 92-2780)

JULY 13, 1999

MOON, C.J., KLEIN, LEVINSON, NAKAYAMA, AND RAMIL, JJ.

OPINION OF THE COURT BY LEVINSON, J.

The defendant-appellant William Kotis appeals from the order of the circuit court granting the motion of the director of health (the director) for an order authorizing the involuntary administration of antipsychotic medications. On appeal, Kotis argues that: (1) the circuit lacked authority to issue its order; (2) the circuit court's order violated Kotis's constitutionally-protected interest in being free from the involuntary administration of antipsychotic medication because, in the alternative, (a) it is always constitutionally prohibited to authorize such involuntary medication of a defendant immediately prior to, and/or during trial, or (b) the circuit court erroneously applied the burden of proof by the "preponderance of the evidence" rather than by "clear and convincing evidence"; (3) the circuit court erred in taking judicial notice of certain facts in the record; and (4) there was an insufficient evidentiary basis to support the circuit court's findings of fact (FOFs) that (a) due to his mental illness, Kotis posed a danger to himself and to others, (b) the proposed treatment plan was medically appropriate and essential, and (c) alternative treatments had been inadequate.

Kotis's assertions that the circuit court lacked authority to issue an order authorizing the director to administer involuntary medication and that a circuit court may never order the involuntary administration of antipsychotic medications to a defendant before or during trial are without merit. We agree with Kotis that the burden of proof applicable to the Director's motion was proof by clear and convincing evidence. However, because the record does not indicate which burden of proof the circuit court applied with respect to the evidence, this court cannot presume that the circuit court erred. Furthermore, although we agree that the circuit court apparently erred in taking judicial notice of certain "facts," the mistake did not rise to the level of plain error. Finally, we disagree that the circuit court lacked substantial evidence to support its FOFs. Accordingly, we affirm the circuit court's order.

I. BACKGROUND

On September 10, 1992, Kotis was indicted for (1) murder in the second degree, in violation of Hawai'i Revised Statutes (HRS) § 707-701.5(1) (1993),⁽¹⁾ (2) kidnapping, in violation of HRS § 707-720(1)(e) (1993),⁽²⁾ and (3) terroristic threatening in the first degree, in violation of HRS § 707-716(1)(d) (1993).⁽³⁾ The charges arose from an incident that occurred on or about September 7, 1992, in which Kotis allegedly threatened his wife, Lynne Kotis, and her companion, Gregory Wittman, with a knife, restrained Lynne with intent to terrorize her, and caused Lynne's death while in possession of a firearm. On September 28, 1993, Kotis filed a notice of his intention to rely on the defense of lack of penal responsibility. On October 19, 1993, he filed a motion for a mental examination by a three-member panel.⁽⁴⁾ Kotis's motion was granted. Each of the three examiners, Elizabeth Adams, M.D., Peter Bianchi, Ph.D., and Olaf Gitter, Ph.D., reported that Kotis was unfit to proceed to trial. Each of the examiners also opined that Kotis was dangerous to himself and to others due to his mental illness. At the February 16, 1994 hearing on the motion, the prosecution conceded that Kotis was unfit to proceed to trial. In a written order filed on February 17, 1994, the circuit court found Kotis unfit to proceed to trial, pursuant to HRS § 704-405 (1993),⁽⁵⁾ and therefore suspended the proceedings pursuant to HRS § 704-406 (1993).⁽⁶⁾ In a subsequent order, the circuit court committed Kotis to the custody of the director.⁽⁷⁾

On September 7, 1994, during a hearing pertaining to a proposed transfer of the location of Kotis's confinement, see supra note 7, the director orally indicated that he intended to file a motion requesting an order authorizing him to medicate Kotis involuntarily. The director requested that the circuit court appoint a guardian ad litem (GAL) for Kotis to make a recommendation on the motion. The circuit court agreed to appoint a GAL, although it also made clear that Kotis's court-appointed defense counsel remained Kotis's advocate in the matter. The circuit court ordered the director to provide an outline of the specific course of medication being recommended for Kotis, together with a summary of the side effects associated with the drugs proposed for use in his treatment.

The circuit court's written order appointing a GAL was filed on September 12, 1994. On November 25, 1994, the GAL filed an ex parte motion for an order appointing an independent medical examiner to assist him in preparing his report to the circuit court. The circuit court granted the motion in an order apparently filed on the same day, appointing Vit U. Patel, M.D., as an examiner "to assist the [GAL] by rendering information, and by performing other services reasonably related to the [director's] motion for an order authorizing the administration of involuntary medication."

On December 27, 1994, the GAL submitted a report to the circuit court, noting, inter alia, that the basis of the director's claim of Kotis's dangerousness was vague and should be subjected to "further inquiry." Nevertheless, the GAL approved the treatment plan proposed by the director and recommended that it "be instituted, subject to review as needed, based on any adverse health affects to Mr. **Kotis**." (Emphasis in original.) The GAL attached Dr. Patel's report, which generally approved the course of treatment

offered by the director, subject to "some concerns" regarding the use of the medications lithium and Mellaril.

The director's written motion requesting an order authorizing involuntary medication was filed on October 21, 1994, and an amended motion, including various new attachments, was filed on October 28, 1994. The memorandum in support of the director's motion alleged that the order was necessary because Kotis's mental condition rendered him dangerous to himself and others.

A hearing was held on the director's motion on December 29 and 30, 1994. At the hearing, the director's expert witness, Toshiyuki Shibata, M.D., who was qualified in the fields of medicine and psychiatry, testified that he had interviewed Kotis approximately seven times over a period of two and one-half to three months, in sessions ranging in length from ten to forty minutes. Dr. Shibata testified that he had diagnosed Kotis as suffering from "schizoaffective disorder," a condition manifested in Kotis by anger, paranoid delusions, and extreme mood swings. He testified that he had recommended that Kotis be placed on a course of antipsychotic and other medications, outlined in Director's Exhibits 3 and 4,⁽⁸⁾ which he believed to be "medically appropriate" because Kotis's "delusional belief status prevents him from becoming fit in court" and "the medications would stabilize his mood and potentially decrease his dangerousness."

With regard to Kotis's dangerousness to others, Dr. Shibata testified that Kotis's medical reports from the O`ahu Community Correctional Center (OCCC) indicated that "he ha[d] made threatening remarks to his attending physician," but that he had not threatened or accosted anyone else at OCCC. When asked his opinion "as to whether the defendant . . . present[s] a danger to others," Dr. Shibata responded that he "believe[d] that [Kotis] may pose a possible danger to others." (Emphases added.) In this connection, Dr. Shibata opined that "[t]here's no empirical way of measuring or predicting future dangerousness," but noted that he had taken into account the fact that Kotis had been charged with kidnapping, as well as "the fact that he showed mood instabilities, display[ed] lots of anger, . . . past substance abuse history, [and] his delusional belief status where he feels threatened by quite a few people." Nevertheless, although Dr. Shibata believed that his proposed treatment would diminish Kotis's dangerousness, he testified that he "couldn't say for a certainty, whether it would be essential" to that objective.

With regard to Kotis's dangerousness to himself, Dr. Shibata testified that he did not believe that Kotis was "imminently suicidal," but noted that "there is always the possibility[,] knowing Mr. Kotis'[s] labile mood, which could swing from agitation to depression." (Emphasis added.) He added that Kotis "has made statements about thoughts of dying, thoughts of committing suicide. He has made several statements about possibly hanging himself, getting the police to shoot him[.]" Dr. Shibata testified that the medications that he had proposed were "standard" for addressing the risk of suicide, inasmuch as they "decrease the mood swings . . . , making the person more stable emotionally, which would greatly reduce the possibility of suicide." He also noted that "[s]cientific reports indicate that[,], without treatment[,], people [who] . . . suffer from

mood swings[,] up to 15 per cent will complete the suicide and that number is greatly reduced with the use of medication."

Dr. Shibata also testified that he had considered two "other modalities of treatment" in Kotis's case: psychotherapy and behavior modification. Based on the medical reports from OCCC, Dr. Shibata concluded that these modalities had been useful "[a]t times . . . in getting Mr. Kotis to calm down[,] but they are very limited in their effectiveness."

Additional testimony was given by Keith Brown, M.D., the attending psychiatrist at OCCC, who had treated Kotis since September 1992 and had seen him approximately eighty times. Dr. Brown testified that he did not believe Kotis to be dangerous to himself or to others and that medication would not be effective in treating him.

After the parties had concluded their examination of Dr. Brown, the circuit court asked him several clarifying questions regarding his testimony. During this questioning, the circuit court made reference to judicial notice:

THE COURT: Doctor, have you seen the reports -- and I know these reports are pretty old now, but the original reports of Dr. Adams, Dr. Bianchi and Dr. Gidder with respect to the defendant's fitness and their respective diagnos[e]s?

THE WITNESS: I talked to a Dr. Gidder. . . .

....

THE COURT: And did you agree or disagree with his diagnosis and findings?

THE WITNESS: I disagreed with it.

THE COURT: You disagreed with them.

....

THE COURT: So if the other two doctors on this panel had findings and diagnos[e]s consistent with Dr. Gidder's[,] you would disagree with their findings and diagnos[e]s as well, is that right?

THE WITNESS: Yes.

THE COURT: Let me ask you this, Doctor. . . . I'm having to make a decision based on the information before me and -- before I forget, the Court does take judicial notice of the records and files in this case -- well, obviously in having to make this decision[,] I have to weigh . . . your respective opinions of what is before me.

Now, if this situation is such that you represent a minority position, what is it about your position that you feel is more credible than the other positions?

(Emphasis added.) Kotis's counsel did not object to the circuit court's statement regarding judicial notice. The records on file in the case at that point included affidavits, reports, and letters of other psychiatrists and psychologists who had examined Kotis during the course of his detention. Drs. Brown and Shibata were the only witnesses at the hearing.

During the oral arguments regarding the director's motion, the deputy prosecuting attorney urged that involuntary medication was necessary to render Kotis competent to stand trial. As in his written motion, however, counsel for the director argued only that the order was necessary by virtue of Kotis's dangerousness. The circuit court took the matter under advisement without oral comment.

On February 16, 1995, the circuit court filed its written order. The order recited that the circuit court had arrived at its FOFS and conclusions of law (COLs), "having considered the evidence presented at the hearing on this motion, having taken judicial notice of the records and files herein, having taken judicial notice of the report of the Guardian ad Litem, having heard the arguments of counsel, and being fully apprised of the issues[.]" The circuit court's "findings" were as follows:

1 Pursuant to sections 551-2 and/or 346-234, Hawaii Revised Statutes, the Guardian Ad Litem was properly and legally appointed by the Court;

2 The Court has jurisdiction over this case;⁽⁹⁾

3 The Defendant William Kotis poses a danger to himself in that he has had suicidal ideation and incidents of head banging;

4 The Defendant poses a threat to others in that he suffers from frequent and severe mood swings, delusional beliefs of being threatened by others, and substance abuse;

5 Based on Dr. Shibata's testimony, Dr. Patel's report, the reports and findings of the sanity panel, and Judge Acoba's prior findings, the Court concludes that Defendant suffers from a mental disease, disorder, or defect;

6 The involuntary medication treatment plan for the Defendant . . . is medically appropriate because of Defendant's mental disease, disorder, or defect as diagnosed and confirmed by Toshiyuki Shibata, M.D., and Vit U. Patel, M.D., in their respective written reports and testimony;

7 Under the circumstances, involuntary medication is essential for Defendant's benefit and for the benefit of others since no other less intrusive treatment is available;

8 As testified to by Dr. Shibata, Defendant's condition will not improve without medication since alternative treatments such as psychotherapy and behavior modification have been inadequate;

9 The Court finds Dr. Brown's testimony not credible.

Accordingly, the director's motion for an order authorizing the administration of involuntary medication was granted. Kotis filed a timely notice of appeal and requested a stay of the order pending the appeal. The stay was denied.

II. STANDARDS OF REVIEW

A. Interpretation Of A Statute

"[T]he interpretation of a statute . . . is a question of law reviewable de novo." State v. Arceo, 84 Hawai'i 1, 10, 928 P.2d 843, 852 (1996) (quoting State v. Camara, 81 Hawai'i 324, 329, 916 P.2d 1225, 1230 (1996) (citations omitted)). See also State v. Toyomura, 80 Hawai'i 8, 18, 904 P.2d 893, 903 (1995); State v. Higa, 79 Hawai'i 1, 3, 897 P.2d 928, 930, reconsideration denied, 79 Hawai'i 341, 902 P.2d 976 (1995); State v. Nakata, 76 Hawai'i 360, 365, 878 P.2d 669, 704, reconsideration denied, 76 Hawai'i 453, 879 P.2d 556 (1994), cert. denied, 513 U.S. 1147, 115 S.Ct. 1095, 130 L.Ed.2d 1063 (1995).

Gray v. Administrative director of the Court, 84 Hawai'i 138, 144, 931 P.2d 580, 586 (1997) (some brackets added and some in original). See also State v. Soto, 84 Hawai'i 229, 236, 933 P.2d 66, 73 (1997). Furthermore, our statutory construction is guided by established rules:

When construing a statute, our foremost obligation is to ascertain and give effect to the intention of the legislature, which is to be obtained primarily from the language contained in the statute itself. And we must read statutory language in the context of the entire statute and construe it in a manner consistent with its purpose.

When there is doubt, doubleness of meaning, or indistinctiveness or uncertainty of an expression used in a statute, an ambiguity exists. . . .

In construing an ambiguous statute, "[t]he meaning of the ambiguous words may be sought by examining the context, with which the ambiguous words, phrases, and sentences may be compared, in order to ascertain their true meaning." HRS § 1-15(1) [(1993)]. Moreover, the courts may resort to extrinsic aids in determining legislative intent. One avenue is the use of legislative history as an interpretive tool.

Gray, 84 Hawai'i at 148, 931 P.2d at 590 (quoting State v. Toyomura, 80 Hawai'i 8, 18-19, 904 P.2d 893, 903-04 (1995)) (brackets and ellipsis points in original) (footnote omitted). This court may also consider "[t]he reason and spirit of the law, and the cause which induced the legislature to enact it . . . to discover its true meaning." HRS § 1-15(2) (1993). "Laws in pari materia, or upon the same subject matter, shall be construed with reference to each other. What is clear in one statute may be called upon in aid to explain what is doubtful in another." HRS § 1-16 (1993).

State v. Dudoit, No. 21417, slip op. at 6-7 (Haw. Apr. 26, 1999) (quoting State v. Stocker, 90 Hawai'i 85, 90-91, 976 P.2d 399, 404-05 (1999) (quoting Ho v. Leftwich, 88

Hawai`i 251, 256-57, 965 P.2d 793, 798-99 (1998) (quoting Korean Buddhist Dae Won Sa Temple v. Sullivan, 87 Hawai`i 217, 229-30, 953 P.2d 1315, 1327-28 (1998))).

B. Questions Of Constitutional Law

... We answer questions of constitutional law "by exercising our own independent constitutional judgment based on the facts of the case." State v. Trainor, 83 Hawai`i 250, 255, 925 P.2d 818, 823 (1996) (citation and internal quotation marks omitted); State v. Lee, 83 Hawai`i 267, 273, 925 P.2d 1091, 1097 (1996) (citations, internal quotation marks, and brackets omitted). Thus, we review questions of constitutional law under the "right/wrong" standard. See State v. Toyamura, 80 Hawai`i 8, 15, 904 P.2d 893, 900 (1995) (citing State v. Higa, 79 Hawai`i 1, 3, 897 P.2d 928, 930 (1995), and State v. Gaylord, 78 Hawai`i 127, 137, 890 P.2d 1167, 1177 (1995)); State v. Baranco, 77 Hawai`i 351, 355, 884 P.2d 729, 733 (1994) (issue whether defendant's constitutional rights against double jeopardy would be violated unless indictment dismissed is a question of law, reviewed under right/wrong standard); In re Doe, Born on January 5, 1976, 76 Hawai`i 85, 93, 869 P.2d 1304, 1312 (1994) (whether speech is protected by first amendment to United States Constitution as applied to the states through fourteenth amendment and by article I, section 4 of Hawai`i Constitution are questions of law freely reviewable on appeal).

State v. Quitog, 85 Hawai`i 128, 139, 938 P.2d 559, 570 (1997) (quoting State v. Arceo, 84 Hawai`i 1, 11, 928 P.2d 843, 853 (1996)).

C. Findings Of Fact

"A[n] [FOF] is clearly erroneous when, despite evidence to support the finding, the appellate court is left with the definite and firm conviction in reviewing the entire evidence that a mistake has been committed." State v. Kane, 87 Hawai`i 71, 74, 951 P.2d 934, 937 (1998) (quoting Aiken v. Ocean View Investments Co., 84 Hawai`i 447, 453, 935 P.2d 992, 998 (1997) (quoting Dan v. State, 76 Hawai`i 423, 428, 879 P.2d 528, 533 (1994))). An FOF is also clearly erroneous when "the record lacks substantial evidence to support the finding." Alejado v. City and County of Honolulu, 89 Hawai`i 221, 225, 971 P.2d 310, 314 (App. 1998) (quoting Nishitani v. Baker, 82 Hawai`i 281, 287, 921 P.2d 1182, 1188 (App. 1996)). See also State v. Okumura, 78 Hawai`i 383, 392, 894 P.2d 80, 89 (1995). "We have defined 'substantial evidence' as credible evidence which is of sufficient quality and probative value to enable a person of reasonable caution to support a conclusion." Roxas v.

Marcos, 89 Hawai'i 91, 116, 969 P.2d 1209, 1234 (1998) (quoting Kawamata Farms v. United Agri Products, 86 Hawai'i 214, 253, 948 P.2d 1055, 1094 (1997) (quoting Takayama v. Kaiser Found. Hosp., 82 Hawai'i 486, 495, 923 P.2d 903, 912 (1996) (citation, some internal quotation marks, and original brackets omitted)).⁽¹⁰⁾

D. Judicial Notice Of Records And Files

A trial court's sua sponte decision to take judicial notice of an adjudicative fact constitutes an exercise of its discretion. See Hawai'i Rules of Evidence (HRE) Rule 201(c) (1993) (providing in relevant part that "[a] court may take judicial notice, whether requested or not"). "'The trial court abuses its discretion when it clearly exceeds the bounds of reason or disregards rules or principles of law or practice to the substantial detriment of a party litigant.'" Tabieros v. Clark Equip. Co., 85 Hawai'i 336, 351, 944 P.2d 1279, 1294 (1997) (quoting Arceo, 84 Hawai'i at 11, 928 P.2d at 853 (quoting State v. Ganai, 81 Hawai'i 358, 373, 917 P.2d 370, 385 (1996))).

E. Plain Error

"We may recognize plain error when the error committed affects substantial rights of the defendant." State v. Cullen, 86 Hawai'i 1, 8, 946 P.2d 955, 962 (1997) (citations and internal quotation signals omitted). See also Hawai'i Rules of Penal Procedure (HRPP) Rule 52(b) (1993) ("Plain error or defects affecting substantial rights may be noticed although they were not brought to the attention of the court.").

State v. Lee, 90 Hawai'i 130, 134, 976 P.2d 444, 448 (1999) (quoting State v. Davia, 87 Hawai'i 249, 253, 953 P.2d 1347, 1351 (1998)).

III. DISCUSSION

A. The Circuit Court Possessed The Authority To Issue The Order Permitting The Administration Of Involuntary Medication.

Kotis argues that there was neither statutory nor any other authority for the circuit court's order permitting the director to medicate him involuntarily. We disagree.

HRS § 704-406 expressly provides that, upon a determination that a criminal defendant is unfit to proceed, "the court shall commit the defendant to the custody of the director of health to be placed in an appropriate institution for detention, care, and treatment." (Emphasis added.) Both the plain language of HRS § 704-406 and its legislative history are silent as to whether "detention, care, and treatment" may include a court order authorizing the involuntary administration of antipsychotic drugs. Common sense, and an analysis of other statutes in pari materia, however, demonstrate that such an order is included within the authority vested by HRS § 704-406.

HRS § 334-34 (1993) provides in relevant part that "[t]he director of health shall be responsible for the safekeeping of all patients who may be admitted to the state hospital and for the enforcement of proper order among and concerning the patients." The director's motion in this case alleged that it was necessary to medicate Kotis involuntarily because of the danger he posed to himself and to others in the hospital. Thus, the circuit court's order appears to be justified by the director's statutory responsibility for Kotis's "safekeeping" and for the maintenance of "proper order among and concerning the patients."

Kotis argued in the circuit court that his informed consent was required before being administered any medication pursuant to HRS § 334E-1 (1993), which provides in relevant part that,

[b]efore any nonemergency treatment for medical illness can commence, informed consent, as required by section 671-3⁽¹¹⁾ and as defined by the board of medical examiners pursuant to the authority vested in it by that section, shall be obtained from the patient, or the patient's guardian, if the patient is not competent to give informed consent.

(Emphases added.) As Kotis points out, the circuit court did not make any express finding regarding Kotis's competence to give informed consent to his treatment.⁽¹²⁾ Moreover, although a GAL was appointed in this case, the circuit court did not appoint a guardian of Kotis's person.⁽¹³⁾ Arguably, therefore, the circuit court failed to comply with HRS § 334E-1 because it failed to obtain Kotis's "informed consent."

However, HRS § 334E-2 (1993), which contains a lengthy list of the rights accorded to "[a]ny patient in a psychiatric

facility" to be exercised either by the patient or by "the patient's legal guardian or legal representative," provides in subsection (a) (9) for a right of "[r]efusal of treatment except in emergency situations or where a court order exists[.]" (Emphases added.) Accordingly, by its express terms, HRS § 334E-2(a) (9) contemplates a situation, such as the one at bar, in which the circuit court may be called upon to authorize involuntary treatment of the patient, i.e., where neither the patient nor his or her guardian consents to the treatment, even absent an emergency. See also Hawai'i Administrative Rules (HAR) § 11-175-33(a) (1988) (providing in relevant part that "[m]ental health . . . programs shall obtain informed consent to treatment . . . except for a person specifically ordered by a court to be involuntarily treated" (emphasis added)).

"[W]here there is a 'plainly irreconcilable' conflict between a general and a specific statute concerning the same subject matter, the specific will be favored. However, where the statutes simply overlap in their application, effect will be given to both if possible, as repeal by implication is disfavored." State v. Vallesteros, 84 Hawai'i 295, 303, 933 P.2d 632, 640, reconsideration denied, 84 Hawai'i 496, 936 P.2d 191 (1997) (citations and internal quotation signals omitted). Reading HRS §§ 334E-1 and 334E-2(a) (9) in pari materia, therefore, it is apparent that HRS § 334E-2 carves an exception to the general rule, as set forth in HRS § 334E-1, that the patient or his or her guardian must consent to a particular course of treatment.⁽¹⁴⁾ Furthermore, construing HRS § 704-406 in light of HRS § 334E-2, it appears that the former statute's allowance for "detention, care, and treatment" of a pretrial detainee may legitimately include seeking court approval for involuntary medication.

The Department of Health appears to have arrived at the same conclusion, as demonstrated by HAR § 11-175-45 (1988), the rule promulgated to enforce HRS § 334E-2. That rule provides in relevant part:

Right to refuse nonemergency treatment.

(a) Psychiatric facilities and residential treatment facilities shall establish policies and procedures for exercise of the right to refuse nonemergency treatment by consumers, except consumers ordered by a court to receive specific treatment. . . .

....

(b) When informed consent to proposed treatment is not obtained, the facility shall:

...

(2) Petition for a guardian for the consumer if the consumer has been clinically determined not to have the capacity to make a decision regarding treatment and the consumer does not have a guardian or attorney-in fact, and obtain consent from the guardian or attorney-in-fact before nonemergency treatment begins;⁽¹⁵⁾ or

(3) Obtain a specific court order for involuntary treatment if the consumer appears to have the capacity to make a decision regarding treatment and has been ordered by a court to be involuntarily hospitalized.

(Emphases added.)

Because Kotis was involuntarily hospitalized by order of the circuit court, HAR § 11-175-45(b) (3) applies to his case and authorizes the director's motion for an order of involuntary medication. Administrative rules, like statutes, have the force and effect of law. State v. Kirn, 70 Haw. 206, 208, 767 P.2d 1238, 1239-40 (1989) (citing Abramson v. Board of Regents, University of Hawaii, 56 Haw. 680, 54 P.2d 253 (1976), and Aguilar v. Hawaii Hous. Auth., 55 Haw. 478, 522 P.2d 1255 (1974)); Beldeviso v. Thompson, 54 Haw. 125, 129, 504 P.2d 1217, 1221 (1972) (citing State v. Kimball, 54 Haw. 83, 503 P.2d 176 (1972)). Kotis has not alleged any infirmity in the promulgation of HAR § 11-175-45(b) (3). Accordingly, inasmuch as we discern no conflict between HRS § 11-175-45(b) (3) and the governing statutes, Kotis's argument that the circuit court acted without authority fails.

B. The State's Interest In Preventing A Defendant From Harming Himself Or Herself Or Others May Override The Defendant's Liberty Interest In Bodily Integrity And The Right, As A Matter Of Substantive Due Process, To Have His Or Her Mental Functions Unimpeded While Preparing For Trial.⁽¹⁶⁾

Kotis next asserts that a trial court may never constitutionally authorize the administration of involuntary antipsychotic medication of a criminal defendant prior to, or during, trial.⁽¹⁷⁾ In support, he cites the United States Supreme Court's decisions in Washington v. Harper, 494 U.S. 210 (1990), and Riggins v. Nevada, 504 U.S. 127 (1992).

In Harper, the Supreme Court addressed the question whether the State of Washington had violated the right of a prison inmate to due process of law by forcibly administering antipsychotic drugs to him. 494 U.S. at 213. The Harper Court recognized that the degree of the state's proposed intrusion on the prisoner's bodily integrity was substantial:

The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty. Cf. Winston v. Lee, 470 U.S. 753 (1985); Schmerber v. California, 384 U.S. 757, 772 (1966). The purpose of the drugs is to alter the chemical balance in a patient's brain, leading to changes, intended to be beneficial, in his or her cognitive processes. While the therapeutic benefits of antipsychotic drugs are well documented, it is also true that the drugs can have serious, even fatal, side effects. One such side effect . . . is acute dystonia, a severe involuntary spasm of the upper body, tongue, throat, or eyes. . . . [I]t may be treated and reversed within a few minutes through use of the medication Cogentin. Other side effects include akath[i]sia (motor restlessness, often characterized by an inability to sit still); neuroleptic malignant syndrome (a relatively rare condition which can lead to death from cardiac dysfunction); tardive dyskinesia, perhaps the most discussed side effect of antipsychotic drugs. Tardive dyskinesia is a neurological disorder, irreversible in some cases, that is characterized by involuntary, uncontrollable movements of various muscles, especially around the face. . . . [T]he evidence . . . suggests that the proportion of patients treated with antipsychotic drugs who experience the symptoms of tardive dyskinesia ranges from 10% to 25%. According to the American Psychiatric Association, studies of the condition indicate that 60% of tardive dyskinesia is mild or minimal in effect, and about 10% may be characterized as severe.

Id. at 229-30 (some citations omitted).

However, while recognizing that an inmate retains some constitutional rights, the Harper Court noted that the extent of those rights must be defined within the context of the inmate's confinement as a convicted person. Id. at 222-23. Having balanced the inmate's liberty interest against the prison administrator's (1) "obligation to

provide prisoners with medical treatment consistent not only with their own medical interests, but also with the needs of the institution," (2) "interest in ensuring the safety of prison staffs and administrative personnel," and (3) "duty to take reasonable measures for the prisoners' own safety," the Harper Court concluded that "the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest." Id. at 225, 227.

In Riggins, a criminal defendant moved for an order suspending the administration of antipsychotic drugs until the end of his trial. 504 U.S. at 130. Riggins claimed that the effects of the medications on his demeanor and mental state during trial would deny him due process and that, because he planned to offer an insanity defense, continued treatment would prevent jurors from observing his "true mental state." Id. The Nevada trial court denied the motion, and Riggins was tried and convicted of murder and sentenced to death. Id. at 131.

On appeal following the conviction, the United States Supreme Court noted that, "[u]nder Harper, forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of overriding justification and a determination of medical appropriateness. The Fourteenth Amendment affords at least as much protection to persons the State detains for trial." Riggins, 504 U.S. at 135 (citation omitted). Accordingly, the Riggins Court held that the forced administration of antipsychotic drugs during Riggins's trial had violated his constitutional rights under the sixth and fourteenth amendments, because the trial court had not found that "administration of antipsychotic medication was necessary to accomplish an essential state policy." Id. at 138. However, the Riggins Court declined to "prescribe substantive standards" for the involuntary administration of antipsychotic drugs because the trial court had allowed the administration "without making any determination of the need for this course or any findings about reasonable alternatives. . . . Nor did the order indicate a finding that safety considerations or other compelling concerns outweighed Riggins'[s] interest in freedom from unwanted antipsychotic drugs." Id. at 136 (emphases in original).

On the other hand, the Riggins Court noted that "Nevada certainly would have satisfied due process if the prosecution had demonstrated . . . that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins'[s] own safety or the safety of others." Id. at 135 (citing Harper, 494 U.S. at 225-26, and Addington v. Texas, 441 U.S. 418 (1979)). The Riggins Court also stated that Nevada "might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins'[s] guilt or innocence by using less intrusive means." Id. (emphasis added) (citation omitted).

We agree with Kotis that, although Riggins hinted that it "might" be permissible for a trial court to order the involuntary treatment of a defendant with antipsychotic drugs in order to render him fit to stand trial, it left that issue essentially unsettled. In any event, this court is not faced with that issue in the present appeal. Although the prosecution argued the need to render Kotis fit to stand trial during the hearing on the director's motion, the director invoked only the need to forestall the danger Kotis allegedly posed to himself and others. In its order granting the director's motion, the circuit court also relied solely upon that alleged danger and made no mention of the need to try Kotis on the charges against him. Thus, the sole issue before this court is whether, on the record before us, it was permissible for the circuit court to authorize involuntary medication to ameliorate the purported danger that Kotis posed to himself and others.

In light of the narrow issue presented, Kotis's reliance upon Harper and Riggins for the extreme proposition that a pretrial detainee may never be forcibly medicated is therefore misplaced. As discussed supra, Harper concerned convicted prisoners and affirmed that it was possible for the state's penological interests to override an inmate's liberty interests with respect to involuntary medication. Riggins suggested that, although a criminal defendant, like any other mental health patient, possesses a fundamental right to refuse treatment threatening his bodily integrity, that right may be overridden by the state's interest in preventing him or her from causing physical harm to self or others. Similarly, although the Riggins Court recognized that involuntary administration of antipsychotic medication might have a prejudicial impact on a defendant's ability to

prepare and assist in his own defense, "trial prejudice can sometimes be justified by an essential state interest." Riggins, 504 U.S. at 138 (citations omitted).

In sum, we read Riggins to require the following three findings before a criminal defendant may constitutionally be involuntarily medicated with antipsychotic drugs, where it is alleged that the medication is necessary because the defendant poses a danger to himself or herself or others: (1) that the defendant actually poses a danger of physical harm to himself or herself or others; (2) that treatment with antipsychotic medication is medically appropriate, that is, in the defendant's medical interest; and (3) that, considering less intrusive alternatives, the treatment is essential to forestall the danger posed by the defendant. Cf. State v. Odiaga, 871 P.2d 801, 804 (Idaho 1994) (construing Riggins to hold that "the burden rests with the prosecution to show that medication is medically appropriate, essential to protect some significant interest, such as [the defendant's] safety or the safety of others, and that no less obtrusive means of protecting that interest exists"), cert. denied, 513 U.S. 952 (1994); Harrison v. State, 635 So.2d 894, 905 (Miss. 1994) (construing Riggins to hold that "involuntary treatment of the criminally accused with antipsychotic medication is permissible only where medically appropriate and, considering less intrusive alternatives, essential for safeguarding a compelling state interest").⁽¹⁸⁾

Kotis suggests that, notwithstanding the implications of Riggins upon his federal constitutional rights, this court should hold, as a matter of state law, that the circuit court's order was unconstitutional. This court has repeatedly recognized that it may accord greater protection to criminal defendants under the Hawai'i Constitution than that conferred under the United States Constitution. See, e.g., State v. Mendoza, 82 Hawai'i 143, 146, 920 P.2d 357, 360 (1996) (citing State v. Wallace, 80 Hawai'i 382, 397 n.14, 910 P.2d 695, 710 n.14 (1996) (citing State v. Teixeira, 50 Haw. 138, 142 n.2, 433 P.2d 593, 597 n.2 (1967))). Certainly, as Kotis suggests, his liberty interest in bodily integrity and his right to a fair trial are protected by article I, section 5 of the Hawai'i Constitution (1978) (providing in relevant part that "[n]o person shall be deprived of life, liberty, or property without due process of law . . .").⁽¹⁹⁾ However, Kotis offers no rationale justifying a departure from the Riggins due

process analysis. Inasmuch as the Riggins test, as articulated above, succinctly and fairly directs the trial court's inquiry into the bases for the state's decision involuntary to medicate him for purposes of mitigating the harms associated with mental illness, we can discern no reason why the due process clause of the Hawai'i Constitution should require more.

In the present case, the circuit court expressly found (1) that "Kotis poses a danger to himself" and "to others," (2) that "[t]he involuntary medication treatment plan . . . is medically appropriate," and (3) that, "[u]nder the circumstances, involuntary medication is essential for [Kotis's] benefit and for the benefit of others since no other less intrusive treatment is available[.]" Accordingly, we hold that the circuit court correctly applied the Riggins test in arriving at its ruling on the director's motion.

C. Article I, Section 5 Of The Hawai'i Constitution Requires Clear And Convincing Evidence To Support The Circuit Courts' FOFs In Proceedings Concerning Involuntary Medication.

Kotis argues that, even assuming that it is permissible in some circumstances involuntarily to administer antipsychotic medication to pretrial detainees, the requisite factual findings must be supported by clear and convincing evidence. The director counters that Kotis's position as an indicted defendant, detained as an inpatient in the director's custody, warrants a lower burden of proof. We agree with Kotis that his constitutional right to procedural due process mandates the burden of proof by clear and convincing evidence.

The seminal United States Supreme Court decision addressing the due process considerations relevant to the determination of the appropriate burden of proof is Addington v. Texas, 441 U.S. 418 (1979). The Addington Court considered "what standard of proof [was] required by

the Fourteenth Amendment to the Constitution in a civil proceeding brought under state law to commit an individual involuntarily for an indefinite period to a state mental hospital." 441 U.S. at 419. In that connection, the United States Supreme Court observed that

[t]he function of a standard of proof, as that concept is embodied in the Due Process Clause and in the realm of factfinding, is to "instruct the factfinder concerning the degree of confidence our society thinks he should have in the correctness of factual conclusions for a particular type of adjudication." In re Winship, 397 U.S. 358, 370 (1970) (Harlan, J., concurring). The standard serves to allocate the risk of error between the litigants and to indicate the relative importance attached to the ultimate decision.

Generally speaking, the evolution of this area of the law has produced across a continuum three standards or levels of proof for different types of cases. At one end of the spectrum is the typical civil case involving a monetary dispute between private parties. Since society has a minimal concern with the outcome of such private suits, plaintiff's burden is a mere preponderance of the evidence. The litigants thus share the risk of error in roughly equal fashion.

In a criminal case, on the other hand, the interests of the defendant are of such magnitude that[,] historically[,] and without any explicit constitutional requirement[,] they have been protected by standards of proof designed to exclude as nearly as possible the likelihood of an erroneous judgment. In the administration of criminal justice, our society imposes almost the entire risk of error upon itself. This is accomplished by requiring[,] under the Due Process Clause[,] that the state prove the guilty of an accused beyond a reasonable doubt. In re Winship, *supra*.

Id. at 423-24. Between the preponderance of the evidence and beyond a reasonable doubt standards, the Addington Court identified an "intermediate" standard, "which usually employs some combination of the words 'clear,' 'cogent,' 'unequivocal' and 'convincing[.]'" Id. at 424. See also Iddings v. Mee-Lee, 82 Hawai'i 1, 13, 919 P.2d 263, 275 (1996) ("'[C]lear and convincing' evidence may be defined as an intermediate standard of proof greater than a preponderance of the evidence, but less than proof beyond a reasonable doubt required in criminal cases. It is the degree of proof which will produce in the mind of the trier of fact a firm belief or conviction as to the allegations sought to be established, and requires the existence of a fact be highly probable." (Quoting Masaki v. General Motors Corp., 71 Haw. 1, 15, 780 P.2d 566, 574 (1989) (citations omitted).)).

The Addington court noted that the standard of proof by clear and convincing evidence had been required "in civil cases involving allegations of fraud or some other quasi-criminal wrongdoing by the defendant" because "[t]he interests at stake in those cases are deemed to be more substantial than mere loss of money" 441 U.S. at 424 (emphasis added). Moreover, the Court observed that it had "used the 'clear, unequivocal and convincing' standard of proof to protect particularly important individual interests in various civil cases. See, e.g., Woodby v. INS, [385 U.S. 276,] 285 [(1966)] (deportation); Chaunt v. United States, 364 U.S. 350, 353 (1960) (denaturalization); Schneiderman v. United States, 320 U.S. 118, 125, 159 (1943) (denaturalization)." Id. (emphasis added).⁽²⁰⁾ Acknowledging that "the ultimate truth as to how the standards of proof affect decisionmaking may well be unknowable," the Addington Court nevertheless affirmed that "a standard of proof is more than an empty semantic exercise" and that, "[i]n cases involving individual rights, whether criminal or civil, [t]he standard of proof [at a minimum] reflects the value society places on individual liberty." Id. at 425 (citations and internal quotation signals omitted) (some brackets added and some in original).

With respect to the issue of civil commitment, the Addington Court noted that the United States Supreme Court "has repeatedly recognized that civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection." Id. at 425 (citations omitted). The Addington Court then weighed the potential harms to either side from an erroneous determination of the commitment question. In doing so, the Addington Court observed that "[t]he state has a legitimate interest under its parens patriae powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of the mentally ill." Id. at 426. Nevertheless, the Addington Court determined that the person subject to an involuntary civil commitment proceeding faced the greater risk of harm because of the "significant deprivation of liberty" involved, the danger that such an individual might be committed for mere "idiosyncratic behavior," and the damaging effects of the "stigma" of being associated with severe mental illness."⁽²¹⁾ Id. at 425-27. The Addington Court therefore held that, on

balance, "the individual's interest in the outcome of a civil commitment proceeding is of such weight and gravity that due process requires the state to justify confinement by proof more substantial than a mere preponderance of the evidence." Id. at 427.

Two distinct modes of analysis were thus employed simultaneously in Addington. Addington first referred to the burden of proof as a measure of "the value society places on individual liberty." In this regard, the Addington Court pointed out that the burden of proof by clear and convincing evidence has been invoked where "[t]he interests at stake . . . are deemed to be more substantial than mere loss of money," e.g., a tarnished reputation due to a fraud claim or the dislocation attendant upon deportation or denaturalization. Accordingly, the initial consideration pursuant to the Addington analysis is the importance of the liberty interest at stake. Second, the Addington Court employed a balancing test, weighing the potential harm to the state against the potential harm to the committed person in order fairly to distribute the risks of an erroneous decision.

Applying the two-pronged Addington analysis to the present case, we note at the outset that it is well established that an individual's interest in bodily integrity is of paramount social importance. See, e.g., Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 849 (1992) (noting that "the Constitution places limits on a State's right to interfere with a person's most basic decisions about . . . bodily integrity," (citing Harper, 494 U.S. at 221-222; Winston v. Lee, 470 U.S. 753 (1985); Rochin v. California, 342 U.S. 165 (1952)); State v. Miller, 84 Hawai'i 269, 273, 933 P.2d 606, 610 ("Freedom from unjustified governmental intrusions into . . . bodily autonomy [is] at the core of the liberty protected by due process." (Citing Foucha v. Louisiana, 504 U.S. 71, 80 (1992).), reconsideration denied, 84 Hawai'i 496, 936 P.2d 191 (1997)). Similarly, a defendant's ability adequately to assist in his or her own defense in a criminal proceeding is a carefully protected and crucial interest. See, e.g., State v. Soares, 81 Hawai'i 332, 345-46, 916 P.2d 1233, 1246-47 (App. 1996) (noting that "[c]ompetence to stand trial is rudimentary, for upon it depends the main part of those rights deemed essential to a fair trial" (quoting Cooper v. Oklahoma, 517 U.S. 348, 354 (1996) (quoting Riggins, 504 U.S. at 139-40 (Kennedy, J.,

concurring) (quoting Drope v. Missouri, 420 U.S. 162, 171-72 (1975))). Manifestly, society's interest in protecting a defendant from being improperly administered mind-altering drugs against his or her will is at least as great as its interests in protecting the reputations of persons sued for fraud and protecting individuals from wrongful deportations and denaturalizations. Cf. Woodruff v. Keale, 64 Haw. 85, 100-101, 637 P.2d 760, 770 (1981) (concluding, after examination of the Addington factors, that "[t]ermination [of parental rights] is a drastic remedy and is of such weight and gravity that due process requires the state to justify termination of the parent-child relationship by proof more substantial than a preponderance of the evidence" (citation and internal quotation signals omitted)).

Moreover, applying the second prong of the Addington analysis, as Kotis argues, the risk of harm due to error faced by the individual subject to forcible antipsychotic medication is considerable, potentially involving fundamental changes in the nature of the individual's brain chemistry and thought processes, acute side effects, and associated risks as grave as death. See Harper, 494 U.S. at 229-30. Indeed, the director's own treatment plan in this case conceded the potential severity of the "risks" and "side effects" associated with the proposed medications.

On the other hand, the director points out that an erroneous determination that the defendant is not dangerous presents a significant risk of harm to hospital staff, other patients, and the defendant himself or herself. Relying on Harper, the director asserts that he not only has an interest, as parens patriae, in the safety of Kotis and other patients at the State Hospital who might be placed in danger by Kotis's violence, but that he also has an "obligation," as a "custodian," to protect that safety. See Harper, 494 U.S. at 225-26;⁽²²⁾ see also Lee v. Corregedore, 83 Hawai'i 154, 159, 925 P.2d 324, 329 (1996) (noting that "one who is required by law to take or who voluntarily takes the custody of another under circumstances such as to deprive the other of his normal opportunities for protection is under a . . . duty [to take reasonable action to protect the other person from unreasonable risk of physical harm]" (quoting Restatement (Second) of Torts § 314A(4) (1965)) (brackets in original) (emphasis in original omitted)).

The director fails to persuade us that the present case is distinguishable from Addington. In Addington, the trial court was charged by statute in the civil commitment proceeding to determine, inter alia, "whether [the proposed patient] require[d] hospitalization in a mental hospital for his own welfare and protection or the protection of others[.]" 441 U.S. at 420 (emphases added). In other words, the respondent's potential dangerousness was as much the focus of the trial court's inquiry in Addington as it is in the present case. Indisputably, as the Addington Court expressly recognized, the State of Texas had an important interest in protecting its citizens from the potential danger posed by a proposed patient living at large in the community and in preventing the proposed patient from harming himself. Nevertheless, Addington held that the importance of the liberty interests was such that proof by clear and convincing evidence was required to overcome them.

In the present case, the director has a greater opportunity to take palliative measures in the event of an erroneous decision than was available to the state in Addington. Where the state has failed to obtain an order committing an individual whom it believes to be dangerous, it has few options for controlling that individual. By contrast, where the director fails to obtain an order for involuntary medication of a custodial patient, he retains the power to restrain and monitor (i.e., "detain" and "treat," see HRS § 704-406(1)) the patient by other, albeit perhaps not ideal, means.⁽²³⁾

The additional element of a custodial "obligation" does not alter our analysis. The director's legal "obligation" to protect his staff and custodial patients can more accurately be described as a duty for purposes of tort law. See Lee, 83 Hawai'i at 159, 925 P.2d at 329. Where the director has acted with reasonable diligence in moving for a court order approving the involuntary administration of antipsychotic medications in appropriate circumstances, he obviously would not be subject to tort liability merely because the circuit court denied the motion for failure to meet the constitutionally mandated burden of proof. Cf. Ruf v. Honolulu Police Department, 89 Hawai'i 315, 327, 972 P.2d 1081, 1093 (1999) (holding that the imposition of a tort duty upon the police not to negligently release an arrestee would violate the public policy underlying article I, section 7 of the Hawai'i Constitution (1978) and the

fourth amendment to the United States Constitution). Thus, the director's exposure to potential tort liability as a "custodian" adds little weight, for purposes of due process analysis, to the state's more general interest in protecting Kotis and other persons from Kotis's purported dangerousness.

Although we acknowledge that the risk of harm to the interests protected by the director is substantial, in light of the crucial interests at stake for Kotis and those similarly situated, we hold, on balance, that Kotis risks the greater harm. As the United States Supreme Court impliedly recognized in Riggins, the involuntary administration to a criminal defendant of antipsychotic medications by the state is so unique, with regard to the degree of intrusion into the most zealously guarded of a defendant's rights and liberty interests, that it must be approached with extreme caution, even in the custodial context. Moreover, in contrast to federal jurisprudence, this court has held, pursuant to the Hawai'i Constitution, that "the rights of persons not yet convicted of crimes must be more closely scrutinized than the rights of prisoners." State v. Bayaoa, 66 Haw. 21, 25 n.2, 656 P.2d 1330, 1332 n.2 (1982) (rejecting the United States Supreme Court's reasoning to the contrary, pursuant to the United States Constitution, in Bell v. Wolfish, 441 U.S. 520 (1979)) (citing State v. Clark, 65 Haw. 488, 498 n.11, 654 P.2d 355, 362 n.11 (1982)). Cf. Riggins, 504 U.S. at 157 (Thomas, J., dissenting) (noting that "[t]he standards for forcibly medicating inmates may well differ from those for persons awaiting trial"). Thus, at least for purposes of article I, section 5 of the Hawai'i Constitution, we hold that due process requires that an order for the nonemergency, involuntary administration of antipsychotic medications to a criminal defendant must be based upon facts found by clear and convincing evidence.

D. Inasmuch As The Record Is Silent As To Which Burden Of Proof The Circuit Court Employed, This Court Should Presume That It Applied The Correct Burden Of Proof.

The circuit court did not expressly indicate which burden of proof it applied to the evidence adduced in connection with the director's motion. Rather, it merely ruled that,

"having considered the evidence," it "found" the facts described supra in section I. Accordingly, the record does not indicate whether the circuit court employed the burden of proof by "clear and convincing evidence," consistent with the imperatives of procedural due process. See supra section III.C.

Kotis had the opportunity to raise the issue of the appropriate burden of proof in the circuit court, but he did not do so. Inasmuch as he is the party alleging error, it was his burden to raise the issue, and any ambiguity in the circuit court's ruling may therefore be attributed to him. Where a trial court does not refer to the burden of proof, "'a presumption arises that it applied the correct [burden].'" Crosby v. State Department of Budget & Finance, 76 Hawai'i 332, 342, 876 P.2d 1300, 1310 (1994) (quoting State v. Aplaca, 74 Haw. 54, 66, 837 P.2d 1298, 1305 (1992)), cert. denied, 513 U.S. 1081 (1995). The foregoing holds true even if the correct burden of proof has not yet been clarified by an appellate decision on the issue at the time of the trial court's determination. See id. at 342-43 (presuming that the trial court applied the correct burden of proof in "whistleblower" case, despite the absence of Hawai'i case law on the issue). Accordingly, we presume that the circuit court applied the "clear and convincing" burden of proof.

E. The Circuit Court Did Not Commit Plain Error In Taking Judicial Notice Of "The Records And Files In This Case."

Kotis argues that the circuit court erred at the hearing on the director's motion by taking judicial notice of "the records and files in this case." He complains that the circuit court thereby took notice of "hundreds of pages of documents containing hearsay, double hearsay[,] and triple hearsay," without providing adequate notice, either to Kotis or to this court for purposes of review on appeal, of the content of the evidence noticed. Because Kotis failed to object at trial, however, this court must examine the circuit court's ruling for plain error. See Hawai'i Rules of Evidence (HRE) Rule 103(a)(1) and (d) (1993).⁽²⁴⁾

HRE Rule 201 (1993) provides in relevant part:

Judicial notice of adjudicative facts. (a) Scope of rule. This rule governs only judicial notice of adjudicative facts.

(b) Kinds of facts. A judicially noticed fact must be one not subject to reasonable dispute in that it is either (1) generally known within the territorial jurisdiction of the trial court, or (2) capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned.

(c) When discretionary. A court may take judicial notice, whether requested or not.

....

(e) Opportunity to be heard. A party is entitled upon timely request to an opportunity to be heard as to the propriety of taking judicial notice and the tenor of the matter noticed. In the absence of prior notification, the request may be made after judicial notice has been taken.

(f) Time of taking notice. Judicial notice may be taken at any stage of the proceeding.

This court has never directly considered whether a trial court may take judicial notice of the "records and files" in the case before it pursuant to HRE Rule 201, although it has indicated that a trial court may take judicial notice of "the pleadings, findings of fact and conclusions of law" filed in a separate court proceeding.⁽²⁵⁾ See Fujii v. Osborne, 67 Haw. 322, 329, 687 P.2d 1333, 1338-39 (1984) (citing Lalakea v. Baker, 43 Haw. 321 (1959); McAulton v. Smart, 54 Haw. 488, 510 P.2d 93 (1973)). See also State v. Akana, 68 Haw. 164, 165, 706 P.2d 1300, 1302 (1985) ("This court has validated the practice of taking judicial notice of a court's own records in an interrelated proceeding where the parties are the same." (Citing State v. Wong, 50 Haw. 42, 43, 430 P.2d 330, 332 (1967).)). As the director points out, a number of other jurisdictions have held that a trial court may take judicial notice of its own acts or of the existence of records on file in the same case. See, e.g., Hatch v. Wagner, 590 P.2d 973, 976 (Colo. Ct. App. 1978) (approving of the trial court's decision to take judicial notice of a stipulation between the parties on record); Perry v. Schaumann, 716 P.2d 1368, 1371 (Idaho Ct. App. 1986) (holding that it would have been appropriate for the trial court to take judicial notice of a stipulation between the parties filed with that court); In re A.S., 752 P.2d 705, 709 (Kan. 1988) (approving the trial court's

decision to take judicial notice of the court file); Riche v. Riche, 784 P.2d 465, 468 (Utah Ct. App. 1989) (noting that "[c]ourts may take judicial notice of the records and prior proceedings in the same case" (citations omitted)); State v. Blow, 602 A.2d 552, 557 (Vt. 1991) (approving the trial court's decision to take judicial notice of the date of the defendant's arraignment on two of the charges before it); Fontana v. Fontana, 426 So.2d 351, 355 (La. Ct. App.) (approving the trial court's decision to take judicial notice of its own judgment on record in the same case), cert. denied, 433 So.2d 150 (La. 1983).

However, as one court has expressed:

A distinction must be carefully drawn between taking judicial notice of the existence of documents in the Court file as opposed to the truth of the facts asserted in those documents. . . .

. . . [W]hile a Court may take judicial notice of each document in the Court's file[,] it may only take judicial notice of the truth of facts asserted in documents such as orders, judgments and findings of fact and conclusions of law because of the principles of collateral estoppel, res judicata, and the law of the case.

. . . . In re Snider Farms, Inc., 83 B.R. 977, 986 (N.D. Ind. 1988). See[] also[] . . . M/V American Queen v. San Diego Marine Const., 708 F.2d 1483, 1491 (9th Cir. 1983) ("[a]s a general rule, a court may not take judicial notice of proceedings or records in another cause so as to supply, without formal introduction of evidence, facts essential to support a contention in a cause then before it"); United States v. Am. Tel. & Tel. Co., 83 F.R.D. 323 (D. D.C. 1979) (judicial notice of court records should be limited to the fact of their existence rather than the truth of the matters contained in the court records)

Gottisch v. Bank of Stapleton, 458 N.W.2d 443, 455-56 (Neb. 1990) (emphasis in original omitted and emphases added) (some citations omitted) (some brackets in original and some added). See also Annis v. First State Bank of Joplin, 78 B.R. 962, 964 n.4 (Bankr. W.D. Miss. 1987) (holding that the hearsay contents of records and files in the case may not be rendered admissible by means of judicial notice); Leslie v. Leslie, 181 B.R. 317, 322 (Bankr. N.D. Ohio 1995) (holding that hearsay may not be admitted pursuant to judicial notice); One Hour Cleaners v. Industrial Claim Appeals Office, 914 P.2d 501, 505 (Colo. Ct. App. 1995) (holding that, while a court may take judicial notice of its records and files, it may not admit the facts stated

within those documents if they are not "generally known or capable of accurate and ready determination"); Addison M. Bowman, Hawaii Rules of Evidence Manual § 201-2C (2d ed. 1998) (noting that "entire court records will typically not qualify for judicial notice, containing as they do much material that is disputed and not indisputable").

The director asserts that the circuit court's taking judicial notice was proper in this case in light of "the statutory framework for determinations of fitness and penal responsibility under which the circuit court was operating," Director's Answering Brief at 18, and observes that HRS § 704-405, see supra note 5, contemplates the admission of the medical examiners' reports notwithstanding the hearsay rules. However, the director fails to apprehend that the instant proceeding is independent of, and only indirectly related to, the proceedings regarding Kotis's fitness to proceed. By its own terms, HRS § 704-405 applies to the "[d]etermination of fitness to proceed" and not to any issue that might be raised incident to the director's custody of a defendant after such a determination has been made. It is well established that evidence may be admissible for certain kinds of hearings but not for others, even when both hearings are part of the same criminal proceeding. See Thompson v. Yuen, 63 Haw. 186, 190, 623 P.2d 881, 884 (1981) (noting "the distinction between the adversary proceedings to determine guilt or innocence and the disposition phase of the proceeding[,] which allows for different application of the rules of evidence" (citing State v. Nobriga, 56 Haw. 75, 527 P.2d 1269 (1974))). The legislature has not provided for a comparable waiver of the hearsay rules for purposes of proceedings regarding the involuntary administration of antipsychotic medication. Accordingly, the general rule articulated in HRE Rule 101 (1993) (providing that the HRE "govern proceedings in the courts of the State of Hawaii, to the extent and with the exceptions stated in rule 1101") and HRE Rule 1101(b) (1993) (providing that the HRE "apply generally to civil and criminal proceedings") applies, and the rules proscribing, inter alia, hearsay, see HRE Rule 802 (1993), must be given full effect.⁽²⁶⁾

More cogently, however, the director urges that, by failing to interpose a timely objection, Kotis effectively waived his opportunity, pursuant to HRE Rule 201(e), to induce the circuit court to clarify its statement that it took "judicial notice of the records and files in this case."

Accordingly, the record is unclear as to the extent of the judicial notice taken and for what purposes the various "records and files" in the record were considered. As discussed above, taking judicial notice of the records and files of a case may or may not be proper, depending upon the type of record at issue and the purpose for which it is considered. For example, it would have been perfectly appropriate for the circuit court to take judicial notice of the existence and contents of its own order appointing a GAL in support of FOF No. 1 regarding the propriety of that appointment. Inasmuch as this court resorts to plain error analysis cautiously, see, e.g., State v. Lee, 83 Hawai'i 267, 274, 925 P.2d 1091, 1099 (1996) ("This court's power to deal with plain error is one 'to be exercised sparingly and with caution because the rule represents a departure from a presupposition of the adversarial system -- that a party must look to his or her counsel for protection and bear the cost of counsel's mistakes.'" (Quoting Raines v. State, 79 Hawai'i 219, 226, 900 P.2d 1286, 1293 (1995) (quoting State v. Kupau, 76 Hawai'i 387, 393, 879 P.2d 492, 298 (1992).), and State v. Fox, 70 Haw. 46, 56, 760 P.2d 670, 675-76 (1988))), it should refrain from speculating as to whether the circuit court relied upon "hundreds of pages" of hearsay in arriving at its ruling on the director's motion; rather, we should presume, absent an indication in the record to the contrary, that the circuit court took judicial notice only where appropriate. Cf. supra section III.D.

We must acknowledge, however, that it appears that the circuit court relied upon the contents of at least several documents in the record that were not court orders. With regard to FOF No. 5, for example, the circuit court expressly referenced the reports of the fitness panel. The circuit court's error in this regard, however, was arguably harmless, inasmuch as its finding that Kotis "suffers from a mental disease, disorder, or defect" was not, in and of itself, a component of the Riggins test. FOF No. 6, on the other hand, concerned the circuit court's related finding that the director's treatment plan was "medically appropriate," a finding that is a critical element of the Riggins test. See supra section III.B. In this regard, FOF No. 6 made express reference to Dr. Patel's report. Furthermore, the circuit court's questioning of Dr. Brown at trial indicates that it regarded Dr. Brown's opinion concerning Kotis's dangerousness and the appropriateness of the treatment plan as constituting the "minority" opinion

among the physicians who had assessed Kotis and the appropriate treatment plan, including those who had submitted reports for the purpose of the fitness proceedings but who did not testify at the hearing.

Inasmuch as the opinions and facts set forth in the various medical reports were neither "generally known within the territorial jurisdiction of the trial court" nor "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," they were not a proper subject of judicial notice. Moreover, as out-of-court statements, the contents of the reports constituted inadmissible hearsay. See HRE Rules 801 (1993) (defining hearsay) and 802 (1993) (providing that hearsay is generally inadmissible).

The remaining question, therefore, is whether the admission of the reports constituted plain error.

It is the general rule that evidence to which no objection has been made may properly be considered by the trier of fact and its admission will not constitute a ground for reversal. It is equally established that an issue raised for the first time on appeal will not be considered by the reviewing court. Only where the ends of justice require it, and fundamental rights would otherwise be denied, will there be a departure from these principles. [Hawai'i Rules of Penal Procedure (HRPP) Rule 52(b) (1994)].

Wallace, 80 Hawai'i at 410, 910 P.2d at 723 (quoting State v. Naeole, 62 Haw. 563, 570-71, 617 P.2d 820, 826 (1980) (some citations omitted)) (brackets in original) (emphasis added).

In Wallace, this court held that the admission of testimony regarding the weight of cocaine, although erroneous (inasmuch as insufficient foundation had been laid regarding the accuracy of the scale used to weigh the cocaine), did not rise to the level of plain error. Id. Similarly, in Naeole, this court held that the erroneous admission of testimony regarding pretrial photographic identifications was insufficiently serious to constitute plain error. 62 Haw. at 570-71, 617 P.2d at 826. Closer to the facts at bar, in Tabieros, 85 Hawai'i at 379 n.29, 944 P.2d at 1322 n.29, this court rejected the appellant's hearsay challenge to an accident report admitted at trial without objection. See also State v. Hoglund, 71 Haw. 147,

150-51, 785 P.2d 1311, 1313 (1990) (declining to address the defendant's argument, raised for the first time on appeal, that the trial court had erred in admitting a traffic abstract to provide his prior conviction).

In light of the foregoing precedent, we do not believe that the admission of the medical reports violated Kotis's "fundamental rights." Kotis had the opportunity to call any of the physicians involved in the case as witnesses at the hearing and failed to do so. Accordingly, the circuit court did not commit plain error in considering the reports.

F. There Was Substantial Evidence Supporting The Circuit Court's Relevant FOFs.

Kotis urges that the circuit court lacked substantial evidence to support its FOFs that Kotis was dangerous to himself and to others, that the treatment plan was medically appropriate and essential, and that alternative treatments would be inadequate.

1. There was substantial evidence that Kotis was dangerous to himself.

Kotis rightly points out that Dr. Shibata's opinion testimony on the subject of Kotis's dangerousness was highly equivocal. Dr. Shibata testified that Kotis "may pose a possible danger to others," but that "[t]here's no empirical way of measuring or predicting future dangerousness." Distressingly, Dr. Shibata also appeared to indicate that he had based his opinion of Kotis's dangerousness to others, at least in part, on the fact, per se, that Kotis had been charged with kidnapping. Moreover, Dr. Shibata testified that he did not believe Kotis to be imminently suicidal, but opined that there was a "possibility" that, due to a mood swing, he might become suicidal in the future.

Kotis is correct that, if the foregoing opinion testimony had represented the full extent of the evidence before the circuit court, it might well have been insufficient to

support the FOFs. In addition to his opinion testimony, however, Dr. Shibata testified to facts relevant to the question of Kotis's dangerousness to himself. Dr. Shibata testified that Kotis had "made statements about thoughts of dying, thoughts of committing suicide," and that he had "made several statements about possibly hanging himself, getting the police to shoot him."⁽²⁷⁾ It is not perfectly clear from the context of Dr. Shibata's testimony whether he learned of Kotis's statements from his review of the medical records or whether Kotis made the statements directly to Dr. Shibata during one of his several meetings with Kotis. Nevertheless, the circuit court could rationally have inferred that the gist of Dr. Shibata's testimony was that Kotis had made the statements directly to him. Accordingly, Kotis's statements were admissible for the truth of the matters asserted, pursuant to HRE Rule 803(a)(1) (1993).⁽²⁸⁾ These statements alone constitute substantial evidence to support the circuit court's FOF that Kotis was dangerous to himself. Moreover, each of the medical examiners who submitted reports in connection with the fitness proceedings (which must be considered "competent evidence" although erroneously admitted, see supra section III.E) opined that Kotis was dangerous both to himself and to others. Accordingly, the circuit court's FOFs regarding Kotis's dangerousness were not clearly erroneous.

2. There was substantial evidence to support the circuit court's FOFs that the medication treatment plan was medically appropriate and, in light of the inadequacy of less intrusive alternatives, essential to address Kotis's dangerousness.

Kotis asserts, without argument, that there was insufficient evidence to support the circuit court's finding that the director's proposed treatment plan was medically appropriate. However, Dr. Shibata testified that, in his opinion, the proposed medications would "decrease . . . mood swings" and render Kotis "more stable emotionally, which would greatly reduce the possibility of suicide." Moreover, Dr. Shibata expressly testified that he believed the director's treatment plan to be medically appropriate and "standard" for Kotis's condition.

Furthermore, Dr. Shibata expressly testified that, in his medical opinion, he believed the plan to be essential for Kotis's safety and that the other modalities of treatment that he had considered -- behavior modification and psychotherapy -- are "not [l]very effective when somebody is having psychotic delusions." Kotis complains that Dr. Shibata offered insufficient details regarding the alternative treatments he considered; however, he fails to suggest what amount of detail would have been necessary. In any event, this court's task is not to determine whether the evidence was "clear and convincing," but, rather, whether there was sufficient evidence to enable a person of reasonable caution to arrive at the circuit court's FOF. See Roxas, 89 Hawai`i at 116, 969 P.2d at 1234 (citations omitted). It appears to us that Dr. Shibata's testimony meets that test.

Accordingly, Kotis's argument that there was insufficient evidence to support the circuit court's FOFs fails.

IV. CONCLUSION

Based on the foregoing analysis, we affirm the circuit court's order.

On the briefs:

David Glenn Bettencourt for

the defendant-appellant

William Kotis

Donn Fudo, Deputy Prosecuting

Attorney, for the plaintiff-

appellee State of Hawai`i

Blair Goto and Heidi M. Rian,
Deputy Attorneys General,
for the party in interest-
appellee Director of Health,
Department of Health of the
State of Hawai`i

1. HRS § 707-701.5 provides in relevant part that "a person commits the offense of murder in the second degree if the person intentionally or knowingly causes the death of another person."

2. HRS § 707-720 provides in relevant part that "[a] person commits the offense of kidnapping if the person intentionally or knowingly restrains another person with intent to: . . . [t]errorize that person or a third person[.]"

3. HRS § 707-716 provides in relevant part that "[a] person commits the offense of terroristic threatening in the first degree if the person commits terroristic threatening: . . . [w]ith the use of a dangerous instrument."

HRS § 707-715 (1993) provides in relevant part:

Terroristic threatening, defined. A person commits the offense of terroristic threatening if the person threatens, by word or conduct, to cause bodily injury to another person . . . or to commit a felony:

(1) With the intent to terrorize, or in reckless disregard of the risk of terrorizing, another person[.]

4. HRS §§ 704-404(1) and (2) (1993) provide in relevant part that

[w]henver the defendant has filed a notice of intention to rely on the defense of physical or mental disease, disorder, or defect excluding responsibility, or there is reason to doubt

the defendant's fitness to proceed, . . . the court may immediately suspend all further proceedings in the prosecution. . . . Upon suspension of further proceedings in the prosecution, the court shall appoint three qualified examiners to examine and report upon the physical and mental condition of the defendant. . . .

5. HRS § 704-405 provides:

Determination of fitness to proceed. When the defendant's fitness to proceed is drawn in question, the issue shall be determined by the court. If neither the prosecuting attorney nor counsel for the defendant contests the finding of the report filed pursuant to section 704-404, the court may make the determination on the issue. When the report is received in evidence upon such hearing, the party who contests the finding thereof shall have the right to summon and to cross-examine the persons who joined in the report or assisted in the examination and to offer evidence upon the issue.

6. HRS § 704-406(1) provides in relevant part that, "[i]f the court determines that [a] defendant lacks fitness to proceed, the proceeding against the defendant shall be suspended, except as provided in section 704-407, and the court shall commit the defendant to the custody of the director of health to be placed in an appropriate institution for detention, care, and treatment. . . ."

7. In his opening brief, Kotis describes at length the parties' dispute over whether he should have been housed at the O`ahu Community Correctional Center (OCCC), as requested by the prosecution, or at the State Hospital, as requested by Kotis. As Kotis's opening brief itself notes, however, Kotis has been housed continuously at the State Hospital since December 1996. Accordingly, that issue is moot. Moreover, the location of Kotis's confinement has nothing to do with the question whether it was permissible to medicate Kotis involuntarily, which is the sole issue on appeal. Therefore, we do not address the issue of the location of Kotis's confinement.

8. Director's Exhibit 3 was a document entitled "Department of Health Psychiatric Medication Report October 18, 1994," which was introduced into evidence. The report contained a list of proposed medications and the "target symptoms," side effects, and risks associated with them. The report stated that, "[a]lthough this list contains many medications, it is likely that Mr. Kotis would only receive about two or three concurrently" and that only some of those listed could be involuntarily administered as injections. The report listed, *inter alia*, antipsychotic medications, such as lithium, Thorazine, Mellaril, Prolixin, Haldol, Riperdal, and Clozaril, "beta-blockers," prescribed "for the treatment of akathisia (restlessness) caused by antipsychotic medication," "anti-anxiety, agitation, and sleep medication," and other types of medications. With regard to the antipsychotic medications, the report recited side effects, including "[b]lurry vision, [c]onstipation, [l]ess sweating, [d]izziness, [d]ry mouth, [s]hakiness, [s]tiffness, [m]uscle spasms, [n]asal stuffiness, [f]ast heartbeat, [d]rowsiness, [s]kin rash, [and] [w]eight gain,"

and described "risks," including "[i]rreversible movement problems, [n]euroleptic malignant syndrome: ([f]are but can be fatal, [s]evere stiffness, [f]ever, [m]uscle problems, [k]idney problems), [l]iver problems ([j]aundice), [l]ow blood count: ([s]ore throat, [f]ever, [s]ores in the mouth or skin, [u]nusual bleeding or bruising, [and] [w]eakness)[.]" Additionally, the report specified that side effects might include akathisia and tardive dyskinesia, defined as an "irreversible movement problem" that "can be disfiguring if severe" but that is "usually mild in most cases."

Director's Exhibit 4 was a document entitled "Addendum to Psychiatric Medication Report October 24, 1994," signed by R. Andrew Schultz-Ross, M.D., a staff psychiatrist at the Hawai'i State Hospital. The addendum recommended that "a judicial order authorizing treatment (and blood levels) not be specific to agents or classes, and therefore allow medical judgment to change treatment based on response." Dr. Schultz-Ross recommended that certain medications from the list in Exhibit 3 be administered by injection "[d]uring active refusal" and that others be taken orally "[a]fter active refusal."

9. We agree with the circuit court that it appropriately exercised jurisdiction over the director's motion, as a matter arising out of the circuit court's commitment of Kotis to the director's custody, pursuant to HRS § 704-406.

[T]he circuit courts in this state are courts of general jurisdiction. State v. Villados, 55 Haw. 394, 520 P.2d 427 (1974). As such, "jurisdiction extends to all matters properly brought before them, unless precluded by constitution or statute." In re Chow, 3 Haw. App. 577, 656 P.2d 105, 109 (1982) (citing In re Keamo, 3 Haw. App. 360, 650 P.2d 1365 (1982)).

State v. Medeiros, 89 Hawai'i 361, 365 n.4, 973 P.2d 736, 740 n.4 (1999) (quoting State v. Dwyer, 78 Hawai'i 367, 370, 893 P.2d 795, 798 (1995)). See also HRS § 603-21.9 (1993) (providing in relevant part that "[t]he several circuit courts shall have power . . . [t]o make and award such . . . orders . . . and do such other acts and take such other steps as may be necessary to carry into full effect the powers which are or shall be given them by law or for the promotion of justice in matters pending before them").

10. Kotis suggests that, because of the importance of the issues involved in the present case, this court should extend its de novo review to the circuit court's factual findings as well as to its legal conclusions. In support, he cites, inter alia, to this court's decisions in Trainor, 83 Hawai'i at 255, 925 P.2d at 832, State v. Navas, 81 Hawai'i 113, 123, 913

P.2d 39, 49 (1996), State v. Baranco, 77 Hawai'i 351, 355, 884 P.2d 729, 733 (1994), State v. Hoey, 77 Hawai'i 17, 32, 881 P.2d 504, 519 (1994), and State v. Kelekolio, 74 Haw. 479, 502, 849 P.2d 58, 69 (1993). We agree that the ultimate issue at stake in this case -- whether the state's interests in a particular case outweigh the defendant's liberty interest in being free from unwanted medication -- is a question of constitutional law and is therefore subject to de novo review. See supra section II.B. However, the circuit court's findings with regard to the underlying facts relevant to the foregoing determination are subject to the clearly erroneous standard. Cf. Trainor, 83 Hawai'i at 255, 925 P.2d at 823 (making the distinction that the assessment of the "ultimate issue" of consent to a seizure is reviewable de novo, whereas the underlying factual issues, i.e., "(1) whether the person was timely advised that he or she had the right to decline to participate in the encounter and could leave at any time, and (2) whether, thereafter, the person voluntarily participated in the encounter," are reviewable under the clearly erroneous standard); Hoey, 77 Hawai'i at 32, 881 P.2d at 519 (noting that the circuit court's FOFs relevant to the issue of the voluntariness of a confession are reviewed under the clearly erroneous standard, but that the circuit court's "application of constitutional principles to the facts as found" is reviewed de novo); Kelekolio, 74 Haw. at 502, 849 P.2d at 69 (determining that the de novo standard applies to the "ultimate issue of voluntariness" of a suspect's statement to the police).

11. HRS § 671-3(a) (1993) provides in relevant part:

The board of medical examiners, insofar as practicable, shall establish standards for health care providers to follow in giving information to a patient, or to a patient's guardian if the patient is not competent to give an informed consent, to ensure that the patient's consent to treatment is an informed consent. . . .

12. The director does not argue, and we do not believe, that the circuit court's finding that Kotis was unfit to proceed to trial -- i.e., that "as a result of physical or mental disease, disorder, or defect, [Kotis] lack[ed] capacity to understand the proceedings against [him] or to assist in [his] own defense," see HRS § 704-403 (1993) -- may reasonably be construed as a simultaneous finding that Kotis was incompetent to decide to refuse nonemergency medications.

13. A guardian ad litem does not possess the same general powers and responsibilities as a guardian of the person. "A guardian ad litem is a special guardian appointed by the court in which a particular litigation is pending to represent an infant, ward, or unborn person in that particular litigation, and the status of guardian ad litem exits only in that specific litigation in which the appointment occurs." Black's Law Dictionary 706 (6th ed. 1990) (emphasis in original). "A general guardian is one who has the general care and control of the person and estate of a ward; while a special guardian is one who has special or limited powers and duties with respect to a ward, e.g., a guardian who has the custody of the estate but not of the person, or vice versa, or a guardian ad litem." Id. (emphases in

original). See also HRS §§ 334-60.5(c) and (j) (Supp. 1998) (distinguishing between the appointment of a guardian ad litem "to represent the subject [of a petition for involuntary hospitalization] throughout the proceedings" and a "guardian of the person, or property, or both"), 554B-1 (1993) (defining, for purposes of the Uniform Custodial Trust Act, the term "guardian" as "a person appointed or qualified by a court as a guardian of an individual and includ[ing] a limited guardian, but exclud[ing] a person who is merely a guardian ad litem" (emphasis added)); 560:1-201(17), (18), and (19) (1993) (providing separate definitions for the terms "guardian ad litem," "guardian of the person," and "guardian of the property" for purposes of the Uniform Probate Code); 560:3-203 (d) (Supp. 1998) (providing in relevant part that "any guardian except a guardian ad litem of a minor or incapacitated person[] may exercise the same right[s]" as the ward with respect to nomination proceedings for a personal representative of a decedent (emphasis added)). Whereas a guardian ad litem is only empowered to represent an incapacitated person's interests in particular litigation, a "guardian of the person" "has the same powers, rights and duties respecting the guardian's ward that a parent has respecting the parent's unemancipated child," including the power to "give any consents or approvals that may be necessary to enable the ward to receive medical or other professional care, counsel, treatment or service." HRS § 560:5-312(a) (1993).

14. Moreover, we note that, in Part VIII of HRS ch. 334, the legislature has established procedures for the imposition of involuntary outpatient treatment upon certain mentally ill persons who are, inter alia, "capable of surviving safely in the community with available supervision from family, friends, or others." See HRS § 334-121(2) (1993). Such outpatient treatment may include "medication specifically authorized by court order." HRS § 334-122 (1993). It would defy logic for the legislature to allow for involuntary medication of a patient on an outpatient basis, but to disallow such treatment of a patient who must be detained in a psychiatric facility.

15. Inasmuch as a guardian of the person, see supra note 13, was never appointed in this case, this court is not called upon to examine the ramifications of Riggins v. Nevada, 504 U.S. 127 (1992), see infra section III.B, with respect to the application of HAR § 11-175-45(b)(2).

16. Kotis has not placed at issue his right to privacy, pursuant to article I, section 6 of the Hawai'i Constitution (1978), in the present matter, and we therefore do not address it.

17. The director argues in his answering brief that Kotis "waived his ability to challenge a violation of his rights under the Constitution of the United States." The director bases his argument on the following language appearing in a declaration of Kotis's counsel, attached to a motion for extension of time to file his opening brief:

. . . At all times subsequent to 1 November 1996 [when the declarant counsel was appointed], Appellant KOTIS has been

unable to assist your Declarant in any manner, pursuant to the standards and criteria set forth in Dusky v. United States, 362 U.S. 402 . . . (1960)[,] and Drope v. Missouri, 420 U.S. 162, 171 . . . (1975)[.]

. . . .
Your Declarant, mindful of the decisions of the United States Supreme Court in Riggins v. Nevada, 504 U.S. 127 . . . (1992)[,] and Cooper v. Oklahoma, [517 U.S. 348 (1996) (holding that a state may not require a defendant to prove incompetency by clear and convincing evidence)], does not believe that the record in this case allows him to presently claim, consistently with the requirements of Rule 3.1 of the Hawai'i Rules of Professional Conduct, that Appellant KOTIS' rights under the Constitution of the United States were violated by the proceedings conducted below, but your Declarant cannot adequately discuss the factual issues with KOTIS due to his unfitness to proceed.

(Emphases added.) Assuming, arguendo, that it is possible for a criminal defendant's appointed appellate counsel to waive the client's points of error on appeal through a declaration associated with a procedural motion filed with this court, no such waiver could have occurred here. Kotis's counsel made clear in his declaration that his doubt regarding the constitutional arguments depended not only upon his understanding of the United States Supreme Court's decisions in Riggins and Cooper, but also upon his inability to "discuss the factual issues" with his client. We may assume that counsel was subsequently able to ascertain the facts he felt necessary to support the constitutional arguments presented herein subsequent to his motion. Accordingly, we reject the director's argument.

18. We note that the majority in Riggins rejected the dissent's characterization of its approach as "strict scrutiny" review of the state's decision involuntarily to medicate the defendant, claiming instead that it "ha[d] no occasion to finally prescribe such substantive standards . . . , since the District Court allowed administration of Mellaril to continue without making any determination of the need for this course or any findings about reasonable alternatives." 504 U.S. at 136 (emphases in original).

Having been left to fend for themselves as to this element of the analysis, the federal courts have split on the question whether "rational basis" or "strict scrutiny" review should apply to the task. Compare United States v. Brandon, 158 F.3d 947, 956-58 (6th Cir. 1998) (holding strict scrutiny applies because the defendant's right to be free from involuntary medication is a fundamental right), and Woodland v. Angus, 820 F. Supp. 1497, 1509-10 (D. Utah 1993) (same), with Hightower ex rel. Diehler v. Olmstead, 959 F. Supp. 1549, 1561 (N.D. Ga. 1996) (holding that Riggins had "rejected strict scrutiny as the appropriate standard to review state limitations on this type of liberty interest"), and Jurasek v. Payne, 959 F. Supp. 1441, 1454 (D. Utah 1997) ("This court adopts the 'reasonably related' test rather than the 'compelling necessity' or 'strict scrutiny' tests . . . as the proper standard of review applicable to the policies and regulations . . . concerning involuntary medication of patients . . .").

We agree with the Riggins dissent that the majority's hesitation to label its test "strict scrutiny" is curious in light of its language, inter alia, requiring the trial court to make findings whether "antipsychotic medication was necessary to accomplish an essential state policy," Riggins, 504 U.S. at 138 (emphases added), and its observation that the trial court could have comported with due process had it found, inter alia, that, "considering less intrusive alternatives," the involuntary medication was "essential for the sake of Riggins' own safety or the safety of others." Id. at 135 (emphasis added). See also id. at 156-57 (Thomas, J., dissenting). Cf. Madsen v. Women's Health Center, Inc., 512 U.S. 753, 790-91 (1994) (describing the "strict scrutiny" test as "'necessary to serve a compelling state interest and . . . narrowly drawn to achieve that end'" (quoting Perry Ed. Ass'n v. Perry Local Educators Ass'n, 460 U.S. 37, 45 (1983) (emphases added)); United States v. Lee, 455 U.S. 252, 257-258 (1982) ("The state may justify a limitation on religious liberty by showing that it is essential to accomplish an overriding governmental interest." (Emphases added.)).

In any event, it appears to us that the three-part test articulated supra, which we adopt herein for purposes of article I, section 5 of the Hawai'i Constitution, see infra, expresses the full substantive due process analysis of a state's decision involuntarily to administer antipsychotic medication for the purpose of addressing the dangerousness of a patient. But see infra section III.C regarding the requisite burden of proof regarding the Riggins factors, as necessitated by the defendant's right to procedural due process. In other words, the Riggins test is more specific than, and a replacement for, the usual "necessary for an essential state interest" or "rationally related to a legitimate state interest" formulations associated with "strict scrutiny" and "rational basis" review. Accordingly, we regard the debate over which standard of review the Riggins test truly reflects to be academic.

19. As implied supra in note 16, Kotis's right to privacy, pursuant to article I, section 6 of the Hawai'i Constitution (providing in relevant part that "[t]he right of the people to privacy is recognized and shall not be infringed without the showing of a compelling state interest"), is also implicated, inasmuch as that clause "gives each and every individual the right to control highly personal and intimate affairs of his own life." State v. Kam, 69 Haw. 483, 492, 748 P.2d 372, 378 (1988) (quoting Stand. Comm. Rep. No. 69, in 1 Proceedings of the Constitutional Convention of Hawaii of 1978, at 674 (1980) (emphasis in original omitted)). However, despite citing article I, section 6 in his memorandum in opposition to the director's motion in the circuit court, Kotis has not invoked the right to privacy on appeal.

20. As this court noted in Iddings, in which it held that "claims based on wilful and wanton misconduct must be proven by clear and convincing evidence," this jurisdiction has also frequently imposed the burden of proof by clear and convincing evidence in "particularly important" civil proceedings:

Clear and convincing proof is a standard frequently imposed in civil cases where the wisdom of experience has demonstrated the need for greater certainty, and where this

high standard is required to sustain claims which have serious social consequences or harsh or far reaching effects on individuals to prove willful, wrongful and unlawful acts to justify an exceptional judicial remedy.

So, in a number of cases where an adverse presumption is to be overcome, or on grounds of public policy and in view of the peculiar facilities for perpetrating injustice by fraud or perjury, the degree of proof required is expressed in such terms as "clear and convincing" and the phrase "preponderance of the evidence" has been expressly disapproved as an insufficient measure of the proof required.

[Masaki, 71 Haw.] at 15-16, 780 P.2d at 575 (quoting Travelers Indem. Co. v. Armstrong, 442 N.E.2d 349, 360 (Ind. 1982) (brackets and ellipsis points omitted)). In keeping with these principles, Hawai'i's appellate courts have implemented the clear and convincing standard of proof in a myriad of situations. See, e.g., Carr v. Strode, 79 Hawai'i 475, 904 P.2d 489 (1995) (proof to overcome presumption of paternity); State v. Miller, 79 Hawai'i 194, 900 P.2d 770 (1995) (proof to establish that criminal defendant is not a flight risk or danger to the community); State v. Lopez, 78 Hawai'i 433, 896 P.2d 889 (1995) (inevitable discovery rule); Cresencia v. Kim, 10 Haw.App. 461, 878 P.2d 725 (1994) (fraud); Calleon v. Miyagi, 76 Hawai'i 310, 876 P.2d 1278 (1994) (punitive damages); Maria v. Freitas, 73 Haw. 266, 832 P.2d 259 (1992) (constructive trust); Office of Disciplinary Counsel v. Rapp, 70 Haw. 539, 777 P.2d 710 (1989) (professional misconduct); Chan v. Chan, 7 Haw.App. 122, 748 P.2d 807 (1987) (civil contempt); Mehau v. Gannett Pacific Corp., 66 Haw. 133, 658 P.2d 312 (1983) (defamation); Woodruff v. Keale, 64 Haw. 85, 637 P.2d 760 (1981) (termination of parental rights); Tanuvasa v. City and County of Honolulu, 2 Haw.App. 102, 626 P.2d 1175 (1981) (proof that government official acted with malice); Boteilho v. Boteilho, 58 Haw. 40, 564 P.2d 144 (1977) (oral contract for sale of real estate).

Iddings, 82 Hawai'i at 14, 919 P.2d at 276.

21. In Jones v. United States, 463 U.S. 354 (1983), the United States Supreme Court distinguished Addington in the

context of a commitment hearing conducted subsequent to an acquittal by reason of insanity. The Jones Court noted that the main concern in Addington had been that "members of the public could be confined on the basis of 'some abnormal behavior which might be perceived by some as symptomatic of a mental or emotional disorder, but which is in fact within a range of conduct that is generally acceptable.'" Id. at 367 (quoting Addington, 441 U.S. at 426-27). After an insanity acquittal, however, the Jones Court held that the foregoing concern was greatly diminished, inasmuch as, pursuant to the statute at issue in Jones, "automatic commitment . . . follows only if the acquittee himself advances insanity as a defense and proves that his criminal act was a product of his mental illness[.]" Id. (emphasis added). Accordingly, the Jones Court held that an insanity acquittee may constitutionally be committed based upon facts found by a preponderance of the evidence. Id. at 368.

This court came to a similar conclusion in Thompson v. Yuen, 63 Haw. 186, 623 P.2d 881 (1981), in the context of an equal protection challenge. In Thompson, we approved the following analysis:

The difference between [insanity acquittees and civil committees] for purposes of burden of proof, is in the extent of possibility and consequence of error. If there is error in a determination of mental illness that results in a civil commitment, a person may be deprived of liberty although he never posed any harm to society. If there is a similar error in confinement of an insanity-acquitted individual, there is not only the fact of harm already done, but the substantial prospect that the same error, ascribing the quality of mental disease to a less extreme deviance, resulted in a legal exculpation where there should have been legal responsibility for antisocial action.

63 Haw. at 189, 623 P.2d at 883 (quoting United States v. Brown, 478 F.2d 606, 611 (D.C. Cir. 1973). Cf. State v. Miller, 84 Hawai'i 269, 275, 933 P.2d 606, 612 (rejecting a due process challenge to a statute placing the burden, by preponderance of the evidence, upon the defendant to demonstrate recovery sufficient to justify release from commitment after an acquittal by reason of insanity), reconsideration denied, 84 Hawai'i 496, 936 P.2d 191 (1997).

Jones and Thompson are distinguishable from the present case. Unlike an insanity acquittee, a defendant committed to the custody of the director because of unfitness need never voluntarily assert his own mental illness. See HRS § 704-404(1) (1993) (providing in relevant part that "[w]henver the defendant has filed a notice of intention to rely on the defense or mental disease, disorder, or defect excluding responsibility, or there is reason to doubt the defendant's fitness to proceed, . . . the court may immediately suspend all further proceedings in the prosecution" (emphasis added)). Moreover, as a pretrial detainee, such a defendant is presumed innocent of the crimes with which he is charged, and no inappropriate exculpation has occurred. Thus, the rationales of Jones and Thompson, justifying reliance upon proof by a preponderance of the evidence, are inapposite to our analysis in the present case.

22. We note that the language of Harper, upon which the director relies, arose in the context of the Harper Court's substantive constitutional balancing of the state's interests against the prisoner's interests. It was not directly related to the manner, procedurally, by which the factual findings that form the basis of that substantive balancing were established.

In a separate section of the opinion dealing with procedural due process, the Harper Court expressly rejected the prisoner's contention that the burden of proof by clear and convincing evidence was required in that case. However, the basis for its conclusion was the fact that, on the

record before it, the determination regarding involuntary medication had been made, pursuant to prison policies, by medical professionals, rather than by a judge. Harper, 494 U.S. at 235 (holding that "[the clear and convincing] standard is neither required nor helpful when medical personnel are making the judgment required by the regulations here" (emphasis added)). In the present case, no policy or rule has imparted to medical professionals the responsibility for the determination regarding the appropriateness of nonemergency forced medication of inpatients. Rather, as noted supra in section III.A, the determination is reserved to the circuit court, although the opinions of medical professionals may be available to the circuit court as evidence relevant to the parties' positions.

23. We note that we are not concerned in the present case with the director's options regarding involuntary medication under emergency circumstances.

24. HRE Rule 103 provides in relevant part:

Rulings on evidence. (a) Effect of erroneous ruling. Error may not be predicated upon a ruling which admits or excludes evidence unless a substantial right of the party is affected, and:

(1) Objection. In the case the ruling is one admitting evidence, a timely objection or motion to strike appears of record, stating the specific ground of objection, if the specific ground was not apparent from the context[.]

. . . .

(d) Plain error. Nothing in this rule precludes taking notice of plain errors affecting substantial rights although they were not brought to the attention of the court.

25. Similarly, this court has held that "an appellate court may[,] in its discretion, take judicial notice of files or records of a case on appeal." Roxas v. Marcos, 89 Hawai'i 91, 110 n.9, 969 P.2d 1209, 1228 n.9 (1998) (quoting State v. Schmidt, 70 Haw. 443, 446, 774 P.2d 242, 244 (1989))

(citing Eli v. State, 63 Haw. 474, 478, 630 P.2d 113, 116 (1981), and HRE Rule 201)). See also Brooks v. Minn, 73 Haw. 566, 569 n.2, 836 P.2d 1081 (1992) (taking judicial notice of a divorce decree in a family court proceeding for reference in a separate appeal involving an alleged breach of contract).

26. There are, of course, some proceedings, even those incident to a criminal prosecution, in which none of the HRE apply. See HRE Rule 1101(d) (1993) (providing that, with the exception of privileges, the HRE do not apply, inter alia, in preliminary hearings, bail hearings, and sentencing hearings). In those proceedings, therefore, the restrictions on judicial notice imposed by HRE Rule 201 would be inapplicable.

27. Dr. Shibata also testified, over Kotis's objection, that he had read in unspecified medical reports that Kotis had threatened Dr. Brown. Moreover, Dr. Shibata testified that "[m]edical reports show that he's . . . required to be put in seclusion at Hawaii State Hospital because of his head banging against the walls and required emergency medication at that time to decrease his agitation[.]" As Kotis's trial counsel rightly pointed out, however, Dr. Shibata's testimony as to these matters was admissible solely to demonstrate the basis of his expert opinion. See Tabieros, 85 Hawai'i at 384, 944 P.2d at 1326 (holding that "an expert witness [may] reveal[], in the course of direct examination, the contents of the materials upon which he or she has reasonably relied -- hearsay though they may be -- in order to explain the basis of his or her opinion" (citing HRE Rules 703 (1993) and 705 (1993) (emphasis added))).

28. HRE Rule 803(a) (1) provides in relevant part that "[a] statement that is offered against a party and is . . . the party's own statement" is "not excluded by the hearsay rule, even though the declarant is available as a witness[.]"

Hawaii Code Definitions

"Dangerous to others" means likely to do substantial physical or emotional injury on another, as evidenced by a recent act, attempt or threat.

"Dangerous to property" means inflicting, attempting or threatening **IMMINENTLY** to inflict damage to any property in a manner which constitutes a crime, as evidenced by a recent act, attempt or threat.

"Dangerous to self" means the person recently has threatened or attempted suicide or serious bodily harm; or the person recently has behaved in such a manner as to indicate that the person is unable, without supervision and the assistance of others, to satisfy the need for nourishment, essential medical care, shelter or self-protection, so that it is probable that death, substantial bodily injury, or serious physical debilitation or disease will result unless adequate treatment is afforded.

"Gravely disabled" means a condition in which a person, as a result of a mental disorder, (1) is unable to provide for that individual's basic personal needs for food, clothing, or shelter; (2) is unable to make or communicate rational or responsible decisions concerning the individual's personal welfare; and (3) lacks the capacity to understand that this is so.

§334-61 Presumption; civil rights.

No presumption of insanity or legal incompetency shall exist with respect to any patient by reason of the patient's admission to a psychiatric facility under this chapter. The fact of the admission shall not in itself modify or vary any civil right of any such person, including but not limited to civil service statutes or rights relating to the granting, forfeiture, or denial of a license, permit, privilege, or benefit pursuant to any law, or the right to dispose of property, execute instruments, make purchases, enter into contractual relationships, and to vote. If the administrator of a psychiatric facility or the deputy is of the opinion that a patient should not exercise any civil right, application for a show cause order shall be made to the court under the above proceedings after notice pursuant to section 334-60.4. [L 1976, c 130, pt of §4-. am L 1977, c 76, pt of §3; am L 1985, c 68, §7]

§334-13 Representative payee program.

(a) There is established a representative payee program within the department of health, to be administered by the director of health, to provide representative payee services to "mentally ill persons," "persons suffering from substance abuse," and persons referred from the department of human services who receive financial assistance and have a primary medical diagnosis of substance abuse.

(b) In developing this program, the department of health shall consider following:

- (1)** Services to the neighbor islands;
- (2)** Training for representative payees;
- (3)** Representative payees for care home residents;
- (4)** Representative payees for homeless persons;
- (5)** The use of case managers as representative payees;
- (6)** The development of due process procedures to protect the rights of mentally ill persons and persons suffering from substance abuse; and
- (7)** The development and implementation of an inter-agency working agreement with the department of human services to carry out the purposes of this program.

[L 1990, c 169, §2; am L 1995, c 207, §3]

Note Transfer of funds and reporting requirements. L 1995, c 207, §§4. 5.

APPENDIX D
MATERIALS FROM WORK GROUP MEETINGS

Report Title:

Involuntary Medication

Description:

Authorizes DOH to adopt rules to establish an administrative process allowing involuntary medication of psychiatric patients institutionalized at the Hawaii state hospital, to alleviate mental illness and restore competency while protecting the rights of patients.

HOUSE OF
REPRESENTATIVES
TWENTY-SECOND
LEGISLATURE, 2004
STATE OF HAWAII

H.B. NO. 2100

A BILL FOR AN ACT

RELATING TO INVOLUNTARY PSYCHIATRIC TREATMENT.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The purpose of this Act is to authorize the department of health to adopt rules to establish an administrative process allowing involuntary medication of psychiatric patients institutionalized at the Hawaii state hospital, to alleviate mental illness and restore competency while protecting the rights of patients.

SECTION 2. Chapter 334, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"§334- Involuntary treatment with psychiatric medication. (a) The department shall adopt rules under chapter 91 to enable interdisciplinary clinical review panels to authorize the involuntary administration of psychiatric medication for appropriate patients committed to:

(1) The state hospital for involuntary hospitalization pursuant to this chapter;

(2) The state hospital for examination with respect to physical or mental disease, disorder, or defect pursuant to section 704-404;

(3) The custody of the director and placed in the state hospital for detention, care, and treatment pursuant to section 704-406;

(4) The custody of the director and placed in the state hospital for custody, care, and treatment pursuant to section 704-411; or

(5) The custody of the director and placed in the state hospital pursuant to section 704-413.

(b) The rules shall:

(1) Permit involuntary administration of psychiatric medication only when medically appropriate; and

(A) Considering less intrusive alternatives, essential for the safety of the individual or the safety of others; and

(B) In the case of individuals placed in the state hospital pursuant to sections 704-404 or 704-406, when treatment is necessary

to obtain an adjudication of
the individual's guilt or
innocence; and

(2) Include an appeals process to a
second body, appointed by the director,
whose decision shall be deemed the
final administrative decision.

(c) The final decision in the administrative process may be
appealed to the circuit courts within fourteen days.

(d) The administrative process established under the rules
adopted under subsection (a) shall not be construed as a
contested case under chapter 91."

SECTION 3. Section 334E-2, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) Any patient in a psychiatric facility shall be afforded rights; and any psychiatric facility shall provide the rights to all patients; provided that when a patient is not able to exercise the patient's rights, the patient's legal guardian or legal representative shall have the authority to exercise the same on behalf of the patient. The rights shall include, but not be limited to, the following:

(1) Access to written rules and regulations with which the patient is expected to comply;

(2) Access to the facility's grievance procedure or to the department of health as provided in section 334-3;

(3) Freedom from reprisal;

(4) Privacy, respect, and personal dignity;

(5) A humane environment;

(6) Freedom from discriminatory treatment based on race, color, creed, national origin, age, and sex;

- (7) A written treatment plan based on the individual patient;
- (8) Participation in the planning of the patient's treatment plan;
- (9) Refusal of treatment except in emergency situations or where a court order or administrative authorization pursuant to section 334- exists;
- (10) Refusal to participate in experimentation;
- (11) The choice of physician if the physician chosen agrees;
- (12) A qualified, competent staff;
- (13) A medical examination before initiation of non-emergency treatment;
- (14) Confidentiality of the patient's records;
- (15) Access to the patient's records;
- (16) Knowledge of rights withheld or removed by a court or by law;
- (17) Physical exercise and recreation;
- (18) Adequate diet;
- (19) Knowledge of the names and titles of staff members with whom the patient has frequent contact;
- (20) The right to work at the facility and fair compensation for work done; provided that work is available and is part of the patient's treatment plan;
- (21) Visitation rights, unless the patient poses a danger to self or others; provided that where visitation is prohibited, the legal guardian or

legal representative shall be allowed to visit the patient upon request;

(22) Uncensored communication;

(23) Notice of and reasons for an impending transfer;

(24) Freedom from seclusion or restraint, except:

(A) When necessary to prevent injury to self or others;
[~~or~~]

(B) When part of the treatment plan; or

(C) When necessary to preserve the rights of other patients or staff;

(25) Disclosure to a court, at an involuntary civil commitment hearing, of all treatment procedures ~~[which]~~ that have been administered prior to the hearing;

(26) Receipt by the patient and the patient's guardian or legal guardian, if the patient has one, of this enunciation of rights at the time of admission."

SECTION 4. Statutory material to be repealed is bracketed. New statutory material is underscored.

SECTION 5. This Act shall take effect upon its approval.

INTRODUCED BY: _____

A BILL FOR AN ACT

RELATING TO INVOLUNTARY PSYCHIATRIC TREATMENT.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 SECTION 1. Section 334-1, Hawaii Revised Statutes, is
2 amended by adding a new definition to be appropriately inserted
3 and to read as follows:

4 "Competency or competent," as used in Part IV of this
5 chapter, means possession of sufficient understanding or capacity
6 to make a non-delusional decision concerning one's person."

7 SECTION 2. Section 334-60.3, Hawaii Revised Statutes, is
8 amended to read as follows:

9 "§334-60.3 Initiation of proceeding for involuntary
10 hospitalization[.]; petition for involuntary medication. (a)
11 Any person may file a petition for involuntary hospitalization
12 alleging that a person located in the county meets the criteria
13 for commitment to a psychiatric facility. The petition shall be
14 executed subject to the penalties of perjury but need not be
15 sworn to before a notary public. The attorney general, the
16 attorney general's deputy, special deputy, or appointee
17 designated to present the case shall assist the petitioner to
18 state the substance of the petition in plain and simple language
19 The petition may be accompanied by a certificate of the licensee

20 physician or psychologist who has examined the person within tw

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1 days before submission of the petition, unless the person whose
2 commitment is sought has refused to submit to medical or
3 psychological examination, in which case the fact of refusal
4 shall be alleged in the petition. The certificate shall set
5 forth the signs and symptoms relied upon by the physician or
6 psychologist to determine the person is in need of care or
7 treatment, or both, and whether or not the person is capable of
8 realizing and making a rational decision with respect to the
9 person's need for treatment. If the petitioner believes that
10 further evaluation is necessary before commitment, the petition
11 may request such further evaluation.

12 (b) In the event the subject of the petition for
13 involuntary hospitalization has been given an examination,
14 evaluation, or treatment in a psychiatric facility within five
15 days before submission of the petition, and hospitalization is
16 recommended by the staff of the facility, the petition may be
17 accompanied by the administrator's certificate in lieu of a
18 physician's or psychologist's certificate.

19 (c) The subject's treating psychiatrist may file a petiti
20 for involuntary psychoactive medication. The petition shall be
21 executed subject to the penalties of perjury but need not be

22 sworn to before a notary public.

23 (d) The petition for involuntary psychoactive medication

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1 must be accompanied by a certificate of the licensed treating
2 psychiatrist and a certificate of a licensed non-treating
3 psychiatrist. Both psychiatrists shall have examined the subject
4 within two days before submission of the certificates, unless the
5 subject has refused to submit to medical or psychiatric
6 examination, in which case the fact of refusal shall be alleged
7 in the certificates.

8 (1) The certificate of the treating psychiatrist shall
9 include:

0 (A) A description of the nature of the subject's
1 mental illness and the prognosis of the mental
2 illness without the proposed psychoactive
3 medication;

4 (B) A description of the proposed psychoactive
5 medication trials and the relevant considerations
6 about the proposed psychoactive medication,
7 including:

8 (i) The expected results;
9 (ii) The possibility of common, severe, or
0 irreversible side effects or conditions;
1 (iii) The associated risks of such side effects or

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conditions;

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(iv) Any pain or discomfort connected with or

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caused by the psychoactive medication or its

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administration; and

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(v) The prognosis as to the length of time before

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the subject's competency will be restored or

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before the subject's ability to function will

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be improved;

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(C) A medical opinion regarding the subject's capacity

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to make an informed decision concerning the

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proposed psychoactive medication;

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(D) A medical opinion that:

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(i) The proposed course of psychoactive

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medication trials is medically appropriate

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and the least intrusive treatment alternative

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available;

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(ii) The proposed psychoactive medication is

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necessary to prevent a significant and like

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long-term deterioration in the subject's

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mental condition;

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(iii) The proposed psychoactive medication is

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essential for the subject's safety or the

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safety of others; and

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(iv) The known beneficial mental and physical

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effects of the proposed psychoactive

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medication substantially outweigh the

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detrimental and physical effects; and

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(E) Any additional relevant information regarding:

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(i) If applicable, the experimental nature or

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method of treatment of the proposed

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psychoactive medications and its acceptance

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by the medical community of this State;

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(ii) The manner in which the side effects or

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conditions will be monitored and managed, if

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they occur;

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(iii) The extent of intrusion into the subject's

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body and the pain or discomfort connected

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with or caused by the psychoactive

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medications; and

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(iv) The subject's statements made both while

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competent or incompetent regarding the

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effects of the psychoactive medication on the

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subject's person;

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(2) The certificate of the non-treating psychiatrist shall

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include:

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(A) A statement that the non-treating psychiatrist 83

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not directly involved with the subject's current
or proposed treatment;

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(B) A medical opinion that the non-treating
psychiatrist concurs with the treating
psychiatrist's medical opinion that the subject
incompetent and with the proposed plan for
involuntary medication of the subject; and
(C) Any statements or medical opinions which differ
from the statements or opinions set forth by the
treating psychiatrist in the certificate attached
to the petition."

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SECTION 3. Section 334-60.5, Hawaii Revised Statutes, is
amended to read as follows:

"§334-60.5 Hearing on petition[.] for involuntary
hospitalization and order; hearing on petition for involuntary
medication and order. (a) The court may adjourn or continue a
hearing for involuntary hospitalization or involuntary medication
for failure to timely notify a spouse or reciprocal beneficiary
guardian, relative, or other person determined by the court to
entitled to notice, or for failure by the subject to contact an
attorney as provided in section 334-60.4(b)(7) if the court
determines the interests of justice so require.

21 (b) The time and form of the procedure incident to hearing
22 the issues in the petition for involuntary hospitalization or
23 involuntary medication shall be provided by court rule. [Unles

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1 the hearing is waived, the] The judge shall hear the petition f
2 involuntary hospitalization or involuntary medication as soon a
3 possible and no later than ten days after the date the petition
4 is filed unless a reasonable delay is sought for good cause sho
5 by the subject of the petition, the subject's attorney, or thos
6 persons entitled to receive notice of the hearing under section
7 334-60.4.

8 (c) The subject of the petition for involuntary
9 hospitalization or involuntary medication shall be present at a
10 hearings unless the subject waives the right to be present, is
11 unable to attend, or creates conditions which make it impossibl
12 to conduct the hearing in a reasonable manner as determined by
13 the judge. A waiver is valid only upon acceptance by the court
14 following a judicial determination that the subject understands
15 the subject's rights and is competent to waive them, or is unab
16 to participate. If the subject is unable to participate, the
17 judge shall appoint a guardian ad litem or a temporary guardian
18 as provided in Article V of chapter 560, to represent the subje
19 throughout the proceedings.

20 (d) Hearings may be held at any convenient place within t

21 circuit. The subject of the petition, any interested person, or
22 the court on its own motion may request a hearing in another
23 circuit because of convenience to the parties, witnesses, or the

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1 court or because of the individual's mental or physical
2 condition.

3 (e) The attorney general, the attorney general's deputy,
4 special deputy, or appointee shall present the case for hearing
5 convened under this chapter, for involuntary hospitalization,
6 except that the attorney general, the attorney general's deputy
7 special deputy, or appointee need not participate in or be
8 present at a hearing whenever a petitioner or some other
9 appropriate person has retained private counsel who will be
10 present in court and will present to the court the case for
11 involuntary hospitalization.

12 (f) Counsel for the subject of the petition shall be
13 allowed adequate time for investigation of the matters at issue
14 and for preparation, and shall be permitted to present the
15 evidence that the counsel believes necessary to a proper
16 disposition of the proceedings, including evidence as to
17 alternatives to inpatient hospitalization[.] or medication.

18 (g) No individual may be found to require treatment in a
19 psychiatric facility unless at least one physician or
20 psychologist who has personally examined the individual testifi

21 in person at the hearing[.] for involuntary hospitalization.
22 This testimony may be waived by the subject of the petition[.]
23 for involuntary hospitalization. If the subject of the petition

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1 for involuntary hospitalization has refused to be examined by a
2 licensed physician or psychologist, the subject may be examined
3 by a court-appointed licensed physician or psychologist. If the
4 subject refuses and there is sufficient evidence to believe that
5 the allegations of the petition for involuntary hospitalization
6 are true, the court may make a temporary order committing the
7 subject to a psychiatric facility for a period of not more than
8 five days for the purpose of a diagnostic examination and
9 evaluation. The subject's refusal shall be treated as a denial
0 that the subject is mentally ill or suffering from substance
1 abuse. Nothing in this section, however, shall limit the
2 individual's privilege against self-incrimination.

3 (h) The subject of the petition for involuntary
4 hospitalization or involuntary medication in a hearing under this
5 section has the right to secure an independent medical or
6 psychological evaluation and present evidence thereon.

7 (i) If after hearing all relevant evidence, including the
8 result of any diagnostic examination ordered by the court, the
9 court finds that an individual is not a person requiring medical
0 psychiatric, psychological, or other rehabilitative treatment or

21 supervision, the court shall order that the individual be
22 discharged if the individual has been hospitalized prior to the
23 hearing. If the court finds that the criteria for involuntary

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1 hospitalization under section 334-60.2(1) has been met beyond a
2 reasonable doubt and that the criteria under sections 334-60.2(2)
3 and 334-60.2(3) have been met by clear and convincing evidence,
4 the court may issue an order to any police officer to deliver the
5 subject to a facility that has agreed to admit the subject as an
6 involuntary patient, or if the subject is already a patient in a
7 psychiatric facility, authorize the facility to retain the
8 patient for treatment for a period of ninety days unless sooner
9 discharged. An order of commitment for involuntary
10 hospitalization shall specify which of those persons served with
11 notice pursuant to section 334-60.4, together with such other
12 persons as the court may designate, shall be entitled to receive
13 any subsequent notice of intent to discharge, transfer, or
14 recommit.

15 (j) The court may find that the subject of the petition for
16 involuntary hospitalization is an incapacitated or protected
17 person, or both, under Article V of chapter 560, and may appoint
18 a guardian of the person, or property, or both, for the subject
19 under the terms and conditions as the court shall determine.

20 (k) If a petition for involuntary psychoactive medication
21 has been filed, the court may order the administration of
22 involuntary medication if:

23 (1) The subject was involuntarily hospitalized pursuant t

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1 this chapter based on the criteria that the subject i
2 imminently dangerous to self or others;

3 (2) The treating psychiatrist, who has personally examine
4 the subject and filed the certificate accompanying th
5 petition, testifies in person at the hearing;

6 (3) The court finds clear and convincing evidence that th
7 subject is incompetent to make an informed decision
8 concerning the proposed psychoactive medication;

9 (4) The court finds by clear and convincing evidence that
10 the proposed psychoactive medication is necessary to
11 prevent a significant and likely long-term
12 deterioration in the subject's mental condition. In
13 making this finding, the court shall consider the
14 following factors:

15 (A) The subject's actual need for the psychoactive
16 medication;

17 (B) The nature and gravity of the subject's mental
18 illness;

19 (C) The extent to which the medication is essential

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effective treatment; and
(D) The subject's prognosis without the medication;
(5) The court finds by clear and convincing evidence that
the known beneficial mental and physical effects of t
proposed psychoactive medication substantially outweigh

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the detrimental mental and physical effects, which
findings shall be based on:
(A) The extent and duration of changes in behavior
patterns and mental activity effected by the
psychoactive medication;
(B) The detrimental mental and physical effects of t
psychoactive medication and the risk that they
will occur;
(C) The experimental nature or method of treatment o
the proposed psychoactive medications and its
acceptance by the medical community of this Stat
(D) The extent of intrusion into the subject's body
and the pain or discomfort connected with or
caused by the psychoactive medication; and
(E) The subject's statements made both while compete
or incompetent regarding the effects of the
psychoactive medication on the subject's person;
and

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(6) The court finds by clear and convincing evidence that the proposed psychoactive medication is medically appropriate, the least intrusive treatment alternative available, and essential for the subject's safety or the safety of others.

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(l) The order for involuntary medication shall authorize the treating physician or designee to administer medication which the treating physician or designee deems necessary for treatment of the subject; provided that the subject or the subject's representative may petition the court for a hearing to determine the necessity of the medication administered. The order for involuntary medication may specify types or classes of medication to be prescribed by the person's treating physician and administered on an involuntary basis if necessary. The person's treating physician or designee shall make all reasonable efforts to solicit the person's compliance with the prescribed medication prior to the involuntary administration of medication. All treatment shall be clinically indicated and consistent with accepted medical standards and the court order.

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(m) The order for involuntary medication shall be effective for no longer than ninety days. If the subject believes that the subject has regained competency, the subject or the subject's representative may petition the court for a hearing on the

19 subject's competency no sooner than forty-five days after the
20 issuance of the order for involuntary medication. The court
21 shall hold a hearing within ten days of this petition and must
22 make the identical findings set forth in subsection (k) before
23 the order for involuntary medication may continue for the

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1 remaining unexpired period."

2 SECTION 4. Section 802-1, Hawaii Revised Statutes, is
3 amended to read as follows:

4 "§802-1 Right to representation by public defender or other
5 appointed counsel. Any indigent person who is (1) arrested for
6 charged with or convicted of an offense or offenses punishable by
7 confinement in jail or prison or for which such person may be ordered
8 is subject to the provisions of chapter 571; or (2) threatened with
9 confinement, against the indigent person's will, in any
10 psychiatric or other mental institution or facility; or (3) the
11 subject of a petition for involuntary outpatient treatment or
12 involuntary medication under chapter 334 shall be entitled to be
13 represented by a public defender. If, however, conflicting
14 interests exist, or if the public defender for any other reason
15 is unable to act, or if the interests of justice require, the
16 court may appoint other counsel.

17 The appearance of the public defender in all judicial

18 proceedings shall be subject to court approval.

19 The appearance of a public defender in all hearings before
20 the Hawaii paroling authority or other administrative body or
21 agency shall be subject to the approval of the chairperson of t
22 Hawaii paroling authority or the administrative head of the bod
23 or agency involved."

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1 SECTION 5. Statutory material to be repealed is bracketed

2 New statutory material is underscored.

3 SECTION 6. This Act shall take effect on

STAND. COM. REP. NO. 1762

Honolulu, Hawaii
, 1999

RE: S.B. No. 1032
S.D. 1
H.D. 2

Honorable Calvin K.Y. Say
Speaker, House of Representatives
Twentieth State Legislature
Regular Session of 1999
State of Hawaii

Sir:

Your Committee on Judiciary and Hawaiian Affairs, to which was referred S.B. No. 1032, S.D. 1, H.D. 1, entitled:

"A BILL FOR AN ACT RELATING TO INVOLUNTARY PSYCHIATRIC TREATMENT,"

begs leave to report as follows:

The purpose of this bill is to authorize the Department of Health to adopt administrative rules to establish an administrative process allowing involuntary medication of institutionalized psychiatric patients.

Your Committee received testimony in support of this bill from the Department of Health, the Hawaii Government Employees Association, the Hawaii Psychiatric Medical Association and other concerned individuals. Comments were received from the Office of the Public Defender, United Self-Help and concerned individuals.

Your Committee finds that there is a lack of statutory guidelines to authorize the issuance of court orders for involuntary medication of individuals who are involuntarily committed to psychiatric institutions.

Your Committee amended this bill by deleting its contents and inserting provisions to:

1. Initiate proceedings for involuntary medication;

2. Require that petitions be filed for involuntary psychoactive medication accompanied by a certificate of the treating psychiatrist and a certificate of a licensed non-treating psychiatrist;
3. Establish criteria for hearings on petitions for involuntary medication and the issuance of court orders for medication;
4. Allow for judicial determination for the issuance of orders for involuntary medication upon meeting a set of criteria where there is proof by clear and convincing evidence; and
5. Authorize patient representation by a public defender during proceedings for involuntary medication.

As affirmed by the record of votes of the members of your Committee on Judiciary and Hawaiian Affairs that is attached to this report, your Committee is in accord with the intent and purpose of S.B. No. 1032, S.D. 1, H.D. 1, as amended herein, and recommends that it pass Third Reading in the form attached hereto as S.B. No. 1032, S.D. 1, H.D. 2.

Respectfully submitted on
behalf of the members of the
Committee on Judiciary &
Hawaiian Affairs,

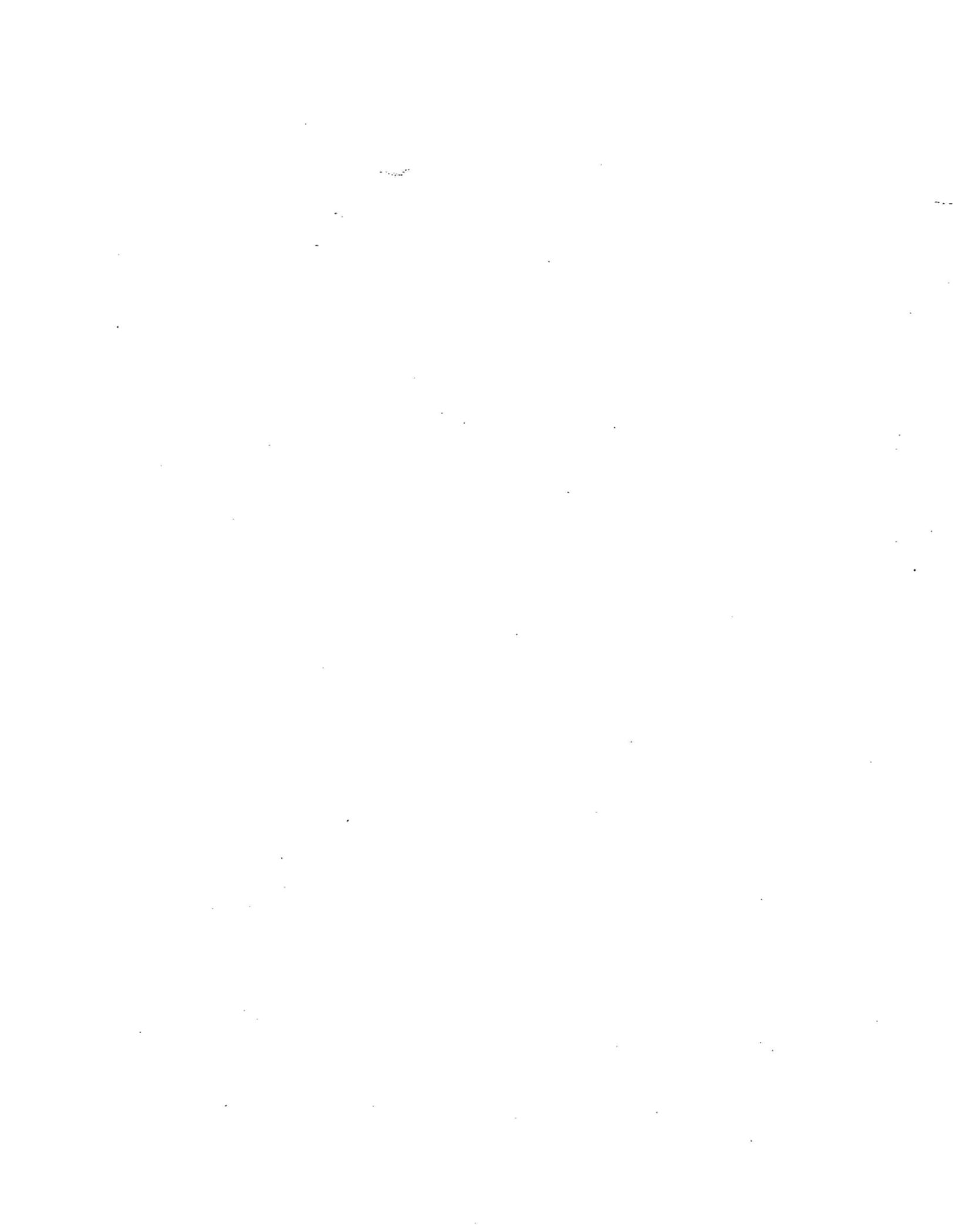
PAUL T. OSHIRO, Chair

PRETRIAL DETAINEES
ANALYSIS OF A SAMPLE OF CRIMINAL DEFENDANTS
ORDERED FOR MENTAL EVALUATION

Executive Summary

The Hawaii Disability Rights Center studied a random sampling of 67 pretrial detainees who were the subject of Court-ordered forensic examinations in 2002 and 2003. Each person's criminal justice proceedings was examined in-depth to construct individual timelines for the mental evaluation process provided by H.R.S. § 704-404:

- Basic constitutional rights to a speedy trial are suspended throughout the mental evaluation process. In order to protect the Fourteenth Amendment due process rights of a possibly incompetent criminal defendant, a detainee's Fifth Amendment due process right to liberty and Sixth Amendment right to a speedy trial are (indefinitely) suspended.
- The mental evaluation process averaged 84 days from the Court's order for mental examination to the judicial ruling of fitness or unfitness to proceed.
- During the forensic evaluation process, persons suspected of mental illness may remain in prison for weeks or months without appropriate medical treatment.
- Courts order mental examinations to take place wherever the defendant is currently being detained, although H.R.S. § 704-404 specifically permits outpatient evaluation.
- Nearly 89% of the court-ordered examinations permitted the evaluation process to take place where the pretrial detainee was currently held. If a pretrial detainee is incarcerated when a mental exam is ordered, it is likely that the suspended proceedings will keep the potentially mentally ill individual in prison without appropriate medical treatment.
- 35% of all persons who undergo a forensic examination are declared unfit to proceed or are acquitted and/or conditionally released.
- In 31.4% of the cases reviewed, the initial period of evaluation was extended by the Court for additional periods of 30-180 days.



- In 31% of the cases reviewed, the motion for mental evaluation took place within 10 days from the arraignment hearing. Another 22% of the motions for mental examination occurred just before trial was scheduled to commence.
- Deadlocks or conflicting reports among experts are a primary cause of judicial delays in the 404 process. In 23% of the cases reviewed, a tiebreaker examiner or updated reports were ordered to satisfy unanswered legal questions, adding another 60-90 days to the forensic examination process. During this period, the pretrial detainee remains incarcerated with limited mental health treatment.
- Pretrial detainees' uncooperative behavior accounted for only 5% of all procedural delays.
- Many delays in the evaluation process that are attributed to defense counsel occur *after* the 404 order is granted and the court has not delivered its decision. Continuances were granted for defense counsel's vacations, military duty, and attendance at professional seminars (9%), for conflicting trial or hearing dates (14%), and extensions of time for procedural matters (25.6%).
- Over 34% of all cases reviewed were related to illegal drug activities.
- Generally, misdemeanor pretrial detainees who undergo forensic examinations are incarcerated far longer than if they were convicted of the crime with which he/she is charged.
- There is an inevitable tension between the individualized approach to accommodating mental disabilities and the needs of prison security and administration.

APPENDIX E
HAWAII DISABILITY RIGHTS CENTER COMMENTS
ON H.C.R.156 H.D.1 REPORT

COMMENTS ON HCR 156 REPORT

The Hawaii Disability Rights Center wants to comment on the proposals in this report which suggest revisions to the Hawaii Revised Statutes or to the Hawaii Administrative Rules which would eliminate the current legal and constitutional protections which are afforded to individuals before they can be involuntarily treated with psychotropic medications. More specifically, these are found at items 6 and 7 under "Recommendations to Streamline and Expedite Orders To Treat."

It seems that these recommendations not only propose to amend the current statutes. They also seek to overturn court precedents from the United States Supreme Court as well as the Hawaii Supreme Court. Additionally, they propose to repeal administrative rules promulgated by the Department of Health itself for the protection of the patients committed to its custody.

Creating a departmental treatment review panel to authorize the administration of involuntary medication is a very dangerous idea which, as noted, flies in the face of constitutional precedents. The rationale put forth at the Task Force meetings was that since current law commits residents to the hospital for "care and treatment", that ought to include the administration of involuntary medication if such were deemed to be part of the patient's care and treatment. In particular, it was stated that this type of provision would be particularly applicable to the "406" proceedings wherein individuals were committed to the state hospital in order to render them fit to proceed to trial.

However, our State Supreme Court has stated very clearly in *State v. Kotis* that "construing HRS 407-406 in light of HRS 334E-2, it appears that the former statute's allowance for detention, care and treatment of a pretrial detainee may legitimately include **seeking court approval for involuntary medication**". Thus, the Court is clearly stating that the interpretation of this statute is not that it automatically renders a committed individual subject to involuntary medication if deemed necessary for care and treatment. It merely authorizes the state to petition the court to enter such an order.

Further, the potential use of these review panels to authorize treatment to render one fit to proceed to trial clearly contradicts the holding of the United States Supreme Court in *Sell v. United States*. The court there went to great lengths to explain that treatment for the purpose of fitness restoration is very different than treatment for either dangerousness or for therapeutic reasons. The issue to be considered there is whether the potential effects of the involuntary medication may have a tendency to impact the defendant's demeanor in the courtroom or otherwise affect factors bearing on the ability

to obtain a fair trial. This is very different from medical, treatment decisions. These are legal rather than medical issues and are appropriately decided by courts, not by doctors alone. The Sell court was very clear to state that involuntary medication could be authorized to restore a defendant's fitness to proceed to trial, but only by a COURT. The recommendation of the Task Force to authorize a treatment panel to make this decision has no basis in law whatsoever.

We submit that proposals to amend the Hawaii Revised Statutes in such a way as to overturn the holdings of our State and United States Supreme Court represent bad public policy. The Department's own administrative rules even provide for these constitutional protections. Hawaii Administrative rule 11-175-45 specifically requires treatment facilities to establish policies providing for the right to refuse non emergency treatment except in cases where consumers are ordered by a Court to receive treatment. So, the Task Force proposes not only to re write state and federal constitutional law, it also proposes to re write rules drafted by its own Department for the protection of individuals committed to its custody. We believe we can do better than that in terms of protecting the rights of our most vulnerable citizens. Inasmuch as the primary rationale offered in support of these proposals was the supposed length of time it takes to obtain a court order, we believe that the legal, sensible approach to solving this problem lies in expediting the judicial procedure rather than designing a potentially unconstitutional administrative procedure in which clinicians are making these decisions outside of the public purview with no judicial oversight to safeguard individual liberties.

Our remarks should not be construed as an indication that we were otherwise generally opposed to either the methodology of the Task Force or its overall findings. The report notes on page one that consensus existed on three main points: the need to balance the different facets of this very complex issue; the recognition that the current system needs improvement; and the need to utilize Best Practices in the area of Mental Health treatment and law. We would certainly agree with those propositions. We may strongly disagree with these specific proposals. However, we fully acknowledge that there is a need to reform the current system and we were in support of most of the other proposals which did focus on either expediting the judicial process or providing treatment at an earlier stage of the proceeding. We are particularly supportive of those proposals to provide more "up front" treatment to individuals in the criminal justice system. Last year, our center conducted an analysis of Pretrial Detainees and concluded that treatment was needed at an earlier stage of the proceeding and that the length of time to complete examinations under Chapter 704 of the Hawaii Revised Statutes needed to be shortened. We are pleased that this Task Force was receptive to our proposals in this regard.

to obtain a clear and unambiguous definition of the term "treatment" for the purposes of the proposed legislation. It is noted that the current definition of "treatment" in the Health Insurance Act 1973 is broad and encompasses a wide range of services, including medical, dental, and optical services. It is suggested that the proposed definition should be more specific and should exclude certain services, such as those provided by private health insurance companies, to ensure that the proposed legislation is targeted and effective.

The proposed definition of "treatment" should be based on the nature of the service provided, rather than the provider of the service. It should include services that are provided by a health care professional, such as a doctor, nurse, or dentist, and that are intended to prevent, diagnose, or cure a disease, injury, or condition. It should also include services that are provided by a health care professional, such as a physiotherapist, occupational therapist, or speech therapist, and that are intended to prevent, diagnose, or cure a disease, injury, or condition. It should not include services that are provided by a private health insurance company, such as those provided by a private hospital or private health care provider, or services that are provided by a health care professional, such as a doctor, nurse, or dentist, and that are intended to prevent, diagnose, or cure a disease, injury, or condition, but which are not provided by a health care professional, such as a physiotherapist, occupational therapist, or speech therapist.

The proposed definition of "treatment" should also be based on the nature of the service provided, rather than the provider of the service. It should include services that are provided by a health care professional, such as a doctor, nurse, or dentist, and that are intended to prevent, diagnose, or cure a disease, injury, or condition. It should also include services that are provided by a health care professional, such as a physiotherapist, occupational therapist, or speech therapist, and that are intended to prevent, diagnose, or cure a disease, injury, or condition. It should not include services that are provided by a private health insurance company, such as those provided by a private hospital or private health care provider, or services that are provided by a health care professional, such as a doctor, nurse, or dentist, and that are intended to prevent, diagnose, or cure a disease, injury, or condition, but which are not provided by a health care professional, such as a physiotherapist, occupational therapist, or speech therapist.

