CHAPTER 9: Representing Clients in Hearings

Most advocates have among their duties the responsibility for representing clients at certification review hearings with some advocates having the responsibility at medication capacity (Riese) hearings as well. This chapter will provide you with tips on representing your client at hearings.

(Contact COPR for more information on hearings and the legal criteria applied at those hearings)

PRE- HEARINGS PREPARATION

BEFORE YOU BEGIN

Observing other advocates can be one of the most effective ways to develop your own advocacy skills. Watch the proceeding carefully, analyzing strategy, language and presentation. Familiarize yourself with the patient records and medical abbreviations. Although facilities may organize their charts differently, they all contain the same basic components. Know what information is found in each of the components. (See appendix to this chapter: Common Medical Abbreviations and Symbols).

INTERVIEWING THE CLIENT

Meet with your client in a quiet, private area.

Give a clear explanation of your role. Explain that you are not employed by the hospital and that your duty is to advocate for the clients expressed interests in the hearing.

Encourage the client to talk openly with you before the hearing about their concerns. Let them know that you can do a better job of advocating for them if you know all the facts.

Explain the following:

- The nature and purpose of the hearing.
- The possible results.
- The role of the participants and how the hearing will be conducted.
- The evidence that will be considered.

- The questions you will ask the client during the hearing.

It is important that the Advocate listen carefully and probe where clarification is needed. Follow up on leads and potential witnesses.

Explain to the client that the facility representative will speak first as they have the burden of establishing probable cause to detain the client. Advise the client against interrupting others during the hearing and ask the client to listen carefully to the questions. Warn the client that they may hear things they disagree with or that anger them, but they will have a chance to speak as well. If you feel your client will have a difficult time waiting for his/her turn to speak, offer the client a pencil and paper to take notes and write down his/her rebuttal remarks.

If the client indicates that they won't participate in the hearing, acknowledge that option. However, they should be advised of the implications of not attending. Explain that hearing officers are often reluctant to release individuals that they have not observed first hand. If the client is not attending because he/she is fearful of the hearing process, explain that the hearing is informal in nature and that he/she will be free to leave the hearing at any time. Note: In hearings where the client is absent or not contesting the hold, the facility is still required to present evidence of a mental disorder and the client's need for continued involuntary treatment as a danger to self/others, or gravely disabled. Advocates should hold the facility to this standard in every instance.

The Advocate should educate the client regarding the certification hearing and commitment process and how to successfully challenge it.

REVIEW DOCUMENTATION

Explain to the client that to provide them the best representation, you will need to know what evidence the facility plans to present at the hearing by reviewing what the staff have written in his/her medical record. Obtain the clients consent to review their medical record. If the client refuses consent, explain that it will hamper your ability to effectively assist them, but if the client still refuses, the advocate must respect this decision. Note: Advocates are entitled to a copy of the Notice of Certification without client consent. (Welfare and Institutions Code (WIC) Section 5253).

Provide the client with copies of forms and advisements to assist in refreshing his/her memory. In capacity hearings, offer the written medication information required to be provided. Review the material about medication with the client. Note: The Notice of Certification should have already been "personally delivered"

to the client prior to the day of the hearing and the client should have been advised of the hearing and of his/her right to a writ of habeas corpus. (WIC Sections 5252 and 5253).

Advocates sometimes find, however, that clients have not been fully informed of the certification or the pending hearing. Hearing preparation provides a good opportunity for advocates to track and address patterns of due process violations at a particular facility, e.g. dropping Notices of Certification on the nightstand beside a sleeping patient, failure to timely initiate certification, missing signatures, etc.

After you have reviewed the medical record and Notice of Certification, ask the client to give their version of events documented in the medical record and to expand on reports of behavior that may be helpful in presenting the case. Take notes of key facts and arguments you plan to make.

CERTIFICATION HEARINGS

Evidence gleaned from the medical record and the client interview that may be helpful in challenging certification as gravely disabled include the following:

- The client has been showering and dressing appropriately in the hospital
- The client has been eating in the hospital; his/her lab values are within normal limits; his/her body mass index (BMI) is at or above normal limits
- The client has a home to return to; he/she has knowledge of, or experience with, homeless resources

Evidence that may be helpful in establishing that the client is not a danger to self may include the following:

- The client can articulate a plan for emotional self-care after discharge
- The client has support from friends and family
- If the client contemplated or attempted suicide, he she can articulate what has changed since that time
- The client has a crisis plan and agrees to ask for help before acting on self-destructive impulses

Evidence that may be helpful in establishing that the client is not a danger to others may include the following:

- No violent or aggressive acts in the hospital or within the last several days
- Decrease in psychosis or other psychiatric symptoms

CAPACITY HEARINGS

Keep in mind that the client does not have to prove that his/her reason for refusing medication is a good one or that the medication is inappropriate or unhelpful, only that client client's decision is based on some reasonable belief.

Evidence that may be helpful in establishing that the client has capacity may include the following:

- The client understands and acknowledges he/she has been diagnosed with a mental disorder
- The client has experience with this or other psychiatric medications
- The client is able to articulate objectionable side effects he/she has experienced or fears
- The client has a documented history of medication side effects
- The client is willing to take a reasonable alternative medication
- No evidence was presented by the physician or documented in the medical record of the client having delusions, especially those related to medication

KNOW THE NECESSARY STANDARDS AND CRITERIA

Be familiar with the criteria and standards for certification review and capacity hearings.

The criteria for certification review hearings are due to a mental disorder the person is a danger to self or others or gravely disabled. The standard is "probable cause." To constitute probable cause to detain an individual for purposes of civil commitment, a statement of facts must be known to the peace officer (or other authorized person) that would lead a person of ordinary care and prudence to believe, or entertain a strong suspicion, that the person is mentally disordered and is a danger to self, others or is gravely disabled. (Contact COPR for further information about these criteria).

For capacity hearings, the criterion is capacity to consent as defined as the ability "to understand and knowingly and intelligently act upon the information required to be given regarding the treatment." (Riese v. St. Mary's Hosp. & Med. Ctr. 209 Cal.App. 3d 1303, 1321 - 22 192 Cal. Rptr. 537 (1987))

The standard for capacity hearings is "clear and convincing evidence," defined as evidence which is "so clear as to leave no substantial doubt, sufficiently strong to command the unhesitating assent of every mind." (Lillian F. v. Superior Court 160 Cal. App. 3d 314, 320, 206 Cal. Rptr. 603, 606 (1984)) (Contact COPR for further information about informed consent criterion).

Also for capacity hearings, learn about medications. The physician has a major advantage in the hearing in that he/she has knowledge about and experience with medication. The advocate must have a good enough knowledge about the medication that he/she is not forced to rely entirely upon the physician's expertise. If the client is willing to take one medication but not another, the advocate needs to know whether the alternative offered by the client is realistic. If the client indicates a fear of a side effect that has not been acknowledged, the advocate needs some basis for arguing that the side effect is reasonable to fear. Read about medications and learn how to use the Physician's Desk Reference.

HEARING SKILLS

In most counties both certification review hearings and capacity hearings take place at the facility and are relatively informal in nature. Try to use a pleasant style and tone to avoid alienating the decision maker when presenting your clients' case and soliciting testimony. Try as well to put your client at ease as much as possible. Make sure that she/he has been introduced to all the individuals in the hearing and is aware of each person's role.

PROCEDURAL ARGUMENTS

Insist on procedural compliance even when the hearing officer will not consider procedural defects in the certification or Riese petition, the advocate should point out all procedural problems and the correct procedure to avoid problems in the future. Normally, hearing officers prefer to hear argument on any procedural issue prior to presentation of substantive evidence. Procedural issues that come up in a certification review hearing may include lack of signatures, timing problems, evidence that the client was not advised etc. Procedurals issues in Riese hearings may include evidence that the client is not refusing medication,

that the facility did not complete and file the petition appropriately, or that the facility did not properly advise the client, etc. Advocates should continue to push the hearing officer to consider procedural defects in determining the validity of the certification or petition.

ADDRESS WILLINGNESS AND ABILITY TO BE VOLUNTARY

Willingness and ability to be voluntary should be addressed by the advocate both before and during the hearing. If the client indicates his/her willingness to stay voluntarily, it is appropriate for the advocate to approach the treating physician with this information and explore the possibility of the client signing in voluntarily prior to the hearing. Note: Both patients and physicians sometimes mistakenly believe that a hospitalization will not be covered by insurance unless the patient requires involuntary treatment. However, California's Mental Health Parity regulations require health maintenance organizations (HMOs) to cover voluntary psychiatric inpatient services. (Title 28 CCR section 1300.74.72 (a)).

Further, DMH Information Notice No. 01-01 clarifies that "nothing in Medi-Cal mental health regulations prevents payment solely on the basis of legal status for a voluntary emergency psychiatric inpatient hospital stay."

The advocate should address voluntariness at the hearing as well. Even when hearing officers will not rule on voluntary status, the advocate should highlight facts demonstrating the client's willingness and ability to receive treatment on a voluntary basis. Emphasize that willingness and ability to be voluntary is a threshold issue in the certification; when placing an individual a hold for continued intensive treatment, the doctor is required to certify that the individual has been advised of, but unwilling or unable to accept voluntary treatment. Even if the hearing office is does not rule on voluntariness, willingness and ability to be voluntary can also be used to indicate that the client is not dangerous or gravely disabled.

PUSH FOR REMOVAL OF DANGER TO SELF AND/OR OTHERS GROUNDS

Eliminating a danger to self and/or others grounds for certification not only reduces the number of elements to be challenged in a later proceeding, but reduces the stigma and negative implications of a finding of dangerousness.

CHALLENGE THE FACTS PRESENTED

Listen carefully to the facts presented. Challenge misstatements, inference, hyperbole and speculation. Point out errors and omissions in factual presentations. Be sure you round out the facts with additional information

emphasizing the client strength and abilities. When opinion or theory are put forward, identify them and contrast them with the facts.

WITNESSES AND OTHER EVIDENCE

Make sure you know what a witness will say before you ask them to testify in the hearing. Family, friends and clinical staff may have important evidence.

Remember that clinical staff may present adverse testimony; make sure to construct your questions precisely enough to narrow their testimony and don't go on a fishing expedition.

If an outside witness with good evidence refuses or is unable to testify, you may summarize the evidence for the hearing officer.

If you have documentary evidence (e.g., a description of side effects from a medication text, a letter from the client, friend or family, etc.) to present, be prepared to explain the purpose for which you are introducing it.

CHALLENGE THE WAY THE LAW IS INTERPRETED OR APPLIED IN THE CASE

Despite years of hearing experience, there are still misinterpretations of the law. In addition, hearing officers may misapply the law to specific facts. It is important for the advocate to challenge these mistakes. Provide hearing officers with copies of case decisions or legal memoranda to correct the problems of misinterpretation or misapplication.

USE THE HEARING PROCESS TO EDUCATE

A part of all hearing, preparation should be education of the client on the commitment process and how to successfully challenge it. It's also a good time to encourage the client to ask questions and make requests for assistance on other problems. In addition use the hearing process to educate staff about the law, the value of the legal protections, and the client's needs and interests.

PRESENTING THE CASE

OPENING STATEMENT

- Present background information and identification of the client,
- Summarize what the evidence will show,
- Summarize the law that must be followed by the decision-maker.

TESTIMONY

Keep the following in mind when you are soliciting testimony from the facility representative:

- Ask questions that are leading and closed (preferably those that ask for a yes or no answer);
- Avoid asking "why" questions unless you have a good sense that the answer will be favorable to your case;
- Ask questions designed to elicit favorable responses first. Ask questions that attack unfavorable testimony last;
- Break down questions into components, addressing one fact at a time;
- Listen closely to the answers you get. Revise your questions as appropriate, follow up on leads;
- Don't badger the witness; try to use a pleasant style and tone of voice so as not to alienate the decision-maker or the clinician. For example, don't recite a list of facts, followed with "isn't that a fact?"

KEEP THE FOLLOWING IN MIND WHEN SOLICITING TESTIMONY FROM THE CLIENT:

- Draft a detailed list of questions based on your interview with the client and review of the medical record;
- If the client's testimony is likely to appear to be illogical or disorganized, keep the testimony very brief, narrow in scope and focused;
- Ask the client in advance all the questions that you intend to ask in the hearing. If the client has trouble remembering what you covered in the interview, ask a leading question or remind the client that you've discussed this during preparation for the hearing. Try to avoid the appearance of coaching the client, but if you need the testimony, you can prompt the client;
- Closing Statement;
- State the conclusion you want the hearing officer to reach;
- Summarize what your evidence has shown and then review that evidence. Begin with the evidence that is strongest for your case;

- Recite the weaknesses or problems with the clinician's case, why what has been provided in testimony is not accurate or does not lead to the ultimate conclusion;
- Review why the law- as applied to the evidence as presented- requires the hearing officer to decide in the client's favor.

APPENDIX A - COMMON MEDICAL ABBREVIATIONS AND SYMBOLS

Abbreviation	Meaning
a	before
ac	before meals
abd	abdomen
AD	Alzheimer's disease; right ear
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ADL	activities of daily living
ad lib	as desired
amb	ambulation (walk)
ama	against medical advice
ASAP	as soon as possible
BID, bid	twice in the day
BM	bowel movement
BP	blood pressure
BPD	Bipolar Disorder; Borderline Personality Disorder
BR or br	bath room
BUN	blood urea nitrogen (a lab test)
$\bar{c}$	with

c/o	complaints of
caps	capsule with medication in it
cath	catheter (a tube used to drain out body fluid)
CBC	complete blood count (a blood test)
CC	chief complaint
cont.	continued
COPD	chronic obstructive pulmonary disease
/d	per day
DC or D/C	discharge
dc	discontinue
decub	decubitus ulcer (pressure sore, bedsore)
DD	Developmental Disability
DID	Dissociative Identity Disorder
DM	diabetes mellitus (diabetes)
D.O.	disorder
DOA	date of admission; dead on arrival
DOB	date of birth
Dx	diagnosis
DT, DTs	delirium tremens (“the shakes” from alcohol withdrawal)
ECG, EKG	electrocardiogram
ect, ECT	electroshock therapy
EEG	electroencephalogram (electric brain activity)
e.g.	example
ETOH	ethanol (alcohol)
FBS	fasting blood sugar (a lab test)

F/U FU	follow up
G tube	gastric tube (a tube in the stomach)
GAF	global assessment of functioning
hgb hct	hemoglobin, hematocrit, (blood cell measurements)
HS, hs	hour of sleep, or at bedtime
ht	height
Hx, hx	history
I & O	intake and output (fluid taken in and urine output)
IM	intramuscular
Inj	injection
IV	intravenous
MDD	major depressive disorder
meds	medications
MI	mental illness
MR	mental retardation
N/C	no complaints
NG, NGT	nasogastric (tube)
noc	night
norm	normal
NOS	not otherwise specified
NPO	nothing by mouth
nsg	nursing
OT	occupational therapy
p̄	after

P	pulse
pc, p.c.	after meals
PE pe	physical exam
prn, p.r.n.	as needed or required
PO, po	by mouth
pt	patient
q	every
qam	every am (morning)
qd	every day
qod	every other day
qh	every hour
q2h, q3h, q4h	every 2 hours, every 3 hours, every 4 hours
qhs	every night (hour of sleep)
qid	four times a day
re:	about or regarding
rbc, RBC	red blood cell
reg	regular
resp	respiration or breaths
R/O, r/o	rule out
ROM	range of motion
rx, RX	prescription
$\overline{S}$	without
SAD	Seasonal Affective Disorder
sl	sublingual meaning under the tongue

SOB	short of breath
s & s, s/s	signs and symptoms
stat	immediately
STD	sexually transmitted disease
strep	streptococcus
symp, Sx	symptom
T	temperature
tab	tablet, a tablet of medication, a round pill
TB	tuberculosis
tid	three times a day
T/O,	t/o telephone order
TPR	temperature, pulse, respiration
Tx	treatment
U/A, u/a	urine analysis
UTI	urinary tract infection
VO, v/o	verbal order
vs, VS, v/s	vital signs (temperature, pulse and respiration measurements)
WBC, wbc	white blood cell
W/C	wheel chair
WNL	within normal limits
w/o	without
wt	weight
w/u	work up
x	times
y/o	years old

yr	year		

COMMONLY USED SYMBOLS

↑	increase	↓	decrease
~	approximately	#	number
@	at	o	degree
>	greater than	<	less than
+	positive	-	negative
+, &	and	Ø	nothing, not, none
=	equal to	≠	not equal to
	male		female
	one of something		2,3 of something

APPENDIX B - CERTIFICATION REVIEW HEARING CHECKLIST

INITIAL CONTACT WITH CLIENT

___ 1) Did advocate introduce him/herself to the client?

___ 2) Did advocate ask the client if s/he wished to be called by first name or Mr., Mrs., etc.?

___ 3) Did advocate attempt to find a private place in which to meet with the client?

___ 4) Did advocate make sure that the client understood that advocates are not affiliated with the mental health facility in any way?

___ 5) Did advocate assure client that any information s/he gave would be held in confidence and would not be shared with anyone outside the hearing unless it was with the client's permission?

___ 6) Did advocate adequately explain his/her reason for meeting with the client?

___ 7) Did advocate obtain the client's consent before talking with anyone regarding his/her case or reviewing his/her chart?

HEARING PREPARATION

___ 1) Did advocate explain the hearing procedure including time, place, participants and what the client would be likely to encounter?

___ 2) Did advocate inform the client that the hearing would be informal and that the hearing was being held solely for their own protection and that the burden of proof was on the facility to show that the commitment was justified?

___ 3) Did advocate explain the following:

a. The reason doctor was holding client as shown on the 5250 form?

b. The technical grounds on which client was being held?

c. The ways client could overcome these grounds?

___ 4) In a neutral way, did advocate ask client whether or not s/he wanted to leave the hospital or stay in the hospital?

___ 5) If the client wanted to stay or was unsure about leaving, did the advocate explore with the client, taking the client's lead, the possibility of:

a. Postponing the hearing?

b. Requesting voluntary status?

___ 6) If the client expressed the desire to leave the hospital did advocate:

a. Ask client how hospitalization came about?

b. Ask for permission to read the client's chart?

c. Ask permission to phone family members etc. for support and information?

___ 7) Did the advocate advise client that s/he did not have to answer any questions that would make him/her uncomfortable either in the interview or at the hearing and that s/he did not have to attend the hearing the hearing if s/he didn't want to?

___ 8) If client did not want to attend the hearing, did advocate inform client that the hearing officer might interpret his/her nonparticipation in an unfavorable light?

___ 9) Did advocate inform client that s/he could waive the hearing and proceed directly to court by petitioning for a writ of habeas corpus but that waiving the hearing would not be strategically a wise choice since, by so doing so, s/he would be losing one of his/her due process protections?

___ 10) Did advocate advise client that, although things might be said at the hearing with which s/he might disagree, during the hearing it would be important not so interrupt while others are talking?

___ 11) Did advocate advise client about the importance of his/her demeanor and physical appearance at the hearing?

___ 12) With regard to above, did advocate offer to provide or obtain any assistance the client requested in preparing him/herself for the hearing?

___ 13) Without leading the client to particular decision, did advocate ascertain client's wishes with respect to continued hospitalization?

___ 14) Did advocate ask client if s/he would like to contact anyone to verify living arrangements?

___ 15) If yes to above, did advocate identify him/her as a patients' rights advocate and clearly convey to the family member that s/he is not connected with the hospital in any way?

___ 16) Did advocate clearly convey to the family member that if the client were released at the hearing that it would likely be against medical advice, but that the hearing officer would be making a decision as to whether or not, with their assistance, the client could meet his/her basic needs for food, clothing and shelter?

___ 17) If the hearing was postponed, was it postponed based on the expressed wishes of the client?

___ 18) Did advocate leave a number with the client where s/he could be reached in case the client had any questions or problems?

REVIEWING CHART

Did advocate look for any statements in the chart that indicated:

___ 1) That the client was calm or cooperative in admission?

___ 2) That the client's condition had improved?

___ 3) Positive description of client's condition or behavior?

___ 4) That medication had been decreased or discontinued?

___ 5) Positive physical health reports?

___ 6) Existence of financial and family support?

___ 7) That client was placed in seclusion or restraint?

___ 8) That the client had been eating/sleeping well?

___ 9) Voluntary consent forms?

Did advocate check to see if:

___ 1) The client had been given a copy of the 14-day certification?

___ 2) The 14-day certification had been signed by two authorized persons?

___ 3) The 72 hr. evaluation form was in the chart and signed?

___ 4) The upper portion of the 72 hr. evaluation form was complete indicating that proper advisement had been given to the client?

___ 5) The legal time constraints regarding detention had been exceeded?

___ 6) The narratives on the 72 hr. hold and 14-day certification substantiated each of the commitment criteria indicated?

___ 7) The involuntary patient advisement form had been completed and was present in the chart?

___ 8) The date of signatures on the 14 day certification coincided with the date of its initiation?

Did advocate note:

___ 1) What supported the doctor's position?

___ 2) What supported the client's position?

___ 3) Names and phone numbers where applicable of those who were familiar with the client?

___ 4) Did advocate advise the client that s/he might be asked some of the same questions at the hearing not because the advocate didn't understand or wasn't listening but so that the hearing officer could hear the answer, too?

___ 5) Did advocate adequately describe the hearing process to the client by explaining?

a) Where it would take place?

b) When it would take place?

c) Who would be present at the hearing?

d) The hearing process?

___ 6) Did advocate clearing explain to the client:

a) The position of the doctor?

b) The evidence that would be used at the hearing to refute the doctor's position?

c) The evidence that would support the doctor's position?

___ 7) Did advocate prepare the client for the hearing by asking him/her questions that the hearing officer might ask?

___ 8) Did advocate give client a pep talk before the hearing?

AT THE HEARING

___ 1) Did advocate cover all points that would enhance the client's case?

___ 2) 2. If the client received medications during the 24 hours prior to the hearing, did advocate ensure that the facility representative informed the hearing officer of the medication and its side effects?

___ 3) Did advocate advise client that although s/he might elect to have family members or friends in attendance at the hearing that their statements might not support the client's own position?

___ 4) Did advocate avoid asking client questions s/he hadn't already asked the client prior to the hearing?

___ 5) Did advocate avoid eliciting information that might have cast the client in a bad light?

___ 6) If client exhibited behavior that might have been a side effect of his/her medication, did advocate point out to the hearing officer that the medication, not a mental disorder, might be responsible for behavior?

___ 7) Did advocate attempt to sit beside the client during the hearing so as to ensure good communications with the client?

___ 8) Did advocate provide pen and paper for the client to take notes during the hearing?

___ 9) Did advocate question the presenters about the source of statements in an attempt to show that, for example, what was being presented as absolute fact might be in reality hearsay several times removed?

___ 10) Did advocate properly present the client's point of view?

___ 11) In order to help provide structure to the client's case, did advocate help direct the client's presentation by asking specific questions?

___ 12) Did advocate ask the facility presenter what positive statements s/he could make about the client?

___ 13) If client wanted to accept treatment on a voluntary basis, did advocate convey this to the hearing officer?

___ 14) Did advocate explain any terminology used in the hearing which might have been unfamiliar to the client?

___ 15) Did advocate make sure that all important issues that the client wanted to address were brought to the hearing officer's attention?

___ 16) Did advocate summarize the most crucial points of his/her argument at the end of his/her presentation?

AFTER THE HEARING

___ 1) Did advocate explain the hearing decision to the client?

___ 2) Did advocate present to the client his/her options if probable cause were found in a way that was not leading the client to a particular decision?

___ 3) Did advocate include the options to stay at the facility and work with his/her doctor; to go to court to try to get released from the hospital, or to think about it before deciding?

___ 4) If probable cause was found, did advocate advise client of his/her right to file for a writ of habeas corpus?

___ 5) Did advocate explain the judicial procedure to the client including the fact that a public defender would be appointed if the client could not afford legal counsel and that the hearing would be held within two judicial days of the petition's filing date?

APPENDIX C - CODES/ REGULATIONS RELATED TO CAPACITY HEARINGS

WELFARE AND INSTITUTIONS CODES

1) Section 5325.2. Persons subject to detention pursuant to Section 5150, 5250, 5260, 5270.15; right to refuse antipsychotic medication

Any person who is subject to detention pursuant to Section 5150, 5250, 5260, or 5270.15 shall have the right to refuse treatment with antipsychotic medication subject to provisions set forth in this chapter.

(Added by Stats.1991, c. 681 (S.B.665), Section 2.)

2) Section 5332. Administration of antipsychotic medication to persons subject to detention; consideration of treatment alternatives; internal procedures at hospitals; acquisition of person's medication history; emergency procedures

(a) Antipsychotic medication, as defined in subdivision (l) of Section 5008, may be administered to any person subject to detention pursuant to Section 5150, 5250, 5260, or 5270.15, if that person does not refuse that medication following disclosure of the right to refuse medication as well as information required to be given to persons pursuant to subdivision (c) of Section 5152 and subdivision (b) of Section 5213.

(b) If any person subject to detention pursuant to Section 5150, 5250, 5260, or 5270.15, and for whom antipsychotic medication has been prescribed, orally refuses or gives other indication of refusal of treatment with that medication, the medication shall be administered only when treatment staff have considered and determined that treatment alternatives to involuntary medication are unlikely to meet the needs of the patient, and upon a determination of that person's incapacity to refuse the treatment, in a hearing held for that purpose.

(c) Each hospital in conjunction with the hospital medical staff or any other treatment facility in conjunction with its clinical staff shall develop internal procedures for facilitating the filing of petitions for capacity hearings and other activities required pursuant to this chapter.

(d) When any person is subject to detention pursuant to Section 5150, 5250, 5260, or 5270.15, the agency or facility providing the treatment shall acquire the person's medication history, if possible.

(e) In the case of an emergency, as defined in subdivision (m) of Section 5008, a person detained pursuant to Section 5150, 5250, 5260, or 5270.15 may be treated with antipsychotic medication over his or her objection prior to a capacity hearing, but only with antipsychotic medication that is required to treat the emergency condition, which shall be provided in the manner least restrictive to the personal liberty of the patient. It is not necessary for harm to take place or become unavoidable prior to intervention.

(Added by Stats.1991, c. 681 (S.B.665), Section 3. Amended by Stats.2001, c. 506 (A.B.1424), Section 9.)

3) Section 5333. Capacity hearings; representation by advocate or counsel; petition; notice

(a) Persons subject to capacity hearings pursuant to Section 5332 shall have a right to representation by an advocate or legal counsel.

"Advocate," as used in this section, means a person who is providing mandated patients' rights advocacy services pursuant to Chapter 6 (commencing with Section 5500), and this chapter. If the Department of Mental Health provides training to patients' rights advocates, that training shall include issues specific to capacity hearings.

(b) Petitions for capacity hearings pursuant to Section 5332 shall be filed with the superior court. The director of the treatment facility or his or her designee shall personally deliver a copy of the notice of the filing of the petition for a capacity hearing to the person who is the subject of the petition.

(c) The mental health professional delivering the copy of the notice of the filing of the petition to the court for a capacity hearing shall, at the time of delivery, inform the person of his or her legal right to a capacity hearing, including the right to the assistance of the patients' rights advocate or an attorney to prepare for the hearing and to answer any questions or concerns.

(d) As soon after the filing of the petition for a capacity hearing is practicable, an attorney or a patients' rights advocate shall meet with the person to discuss the capacity hearing process and to assist the person in preparing for the capacity hearing and to answer questions or to otherwise assist the person, as is appropriate.

(Added by Stats.1991, c. 681 (S.B.665), Section 4.)

4) Section 5334. Capacity hearings; time for hearing; location; hearing officer; determination; notification; appeal; habeas corpus

(a) Capacity hearings required by Section 5332 shall be heard within 24 hours of the filing of the petition whenever possible.

However, if any party needs additional time to prepare for the hearing, the hearing shall be postponed for 24 hours. In case of hardship, hearings may also be postponed for an additional 24 hours, pursuant to local policy developed by the county mental health director and the presiding judge of the superior court regarding the scheduling of hearings. The policy developed pursuant to this subdivision shall specify procedures for the prompt filing and processing of petitions to ensure that the deadlines set forth in this section are met, and shall take into consideration the availability of advocates and the treatment needs of the patient. In no event shall hearings be held beyond 72 hours of the filing of the petition. The person who is the subject of the petition and his or her advocate or counsel shall receive a copy of the petition at the time it is filed.

(b) Capacity hearings shall be held in an appropriate location at the facility where the person is receiving treatment, and shall be held in a manner compatible with, and the least disruptive of, the treatment being provided to the person.

(c) Capacity hearings shall be conducted by a superior court judge, a court–appointed commissioner or referee, or a court–appointed hearing officer. All commissioners, referees, and hearing officers shall be appointed by the superior court from a list of attorneys unanimously approved by a panel composed of the local mental health director, the county public defender, and the county counsel or district attorney designated by the county board of supervisors. No employee of the county mental health program or of any facility designated by the county and approved by the department as a facility for 72–hour treatment and evaluation may serve as a hearing officer. All hearing officers shall receive training in the issues specific to capacity hearings.

(d) The person who is the subject of the capacity hearing shall be given oral notification of the determination at the conclusion of the capacity hearing. As soon thereafter as is practicable, the person, his or her counsel or advocate, and the director of the facility where the person is receiving treatment shall be provided with written notification of the capacity determination, which shall include a statement of the evidence relied upon and the reasons for the determination. A copy of the determination shall be submitted to the superior court.

(e)(1) The person who is the subject of the capacity hearing may appeal the determination to the superior court or the court of appeal.

(2) The person who has filed the original petition for a capacity hearing may request the district attorney or county counsel in the county in which the person is receiving treatment to appeal the determination to the superior court or the court of appeal, on behalf of the state.

(3) Nothing shall prohibit treatment from being initiated pending appeal of a determination of incapacity pursuant to this section.

(4) Nothing in this section shall be construed to preclude the right of a person to bring a writ of habeas corpus pursuant to Section 5275, subject to the provisions of this chapter.

(f) All appeals to the superior court pursuant to this section shall be subject to de novo review.

(Added by Stats.1991, c. 681 (S.B.665), Section 5.)

5) Section 5336. Capacity hearings; effect of determination

Any determination of a person's incapacity to refuse treatment with antipsychotic medication made pursuant to Section 5334 shall remain in effect only for the duration of the detention period described in Section 5150 or 5250, or both, or until capacity has been restored according to standards developed pursuant to subdivision (c) of Section 5332, or by court determination, whichever is sooner.

(Added by Stats.1991, c. 681 (S.B.665), Section 6.)

INFORMED CONSENT

1) Section 5152 (c)

A person designated by the mental health facility shall give to any person who has been detained at that facility for evaluation and treatment and who is receiving medication as a result of his or her mental illness, as soon as possible after detention, written and oral information about the probable effects and possible side effects of the medication. The State Department of Health Care Services shall develop and promulgate written materials on the effects of medications, for use by county mental health programs as disseminated or as modified by the county mental health program, addressing the probable effects and the possible side effects of the medication. The following information shall be given orally to the patient:

(1) The nature of the mental illness, or behavior, that is the reason the medication is being given or recommended.

(2) The likelihood of improving or not improving without the medication.

(3) Reasonable alternative treatments available.

(4) The name and type, frequency, amount, and method of dispensing the medication, and the probable length of time the medication will be taken.

The fact that the information has or has not been given shall be indicated in the patient's chart. If the information has not been given, the designated person shall document in the patient's chart the justification for not providing the information. A failure to give information about the probable effects and possible side effects of the medication shall not constitute new grounds for release.

REGULATIONS

1) Title 9, Section 851. Informed Consent to Antipsychotic Medications.

A voluntary patient shall be treated with antipsychotic medications only after such person has been informed of his or her right to accept or refuse such medications and has consented to the administration of such medications. In order to make an informed decision, the patient must be provided with sufficient information by the physician prescribing such medications (in the patient's native language, if possible) which shall include the following:

(a) The nature of the patient's mental condition,

(b) The reasons for taking such medication, including the likelihood of improving or not improving without such medication, and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff,

(c) The reasonable alternative treatments available, if any,

(d) The type, range of frequency and amount (including use of PRN orders), method (oral or injection), and duration of taking the medications,

(e) The probable side effects of these drugs known to commonly occur, and any particular side effects likely to occur with the particular patient,

(f) The possible additional side effects which may occur to patients taking such medication beyond three months. The patient shall be advised that such side effects may include persistent involuntary movement of the face or mouth and

might at times include similar movement of the hands and feet, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after medications have been discontinued.

NOTE: Authority cited: Sections 5325 and 5326.95, Welfare and Institutions

Code. Reference: Sections 5325 and 5325.1, Welfare and Institutions

Code; Cobbs v. Grant (1972) 8 Cal. 3d 229.

2) Title 9, Section 852. Maintenance of Records.

For each patient receiving antipsychotic medications, the facility shall maintain a written record of the patient's decision to consent to such medications. That written record shall be a written consent form signed by the patient indicating that items (a) through (f) of Section 851 have been discussed with the patient by the prescribing physician.

In the event that the patient has been shown but does not wish to sign the written consent form, it shall be sufficient for the physician to place the unsigned form in the patient's records maintained by the facility together with the notation that while the patient understands the nature and effect of antipsychotic medications and consents to the administration of such medications, the patient does not desire to sign a written consent form.

NOTE: Authority cited: Sections 5325 and 5326.95, Welfare and Institutions

Code. Reference: Sections 5325 and 5325.1, Welfare and Institutions Code.

3) Title 9, Section 853. Emergency.

Nothing in this article is intended to prohibit the physician from taking appropriate action in an emergency. An emergency exists when there is a sudden marked change in the patient's condition so that action is immediately necessary for the preservation of the life or the prevention of serious bodily harm to the patient or others, and it is impracticable to first obtain consent. If antipsychotic medication is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the patient.

NOTE: Authority cited: Sections 5325, 5326 and 5326.95, Welfare and Institutions Code. Reference: Sections 5325 and 5325.1, Welfare and Institutions Code; Cobbs v. Grant (1972) 8 Cal. 3d 229.

4) Title 9, Section 854. Withdrawal of Consent.

A voluntary patient may withdraw consent to the administration of antipsychotic medications at any time by stating such intention to any member of the treatment staff.

NOTE: Authority cited: Sections 5325 and 5326.95, Welfare and Institutions Code. Reference: Sections 5325, 5325.1, 6000, 6002 and 6004, Welfare and Institutions Code

5) Title 9, Section 855. Consequence of Refusal.

The refusal to consent to the administration of antipsychotic medications shall not in itself constitute grounds for initiating an involuntary commitment.

NOTE: Authority cited: Sections 5325 and 5326.95, Welfare and Institutions

Code. Reference: Sections 5150, 5250, 5325 and 5325.1, Welfare and Institutions Code.

6) Title 9, Section 856. Definition of Antipsychotic Medication.

For purposes of this article, ‘‘antipsychotic medication’’ means any drug customarily used for the treatment of symptoms of psychoses and other severe mental and emotional disorders.

NOTE: Authority cited: Sections 5325 and 5326.95, Welfare and Institutions Code. Reference: Title 9, California Administrative Code, Sections 850–855.