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**OVERVIEW:
BRIEFING ON
THE MYERS &
WEATHERHORN
AK SUPREME
COURT
DECISIONS**


PsychRights[®]

Law Project for
Psychiatric Rights, Inc.

BRIEFING POINTS

TO: Jay Ramras, Chair: House Judiciary Committee
Hollis French, Chair: Senate Judiciary Committee
Talis Colberg, Attorney General

RE: Myers & Wetherhorn Decisions & Related Matters

FROM: James B. Gottstein, Esq. 

DATE: February 7, 2007

SUMMARY

Due to the abject failure of the Public Defender Agency to assert the rights of its AS 47.30 clients, Alaska's involuntary commitment and forced drugging process operates largely illegally. The Law Project for Psychiatric Rights (PsychRights) was formed in late 2002 to mount a strategic litigation campaign against unwarranted forced psychiatric drugging. The first two Alaska Supreme Court Decisions arising out of this litigation campaign recently recognized the unconstitutional nature of these proceedings. The objective of this briefing is to facilitate bringing Alaska into legal compliance without, or minimal, additional litigation.

Myers v. API, 138 P.3d 238 (Alaska 2006)

- Held AS 47.30.839 forced psychiatric drugging provisions unconstitutional for failure to require *the court* to find by *clear and convincing evidence* that:
 - (a) it is in the best interests of the person sought to be forcibly drugged, and
 - (b) there are no less restrictive alternatives (available).¹

Wetherhorn v. API, Opinion No. 6091 (January 12, 2007)

- Held people can only be involuntarily committed for being "gravely disabled," if they are "*unable to survive safely in freedom*," essentially invalidating the definition of "gravely disabled" in AS 47.30.915(7).
 - Petition for Rehearing filed with respect to why commitment was not vacated in light of no evidence meeting standard and Court asked the State to respond.
 - Petition for *certiorari* to the US Supreme Court possible on ruling that API does not have to identify witnesses before hearing.
 - Court held direct appeal not proper procedure for attacking effectiveness of counsel (which it found constitutionally required).

MOST IMPORTANT PROSPECTIVE PROCEEDINGS

- Lack of Constitutionally Required Alternatives
- Ineffective Assistance of Counsel
- Psychiatric Drugging of Children in State Custody
- API's Flouting of *Myers*
- Illegal Use of *Ex Parte* proceedings
- Universal Failure to Obtain Informed Consent

¹ It is pretty clear the less restrictive alternative requirement prohibits involuntary commitment and forced drugging if the alternative could be made available, but chooses not to (presumably within limits of reasonableness). If the State disagrees, litigation establishing this will likely ensue.

How the Legal System Can Help Create a Recovery Culture in Mental Health Systems

by
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**Law Project for
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Leading the Transformation to Recovery
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II. Summary

The purpose of this paper is to show how strategic litigation can and should be a part of efforts to transform mental health systems to culture of recovery. Currently, involuntary commitment and forced drugging are by far the "path of least resistance" when society is faced with someone who is disturbing and their thinking does not conform to society's norms.¹ In other words, it is far easier for the system to lock people up and drug them into submission, then it is to spend the time with them to develop a therapeutic relationship and thus able to engage the person with voluntary humane alternatives leading to recovery.² I estimate that 10% of involuntary commitments in the United States and none of the forced drugging under the *parens patriae* doctrine³ are legally justified. This presents a tremendous opportunity to use litigation to "encourage" the creation of voluntary, recovery oriented services.⁴

In my view, though, in order to be successful, various myths of mental illness need to be debunked among the general public and humane, effective recovery oriented, non-

¹ By phrasing it this way, I am not disputing that people become psychotic. I have been there. See, <http://akmhweb.org/recovery/jgrec.htm>. However, there are lots of degrees - a continuum, if you will -- and there are different ways of looking at these unaccepted ways of thinking, or altered states of consciousness. So, what I mean by this terminology is that people are faced with involuntary commitment and forced drugging when two conditions exist: One, they are bothering another person(s), including concern about the risk of suicide or other self-harm, and Two, they are expressing thoughts that do not conform to those accepted "normal" by society. Of course, this ignores the reality that a lot of both are often trumped up, especially against people who have previously been subjected to the system.

² The system believes it is also less expensive, but the opposite is actually true. The over-reliance on neuroleptics and, increasingly, polypharmacy, has at least doubled the number of people who become permanently reliant on government transfer payments. In *Anatomy of an Epidemic: Psychiatric Drugs and the Astonishing Rise of Mental Illness in America*, which is available at

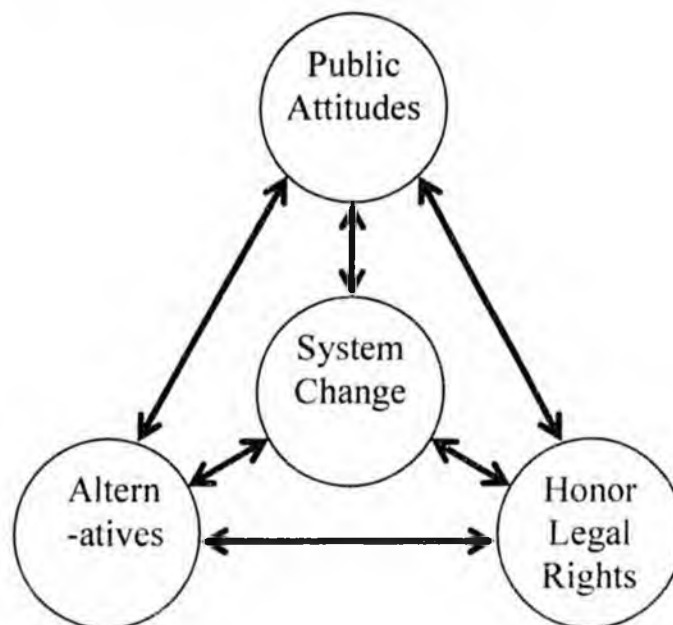
[http://psychrights.org/Articles/EHPPPsychDrugEpidemic\(Whitaker\).pdf](http://psychrights.org/Articles/EHPPPsychDrugEpidemic(Whitaker).pdf), Robert Whitaker demonstrates the rate of disability has increased six fold since the introduction of Thorazine in the mid '50s. The Michigan State Psychotherapy Project demonstrated extremely more favorable long-term outcomes for those receiving psychotherapy alone from psychotherapists with *relevant* training and experience. The short term costs were comparable to the standard treatment and the long term savings were tremendous. This study can be found at <http://psychrights.org/Research/Digest/Effective/MIPsychProj.pdf>.

³ "Parens Patriae" is legal Latin, literally meaning "parent of his or her country". Black's Law Dictionary, Seventh Edition defines it as "the state in its capacity as provider of protection to those unable to care for themselves." It is invoked with respect to minors and adults who are deemed incompetent to make their own decisions. In the context of forced drugging under the *parens patriae* doctrine, it basically is based on the notion, "If you weren't crazy, you'd know this was good for you."

⁴ At the same time there are impediments to doing so, primarily the lack of legal resources.

coercive alternatives must be made available. This conference, Alternatives, is focused on the creation of such alternatives and the thesis of this paper is that strategic litigation (and public education) are likely essential to transforming the mental health system to one of a recovery culture.

These three elements, (1) Creation of Alternatives, (2) Public Education, and (3) Strategic Litigation (Honoring Rights), each reinforce the others in ways that can lead to meaningful system change in a way that might be depicted as follows:



For example, debunking the myth among the general public that people do not recover from a diagnosis of serious mental health illness can encourage the willingness to invest in recovery oriented alternatives. Similarly, having successful, recovery oriented alternatives will help in debunking the myth that people don't recover from serious mental illness. In like fashion, judges and even counsel appointed to represent psychiatric defendants, believe the myth "if this person wasn't crazy, she would know these drugs are good for her" and therefore don't let her pesky rights get in the way of doing the "right thing," i.e., forced drugging. The myth of dangerousness results in people being locked up. In other words, the judges and lawyers reflect society's views and to the extent that society's views change, the judges and lawyers' responses will change to suit. That leads to taking people's rights more seriously. The converse is true as well. Legal cases can have a big impact on public views. *Brown v. Board of Education*,⁵ which resulted in outlawing segregation is a classic example of this. Finally, the involuntary

⁵ U.S. 294, 75 S.Ct. 753, 99 L.Ed. 1083 (1955).

mental illness system⁶ operates largely illegally, including through its failure to offer less restrictive alternatives.⁷ Thus, litigation can force the creation of such alternatives. At the same time, as a practical matter, the availability of acceptable (to the person), recovery oriented, alternatives is necessary for anyone to actually be able to get such services when faced with involuntary commitment and forced drugging.

III. The Involuntary Mental Illness System Operates Largely Illegally

Involuntary "treatment"⁸ in the United States largely operates illegally in that court orders for forced treatment are obtained without actual compliance with statutory and constitutional requirements. One of the fundamental constitutional rights that is ignored in practice is that of a "less restrictive alternative."⁹ Thus, enforcement of this right through the courts can be instrumental in bringing about change. First, I will discuss the key constitutional principles.

A. Constitutional Protections

(1) Procedural Due Process

The 14th Amendment to the United States provides in pertinent part, that "No State shall . . . deprive any person of life, liberty, or property, without due process of law." Most, if not all, states have similar provisions. Under due process, the procedures used must meet a minimum level of fairness. Three essential elements of this procedural due process are (1) a neutral decisionmaker, (2) meaningful notice and (3) meaningful opportunity to respond. These were recently reiterated by the United States Supreme Court in the case involving a United States citizen who was being detained in Cuba as an enemy combatant, as follows:

[D]ue process requires a 'neutral and detached judge in the first instance.' . . . For more than a century the central meaning of procedural due process has been clear: "Parties whose rights are to be affected are entitled to be heard; and in order that they may enjoy that right they must first be notified." It is equally fundamental that the right to notice and an

⁶ In light of the system basically creating massive numbers of people who become categorized as chronically mentally ill, I call it the mental illness system, rather than the mental health system.

⁷ By saying the mental illness system operates largely illegally I mean that to the extent people are locked up and forcibly drugged when the statutory and constitutional requirements are not being met, that is illegal. Of course, this is done by filing paperwork and getting court orders, which looked at another way, makes it legal.

⁸ "Treatment" is in quotes because it is both (1) pretty clear the current, virtually exclusive reliance on psychiatric drugs by the public mental illness system hinders recovery for the vast majority of people, and (2) if it isn't voluntary, it isn't treatment.

⁹ See, e.g., *Sell v. United States*, 539 U.S. 166 (2003). However, not everyone agrees with my legal analysis of the right to the least restrictive alternative.

opportunity to be heard "must be granted at a meaningful time and in a meaningful manner."

Hamdi v. Rumsfeld, 542 U.S. 507, 124 S.Ct. 2633, 2648-9 (2004)

In addition to these "procedural due process" rights, there can be "substantive due process" rights, which essentially involves balancing people's rights to life, liberty or property" against the government's interests in curtailing those rights. Thus, there are substantive constitutional due process rights with respect to both involuntary commitment and forced drugging.

(2) Constitutional Limits on Involuntary Commitment.

The United States Supreme Court has recognized for a long time that involuntary civil commitment is a "massive curtailment of liberty"¹⁰ requiring substantive due process protection:

Freedom from bodily restraint has always been at the core of the liberty protected by the Due Process Clause from arbitrary governmental action. "It is clear that commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection."¹¹

The Supreme Court went on to say in this and other cases that involuntary commitment was permissible only when the following factors were present:

(1) "the confinement takes place pursuant to proper procedures and evidentiary standards," (2) there is a finding of "dangerousness either to one's self or to others." and (3) proof of dangerousness is "coupled ... with the proof of some additional factor, such as a 'mental illness' or 'mental abnormality.'"¹²

Many states allow someone to be involuntarily committed for being "gravely disabled," but it seems this can only be constitutional if the "grave disability" means the person is a harm to self. While not ruling on this directly, in my view, the United States Supreme Court essentially said so as follows:

Of course, even if there is no foreseeable risk of self-injury or suicide, a person is literally 'dangerous to himself' if for physical or other reasons he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends.¹³

To reiterate then, involuntary commitment is constitutional only (1) when done under proper procedures and evidentiary standards, (2) upon a finding of dangerousness

¹⁰ *Humphrey v. Cady*, 405 U.S. 504 (1972).

¹¹ *Addington v. Texas*, 441 U.S. 418 (1979).

¹² *Kansas v. Crane*, 534 U.S. 407 (2002).

¹³ Footnote 9, in *O'Connor v. Donaldson*, 422 U.S. 563, 95 S.Ct. 2486 (1975).

to self or others,¹⁴ and (3) the dangerousness is a result of mental illness. Being committed for being gravely disabled is only permissible if the requisite level of dangerousness is found. As will be discussed below, when leaving aside the whole issue of the validity of mental illness diagnoses, proper procedures and evidentiary standards are generally not followed and people are committed without meeting the dangerousness threshold.

(3) Constitutional Limits on Forced Drugging

The United States Supreme Court has also held a number of times that being free of unwanted psychiatric medication is a fundamental constitutional right.¹⁵ In the most recent case, *Sell*, the United States Supreme Court reiterated:

[A]n individual has a "significant" constitutionally protected "liberty interest" in "avoiding the unwanted administration of antipsychotic drugs."¹⁶

The different contexts in which forced psychiatric drugging comes up makes a difference as to the extent of this right, however. *Sell* and *Riggins* are forced drugging to make someone competent to stand trial cases. *Harper* is a convicted person in prison case, where people have the least rights.

The only one of these cases involving forced drugging in the non-criminal (civil) context is *Mills v. Rogers*.¹⁷ There, the United States Supreme Court assumed a person has United States Constitutional protection against forced psychiatric drugging under the Due Process Clause, but held the exact extent of these protections are intertwined with state law. The same day, June 18, 1982, the Court decided *Youngberg v. Romeo*¹⁸ involving a civilly committed mentally retarded man, Nicholas Youngberg, whom all of the professionals agreed was not receiving appropriate services resulting in excessive physical restraints and the Court ruled he was entitled to the services that "professional judgment" dictated. The exact phrase the court used was "the Constitution only requires that the courts make certain that professional judgment in fact was exercised."¹⁹ A few days later, on July 2, 1982, the Court remanded another case, *Rennie v. Klein*, to the United States Court of Appeals for the Third Circuit for further consideration in light of *Youngberg*.²⁰ This has (not universally) been interpreted to mean people can be force

¹⁴ The cases are not uniform on what level of dangerousness and how imminent it must be, but it seems clear that the level of dangerousness must meet a relatively high level of seriousness and the threat has to have some immediacy to it.

¹⁵ *Mills v. Rogers*, 457 U.S. 291 (1982); *Washington v. Harper*, 494 U.S. 210 (1990); *Riggins v. Nevada*, 504 U.S. 127 (1992); and *Sell v. United States*, 539 U.S. 166 (2003).

¹⁶ *Sell v. United States*, 539 U.S. 166, 177-8 (2003), citing to the Due Process Clause, U.S. Const., amend. 5, and *Washington v. Harper*, 494 U.S. 210, 110 S.Ct. 1028 (1990).

¹⁷ 457 U.S. 291 (1982).

¹⁸ 457 U.S. 307 (1982).

¹⁹ *Mills* was not mentioned in this decision.

²⁰ 458 U.S. 1119 (1982).

drugged if "professional judgment" is exercised, ie., if the psychiatrist (exercising "professional judgment") says the person should be force drugged.²¹

I will get to this being an incorrect interpretation in my view and how *Sell* changes it, in any event in a bit, but as a result of the combination of *Mills* saying due process rights in state courts under the Fourteenth Amendment depends at least in part on state law and the interpretation that under *Rennie* and *Youngberg* federal constitutional protection was subject to the "professional judgment" rule, the action moved to state courts. The upshot in state courts has been mostly good, from a legal perspective, with such cases as the final result in *Mills (v. Rogers)*, being the Supreme Judicial Court of Massachusetts' ruling in *Rogers*,²² which is that people have the absolute right to decline medication unless they are incompetent to make such a decision and if they are incompetent they can not be medicated against their will except by a court made Substituted Judgment Decision that includes the following factors:

1. The patient's expressed preferences regarding treatment.
2. The strength of the incompetent patient's religious convictions, to the extent that they may contribute to his refusal of treatment.
3. The impact of the decision on the ward's family -- this factor being primarily relevant when the patient is part of a closely knit family.
4. The probability of adverse side effects.
5. The prognosis without treatment.
6. The prognosis with treatment.
7. Any other factors which appear relevant.

In *Rogers*, the Court made clear that involuntary civil commitment, in and of itself, is insufficient to conclude the person is incompetent to decline the drugs. The *Rogers* court also specifically re-affirmed an earlier decision, *Guardianship of Roe*, that "No medical expertise is required [for making the substituted judgment decision], although medical advice and opinion is to be used for the same purposes and sought to the same extent that the incompetent individual would, if he were competent." The Massachusetts Supreme Court also held because of the inherent conflicts in interest, the doctors should not be allowed to make this decision.

²¹ I do not believe this is a correct interpretation. In *Rennie*, the Supreme Court never actually held that; instead it remanded it in light of its decision in *Youngberg v. Romeo*. However, *Youngberg* involved a mentally retarded man who was being subject to physical restraints under conditions that no professional judgment would support, especially because the person could have been trained in a way to minimize or even reduce the use of restraints. Thus, in a lot of ways it was a right to appropriate treatment holding, and definitely not a case authorizing forced drugging. I think the concurring opinion of Circuit Judge Weis on remand, which was joined by two other circuit judges, is a much better way to interpret the decision. ("I fear that the latitude the majority allows in 'professional judgment' jeopardizes adequate protection of a patient's constitutional rights.") *Rennie v. Klein*, 720 F.2d 266 (CA3 1983).

²² *Rogers*, 458 N.E. 2d 308 (Mass 1983)

The fact that a patient has been institutionalized and declared incompetent brings into play the factor of the likelihood of conflicting interests. The doctors who are attempting to treat as well as to maintain order in the hospital have interests in conflict with those of their patients who may wish to avoid medication.

This extremely favorable legal ruling has, however, been turned on its head and become a "Rogers Order" assembly-line.²³

Similarly, in *Rivers v. Katz*²⁴, decided strictly on common law and constitutional due process grounds, New York's highest court held a person's right to be free from unwanted antipsychotic medication is a constitutionally protected liberty interest:

"[i]f the law recognizes the right of an individual to make decisions about . . . life out of respect for the dignity and autonomy of the individual, that interest is no less significant when the individual is mentally or physically ill"

* * *

We reject any argument that the mere fact that appellants are mentally ill reduces in any manner their fundamental liberty interest to reject antipsychotic medication. We likewise reject any argument that involuntarily committed patients lose their liberty interest in avoiding the unwanted administration of antipsychotic medication.

* * *

If . . . the court determines that the patient has the capability to make his own treatment decisions, the State shall be precluded from administering antipsychotic drugs. If, however, the court concludes that the patient lacks the capacity to determine the course of his own treatment, the court must determine whether the proposed treatment is narrowly tailored to give substantive effect to the patient's liberty interest, taking into consideration all relevant circumstances, including the patient's best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments. The State would bear the burden to establish by clear and convincing evidence that the proposed treatment meets these criteria.

Just as in Massachusetts, however, in practice, people's rights are not being honored.²⁵ There are other states which have just as good legal rights and some that don't under state

²³ I wrote a memo about this in early February of 2004, which can be found at <http://psychrights.org/States/Massachusetts/RogersOrders/RogersOrdersMemo.pdf>.

²⁴ *Rivers v. Katz*, 495 N.E.2d 337, 341-3 (NY 1986).

²⁵ See, Mental Hygiene Law Court Monitoring Project: Part I of Report: Do Psychiatric Inmates in New York Have the Right to Refuse Drugs? An Examination of Rivers

law, but the common denominator in all of them is whatever rights people have, they are uniformly ignored. Before getting to that, I want to get back United States Constitutional law under *Sell*.

In *Sell*, decided in 2003, the United States Supreme Court held someone could not be force drugged to make them competent to stand trial unless:

1. The court finds that *important* governmental interests are at stake.
2. The court must conclude that involuntary medication will *significantly further* those concomitant state interests.
3. 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.
4. The court must conclude that administration of the drugs is *medically appropriate*, i.e., in the patient's best medical interest in light of his medical condition. The specific kinds of drugs at issue may matter here as elsewhere. Different kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success.

(italics in original) These are general constitutional principles and should apply in the civil context. Thus, for example, while in *Sell*, the "*important* governmental interest" is in bringing a criminal defendant to trial, the governmental interest in the civil context is (supposedly) the person's best interest, i.e., the *parens patriae* doctrine.²⁶

With respect to the second requirement that the forced drugging "*will significantly further*" those interests, the question in the competence to stand trial context is whether the forced drugging is likely to make the person competent to stand trial, while in the civil context, the question is whether it is in the person's best interest or is the decision the person would make if he or she were competent.

The third requirement that the forced drugging must be *necessary* and there is no less restrictive alternative is hugely important in the civil context because it is a

Hearings in the Brooklyn Court, which can be accessed on the Internet at <http://psychrights.org/States/NewYork/courtmonitoringreport.htm>.

²⁶ I say, "supposedly," because in truth, controlling the person's behavior is a primary interest. "Police power" justification, which actually is based on controlling dangerous behavior, has also been used to justify forced drugging. See, *Rivers v. Katz*, 495 N.E.2d 337, 343 (NY 1986). However, the behavior presumably has to be very extreme to invoke "police power" and is not normally the stated basis for seeking forced drugging orders. It has been suggested there is an important government interest in ending indeterminate commitment and returning the individual to society, which can be done most effectively if the person is required to take the prescribed drugs. However, this is not the basis normally asserted and I would argue it is not a sufficient interest to override a person's rights to decline the drugs, particularly in light of the physical harms they cause.

potential lever to require less restrictive (ie., non-drug, recovery oriented alternatives). It is important to note here that failure to fund these alternatives does not give the government the right to force drug someone. If a less restrictive alternative could be made available, the forced drugging is unconstitutional.²⁷

New York Law School professor, Michael L. Perlin agrees this is so:

The Supreme Court's decisions in *Washington v. Harper*, *Riggins v. Nevada*, and, most recently, *Sell v. United States*, make it clear that: a qualified right to refuse medication is located in the Fourteenth Amendment's Due Process Clause; the pervasiveness of side effects is a key factor in the determination of the scope of the right; the state bears a considerable burden in medicating a patient over objection, and the "least restrictive alternative" mode of analysis must be applied to right to refuse cases.²⁸

The fourth requirement is also very important because it essentially requires the state to prove the drugging is in the person's best interest and not merely recite "professional judgment."

The take away message is, in my view, people are constitutionally entitled to non-coercive, non-drugging, recovery oriented alternatives before involuntary commitment and forced drugging can occur and even then forced drugging can only constitutionally occur if it is in the person's best interest. There are a couple of ways to look at this since the reality is so far from what the law requires. One is to see it as a tremendous opportunity to improve the situation. The other is that there are forces operating to totally defeat people's rights. Both are true and this paper suggests there are actions that can be taken to have people's rights honored that can play a crucial part in transforming the mental health system to one of a recovery culture.

B. Proper Procedures and Evidentiary Standards

Mentioned above is the United States Supreme Court rulings that involuntary commitment can occur only pursuant to proper procedures and evidentiary standards. In contrast to this legal requirement, involuntary commitment and forced drugging

²⁷ There are likely limits on this, such as there being no requirement for Herculean efforts or where the cost is prohibitive. See, e.g., *Mathews v. Eldridge*, 424 U.S. 319, 334-35 (1976).

²⁸ Perlin, "And My Best Friend, My Doctor/Won't Even Say What It Is I've Got": The Role And Significance Of Counsel In Right To Refuse Treatment Cases, 42 San Diego Law Review 735 (2005)

proceedings can quite fairly be characterized as a sham, a farce, Kangaroo Courts, etc., in the vast majority of cases.²⁹

(1) Proper Procedures

Ex Parte Proceedings. It will be recalled that the hallmarks of procedural due process are meaningful notice and meaningful opportunity to be heard (respond). There are a few situations, such as search and arrest warrants where prior notice are not required because giving warning would defeat the purpose. Proceedings where the person isn't given notice or an opportunity to respond are called "*ex parte*."³⁰ However, the mental illness system regularly takes people into custody without any advance notice and no opportunity to respond when there is no emergency that justifies the failure to notify and denial of any opportunity to respond. The Washington Supreme Court has explicitly ruled "The danger must be impending to justify detention without prior process."³¹ However, I don't believe the legitimacy of *ex parte* procedures has been challenged much around the country, leading to what I believe are pervasive violations of due process rights in this regard.

There are many other ways in which proper procedures are not utilized in the various states and these should also be challenged.³²

(a) Proper Evidentiary Standards.

As set forth above, involuntary commitment is constitutionally permissible only if the person is a harm to self or others as a result of a "mental illness." In *Addington v. Texas*³³ the United States held that this has to be proven by "clear and convincing evidence," which is less than "beyond a reasonable doubt," but more than the normal "preponderance of the evidence"³⁴ standard in most civil cases.

There are essentially two different evidence standards regarding expert witness testimony. The older "Frye"³⁵ standard is basically whether it has gained "general

²⁹ An example is described in the recent Alaska Supreme Court brief we filed in *Wetherhorn v. Alaska Psychiatric Institute*, which can be found on the Internet at <http://psychrights.org/States/Alaska/CaseFour/WetherhornBrief.pdf>.

³⁰ *Ex Parte*, is Latin for "from the part" and Black's Law Dictionary, Seventh Edition defines it as "On or from one party only, usually without notice to or argument from the adverse party."

³¹ *In re: Harris*, 654 P.2d 109, 113 (Wash. 1982)

³² I have identified a number of them in Alaska and intend to raise them in appropriate cases.

³³ 441 U.S. 418 (1979)

³⁴ "Preponderance of the evidence," means more likely than not or, put another way, it only requires the balance to be slightly more on one side than the other. Yet another way to look at it is it just has to be more than 50% likely.

³⁵ *Frye v. United States*, 293 F. 1013 (D.C.Cir.1923)

acceptance in the particular field." The more modern standard, *Daubert*,³⁶ which was adopted by the United States Supreme Court for the federal courts and by many state courts, recognizes that "generally accepted" methods may not be valid and methods which have not yet gained general acceptance can be extremely valid, and therefore the proper focus is on scientific reliability.

Because psychiatry bases its "treatments" and pronouncements on scientifically dubious bases, but they are generally accepted within the field, the *Daubert* standard is better for challenging psychiatric practices in court, but there are still ways to get at them under the *Frye* standard. In practice, both standards are ignored and psychiatrists are allowed to offer opinions without satisfying either *Daubert* or *Frye*.

The truth is psychiatric testimony as to a person's dangerousness is highly unreliable with a high likelihood of over-estimating dangerousness.

The voluminous literature as to the ability of psychiatrists (or other mental health professionals) to testify reliably as to an individual's dangerousness in the indeterminate future had been virtually unanimous: "psychiatrists have absolutely no expertise in predicting dangerous behavior -- indeed, they may be less accurate predictors than laymen -- and that they usually err by overpredicting violence."³⁷

This is the primary reason why I estimate only 10% of involuntary commitments are legally justified. If people were only involuntarily committed when it can be shown, by clear and convincing evidence, under scientifically reliable methods of predicting the requisite harm to self or others, my view is 90% of current commitments would not be granted. One doesn't need to get into the legitimacy of mental illness diagnosing.

With respect to forced drugging, one of the pre-requisites is the person must be found to be incompetent to decline the drug(s). Here, too, psychiatrists, to be kind, over-estimate incompetence.

[M]ental patients are not always incompetent to make rational decisions and are not inherently more incompetent than nonmentally ill medical patients.³⁸

³⁶ *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993).

³⁷ Michael L. Perlin, *Mental Disability Law: Civil and Criminal*, §2A-4.3c, p. 109 (2d. Ed. 1998), footnotes omitted. See, also, Morris, Pursuing Justice for the Mentally Disabled, 42 San Diego L. Rev 757, 764 (2005) ("recent studies confirm[] that psychotic symptoms, such as delusions or hallucinations, currently being experienced by a person, do not elevate his or her risk of violence.")

³⁸ Perlin, "And My Best Friend, My Doctor/Won't Even Say What It Is I've Got: The Role And Significance Of Counsel In Right To Refuse Treatment Cases." 42 San Diego Law Review 735, 746-7 (2005), citing to Thomas Grisso & Paul S. Appelbaum, *The*

Not even the competency test against competency developed by Paul Appelbaum for the MacArthur Foundation³⁹ is used. Thus, psychiatric testimony concerning this threshold question of competency is very often invalid. However, this is not why I suggest no forced drugging in the civil context is legally justified.

The reason why I believe no forced drugging in the civil context is legally justified is it simply can not be scientifically proven it is in a person's best interest.⁴⁰ It would make this paper even more too long than it already is to fully support this assertion, but some will be presented. First, there is really no doubt the current over-reliance on the drugs is at least doubling the number of people becoming defined by the system as chronically mentally ill with it recently being estimated it has increased the rate of disability due to "mental illness" six-fold.⁴¹ In the case where we litigated the issue in Alaska, the trial court found

The relevant conclusion that I draw from [the evidence presented by the Respondent's experts] is that there is a real and viable debate among qualified experts in the psychiatric community regarding whether the standard of care for treating schizophrenic patients should be the administration of anti-psychotic medication.

* * *

MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments, 19 Law & Hum. Behav. 149 (1995).

³⁹ Thomas Grisso & Paul S. Appelbaum, *MacArthur Competence Assessment Tool-Treatment (MacCAT-T)*, Professional Resources Press (1998). My view is this test is at least somewhat biased against competency because disagreement with a diagnoses of mental illness is a basis for finding incompetence. I personally don't believe in that level of infallibility of psychiatric diagnosis and credit people's own interpretations more than psychiatrists tend to. I will allow, however, that this may be my own bias.

⁴⁰ While I believe this is true in the forced drugging context in terms of meeting the legal burden of justifying overriding a person's right to decline the medications, and I know this paper comes off as a polemic against psychiatric drugs, I absolutely believe people also have the right to choose to take them. I do think people should be fully informed about them, of course, which is normally not done, but that is a different issue. Not surprisingly, in a study of people who have recovered after being diagnosed with serious mental illness, those who felt the drugs helped them, used them in their recovery and those that didn't find them helpful, didn't use the drugs in their recovery. "How do We Recover? An Analysis of Psychiatric Survivor Oral Histories," by Oryx Cohen, in *Journal of Humanistic Psychology*, Vol. 45 No. 3, Summer 2005 333-35, which is available on the Internet at

http://12.17.186.104/recovery/oryx_journal_of_humanist_psych.pdf.

⁴¹ Anatomy of an Epidemic: Psychiatric Drugs and the Astonishing Rise of Mental Illness in America, by Robert Whitaker, *Ethical Human Psychology and Psychiatry*, Volume 7, Number 1: 23-35 Spring 2005, which can be accessed on the Internet at [http://psychrights.org/Articles/EHPPPsychDrugEpidemic\(Whitaker\).pdf](http://psychrights.org/Articles/EHPPPsychDrugEpidemic(Whitaker).pdf).

[T]here is a viable debate in the psychiatric community regarding whether administration of this type of medication might actually cause damage to her or ultimately worsen her condition.⁴²

A recent study in Ireland concluded the already elevated risk for death in schizophrenia due to the older neuroleptics was doubled with the newer, so-called "atypical" neuroleptics, such as Zyprexa and Risperdal.⁴³ More information on these drugs can be found on PsychRights' website at <http://psychrights.org/Research/Digest/Researchbytopic.htm>.

In sum, my view is the state can never (or virtually never) actually meet its burden of proving forced drugging is in a person's best interest (assuming that is required) because of the lack of long-term effectiveness and great harm they cause. Again, this raises the question of why forced drugging is so pervasive and what might be done about it. In other words, it is an opportunity for strategic litigation playing a key role in a transformation to a recovery oriented system.

(2) Corrupt Involuntary Mental "Treatment" System

As set forth above, people are locked up under judicial findings of dangerousness and force drugged based on it being in their best interests without any legitimate scientific evidence of either dangerousness or the drugs being in a person's best interests. As Professor Michael Perlin has noted:

[C]ourts accept . . . testimonial dishonesty. . . specifically where witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends." . . .

Experts frequently . . . and openly subvert statutory and case law criteria that impose rigorous behavioral standards as predicates for commitment . . .

This combination . . . helps define a system in which (1) dishonest testimony is often regularly (and unthinkingly) accepted; (2) statutory and case law standards are frequently subverted; and (3) insurmountable barriers are raised to insure that the allegedly "therapeutically correct"

⁴² Order, in *In the Matter of the Hospitalization of Faith Myers*, Anchorage Superior Court, Third Judicial District, State of Alaska, Case No. 3AN-03-277 PR, March 14, 2003, pp. 8, 13, which can be accessed on the Internet at <http://psychrights.org/States/Alaska/CaseOne/30-Day/Order.pdf>.

⁴³ Prospective analysis of premature mortality in schizophrenia in relation to health service engagement: a 7.5-year study within an epidemiologically complete, homogeneous population in rural Ireland, by Maria G. Morgan, Paul J. Scully, Hanafy A. Youssef, Anthony Kinsellac, John M. Owens, and John L. Waddington, *Psychiatry Research* 117 (2003) 127-135, which can be found on the Internet at <http://psychrights.org/Research/Digest/NLPs/MM-PsychRes2003.pdf>.

social end is met In short, the mental disability law system often deprives individuals of liberty disingenuously and upon bases that have no relationship to case law or to statutes.⁴⁴

In other words, testifying psychiatrists lie,⁴⁵ the trial (but generally not appellate) courts don't care, and lawyers assigned to represent defendants in these cases, are "woefully inadequate--disinterested, uninformed, roleless, and often hostile. A model of "paternalism/best interests" is substituted for a traditional legal advocacy position, and this substitution is rarely questioned."⁴⁶ Counsel appointed to represent psychiatric defendants are, more often than not, actually working for the other side, or barely put up even a token defense, which amounts to the same thing.⁴⁷

No one in the legal system is taking psychiatric defendants' rights seriously, including the lawyer appointed to represent the person. There are two reasons for this: The first is the belief that "if this person wasn't crazy, she'd know this is good for her." The second is the system is driven by irrational fear. All the evidence shows people who end up with psychiatric labels are no more likely to be dangerous than the general population and that medications increase the overall relapse rate, yet society's response has been to lock people up, and whether locked up or not, force them to take these drugs.⁴⁸

⁴⁴ *The ADA and Persons with Mental Disabilities: Can Sanist Attitudes Be Undone?* Journal of Law and Health, 1993/1994, 8 JLHEALTH 15, 33-34.

⁴⁵ "It would probably be difficult to find any American Psychiatrist working with the mentally ill who has not, at a minimum, exaggerated the dangerousness of a mentally ill person's behavior to obtain a judicial order for commitment." Torrey, E. Fuller. 1997. *Out of the Shadows: Confronting America's Mental Illness Crisis*, New York: John Wiley and Sons, page 152. Dr. Torrey goes on to say this lying to the courts is a good thing. Of course, lying in court is perjury. Dr. Torrey also quotes Psychiatrist Paul Applebaum as saying when "confronted with psychotic persons who might well benefit from treatment, and who would certainly suffer without it, mental health professionals and judges alike were reluctant to comply with the law," noting that in "the dominance of the commonsense model, the laws are sometimes simply disregarded."

⁴⁶ Perlin, "And My Best Friend, My Doctor/Won't Even Say What It Is I've Got": *The Role And Significance Of Counsel In Right To Refuse Treatment Cases*, 42 San Diego Law Review 735, 738 (2005)

⁴⁷ This is a violation of professional ethics. For example, the Comment to the Model Rules of Professional Conduct for attorneys, Rule 1.3, includes, "A lawyer should pursue a matter on behalf of a client despite opposition, obstruction or personal inconvenience to the lawyer, and take whatever lawful and ethical measures are required to vindicate a client's cause or endeavor. A lawyer must also act with commitment and dedication to the interests of the client and with zeal in advocacy upon the client's behalf."

⁴⁸ "Kendra's Law" in New York is a classic example of this. There a person who had been denied numerous attempts to obtain mental health services pushed Kendra in front of a moving subway and when he was grabbed, said something like "now maybe I will get some help." The response was to pass an outpatient commitment law requiring

(3) Legal Representation: This Is Where the Legal System is Broken.

I analogize the current situation of pervasive coercion to water seeking the path of least resistance and by making it hard enough to obtain involuntary commitment and forced drugging orders, it will no longer be the path of least resistance and the involuntary system will find other ways to deal with the people that come to its attention. As things stand now, obtaining involuntary commitment and forced drugging orders is by far the easiest thing for the system to do. It takes about 15 minutes of psychiatrist time in Alaska, for example. In California, in a study of 63 involuntary commitment hearings, which are not even done by the courts, eight hearings were one minute or less in duration; nineteen were between one and two minutes; nine were between two and three minutes in duration and only nine hearings were more than eight minutes in duration.⁴⁹

As has been noted by New York Law School professor Michael L. Perlin, the lawyers appointed to represent psychiatric defendants are not doing their job.

The assumption that individuals facing involuntary civil commitment are globally represented by adequate counsel is an assumption of a fact not in evidence. The data suggests that, in many jurisdictions, such counsel is woefully inadequate—disinterested, uninformed, roleless, and often hostile. A model of "paternalism/best interests" is substituted for a traditional legal advocacy position, and this substitution is rarely questioned. (at 738, footnotes omitted)

* * *

The track record of lawyers representing persons with mental disabilities has ranged from indifferent to wretched; in one famous survey, lawyers were so bad that a patient had a better chance of being released at a commitment hearing if he appeared pro se. (at 743, footnote omitted)

* * *

A right without a remedy is no right at all; worse, a right without a remedy is meretricious and pretextual—it gives the illusion of a right without any legitimate expectation that the right will be honored. . . . "Empirical surveys consistently demonstrate that the quality of counsel remains the single most important factor in the disposition of involuntary civil commitment cases." (at 745-6, footnotes omitted)

people to take psychiatric drugs or be locked up in the hospital. This is a characterization, but when this was challenged, New York's high court ruled Kendra's Law didn't require people to take the drugs; that all it did was subject people to "heightened scrutiny" for involuntary commitment if they didn't. *See, In the Matter of K.L.*, 806 N.E.2d 480(NY 2004).

⁴⁹ Morris, Pursuing Justice for the Mentally Disabled, 42 San Diego L. Rev 757, 759-60 (2005).

* * *

Without such [adequate] counsel, it is likely that there will be no meaningful counterbalance to the hospital's "script," and the patient's articulated constitutional rights will evaporate. (at 749)⁵⁰

In a companion article to Professor Perlin's 2005 article in the San Diego Law Review, Professor Grant Morris states:

If Michael Perlin spoke in a forest, and no one heard him speak, would he still make a sound? That is the question I ask you to consider as I respond to Michael's article.

Lawyers who represent mentally disabled clients in civil commitment cases and in right to refuse treatment cases, Michael tells us, are guilty of several crimes. They are inadequate. They are inept. They are ineffective. They are invisible. They are incompetent. And worst of all, they are indifferent. Is Michael right in his accusations? You bet he is!⁵¹

Professor Morris then goes on to note that this is a violation of lawyers' professional ethics.

The only case that has really come to grips with this issue is *KGF* out of Montana.⁵²

As a starting point, it is safe to say that in purportedly protecting the due process rights of an individual subject to an involuntary commitment proceeding—whereby counsel typically has less than 24 hours to prepare for a hearing on a State petition that seeks to sever or infringe upon the individual's relations with family, friends, physicians, and employment for three months or longer—our legal system of judges, lawyers, and clinicians has seemingly lost its way in vigilantly protecting the fundamental rights of such individuals.⁵³

⁵⁰ Perlin, "And My Best Friend, My Doctor/Won't Even Say What It Is I've Got: The Role and Significance of Counsel in Right to Refuse Treatment Cases," 42 San Diego Law Review 735 (2005)

⁵¹ Morris, Pursuing Justice for the Mentally Disabled, 42 San Diego L. Rev 757, 757-8 (2005).

⁵² However, PsychRights currently has a case before the Alaska Supreme on this issue. See, <http://psychrights.org/States/Alaska/CaseFour.htm>,

⁵³ *In re: K.G.F.*, 29 P.3d 485 (Mont. 2001). This case can be found on the Internet at <http://www.lawlibrary.state.mt.us/dscgi/ds.py/Get/File-11399/00-144.htm>.

The court in *KGF* then went on to lay down some very good requirements for the performance of the lawyers. However, it appears these have been largely ignored in practice.⁵⁴

IV. The Requirement and Necessity of Alternatives

Hopefully it is apparent from the foregoing that people should be allowed (less restrictive) alternatives when they are faced with forced drugging. The same is basically true of involuntary commitment.⁵⁵ These alternatives, I suggest, should primarily include non-coercive, for sure, and non-drug alternatives that are known to lead to recovery for many people.⁵⁶ The reality is likely a "which came first, the chicken or the egg?" situation, because judges will be reluctant to deny petitions for forced drugging on the basis that a less restrictive alternative could be made available, but in fact is not available. Thus, the actual availability of alternatives is important. However, where sufficient legal pressure is applied, the courts will simply not be able to order forced drugging. I know these are contradictory statements, but that is why they reinforce each other as set forth above (and below).

This can be illustrated by the situation involving Advance Directives. As set forth above, everyone has the absolute constitutional right to decline psychiatric drugs, with one exception, which is if they are incompetent to do so. Currently, the competency determinations are not legitimate. One reason I would posit, is that the system simply does not know what else to do with people so the system deals with it by finding people incompetent when they are not.

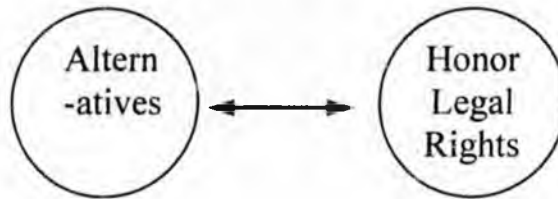
More legal trouble for the system comes in if people were to have Advance Directives that were made when they were certifiably (I would even suggest certified) competent at the time they made them. The system still doesn't know what to do with them, so it has to come with some way to ignore them, but it is a lot harder to come up with a pretext for the forced drugging. This presents at least the theoretical possibility of getting the judge (or jury) to essentially say, "well since you can't force drug this person, you had better figure out something else to do." Again, however, having the alternatives available will immeasurably help in enforcing people's legal rights to them. Litigation can also support the economic viability of the alternatives, because people faced with involuntary commitment and forced drugging can argue since they have the right to the less restrictive alternative the state must pay for it. Thus, the way the availability of

⁵⁴ See, February 28, 2005, letter from James B. Gottstein to the Chief Justice of the Montana Supreme Court, which can be accessed on the Internet at <http://psychrights.org/States/Montana/CJGrayLtr.pdf>.

⁵⁵ Many state statutes certainly require it, and I would suggest it is constitutionally required as well.

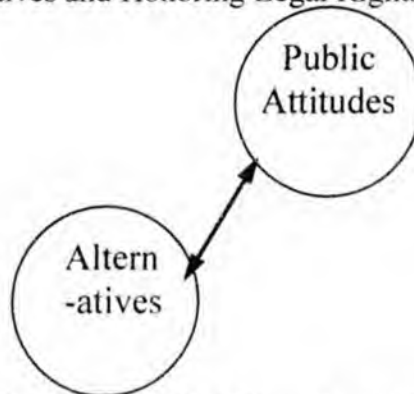
⁵⁶ See, Effective Non-Drug Treatments, which can be found on the Internet at <http://psychrights.org/Research/Digest/Effective/effective.htm>, for some specific examples.

recovery oriented alternatives and litigation reinforce each other can be broken out separately from the figure above as follows:



V. The Importance of Public Opinion

It is perhaps easier to see the same sort of process involved between Public Education and the Availability of Alternatives. Alternatives to the hopelessness driven, medication only, stabilization oriented, system are not available because our society believes it is the only possibility, in spite of all kinds of evidence to the contrary. Thus, to the extent effective alternatives become known to society in general, these alternatives will become desired by society because they produce much more desired outcomes. Not only do people get better, but huge amounts of money will be saved by more than halving the number of people who become a permanent ward of government. At the same time, having successful Alternatives will show society that they are viable. Thus, as with the Availability of Alternatives and Honoring Legal Rights, they reinforce each other:

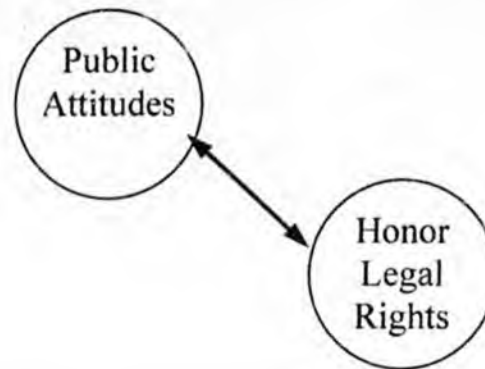


VI. Interplay Between Public Education and Honoring Legal Rights

As set forth above, the judges and even the lawyers representing people facing forced psychiatry accept the current societal view that people need to be locked up and forcibly drugged for society's and the person's own safety and best interests. To the extent society becomes aware this is not true, the judicial system will reflect that and be much more willing to honor people's rights. Perhaps harder to see, and maybe even a weaker link, is the extent to which successful litigation can impact public opinion. In order to illustrate that, however, I draw back upon *Brown v. Board of Education*,⁵⁷ which outlawed legal segregation and was one of the instrumental factors in changing public

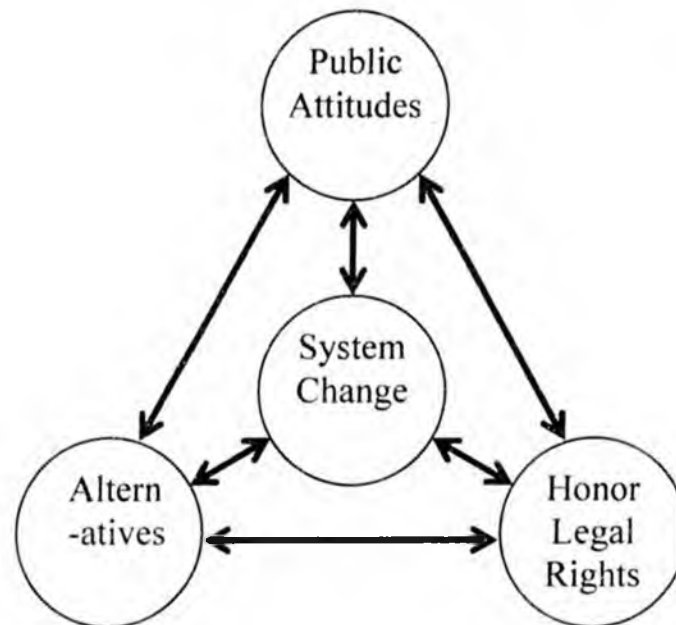
⁵⁷ U.S. 294, 75 S.Ct. 753, 99 L.Ed. 1083 (1955).

opinion from accepting segregation to one of finding it unacceptable. Thus, Public Attitudes and Honoring Legal Rights also reinforce each other.



VII. The Role of Litigation in Creating a Recovery Culture in Mental Health Systems

Putting these pieces together, we have the original figure set forth at the outset.



This is why I believe working on all three of these areas is important in transforming mental health systems to a recovery culture. Strategic litigation has an important, but not exclusive, role in this.

VIII. Requirements for Successful Litigation -- Attorneys & Expert Witnesses

The building blocks for mounting successful strategic litigation are recruiting attorneys who will put forth a serious effort to discharge their ethical duties to their clients and expert witnesses who can prove the junk science behind current "treatment" and the effectiveness of recovery oriented alternatives.

IX. Types of Legal Actions

There are a number of types of cases that can be brought to bear. All of these involve taking appeals where appropriate -- the appellate courts tend to take people's rights in these cases far more seriously than the trial courts. The following is by no means an exhaustive list.

A. Establishing the Right to Effective Assistance of Counsel

If people's rights were being honored, the problem of forced psychiatry would be mostly solved and this would absolutely force society to come up with alternatives -- hopefully recovery oriented. Thus, challenges to the effectiveness of counsel should be made. In light of the current state of affairs, there seems little downside to trying to get the United States Supreme Court to hold it is a right under the United States Constitution. I also believe that ethics complaints should be brought against the attorneys who do not discharge their duty to zealously represent their clients. If every involuntary commitment and forced drugging hearing were zealously represented, each case should take at least half a day. In my view it takes that long to fully challenge the state's case and present the patient's. This, in itself, would encourage the system to look for alternatives (the "path of least resistance" principle).

B. Challenges to State Proceedings.

States that proceed under the "professional judgment" rule should be challenged. The right to state paid expert witnesses should be pursued. The right to less restrictive alternatives should be pursued. Challenges to "expert witness" opinion testimony regarding dangerousness and competence should be made. Challenges to *ex parte* proceedings should be made. There are a myriad of challenges that can be made in the various states, depending on the statutes and procedures utilized in them.⁵⁸

C. 42 USC §1983 Claims

The federal civil rights statute, 42 USC §1983, often known simply as "Section 1983" provides:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this

⁵⁸ For example, I have identified a lot of things under Alaska law where I think valid challenges to what is going on can and should be made.

section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

This statute allows people to go into federal court and obtain injunctions against the constitutional violations that have been outlined here as well as money damages. This is a potentially very fruitful avenue, especially with respect to states where their supreme courts are not honoring people's constitutional rights.⁵⁹

X. Organizing Legal Challenges

At the Action Conference for Human Rights in Mental Health put on by MindFreedom in Washington, DC, last spring,⁶⁰ the Legal Track decided it would focus on fighting forced treatment as a single action item that outweighed everything else and certainly a large enough task.⁶¹ It was further decided to establish a State Coordinator system whereby the various states (& countries) would have a single person (or group) that would coordinate efforts for such states with PsychRights offering assistance and over-all coordination as able. There are currently coordinators for eight states and two countries,⁶² and coordinators for the other states are wanted. There is not a huge amount going on in any state except Alaska because of the problem of finding an attorney(s) willing to really work zealously on these types of cases, but some progress has been made.

A. Alaska

Since I get to represent people in Alaska and have been active for twenty years, I have been able to pursue the types of actions laid out here, with two challenges to what is going on currently in the Alaska Supreme Court and serious efforts being made to establish effective, recovery-oriented alternatives.⁶³ A report on these activities as of August 2, 2005, is available on the Internet at <http://akmhweb.org/News/AKEfforts.pdf> and if there are any significant developments by the time I present this information at NARPA in November in Hartford, they will be presented there.⁶⁴ The two Alaska Supreme Court cases are *Myers v. Alaska Psychiatric Institute*, in which we are seeking to establish that the State must prove forced drugging is in the person's best interest and people have the right to the least restrictive alternative, neither of which are contained in

⁵⁹ One can ask the United States Supreme Court to take cases where a state supreme court does not honor people's federal constitutional rights, but very few cases are heard. By utilizing 41 USC §1983, direct access to the federal courts is possible.

⁶⁰ See, the Final Report of the Conference, which can be found on the Internet at <http://psychrights.org/Education/2005ActionConference/FinalReport.pdf>.

⁶¹ See, the web page for the Legal Track at <http://psychrights.org/Education/2005ActionConference/Legal.htm>.

⁶² See, <http://psychrights.org/States/Coordinators.htm> for a list of current states (& countries) with coordinators.

⁶³ Descriptions of such alternatives can be found on the Internet at <http://psychrights.org/Research/Digest/Effective/effective.htm>.

⁶⁴ For information on the NARPA conference, see, <http://www.narpa.org/narpa.2005.htm>.

Alaska Statutes.⁶⁵ *Wetherhorn v. Alaska Psychiatric Institute* dramatically illustrates the sham nature of civil commitment and forced drugging proceedings and seeks to establish the right to effective assistance of counsel.⁶⁶

B. Massachusetts

Massachusetts has the very active Freedom Center,⁶⁷ which is doing a lot of effective work through its grass roots organizing. Aby Adams from the Freedom Center is the Massachusetts State Coordinator. As mentioned above, in February of 2004, I wrote a memo on how the *Rogers* case has been turned on its head and become a forced drugging assembly line.⁶⁸ Next month, Robert Whitaker, author of *Mad in America*, Grace Jackson, MD, author of *Rethinking Psychiatric Drugs: A Guide to Informed Consent*, Dan Kreigman, a local psychologist, Will Hall of the Freedom Center, and I will be presenting a Continuing Legal Education (CLE) program to lawyers representing people in these types of proceedings. I feel changing these lawyers' attitudes is more important than the legal information, which is why the other people presenting are so key.

It turns out that just last week, I was contacted by someone in a Massachusetts hospital and faced with an involuntary commitment and forced drugging petition. I was trying to jack up his attorney and sent her an e-mail with the following:

Do you have a good expert(s) lined up? Are you going to take the doc's deposition? Any others? In Alaska I just asserted the right to take depositions and got away with it (I think I have the right). Do you know what the asserted grounds of dangerousness are? Have you thought about challenging the proposed guardian, if there is one and suggesting someone else who will be more likely to follow what _____ wants with respect to the drugs? Are you going to move to dismiss the petition? Are you going to make any constitutional challenges? Have you talked to the hospital about what it might take to let him out? I have found here that really challenging what they are doing by these types of steps and especially by taking depositions, they become much more willing to consider a discharge.

Apparently, hospital staff saw the patient's copy of this e-mail and decided to discharge him. The patient believes this was instrumental in his release and supports the concept that making it harder to commit and force drug people, in itself, can be a successful strategy. Here, just contemplating facing a real challenge was enough to have the person released.

⁶⁵ See, <http://psychrights.org/States/Alaska/CaseOne.htm>.

⁶⁶ See, <http://psychrights.org/States/Alaska/CaseFour.htm>.

⁶⁷ See, <http://www.freedom-center.org/>.

⁶⁸ <http://psychrights.org/States/Massachusetts/RogersOrders/RogersOrdersMemo.pdf>.

C. Minnesota

In Minnesota, we have a State Coordinator, Lousie Bouta, other interested people and a psychiatrist who is willing to testify as an expert witness. We are working on obtaining some good legal assistance and then putting together a case(s).

D. New York

In New York, we have a State Coordinator, Anne Dox and there has recently been some other organizing. We have identified a couple of good attorneys -- especially one -- but financing, as always, is a problem. It seems like we should be able to put something together there.

E. Other States

As mentioned, we also have state coordinators in other states and want them in the states that don't have them.⁶⁹

XI. Public Attitudes

Even though this paper is about the court's potential role in transforming mental health systems to a recovery culture, it seems worthwhile to also make a few comments about changing public attitudes. There is an historic opportunity right now to make substantial inroads against the Psychopharmacology/Psychiatric hegemony because of the revelations in the media regarding dangerous, ineffective drugs, but this must be seized or it will be lost. **A serious public education program must be mounted.**

A. An Effective Public Relations Campaign

In the main, perhaps unduplicated for any other issue, the power of the Psychopharmacology/Psychiatric Hegemony has so controlled the message that the media tends not to even acknowledge there is another side. For most issues, the media will present at least one spokesperson from each side. However, when the latest bogus breakthrough in mental illness research or "treatment" is announced, the other side is not even presented. One might want to pass this off as Big Pharma advertising money infecting the news departments, but I think that is way too simplistic and perhaps even largely untrue.

In order to get our side presented, we need to have established relationships before stories break so they know who to call. An illustration of this is that David Oaks, the Executive Director of MindFreedom, was recently quoted in a recent, important Washington Post article about the NIH study finding "atypical" neuroleptics are neither more effective, nor safer than the older ones.⁷⁰ David has worked on his relationship

⁶⁹ See, <http://psychrights.org/States/Coordinators.htm> for a list of current states (& countries) with coordinators.

⁷⁰ The article in which David was quoted was "New Antipsychotic Drugs Criticized: Federal Study Finds No Benefit Over Older, Cheaper Drug," *Washington Post*, Tuesday,

with Shankar Vedantam, the person who wrote the story, educating him to the issues, and the result was that when the story broke, David was one of the people Mr. Vedantam called.

There should be an organized, ongoing and sustained public relations effort. There needs to be a person who is able to spend a considerable amount of their time devoted to organizing and coordinating this effort. I've mentioned establishing relationships so that the media will know who to call. As part of this there needs to be a list of potential speakers. These folks are often referred to in the media as "talking heads." Stories also need to be promoted.

B. Potential Talking Heads

The following is a list of people, I believe would be good spokespeople for the major media outlets. It is by no means comprehensive and I apologize in advance to people I no doubt should have included. Also, I don't know everyone on the list well and there may be some people listed, who perhaps would serve the effort better in another capacity(ies). Very importantly, everyone can and should position themselves as spokespeople in their own communities.

Psychiatrists/MDs	Ph.D.s		Survivors*	Attorneys
Peter Breggin	David Cohen	Al Galves	David Oaks	Michael Perlin
Grace Jackson	Bert Karon	Paula Caplan	Judi Chamberlin	Jim Gottstein*
David Healy	Ron Bassman*	Rich Shulman	Celia Brown	Susan Stefan
Joseph Glenmullen.	Bruce Levine	Sarah Edmonds	Laurie Ahern	William Brooks
Dan Fisher*	Larry Simon	Gail Hornstein	Darby Penny	Tom Behrendt
Dan Dorman	Al Siebert*	John Breeding	Pat Deegan	Kim Darrow
Kurt Langsten	Ann Blake Tracy	John Read	Bill Stewart	Dennis Feld
Ann Louise Silver	Barry Duncan	Cloe Madanes	Pat Risser	Maureen Gest
Stuart Shipko	Dominick Riccio	Edward Albee	Francesca Allan	Grant Morris
Ron Leifer	Jonathon Leo	Courtenay Harding	Krista Erickson	
Thomas Szasz	Jay Joseph	David Antonuccio	Linda Andre	
Fred Baughman	Diane Kern	Dathan Paterno	Oryx Cohen	
Karen Effrem	Keith Hoeller	Toby Watson	Catherine Penney	
	Tomi Gomory		Will Hall	

*People in other categories who are also self-identified survivors, are designated with an asterisk. I may have missed some.

C. Promoting and Making Stories

In addition to establishing relationships, and in fact also a way to establish relationships, is to pitch, promote and make stories. The 2003 Fast for Freedom in

September 20, 2005. The study, itself, can be found at <http://psychrights.org/Research/Digest/NLPs/NEJoMATypicalsnobetter.pdf>.

Mental Health put on by MindFreedom was an example of making a story.⁷¹ The most significant coverage it received was in the Washington Post and the LA Times Magazine, but there were a number of other stories and op ed pieces.⁷² The Hunger Strike was incredibly successful in one way, which was the brave fasters actually got the American Psychiatric Association to admit it has no evidence for psychiatry's claims that mental illness is a biologically based brain defect.⁷³ Ultimately, though, the Hunger Strike should have garnered much more media and the reason it didn't was that the prior relationship building had not been done.⁷⁴

XII. Alternatives

It also seems worthwhile to spend a little bit of space here on creating alternatives. Ultimately, in order to be successful, alternatives need to be funded by the public system.⁷⁵ One argument in its favor that should be attractive to government (but has not heretofore been) is the current system is breaking the bank. As Whitaker has shown, the disability rate for mental illness has increased six-fold since the introduction of Thorazine.⁷⁶ Making so many people permanently disabled and financially supported by the government, rather than working and supporting the government, is not only a huge human tragedy, but is also a massive, unnecessary governmental expense.

One of the simplest, but very important things that should be done is to compile a readily accessible, accurate, list of existing alternatives and efforts to get them going. I have seen lists of alternatives, but then I hear that this program or that is really not a true non-drugging and/or non-coercive alternative. It would be extremely helpful for there to be a description of each such program with enough investigation to know what is really happening. The following are some of the current alternatives and efforts to get more going:

- INTAR⁷⁷
- Action Conference⁷⁸
- Alaska -- Soteria-Alaska, CHOICES, Peer Properties⁷⁹

⁷¹ See, <http://mindfreedom.org/mindfreedom/hungerstrike.shtml>.

⁷² See, <http://www.mindfreedom.org/mindfreedom/hungerstrike22.shtml>.

⁷³ See, <http://mindfreedom.org/mindfreedom/hungerstrike1.shtml>.

⁷⁴ This is not a criticism at all. From my perspective the Hunger Strike was wildly successful.

⁷⁵ However, I am also in favor of non-system alternatives and especially "Underground Railroad" and "Safe Houses" types of efforts to which people facing involuntary commitment and forced drugging can escape.

⁷⁶ See, *Anatomy of an Epidemic: Psychiatric Drugs and the Astonishing Rise of Mental Illness in America*, which is available at [http://pschrights.org/Articles/EHPPPsychDrugEpidemic\(Whitaker\).pdf](http://pschrights.org/Articles/EHPPPsychDrugEpidemic(Whitaker).pdf).

⁷⁷ See, <http://intar.org/>

⁷⁸ See, Choices Track at

<http://pschrights.org/Education/2005ActionConference/FinalReport.pdf>

⁷⁹ <http://akmheweb.org/News/AKEfforts.pdf>.

- Arizona -- Meta Services⁸⁰
- California -- Golden State Psychological Health Center⁸¹
- Illinois -- Associated Psychological Health Services⁸²
- Massachusetts -- Freedom Center -- Soteria-New England, Zuzu's Place⁸³
- New Hampshire -- The Cypress Center⁸⁴
- Washington -- Ani'sahoni Consulting (Dr. David Walker)⁸⁵
- Wisconsin -- Associated Psychological Health Services⁸⁶

XIII. Conclusion

A final word about the importance of the potential role of the courts and the forced psychiatry issue. While it is true that many, even maybe most, people in the system are not under court orders at any given time, it is my view that the forced psychiatry system is what starts a tremendous number of people on the road to permanent disability (and poverty) and drives the whole public system. Of course, coercion to take the drugs is pervasive outside of court orders too, but again I see the legal coercion as a key element. If people who are now being dragged into forced psychiatry were given, non-coercive, recovery oriented options, they would also become available for the people who are not subject to forced psychiatry. I hope this paper has conveyed the role that strategic litigation can play in transforming mental health systems to a culture of recovery.

⁸⁰ See, <http://metaservices.com/>. They have done a lot of very interesting things, although at this point a lot of their clients are medicated.

⁸¹ See, <http://www.gsphe.net/>.

⁸² See, <http://www.abcmadsfree.com/>.

⁸³ See, <http://www.freedom-center.org/>.

⁸⁴ See, <http://psychrights.org/States/NewHampshire/NewHampshire.htm>.

⁸⁵ See, <http://www.anisahoni.com/about/>.

⁸⁶ See, <http://www.abcmadsfree.com/>.

REPORT

MULTI-FACETED GRASS-ROOTS EFFORTS TO BRING ABOUT MEANINGFUL CHANGE TO ALASKA'S MENTAL HEALTH PROGRAM

by

Jim Gottstein
August 2, 2005
with some updates to
September 29, 2006

The August 2, 2005 version of this Report was updated in February, 2006 and again in August and September of 2006, because of significant developments. Both Soteria-Alaska and CHOICES, Inc., have received funding since the original report was issued and the Alaska Supreme Court decided the *Myers* case in June, 2006. Some other minor updates have occurred, such as to the *Wetherhorn* case description, but a comprehensive review and update has not been made.

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II. INTRODUCTION

A number of people both in and out of Alaska have heard of various efforts in Alaska which attempt to create alternatives to the current virtually exclusive reliance on medication for people diagnosed with serious mental illness and have asked for a description of these efforts. I have also been thinking for quite a while that I should describe the various efforts I, along with others, are working on in Alaska. This will not be entirely new to everyone because in 2005 Jeff Jessee, the Executive Director of the Alaska Mental Health Authority (Trust Authority) called me into a meeting where he basically asked what the heck the idea was for four recently formed non-profits: CHOICES, Inc., Soteria-Alaska, Peer Properties and the Law Project for Psychiatric Rights (PsychRights®).¹ Thus, the basic vision was conveyed to the group of people at that meeting. Also, I have described it at Consumers Consortium meetings, where it has been met uniformly with great enthusiasm. I hope it will be helpful to have it laid out in writing.²

The four non-profits serve complementary roles in the effort to create alternatives to our mental illness system's³ virtually exclusive focus on the administration of psychiatric drugs for "treatment" of people diagnosed with serious mental illness. The drugs are of dubious, at best, over all effectiveness, are extremely harmful, and are at least halving the number of people who recover from a diagnosis of serious mental illness. Another way to put it is our system is creating large numbers of people⁴ who become seriously and persistently mentally ill,⁵ most of whom become permanent burdens on government financial resources. More importantly from my perspective, they lead much less satisfying, shorter, and less fulfilling lives than they otherwise could.

There is a huge debate over this assertion and it is not my purpose to engage in that debate here⁶ because the efforts described here are to allow choice. I know people who find the drugs helpful and some who feel they saved their lives. I think people who want the drugs should have access to them.⁷ By the same token, those who do not want the drugs should be given the choice to decline them. And they should have support for this choice. Each of the four non-profits is designed to play a role in this, although one of them, Soteria-Alaska, could be rolled into CHOICES, Inc., depending on timing and funding.

¹ Due to sustainability problems, multiplicity of administrative departments, and human resources constraints, both the Trust and the Rasmuson Foundation, which is the largest private foundation in Alaska, are discouraging the proliferation of non-profits.

² This Report suffers from speaking to different audiences. For example, the section on Alaska isn't necessary for people in Alaska and the names are of no relevance to people outside of Alaska. Hopefully, it will be sufficient unto the day for all readers.

³ Because of the way what we call the "mental health system" channels people into chronic mental illness. I think it is more fairly described as a mental illness, rather than a mental health system.

⁴ At least doubling.

⁵ Also known as "chronically mentally ill."

⁶ However, there are references and links which demonstrate these are the facts.

⁷ I do think the truth about them should be disclosed, though.

The purpose of this Report then is to describe the strategy, history, progress to date and current prospects for this effort in Alaska⁸ to improve the outcomes of people diagnosed with serious mental illness by making available alternatives to the coercive, substantially illegal, essentially exclusive, over-medication regime now in effect.

It can not be over emphasized this effort is about honoring people's right to make choices regarding whether or not to take the risks associated with these drugs in the hope of achieving their perceived benefits, or to try something else.

The report is extensively footnoted for those who wish to explore the topics in greater depth, and a glossary is included to define unfamiliar terms and acronyms.

III. BACKGROUND

The underlying premise is the mental illness system's over-reliance on medication is at least doubling the number of people who become seriously and persistently mentally ill and causing great harm to a great number of people,⁹ including death,¹⁰ and that by offering various alternatives to medication, many of which have been proven to work,¹¹ substantially better outcomes will result.¹² That the over-reliance on psychiatric drugs is not only worsening outcomes, but creating great harm, makes involuntary medication (Forced Drugging) particularly abhorrent. Legal proceedings in the US for involuntary commitment and medication are

⁸ I live in Alaska and as will be described below, it has some unique potential advantages, which makes it a good place to attempt to effect the type of meaningful change described here. The general ideas, however, can be used by people around the country (and to a certain extent, around the world) and I am also working with people around the country on various such efforts.

⁹ It would unacceptably increase the length of this Report to support this statement here, and readers are directed to the Scientific Research by Topic section of the PsychRights website, <http://psychrights.org/Research/Digest/Researchbytopic.htm> as well as its Suggested Reading webpage, <http://psychrights.org/Market/storefront.htm>, for such support. I have no doubt about the accuracy of the statement. If only one book is to be read on this topic, *Mad in America: Bad Medicine, Bad Science and the Enduring Mistreatment of the Mentally Ill*, by Robert Whitaker is recommended. *Toxic Psychiatry*, by Peter Breggin would be the next one.

¹⁰ See, e.g., Prospective analysis of premature mortality in schizophrenia in relation to health service engagement: a 7.5-year study within an epidemiologically complete, homogeneous population in rural Ireland, *Psychiatry Research*, 117 (2003) 127-135, which can be found at <http://psychrights.org/Research/Digest/NLPs/MM-PsychRes2003.pdf>. This study concluded: "On long-term prospective evaluation, risk for death in schizophrenia was doubled on a background of enduring engagement in psychiatric care with increasing provision of community-based services and introduction of second-generation antipsychotics." In other words the death rate doubled over the already elevated rate with the introduction of the so-called "atypical" neuroleptics, such as Zyprexa and Risperdal.

¹¹ See, e.g., the material at Effective Non-Drug Treatments, <http://psychrights.org/Research/Digest/Effective/effective.htm>.

¹² The current system essentially channels people into becoming permanently disabled and thus a permanent financial burden on government. One of the side benefits of the change envisioned here is a substantial number of people can get off, or never get on the disability rolls, thus not only having much better lives, but decreasing the cost to government.

essentially a sham¹³ and the lack of efficacy and the serious harm caused by the medications (and other treatments, such as electroshock) eliminate the justification for the prevailing paternalistic attitude that "we can't let these pesky rights get in the way of what we know is in the person's best interests."

If people's rights were actually honored, my sense is *at least* 90% of court orders for Forced Drugging would not occur.¹⁴ However, it is recognized (a) that society will not tolerate just letting people go who come to the attention of authorities in a way that invokes the involuntary "treatment" mechanisms, and (b) such people often really can benefit from (and want) a safe, nurturing and helpful environment to get through their acute problems. Thus, even with respect to legal rights to be free from illegally imposed forced "treatment," it is absolutely essential that alternatives to the current, essentially medication only treatment regime must become available.

The four non-profits are designed to offer the choice to pursue a non-medication approach in four distinct functional areas: Acute Care, Community Based Services, Housing, and Honoring the Legal Right to Choose. As mentioned previously, acute and community based services could be performed by one agency. There would be a number of benefits to this, the most important perhaps being that people would not lose the community based support system they have when they need acute services and *vice versa*. In other words, they can continue working with the people whom they have grown to trust.

IV. ALASKA ATTRIBUTES

There are several attributes in Alaska that are fairly important in perhaps making it a more favorable place to accomplish the goals presented here than other places.

A. Small Population

Alaska has a very small population, which makes it easier for one person or a relatively small group of people to impact things. Policy makers are generally much more accessible than in most places. I have been involved in mental health policy development for a long time, know many of the key players, and have a certain amount of credibility and respect. As will be evident, however, while all of this may be true, the goals are still not easy to accomplish.

B. Alaska Mental Health Trust Authority

A totally unique attribute of Alaska is the Trust Authority, which was created as a result of the settlement of litigation (Trust Settlement) over the state of Alaska stealing one million

¹³ See, Section VI. D(3) below.

¹⁴ This is based on the premise that people may not constitutionally be Force Drugged unless it can be scientifically proven it is in their best interests and there is no less restrictive alternative that could be made available. Involuntary commitments are perhaps legally justified a greater percentage of the time under the current state of the law, but not therapeutically.

acres of land granted in trust for Alaska's mental health program (Trust).¹⁵ The Trust now has about \$300 million in cash corpus, makes some money off its land corpus, and spends about \$20 million a year on what it considers innovative programs and to facilitate major initiatives, such as constructing a new state hospital. In addition to people diagnosed with mental illness, the Trust's beneficiaries include chronic alcoholics with psychosis, the mentally retarded and mentally defective, and people with Alzheimer's Disease and related dementias. The influence and ability of the Trust Authority to impact Alaska's mental health program far exceeds the relatively small amount of money it has to spend on it and should not be underestimated.¹⁶

C. Alaska Mental Health Board

Under the Trust Settlement, four state boards, each representing one of the four groups of Trust beneficiaries, provide recommendations to the Trust Authority regarding mental health program funding. The Alaska Mental Health Board provides recommendations with respect to people diagnosed with mental illness. The quality and influence of the Mental Health Board has waxed and waned over the years depending on its personnel and the political climate. At least one half of the members of the Alaska Mental Health Board must be people with a mental disorder or members of their family, which potentially gives excellent representation for Consumers' interests in policy development.¹⁷ Appointments to the board are by the Governor, though, and are thus political to a greater or lesser extent.¹⁸

D. Consumers Consortium

In 2002, all of the Consumer run programs in the state got together and formed the "Consumers Consortium" to provide a united voice to policy makers.¹⁹ See, <http://akmheweb.org/Announcements/2002rfr/consortiumproposals.htm> for its initial set of proposals. It seems worth quoting its organizational statement:

Consumers Consortium came together when disparate and exhausted consumer run organizations discovered their common problems and began looking for common solutions. The consortium has the assumption of commonness rather than the assumption of separation. We believe that it will be

¹⁵ See, <http://www.touchngo.com/lglentr/spelint/mht.htm>. I was one of the four plaintiffs' attorneys in that case. The Trust Settlement was valued at \$1.1 billion by the trial court and consisted of \$200 million in cash and a little under 1 million acres of land, approximately half of which was mineral estate only, such as the oil and gas rights.

¹⁶ Having said that, the current state Administration is generally disinterested in any outside input, which has diminished the Trust's influence since 2003.

¹⁷ See, AS 47.30.662(b), which can be accessed at <http://www.touchngo.com/lglentr/akstats/Statutes/Title47/Chapter30/Section662.htm>

¹⁸ I was on the Mental Health Board from 1998 to 2004, but was not reappointed after I sued the State regarding the interpretation of the Trust Settlement. See, <http://psycrights.org/States/Alaska/4bdSuit/4bdSuit.htm>. Being re-appointed under the Murkowski Administration was always unlikely because I was not of the right political party.

¹⁹ A Consumer membership organization, Mental Health Advocates of Alaska (MHA AK), was formed in 2004/05 with the intent of representing Consumers (as contrasted with Consumer run programs) statewide to policy makers. It is too early to tell if it will attract enough members to legitimately claim such status.

much easier for the MH system to respond effectively to us as a group, working together. In that spirit, we have come together to build a consensus around the mental health system in response to the Board's call for input into the budget building process.

From 2002 until 2005, the Consortium's members were able to reach a consensus on how available funds for Consumer run programs should be allocated. However, for the state fiscal year starting in July, 2005, funding was cut so much²⁰ this was no longer possible, which resulted in the more typical free-for-all competition process with winners and losers.

E. Ionia

In 1987, a group of what I think of as refugees from the mental illness system in Massachusetts founded the community and non-profit, Ionia, in Kasilof, Alaska. They pooled their resources and created a lifestyle that totally works for them.²¹ They now have over 40 people living there, including many children. I don't think they have had a psychiatric crisis in well over ten years, perhaps not since the community was founded. They built their own log houses, eat a strict macrobiotic diet, growing and gathering much of their own food, and meet every morning for as long as it takes to work through any issues. A few years ago, they needed some grant funding to expand their agricultural operation and build a community building they call the "Longhouse." The grant application brought what they were doing to the attention of policy makers, and Ionia became an example of a group of people who, after being pronounced hopelessly and permanently mentally ill, created their own environment, and proved it is possible to recover from a diagnosis of serious mental illness and thrive.

V. GENESIS OF EFFORT

While I have been involved in mental health policy in Alaska for quite a long time in various capacities²² and had a pretty good sense of the failure of the mental illness system to truly help most people diagnosed with serious mental illness, this particular effort arose out of my reading *Mad in America* in late 2002. It is an excellent, very readable and enjoyable, yet extremely alarming book in that it revealed vast numbers of people are being greatly harmed by the current "treatment" paradigm.²³ Of course, there have actually been many books documenting the same thing, including Dr. Peter Breggin's seminal book *Toxic Psychiatry*. *Toxic Psychiatry* is also a compelling and well documented indictment of the current system, but I found it was when people read *Mad in America* that they really "got" on an almost visceral level the scientific and moral bankruptcy of the current system and the scope of the harm being done.

²⁰ The Trust Authority doubled the amount of money it had previously allocated for what was called Consumer run programs, but expanded eligibility to include all four of its beneficiary groups in what it now calls its "Trust Beneficiary Group Initiative" or "TBGI."

²¹ See, <http://akmhweb.org/recovery/ioniaadn.html> and <http://ionia.org/>.

²² A brief bio can be found at <http://psvchrights.org/about/Gottstein.htm>.

²³ This is one of the reasons why I often put "treatment" in quotation marks. Another is the idea that if it isn't voluntary it isn't treatment.

I was on the Alaska Mental Health Board at the time and sent every member of it, as well as every member of the Trust Authority, a copy of *Mad in America*, exhorting them to take action to improve the outcomes for people diagnosed with serious mental illness by providing alternatives to medication.²⁴ PsychRights brought Bob Whitaker, the author of *Mad in America*, to Anchorage in December 2002, to give a presentation to the Alaska Mental Health Board. While he was here, Whitaker also spoke to the Alaska Psychiatric Institute and to the state-wide organization of community mental health centers. The Mental Health Board's reaction was mostly positive, though with state personnel and NAMI-Alaska members on the Board tending to be negative. However, there was general agreement people ought to have the choice to pursue a non-medication approach. No such changes to Alaska's mental health program have occurred.

In the Spring of 2003, as chair of the Mental Health Board's Finance Committee, I convened a Budget Summit, which produced a report which can be found at <http://akmhweb.org/Docs/AMHB/2003BudgetSummitReport.pdf>. This report was formally adopted by the whole board in August of 2003. A couple of quotes from it are:

There were discussions of . . . whether it was clear enough from the data that the current reliance on psychiatric medications substantially increases chronicity. These and similar items are referred to the full Board/Planning Committee for further development and consideration. (p.1)

The Mental Health System currently relies heavily on psychiatric medications. It is recommended that further research on how the use of these medications impact desired results should be conducted. (p.10)

I think it is fair to say there has been little, if any, follow-up on this, although I can't say for sure because I am no longer on the board. Much of this can be attributed to the animosity of the Murkowski administration to the Alaska Mental Health Board and to its attempts to enfeeble the board by reducing its funding and combine it with the Alaska Board on Alcoholism and Drug Abuse.²⁵

The four non-profit effort is designed to work within existing mechanisms to make non-coercive, non-medication options available in Alaska.

²⁴ The transmittal to the members of the Alaska Mental Health Board can be found at <http://psychrights.org/states/alaska/2002/MadInAmericatxtoMHBtr4Web.pdf>. In March of 2003, I also transmitted a copy of *Mad in America* and other materials to the Commissioner of the Alaska Department of Health and Social Services exhorting him to address the situation. This transmittal letter can be found at <http://psychrights.org/alaska/DMHDD/3-24-03jtgogilbertson.pdf>.

²⁵ When the Administration discovered it could not do this without breaching the Trust Settlement, it accomplished much the same thing by forcing the Alaska Mental Health Board and the Alaska Board on Alcoholism and Drug Abuse to share staff and hold joint meetings and by refusing to appoint the person they selected as their joint Executive Director.

VI. SPECIFIC EFFORTS: STATUS & PROSPECTS

A. Acute Care: Soteria-Alaska

Dr. Loren Mosher's Soteria-House project and study in the 1970's proved that people who are in acute psychiatric crisis, who would normally be hospitalized, can be at least as successfully treated and have better long term outcomes (lives) if they are allowed to get through their initial psychotic episode(s).²⁶ The Michigan State Psychotherapy study proves the same thing.²⁷ The Michigan study also shows that in the short term there are significant cost savings and the long-term cost savings are enormous.²⁸

Soteria-Alaska, Inc. was incorporated in January of 2003 as a vehicle to create a Soteria-like program in Alaska.²⁹ Shortly thereafter, Jerry Jenkins came to Alaska to be the Executive Director of Anchorage Community Mental Health Services (ACMHS), the largest community mental health center in the state, and he was (and continues to be) very supportive of people being given non-medication choices. The decision was made that it would be easier to try and develop a Soteria-like program through ACMHS, and therefore Soteria-Alaska, Inc., as a separate entity trying to do so was put on hold. However, as the 15 month deadline approached for filing for tax exempt status approached with no concrete progress towards ACMHS establishing a Soteria-like program, Soteria-Alaska filed its application for tax-exempt status in the spring of 2004 in order to be in a position to move forward, itself.³⁰

In the summer of 2004, there was an indication of interest in Soteria-Alaska from at least one member of the Trust Authority, and it was suggested a proposal should be put together for

²⁶ See, "Soteria and Other Alternatives to Acute Psychiatric Hospitalization. A Personal and Professional Review," by Loren R. Mosher, M.D., *The Journal of Nervous and Mental Disease*, 187:142-149, 1999, which can be found at <http://psychrights.org/Research/Digest/Effective/soteria.pdf> and the other studies located at <http://psychrights.org/Research/Digest/Effective/effective.htm>. In addition, Dr. Mosher's book, *Soteria: Through Madness to Deliverance* (published posthumously) is an incredibly good book about Soteria and gives one the feeling of what Soteria House was like.

²⁷ See, *The Michigan State Psychotherapy Project*, by Bertram P. Karon and Gary R. VandenBos, which can be found at <http://psychrights.org/Research/Digest/Effective/MIPsychProj.pdf>. Also, see, *Psychotherapy of Schizophrenia: The Treatment of Choice* (Jason Aronson, 1996), by Bertram P. Karon and Gary R. Vandenbos, which has the most complete description of the Michigan study.

²⁸ One of the things that happens is that people who get caught by the system are channeled onto SSI/SSDI/Medicaid as a way to get them basic living funds and medical insurance. However, as the Budget Summit Report points out, "the Medicaid/SSDI/SSI eligibility and funding mechanism is essentially a one way ticket to permanent disability and poverty." <http://akmhweb.org/Docs/AMHB/2003BudgetSummitReport.pdf>, page 8. This approach is part and parcel of the erroneous view that people don't recover from serious mental illness, especially a diagnosis of schizophrenia. This means droves of people unnecessarily become permanent financial burdens on the government.

²⁹ Soteria-Alaska was not envisioned as necessarily being a Consumer run program, which is in contrast to CHOICES, Inc., described below.

³⁰ Probably the biggest concern with ACMHS implementing a Soteria-like program is whether it would remain faithful to Soteria precepts. As a traditional community mental health center, it has historically been very oriented toward requiring its clients to take medication, which is its corporate culture.

presentation to the Alaska Mental Health Board for its recommendation. The Consumers Consortium had a modest amount of funding available for planning and an agreement was made with Dr. Aron Wolf for assistance in preparing such a proposal.³¹ A proposal was prepared and submitted to the Alaska Mental Health Board, which recommended it for funding to the Trust.³² The prospect of a Soteria-Alaska has generated a lot of interest and support from outside Alaska. For example, psychiatrists Ann- Louise Silver,³³ Peter Stastny,³⁴ Dan Dorman,³⁵ Luc Ciompi,³⁶ Nathaniel Lehrman,³⁷ and Grace Jackson,³⁸ all of whom have experience in treating people without drugs have indicated a willingness to help. Non-psychiatrist experts who also indicated a willingness to help include Alma Menn,³⁹ the administrator of the original Soteria-House project, John Bola, who collaborated with Dr. Mosher in a number of studies and papers and Judy Schreiber, Dr. Mosher's widow. In addition to myself, Eliza Eller of Ionia and Andrea Schmook currently comprise Soteria-Alaska's board of directors.

In October of 2005, Soteria-Alaska was granted \$10,000 from the Trust, to continue the planning. This enabled it to make another proposal to the Trust in January of 2006 and the Trust granted \$78,000 to support further development of the Soteria-Alaska program in preparation for

³¹ Dr. Wolf has been Ionia's psychiatrist for many years, has been practicing psychiatry in Alaska since 1967, was the Regional Medical Director of Providence Health System, and holds a Masters of Medical Management Degree, which is the equivalent of a Masters of Business Administration for medical management. Especially exciting from our perspective is Dr. Wolf had experience at Chestnut Lodge in Maryland, which pioneered psychotherapeutic treatment of people diagnosed with serious mental illness. Dr. Wolf's CV can be found at <http://choices-ak.org/grants/05TBGI/Operating/AWolfCV.pdf>.

³² A copy of the proposal can be found at <http://soteria-alaska.com/Soteria-Alaskawapdx.pdf>. The initial business plan can be found at <http://soteria-alaska.com/grants/05TBGI/SoteriaInitialBizPlan.pdf>.

³³ Dr. Silver practiced at Chestnut Lodge when it did not use medications and has written a number of articles about treating people with psychosis without drugs. For example, she has reported that when she first worked at Chestnut Lodge, her schizophrenic patients were not medicated. Later, all of her patients were medicated as a matter of policy. In the premedication days, she had patients who got romantically involved, got married, had children, and related to their spouses and children. None of her medicated patients ever formed a new relationship. See, <http://psychrights.org/Articles/KaronMedication.htm>.

³⁴ Dr. Stastny is a driving force behind the international effort to create more programs like Soteria-House through an organization known as International Network of Treatment Alternatives for Recovery (INTAR). See, <http://www.intar.org/>.

³⁵ Dr. Dorman has treated people diagnosed with serious mental illness without drugs for many years and is the author of the fantastic book, *Dante's Cure*, a true account of a young woman's descent into psychosis and then, through hard work, understanding and most importantly, having a psychiatrist willing to spend the time and have a true caring relationship, her journey back from madness into full recovery.

³⁶ Dr. Ciompi has run Soteria-Berne in Switzerland for a long time.

³⁷ Dr. Lehrman is the former Clinical Director, Kingsboro Psychiatric Center, Brooklyn, NY and has published extensively on successful non-medication treatment. See, e.g., *The Rational Organization of Care for Disabling Psychosis - "If I Were Commissioner,"* which can be accessed at <http://akmlheweb.org/articles/ilehrmanecommissioner.htm>. Dr. Lehrman identifies having the same person involved in both the community and acute settings as being extremely important.

³⁸ Dr. Jackson was described by Dr. Mosher as the most knowledgeable person he knew of about the actual effects of psychiatric drugs. Her book definitive book on the topic, *Rethinking Psychiatric Drugs: A Guide to Informed Consent* has just been published.

³⁹ Ms. Menn is currently a consultant to the project.

a full business plan presentation to the Trust in September, 2006.⁴⁰ Susan Musante was hired as the Project Manager⁴¹ and the Business Plan was submitted on August 4, 2006.⁴² Because the long-term viability of Soteria-Alaska depends on State of Alaska financial participation and there are a number of other hurdles, making it hard to determine when Soteria-Alaska might be ready to open, the Trust staff recommended the Trust fund continued planning and pre-development efforts with the idea that it will fund the start-up when all of the pieces are in place, including inclusion in the state's budget. This recommendation was accepted and on September 6, 2006, the Trust passed a motion approving the following:

Fiscal Year 2007 (ending June 30, 2007)

\$120,000 in Trust Funds for continued development work.

Fiscal Year 2008 (ending June 30, 2008)

\$160,000 in Trust Funds.

Recommendation that \$220,000 in State of Alaska General Fund/Mental Health (GF/MH) be appropriated for Soteria-Alaska operations.

Fiscal Year 2009 (ending June 30, 2009)

\$160,000 in Trust Funds.

It doesn't appear the Trust actually passed a motion regarding FY 2009 GF/MH, but it is understood the plan is if the State does appropriate the \$220,000 in FY 2008, that it would go up to \$470,000 in FY 2009

The key then, to opening Soteria-Alaska is getting the Legislature to include it in the state budget. Because of all of the support for it the chances are reasonable for that to happen. In addition to the Trust's support, the Alaska Division of Behavioral Health is supporting state funding as is the Executive Director of the state hospital. It appears the earliest Soteria-Alaska could possibly open would be January or February of 2008, and that is probably too optimistic.

B. Community Based Services: CHOICES, Inc.

CHOICES, Inc., which stands for Consumers Having Ownership In Creating Effective Services (hereafter referred to as CHOICES), was formed at the same time as Soteria-Alaska to provide an alternative to the drug-only treatment modality in the community. It is a Consumer run program. On its website, CHOICES describes its program as follows:⁴³

⁴⁰ The planning proposal funded by the Trust can be found at <http://soteria-alaska.com/grants/FY06-07PreDev/TrustFinanceCmtee4Feb7-806.pdf>.

⁴¹ Ms. Musante has proven to be terrific. A brief bio can be found at <http://soteria-alaska.com/Info/AnnounceSMusante.htm>

⁴² A copy of the Business Plan can be obtained from <http://soteria-alaska.com/Grants/FY06-07PreDev/SoteriaSept06BizPlan.pdf>

⁴³ See, <http://choices-ak.org/>.

CHOICES, Inc., was formed to provide alternatives in the community to the current medication dominated mental health system. Tax exempt status was received on March 15, 2005, and CHOICES is now able begin operations.

CHOICES is what is known as a Consumer Run program, where "consumer" means someone who has been labeled with a serious mental illness and is a past or present recipient of mental health services. More specifically, Article III, §2, of the Bylaws requires, "at least 2/3rds of the members of the Board of Directors shall be a past or present recipient of mental health services of such a nature that inpatient care may have been necessary."

The philosophy behind CHOICES is reflected in both its name and the words which create the acronym CHOICES -- Consumers Having Ownership In Creating Effective Services -- which is people having options of their own creation and choosing.

CHOICES anticipates three primary modes of operation. The first is to provide people the types of services or other resources they **choose** to help them recover. The second is to develop and provide, to the extent possible, the types of community mental health services described by Loren Mosher and Lorenzo Burti in Chapter 9 of their excellent book, *Community Mental Health: A Practical Guide*. The third is to be a conduit for "pass-through" grants to other Consumer Run programs that do not have tax exempt status or the administrative wherewithal to do so themselves.

To reiterate, there are three basic components to the CHOICES program as currently envisioned:

- (1) Helping people (and parents of younger children) get what they want.
- (2) Providing the types of services Loren Mosher describes in Chapter 9 of his and Lorenzo Burti's excellent book, *Community Mental Health: A Practical Guide*, which can be found at <http://choices-ak.org/grants/05TBGIOperating/Ch9.pdf> (9 Megabytes).
- (3) Being a conduit for pass-through grants for consumer run programs that have not obtained 501(c)(3) status.

It is not envisioned that Soteria-Alaska would provide community services, but there are scenarios where CHOICES could/would run a Soteria-like program. In other words, if CHOICES is able to commence operations and moves to a position to accomplish it, it could establish a Soteria-like program as part of its programming. As mentioned above, this would have the major advantage of more easily allowing people to retain the support people they have come to trust, even when they move between acute and non-acute situations.⁴⁴

⁴⁴ It should be pointed out here, however, that the goal and expectation is that people will recover and come to rely on the mental health system much less, if at all.

Andrea Schmook, who has tremendous, successful experience with consumer run programs and is currently working on ACMHS' consumer driven section,⁴⁵ serves as CHOICES' initial executive director on a part-time basis under contract from ACMHS. In addition to myself, Eliza Eller of Ionia and Michele Turner currently comprise CHOICES' board of directors.

CHOICES is designed to access current financing mechanisms, such as Medicaid, which would make it self-sustaining. CHOICES has received a \$150,000 grant to provide Independent Case Management and Flexible Support Services.⁴⁶ It is hoped that this grant will be the start to allow CHOICES to become a self-sustaining part of Alaska's mental health system.

CHOICES also serves as "pass-through" agency or "fiscal agent" for a number of organizations and grants.

C. Housing: Peer Properties

Peer Properties, Inc., was formed by myself and Katsumi Kenaston to provide housing for people diagnosed or diagnosable with serious mental illness and homeless, at risk of homelessness or in a bad living situation. Peer Properties does not provide services, but operates on the peer support principle. The peer support principle is relationships based upon shared experiences and values, and characterized by reciprocity, mutuality, and mutual acceptance and respect. The helper's principle, a corollary of the peer principle, is that working for the recovery of others facilitates personal recovery.

It has long been recognized that being homeless or in a bad living situation contributes to psychiatric symptoms and prevents recovery.⁴⁷ It has more recently been recognized that linking housing to services can be counterproductive. There is a rather pervasive policy of community mental health centers requiring "compliance" with medication and/or utilizing certain services as a condition to receiving and/or being allowed to remain in housing. Peer Properties neither encourages nor discourages the use of psychiatric medications; instead, it supports its tenants' choices in the matter.

In 2004, Peer Properties received a capital grant of approximately \$190,000 from the Trust, which combined with a \$25,000 grant from the Rasmuson Foundation enabled the purchase of a four bedroom house.⁴⁸ After some initial difficulties, four women now share the house and it is operating very well, although finances are very tight.

⁴⁵ Ms. Schmook's resume can be found at <http://choices-ak.org/grants/05TBGIOperating/ASchmookResume-9-24-04.pdf>.

⁴⁶ Both Independent Case Management and Flexible Support Services were in the Consumers Consortium 2002 package of budget proposals (<http://akmheweb.org/Announcements/2002rfr/casemanagement.pdf> and <http://akmheweb.org/Announcements/2002rfr/flexible.pdf>).

⁴⁷ In the *Myers* case described below, Dr. Mosher testified (by affidavit), that "Without adequate housing, mental health 'treatment' is mostly a waste of time and money." See, <http://psychrights.org/States/Alaska/CaseOne/30-Day/ExhibitRLRMosherAff.htm>, emphasis in original.

⁴⁸ See, <http://peerproperties.org/Properties/outside.jpg>

In 2004, Peer Properties was also awarded a pre-development grant to apply for a Special Needs Housing Grant (SNHG). Peer Properties teamed up with a very sophisticated and experienced developer, the Venture Development Group, and submitted an application under the SNHG program as well as for Low Income Housing Tax Credits. Peer Properties was awarded both a SNHG Grant and tax credits to build an 11 unit apartment building, including one for a resident manager (called "Peer One"), aimed at housing people who repeatedly cycle through the Alaska Department of Corrections and the Alaska Psychiatric Institute (API). Unfortunately, this project proved just too difficult to pull off.

Peer Properties is currently operated entirely by its volunteer board of directors, Andrea Schmook,⁴⁹ Mel Henry,⁵⁰ Barry Creighton and myself. In the final analysis, the Peer One Project proved too complicated and/or ambitious for Peer Properties' organizational capacity at that time and it is no doubt a good thing that the project was abandoned rather than have it built and become a failure. Such a failure would certainly have been a black eye for Peer Properties and also a blow to Consumer run programs in Alaska, generally. Many people worked with good faith on the project and no one should be blamed that it was not completed. Nor should people cease working on providing housing for the very challenging population it was intended to serve. Peer Properties is willing to increase the housing it is providing, but only if there is sufficient capacity and operating support.

D. Legal: Law Project for Psychiatric Rights (PsychRights)⁵¹

PsychRights is a non-profit, tax exempt, 501(c)(3), public interest law firm whose mission is to bring fairness and reason into the administration of legal aspects of the mental health system, particularly unwarranted court ordered psychiatric drugging. Its purpose is to promote and implement a legal campaign in support of psychiatric rights and against unwarranted court ordered psychiatric medication akin to what Thurgood Marshall and the NAACP mounted in the 40's and 50's on behalf of African American civil rights. When one has a situation such as exists now in the mental illness system where entrenched and well-financed interests support an illegal system, litigation may very well be an essential element of reform.⁵²

In addition to myself, Don Roberts and Chris Cyphers serve on its board of directors.⁵³ I donate all my services *pro bono publico*.

(1) Development

Prior to reading *Mad in America*, while I had a general sense of what was happening with Forced Drugging, I didn't feel I had anything in particular to contribute. In addition to *Mad in*

⁴⁹ Ms. Schmook's resume can be found at <http://choices-ak.org/grants/05TBGI/Operating/ASchmookResume-9-24-04.pdf>.

⁵⁰ Dr. Henry's Resume can be found at <http://peerproperties.org/grants/05TBGI/MHenryResume.pdf>.

⁵¹ Since this Report is about Alaska efforts, PsychRights' efforts in other states is not covered.

⁵² The article How the Legal System Can Help Create a Recovery Culture in Mental Health Systems, which can be found at <http://psychrights.org/Education/Alternatives05/RoleofLitigation.pdf> describes in some detail how strategic litigation, combined with influencing public opinion and the creation of alternatives to medication is a key component in system change.

⁵³ Bios of the board of directors and other key personnel can be found at <http://psychrights.org/about.htm>.

America being a great book, to me it was a litigation roadmap for marshalling the scientific evidence against Forced Drugging. It turned out the NARPA conference that November, 2002, included as keynote speakers: (1) Bob Whitaker, the author of *Mad in America*, (2) Loren Mosher, M.D., of Soteria House fame, and (3) Professor Michael Perlin, the author of "the" treatise on mental health disability law and over 150 legal articles on the subject.

I wrote the articles Unwarranted Court Ordered Medication: A Call to Action,⁵⁴ and Psychiatry: Force of Law,⁵⁵ attended the November 2002, NARPA conference and arranged for an off-agenda presentation.⁵⁶ There I met Mr. Whitaker, Dr. Mosher and Michael Perlin. Mentioned above is bringing Bob Whitaker to Alaska in December, 2002. I also asked him to send me all of the articles cited in *Mad in America*. These articles were scanned and posted on the Internet to make them more accessible, and particularly so other attorneys could download and attach them as exhibits when fighting Forced Drugging cases.⁵⁷

(2) Finances

PsychRights has a general policy against taking government funding because it is felt one can not seriously challenge what the government is doing with its money. This has certainly proven to be true with respect to other government funded attorneys in the arena. However, because of the unique nature of the Trust Authority, \$5,000 in funding has been accepted from it to help present a seminar on Mental Health Disability Law in September of 2003 by Professor Perlin and Robert Whitaker⁵⁸ and a \$10,000 Small Project grant for representation expenses, such as filing fees, deposition costs, expert witness fees, etc. Otherwise, PsychRights is entirely sustained by private donations.⁵⁹ PsychRights submitted a TBGI systems change grant application to fund one attorney and assistant, which was not awarded.⁶⁰ PsychRights' finances are completely transparent, with financial information being posted at <http://psychrights.org/about.htm>.

(3) The Role of Litigation for System Change

Litigation as a means for changing systems is a proven strategy. The civil rights litigation by Thurgood Marshall and the NAACP in the 1950's and '60's overturning segregation is a classic example. In Alaska, in addition to the Mental Health Trust Lands litigation, we have had the Molly Hootch case for rural education and the Cleary case for prison administration. In situations such as currently exists with our mental illness system, where governmental policies are supported by large economic interests, litigation is often a necessary element in eliminating the abuses.

⁵⁴ <http://psychrights.org/calltoaction.htm>.

⁵⁵ http://psychrights.org/force_of_law.htm.

⁵⁶ PsychRights provided a number of free copies of *Mad in America* to people who could not afford to purchase it, which helped with attendance.

⁵⁷ <http://psychrights.org/Research/Digest/Chronicity/NeurolepticResearch.htm>

⁵⁸ See, <http://psychrights.org/Education/ak03CLE/Brochure.htm>.

⁵⁹ Regular financial statements may be found at <http://psychrights.org/about.htm#financial>.

⁶⁰ The operating grant application can be found at <http://psychrights.org/grants/05tbgi/PsychRightsOperating.htm> and the companion capital grant application at <http://psychrights.org/grants/05tbgi/PsychRightsCapital.htm>.

The Introduction mentions that Forced "Treatment" proceedings are essentially a sham. This is well known to those involved. Psychiatrists, with the full understanding and tacit permission of the trial judges, regularly lie in court⁶¹ to obtain involuntary commitment and forced medication orders:

[C]ourts accept . . . testimonial dishonesty, . . . specifically where witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends." . . .

Experts frequently . . . and openly subvert statutory and case law criteria that impose rigorous behavioral standards as predicates for commitment . . .

This combination . . . helps define a system in which (1) dishonest testimony is often regularly (and unthinkingly) accepted; (2) statutory and case law standards are frequently subverted; and (3) insurmountable barriers are raised to insure that the allegedly "therapeutically correct" social end is met . . . In short, the mental disability law system often deprives individuals of liberty disingenuously and upon bases that have no relationship to case law or to statutes.⁶²

The psychiatric profession explicitly acknowledges psychiatrists regularly lie to the courts in order to obtain forced treatment orders. E. Fuller Torrey, M.D., one of the most outspoken proponents of involuntary psychiatric "treatment" says:

It would probably be difficult to find any American Psychiatrist working with the mentally ill who has not, at a minimum, exaggerated the dangerousness of a mentally ill person's behavior to obtain a judicial order for commitment.⁶³

Dr. Torrey goes on to say this lying to the courts is a good thing. Dr. Torrey also quotes psychiatrist Paul Applebaum as saying when "confronted with psychotic persons who might well benefit from treatment, and who would certainly suffer without it, mental health professionals and judges alike were reluctant to comply with the law," noting that in "'the dominance of the commonsense model,' the laws are sometimes simply disregarded."⁶⁴

⁶¹ This is perjury, a crime.

⁶² "The ADA and Persons with Mental Disabilities: Can Sanist Attitudes Be Undone?" by Michael L. Perlin, *Journal of Law and Health*, 1993/1994, 8 JLHEALTH 15, 33-34

⁶³ Torrey, E. Fuller. 1997. *Out of the Shadows: Confronting America's Mental Illness Crisis*. New York: John Wiley and Sons. 152.

⁶⁴ In other words, "we can't let people's rights get in the way of us doing to them what we know is good for them."

It is also well known that:

Traditionally, lawyers assigned to represent state hospital patients have failed miserably in their mission.⁶⁵

The sham nature of Forced "Treatment" proceedings, supported by the meretricious and overwhelming financial juggernaut of the pharmaceutical industry, has resulted in Forced Drugging being by far the "path of least resistance."⁶⁶ In the *Myers* case described below, Dr. Loren Mosher testified by affidavit that as a therapeutic principle, "Involuntary treatment should be difficult to implement and used only in the direst of circumstances".⁶⁷ PsychRights' goal is to accomplish this therapeutic goal by making Forced "Treatment" more trouble than the more helpful alternatives that are currently eschewed. In that way, PsychRights hopes to create an environment in which these more helpful, more humane alternatives can flourish.

Of course, to the extent the system recognizes people have the right to decline medication⁶⁸ and provides the choices to which they are entitled before they can legally be forced to take these drugs, litigation would/will not be necessary. In the absence of this, however, there has been some litigation already undertaken and other contemplated.

(4) Undertaken Litigation

(a) Myers -- Forced Drugging

PsychRights' first case, *Myers v. Alaska Psychiatric Institute*,⁶⁹ directly challenging Alaska's Forced Drugging procedures, was decided by the Alaska Supreme Court on June 30, 2006.⁷⁰ In *Myers*, the trial court, after receiving expert testimony from Dr. Loren Mosher and Grace Jackson, as well as the State's psychiatrists, found as a factual matter:

⁶⁵ *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, Michael L. Perlin, *Houston Law Review*, 28 *Hous. L. Rev.* 63 (1991).

⁶⁶ While court ordered involuntary psychiatric drugging is the most dramatic, coercion to take these harmful drugs is pervasive. As mentioned before, people are told they will not get or will lose their housing if they don't "comply." Other services will be denied. People will be "violated" on parole (i.e., sent back to prison to complete their sentences) if they do not comply. Children are taken away from their parents if they are not given drugs. Children are taken away from parents if the parent(s) don't take the drugs and then they are taken away because the parent takes the drugs and becomes too mentally ill. And, of course, all of the current financing systems are primarily for medications.

⁶⁷ See, <http://psychrights.org/States/Alaska/CaseOne/30-Day/ExhibitRLRMosherAff.htm>.

⁶⁸ One normally sees this phrased as the right to "refuse" medication, but I find that a misleading and pejorative term that assumes exercising the right is a bad thing. People have the right to decline a medication recommendation and it should be phrased that way, in my view.

⁶⁹ See, <http://psychrights.org/States/Alaska/CaseOne.htm> for more information on this case, including the briefs and transcripts of some of the hearings. A video of the oral argument before the Alaska Supreme Court is also available upon request.

⁷⁰ 138 P.3d 238. A copy of the Decision is available at <http://psychrights.org/States/Alaska/CaseOne/MyersOpinion.pdf>.

[T]here is a real and viable debate among qualified experts in the psychiatric community regarding whether the standard of care for treating schizophrenic patients should be the administration of anti-psychotic medication

and

[T]here is a viable debate in the psychiatric community regarding whether administration of this type of medication might actually cause damage to her or ultimately worsen her condition

yet ordered involuntary drugging because the relevant statute only requires a finding of incompetence to decline the medication.⁷¹ We argued the Alaska and US constitutions require at least that there must be a finding the medication is in the person's best interest. More importantly for changing the system, we also argued involuntary medication can only be constitutionally administered if no less restrictive alternative could be offered.

The Alaska Supreme Court agreed, holding:

[B]efore a state may administer psychotropic drugs to a non-consenting mentally ill patient in a non-emergency setting, an independent judicial best interests determination is constitutionally necessary to ensure that the proposed treatment is actually the least intrusive means of protecting the patient.⁷²

This decision, of course, is very good. It respects people's rights and has created the legal foundation for the creation of alternatives by not allowing people to be locked up and forcibly drugged as easily as they are now. However, this is not enough. As discussed above, people's rights in these types of proceedings are dishonored as a matter of course. Unless legal rights are honored, the only impact of the *Myers* decision is likely to be the addition of two sentences to the forced drugging petition forms and court orders reciting it is in the person's best interests and there is no less restrictive alternative available. In order for *Myers* to be meaningful people need at least a reasonable level of legal representation.

(b) Wetherhorn -- Ineffective Assistance of Counsel

The *Wetherhorn* appeal is primarily about such representation, although there are a couple other issues in the case.⁷³ If people actually had vigorous representation, only a small fraction of those currently subjected to Involuntary Commitment and Forced Drugging would lose their cases. We are hoping to establish some minimum standards for the performance of counsel, and also that people are entitled to have an "expert witness" paid for, because without an "expert witness" to counter the state's "expert witness" (the psychiatrist), it is not a fair process. Other issues include the legally insufficient nature of the proceedings and the unconstitutionality of part of Alaska's "gravely disabled" grounds for Involuntary Commitment. We are also attempting to establish the right to attorneys fees in the event the State does not prevail on its petition(s) for involuntary commitment and/or forced drugging because if we can do so, it will

⁷¹ See, <http://psychrights.org/States/Alaska/CaseOne/30-Day/Order.pdf>, pages 8 and 13.

⁷² 138 P.3d at 250.

⁷³ More information on this case can be found at <http://psychrights.org/States/Alaska/CaseFour.htm>.

encourage members of the private bar to take some of these cases and adequately represent their clients.

(c) Bavilla -- Forced Drugging in Prison

In the *Bavilla* case, which challenges the procedures for Forced Drugging in prison, the Alaska Department of Corrections admitted to facts constituting violations of the United States Constitution.⁷⁴ However, the trial court dismissed the case on sovereign immunity grounds, meaning we should have sued the Commissioner of the Department of Corrections, rather than the state. It is very unclear the judge was correct about this, but we had successfully prevented Ms. Bavilla's Forced Drugging up to that point, the prison was putting intense pressure on her in its attempt to "break" her, and Ms. Bavilla declined to file an appeal or recommence the case. However, at an opportune time when we have the resources and a client, we have the admissions of the State regarding their illegal procedures and can commence a new case challenging Forced Drugging in prison here.

(5) Prospective Litigation

We also have a number of prospective issues identified for system changing litigation.

(a) Kids in Custody/Out of State Placements

The state takes custody of a large number of children, and is paying for over 400 in out of state facilities.⁷⁵ Based on what is happening in other states, one can assume well over half are being subjected to psychiatric drugging. Polypharmacy, which has never been approved, is rampant with kids as well as adults and most of the drugs have never even been approved for pediatric use. We know these drugs create structural changes in the brain,⁷⁶ but no one has any idea what these drugs are doing to the developing brains of our children. Whenever children are given drugs, they are being Force Drugged because they have no choice. It is especially egregious that those responsible for the well-being of children are blaming the children and subjecting them to the horrors of psychiatric drugging. When the resources are available to litigate, an appropriate case to challenge child in custody drugging practices may present itself. For example, is it legal for the state to drug kids in its custody with drugs that are not approved for pediatric use?

⁷⁴ More information on this case can be found at <http://psychrights.org/States/Alaska/CaseThree.htm>.

⁷⁵ See, <http://www.mltrust.org/documents/BringtheKidsHome.pdf>. The Trust has instituted a "Bring the Kids Home" initiative, but if that just means locking them up and drugging them in Alaska, rather than somewhere else, it is not a real solution.

⁷⁶ In fact most of the neuroimaging used by proponents of the drugs for the proposition that people with mental illness have brain differences really show the effects of the drugs. See, e.g., Broken Brains or Flawed Studies? A Critical Review of ADHD Neuroimaging Research, by Jonathon Leo and David Cohen, *The Journal of Mind and Behavior*, Winter 2003, Volume 24, Number 1, pp 29-56, which can be accessed at <http://psychrights.org/Research/Digest/NLPs/criticalreviewofadhd.pdf>.

(b) In-State Residential Treatment Centers

In addition to kids who are in out of state residential treatment centers, many children are drugged on inpatient units or other residential settings in Alaska. North Star here in Anchorage is notorious for heavily drugging kids and engaging in polypharmacy. An appropriate case to challenge such practices when the resources are available to do so may present itself at any time. For example, is it child abuse to medicate kids with drugs that are not approved for pediatric use in the way it is now done?

(c) Elder Drugging Abuses

It has become increasingly common around the country for the elderly to be so medicated they can't get out of bed. It is likely that this occurs in Alaska also and an appropriate case may present itself when resources are available.

(d) Informed Consent

A choice to take psychiatric drugs is truly voluntary only if people are told the truth about the drugs. This is called informed consent. The truth, however, is uniformly not told, which constitutes a lack of informed consent. Alaska has a relatively explicit statute on informed consent in an inpatient setting.⁷⁷ We have had a complaint against API drafted for over two years now waiting for a suitable plaintiff.⁷⁸

(6) 42 USC 1983 Civil Rights Action(s)

Under the federal law, 42 USC §1983, it is illegal for anyone "acting under color of law" to deprive someone of their legal rights.⁷⁹ This law grants the right to injunctions and damages. In other words, API and its psychiatrists are liable for the way they violate the rights of their patients and an injunction against such violations should be available.⁸⁰ To the extent these illegal behaviors are not corrected through the other efforts outlined here, resort "Section 1983" in federal court to seek redress will be indicated. Challenging forced drugging in Alaska's prisons, for example, might be brought as such a civil rights case.

(7) Ethics Complaints.

It is apparent that the public defenders assigned to represent psychiatric respondents in Involuntary Commitment and Forced Drugging cases are violating their ethical obligations. If

⁷⁷ See, AS 47.30.837, which can be accessed at <http://touchngo.com/legentr/akstats/Statutes/Title47/Chapter30/Section837.htm>.

⁷⁸ See, <http://psychrights.org/States/Alaska/CaseTwo/draftInformedConsentComplaint.htm>.

⁷⁹ This is a simplification and more information about "Section 1983" rights can be found at <http://psychrights.org/Research/Legal/1983/1983.htm>.

⁸⁰ Yesterday PsychRights filed a Reply re: Motion for Attorney's Fees, which detail such illegal deprivation of rights in that case. This can be found at <http://psychrights.org/States/Alaska/CaseFour/AttysFees/attyFeeReply.pdf>. It is apparent such violations of rights are pervasive at API.

other means to obtain effective representation are not successful, it is likely ethics complaints will be filed.

(8) Strategy/Attorney Recruitment

The cases described above are designed to set precedent and consequently be system changing in that way. In addition to this, however, just having one serious representation of an API inmate⁸¹ per week, or even per month will substantially increase demands on state resources to involuntarily commit and Force Drug its inmates. In other words, make Forced "Treatment" not necessarily the path of least resistance. Serious representations involve depositions of the psychiatrist(s) and other treating personnel as well as potentially other witnesses, filing motions, etc. I make it a practice to elect the hearing be held in a real courtroom under AS 47.30.735(b)⁸² and, in my view, a jury trial should be demanded under AS 47.30.745(c)⁸³ for every 90-day commitment petition. The trials should last at least hours, if not days, rather than the approximately 15 minutes they do now. Objections should be made to unfavorable Probate Master recommendations.⁸⁴ Requests for emergency stays against Forced Drugging should be made.⁸⁵ Appeals should be taken when appropriate.⁸⁶ In 2004, I met with the Public Defender and the Assistant Public Defenders who normally handle these cases.⁸⁷ I gave them copies of *Mad in America* and informed them what I thought it took to adequately represent psychiatric defendants. It does not appear anything changed and when the opportunity arose, PsychRights appealed an involuntary commitment and Forced Drugging Order to try and obtain more than sham representation.⁸⁸

I think it is fair to say the all-out, four month legal battle that was the *Myers* case at the trial court⁸⁹ has had at least a minor impact. I have gotten people out or stopped Forced Drugging with a phone call or an e-mail in a few situations since then by suggesting the person

⁸¹ The American Heritage Dictionary, Fourth Edition, defines "inmate" as "A resident of a dwelling that houses a number of occupants, especially a person confined to an institution, such as a prison or hospital."

⁸² See, <http://www.touchngo.com/lglentr/akstats/Statutes/Title47/Chapter30/Section735.htm>.

⁸³ See, <http://www.touchngo.com/lglentr/akstats/Statutes/Title47/Chapter30/Section745.htm>.

⁸⁴ Under Alaska Statutes, the State must go to the Superior Court for involuntary commitment and Forced Drugging Orders. However, under the Alaska Court Rules, they can be assigned to a "Master" to conduct the hearings. (See, Alaska Probate Rule 2 & 2(b)(2)(C), which can be accessed at <http://www.state.ak.us/courts/prob.htm#2>. The Master, however, has limited authority, which is primarily to make recommendations that have to be approved (or not) by a Superior Court judge. The recommendations can be objected to (See, Probate Rule (2)(e)&(f)). It appears these recommendations are virtually never, if ever, objected to by the Public Defenders.

⁸⁵ Under Alaska Probate Rule 2(b)(3)(D), a Master's Forced Drugging order is effective prior to approval by the Superior Court, but under Alaska Probate Rule 2(f)(2) a stay may be requested. I question whether it is proper to make a Forced Drugging recommendation effective without a proper Superior Court order and this is a possible subject of appeal.

⁸⁶ An example of the lack of representation provided by the Public Defenders office is they have never appealed any involuntary commitment or Forced Drugging order.

⁸⁷ A copy of the discussion points for this meeting is available at <http://psychrights.org/states/Alaska/CaseFour/PDONotes.pdf>.

⁸⁸ See, <http://psychrights.org/States/Alaska/CaseFour.htm>.

⁸⁹ See, <http://psychrights.org/States/Alaska/CaseOne.htm>.

did not meet the legal criteria in a way that let the hospital know I would be getting involved in the case if they proceeded. If even a relatively small number of cases were vigorously defended, it could go a long way toward changing the "path of least resistance" to support choice.

There is, of course, a limit to what I can do by myself.

(a) Alaska *Pro Bono* Program

The Alaska Bar Association has a program to recruit *pro bono* attorneys to represent indigent people or people who otherwise can not afford legal representation. We have established contact with the Alaska *Pro Bono* Program, but time constraints have limited my ability to follow-up.

(b) Private Bar

In my view, psychiatrists and organizations who are harming people through their prescribing practices, including not telling the truth about the drugs, should be held accountable for such harm. The Internal Revenue Service does not consider damages cases (suing for money) to be a "charitable activity" appropriate for PsychRights and has indicated if I took such cases in my own law practice they would consider that I was using PsychRights' tax exempt status to further my own financial interests. In essence, I am prohibited from representing people in such cases. However, I can encourage and even assist other members of the private bar to do so.

(c) Attorney's Fees.

In the Wetherhorn case, which is an involuntary commitment and Forced Drugging case, we are asking for enhanced or full attorney's fees to try and establish that as a precedent as a way to discourage API's illegal practices and encourage other attorneys to take these cases.⁹⁰

(9) Educational Programs

Part of PsychRights' program is to provide information and education to attorneys, mental health system personnel, and the public.

(a) Website

PsychRights' website is very deep with information, including posting full articles and studies for use by attorneys and other people. Its Scientific Research by Topic⁹¹ and Articles⁹² web pages are particularly replete with important information from accepted sources. There are many other sections of the website, which is hopefully organized in a user-friendly manner and includes a section with information about various states.⁹³

⁹⁰ See, <http://psychrights.org/states/Alaska/CaseFour/FeeAppeal/Brief.pdf>.

⁹¹ <http://psychrights.org/Research/Digest/Researchbytopic.htm>.

⁹² <http://psychrights.org/Articles/articles.htm>.

⁹³ <http://psychrights.org/States/States.htm>.

(b) Mental Health Disability Law Conference

In September of 2003, with support from the Trust Authority, PsychRights brought up Robert Whitaker, author of *Mad in America*, and Professor Michael Perlin for a two day seminar on Mental Health Disability Law.⁹⁴ This seminar was well attended with a mix of mental health providers, mental health lawyers, judges and psychiatric survivors participating.

VII. FINAL THOUGHTS, ACKNOWLEDGMENTS, AND PERSONAL NOTES

This Report seems far too much "me, me, me," "I did this" and "I did that" and I fear it doesn't adequately credit all of the other terrific people who have been tirelessly working on these issues and projects, such as Michele Turner, Susan Musante, Andrea Schmook, Barry and Cathy Creighton, Eliza and Ted Eller, George Stone, Dr. Aron Wolf, Alma Menn, Mel Henry, Carl Ipock, Kelly Behen and Scot Wheat, Don Roberts, Esther Hopkins, Jamie Dakis, Roslyn Wetherhorn, Aleen Smith, Jerry Jenkins and Richard Rainery. I have no doubt failed to mention people that I should have.

I hope this Report conveys the urgency of addressing the situation. The scale of harm being done every day is enormous. Having become aware of this great harm, I am personally unwilling to stand by and am resolved to do everything I can to reduce, or better yet, eliminate it. The gross violations of rights contribute greatly to the problem, because it is the initial involuntary commitment and Forced Drugging that channel so many people into lifelong disability, largely caused by the debilitating drugs they are authoritatively, but erroneously told they must take for the rest of their lives. The failure of the system to address the problem reminds me of the reaction of the Alaska State Legislature in the late 70's when we told them, their "redesignation" (theft) of Mental Health Trust Lands was illegal. Their response was essentially "We don't care if it is illegal -- sue us." We did. This situation is far more important.

Of course, litigation is not a goal, it is a means to achieve a goal -- the goal of honoring people's right to choose a non-medication alternative to drugs that so many find debilitating, harmful and counter-productive. Instead of litigation, it is greatly preferable to work cooperatively towards achieving this goal. CHOICES and Soteria-Alaska are directly aimed at achieving this goal with Peer Properties playing more of a supporting role. It is my fervent hope we can begin taking these enormously important actions sooner rather than later. The stakes are too high, the human toll too great, to fail to do so.

⁹⁴ See, <http://psychrights.org/Education/ak03CLE/Brochure.htm>.

VIII. GLOSSARY

- "ACMHS" stands for Anchorage Community Mental Health Services, also known as Southcentral Counseling Center.
- "AHFC" stands for the Alaska Housing Finance Corporation.
- "Alaska Mental Health Board" is "the planning and coordinating agency for the purposes of federal and state laws relating to the mental health program of the state of Alaska. The purpose of the board is to assist the state in ensuring an integrated comprehensive mental health program." *See*, AS 47.30.661, which can be accessed at <http://www.touchngo.com/lglentr/akstats/Statutes/Title47/Chapter30/Section661.htm>. The Alaska Mental Health Board is one of the four boards which provide funding recommendations to the Alaska Mental Health Trust Authority. *See*, AS 47.30.666, which can be accessed at <http://www.touchngo.com/lglentr/akstats/Statutes/Title47/Chapter30/Section666.htm>.
- "Alaska Mental Health Trust Authority" *See* "Trust Authority" below.
- "API" stands for the Alaska Psychiatric Institute, which is the sole state psychiatric hospital.⁹⁵
- "Beneficiaries" means the beneficiaries of the Mental Health Lands Trust, which include (1) the mentally ill, (2) the mentally defective and retarded, (3) chronic alcoholics suffering from psychoses, and (4) senile people who as a result of their senility suffer major mental illness.⁹⁶
- "Budget Summit Report" is the report by the Budget Committee of the Alaska Mental Health Board, adopted by the full board in August of 2003. *See*, <http://akmheweb.org/Docs/AMHB/2003BudgetSummitReport.pdf>.
- "Consumer" means someone who is or has received mental health services, normally after being diagnosed with a serious mental illness.
- "Consumers Consortium" is the statewide group consisting of all Consumer run programs in the state. *See*, <http://akmheweb.org/Announcements/2002rfr/consortiumproposals.htm> for its initial set of proposals to the Alaska Mental Health Board.
- "Corpus" as employed herein is the principal amount of the Trust's endowment, as contrasted to the earnings or income. The corpus is not to be spent.

⁹⁵ There are, however, some "designated beds" in other hospitals and psychiatric units at other hospitals in Anchorage, Fairbanks and Juneau.

⁹⁶ *See*, AS 47.30.056(b)&(c), which can be accessed at <http://www.touchngo.com/lglentr/akstats/Statutes/Title47/Chapter30/Section056.htm>. *See*, also http://mhtrust.org/index.cfm?section=about_trust&page=Beneficiaries.

- "C/S/X" stands for Consumers of mental health services, Survivors of Psychiatry and eX-psychiatric patients and refers to people who have received mental health treatment. There has never been a consensus on what term should be used. Other terms that have been used include "users," "recipients," "patients," and "psychiatrized." In Alaska, because of the Mental Health Lands Trust, they are often called "beneficiaries."
- "Department" means the Alaska Department of Health and Social Services.
- "Mental Health Board." *See* Alaska Mental Health Board.
- "Mental Health Lands Trust Litigation" refers to the 15 year long litigation over the state of Alaska's "redesignation" (theft) of the one million acres of land granted to it in trust for Alaska's mental health program. <http://www.touchngo.com/lglcntr/spclint/mht.htm>.
- "MHA AK" stands for Mental Health Advocates of Alaska, a new member organization for Consumers intended to have substantial statewide membership.
- "NAMI" stands for the National Association for the Mentally Ill, which touts itself as "the Nation's Voice on Mental Illness." NAMI was founded by parents of people diagnosed with serious mental illness, is heavily financed by the pharmaceutical industry and vigorously pushes for more Forced Drugging.
- "NAMI-Alaska" is the statewide Alaska affiliate of NAMI. A majority of its board is currently Consumers, which allows it to access funding for Consumer run programs. NAMI-Alaska, as most of NAMI's affiliates, does not understand the extent to which NAMI is controlled by pharmaceutical funding nor the extent to which NAMI pushes Forced Drugging.
- "NARPA" stands for National Association of Rights Protection and Advocacy. *See*, <http://www.narpa.org/>.
- "Polypharmacy" is defined as the use of several drugs or medicines together in the treatment of disease, suggesting indiscriminate, unscientific, or excessive prescription. *See*, <http://classes.kumc.edu/som/amed900/polypharmacy/polypharmdrug.htm>.
- "Rasmuson Foundation" is the largest private foundation in Alaska and has made a number of mental health related grants. *See*, <http://rasmuson.org/>.
- "RECA" stands for Recovery Education Center for Alaska, which was formed to teach Mary Ellen Copeland's WRAP (Wellness Recovery Action Plan) program in Alaska. *See*, <http://copelandcenter.com/whatiswrap.html>.
- "RFP" means Request for Proposal, which is a notice of opportunity to apply for a grant.
- "Section 8 Vouchers" are United States Department of Housing and Urban Development low income housing subsidies.

- "SNHG" stands for Special Needs Housing Grant, which is funded by the Trust Authority and administered by the Alaska Housing Finance Administration.
- "Trust Authority" stands for the Alaska Mental Health Trust Authority, which was created in the settlement of the litigation over the Alaska Mental Health Lands Trust. *See*, <http://mhtrust.org/>.
- "TBGI" stands for Trust Beneficiary Group Initiative, which is an expansion by the Trust Authority of eligibility for funding of Consumer run programs formerly restricted to beneficiaries classified as mentally ill.
- "Trust Settlement" refers to the settlement of the litigation over the state of Alaska "redesignating" (i.e., "stealing") the one million acres of land granted in trust to Alaska's mental health program by the federal government. *See*, <http://www.touchngo.com/lglcntr/spelint/mht.htm>.

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Briefs and Other Related Documents

Wetherhorn v. Alaska Psychiatric Institute
 Alaska, 2007. Only the Westlaw citation is currently available.

NOTICE: THIS OPINION HAS NOT BEEN RELEASED FOR PUBLICATION IN THE PERMANENT LAW REPORTS. UNTIL RELEASED, IT IS SUBJECT TO REVISION OR WITHDRAWAL.

Supreme Court of Alaska.
 Roslyn WETHERHORN, Appellant,
 v.
 ALASKA PSYCHIATRIC INSTITUTE,
 Appellee.
 No. S-11939.

Jan. 12, 2007.

Background: Alleged mentally ill individual appealed from orders of the Superior Court, Third Judicial District, Anchorage. John Suddock, J., approving her involuntary commitment for 30 days and approving non-consensual administration of psychotropic medication.

Holdings: The Supreme Court, Fabe, J., held that:

(1) commitment statute was constitutional if construed to require level of incapacity so substantial that alleged mentally ill individual could not live safely outside of a controlled environment;

(2) factual allegations listed on petition for 30-day involuntary commitment were sufficient to afford notice as required by due process; and

(3) failure to provide visitor's report during hearing on petition for involuntary administration of psychotropic medication was plain error.

Affirmed in part and vacated in part.

[1] Appeal and Error 30 ↪842(1)

30 Appeal and Error

30XVI Review

0XVI(A) Scope, Standards, and Extent, in General

30k838 Questions Considered

30k842 Review Dependent on Whether Questions Are of Law or of Fact

30k842(1) k. In General. Most

Cited Cases

The Supreme Court applies its independent judgment to interpretation of the state constitution and statutes, adopting the rule of law that is most persuasive in light of precedent, reason, and policy.

[2] Mental Health 257A ↪45

257A Mental Health

257AII Care and Support of Mentally Disordered Persons

257AII(A) Custody and Cure

257Ak37 Admission or Commitment Procedure

257Ak45 k. Review. Most Cited Cases

Mental Health 257A ↪51.20

257A Mental Health

257AII Care and Support of Mentally Disordered Persons

257AII(A) Custody and Cure

257Ak51 Restraint or Treatment

257Ak51.20 k. Actions and Proceedings. Most Cited Cases

Factual findings in involuntary commitment or medication proceedings are reviewed for clear error, and the Supreme Court reverses only if its review of the record leaves us with a definite and firm conviction that a mistake has been made.

[3] Appeal and Error 30 ↪970(2)

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30 Appeal and Error
30XVI Review
30XVI(H) Discretion of Lower Court
30k970 Reception of Evidence
30k970(2) k. Rulings on Admissibility
of Evidence in General. Most Cited Cases

Appeal and Error 30 ⇨971(2)

30 Appeal and Error
30XVI Review
30XVI(H) Discretion of Lower Court
30k971 Examination of Witnesses
30k971(2) k. Competency of Witness.
Most Cited Cases

The superior court's decisions regarding the admissibility of evidence, including expert testimony, are generally reviewed for abuse of discretion.

[4] Appeal and Error 30 ⇨842(6)

30 Appeal and Error
30XVI Review
30XVI(A) Scope, Standards, and Extent, in
General
30k838 Questions Considered
30k842 Review Dependent on Whether
Questions Are of Law or of Fact

30k842(6) k. Admissibility and
Reception of Evidence. Most Cited Cases
If admissibility of evidence turns on a question of
law, the Supreme Court applies its independent
judgment.

[5] Mental Health 257A ⇨36

257A Mental Health
257AII Care and Support of Mentally
Disordered Persons
257AII(A) Custody and Cure
257Ak36 k. Persons Subject to Control or
Treatment. Most Cited Cases

Although state has a legitimate interest in providing
care to those who represent a threat to themselves or
the community, or who are unable to care for
themselves, mental illness alone is insufficient to
form a constitutionally adequate basis for
involuntary commitment.

[6] Mental Health 257A ⇨32

257A Mental Health
257AII Care and Support of Mentally
Disordered Persons
257AII(A) Custody and Cure
257Ak32 k. Constitutional and Statutory
Provisions. Most Cited Cases

Commitment statute was constitutional if construed
to require level of incapacity so substantial that
alleged mentally ill individual could not live safely
outside of a controlled environment. AS
47.30.915(7)(B).

[7] Constitutional Law 92 ⇨255(5)

92 Constitutional Law
92XII Due Process of Law
92k255 Deprivation of Life or Liberty in
General

92k255(5) k. Diseased and Mentally
Disordered Persons; Addicts. Most Cited Cases
Involuntary commitment implicates state's
constitutional guarantees of individual liberty and
privacy and therefore entitles alleged mentally ill
individual to due process protections. U.S.C.A.
Const.Amend. 14; Const. Art. 1, § 7.

[8] Appeal and Error 30 ⇨181

30 Appeal and Error
30V Presentation and Reservation in Lower
Court of Grounds of Review
30V(B) Objections and Motions, and Rulings
Thereon

30k181 k. Necessity of Objections in
General. Most Cited Cases
The Supreme Court will find plain error when there
is a high likelihood that injustice has resulted.

[9] Mental Health 257A ⇨45

257A Mental Health
257AII Care and Support of Mentally
Disordered Persons
257AII(A) Custody and Cure
257Ak37 Admission or Commitment
Procedure

257Ak45 k. Review. Most Cited Cases

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Failure to list witnesses in petition for involuntary commitment did not constitute plain error; although petition for 30-day commitment did not list any witnesses, petition was signed by two Alaska Psychiatric Institute (API) physicians, and only witness testifying before hearing was another API physician. AS 47.30.730(a)(6).

[10] Mental Health 257A ⇄38

257A Mental Health

257AII Care and Support of Mentally Disordered Persons

257AII(A) Custody and Cure

257Ak37 Admission or Commitment Procedure

257Ak38 k. Parties and Application.

Most Cited Cases

Petition for 30-day involuntary commitment, which described alleged mentally ill person as being in a "manic state, homeless and no insight and non med compliant," complied with statute requiring that petition allege "facts and specific behavior" supporting conclusion that alleged mentally ill individual met standards for commitment; statute did not articulate standard by which sufficiency of facts and behavior listed was to be judged. AS 47.30.730(a)(7).

[11] Constitutional Law 92 ⇄255(5)

92 Constitutional Law

92XII Due Process of Law

92k255 Deprivation of Life or Liberty in General

92k255(5) k. Diseased and Mentally Disordered Persons; Addicts. Most Cited Cases

Mental Health 257A ⇄38

257A Mental Health

257AII Care and Support of Mentally Disordered Persons

257AII(A) Custody and Cure

257Ak37 Admission or Commitment Procedure

257Ak38 k. Parties and Application.

Most Cited Cases

Factual allegations listed on petition for 30-day

involuntary commitment, listing alleged mentally ill individual's current manic state, state of homelessness, lack of insight, and failure to take her prescribed medication for last three months, were sufficient to afford notice as required by due process; petition and notice of hearing were reasonably calculated to inform individual of nature and purpose of commitment hearing, petition listed "facts and specific behavior" to be raised at hearing, and information was sufficiently detailed to allow individual to prepare for hearing. U.S.C.A. Const.Amend. 14; Const. Art. 1, § 7; AS 47.30.730(a)(7).

Factual allegations listed on petition for 30-day involuntary commitment, listing alleged mentally ill individual's current manic state, state of homelessness, lack of insight, and failure to take her prescribed medication for last three months, were sufficient to afford notice as required by due process; petition and notice of hearing were reasonably calculated to inform individual of nature and purpose of commitment hearing, petition listed "facts and specific behavior" to be raised at hearing, and information was sufficiently detailed to allow individual to prepare for hearing. U.S.C.A. Const.Amend. 14; Const. Art. 1, § 7; AS 47.30.730(a)(7).

[12] Constitutional Law 92 ⇄251.6

92 Constitutional Law

92XII Due Process of Law

92k251.6 k. Notice and Hearing. Most Cited Cases

As a general principle, due process requires that the notice of a hearing must be appropriate to the occasion and reasonably calculated to inform the person to whom it is directed of the nature of the proceedings. U.S.C.A. Const.Amend. 14; Const. Art. 1, § 7.

[13] Constitutional Law 92 ⇄255(5)

92 Constitutional Law

92XII Due Process of Law

92k255 Deprivation of Life or Liberty in General

92k255(5) k. Diseased and Mentally

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Disordered Persons; Addicts. Most Cited Cases
 Due process requires that a subject of involuntary commitment proceeding be notified in such a manner that the subject has a reasonable opportunity to prepare. U.S.C.A. Const.Amend. 14; Const. Art. 1, § 7.

[14] Action 13 ⇌6

13 Action

131 Grounds and Conditions Precedent

13k6 k. Moot, Hypothetical or Abstract Questions. Most Cited Cases

A claim is moot if it is no longer a present, live controversy, and the party bringing the action would not be entitled to relief, even if it prevails.

[15] Action 13 ⇌6

13 Action

131 Grounds and Conditions Precedent

13k6 k. Moot, Hypothetical or Abstract Questions. Most Cited Cases

Three factors in determining whether public interest exception to mootness doctrine applies are: (1) whether the disputed issues are capable of repetition; (2) whether the mootness doctrine, if applied, may cause review of the issues to be repeatedly circumvented; and (3) whether the issues presented are so important to the public interest as to justify overriding the mootness doctrine.

[16] Mental Health 257A ⇌45

257A Mental Health

257AII Care and Support of Mentally Disordered Persons

257AII(A) Custody and Cure

257Ak37 Admission or Commitment Procedure

257Ak45 k. Review. Most Cited Cases

Supreme Court would not consider, pursuant to public interest exception to mootness doctrine, claim by alleged mentally ill individual, who was involuntarily committed for 30 days, that evidence presented at hearing was insufficient to establish that she met standards for commitment; facts supporting commitment were all specific to individual's condition immediately before and at

time of hearing, and if it were to become necessary to seek individual's commitment again, hearing would be based on different set of facts specific to different circumstances, and thus, issue was not capable of repetition. AS 47.30.735(c).

[17] Mental Health 257A ⇌51.20

257A Mental Health

257AII Care and Support of Mentally Disordered Persons

257AII(A) Custody and Cure

257Ak51 Restraint or Treatment

257Ak51.20 k. Actions and Proceedings. Most Cited Cases

Failure to provide visitor's report during hearing on petition for involuntary administration of psychotropic medication was plain error, thus requiring vacating of order approving non-consensual administration of psychotropic medication; since situation was non-emergency situation, there was no reason to neglect statutory protections in interests of speed, and visitor's report was essential to court's mandatory duty to determine whether individual was presently competent to provide informed consent or, if not competent, to decide whether individual was competent to provide informed consent at time of previously expressed wishes to refuse medication. AS 47.30.839(d).

[18] Mental Health 257A ⇌51.20

257A Mental Health

257AII Care and Support of Mentally Disordered Persons

257AII(A) Custody and Cure

257Ak51 Restraint or Treatment

257Ak51.20 k. Actions and Proceedings. Most Cited Cases

For purposes of involuntary administration of psychotropic medication, court must in non-emergency cases make specific findings: (1) that patient is incapable of giving or withholding informed consent and has not made a previous statement while competent expressing a choice; (2) that the proposed treatment is in patient's best interest; and (3) that no less intrusive alternative is available. AS 47.30.839(d).

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[19] Mental Health 257A ↔51.20

257A Mental Health
257AII Care and Support of Mentally
Disordered Persons
257AII(A) Custody and Cure
257Ak51 Restraint or Treatment
257Ak51.20 k. Actions and
Proceedings. Most Cited Cases
Failure to swear in witness at hearing on petition for
30 days involuntary commitment and petition for
involuntary administration of psychotropic
medication did not constitute plain error; purpose of
evidence rule requiring every witness to declare that
he or she will testify truthfully was satisfied by
master's reminder to witness that he had been
previously sworn and remained under oath, and no
injustice was shown to have resulted. Rules of
Evid., Rule 603.

[20] Mental Health 257A ↔45

257A Mental Health
257AII Care and Support of Mentally
Disordered Persons
257AII(A) Custody and Cure
257Ak37 Admission or Commitment
Procedure
257Ak45 k. Review. Most Cited Cases

Mental Health 257A ↔51.20

257A Mental Health
257AII Care and Support of Mentally
Disordered Persons
257AII(A) Custody and Cure
257Ak51 Restraint or Treatment
257Ak51.20 k. Actions and
Proceedings. Most Cited Cases
Supreme Court would decline to address merits of
claim of alleged mentally ill individual, that she was
deprived of her right to counsel during hearing on
petition for 30 days involuntary commitment and
petition for involuntary administration of
psychotropic medication, where no record had been
developed and claim could not be effectively
reviewed for first time on appeal. U.S.C.A.
Const.Amend. 6;AS 47.30.725(d).

[21] Constitutional Law 92 ↔255(5)

92 Constitutional Law
92XII Due Process of Law
92k255 Deprivation of Life or Liberty in
General
92k255(5) k. Diseased and Mentally
Disordered Persons; Addicts. Most Cited Cases

Mental Health 257A ↔41

257A Mental Health
257AII Care and Support of Mentally
Disordered Persons
257AII(A) Custody and Cure
257Ak37 Admission or Commitment
Procedure
257Ak41 k. Hearing and Determination
in General. Most Cited Cases

Mental Health 257A ↔51.20

257A Mental Health
257AII Care and Support of Mentally
Disordered Persons
257AII(A) Custody and Cure
257Ak51 Restraint or Treatment
257Ak51.20 k. Actions and
Proceedings. Most Cited Cases
Since fundamental rights to liberty and to privacy of
alleged mentally ill individual are infringed upon by
involuntary commitment and involuntary
administration of psychotropic medication
proceedings, the right to counsel in civil
proceedings is guaranteed by the due process clause
of state constitution. U.S.C.A. Const.Amends. 6, 14
; Const. Art. 1, § 7; AS 47.30.725(d).

Since fundamental rights to liberty and to privacy of
alleged mentally ill individual are infringed upon by
involuntary commitment and involuntary
administration of psychotropic medication
proceedings, the right to counsel in civil
proceedings is guaranteed by the due process clause
of state constitution. U.S.C.A. Const.Amends. 6, 14
; Const. Art. 1, § 7; AS 47.30.725(d).

[22] Trial 388 ↔107

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388 Trial

388V Arguments and Conduct of Counsel

388k107 k. Representation of Party by Counsel. Most Cited Cases

Whenever the right to counsel is constitutionally guaranteed in a particular proceeding, the effective assistance of counsel is also constitutionally required. U.S.C.A. Const.Amend. 6.

James B. Gottstein, Law Project for Psychiatric Rights, Inc., Anchorage, for Appellant.

Laura C. Bottger, Assistant Attorney General, Anchorage, and David W. Márquez, Attorney General, Juneau, for Appellee.

Before: BRYNER, Chief Justice, MATTHEWS, EASTAUGH, FABE, and CARPENETI, Justices.

OPINION

FABE, Justice.

I. INTRODUCTION

*1 Roslyn Wetherhorn appeals two superior court orders: one approving her involuntary commitment for thirty days and the other approving the non-consensual administration of psychotropic medication. Wetherhorn challenges the constitutionality of the statute relied on by the court to order her involuntary commitment. She also raises due process and evidentiary challenges to both orders. We conclude that the commitment statute is constitutional if construed to require a level of incapacity so substantial that the respondent cannot survive safely in freedom. And because the other related challenges to the commitment order are either improperly preserved or without merit, we affirm the granting of the petition for thirty-day commitment. But because the master's action in granting a petition for the administration of psychotropic medication before a visitor's report had been prepared or provided constitutes plain error, we vacate the order granting that petition.

II. FACTS AND PROCEEDINGS

On April 4, 2005 Dr. M. Lee of Valley Hospital

initiated an application for the examination of Wetherhorn pursuant to AS 47.30.705. Alaska Statute 47.30.705 allows a person to be taken into custody and delivered to the nearest evaluation facility.^{FN1} Dr. Lee's application stated that Wetherhorn was mentally ill and gravely disabled and that considerations of safety did not allow the initiation of involuntary commitment proceedings.

On April 5, 2005, Dr. John McKean filed an ex parte petition for initiation of involuntary commitment pursuant to AS 47.30.710(b). Alaska Statute 47.30.710(b) allows emergency hospitalization if, after examination, a person is found to be mentally ill, causing the person to be gravely disabled or to present a likelihood of serious harm to self or others, and to be in need of treatment.^{FN2} Dr. McKean wrote that Wetherhorn was in a "manic state [,] homeless and non medication compliant x 3 months" in support of the petition. Superior Court Judge Philip Volland granted the petition the same day.

Also on April 5, 2005, Dr. McKean and Dr. Laurel Silberschmidt filed a petition for thirty-day commitment, averring that Wetherhorn was mentally ill and as a result was both "likely to cause harm to [herself] or others" and "gravely disabled." The supporting facts were stated as "[m]anic state [,] homeless and no insight and non med compliant x 3 months." No prospective witnesses were listed in the space provided. The case was assigned to Superior Court Judge John Suddock and to Probate Master John E. Duggan.

On April 15, 2005, Dr. Jan Kiele filed a petition for the administration of psychotropic medication. Master Duggan issued a notice of hearing and order for appointment of court visitor on the same day, appointing the Office of Public Advocacy (OPA) as court visitor and the Public Defender Agency as counsel for Wetherhorn. This notice also set the hearing on the involuntary medication petition for 1:30 p.m. that same afternoon. As a result, the hearings on both the petition for thirty-day commitment and the petition for the administration of psychotropic medication were held on the same day.

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*2 The combined hearing on April 15, 2005 lasted approximately fifteen minutes. During this hearing, the psychiatrist who testified was not separately sworn or qualified as an expert because his qualifications were carried over from a previous case. There was no oral or written report presented by the court visitor as required under AS 47.30.839(d).^{FN3}

On April 27, 2005, Judge Suddock issued written orders granting both petitions, *nunc pro tunc* to April 15, 2005. This appeal followed.

III. STANDARD OF REVIEW

[1][2][3][4] We apply our independent judgment to the interpretation of the Alaska Constitution^{FN4} and statutes,^{FN5} adopting "the rule of law that is most persuasive in light of precedent, reason, and policy."^{FN6} Factual findings in involuntary commitment or medication proceedings are reviewed for clear error, and we reverse only if our review of the record leaves us with a definite and firm conviction that a mistake has been made.^{FN7} The question whether factual findings comport with the requirements of AS 47.30 presents a legal issue, which we review *de novo*.^{FN8} The superior court's decisions regarding the admissibility of evidence, including expert testimony, are generally reviewed for abuse of discretion.^{FN9} If admissibility of evidence turns on a question of law, we apply our independent judgment.^{FN10}

IV. DISCUSSION

Wetherhorn challenges both the petition for thirty-day commitment and the petition for the administration of psychotropic medication. Wetherhorn also raises a claim of ineffective assistance of counsel and challenges the qualifications and testimony of the witness in the hearing on both petitions. We first address Wetherhorn's constitutional, procedural, and evidentiary challenges to the petition for thirty-day commitment. We then address Wetherhorn's challenges to the petition for the administration of psychotropic medication.^{FN11} Finally, we address the

claims of ineffective assistance of counsel and alleged errors in the admission of witness testimony.

A. The Petition for Thirty-Day Commitment

1. The constitutionality of AS 47.30.915(7)(B)

[5] The United States Supreme Court has characterized involuntary commitment for a mental disorder as a "massive curtailment of liberty"^{FN11} that cannot be accomplished without due process of law.^{FN12} Although the State has a legitimate interest in providing care to those who represent a threat to themselves or the community, or who are unable to care for themselves,^{FN13} mental illness alone is insufficient to form a constitutionally adequate basis for involuntary commitment.^{FN14} The Supreme Court has therefore determined that before a person can be involuntarily committed, the court must find in addition to mental illness either: (1) that the person presents a danger to self or others; or (2) that the person is "helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends."^{FN15} The precise wording of these two additional requirements is left to the states, "so long as they meet the constitutional minimum."^{FN16}

*3 The two findings required in addition to a finding of mental illness are each aimed at different types of harm. The first finding, of "danger to self or others," is concerned with active forms of harm, where the respondent has demonstrated the affirmative ability or inclination to inflict harm to self or another person.^{FN17} The second finding is concerned with a more passive condition, whereby the respondent is so unable to function that he or she cannot exist safely outside an institutional framework due to an inability to respond to the essential demands of daily life.^{FN18}

Alaska statutes address both types of harm. Alaska Statute 47.30.735(c) permits the court to "commit the respondent to a treatment facility for not more than thirty days if it finds, by clear and convincing evidence, that the respondent is mentally ill and as a result is likely to cause harm to the respondent or

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others or is gravely disabled." In this case, Wetherhorn was found to be gravely disabled.

Alaska Statute 47.30.915(7) defines "gravely disabled" as follows:

(7) "gravely disabled" means a condition in which a person as a result of mental illness

(A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or

(B) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently[.]

Wetherhorn concedes that subsection A is constitutional, but she challenges subsection B's definition of "gravely disabled" as reflecting a standard insufficient to justify the curtailment of liberty involved in involuntary commitment.

Subsection B was added to AS 47.30.915(7) by the legislature in 1984.^{FN19} The addition was part of a major revision of the civil commitment statutes undertaken "to more adequately protect the legal rights of persons suffering from mental illness."^{FN20} In testimony before the House Health, Education and Social Services Standing Committee discussion on the revisions, the Director of the Division of Mental Health and Developmental Disabilities of the Department of Health and Social Services explained that the then-current law only allowed Alaska Psychiatric Institute (API) to hold people with violent tendencies and that the addition of the "gravely disabled" language would allow API "to hold people that need to [be held], but haven't shown a violent tendency enough to hold them. There is a very significant number who don't fit into [the] present standard, but can walk out."^{FN21} The expert concluded, "[o]ur hands are tied behind our back, when [a] patient walks out. We only attempt to hold people who are gravely in danger."^{FN22} The committee discussion reveals that the gravely disabled language was added "so that a person can be committed before it's too late."^{FN23} The

addition of subsection B was thus intended to broaden the scope of civil commitment standards in order to reach those persons in need of treatment who did not fit within the pre-1984 statutory criteria, which required a showing of violent tendencies before a person could be held involuntarily.^{FN24}

*4 Essentially, then, the dispute between Wetherhorn and API is whether API must wait until the danger caused by a person's mental illness rises to the level indicated by AS 47.30.915(7)(A) before a person may be involuntarily committed. According to Wetherhorn, "only the level of harm described in [AS 47.30.915(7)(A)], i.e., 'serious accident, illness, or death highly probable if care by another is not taken,' is sufficient to justify the 'massive curtailment of liberty' which is involuntary commitment." API, on the other hand, relies on language in *Addington v. Texas*, which states that a person need only pose "some danger" to self or others^{FN25} to argue that the commitment standard has been properly expanded. We disagree with both arguments.

API's citation to *Addington's* use of the phrase "some danger"^{FN26} ignores the United States Supreme Court's repeated admonition that, given the importance of the liberty right involved, a person may not be involuntarily committed if they "are dangerous to no one and can live safely in freedom."^{FN27} This standard is certainly higher than the requirement that a person merely present "some danger" to herself. API allows that the language of subsection B requires that the respondent must suffer distress that rises to the level of "genuine and serious suffering." Moreover, the plain language of subsection B requires that there be a "significant" impairment causing a "substantial" deterioration.^{FN28} Given that subsection B was added nearly ten years after *O'Connor v. Donaldson*,^{FN29} the plain language of the statute requiring a "substantial deterioration of the person's previous ability to function independently"^{FN30} appears to respond to *O'Connor's* direction that the State "cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom."^{FN31}

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We furthermore agree with the Supreme Court of Washington that “[i]t is not enough to show that care and treatment of an individual’s mental illness would be preferred or beneficial or even in his best interests.”^{FN32} Indeed, AS 47.30.730 does require more than a best interests determination. For example, it requires that the petition for commitment “allege that the evaluation staff has considered but has not found that there are any less restrictive alternatives available”^{FN33} and “allege with respect to a gravely disabled respondent that there is reason to believe that the respondent’s mental condition could be improved by the course of treatment sought.”^{FN34} As further protection, the statute directs the court to make its findings by “clear and convincing” evidence.^{FN35}

[6] We conclude that in order to be constitutional, AS 47.30.915(7)(B) must be construed so that the “distress” that justifies commitment refers to a level of incapacity that prevents the person in question from being able to live safely outside of a controlled environment. This construction of the statute is necessary not only to protect persons against the “massive curtailment of liberty”^{FN36} that involuntary commitment represents, but also to protect against a variety of dangers particular to those subject to civil commitment. For example, there is a danger that the mentally ill may be confined merely because they are “physically unattractive or socially eccentric”^{FN37} or otherwise exhibit “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.”^{FN38} A similar concern with the perils of imposing majoritarian values forbids civil commitment to be based on the justification that a person would thereby enjoy a higher standard of living because, as the *O’Connor* Court explained, mental illness, without more, “does not disqualify a person from preferring his home to the comforts of an institution.”^{FN39} The level of incapacity represented by AS 47.30.915(7)(B) must be such so as to justify the social stigma that affects the social position and job prospects of persons who have been committed because of mental illness.^{FN40} So construed, AS 47.30.915(7)(B) is constitutional.

*5 Wetherhorn additionally argues that AS 47.30.915(7)(B) is unconstitutional because it does not require that the danger be “imminent.” She relies on *Suzuki v. Yuen*, in which a Hawaii civil commitment statute was determined to be unconstitutional because it “failed to specify that the ‘danger’ to self or others be imminent.”^{FN41} But the United States Supreme Court has not made imminence a requirement.^{FN42} We have not yet addressed the question whether the concept of imminence is compatible with the passive nature of harm reflected in the “gravely disabled” definition or whether the “facts and specific behavior of the respondent” required by AS 47.30.730(a)(7) must include recent acts.^{FN43} But we need not address those issues here, because the facts alleged in this case were drawn from the recent past. The petition stated that Wetherhorn had shown a manic state, a lack of insight, and non-compliance with her medication for the past three months. And during the hearing, Dr. Kiele testified that Wetherhorn remained confused and agitated and that her difficulties with insight had not changed since she had been at the hospital. He further noted that she had struck people and therefore presented “a direct risk of harm to others and more of an indirect risk of harm to herself.” Because all these examples of specific behavior were drawn from the recent past, they were sufficient to meet the evidentiary standards established by those states that have addressed the question of imminence.^{FN44}

2. Procedural due process concerns

[7][8] Having concluded that AS 47.30.915(7)(B) is constitutional if construed to require a level of incapacity so substantial that the respondent is not “capable of surviving safely in freedom,”^{FN45} we now address Wetherhorn’s procedural due process challenges to the petition for thirty-day commitment. Involuntary commitment implicates Alaska’s constitutional guarantees of individual liberty^{FN46} and privacy^{FN47} and therefore entitles the respondent to due process protections.^{FN48} But in this case, these procedural issues were not raised below and are therefore waived unless they constitute plain error.^{FN49} We will find plain error when there is a “high likelihood that injustice

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has resulted.”^{FN50}

[9] Alaska Statute 47.30.730(a)(6) requires a petition for involuntary commitment to “list the prospective witnesses who will testify in support of commitment or involuntary treatment.” The petition in this case did not list any witnesses. API concedes that the petition failed to satisfy the statutory requirements. Although Wetherhorn did not object to this error during the hearing, she now argues that the failure to list witnesses amounts to plain error.

But it is unclear what prejudice resulted from the failure to list witnesses in this case. Here, the petition for thirty-day commitment was signed by two API physicians and the only witness testifying before the hearing was another API physician. As API puts it, “[t]hat a psychiatrist from API would testify in support of a petition initiated by API could surprise no one.” We therefore conclude that the failure to list witnesses in this case does not constitute plain error.

*6 Wetherhorn also claims that the requirements of AS 47.30.730(a)(7) were not fulfilled. Alaska Statute 47.30.730(a)(7) requires a petition for thirty-day commitment to list the facts and specific behavior that support the petition for involuntary commitment. The commitment petition in this case states: “Manic state[,] homeless and no insight and non med compliant x 3 months.” Wetherhorn argues both that this statement was inadequate to support the petition and that it constituted a due process violation because the sentence did not afford her meaningful notice or a meaningful opportunity to respond. Again, because Wetherhorn did not raise this objection below, we review her complaints under the plain error standard.

[10][11] In her challenge to the sufficiency of the language on the petition, Wetherhorn argues that the list of facts and specific behaviors on the petition must: “(1) be sufficient, without supplementation, to entitle the petitioner to the granting of the petition as a matter of law, and (2) to at least summarize all of the evidence the state intends to put on in its case in chief.” But Wetherhorn’s proposed requirements go far beyond what Alaska statutes require. Alaska Statute

47.30.730(a)(7) merely requires that the petition allege “facts and specific behavior” supporting the conclusion that the respondent meets the standards for commitment and does not articulate the standard by which the sufficiency of the facts and behavior listed is to be judged. And because whether a person is actually committed depends on the hearing, not on the petition standing alone,^{FN51} there is no reason to require that the petition summarize all the evidence or be sufficient in itself to entitle the petitioner to a grant of the petition as a matter of law.

[12][13] Wetherhorn’s second argument is that the factual allegations listed on the petition were insufficient to afford notice as required by due process. As a general principle, due process “requires that the notice of a hearing must be appropriate to the occasion and reasonably calculated to inform the person to whom it is directed of the nature of the proceedings.”^{FN52} Due process also requires that a respondent be notified in such a manner that respondent has a reasonable opportunity to prepare.^{FN53} Here, the petition and notice of hearing were reasonably calculated to inform Wetherhorn of the nature and purpose of the commitment hearing. The petition listed the “facts and specific behavior” to be raised at the hearing: Wetherhorn’s (1) current manic state; (2) state of homelessness; (3) lack of insight; and (4) failure to take her prescribed medication for the last three months. We conclude that no prejudice resulted because this information was sufficient to inform Wetherhorn of the purpose of the hearing, the statutory scheme and evidentiary standard to be applied, and the kind of facts to be adduced at the hearing. It was sufficiently detailed to allow her to prepare for the hearing.

3. Evidentiary challenges to the petition for thirty-day commitment

*7 [14][15] Finally, Wetherhorn contends that the evidence presented at the hearing was insufficient to establish that she met the standards for commitment under the clear and convincing standard required by AS 47.30.735(c). But the thirty-day period for which Wetherhorn was committed has long since

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passed, and the question is thus moot. "A claim is moot if it is no longer a present live controversy, and the party bringing the action would not be entitled to relief, even if it prevails." ^{FN54} We will, however, consider a question otherwise moot if it falls within the public interest exception to the mootness doctrine. The three factors in determining whether the public interest exception applies are: "(1) whether the disputed issues are capable of repetition, (2) whether the mootness doctrine, if applied, may cause review of the issues to be repeatedly circumvented, and (3) whether the issues presented are so important to the public interest as to justify overriding the mootness doctrine." ^{FN55}

[16] In this case, Wetherhorn was committed based on a specific set of facts that amounted to a finding that she was gravely disabled. For example, her beliefs that the owner of the local grocery store was going to transport her to the Pope's funeral and that she had bought a church indicated that she lacked insight. She was diagnosed with bipolar disorder, the most recent episode of which was manic. She had also struck people at the hospital and was alternately confused and agitated and had trouble sleeping. At her hearing, Wetherhorn told the master that she wanted to stay at the hospital "until I get well, until I'm stabler than I am now." These facts are all specific to Wetherhorn's condition immediately before and at the time of her hearing. If it were to become necessary to seek Wetherhorn's commitment again, the hearing would be based on a different set of facts specific to different circumstances. It is unclear how two different hearings based on different facts and circumstances could be compared, and thus the factual questions are not capable of repetition. Because the issue here is not capable of repetition, the public interest exception to the mootness doctrine does not apply, and we refrain from considering this issue.

B. The Petition for Administration of Psychotropic Medication

Wetherhorn raises two challenges specific to the petition for the administration of psychotropic medication. Both of these challenges are affected by our decision in *Myers v. Alaska Psychiatric*

Institute, ^{FN56} which had not yet been decided at the time of Wetherhorn's hearing.

1. The failure to submit a visitor's report

[17] Alaska Statute 47.30.839(d) provides that when a petition for the involuntary administration of medication is filed, the court must direct OPA "to provide a visitor to assist the court in investigating the issue of whether the patient has the capacity to give or withhold informed consent to the administration of psychotropic medication." Here, the superior court appointed OPA, as required, but no visitor's report was presented during the hearing and there was no reason given for the failure to present it. API concedes that an "obvious mistake was made with regard to the statutorily-required court visitor report" and agrees that the requirement of a visitor's report is mandatory. API nevertheless attempts to explain that the lack of a visitor's report was an "inevitable and regrettable consequence of the timing of events," because in Wetherhorn's case the hearing was held on the same day that the petition was filed and OPA was appointed as visitor. API insists that "[t]his schedule permitted no time for the court visitor to fulfill its statutory obligation."

*8 But this was a petition for the involuntary administration of psychotropic medication in a non-emergency situation. Unlike involuntary commitment petitions, ^{FN57} there is no statutory requirement that a hearing be held on a petition for the involuntary administration of psychotropic drugs within seventy-two hours of a respondent's initial detention. The expedited process required for involuntary commitment proceedings is aimed at mitigating the infringement of the respondent's liberty rights that begins the moment the respondent is detained involuntarily. In contrast, so long as no drugs have been administered, the rights to liberty and privacy implicated by the right to refuse psychotropic medications ^{FN58} remain intact. Therefore, in the absence of an emergency, there is no reason why the statutory protections should be neglected in the interests of speed. As API itself concedes, a hearing on a medication petition should be continued rather than proceed without a visitor's

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report.

Furthermore, the court visitor's report is no mere technical requirement. As we explained in *Myers*, psychotropic medications are "highly intrusive" medications^{FN59} and have been equated with the "intrusiveness of electroconvulsive therapy and psychosurgery."^{FN60} Alaska requires a two-step process before psychotropic drugs may be administered involuntarily in a non-crisis situation: the State must first petition for the respondent's commitment to a treatment facility,^{FN61} and then petition the court to approve the medication it proposes to administer.^{FN62} The second step requires that the State prove by clear and convincing evidence that: (1) the committed patient is currently unable to give or withhold informed consent;^{FN63} and (2) the patient never previously made a statement while competent that reliably expressed a desire to refuse future treatment with psychotropic medication.^{FN64} In order that the court may make an informed decision concerning these two issues, the court visitor is appointed "to assist the court in investigating the issue of whether the patient has the capacity to give or withhold informed consent" by evaluating "the patient's responses to a capacity assessment instrument administered at the request of the visitor"^{FN65} and to document "any expressed wishes of the patient regarding medication, including wishes that may have been expressed in a power of attorney, a living will, an advance health care directive ..., or oral statements of the patient."^{FN66} The visitor's report is therefore essential to the court's mandatory duty to determine whether the patient is presently competent to provide informed consent^{FN67} or, if the patient is determined not to be presently competent, to decide whether the patient was competent to provide informed consent at the time of previously expressed wishes to refuse psychotropic medication.^{FN68} The prejudice to the respondent whose case is decided without the visitor's report is clear. Because the visitor's report is an essential component of the statutory scheme, the failure to prepare and present the report before the hearing in Wetherhorn's case is an instance of plain error.

2. Evidentiary challenges to the petition for the involuntary administration of psychotropic medication

*9 [18] Wetherhorn additionally argues that the evidence presented with regard to the petition for the involuntary administration of psychotropic medication was insufficient to meet the clear and convincing standard. As an initial matter, the issue is again moot with regard to Wetherhorn because the facts given in support of the need for medication are specific to a certain time and place as was the case of the petition for thirty-day commitment. Nevertheless, in light of our decision in *Myers*, the court must in non-emergency cases make specific findings: (1) that the respondent is incapable of giving or withholding informed consent and has not made a previous statement while competent expressing a choice; (2) that the proposed treatment is in the respondent's best interest; and (3) that no less intrusive alternative is available.^{FN69}

C. Remaining Procedural Challenges

The master addressed the petition for thirty-day commitment and the petition for the administration of psychotropic medication in the same hearing. We now turn to Wetherhorn's challenges to the procedures followed in that hearing.

1. Failure to swear in and qualify the witness as an expert

[19] Dr. Jan Kiele was the sole witness to testify at the hearing on the two petitions. At the beginning of the hearing, Master Duggan stated that "Dr. Kiele has previously been sworn, so just a reminder that he is still under oath. And also, he's been qualified as an expert in the field of psychiatry." Although Wetherhorn did not object to this method of reminding Dr. Kiele that he remained under oath at the hearing, Wetherhorn now argues that the failure to require Dr. Kiele to give an oath before each case and to qualify him as an expert in her particular case constituted plain error.

Alaska Evidence Rule 603 requires every witness

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to declare that he or she will testify truthfully. The intent of the rule is expressed in its requirement that a witness be sworn in a manner "calculated to awaken the witness' conscience and impress the witness' mind with the duty to [testify truthfully]." ^{FN70} This purpose was satisfied by the master's reminder to Dr. Kiele that he had been previously sworn and remained under oath. Furthermore, Wetherhorn makes no argument or showing that injustice resulted from the failure to swear in Dr. Kiele. Because the intent of the rule was satisfied and because no injustice was shown to have resulted, we conclude that the failure to swear in Dr. Kiele in this case does not constitute plain error.

Alaska Evidence Rule 702(a) requires that a witness be qualified as an expert before proceeding to provide expert opinion testimony. ^{FN71} Wetherhorn argues that the failure to qualify Dr. Kiele during her hearing constitutes error because no record was produced from which the trial or appellate courts could determine that his qualifications were proper. But Wetherhorn does not argue that a psychiatrist working for API would not be qualified as an expert in psychiatry or that a psychiatrist already qualified as an expert in another case would fail to be similarly qualified in her case. Dr. Kiele also made no attempt to hide his limited knowledge of Wetherhorn's case. Because it is unclear what injustice resulted from the failure to qualify the API psychiatrist, we conclude that it did not constitute plain error.

2. Ineffective assistance of counsel

*10 [20] Wetherhorn additionally contends that she was deprived of her right to counsel during the hearing because her counsel failed to deploy a number of strategies that may have changed the outcome of the hearing. She raises this claim for the first time on appeal. The right to counsel provided for in AS 47.30.725(d) necessarily includes both the right to effective counsel and the right to challenge court orders based on a claim of ineffective assistance of counsel. But because such a claim cannot be effectively reviewed for the first time on appeal, we decline to address the merits of the claim in this case.

[21][22] Alaska Statute 47.30.725(d) provides: "[t]he respondent has the right to be represented by an attorney, to present evidence, and to cross-examine witnesses who testify against the respondent at the hearing." Alaska Statute 47.30.700(a) provides that an attorney shall be appointed for the respondent within forty-eight hours of the initial investigation. Because, as we have already noted, a respondent's fundamental rights to liberty and to privacy are infringed upon by involuntary commitment and involuntary administration of psychotropic medication proceedings, the right to counsel in civil proceedings is guaranteed by the due process clause of the Alaska Constitution. ^{FN72} As we noted in *V.F. v. State*, "whenever the right to counsel is constitutionally guaranteed in a particular proceeding, the effective assistance of counsel is also constitutionally required." ^{FN73} And the right to challenge a court order based on a claim of ineffective assistance of counsel derives necessarily from the right to the effective assistance of counsel.

But as has been previously discussed in the criminal context, it is difficult for an appellate court to review a claim of ineffective assistance of counsel unless a record has been developed that includes findings of facts and conclusions of law regarding the claim. ^{FN74} Therefore, in *Barry v. State*, the court of appeals "require[d] that the question of ineffective assistance of counsel be argued first to the trial judge either in a motion for a new trial or an application for post-conviction relief." ^{FN75} In this case, we cannot review a claim for ineffective assistance of counsel without an explanation in the record for counsel's actions; otherwise we become engaged "in the perilous process of second-guessing." ^{FN76} Because in this case no record has been developed, we do not review the issues. We therefore require respondents to establish a record concerning counsel's challenged acts or omissions by applying to the trial court to seek a new commitment and medication hearing by a motion for relief under Alaska Civil Rule 60(b) or by a Civil Rule 86 habeas corpus petition. ^{FN77}

V. CONCLUSION

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We conclude that the definition of "gravely disabled" in AS 47.30.915(7)(B) is constitutional if construed to require a level of incapacity so substantial that the respondent is incapable of surviving safely in freedom. And because we conclude that Wetherhorn's other challenges to the petition for thirty-day commitment and to the conduct of counsel and the swearing in and qualification of the witness are without merit, we AFFIRM the superior court's order granting that petition. But because we conclude that the failure to provide a visitor's report during the hearing on a petition for the administration of psychotropic medication as required by AS 47.30.839(d) is an instance of plain error, we VACATE the order granting that petition. Although no further proceedings are required because Wetherhorn's case is moot, we hold that in future non-emergency cases, a court may not grant a petition for the administration of psychotropic medication unless a visitor's report is properly prepared and presented in the hearing.

FN1. AS 47.30.705. "Emergency detention for evaluation," provides:

(a) A peace officer, a psychiatrist or physician who is licensed to practice in this state or employed by the federal government, or a clinical psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners who has probable cause to believe that a person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to self or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700, may cause the person to be taken into custody and delivered to the nearest evaluation facility. A person taken into custody for emergency evaluation may not be placed in a jail or other correctional facility except for protective custody purposes and only while awaiting transportation to a treatment facility. However, emergency protective custody under this section may not include

placement of a minor in a jail or secure facility. The peace officer or mental health professional shall complete an application for examination of the person in custody and be interviewed by a mental health professional at the facility.

(b) In this section, "minor" means an individual who is under 18 years of age.

FN2. AS 47.30.710 provides:

(a) A respondent who is delivered under AS 47.30.700-47.30.705 to an evaluation facility for emergency examination and treatment shall be examined and evaluated as to mental and physical condition by a mental health professional and by a physician within 24 hours after arrival at the facility.

(b) If the mental health professional who performs the emergency examination has reason to believe that the respondent is (1) mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others, and (2) is in need of care or treatment, the mental health professional may hospitalize the respondent, or arrange for hospitalization, on an emergency basis. If a judicial order has not been obtained under AS 47.30.700, the mental health professional shall apply for an ex parte order authorizing hospitalization for evaluation.

FN3. AS 47.30.839, "Court-ordered administration of medication," states in relevant part:

(d) Upon the filing of a petition under (b) of this section, the court shall direct the office of public advocacy to provide a visitor to assist the court in investigating the issue of whether the patient has the capacity to give or withhold informed consent to the administration of psychotropic medication. The visitor shall gather pertinent information and present it to the court in written or oral form at the hearing. The information must include documentation of the following:

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(1) the patient's responses to a capacity assessment instrument administered at the request of the visitor;

(2) any expressed wishes of the patient regarding medication, including wishes that may have been expressed in a power of attorney, a living will, an advance health care directive under AS 13.52, or oral statements of the patient, including conversations with relatives and friends that are significant persons in the patient's life as those conversations are remembered by the relatives and friends; oral statements of the patient should be accompanied by a description of the circumstances under which the patient made the statements, when possible.

FN4. *Grinols v. State*, 74 P.3d 889, 891 (Alaska 2003).

FN5. *Holderness v. State Farm Fire & Cas. Co.*, 24 P.3d 1235, 1237 (Alaska 2001).

FN6. *Guin v. Ha*, 591 P.2d 1281, 1284 n. 6 (Alaska 1979).

FN7. *Martin N. v. State, Dep't of Health & Soc. Servs., Div. of Family & Youth Servs.*, 79 P.3d 50, 53 (Alaska 2003).

FN8. *Id.*

FN9. *Laidlaw Transit, Inc. v. Crouse ex rel. Crouse*, 53 P.3d 1093, 1097 (Alaska 2002).

FN10. *Id.*

FN11. *Humphrey v. Cady*, 405 U.S. 504, 509, 92 S.Ct. 1048, 31 L.Ed.2d 394 (1972).

FN12. *Addington v. Texas*, 441 U.S. 418, 425, 99 S.Ct. 1804, 60 L.Ed.2d 323 (1979) (citations omitted).

FN13. *Rust v. State*, 582 P.2d 134, 139 n. 16 (Alaska 1978) ("A person who presents

a danger to others is committed under the state's police power. A person who requires care and treatment is committed through exercise of the state's *parens patriae* power. One who poses a danger to himself is committed under a combination of both powers."); *see also Addington*, 441 U.S. at 426, 99 S.Ct. 1804.

FN14. *O'Connor v. Donaldson*, 422 U.S. 563, 575-76, 95 S.Ct. 2486, 45 L.Ed.2d 396 (1975).

FN15. *Id.* at 575 & n. 9, 95 S.Ct. 2486; *see also Cooper v. Oklahoma*, 517 U.S. 348, 368, 116 S.Ct. 1373, 134 L.Ed.2d 498 (1996).

FN16. *Addington*, 441 U.S. at 431, 99 S.Ct. 1804; *see also Kansas v. Hendricks*, 521 U.S. 346, 359 & 360 n. 3, 117 S.Ct. 2072, 138 L.Ed.2d 501 (1997).

FN17. *In re LaBelle*, 107 Wash.2d 196, 728 P.2d 138, 144 (1986).

FN18. *Id.*

FN19. Ch. 142, § 27, SLA 1984.

FN20. AS 47.30.655.

FN21. *Act Relating to the Treatment of Mentally Ill Persons: Before the Standing and Special Comm. of the M. Health, Educ. & Soc. Servs. Standing 13th Comm., Leg.2d Sess. HHES 84/04/24 1342* (Alaska 1984) (statement of Dr. Shapiro, Dir. of Mental Health & Developmental Disabilities, Dept of Health & Soc. Servs.).

FN22. *Id.*

FN23. *Act Relating to the Treatment of Mentally Ill Persons: Before the Standing and Special Comm. of the M. Health, Educ. & Soc. Servs. Standing 13th Comm., Leg.2d Sess. HHES 84/04/24 1730* (Alaska 1984) (statement of Sen.

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Josephson) (explaining that “[t]he ‘gut’ of the bill is Pages 18 and 19-‘gravely disabled and likely to cause serious harm ...’ changed phrasing to include ‘mental illness’, so that a person can be committed before it’s too late (i.e., before they’ve hurt themselves or someone else)”).

FN24. *Act Relating to the Treatment of Mentally Ill Persons: Before the Standing and Special Comm. of the M. Health, Educ. & Soc. Servs. Standing 13th Comm., Leg.2d Sess. HHES 84/04/24 1342 (Alaska 1984)* (statement of Dr. Shapiro, Dir. of Mental Health & Developmental Disabilities, Dep’t of Health & Soc. Servs.). Dr. Shapiro explained that, “[r]ight now ... we’re sitting with a law that allows people to walk out the door. We know the person is a time bomb, but if they haven’t shown violence in less than [thirty] days, they can [use the courts] to get out.”

FN25. *Addington*, 441 U.S. at 426, 99 S.Ct. 1804 (emphasis added).

FN26. *Addington* was concerned with the standard of evidentiary proof required in civil commitment statutes and held that it must be greater than the preponderance of evidence standard but less than the beyond a reasonable doubt standard. 441 U.S. at 431-33. As *Addington* noted, “[i]ncreasing the burden of proof is one way to impress the factfinder with the importance of the decision and thereby perhaps to reduce the chances that inappropriate commitments will be ordered.” *Id.* at 427, 99 S.Ct. 1804.

FN27. *O’Connor*, 422 U.S. at 575, 95 S.Ct. 2486; see also *id.*, 422 U.S. at 574 n. 9, 95 S.Ct. 2486 (“Of course, even if there is no foreseeable risk of self-injury or suicide, a person is literally ‘dangerous to himself’ if for physical or other reasons he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends.”). In 1996 the Supreme Court noted that “

[a]lthough we have not had the opportunity to consider the outer limits of a State’s authority to civilly commit an unwilling individual, our decision in [*O’Connor*] makes clear that due process requires at a minimum a showing that the person is mentally ill and either poses a danger to himself or others or is incapable of ‘surviving safely in freedom.’ ” *Cooper*, 517 U.S. at 368, 116 S.Ct. 1373 (citations omitted).

FN28. AS 47.30.915(7)(B).

FN29. 422 U.S. 563, 95 S.Ct. 2486, 45 L.Ed.2d 396 (1975).

FN30. AS 47.30.915(7)(B).

FN31. *O’Connor*, 422 U.S. at 576, 95 S.Ct. 2486.

FN32. *LaBelle*, 728 P.2d at 146.

FN33. AS 47.30.730(a)(2).

FN34. AS 47.30.730(a)(3).

FN35. AS 47.30.735(c); see *DeNuptis v. Unocal*, 63 P.3d 272, 278 (Alaska 2003) (acknowledging that the “clear and convincing” standard of proof at minimum is required in civil commitment hearings in Alaska and citing *Addington*, 441 U.S. at 425 99 S.Ct. 1804).

FN36. *Humphrey*, 405 U.S. at 509, 92 S.Ct. 1048.

FN37. *O’Connor*, 422 U.S. at 575, 95 S.Ct. 2486.

FN38. *Addington*, 441 U.S. at 426-27, 99 S.Ct. 1804.

FN39. 422 U.S. at 575, 95 S.Ct. 2486.

FN40. See, e.g., *In re Harris*, 98 Wash.2d 276, 654 P.2d 109, 111 (1982) (citation

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omitted).

FN41. 617 F.2d 173, 176 (9th Cir.1980).

FN42. *Cf. In re Harris*, 98 Wash.2d 276, 654 P.2d 109, 112 (1982) (citing *Humphrey*, 405 U.S. at 509, 92 S.Ct. 1048); *In re LaBelle*, 728 P.2d at 144.

FN43. *See, e.g., LaBelle*, 728 P.2d at 146.

FN44. *Id.*

FN45. *O'Connor*, 422 U.S. at 575, 95 S.Ct. 2486.

FN46. *Humphrey*, 405 U.S. at 509, 92 S.Ct. 1048.

FN47. *Myers v. Alaska Psychiatric Inst.*, 138 P.3d 238, 246 (Alaska 2006) (“[W]e ... similarly hold that Alaska’s statutory provisions permitting nonconsensual treatment with psychotropic medications implicate fundamental liberty and privacy interests.”).

FN48. *Foucha v. Louisiana*, 504 U.S. 71, 80, 112 S.Ct. 1780, 118 L.Ed.2d 437 (1992) (“Freedom from bodily restraint has always been at the core of the liberty protected by the Due Process Clause from arbitrary governmental action. It is clear that commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.”) (citations and internal quotation omitted).

FN49. *Martinez v. Cape Fox Corp.*, 113 P.3d 1226, 1229 (Alaska 2005).

FN50. *Id.*

FN51. AS 47.30.735(c).

FN52. *Huntley v. N.Carolina State Bd. of Ed.*, 493 F.2d 1016, 1019 (4th Cir.1974) (citing *Mullane v. Cent. Hanover Bank &*

Trust Co., 339 U.S. 306, 313, 70 S.Ct. 652, 94 L.Ed. 865 (1950)).

FN53. *French v. Blackburn*, 428 F.Supp. 1351, 1357 (M.D.N.C.1977), *aff'd*, 443 U.S. 901, 99 S.Ct. 3091, 61 L.Ed.2d 869 (1979); *see also In re Richard E.*, 12 A.D.3d 1019, 785 N.Y.S.2d 580 (N.Y.App.Div.2004).

FN54. *Fairbanks Fire Fighters Ass'n, Local 1324 v. City of Fairbanks*, 48 P.3d 1165, 1167 (Alaska 2002).

FN55. *Akpik v. State, Office of Mgmt. & Budget*, 115 P.3d 532, 536 (Alaska 2005) (citation omitted).

FN56. 138 P.3d at 238.

FN57. AS 47.30.725(b).

FN58. *Myers*, 138 P.3d at 246.

FN59. *Id.* at 242.

FN60. *Id.*

FN61. AS 47.30.700-.815.

FN62. AS 47.30.836(3); AS 47.30.839.

FN63. AS 47.30.836(3); AS 47.30.839(g).

FN64. AS 47.30.839(d)(2); AS 47.30.839(g).

FN65. AS 47.30.839(d)(1).

FN66. AS 47.30.839(d)(2).

FN67. AS 47.30.839(f) provides:
 If the court determines that the patient is competent to provide informed consent, the court shall order the facility to honor the patient's decision about the use of psychotropic medication.

FN68. AS 47.30.839(g) provides in

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relevant part:

If the court determines that the patient is not competent to provide informed consent and, by clear and convincing evidence, was not competent to provide informed consent at the time of previously expressed wishes documented under (d)(2) of this section, the court shall approve the facility's proposed use of psychotropic medication.

FN69. 138 P.3d at 254.

FN70. Alaska R. Evid. 603.

FN71. *See L.C.H. v. T.S.*, 28 P.3d 915, 923 (Alaska 2001).

FN72. Alaska Const. art. 1, § 7; *V.F. v. State*, 666 P.2d 42, 45 & n. 2 (Alaska 1983) (holding that the due process clause of the Alaska Constitution guarantees the right to effective counsel in proceedings for the termination of parental rights).

FN73. 666 P.2d at 45 (citations omitted).

FN74. *See, e.g., Barry v. State*, 675 P.2d 1292, 1295 (Alaska App. 1984).

FN75. *Id.*

FN76. *Id.* (citation and quotation omitted).

FN77. Wetherhorn additionally argues for a standard of review to be applied to the acts or omissions of counsel in civil cases that differs from that used in the criminal context. *See Risher v. State*, 523 P.2d 421, 424-25 (Alaska 1974). Wetherhorn also argues for the establishment of five requirements that must be met before counsel may be deemed competent in a civil commitment case. Because we have determined that her claim for ineffective assistance of counsel cannot be reviewed directly on appeal, we do not reach these issues.

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Briefs and Other Related Documents (Back to top)

- 2006 WL 2303876 (Appellate Brief) Reply Brief of Appellant (Mar. 28, 2006)
- 2006 WL 1496887 (Appellate Brief) Brief of Appellee (Jan. 31, 2006)
- 2005 WL 3826235 (Appellate Brief) Brief of Appellant (Oct. 12, 2005)

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Briefs and Other Related Documents

Myers v. Alaska Psychiatric Institute Alaska, 2006.

Supreme Court of Alaska.

Faith J. MYERS, Appellant,

v.

ALASKA PSYCHIATRIC INSTITUTE, Appellee.

No. S-11021.

June 30, 2006.

Background: After being involuntarily committed to state psychiatric institute, patient appealed from order of the Superior Court, Third Judicial District, Anchorage, No. 3AN-03-00277 PR, Morgan Christen, J., approving nonconsensual administration of psychotropic drugs by institute.

Holding: The Supreme Court, Bryner, C.J., held that in absence of emergency, court could not authorize state to administer psychotropic drugs to non-consenting patient unless court determined that medication was in the best interests of patient and that no less intrusive alternative treatment was available.

Order vacated.

West Headnotes

[1] Mental Health 257A ⇨51.20

257A Mental Health

257AII Care and Support of Mentally Disordered Persons

257AII(A) Custody and Cure

257Ak51 Restraint or Treatment

257Ak51.20 k. Actions and Proceedings. Most Cited Cases

Supreme Court would adjudicate, pursuant to public interest exception to moot cases, the claim by patient involuntarily committed to state mental hospital that the nonconsensual administration of

psychotropic drugs violated her constitutional rights to privacy and liberty, notwithstanding that patient was released without administration of drugs soon after trial court's order; given the importance of the issues raised by patient, their likelihood of recurring, and their ability to evade timely appellate review, the public exception applied.

[2] Appeal and Error 30 ⇨781(1)

30 Appeal and Error

30XIII Dismissal, Withdrawal, or Abandonment

30k779 Grounds for Dismissal

30k781 Want of Actual Controversy

30k781(1) k. In General. Most Cited

Cases

Although appellate courts generally refrain from deciding issues where the facts have rendered the legal issues moot, an exception applies when a potentially moot case raises a matter of grave public concern that is recurrent but capable of evading review.

[3] Constitutional Law 92 ⇨82(7)

92 Constitutional Law

92V Personal, Civil and Political Rights

92k82 Constitutional Guaranties in General

92k82(6) Particular Rights, Limitations, and Applications

92k82(7) k. Privacy in General. Most Cited Cases

Constitutional Law 92 ⇨83(1)

92 Constitutional Law

92V Personal, Civil and Political Rights

92k83 Personal Liberty and Security

92k83(1) k. In General. Most Cited Cases

Constitutional Law 92 ⇨255(5)

92 Constitutional Law

92XII Due Process of Law

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92k255 Deprivation of Life or Liberty in
 General

92k255(5) k. Diseased and Mentally
 Disordered Persons; Addic Most Cited Cases

Mental Health 257A ⇨51.15

257A Mental Health

257AII Care and Support of Mentally
 Disordered Persons

257AII(A) Custody and Cure

257Ak5I Restraint or Treatment

257Ak51.15 k. Involuntary Treatment
 or Medication. Most Cited Cases

Statutory provisions governing authorization of nonconsensual treatment with psychotropic medications violated patient's state constitutional guarantees of liberty and privacy; in the absence of emergency, court could not authorize the state to administer psychotropic drugs to non-consenting mental patient unless court determined that the medication was in the best interests of the patient and that no less intrusive alternative treatment was available. Const. Art. 1, §§ 1, 7, 22; AS 47.30.836, 47.30.839.

[4] Constitutional Law 92 ⇨82(7)

92 Constitutional Law

92V Personal, Civil and Political Rights

92k82 Constitutional Guaranties in General

92k82(6) Particular Rights, Limitations,
 and Applications

92k82(7) k. Privacy in General. Most
 Cited Cases

Constitutional Law 92 ⇨83(1)

92 Constitutional Law

92V Personal, Civil and Political Rights

92k83 Personal Liberty and Security

92k83(1) k. In General. Most Cited Cases

Alaska's guarantees of privacy and individual liberty are broader than the federal constitution's. Const. Art. 1, §§ 1, 7, 22.

[5] Constitutional Law 92 ⇨82(1)

92 Constitutional Law

92V Personal, Civil and Political Rights

92k82 Constitutional Guaranties in General

92k82(1) k. In General. Most Cited Cases

Courts determine the boundaries of individual rights guaranteed under the Alaska Constitution by balancing the importance of the right at issue against the state's interest in imposing the disputed limitation.

[6] Constitutional Law 92 ⇨82(1)

92 Constitutional Law

92V Personal, Civil and Political Rights

92k82 Constitutional Guaranties in General

92k82(1) k. In General. Most Cited Cases

When a law places substantial burdens on the exercise of a fundamental right, courts require the state to articulate a compelling state interest and to demonstrate the absence of a less restrictive means to advance that interest.

[7] Constitutional Law 92 ⇨82(1)

92 Constitutional Law

92V Personal, Civil and Political Rights

92k82 Constitutional Guaranties in General

92k82(1) k. In General. Most Cited Cases

When the law interferes with an individual's freedom in an area that is not characterized as fundamental, courts require the state to show a legitimate interest and a close and substantial relationship between its interest and its chosen means of advancing that interest.

[8] Constitutional Law 92 ⇨82(6.1)

92 Constitutional Law

92V Personal, Civil and Political Rights

92k82 Constitutional Guaranties in General

92k82(6) Particular Rights, Limitations,
 and Applications

92k82(6.1) k. In General. Most Cited
 Cases

Given that the right to refuse to take psychotropic drugs is fundamental, when no emergency exists, the state may override a mental patient's right to refuse psychotropic medication only when necessary to advance a compelling state interest and only if no less intrusive alternative exists. Const.

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Art. 1, §§ 1, 7, 22.

[9] Constitutional Law 92 ⇨ 12

92 Constitutional Law

92II Construction, Operation, and Enforcement
of Constitutional Provisions

92k11 General Rules of Construction

92k12 k. In General. Most Cited Cases

Constitutional provisions should be given a
reasonable and practical interpretation in
accordance with common sense.

[10] Mental Health 257A ⇨ 51.15

257A Mental Health

257AII Care and Support of Mentally
Disordered Persons

257AII(A) Custody and Cure

257Ak51 Restraint or Treatment

257Ak51.15 k. Involuntary Treatment
or Medication. Most Cited Cases

In evaluating whether a proposed course of
psychotropic medication is in the best interests of a
patient, courts should consider the information that
state statutes direct the treatment facility to give to
its patients in order to ensure the patient's ability to
make an informed treatment choice. AS
47.30.837(d)(2).

[11] Mental Health 257A ⇨ 51.20

257A Mental Health

257AII Care and Support of Mentally
Disordered Persons

257AII(A) Custody and Cure

257Ak51 Restraint or Treatment

257Ak51.20 k. Actions and

Proceedings. Most Cited Cases

The standard of proof that the state should be
required to meet in establishing the patient's best
interests, for purposes of determining whether
nonconsensual administration of psychotropic drugs
is appropriate, is the clear and convincing evidence
standard.

West CodenotesUnconstitutional as AppliedAS
47.30.836, 47.30.839

*239 James B. Gottstein, Law Project for

Psychiatric Rights, Inc., Anchorage, for Appellant.
Michael G. Hotchkin, Assistant Attorney General,
Anchorage, and Gregg D. Renkes, Attorney
General, Juneau, for Appellee.

Before: BRYNER, Chief Justice, MATTHEWS,
EASTAUGH, FABE, and CARPENETI, Justices.

OPINION

BRYNER, Chief Justice.

I. INTRODUCTION

Faith Myers, after being involuntarily committed to
the Alaska Psychiatric Institute, appealed a superior
court order approving nonconsensual administration
of psychotropic drugs by the institute. She argues
that the statutes relied on by the court in approving
the medication violate the Alaska Constitution's
guarantees of privacy and liberty. We agree. In
keeping with most state courts that have addressed
the issue, we hold that, in the absence of
emergency, a court may not authorize the state to
administer psychotropic drugs to a non-consenting
mental patient unless the court determines that the
medication is in the best interests of the patient and
that no less intrusive alternative treatment is
available.

II. FACTS AND PROCEEDINGS

Faith Myers has suffered with mental illness for
over twenty years. Her symptoms have included
paranoia, dizziness, and vivid hallucinations. She
has been hospitalized on a number of occasions
and, at times, a regimen of psychotropic medication
has seemed to improve her condition.

In 2001 Myers weaned herself off of psychotropic
medication, believing that the drugs actually
worsened her condition. She has described herself
from this time forward as an advocate for the
mentally ill.

In February 2003, as a result of concerns expressed
by Myers's daughter and neighbors, Myers was
involuntarily committed to the Alaska Psychiatric
Institute (API). Once admitted, Myers refused to

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discuss treatment options with institute doctors. API then filed a petition with the superior court requesting authorization to medicate Myers without her consent.

Myers responded by challenging the constitutionality of the statutory scheme that authorizes facilities to administer psychotropic drugs without first securing a patient's consent. She argued that Alaska's constitutional rights to liberty and privacy guarantee her the "right to be free from unwanted mind-altering chemicals." She asserted that the state can abridge this right only when necessary to advance a compelling state interest. In her case, Myers believed that API had "not come close" to making this requisite showing and had also failed to show that involuntary medication was a "[least] restrictive means" of advancing any state interest.

Myers also challenged "the [statutory] limitation on a court's authority to modify or restrict a treatment plan." The statute authorizing court-ordered administration of psychotropic medication provides that once a court "determines that [a] patient is not competent*240 to provide informed consent," the court "shall approve the ... proposed use of psychotropic[s]." ^{FN1} On its face, this provision does not seem to allow the court to consider whether the proposed treatment plan would actually be in the patient's best interest, leaving that decision completely to the treating facility's physicians.

FN1. AS 47.30.839(g) (emphasis added).

During Myers's hearing on API's petition, two institute psychiatrists testified that, in their opinion, administering psychotropic medication to Myers would be appropriate. Myers countered with testimony from two expert psychiatrists who "forcefully present[ed] their differing views on the advisability of administering [psychotropic] medications to patients suffering from schizophrenia." The first testified that psychotropic medication is not the only viable treatment for schizophrenia. While acknowledging that psychotropic medications played an accepted role in the "standard of care for [the] treatment of

psychosis," he advised that, because such drugs "have so many problems," they should be used "in as small a dose for as short a period of time as possible." Myers's second expert offered more specific testimony that one of the drugs that API proposed to administer to Myers-Zyprexa-was, despite being "widely prescribed," a "very dangerous" drug of "dubious efficacy." He based this testimony on a "methodological analysis" of the studies that led the food and drug administration to approve Zyprexa for clinical use.

At the conclusion of the hearing, the superior court found that Myers "lacked ... insight into her own condition" and did "not appreciate that she suffers from a mental disorder." Although it noted that Myers understood the debate about the advisability of psychotropic medication and had articulated a "reasonable objection to the proposed medication," the court nonetheless ruled that she lacked the capacity to make informed decisions regarding her treatment. Construing Alaska's statutes as not allowing it to make an independent determination of Myers's best interests, the court did not consider Myers's expert evidence on the point and authorized API to administer psychotropic medications to Myers based on API's own assessment of Myers's best interests.

The court nevertheless noted that it found Myers's case "troubling"-so much so that it issued an additional order addressing in detail the arguments presented in the parties' pre-hearing briefs. In the order, the court found it troubling that Alaska's statutory scheme prevented it from considering the merits of API's treatment plan, or weighing the objections of Myers's experts. Because it believed that the statute unambiguously limited the superior court's role "to deciding whether Ms. Myers has sufficient capacity to give informed consent," the court felt constrained to adhere to its literal meaning. Yet the court nevertheless emphasized that it found this limitation to be problematic:

Where a patient, such as Ms. Myers, has a history of undergoing a medical treatment she found to be harmful, where she is found to lack capacity to make her own medical decisions and a valid debate exists in the medical/psychiatric community as to the safety and effectiveness of the proposed

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treatment plan, it is troubling that the statutory scheme apparently does not provide a mechanism for presenting scientific evidence challenging the proposed treatment plan.

Myers now appeals.

III. DISCUSSION

Echoing the superior court's concern, Myers contends that Alaska's statutory scheme violates her constitutional rights to liberty^{FN2} and privacy.^{FN3} The central question she raises is whether the state may force an unwilling mental patient to be treated with psychotropic drugs without first obtaining a judicial determination that this treatment is in the patient's best interests and that no less intrusive course of treatment is available.

FN2. Alaska Const. art. I, § 7.

FN3. Alaska Const. art. I, § 22.

Myers argues that the right to refuse forced medication is fundamental and that API cannot abridge this right without first *241 showing that medication would advance a compelling state interest and that no less intrusive alternative is available. She further contends that our state's constitutional liberty and privacy guarantees require that courts authorizing the administration of psychotropic medications must find, first, that the requested course of medication is in the patient's best interests; and, second, that the patient would presently consent to the treatment if capable of making an informed decision.

In response, API initially contends that this appeal should be dismissed as moot because Myers was released from API soon after the superior court issued its ruling, so she never actually received the authorized course of treatment. As to the merits of Myers's constitutional claim, API denies that Myers's interest in refusing unwanted psychotropic medication is fundamental. Because Myers has been judged unable to make informed decisions

about her mental health condition, API analogizes her status to the status of minors, who, API claims, generally receive "a different level of constitutional protection." Therefore, API argues, in order to justify medicating Myers without her consent, the state needs only to show that this treatment would advance something "less than a compelling state interest." API further contends that, "as a committed mental patient," Myers "has a competing constitutional interest in receiving treatment for her illness."^{FN4} It asserts that the state's "duty to provide [Myers] with treatment" amounts to a legitimate state interest—one that we should deem sufficient to overcome Myers's objections.

FN4. *Cf. Ruit v. State*, 582 P.2d 134, 138-40 (Alaska 1978).

A. Alaska's Current Statutory Provisions

To place these arguments in perspective, we must begin by considering Alaska's statutory provisions governing treatment of mental patients. Alaska law recognizes and addresses a distinct class of drugs called "psychotropic medications."^{FN5} Psychotropic drugs "affect the mind, behavior, intellectual functions, perception, moods, and emotions"^{FN6} and are known to cause a number of potentially devastating side effects.^{FN7}

FN5. *See* AS 47.30.836; AS 47.30.838.

FN6. *Steele v. Hamilton County Cmty. Mental Health Bd.*, 90 Ohio St.3d 176, 736 N.E.2d 10, 15 n. 3 (2000) (internal citations omitted).

FN7. API did not dispute that psychotropic medication can cause potentially severe side effects.

[M]ost common ... are the temporary, muscular side effects (extra-pyramidal symptoms) which disappear when the drug is terminated; dystonic reactions (muscle spasms, especially in the eyes, neck, face, and arms; irregular flexing, writhing or

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grimacing movements; protrusion of the tongue); [and] akathisia (inability to stay still, restlessness, agitation) ... Additionally, there are numerous other nonmuscular effects, including drowsiness, weakness, weight gain, dizziness, fainting, low blood pressure, dry mouth, blurred vision, loss of sexual desire, frigidity, apathy, depression, constipation, diarrhea, and changes in the blood.^{FN8}

FN8. *Jarvis v. Levine*, 418 N.W.2d 139, 145 (Minn.1988) (quoting Earl Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 Nw. U.L.Rev. 461, 475-76 (1977)).

Courts have observed that "the likelihood [that psychotropic drugs will cause] at least some temporary side effect appears to be undisputed"^{FN9} and many have noted that the drugs may-most infamously-cause Parkinsonian syndrome and tardive dyskinesia.^{FN10} Parkinsonian syndrome consists of "muscular rigidity, fine resting tremors, a masklike face, salivation, motor retardation, a shuffling gait, and pill-rolling hand movements."^{FN11} Tardive dyskinesia involves "slow, rhythmical, repetitive, involuntary movements of the mouth, lips, and tongue";^{FN12} it is permanent,^{*242} and its symptoms cannot currently be treated.^{FN13}

FN9. *Jarvis*, 418 N.W.2d at 145.

FN10. *Steel*, 736 N.E.2d at 17 (quoting Bruce J. Winick, *The Right to Refuse Mental Health Treatment* 72-73 (1997)).

FN11. *Id.* (quoting Winick, *The Right to Refuse Mental Health Treatment* 72-73 (1997)).

FN12. *Id.* (quoting Winick, *The Right to Refuse Mental Health Treatment* 72-73 (1997)).

FN13. *Id.* (quoting Winick, *The Right to Refuse Mental Health Treatment* 72-73

(1997)).

Side effects aside, the truly intrusive nature of psychotropic drugs may be best understood by appreciating that they are literally intended to alter the mind.^{FN14} Recognizing that purpose, many states have equated the intrusiveness of psychotropic medication with the intrusiveness of electroconvulsive therapy and psychosurgery.^{FN15}

FN14. *Riggins v. Nevada*, 504 U.S. 127, 134, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992) ("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.").

FN15. *See, e.g., Jarvis*, 418 N.W.2d at 146; *In re K.K.B.*, 609 P.2d 747, 749 (Okla.1980) ("[W]e deal today only with consent to so called 'organic therapy' which can change a patient's behavior without his cooperation such as electroshock, psychosurgery and, as in the instant case, the use of anti-psychotic drugs. These treatments are intrusive in nature and an invasion of the body.") (internal citations omitted).

A special statutory regime governs involuntary administration of these highly intrusive medications.^{FN16} It allows the state to administer psychotropic medication without obtaining a patient's consent in both crisis and non-crisis situations.^{FN17} This case involves only the latter, and we emphasize at the outset that our opinion does not extend to the use of psychotropic medication in crisis or emergency situations.

FN16. *See* AS 47.30.836, "Psychotropic medication in nonemergency," and AS 47.30.838, "Psychotropic medication in emergencies."

FN17. *Id.* AS 47.30.839 sets out the procedures for obtaining a court order for

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the forcible administration of psychotropic medication in both emergency and non-emergency situations.

Under Alaska law, to administer psychotropic drugs in a non-crisis situation without first obtaining the patient's consent, the state must follow a two-step judicial process. The first step requires the state to petition for the person's commitment to a treatment facility.^{FN18} Persons may be involuntarily committed in Alaska if the state can show by clear and convincing evidence that they are either mentally ill and, as a result, likely to cause harm to themselves or others, or are "gravely disabled."^{FN19} Persons are deemed "gravely disabled" when they are so unable to care for themselves that it seems very likely that they will come to serious harm without help.^{FN20} To commit a mentally ill person for more than seventy-two hours there must be, in addition, a signed statement by two mental health professionals declaring that treatment staff have considered and dismissed less restrictive alternatives, and that they believe that the proposed course of treatment (including involuntary commitment) will improve the person's condition.^{FN21}

FN18. See AS 47.30.700-.815 for procedures governing involuntary admission of mental patients for treatment.

FN19. See AS 47.30.735(c); AS 47.30.725(b).

FN20. AS 47.30.915(7) defines "gravely disabled" to mean "a condition in which a person as a result of mental illness"

(A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or

(B) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or

behavior causing a substantial deterioration of the person's previous ability to function independently.

FN21. AS 47.30.730(a)(2) & (3).

An order authorizing a person's involuntary commitment does not authorize the state to treat the committed person with psychotropic drugs. Nor does it amount to a finding that the patient is incapable of giving or withholding informed consent to submit to such treatment.^{FN22} To treat an unwilling and "243 involuntarily committed mental patient with psychotropic medication, the state must initiate the second step of the process by filing a second petition, asking the court to approve the treatment it proposes to give. At this second stage, the state must prove two propositions by clear and convincing evidence: (1) that the committed patient is currently unable to give or withhold informed consent regarding an appropriate course of treatment;^{FN23} (2) that the patient never previously made a statement while competent that reliably expressed a desire to refuse future treatment with psychotropic medication."^{FN24}

FN22. Other state courts have noted the "nearly unanimous modern trend in the courts, and among psychiatric and legal commentators" that "there is no significant relationship between the need for hospitalization of mentally ill patients and their ability to make treatment decisions." *Rivers v. Katz*, 67 N.Y.2d 485, 504 N.Y.S.2d 74, 495 N.E.2d 337, 342 (N.Y.1986); see also *Rogers v. Comm'r of the Dep't of Mental Health*, 390 Mass. 489, 458 N.E.2d 308, 314 (1983) ("involuntarily committed patients are competent until adjudicated incompetent"); *Davis v. Hubbard*, 506 F.Supp. 915, 935 (N.D. Ohio 1980) (there is no "necessary relationship" between mental illness and the ability to give informed consent).

FN23. See AS 47.30.836(3); AS 47.30.839(g).

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FN24. See AS 47.30.839(g).

In order to make informed decisions possible, the law requires treatment facilities to give their patients certain information concerning their situation and need for treatment, including advice about: their diagnosis; proposed medications, including possible side effects and interactions with other drugs; their medical history; alternative treatments; and a statement describing their right to give or withhold consent.^{FN25}

FN25. AS 47.30.837(d)(2) provides:

"informed" means that the evaluation facility or designated treatment facility has given the patient all information that is material to the patient's decision to give or withhold consent, including

(A) an explanation of the patient's diagnosis and prognosis, or their predominant symptoms, with and without the medication;

(B) information about the proposed medication, its purpose, the method of its administration, the recommended ranges of dosages, possible side effects and benefits, ways to treat side effects, and risks of other conditions, such as tardive dyskinesia;

(C) a review of the patient's history, including medication history and previous side effects from medication;

(D) an explanation of interactions with other drugs, including over-the-counter drugs, street drugs, and alcohol;

(E) information about alternative treatments and their risks, side effects, and benefits, including the risks of nontreatment; and

(F) a statement describing the patient's right to give or withhold consent to the administration of psychotropic medications in nonemergency situations, the procedure for withdrawing consent, and notification that a court may override the patient's refusal[.]

For non-emergencies, the standard for determining the patient's capacity to give informed consent is

laid out in AS 47.30.837(c).^{FN26} This provision allows a patient to refuse medication unless the state shows, by clear and convincing evidence, that the patient cannot demonstrate the capacity to understand the patient's situation and assimilate relevant facts, is unable to participate in treatment decisions, or is unable to articulate any objections to the proposed medication.^{FN27} Under this provision, a patient's inability to appreciate the presence of a mental disorder is a relevant consideration but is not dispositive.^{FN28}

FN26. AS 47.30.837 provides, in relevant part:

(c) ... If the facility has reason to believe that the patient is not competent to make medical or mental health treatment decisions and the facility wishes to administer psychotropic medication to the patient, the facility shall follow procedures of AS 47.30.839.

(d) In this section,

(1) "competent" means that the patient

(A) has the capacity to assimilate relevant facts and to appreciate and understand the patient's situation with regard to those facts, including the information described in (2) of this subsection;

(B) appreciates that the patient has a mental disorder or impairment, if the evidence so indicates; denial of a significantly disabling disorder or impairment, when faced with substantial evidence of its existence, constitutes evidence that the patient lacks the capability to make mental health treatment decisions;

(C) has the capacity to participate in treatment decisions by means of a rational thought process; and

(D) is able to articulate reasonable objections to using the offered medication[.]

FN27. See also AS 47.30.839(g); AS 47.30.825(c).

FN28. AS 47.30.837(d)(1)(B).

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When the state files its petition to authorize psychotropic medication, the law requires a "visitor" to be appointed to assist the court when it considers the petition. The visitor has a duty to gather and provide information to the court on two issues: first, the visitor must evaluate the patient's present condition by administering a "capacity assessment"; second, the visitor must conduct a search for *244 any prior "expressed wishes of the patient regarding medication."^{FN29} The search for prior expressions regarding medications includes both written and oral statements:

FN29. AS 47.30.839(d).

The visitor shall gather pertinent information and present it to the court in written or oral form at the hearing. The information must include documentation of the following:

- (1) the patient's responses to a capacity assessment instrument administered at the request of the visitor;
- (2) any expressed wishes of the patient regarding medication, including wishes that may have been expressed in a power of attorney, a living will, an advance health care directive under AS 13.52, or oral statements of the patient, including conversations with relatives and friends that are significant persons in the patient's life as those conversations are remembered by the relatives and friends; oral statements of the patient should be accompanied by a description of the circumstances under which the patient made the statements, when possible.^[FN30]

FN30. *Id.*

Before authorizing psychotropic treatment, the court must hold a hearing and consider all relevant evidence presented by the petitioner, the respondent, and the visitor.^[FN31] At the end of the hearing, the court may not authorize nonconsensual psychotropic medication if it finds that the patient is presently competent; in such cases, the court must honor the unwilling patient's wishes:

FN31. *See* AS 47.30.839(e).

If the court determines that the patient is competent to provide informed consent, the court shall order the facility to honor the patient's decision about the use of psychotropic medication.^[FN32]

FN32. AS 47.30.839(f).

But if the court finds that the patient is presently incapable of giving or withholding informed consent, *and* further determines that the patient was also incompetent at the time of any previously expressed wishes not to be medicated, then the statute directs that the court "*shall*" authorize treatment:

If the court determines that the patient is not competent to provide informed consent and, by clear and convincing evidence, was not competent to provide informed consent at the time of previously expressed wishes documented under [the visitor's report], the court shall approve the facility's proposed use of psychotropic medication.^[FN33]

FN33. AS 47.30.839(g).

In short, once the court finds that the patient is presently incapable of consenting and has never before expressed medication-related wishes while competent, these provisions leave the court no discretion to consider a patient's best interests: the provisions require it to approve the treatment.

B. Mootness

[1] Soon after the superior court authorized API to administer treatment, Myers was released. Because no psychotropic medications were ever administered to her without her consent, API argues that Myers's claims are now moot.

[2] We generally "refrain from deciding issues" where the facts have rendered the legal issues moot."^{FN34} But we do not enforce this rule rigidly, and have recognized that an exception applies when

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a potentially moot case raises a matter "of grave public concern" that is "recurrent" but "capable of evading review."^{FN35}

FN34. *Hayes v. Charney*, 693 P.2d 831, 834 (Alaska 1985) (quoting *Doe v. State*, 487 P.2d 47, 53 (Alaska 1971)).

FN35. *Id.* (quoting *Doe*, 487 P.2d at 53).

Here, API acknowledges that medication orders are "time critical," and that it is doubtful that an appeal from a medication order could ever be completed within the order's period of effectiveness. Nonetheless, API maintains that because this case is the first challenge to the relevant statutes in eleven years, it is unlikely that this controversy will actually recur. API urges us to consider the issue's limited "track record of *245 repetition" and to find that the public interest exception does not apply to this case.

We have found the public interest exception to apply in analogous settings. We have held, for example, that the preadjudication detention of children is a matter of public concern that was likely to recur.^{FN36} We similarly applied the exception to a prisoner who challenged an order imposing solitary confinement, even though the solitary time had already been served.^{FN37}

FN36. *See Doe*, 487 P.2d at 53.

FN37. *Brandon v. Dep't of Corr.*, 865 P.2d 87, 92 n. 6 (Alaska 1993).

The United States Supreme Court has applied the public interest exception in a case involving facts similar to those of Myers's case. In *Washington v. Harper*, the Court considered a mentally ill prisoner's claim challenging the state's efforts to medicate him with antipsychotic drugs, even though the state had abandoned its efforts.^{FN38} The Court declined to find the issue moot, noting that the prisoner was still jailed, he still suffered from schizophrenia, and the controversy could recur.^{FN39}

FN38. *Washington v. Harper*, 494 U.S. 210, 218-19, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990).

FN39. *Id.* at 219, 110 S.Ct. 1028; *see also State ex. rel. Jones v. Gerhardstein*, 141 Wis.2d 710, 416 N.W.2d 883, 888 (1987).

Given the importance of the issues Myers raises, their likelihood of recurring, and their ability to evade timely appellate review, we similarly hold that the public interest exception applies to this case.

C. Myers's Constitutional Challenge

[3] Myers argues that, as interpreted in the superior court's order, the provisions governing authorization of treatment with psychotropic medications violate the Alaska Constitution's guarantees of liberty and privacy. We agree.

The Alaska Constitution's opening provision, article I, section 1, declares, "This constitution is dedicated to the principles that all persons have a natural right to life, liberty, the pursuit of happiness, and the enjoyment of the rewards of their own industry."^{FN40} Article I then sets out more specific provisions guaranteeing individual liberty and privacy in sections 7 and 22. Section 7 addresses liberty: "No person shall be deprived of life, liberty, or property, without due process of law."^{FN41} Section 22 guarantees privacy: "The right of the people to privacy is recognized and shall not be infringed."^{FN42}

FN40. Alaska Const. art. I, § 1.

FN41. Alaska Const. art. I, § 7.

FN42. Alaska Const. art. I, § 22.

[4] Although the federal constitution sets the minimum protections afforded to individual liberty and privacy interests, the Alaska Constitution often provides more protection.^{FN43} We have specifically recognized that Alaska's guarantee of privacy is broader than the federal constitution's:

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FN43. See, e.g., *Valley Hosp. Ass'n v. Mat-Su Coalition*, 948 P.2d 963, 966-67 (Alaska 1997).

Since the citizens of Alaska, with their strong emphasis on individual liberty, enacted an amendment to the Alaska Constitution expressly providing for a right to privacy not found in the United States Constitution, it can only be concluded that the right is broader in scope than that of the Federal Constitution.^{FN44}

FN44. *Anchorage Police Dep't Employees Ass'n v. Municipality of Anchorage*, 24 P.3d 547, 550 (Alaska 2001) (quoting *Ravin v. State*, 537 P.2d 494, 514-15 (Alaska 1975) (Boochever, J., and Connor, J., concurring)).

We have similarly declared Alaska's constitutional guarantee of individual liberty to be more protective.^{FN45}

FN45. See, e.g., *Breese v. Smith*, 501 P.2d 159, 170 (Alaska 1972).

[5][6][7] We determine the boundaries of individual rights guaranteed under the Alaska Constitution by balancing the importance of the right at issue against the state's interest in imposing the disputed limitation.^{FN46} When a law places substantial burdens on the exercise of a fundamental right, we require the state to "articulate a compelling [state] interest"^{FN47} and to demonstrate "the absence of a less restrictive means to advance [that] interest."^{FN48} But when the law "interferes with an individual's freedom in an area that is not characterized as fundamental," we require the state to "show a legitimate interest and a close and substantial relationship between its interest and its chosen means of advancing that interest."^{FN49}

FN46. See, e.g., *Sampson v. State*, 31 P.3d 88, 91 (Alaska 2001).

FN47. *Ranney v. Whitewater Eng'g*, 122

P.3d 214, 222 (Alaska 2005).

FN48. *Sampson*, 31 P.3d at 91.

FN49. *Ranney*, 122 P.3d at 222 (quoting *Sampson*, 31 P.3d at 91).

1. Importance of right to choose or reject medication

[8] In the past we have recognized that Alaska's constitutional rights of privacy and liberty encompass the prerogative to control aspects of one's personal appearance,^{FN50} privacy in the home,^{FN51} and reproductive rights.^{FN52} We have noted that "few things [are] more personal than one's own body,"^{FN53} and we have held that Alaska's constitutional right to privacy "clearly ... shields the ingestion of food, beverages or other substances."^{FN54}

FN50. See *Breese*, 501 P.2d at 170.

FN51. See *Ravin*, 537 P.2d at 500, 502-03.

FN52. See *Valley Hosp. Ass'n*, 948 P.2d at 969.

FN53. *Breese*, 501 P.2d at 169; but see *Sampson*, 31 P.3d at 92 (holding that the constitutional right to control one's own body does not create a constitutional right to assisted suicide).

FN54. *Gray v. State*, 525 P.2d 524, 528 (Alaska 1974).

[9] Because psychotropic medication can have profound and lasting negative effects on a patient's mind and body, we now similarly hold that Alaska's statutory provisions permitting nonconsensual treatment with psychotropic medications implicate fundamental liberty and privacy interests.^{FN55}

FN55. The issue before us is a constitutional question to which we apply our independent judgment. Constitutional

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provisions, we have held, "should be given a reasonable and practical interpretation in accordance with common sense." *Arco Alaska, Inc. v. State*, 824 P.2d 708, 710 (Alaska 1992) (citing *Kochutin v. State*, 739 P.2d 170, 171 (Alaska 1987)).

We are hardly the first court to reach this conclusion. A number of state supreme courts have declared that the right to refuse psychotropic medication is fundamental; we find their opinions to be both instructive and persuasive.^{FN56}

FN56. In addressing the importance of a committed patient's right to choose or refuse psychotropic medications, API's briefing relies heavily on United States Supreme Court cases dealing with the forced medication of mentally ill prisoners. See *Sell v. United States*, 539 U.S. 166, 123 S.Ct. 2174, 156 L.Ed.2d 197 (2003) (defendant awaiting federal criminal trial); *Riggins v. Nevada*, 504 U.S. 127, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992) (defendant awaiting state criminal trial); *Washington v. Harper*, 494 U.S. 210, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990) (convicted state prisoner). In contrast to the state cases we rely on, which deal with civilly committed patients, the federal cases cited by API have little value here because prisoners' rights differ markedly from the rights of civilly committed mental patients. The prisoners involved in most of those cases had greatly diminished liberty interests because they had been convicted and incarcerated for criminal offenses, not because they were mentally ill. Further, in all of those prisoner cases—even *Sell v. United States*, which involved a mentally ill prisoner awaiting trial—the extraordinary security risks inherent in managing incarcerated criminal defendants greatly increased the strength of the government's administrative and institutional interests in providing mentally ill prisoners with medical treatment. Cf. *In re Qawi*, 32 Cal.4th 1, 7 Cal.Rptr.3d

780, 81 P.3d 224, 232 (2004) (even competent prison inmate can be forcibly medicated if he is a danger to himself and others and treatment is in his best medical interest). Here, API has never asserted that Myers posed an imminent threat of danger to any of API's patients or staff, and it has never suggested that its institutional or administrative interests compelled it to treat her with psychotropic drugs.

In *Rogers v. Commissioner of the Department of Mental Health*, the Supreme Judicial Court of Massachusetts held that a committed mental patient could not be forcibly medicated with antipsychotic drugs unless a court determined both that he was incompetent and that he would have consented to the administration of the drugs if he was competent.^{FN57} Although the court's opinion relied on Massachusetts's statutory and common law, rather than on interpretation of the state constitution, the court emphasized the "constitutional and common law origins" of "[e]very competent adult[s] ... right 'to [forgo] treatment, or even cure, if it entails what for him are intolerable consequences or risks however unwise his sense of values may be in the eyes of the medical profession.'" ^{FN58} The court further emphasized that mentally ill patients have dignity and worth equal to other individuals; on this basis, the court held that a committed mental patient is entitled to an independent judicial determination of whether the patient would have consented to treatment with psychotropic drugs.^{FN59} And the court explicitly rejected the argument that a "substituted judgment determination" of this kind could safely be left to the treating doctors rather than the courts.^{FN60}

FN57. *Rogers v. Commissioner of Dep't. of Mental Health*, 390 Mass. 489, 458 N.E.2d 308, 311 (1983).

FN58. *Id.* at 310, 314 (quoting *Harnish v. Children's Hosp. Med. Ctr.*, 387 Mass. 152, 439 N.E.2d 240, 242 (1982) (internal citations omitted)).

FN59. *Id.* at 315 ("To protect the

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incompetent person within its power, the State must recognize the dignity and worth of such a person and afford to that person the same panoply of rights and choices it recognizes in competent persons.”).

FN60. *See id.* at 317.

In *Rivers v. Katz*, the New York Court of Appeals similarly located a person's right to control his medical treatment in state common law but went on to declare that “[t]his fundamental common-law right is coextensive with the patient's liberty interest protected by the due process clause of our State Constitution.”^{FN61} It wrote,

FN61. *Rivers v. Katz*, 67 N.Y.2d 485, 504 N.Y.S.2d 74, 495 N.E.2d 337, 341 (1986) (“It is a firmly established principle of the common law of New York that every individual ‘of adult years and sound mind has a right to determine what shall be done with his own body’ and to control the course of his medical treatment.”) (internal citations omitted).

In our system of a free government, where notions of individual autonomy and free choice are cherished, 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[.]^{FN62}

FN62. *Id.*

While acknowledging the state's police power to forcibly medicate mental patients in emergency situations—a situation not at issue in the case before us—the court held that in New York, decisions to forcibly medicate persons in all other circumstances must be made by the courts.^{FN63} If “the court concludes that the patient lacks the capacity to determine the course of his own treatment, the court must [then] determine whether the proposed treatment is narrowly tailored to give substantive

effect to the patient's liberty interest, taking into consideration all relevant circumstances, including the patient's best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments.”^{FN64}

FN63. *Id.* at 343-44.

FN64. *Id.* at 344.

The Minnesota Supreme Court reached a similar result in *Jarvis v. Levine*.^{FN65} It held that Minnesota's constitutional guarantee of privacy “begins with protecting the integrity of one's own body and includes the right not to have it altered or invaded without consent. Commitment to an institution does not eliminate this right. When intrusive treatment is proposed, the ‘professional judgment’ of medical personnel insufficiently protects this basic human right.”^{FN66} Thus, in Minnesota, the forcible medication of a committed mental patient requires both a judicial finding of incapacity to give informed consent and a judicial “hearing to determine the necessity and reasonableness of the treatment.”^{FN67}

FN65. *Jarvis v. Levine*, 418 N.W.2d 139 (Minn.1988).

FN66. *Id.* at 148.

FN67. *Id.* at 148 n. 7.

Most recently, the Ohio Supreme Court held in *Steele v. Hamilton County Community Mental Health Board* that the state could forcibly medicate a mental patient under its *parens patriae* authority only after a *248 court had found, “by clear and convincing evidence, that (1) the patient does not have the capacity to give or withhold informed consent regarding his/her treatment, (2) it is in the patient's best interest to take the medication, *i.e.*, the benefits of the medication outweigh the side effects, and (3) no less intrusive treatment will be as effective in treating the mental illness.”^{FN68} Ruling that the “right to refuse medical treatment is

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a fundamental right in our country, where personal security, bodily integrity, and autonomy are cherished liberties," the court emphasized that "[t]hese liberties were not created by statute or case law ... [r]ather, they are rights inherent in every individual" that find explicit protection under the Ohio Constitution.^{FN69}

FN68. *Steele v. Hamilton County Cmty. Mental Health Bd.*, 90 Ohio St.3d 176, 736 N.E.2d 10, 21 (2000).

FN69. *Id.* at 15.

Given the nature and potentially devastating impact of psychotropic medications^{FN70}-as well as the broad scope of the Alaska Constitution's liberty and privacy guarantees-we now similarly hold that the right to refuse to take psychotropic drugs is fundamental; and we further hold that this right must extend "equally to mentally ill persons," so that the mentally ill are not treated "as persons of lesser status or dignity because of their illness."^{FN71}

FN70. See above, part III.A.

FN71. *Rivers*, 504 N.Y.S.2d 74, 495 N.E.2d at 341; see also *Rogers*, 458 N.E.2d at 315 ("To protect the incompetent person within its power, the State must recognize the dignity and worth of such a person and afford to that person the same panoply of rights and choices it recognizes in competent persons.").

When no emergency exists, then, the state may override a mental patient's right to refuse psychotropic medication only when necessary to advance a compelling state interest and only if no less intrusive alternative exists.^{FN72}

FN72. *Cj. Valley Hosp. Ass'n*, 948 P.2d at 969.

2. Importance of countervailing state interests

API argues that medicating Myers would serve two compelling state interests: it would prevent Myers from harming herself or others, and would ameliorate Myers's condition. These interests, API argues, find legitimate sources in two traditional state powers: the state's police power and its *parens patriae* duty.^{FN73}

FN73. API's brief actually claims three interests; but one of the them-the state's duty to provide treatment to committed mental patients, established in *Rust v. State*, 582 P.2d 134 (Alaska 1978)-derives from the state's *parens patriae* authority, *id.* at 139-40, so we treat the two claimed interests as one.

a. Police power

API argues that the state's police power is implicated here because the superior court found that Myers was a danger to herself and others. Just as citizens have a right to some protection from the state, API argues, the state has a legitimate and compelling interest in the physical safety of its citizens. In API's view, this interest is "sufficient to overcome a patient's right to refuse psychotropic medication."

In an emergency situation, API might be correct. Indeed, the Supreme Court of Ohio has so held, ruling that the police power can justify medication when the state perceives an "imminent threat of harm."^{FN74} But that is not the situation here. As already mentioned, this case centers on the use of psychotropic medication in non-emergency situations.^{FN75} And API has not maintained that Myers posed an imminent threat of harm to herself or anyone else after she was committed for treatment at API. In these circumstances, the state's power of civil commitment sufficed to meet its police-power interest, so we fail to see how the issue of medication implicates the state's police power at all:

FN74. *Steele*, 736 N.E.2d at 18 (holding this to be the "only" situation in which the

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police power can serve as a compelling justification).

FN75. See AS 47.30.839(a)(2).

If there is no emergency, hospital personnel are in no danger; the only purpose of *249 forcible medication in these circumstances would be to help the patient. But the basic premise of the right to privacy is the freedom to decide whether we prefer to be helped, or to be left alone.^[FN76]

FN76. *In re K.K.B.*, 609 P.2d 747, 751 (Okla.1980).

Indeed, it seems noteworthy that the statutory provision that governs petitions to administer psychotropics in non-emergency situations makes no mention of the police power, and does not require a treatment facility to make any showing of institutional risk or danger to others as a condition for authorizing treatment.^{FN77} The applicable statutes allow medication to be authorized without any finding-judicial or medical-that the patient poses a danger.^{FN78}

FN77. Under AS 47.30.839(g), a court can grant authorization to medicate without ever considering whether or not the patient poses a threat of harm to anyone. And a treatment facility may seek involuntary medication of a patient in a non-crisis situation, under AS 47.30.839(a)(2), if the facility "has reason to believe the patient is incapable of giving informed consent" and simply "wishes to."

FN78. See AS 47.30.836, .839.

The state's police power-its power to protect others from Myers-thus provides no justification, compelling or otherwise, for API to override Myers's choice to accept or refuse psychotropic medication.

b. *Parens patriae*

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API proposes a second compelling interest: the state's *parens patriae* obligation-its duty to protect Myers from herself. The doctrine of *parens patriae* refers to the inherent power and authority of the state to protect "the person and property" of an individual who "lack[s] legal age or capacity."^{FN79} Because the superior court found Myers incapable of making informed decisions about her mental illness, API reasons that the state must be permitted to make those decisions for her.^{FN80}

FN79. *Pub. Defender Agency v. Superior Court, Third Judicial Dist.*, 534 P.2d 947, 949 (Alaska 1975); Black's Law Dictionary 1084 (8th ed.2004)

FN80. API also more narrowly and forcefully argues that our decision in *Rust v. State*, 582 P.2d 134 (Alaska 1978), effectively concluded that the state's *parens patriae* duty affirmatively required API to give Myers the medications that its doctors recommended. On this point, we disagree. We noted in *Rust* that some courts have reasoned from the *parens patriae* principle to find that mentally ill persons, once committed, have a "right to treatment." *Id.* at 140. But that observation has no direct bearing here; this case involves the right of a committed patient to refuse forced treatment, not the treatment facility's general obligation to provide treatment to willing patients upon their commitment.

We readily agree that the state's *parens patriae* obligation does give it a compelling interest in administering psychotropic medication to unwilling mental patients in some situations.^{FN81} But this simply raises the difficult question: does the current statutory scheme use an overly intrusive means to attain the state's interest by failing to require an independent judicial determination of the patient's best interests? To answer this question, we turn to the third step of the constitutional balancing test, the least intrusive alternative requirement.

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FN81. To conclude otherwise would mean that the state could *never* use psychotropic drugs without the patient's consent—a position that Myers does not assert.

3. Least intrusive means requirement

Although API acknowledges that its patient's best interests must be considered, it insists that the superior court's order must be affirmed because the current statutory scheme already meets this criterion by requiring the petitioning facility's physicians to determine, before they petition for authorization, that psychotropic drugs would be in their patient's best interests.^{FN82} API maintains that, so long as doctors make this determination, there is no need for the court to give further consideration to the issue in deciding whether to authorize nonconsensual treatment.

FN82. API supports its claim that the current statutory regime requires a medical determination of best interests by citing AS 47.30.523, AS 47.30.547, AS 47.30.590, AS 47.30.655, AS 47.30.660, AS 47.30.690, AS 47.30.785, AS 47.30.825, AS 47.30.870, AS 47.30.875, and AS 47.30.958. Our decision that a judicial determination of best interests is required makes it unnecessary to consider these provisions.

*250 We disagree. In our view, before a state may administer psychotropic drugs to a non-consenting mentally ill patient in a non-emergency setting, an independent judicial best interests determination is constitutionally necessary to ensure that the proposed treatment is actually the least intrusive means of protecting the patient.

API argues that its doctors can be trusted to adequately protect patients' constitutional interests and claims that this is the legislature's position, too. In API's view, the current statutory scheme reflects a legislative belief that doctors alone are the "proper arbiters" of patients' best interests. And API asserts that its medical staff properly arbitrated here by determining that psychotropics were in

Myers's best interest and represented the least intrusive means available to advance the state's interest in her welfare.

But the issue is not one of medical competence or expertise. As we have already seen, the right at stake here—the right to choose or reject medical treatment—finds its source in the fundamental constitutional guarantees of liberty and privacy. The constitution itself requires courts, not physicians, to protect and enforce these guarantees. Ultimately, then, whether Myers's best interests will be served by allowing the state to make a vital choice that is properly hers presents a constitutional question; and though the answer certainly must be fully informed by medical advice received with appropriate deference, in the final analysis the answer must take the form of a legal judgment that hinges not on medical expertise but on constitutional principles aimed at protecting individual choice.

Apart from this overarching need to ensure that courts ultimately decide constitutionally based questions, a secondary factor that militates in favor of independent judicial review of best-interests issues is the inherent risk of procedural unfairness that inevitably arises when a public treatment facility possesses unreviewable power to determine its own patients' best interests. Many cases describe the unavoidable tensions between institutional pressures and individual best interests that can arise in this setting: "The doctors who are attempting to treat as well as to maintain order in the hospital have interests in conflict with those of their patients who may wish to avoid medication.... Economic considerations may also create conflicts [.]"^{FN83} Courts and commentators alike have documented numerous instances in which these tensions have actually resulted in abuse "by those claiming to act in [a patient's] best interests."^{FN84} And even in institutional settings such as prisons, where judicial review of treatment decisions has traditionally not been required, case law strongly suggests that at a minimum, a formal system of independent administrative review may be necessary to guarantee patients' basic due process rights.^{FN85} Notably, in Alaska,*251 no formal system for independent internal review exists for

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best interests determinations made by treating physicians at state institutions like API because, despite an express statutory mandate, the Department of Health and Social Services has not yet adopted regulations establishing formal procedures and standards for treating mental patients with psychotropic drugs.^{FN86}

FN83. *Rogers*, 458 N.E.2d at 317-18 n. 19.

FN84. *Id.* at 320-21. See, e.g., *Rennie v. Klein*, 476 F.Supp. 1294, 1299 (D.N.J.1979) (the medical director of the Marlboro New Jersey State Hospital stated in an office memorandum that the hospital "uses medication as a form of control and as a substitute for treatment"); *Halderman v. Pennhurst State Sch. & Hosp.*, 446 F.Supp. 1295, 1307 (E.D.Pa.1977) (dangerous psychotropic drugs were used on mentally retarded persons "for purposes of behavior control and staff convenience, rather than for legitimate treatment needs"); *Clites v. State*, 322 N.W.2d 917, 921 (Iowa App.1982) (damages awarded where major tranquilizers used on mentally retarded child "as a convenience or expediency program rather than a therapeutic program"); Jessica Litman, Note, *A Common Law Remedy For Forcible Medication of the Institutionalized Mentally Ill*, 82 Colum. L.Rev. 1720, 1721 n. 9 (1982) (describing cases in which psychotropic drugs were found to be used "for the convenience of the staff and for punishment of patients"); Alexander D. Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 Bull. Am. Acad. of Psychiatry and Law 179, 206 (1980) ("staff too often abuses the management function of medications and slips into the use of medications for its own convenience"); Edward Opton, *Psychiatric Violence Against Prisoners: When Therapy Is Punishment*, 45 Miss. L.J. 605, 623 (1974) ("[I]n mental institutions the bureaucratic needs of the institution for passivity, obedience and

submission take precedence over the therapeutic needs of the patients for development of autonomy, initiative, and self-control"); George E. Crane, *Clinical Psychopharmacology in Its 20th Year*, 181 Science 124, 125 (1973) ("drugs are prescribed to solve all types of management problems").

FN85. See, e.g., *Washington v. Harper*, 494 U.S. 210, 233, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990) (upholding Washington's statutory system providing for review of medication decisions for mentally ill pretrial prisoners by an administrative hearing committee made up of individuals who were not "involved in the inmate's current treatment or diagnosis," but strongly suggesting that the review committee's independence was key to finding Washington's procedure "adequate"); cf. *In re Qawi*, 32 Cal.4th 1, 7 Cal.Rptr.3d 780, 81 P.3d 224, 232 (2004) (citing *Harper*, 494 U.S. at 229, 110 S.Ct. 1028, for the proposition that "even a competent prison inmate, for example, may be forcibly medicated, consistent with the federal due process clause, if it is determined that he is a danger to himself and others, and that the treatment is in his medical interest, as determined by an independent medical board").

FN86. See AS 47.30.660(b)(14) & (16).

As the Minnesota Supreme Court pointed out in addressing the need for judicial determination of patients' best interests,

When medical judgments collide with a patient's fundamental rights, ... it is the courts, not the doctors, who possess the necessary expertise.... [T]he final decision to accept or reject a proposed medical procedure and its attendant risks is ultimately *not* a medical decision, but a personal choice.^{FN87}

FN87. *Jarvis*, 418 N.W.2d at 147-48

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(original emphasis).

The Supreme Judicial Court of Massachusetts reached the same conclusion, emphasizing that a judicial resolution of best interests is crucial precisely because decisions based on personal choice often make little sense from a strictly medical perspective:

The defendants argue that they, as doctors, should be responsible for making treatment decisions for involuntarily committed patients, whether competent or not. We do not agree. Every competent adult has a right to '[forgo] treatment, or even cure, if it entails what for him are intolerable consequences or risks however unwise his sense of values may be in the eyes of the medical profession.

... [FN88]

FN88. *Rogers*, 458 N.E.2d at 314 (citing *Harnish v. Children's Hosp. Med. Ctr.*, 387 Mass. 152, 439 N.E.2d 240, 242 (1982)); cf. *Rivers v. Katz*, 67 N.Y.2d 485, 504 N.Y.S.2d 74, 495 N.E.2d 337, 341 (1986) ("a patient's right to determine the course of his medical treatment [is] paramount ... and [] the right of a competent adult to refuse medical treatment must be honored, even though the recommended treatment may be beneficial, or even necessary to preserve the patient's life"); *Steele*, 736 N.E.2d at 20 ("the patient's wishes ... will be honored, no matter how foolish some may perceive that decision to be").

And Ohio's Supreme Court has similarly described the task of deciding "an involuntarily committed mentally ill person's interest in refusing [psychotropic] medication" as "a uniquely judicial function."^{FN89}

FN89. *Steele*, 736 N.E.2d at 22. Cf. *Price v. Sheppard*, 307 Minn. 250, 239 N.W.2d 905, 912-13 (1976) ("Because the potential impact of the more intrusive forms of treatment is so great, we are

reluctant in those cases where the patient or guardian refuse their consent, to leave the imposition of the more intrusive forms of treatment solely within the discretion of medical personnel at our state hospitals."); *Jarvis*, 418 N.W.2d at 148 ("[w]hen intrusive treatment is proposed, the 'professional judgment' of medical personnel insufficiently protects this basic human right").

The Minnesota Supreme Court aptly underscored the constitutional underpinnings for its decision that this issue must be directed to the courts:

The court's responsibility for the patient does not end at commitment. Commitment to an institution does not deprive an individual of all legal rights, ... especially fundamental rights guaranteed by our Constitution. It would be both unreasonable and unnecessary for the courts to become involved in every post-commitment treatment decision; [but] it is equally clear that the courts cannot abdicate *all* responsibility for protecting a committed person's fundamental rights merely because some degree of medical judgment is implicated.^[FN90]

FN90. *Jarvis*, 418 N.W.2d at 147 (original emphasis).

We agree with these decisions and join them in concluding that the right to refuse psychotropic medication is a fundamental *252 right, though not an absolute one; that the ultimate responsibility for providing adequate protection of that right rests with the courts; and that adequate protection of that right can only be ensured by an independent judicial determination of the patient's best interests considered in light of any available less intrusive treatments.^{FN91}

FN91. Cf. *Steele*, 736 N.E.2d at 21 (the state can forcibly medicate a mental patient under its *parens patriae* authority only after a court finds, "by clear and convincing evidence, that (1) the patient does not have the capacity to give or

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withhold informed consent regarding his/her treatment, (2) it is in the patient's best interest to take the medication, *i.e.*, the benefits of the medication outweigh the side effects, and (3) no less intrusive treatment will be as effective in treating the mental illness"); and *Rivers v. Katz*, 67 N.Y.2d 485, 504 N.Y.S.2d 74, 495 N.E.2d 337, 344 (1986) (if a "court concludes that the patient lacks the capacity to determine the course of his own treatment," the court must then "determine whether the proposed treatment is narrowly tailored to give substantive effect to the patient's liberty interest, taking into consideration all relevant circumstances, including the patient's best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments").

4. Best-interests criteria

Having determined that courts must engage in best-interest inquiries, we believe that some discussion is in order concerning appropriate criteria to guide courts on this issue.

[10] Evaluating whether a proposed course of psychotropic medication is in the best interests of a patient will inevitably be a fact-specific endeavor. At a minimum, we think that courts should consider the information that our statutes direct the treatment facility to give to its patients in order to ensure the patient's ability to make an informed treatment choice.^{FN92} As codified in AS 47.30.837(d)(2), these items include:

FN92. AS 47.30.837(d)(2).

(A) an explanation of the patient's diagnosis and prognosis, or their predominant symptoms, with and without the medication;
(B) information about the proposed medication, its purpose, the method of its administration, the recommended ranges of dosages, possible side effects and benefits, ways to treat side effects, and risks of other conditions, such as tardive dyskinesia;

(C) a review of the patient's history, including medication history and previous side effects from medication;

(D) an explanation of interactions with other drugs, including over-the-counter drugs, street drugs, and alcohol; and

(E) information about alternative treatments and their risks, side effects, and benefits, including the risks of nontreatment[.]^{FN93}

FN93. *Id.*

Considering these factors will be crucial in establishing the patient's best interests as well as in illuminating the existence of alternative treatments.
FN94

FN94. *See id.*, subsection (d)(2)(E).

And here, too, we find the work of other state courts to be helpful. The Supreme Court of Minnesota has held that in order to determine the "necessity and reasonableness" of a treatment, "courts should balance [a] patient's need for treatment against the intrusiveness of the prescribed treatment."^{FN95} Factors that the Minnesota court believed should be considered included:

FN95. *Price*, 239 N.W.2d at 913.

(1) the extent and duration of changes in behavior patterns and mental activity effected by the treatment;
(2) the risks of adverse side effects;
(3) the experimental nature of the treatment;
(4) its acceptance by the medical community of the state; and
(5) the extent of intrusion into the patient's body and the pain connected with the treatment.^{FN96}

FN96. *See id.*

We find these approaches to be sensible.

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*253 [11] Finally, we note that the parties have disputed the standard of proof that the state should be required to meet in establishing the patient's best interests. API argues for a preponderance of the evidence standard, but it offers no legal authority to support that position. Other courts that have required best-interests determinations in this area have uniformly adopted the clear and convincing standard.^{FN97} Moreover, our existing statutory scheme already adopts this standard for findings required to authorize psychotropic medication.^{FN98} We see no reason to dilute the standard governing the best-interests determination, and hold that the clear and convincing evidence standard controls the issue.

FN97. See, e.g., *Steele*, 736 N.E.2d at 20; *In re M.P.*, 510 N.F.2d 645, 647 (Ind.1987); *People v. Medina*, 705 P.2d 961, 973 (Colo.1985).

FN98. See AS 47.30.839(g).

5. Substituted-judgment standard

Myers separately argues that we should follow the example of the Supreme Judicial Court of Massachusetts and require courts authorizing medication to make an additional finding applying the "substituted judgment" approach.^{FN99} The substituted-judgment approach would require courts to attempt to determine what course of treatment an incompetent patient would likely choose if currently capable of making an informed decision.

FN99. See *Rogers*, 458 N.E.2d at 323.

But unlike the statutory scheme at issue in Massachusetts cases, our own statutes incorporate provisions designed to achieve the same goals as the substituted-judgment approach, but by a slightly different path. As already mentioned above, when a treatment facility files a petition for authorization to treat a mentally ill patient with psychotropic drugs, Alaska law requires the appointment of a "visitor" to help gather relevant information for the hearing. One of the two core duties assigned to the

visitor under AS 47.30.839(d) is to investigate, document, and report any prior statements—oral or written—that the patient might have made while competent that expressed wishes regarding medication.^{FN100} Moreover, as also described above, if the information gathered and documented by the visitor enables the court to find that the patient has expressed a prior competent desire not to be medicated, then the court may not authorize treatment; this emerges from the language of AS 47.30.839(g), which requires the court to order treatment only if it finds that a patient is presently incompetent *and* that the patient was incompetent at the time of any previously expressed wishes reported by the visitor:

FN100. In relevant part, AS 47.30.839(d) says:

Upon the filing of a petition ... the court shall direct the office of public advocacy to provide a visitor to assist the court in investigating the issue of whether the patient has the capacity to give or withhold informed consent to the administration of psychotropic medication. The visitor shall gather pertinent information and present it to the court in written or oral form at the hearing. The information must include documentation of the following:

....
(2) any expressed wishes of the patient regarding medication, including wishes that may have been expressed in a power of attorney, a living will, an advance health care directive ..., or oral statements of the patient, including conversations with relatives and friends that are significant persons in the patient's life as those conversations are remembered by the relatives and friends; oral statements of the patient should be accompanied by a description of the circumstances under which the patient made the statements, when possible.

(g) If the court determines that the patient is not competent to provide informed consent *and*, by clear and convincing evidence, was not competent

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to provide informed consent at the time of previously expressed wishes documented [by the visitor] under (d)(2) of this section, *the court shall approve the facility's proposed use of psychotropic medication.*^[FN101]

FN101. (Emphasis added.)

Because neither party has briefed or addressed this provision on appeal, and because Myers did not attempt to rely on it below.^{FN102} *254 we need not decide its exact scope and meaning, and express no opinion on the point here. At least arguably, though, it might be read to give courts authority to deny a petition if the patient made prior competent statements expressing a desire not to be medicated; and if so, it would seem to serve a similar purpose to that of the substituted-judgment approach advocated by Myers. Since the meaning of this provision is not at issue here and remains open for future consideration, and since the provision may ultimately be interpreted as performing many of the same functions as the substituted-judgment approach, we see no present need to decide Myers's argument urging us to adopt that approach.

FN102. In fact it appears that the visitor in this case was unable to submit a complete report. Myers voiced no objection, did not ask for a more complete investigation of prior expressed wishes, and did not ask for a ruling addressing the point. The superior court's decision made no finding on the issue of prior expressed wishes, and Myers has not pursued that point on appeal.

IV. CONCLUSION

We conclude that the Alaska Constitution's guarantees of liberty and privacy require an independent judicial determination of an incompetent mental patient's best interests before the superior court may authorize a facility like API to treat the patient with psychotropic drugs. Because the superior court did not determine Myers's best interest before authorizing psychotropic medications, we VACATE its

involuntary treatment order. Although no further proceedings are needed here because Myers's case is now technically moot, we hold that in future non-emergency cases a court may not permit a treatment facility to administer psychotropic drugs unless the court makes findings that comply with all applicable statutory requirements and, in addition, expressly finds by clear and convincing evidence that the proposed treatment is in the patient's best interests and that no less intrusive alternative is available.

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Briefs and Other Related Documents (Back to top)

- 2004 WL 4908681 (Appellate Brief) Appellant's Supplemental Reply Brief (Sep. 23, 2004)
- 2004 WL 4908682 (Appellate Brief) Appellant's Opening Supplemental Brief (Jul. 26, 2004)
- 2003 WL 25257579 (Appellate Brief) Reply Brief (Dec. 17, 2003)
- 2003 WL 25257580 (Appellate Brief) Brief of Appellee (Dec. 1, 2003)
- 2003 WL 25257581 (Appellate Brief) Brief of Appellant (Aug. 13, 2003)

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