

12138

HOUSE

JUDICIARY



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Stan Hubbard

Signature of Camera Operator

6-1-2009

Date

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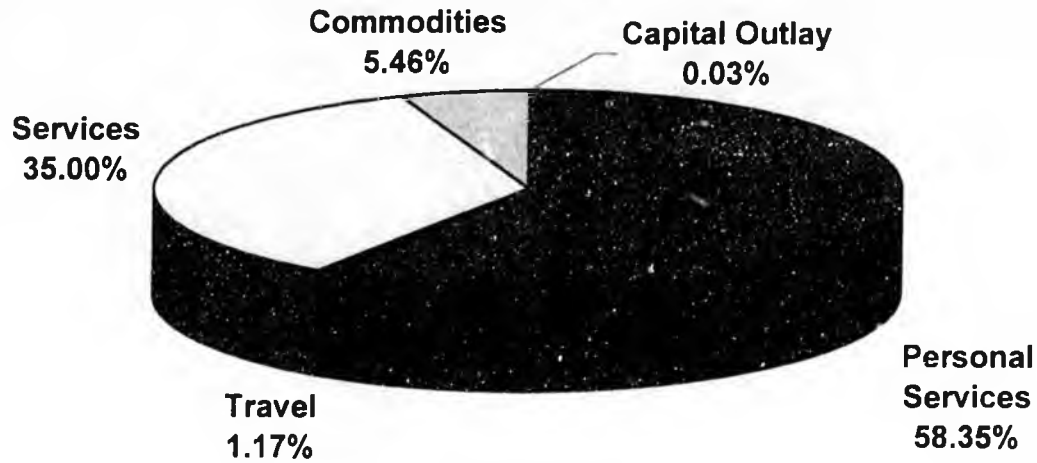
2/7/07

**OVERVIEWS:
DEPT. OF LAW
AND
DEPT OF
CORRECTIONS**

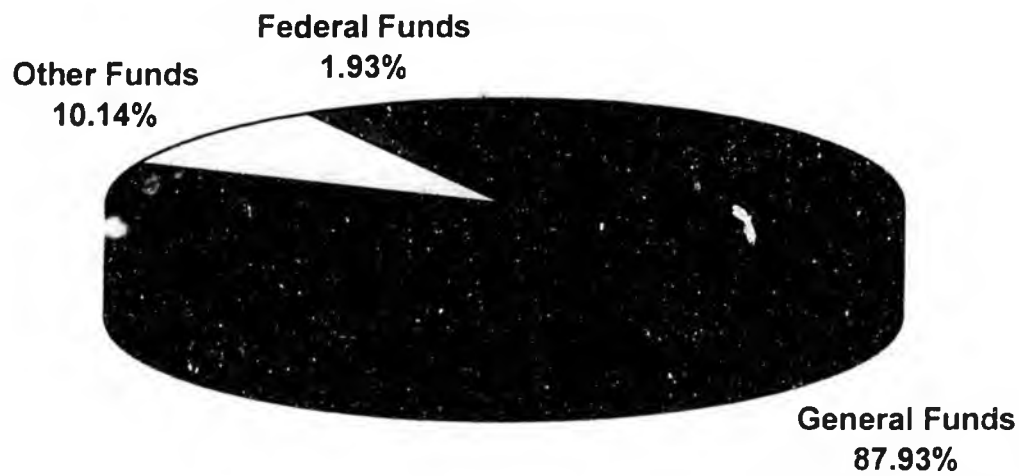
DEPARTMENT OF CORRECTIONS HIGHLIGHTS

- 11 Correctional Institutions with 3,120 Beds
(Emergency Capacity)
- Electronic Monitoring and Offender Supervision
Programs
- 1 Point MacKenzie Farm - 112 Beds
- Out Of State Prison Contracts (currently 1,060 beds
and growing)
- 15 Municipal Jails (Contracted - 153 Beds)
(Bristol Bay Boro, Cordova, Craig, Dillingham,
Haines, Homer, Kodiak, Kotzebue, North Slope Boro,
Petersburg, Seward, Sitka, Unalaska, Valdez,
Wrangell)
- 13 Regional Adult Probation Offices (case load of
5,560)
- 7 Community Residential Centers – 614 Beds

**DEPARTMENT OF CORRECTIONS
FY2008 BUDGET REQUEST**

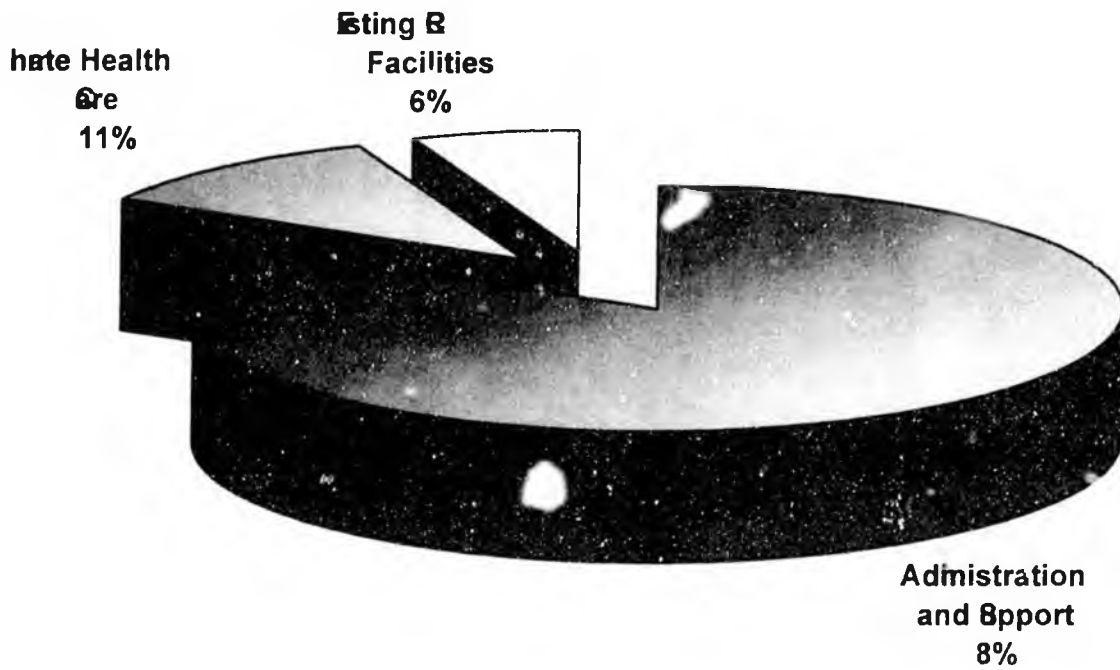


<i>Personal Services</i>	\$141,885.3
<i>Travel</i>	\$2,838.9
<i>Services</i>	\$85,097.9
<i>Commodities</i>	\$13,270.7
<i>Capital Outlay</i>	\$65.8
TOTAL	<u>\$243,158.6</u>



<i>Federal Funds</i>	\$4,695.6
<i>General Funds</i>	\$213,804.7
<i>Other Funds</i>	\$24,658.3
TOTAL	<u>\$243,158.6</u>

**Department of Corrections
Fiscal Year 2008 Operating Budget Request
Overview Summary**



Department of Corrections RDUs

Administration and Support	\$202,485.4
Inmate Health Care	\$26,776.1
Existing CRC Facilities	\$13,897.1

Department of Corrections RDUs Total

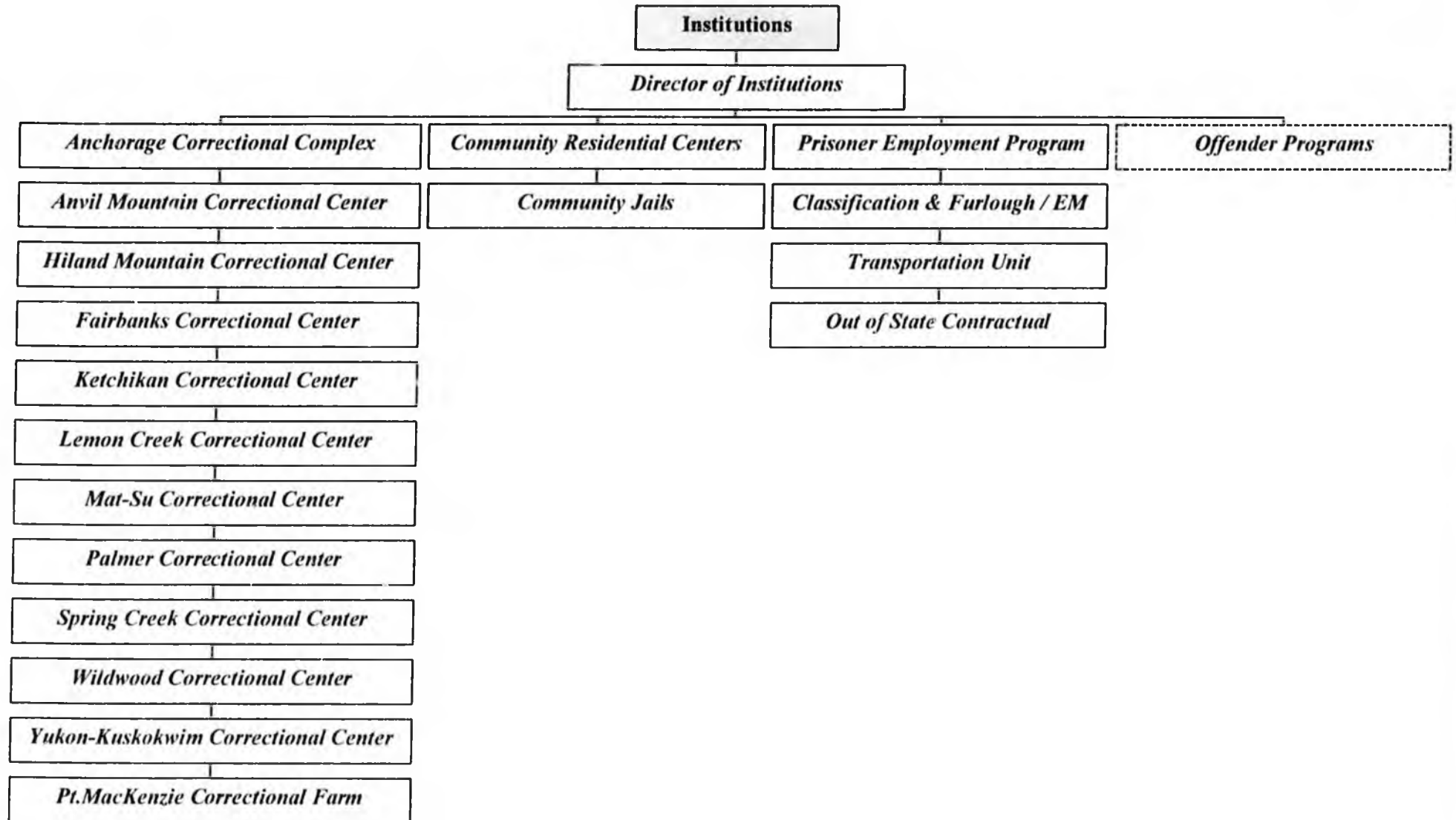
\$243,158.6

*Department of Corrections
Administrative Services
Organizational Structure*

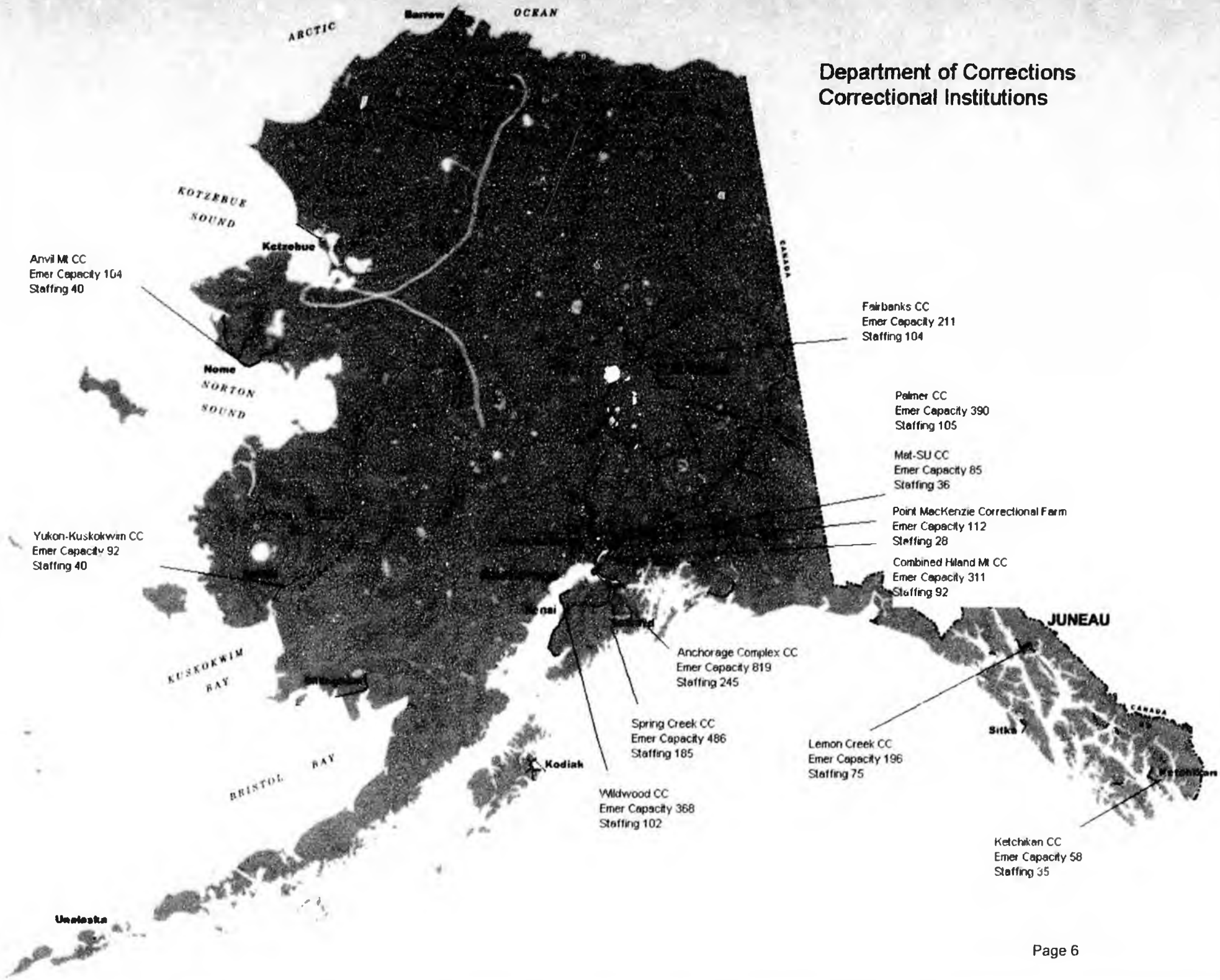
Administrative Services



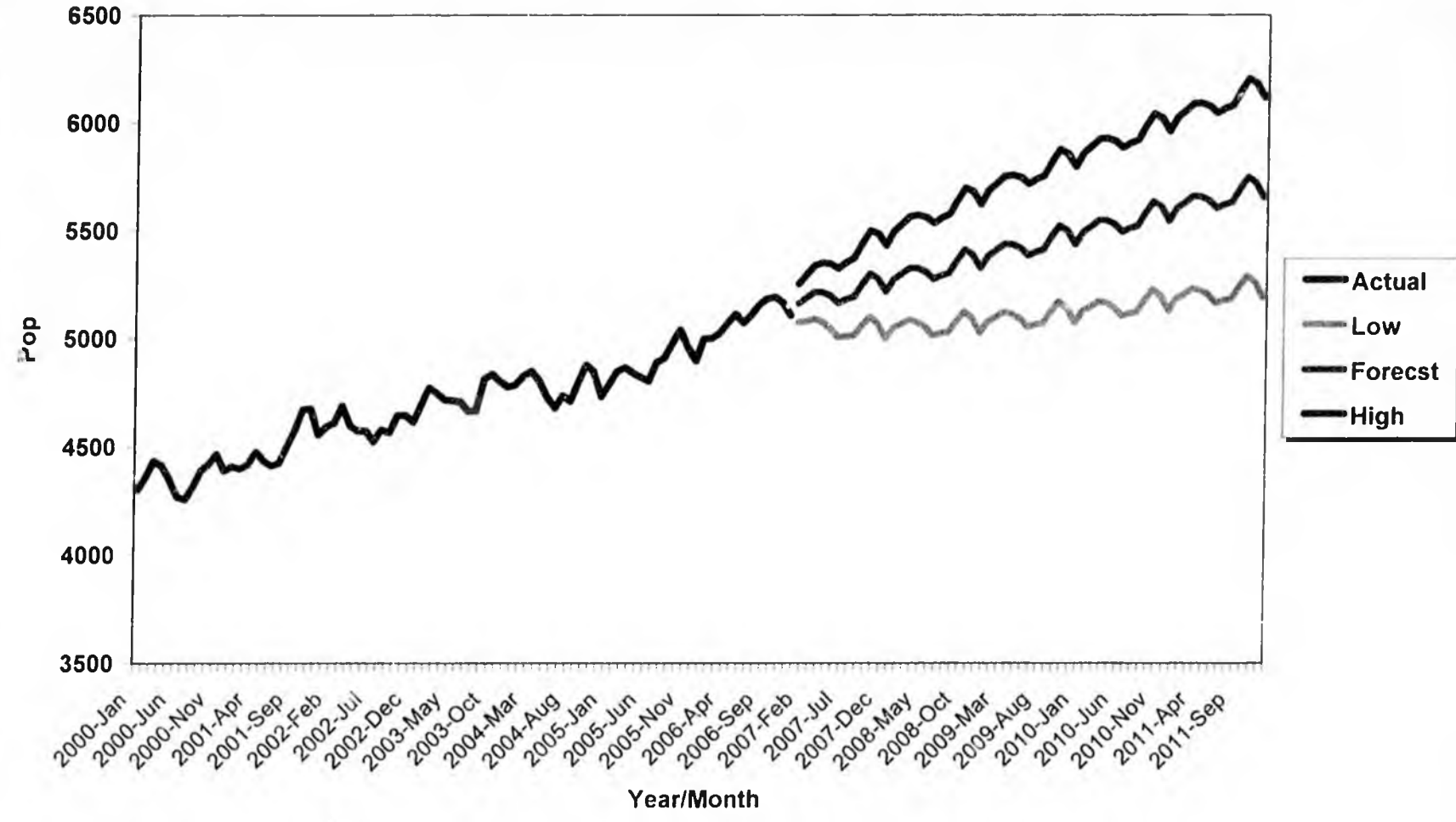
*Department of Corrections
Institutions
Organizational Structure*



**Department of Corrections
Correctional Institutions**



**Total Offender Population Projections
Average Monthly Population
2000 - 2011**



DEPARTMENT OF CORRECTIONS
Three Year Summary Comparison of Convictions

Frequency Distribution for Crime Degree Code	2004		2005		2006	
	Count	Percent	Count	Percent	Count	Percent
Felony (degree unknown)	881	6.0%	811	5.7%	926	6.2%
Felony Class A	94	0.6%	107	0.7%	98	0.7%
Felony Class B	305	2.1%	325	2.3%	303	2.0%
Felony Class C	1,546	10.5%	1,753	12.2%	1,886	12.7%
Felony Unclassified	49	0.3%	55	0.4%	47	0.3%
Misdemeanor	3,837	26.0%	3,202	22.3%	2,905	19.5%
Misdemeanor Class A	6,819	46.2%	6,941	48.4%	7,495	50.3%
Misdemeanor Class B	1,211	8.2%	1,134	7.9%	1,221	8.2%
Misdemeanor Class C	20	0.1%	16	0.1%	19	0.1%
Total	14,762	100.0%	14,344	100.0%	14,900	100.0%

Frequency Distribution for Felony / Misdemeanor	2004		2005		2006	
	Count	Percent	Count	Percent	Count	Percent
Felony	2,875	19.5%	3,051	21.3%	3,260	21.9%
Misdemeanor	11,887	80.5%	11,293	78.7%	11,640	78.1%
Total	14,762	100.0%	14,344	100.0%	14,900	100.0%

Frequency Distribution for Offense Type	2004		2005		2006	
	Count	Percent	Count	Percent	Count	Percent
ADMIN CODE	11	0.1%	14	0.1%	19	0.1%
ALCOHOL	4,087	27.7%	3,667	25.6%	3,629	24.4%
DRIVING/TRAFFIC	1,742	11.8%	1,574	11.0%	1,572	10.6%
DRUGS	266	1.8%	300	2.1%	320	2.1%
PERSON	2,304	15.6%	2,292	16.0%	2,378	16.0%
PROB/PAROLE VIOL	1,820	12.3%	1,911	13.3%	2,193	14.7%
PROPERTY	1,859	12.6%	1,885	13.1%	2,125	14.3%
PUBLIC ADMIN	1,362	9.2%	1,402	9.8%	1,351	9.1%
PUBLIC ORDER	392	2.7%	413	2.9%	345	2.3%
SEX/NON-REGISTERABLE	41	0.3%	71	0.5%	102	0.7%
SEX/REGISTERABLE	192	1.3%	168	1.2%	135	0.9%
WEAPONS	686	4.6%	647	4.5%	731	4.9%
Total	14,762	100.0%	14,344	100.0%	14,900	100.0%

Department of Corrections
Ageing Population
50 +

Facility	Count	Pct
Anchorage Correctional Complex (Anchorage Jail)	56	10.9%
Anvil Mountain Correctional Center	8	1.6%
Arizona Red Rock Correctional Center	193	37.5%
Anchorage Correctional Complex (Cook Inlet)	41	8.0%
Fairbanks Correctional Center	15	2.9%
Combined Hiland Mountain Correctional Center	17	3.3%
Ketchikan Correctional Center	2	0.4%
Lemon Creek Correctional Center	15	2.9%
Mat-Su Correctional Center	10	1.9%
Palmer Correctional Center (Minimum)	20	3.9%
Palmer Correctional Center (Medium)	26	5.0%
Pt. MacKenzie Correctional Farm	8	1.6%
Spring Creek Correctional Center	52	10.1%
Wildwood Correctional Center	30	5.8%
Wildwood Correctional Center (Pre-trial)	18	3.5%
Yukon-Kuskokwim Correctional Center	4	0.8%
Total	515	100.0%

Legal Status	Count	Pct
Sentenced	391	75.9%
Unsentenced	124	24.1%
Total	515	100.0%

Sex	Count	Pct
Female	26	5.0%
Male	489	95.0%
Total	515	100.0%

Race	Count	Pct
Asian/Pacific Island	8	1.6%
Black	53	10.3%
Caucasian	297	57.7%
Hispanic	7	1.4%
Alaska Native	149	28.9%
Unknown	1	0.2%
Total	515	100.0%

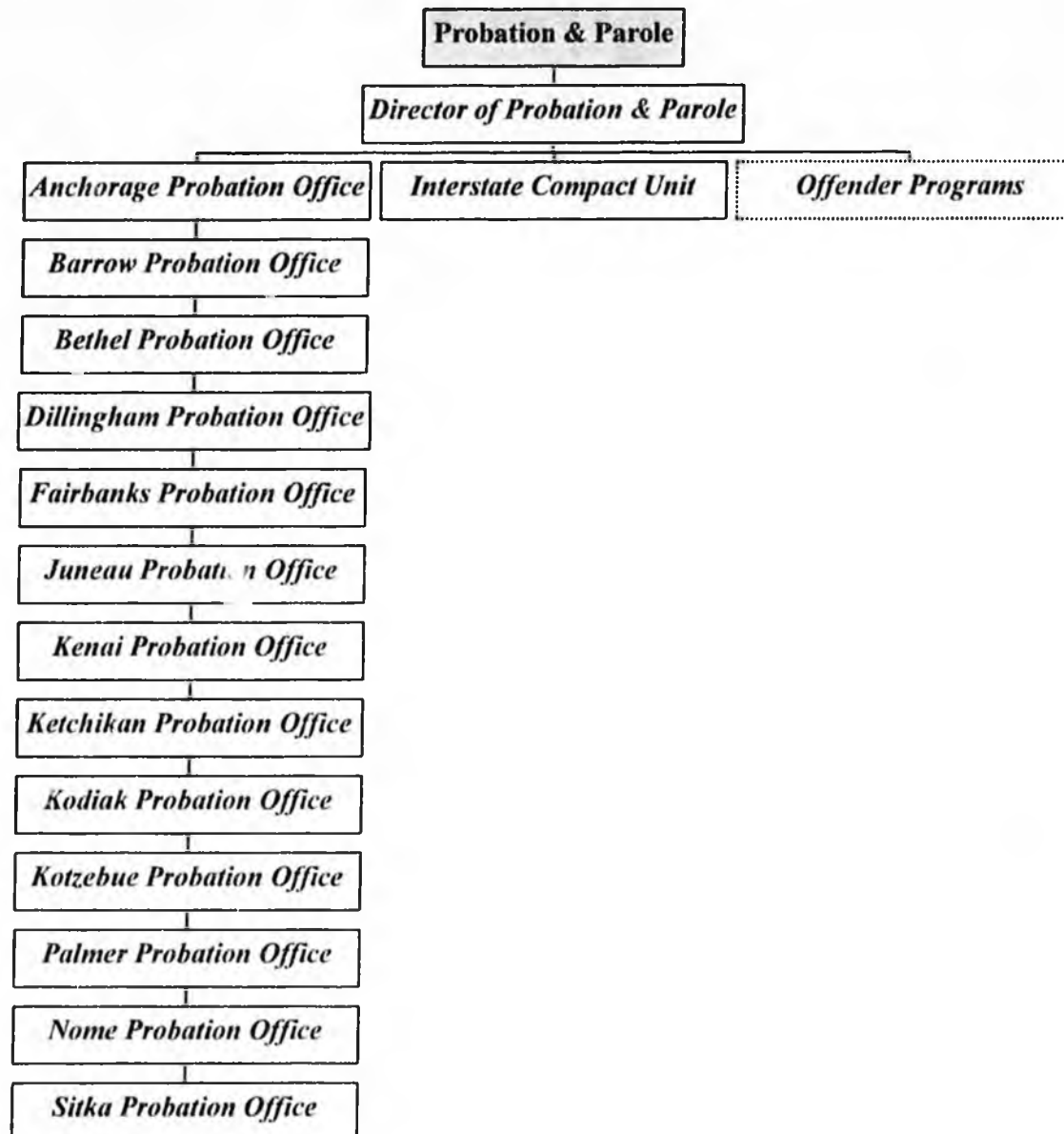
Age Groups	Count	Pct
50-54	261	50.7%
55-59	137	26.6%
60-64	62	12.0%
65-69	34	6.6%
70-74	13	2.5%
75+	8	1.6%
Total	515	100.0%

**Institutions and Arizona January 8, 2007
Population by Age Groups and Sex**

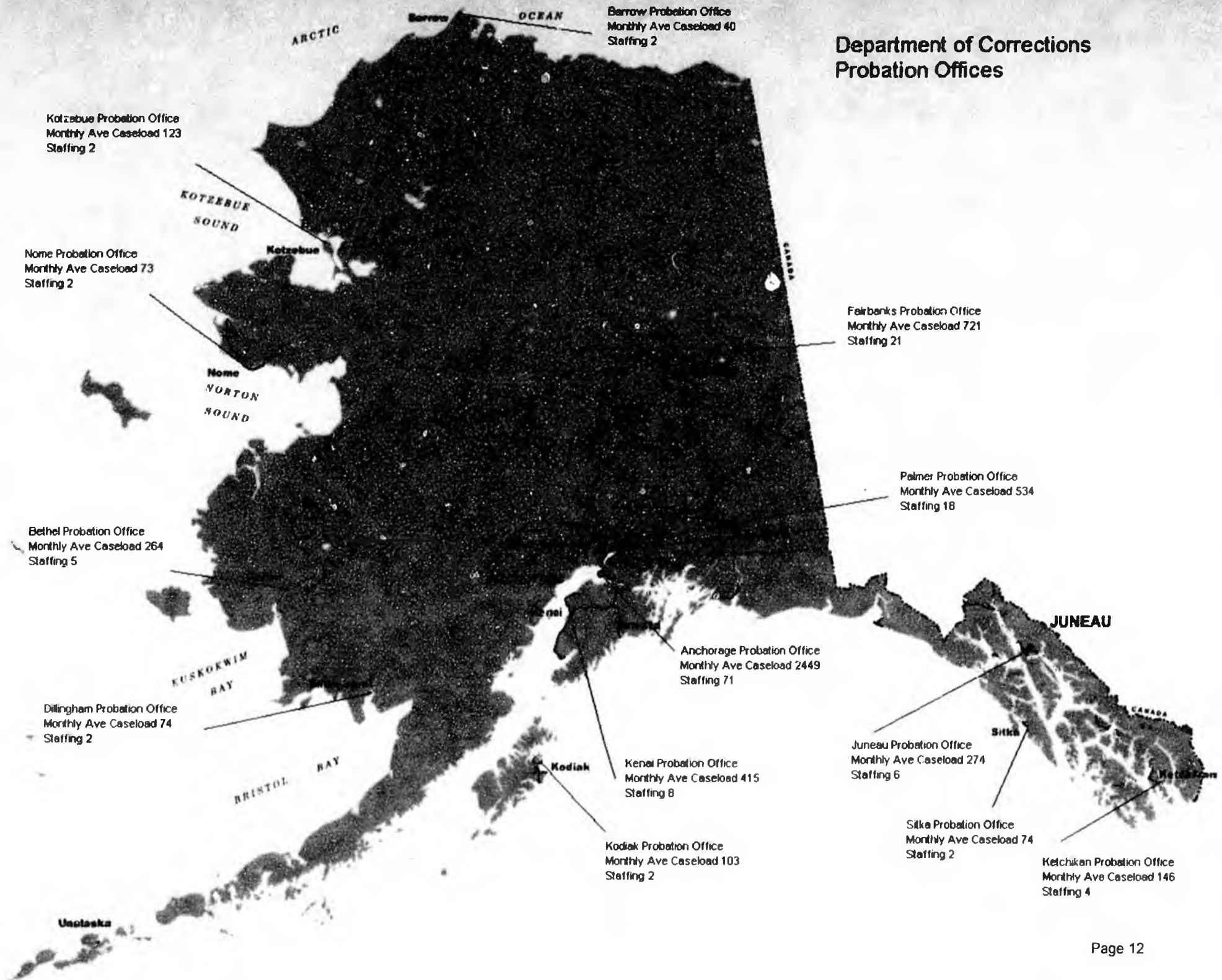
From	To	Male	Female	Total	Pct Tot	Cum Pct
15	19	97	14	111	3%	
20	24	676	65	741	17%	19%
25	29	687	64	751	17%	36%
30	34	504	68	572	13%	49%
35	39	513	57	570	13%	62%
40	44	580	58	638	14%	77%
45	49	448	62	510	12%	88%
50	54	246	16	262	6%	94%
55	59	133	4	137	3%	97%
60	64	59	3	62	1%	99%
65	69	32	3	35	1%	100%
70	74	13	0	13	0%	100%
75	79	7	0	7	0%	100%
80	84	0	0	0	0%	100%
85	89	0	0	0	0%	100%
90	94	1	0	1	0%	100%
		3996	414	4410	100%	

Averages	Male	Female	Total
Mean	36.34	35.40	36.25
Median	35.30	34.79	35.24
Mode	25.57	NA	NA

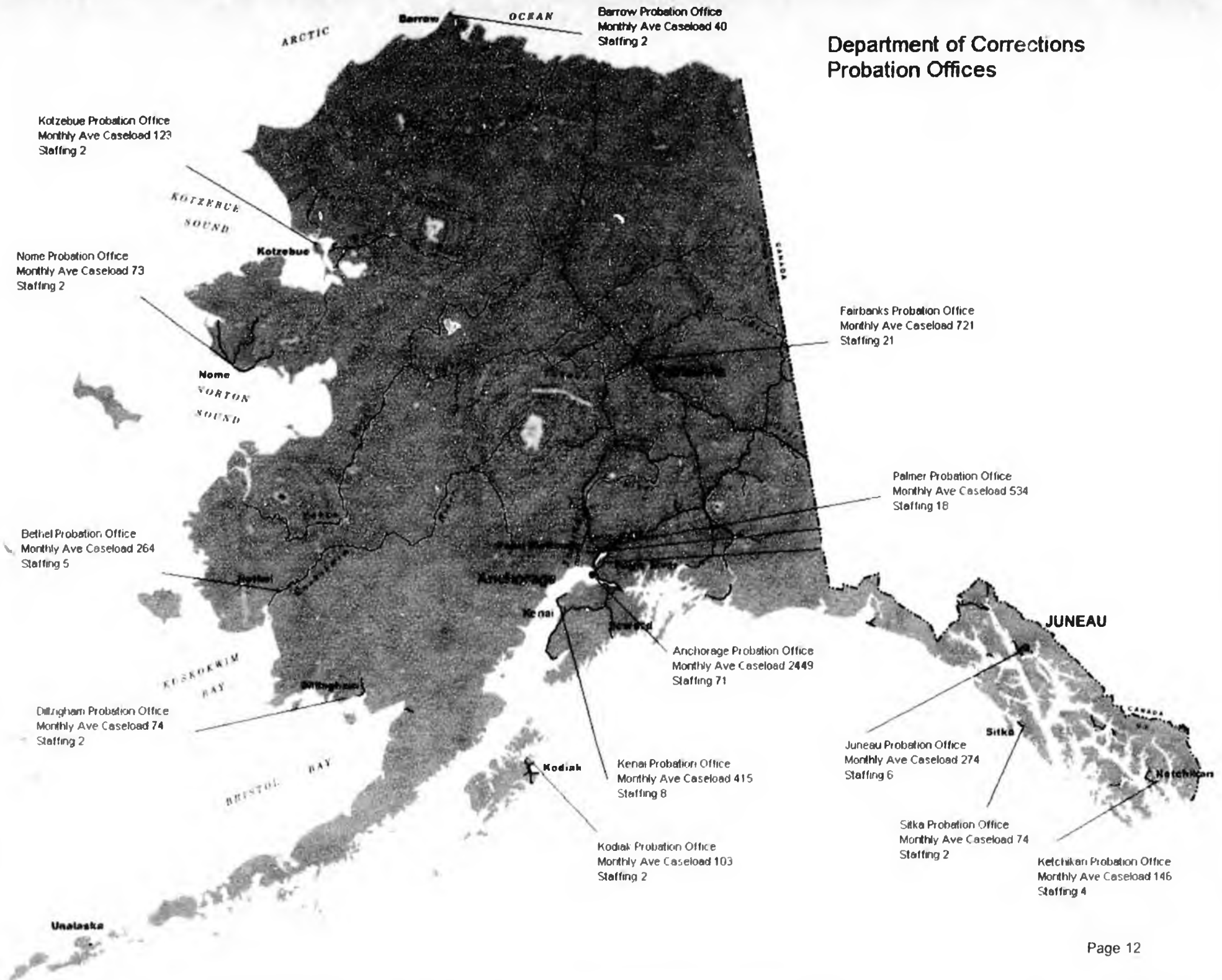
*Department of Corrections
Probation & Parole
Organizational Structure*



Department of Corrections Probation Offices



Department of Corrections Probation Offices



STATE OF ALASKA

SARAH PALIN
GOVERNOR

DEPARTMENT OF CORRECTIONS
Office of the Commissioner

P.O. Box 112000
Juneau, AK 99811-2000
PHONE: (907) 465-4652
FAX: (907) 465-3390

February 14, 2007

Honorable Senator French
Honorable Representative Ramras
State Capitol
Juneau, Alaska 99801-1182

Dear Senator French and Representative Ramras:

The following information is provided in response to questions asked during the Joint Judiciary hearing for the Department of Corrections:

1. How many of the current pre-trial offenders have been incarcerated on a prior offense? Information has been provided from data in the Offender Tracking Information System (OTIS). A count of unsentenced offenders in custody shows that 1,460 (approximately 85%) have had one or more prior admissions.
2. How many Probation Officers have specialty caseloads? Attachment A provides the caseload statistics and a breakdown of specialty caseloads by office.
3. What is the intake protocol for health evaluation was requested. Attachments B provides detail on the intake protocol.
4. How many sex offenders are house in state and how many are housed out-of-state? 203 sex offenders are housed in state and 171 are housed out-of-state.
5. How many offenders who are mental health clients are housed in state and how many are housed out-of-state? There are currently 328 offenders who are mental health clients on psychotropic medications housed in state and an additional 58 housed out-of-state.
6. How many electronic monitoring fees are waived? Based on the six months of data from July 1, 2006 through December 31, 2006, 876 offenders were placed on the electronic monitoring program. There were 112 (or 13%) that were approved to pay a reduced fee. There were no inmates that had a total fee waiver. All indigent inmates must pay a minimum of \$5.00 a day and indigent status is reviewed weekly for continuance or an increase in the fee.
7. Is there a lack of Community Residential Center (CRC) beds for female offenders?
Attachment C

During testimony, Commissioner Schmidt advised the Committee that 92% of Alaska offenders have an issue with alcohol or substance abuse. The percentage of offenders that have an issue with alcohol or substance abuse was provided from the Arrestee Drug Abuse Monitoring Program (ADAM), conducted by the National Institute of Justice (NIJ), year 2001 at the Sixth Avenue and Cook Inlet Pre-trial Facilities.

Additionally, he provided information regarding some mental health statistics for the offender population. The following information was obtained from the database that is maintained by department mental health staff:

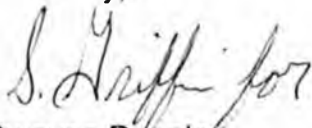
The department processes approximately 33,000 bookings annually – More than 13,000 will have some type of mental health problem.

- Approximately 40% of Alaskan inmates suffer from a mental illness, traumatic brain injury, mental retardation or developmental disability.
- 18% of inmates have a serious, chronic mental illness (Bipolar disorder, schizophrenia, etc).
- Mental health staff are seeing approximately 100 new patients each month that had previously been unidentified as having mental health diagnoses.
- Mental health staff had more than 13,000 inmate contacts in 2005 – a 23% increase since 2001.

The Department of Corrections, with funding assistance from the Alaska Mental Health Trust Authority (AMHTA), initiated a contract with Hornby Zeller Associates, Inc. to conduct a comprehensive outcome study. This study is now in draft form and will soon be available for distribution.

Please contact my office if you have further questions or need clarification on any item.

Sincerely,



Dwayne Peebles
Deputy Commissioner

Attachments (3)

cc: Budget and Finance Files
Legislative Finance
Office of Management and Budget

**Division of Probation Parole
Caseload and PSI Statistics**

Statewide Probation & Parole / February 2007							
Location	Offender Supervision Caseload (Monthly)	PO's supervising caseloads	Average Caseload per PO	PSI's and Letter Updates (annual)	PO I/II	PO III	PO Vacancies February
Barrow	37	1	37	43	0	1	0
Anchorage (DWI)	172	2	86				
Anchorage (general)	1735	17	102	412	39	8	5
Anchorage (ISSP)	47	1	47				
Anchorage (mental health)	98	2	49				
Anchorage (minimum)	335	0					
Anchorage (sex offenders)	346	6	58				
Bethel	254	3	85	78*	4	1	1
Dillingham	75	1	76	31	0	1	0
Fairbanks (general)	548	7	78	155	11	1	0
Fairbanks (mental health)	50	0.5				1	
Fairbanks (sex offender)	56	1	56				
Juneau	285	2	143	95	3	1	1
Kenai	437	4	109	205	5	1	1
Ketchikan	137	1	137	66	2	1	2
Kodiak	103	1	103	6	0	1	0
Kotzebue	124	1	124	25	0	1	0
Name	85	1	85	86	0	1	0
Palmer (general incl min)	504	4.75	106	260	11	1	3
Palmer (sex offenders)	44	0.5					
Sitka	73	1	73	42	0	1	0
TOTAL :	5546	57.75	1553.5	1426	75	21	13

In Anchorage, Palmer, Fairbanks, Juneau and Kenai, some PO's are assigned full-time to writing PSI's. However, all PO's write PSI updates. And, depending on the volume of PSI's due or other staffing issues, other officers are sometimes assigned to write full PSI's.

PO II's in Ketchikan and Juneau carry full caseloads (in excess of 100) due to staffing vacancies and difficulty recruiting.

Only the larger offices (Fairbanks, Palmer, Anchorage, Kenai) break out specialty caseload, and there are combined caseloads containing general supervision caseloads and specialty caseloads.

The smaller offices have caseloads consisting of all types of offenders.

Description of Duties :

Adult Probation Officer I :

Adult Probation Officer I is the entry trainee level. The job class is designed to provide training and experience in the adult probation process, theories and practices. Under the direction of higher level employees and through completion of the Department of Corrections Probation Officer Academy, incumbents learn the techniques of caseload management, pre-sentence investigation, intake, supervision, counseling skills, etc. Tasks are designed to advance knowledge of probation/parole programs, policies and procedures. Positions do not perform the full range of duties generally encountered at the full performance level.

Adult Probation Officer II :


Adult Probation Officer II is the full performance level, in which positions function under general supervision. Positions at this level are distinguished from Adult Probation Officer I by the amount of independence, judgment and discretion exercised and by the assignment of a full, usually diverse caseload requiring a working knowledge of probation programs, policies and procedures. Some positions may have a primary focus such as pre-sentence report writing. An Adult Probation Officer II may be responsible for leading or training other employees including newly hired Adult Probation Officers, however, it is distinguished from the Adult Probation Officer III class in that the latter is the first full supervisory level.

Adult Probation Officer III :

Adult Probation Officer III is the first line supervisory or the advance/expertise level. At this level adult probation officers are responsible for managing a probation program or supervise a probation unit or district office or perform assignments which have been recognized as having significantly greater complexity than those typically assigned at the full performance level. Positions at this level manage, train, assign, review and evaluate staff or oversee and manage a probation program. Some positions at this level manage a caseload. A majority of the positions have substantial supervisory responsibility for the exercise of independent judgment in appointing, promoting, transferring, suspending, discharging and adjudicating grievances of subordinates. It is distinguished from the Adult Probation Officer IV/V classes in that the latter are responsible for managing a complex probation office operation including the supervision of subordinate Adult Probation Officers III at a district or regional level.

Case Classification :

- DWI - Driving while intoxicated
- ISSP - Intensive Supervision Surveillance Program
- PSI - Pre Sentence Investigation Report
- Mental Health - Offenders with Mental health Issues
- Sex Offender - Offenders convicted of a Sex Offense
- Minimum - Offenders that have met ALL conditions of probation and have met at least half of the probation time.

 <p>State of Alaska Department of Corrections Inmate Health</p>	<p>Nursing Protocol</p> <p>Category: Care of Patients</p>
<p>Title: Criminal Remand Screen</p> <p>Number: 2.4</p>	<p>Date: May 2004</p> <p>Supersedes: None</p>

PURPOSE:

To provide guidelines for performing a structured evaluation of a prisoner's health and mental status within 24 hours of the prisoner's admission to a correctional institution.

SKILL LEVEL: RN/LPN with referrals as appropriate, (see note below, #6.)

PROTOCOL:

General guidelines for performing the health screening process are as follows:

1. Criminal Remand Health Care Screen utilizes for 807.14A. See attached.
2. In addition to form 807.14A, thorough documentation in the progress notes is used to elaborate on physical findings and provide details regarding interventions taken.
3. Policy 807.14: Health Examinations provides up to 24 hours for the admission health screening to be completed. When health care staff are on duty the Health Care Screen should be completed as soon as possible in order to evaluate the prisoner's current status, establish a baseline, and determine the need for further interventions.
4. Set priorities for assessment based on the prisoner's presenting signs and symptoms.
5. The nurse's judgment is needed to ensure that the screening process is relevant and inclusive.
6. LPN: Based upon your collection of data that falls outside the normal parameters, a professional judgment is required (or if you have any questions about how to proceed), you must consult with a registered nurse, mid-level practitioner or physician while the patient is still being screened.
7. Use of a systematic approach will facilitate that important information is not deleted.
8. When abnormalities or signs of problems are found appropriate referral to the Health Provider based on current prisoner status will facilitate access to health care. Referrals for abnormal findings on the Health Screen are considered "urgent" or "stat". Please refer to Nursing Protocol 3.4, Criteria for Referral.

PROCEDURE:

The following details the actions taken for an Inmate Remand Screening:

ACTION:

1. Perform intake screening prior to booking in order to visually inspect each prisoner and identify any immediate need for health care.
2. The intake screening is done before booking. Inspect each prisoner to determine apparent immediate need for health care and identify serious health problems. Complete Pre-Remand Screening, Form 807.14A, page 1 of 3, Section A.
 - a) Answer all three questions either "yes" or "no".
 - i. Evidence of serious injury or medical problem requiring immediate medical attention?
 - ii. Remand fails to respond to voice or touch (unconscious)?
 - iii. BRAC more than 300 and remand has not been approved by DOC medical staff.
 - b) Obtain BRAC if remand appears substantially intoxicated. Refer to Attachment A: Effects of Alcohol Intoxication.
 - c) If you answer "yes" to any of the above questions, and the prisoner has not been evaluated and cleared by a responsible health authority *prior* to arrival (such as an Emergency Room physician), medical staff will advise the remanding officer that the prisoner needs to be taken to the local emergency room or other appropriate responsible medical authority.

Points of Emphasis:

- *If the answer to any of the pre-remand screening questions is "Yes," then the remand should be taken directly to an Emergency Room for treatment (except if there is already an external medical clearance.)*
 - *Outside facilities may use form 807.14A, page 1 of 3, Section B to provide medical clearance.*
 - *Any remand requiring evaluation in the Emergency Room will be provided a copy of the form to accompany them.*
3. Complete Post Remand Screening.
 - a) Post Remand Screening can be skipped when the Health Care Screen is completed immediately.
 4. Complete Health Care Screening.
 - a) The following criteria must be addressed with each remand during the health care screen. (Please refer to form 807.14A, page 2 of 3.)

- b) Place a check mark in the box in front of any and all criteria that apply to the specific remand.

Points of Emphasis:

- *If at any time during the screening process it is determined that the remand is in need of immediate medical attention, medical staff should stop the interview and take appropriate action to facilitate the inmate is evaluated in an Emergency Room.*

Health Care Screening

- 1) Vital Signs are done on admission for all remands. Refer to NP 2.4: Obtaining Vital Signs.
 - a) Blood Pressure
 - b) Pulse
 - c) Temperature
 - d) Abnormal Breathing
 - e) O2 Saturation (optional)
 - f) BRAC (Should be done if remand appears intoxicated.) Please refer to Attachment A, Effects of Alcohol Intoxication.
- 2) All abnormal vital signs are followed up with repeat vital signs and referral to the Health Practitioner.

Vital Sign	High	Low
Temperature	>101.5	<96.0
Blood Pressure		
Systolic	>170 mm/Hg	<90 mm/Hg
Diastolic	>115 mm/Hg	
Pulse	>110 beats/minute	<50 beats/minute
Respirations	>30 per minute	<10 per minute
Pulse Oximetry		< 90% O ₂

- 3) Conscious
 - g) Is the remand alert and oriented x3?
- 4) Unconscious
 - a) A prisoner who is unconscious at this time would have gone from conscious during the pre-remand screen to unconscious.
 - b) Immediate medical attention is warranted at this time.
- 5) Obvious Pain
 - a) Identify if prisoner is in obvious pain. Assess characteristics: onset, duration, location, intensity, and quality.

- 6) Skin sores
 - a) Ask the prisoner to indicate if there are any sores that are covered by clothing. Have individual display skin sores by undressing if necessary.
- 7) Night Sweats
 - a) Screen the inmate for any additional signs and symptoms that may be indicative of tuberculosis:
 - i) Cough/Hemoptysis
 - ii) Fever
 - iii) Weight loss
 - iv) Malaise
 - v) Pleuritic chest pain
- 2) Swelling/Deformity
 - a) Instruct the prisoner to perform range of motion.
- 3) Head Injury
 - a) The following questions are significant in determining head injuries:
 - i) What caused the injury?
 - ii) What was the direction and force of the blow?
 - iii) Was there a loss of consciousness?
 - iv) What was the duration of the unconscious period?
 - v) Was there any bleeding from the orifices? Eyes? Ears? Nose? Mouth?
 - vi) Was there paralysis or flaccidity of the extremities?
- 4) Assaultive
 - a) If remand shows excessive aggressiveness/assaultiveness, screening may have to be postponed until the prisoner is better able to cooperate.
- 5) Vermin
 - a) Note any signs of infestation.
- 6) Blood in emesis
 - a) Obtain history of vomiting and when blood was noticed.
 - b) When vomiting occurs shortly after hemorrhage the vomitus is bright red. If blood has been retained in the stomach, digestive processes change the hemoglobin to brown; this gives the vomitus a coffee-ground appearance.
- 7) Bleeding
 - a) Note location and severity of bleeding. If bleeding requires treatment beyond basic first aid, such as bandaging, referral is indicated.
- 8) Cough
 - a) Obtain history of cough. When did it start? Is it productive?
 - b) Identify any other signs of infection and signs of tuberculosis.

- 9) Hearing Impaired
 - a) Obtain history of any hearing loss.

- 10) Obvious infection
 - a) Note any signs of infection.
 - b) An early sign of infection may be an elevated temperature.

- 11) Blood in stool
 - a) Note when inmate first noticed blood in stool and history of related bowel habits.
 - b) Obtain history regarding hemorrhoids.

- 12) Hemoptysis
 - a) Blood streaked sputum often occurs in minor upper respiratory infections or in bronchitis.
 - b) More profuse bleeding may indicate aspergillus infection, lung abscess, tuberculosis, or bronchogenic carcinoma.

- 13) Vision Impaired
 - a) Obtain history of vision loss, use of glasses and/or contact lenses.

- 14) Penile/Vaginal discharge
 - a) Penile or vaginal discharge is indicative of an infection.
 - b) Obtain information regarding type, amount, and color of discharge.
 - c) Example: In males, gonorrhea infection produces a marked purulent, usually painful urethral discharge.

- 15) Painful urination

- 16) Recent use of Rx or non-Rx drugs
 - a) Document:
 - i) Name of drug
 - ii) Dosage and frequency
 - iii) Date and time last used and recent compliance history.
 - iv) History of problems that may have occurred after ceasing use.

- 17) Brought medications
 - a) Refer to DOC Policy 807.05 Use of Pharmaceutical Products for handling of remand medications.

- 18) Influence of alcohol
 - a) Obtain history of alcohol use:
 - i) last time and amount used,
 - ii) daily average amount in past few weeks,
 - iii) history regarding withdrawal.

19) Obtain BRAC test results.

- a) Alcohol is a direct multi-system toxin and central nervous system depressant that causes drowsiness, uncoordinated movements, slurring of speech, belligerency, grandiosity, and uninhibited behavior.
- b) Look for signs of alcohol withdrawal or alcohol induced psychosis.

20) Influence of drugs

- a) Obtain as much information as possible regarding history of drug use.
- b) Although the clinical manifestations may vary with the drug used, the immediate priority is to determine if drug intoxication is compromising respiratory or cardiovascular functions. Barbiturate and benzodiazapine dependence is of concern due to the risk of severe medical problems during detoxification.
 - i) Refer to Nursing Protocol 1.1: Performing a General Survey, Attachment A: Red Flags for Suspicion of Substance Abuse.

21) Signs of alcohol/drug withdrawal

- a) Obtain results of BRAC test.
- b) Consult on-call practitioner for appropriate withdrawal protocol as it relates to the drug or alcohol the remand is withdrawing from.
- c) Signs of impending acute alcohol withdrawal include: anxiety, uncontrollable fear, tremulousness, irritability, agitation, and insomnia.
 - i) The individual will be talkative and preoccupied, and may experience visual, tactile, olfactory, and auditory hallucinations that may be terrifying.
 - ii) Physiological signs may include: tachycardia, dilated pupils, and profuse perspiration. Usually all vital signs are elevated in the alcoholic toxic state.

Point of Emphasis:

- *Medical staff will refer a remand that is in need of medical care to the on-call practitioner. If the institution cannot provide the necessary health care, then a referral will be made to a provider outside the institution.*

History:

- 1) Each issue under History is addressed with the prisoner through the interviewing process.
- 2) Note when applicable:
 - a) Allergies
 - b) Current Conditions
 - c) Medication/Dose
 - d) Private Physician
 - e) Alcohol/Drug Use Past few days
 - f) Withdrawal History (Especially Seizures)
 - g) Other Pertinent History: Injuries, Accidents, Head Trauma, Observations, TB Symptoms, and Comments
- 3) PPD given.
 - a) Yes, indicate area where to PPD was placed, such as LFA (left forearm).

- b) No, explain reason why PPD was not placed.
- c) Refer to Infection Control Nursing Protocol: Tuberculin skin testing: The Mantoux Skin Test.

Point of Emphasis:

- *When a remand indicates they have a pertinent medical history Medical staff are to obtain a Release of Information and obtain the health information from the community provider as soon as possible.*

Mental Health Screening (Form 807.14A, 3 of 3):

- 1) Mental Health Screening will be completed through direct observations of the prisoner.
- 2) Check all criteria under the following categories that apply to the prisoner:
 - a) Appearance
 - b) Attitude
 - c) Motor Behavior
 - d) Speech
 - e) Mood/Affect
 - f) Cognitive
 - g) Thought Process
 - h) Thought Content
 - i) Hallucinations

Suicide Risk Screening:

- 1) Answer "Yes" or "No" to questions 1 through 9.
 - a) See Suicide Screening Guidelines indicated on form 807.14A, 3 of 3.

Point of Emphasis:

- *Questions 1-3 are usually definite indications of risk for suicide. A suicidal Remand who wants to conceal a plan to kill themselves will deny 1-3, but usually will have a number of indicators in 4-9.*

Assessment and Intervention:

- 1) Is this Remand a suicide risk?
 - a) If the answer to this question is "Yes," implement appropriate suicide precautions and notify Mental Health and/or Health Practitioner for follow-up evaluation.
- 2) Does this Remand require assessment by Mental Health Staff due to psychiatric history or symptoms?
 - a) If "Yes," refer to Mental Health for further evaluation.
- 3) Is medical segregation necessary due to medical status?
 - a) If "yes," notify shift supervisor for 15-minute observations.

- 4) Other interventions:
 - a) Document all interventions taken during remand screen. Follow-up with documentation in the progress notes as needed.

- 5) Screener's signature
 - a) When the Health Care Screen is complete the nurse will sign, date and time the form.

- 6) Referral:
 - a) Abnormal health care screens will be referred to the Health Practitioner.
 - i) After the Health Practitioner has reviewed the Health Care Screen they will sign, date and time.
 - b) Prior to release, a remand that is a danger to himself or others due to mental illness will be referred for review to the on-call Mental Health provider if he or she is not going to a treatment facility.

ATTACHMENTS:

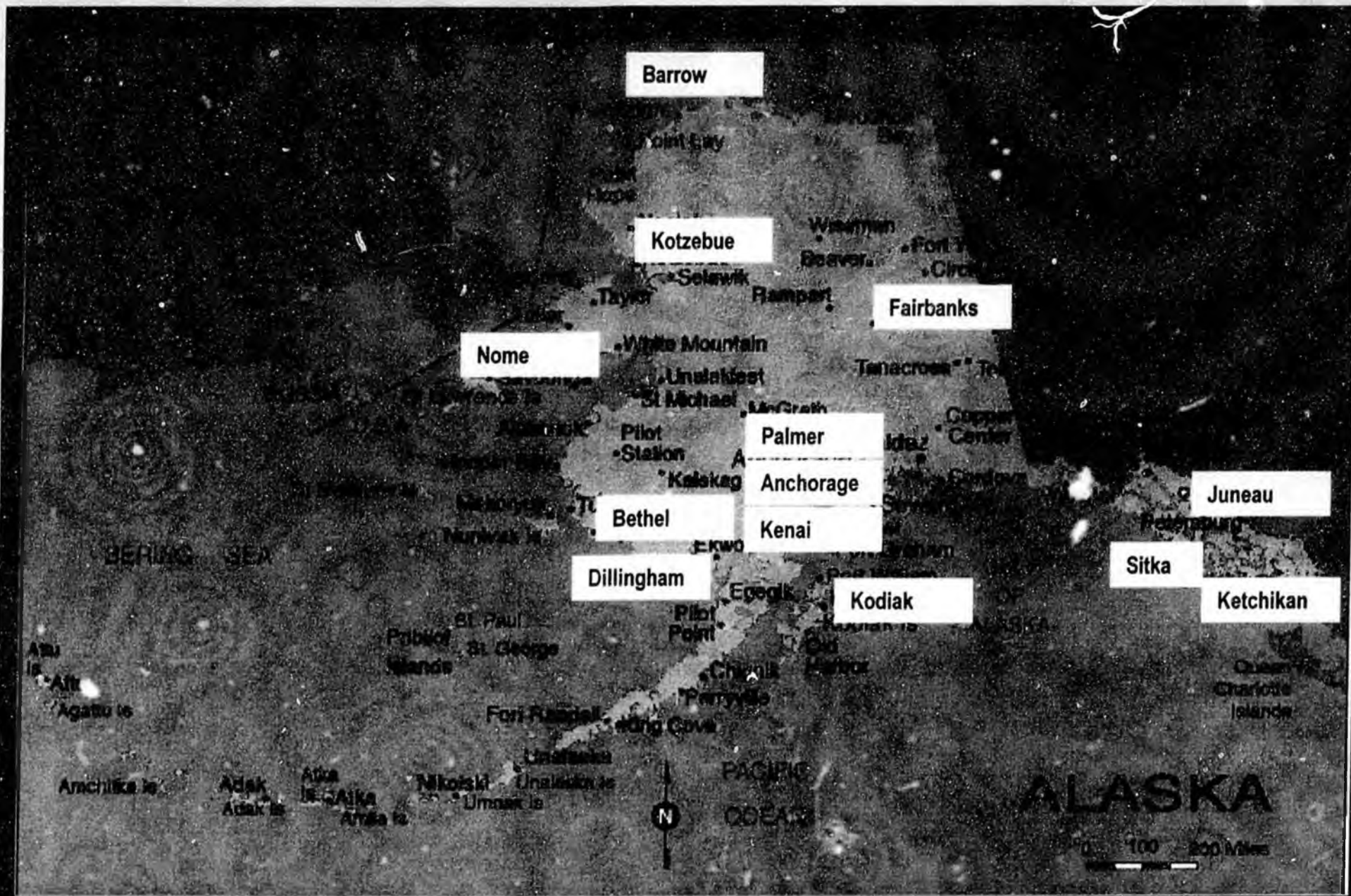
Attachment A: Effects of Alcohol Intoxication
DOC form 807.14A

RELATED DEPARTMENT OF CORRECTIONS POLICIES:

202.04 Airborne Pathogens
807.14 Health Examinations
807.02 Access to Health Care Services
807.05 Use of Pharmaceutical Products

Women Housed in CRC's

	Current Female Count	Beds Assigned to Females	Comments	CRC Contract bed TOTAL
Parkview			NO Females / Houses males only	
Cordova	19	41	(25 for DOC / 16 for Feds)	100 beds = 85 Regular / 15 Guaranteed Per Diem
Glenwood	10	12		88 beds = 74 Regular / 14 Guaranteed Per Diem
North Star	6	19 +	Can house as many as needed	107 beds = 91 Regular / 16 Per Diem
Tundra	3	16	Potential for 19 - 20 max	85 beds = 72 Regular / 13 Per Diem
Glacier	7	15		85 beds = 72 Regular / 13 Per Diem
Seaside	9	20		50 beds = 43 Regular / 7 Per Diem
TOTAL :	54	104		



Alaska's Thirteen Regional District Attorney's Offices

Regional DAO Staffing

Anchorage	- 32 attorneys, 8 paralegals
Fairbanks	- 14 attorneys, 3 paralegals
Palmer	- 10 attorneys, 3 paralegals
Kenai	- 7 attorneys, 3 paralegals
Bethel	- 6 attorneys, 3 paralegals
Juneau	- 3 attorneys, 1 paralegal
Ketchikan	- 3 attorneys, 1 paralegal
Nome	- 2 attorneys, 1 paralegal
Kodiak	- 2 attorneys, 1 paralegal
Sitka	- 1 attorney, 1 paralegal
Kotzebue	- 1 attorney, 1 paralegal
Dillingham	- 1 attorney, 1 paralegal
Barrow	- 1 attorney

Office of Special Prosecutions and Appeals (Anchorage)

- 8 appeals attorneys (criminal appeals)
- 8 statewide special prosecutors (environmental crimes, fish & game prosecution, welfare, PFD, child support and insurance fraud, police and official misconduct)

Regional DAOs - Anchorage

Anchorage DAO staffing

- 32 prosecutors
- 8 paralegals
- 20 administrative support assistant

Judicial staffing

- 15 Superior Court judges
- 9 District Court Judges
- 20 magistrates

Case load increase:

- 2327 felony referrals in 2003
- 2858 felony referrals in 2006

Outlying communities

- Unalaska, St. Paul, Sand Point, Whittier

Unique problems

- The Anchorage office often sends attorneys and paralegals to other offices around the state to help out. The office also handles juvenile delinquency matters that used to be handled in the civil division. The caseload in Unalaska nearly takes up one attorney and one support assistant full time

Regional DAOs - Fairbanks and Barrow DAO

Fairbanks & Barrow DAO staffing

- **14 prosecutors in Fairbanks and 1 in Barrow**
- **4 paralegals in Fairbanks; none in Barrow**
- **10 administrative support assistants in Fairbanks; 1 in Barrow**

•Judicial staffing

- **5 Superior Court judges in Fairbanks; and 1 in Barrow,**
- **3 District Court judges in Fairbanks**
- **2 magistrates in Fairbanks; 1 in Barrow**
- **2 standing masters in Fairbanks**

•Case load increase:

- **819 felony referrals in 2002**
- **1,078 felony referrals in 2006**

•Outlying communities

• **The Fairbanks Court is served by the 5 Superior Court Judges, 3 District Court Judges, 2 Magistrates, and 2 Standing Masters. Magistrate Courts also served by the Fairbanks District Attorney's Office are: Tok, Delta, Nenana, Healy, Cantwell, Fort Yukon, Tanana and Galena.**

• **The Barrow Court is served by 2 Superior Court Judge and 1 Magistrate. Magistrate Courts also served by the Barrow District Attorney's Office are: Kaktovik, Anaktuvuk, Atkasuk, Prudhoe Bay, Wainwright, Point Lay and Nuiqsut.**

Regional DAOs - Fairbanks and Barrow DAO

Service area:

Approximately one-third of the State's land mass is served by the Fairbanks and Barrow District Attorney's Offices. The Fairbanks District Attorney's Office supervises and supplements the Barrow District Attorney's Office.

This area is bordered on the East from the Tok-Northway area along the Alaska-Canada Highway border, North to the Arctic Ocean from Kaktovik to Point Lay; on the West by a Southerly line from Point Lay on the Arctic Ocean to Nulato on the Yukon River; and on the South by a Crooked line from Nulato southeasterly through McKinley Park, then along the Denali Highway and back to Tok-Northway on the Alaska Highway at the Alaska-Canada Highway border.

Unique problems:

The Fairbanks District Attorney's Office works with numerous law enforcement agencies including Alaska State Troopers, Fairbanks Police Department, North Pole Police Department, Airport Police Department, University Police Department, U.S. Military, Village Police Departments and Village Public Safety Officers.

The Iraq war spurred a marked increase in soldiers at Fort Wainwright and airmen at Eielson Air Force Base. This triggered an increase in minor crime - such as DUI prosecution.

Regional DAOs - Palmer

Palmer DAO staffing

- ten prosecutors
- three paralegals
- five admin support assistants

•Judicial staffing

- Four Palmer Superior Court judges,
- four District Court Judges (one in Valdez, three in Palmer)
- three (Glennallen, Cordova, and Palmer)

•Outlying communities

- Valdez, Glennallen, Cordova

•Case load:

- 801 felony referrals in 2003
- 787 felony referrals in 2004
- 869 felony referrals in 2005
- 802 felony referrals in 2006

•Service area

- Includes a population base of over ____,000;
- Palmer-Wasilla is perhaps, one of the fastest-growing areas of the State

Regional DAOs - KENAI

Kenai DAO staffing

- 7 prosecutors
- 3 paralegals
- 5 administrative support assistants

Judicial staffing

- 3 Superior Court judges (Kenai)
- 2 District Court judges (Kenai and Homer)
- 3 magistrates (Kenai and Seward)

Case load increase:

- 484 felony referrals in 2002
- 913 felony referrals in 2006

Outlying communities

• In addition to Homer and Seward, where there are courthouses, the Kenai DAO also covers Nanwalek, Port Graham, Tyonek, Beluga, Seldovia, Moose Pass, Cooper Landing, Sterling, Soldotna, Nikiski, Kasilof, Clam Gulch, Ninilchik, Anchor Point, Happy Valley, Nikolaevsk,

Service area

• The size of the Kenai Peninsula and the outlying areas is over 20,000 square miles, which is almost the size of West Virginia

Regional DAOs - KENAI

•Unique problems:

- A Kenai prosecutor travels to Homer once a month for a week at a time. That prosecutor also must cover daily Homer telephonic court hearings.**
- A Kenai prosecutor travels to Seward once a month for a week at a time.**
- Kenai prosecutors cover Division of Juvenile Justice cases.**
- In the summer, the Kenai DAO is among the state's most popular Alaska tourist destinations. The attraction is Kenai River and Homer fishing activities, as well as Seward's, Fourth of July celebration and Labor Day festivities. These events cause a significant increase in DUIs and other alcohol-related crimes as well as Fish & Game cases involving commercial and personal-use fishing, guide violations, and dip-net charges.**
- Many Kenai-area residences that are occupied only part time because of summer residencies or Slope work are a continual source of burglaries and thefts.**
- The Kenai DAO serves several communities with diverse cultures, such as the Native communities of Tyonek and Nanwalek as well as the Russian/Old Believer communities of Nikolaevsk and Voznesenka.**

Regional DAOs - Bethel

Bethel DAO staffing

- five prosecutors
- three paralegals
- four admin support assistants

•**Judicial staffing**

- Two superior Court judges, one district court judge, and full-time Magistrate
- Most outlying communities have resident magistrates.

•**Outlying communities**

- Chevak, St. Mary's, Aniak and Emmonak; travelling trials occur regularly

•**Case load increase:**

- 76 felony referrals in 2003
- 89 felony referrals in 2006

•**Service area**

- Includes a population base of over 6,000; 51 Yukon-Kuskokwim delta villages --an area roughly the size of the state of Ohio.

Regional DAOs - Bethel

- **Unique problems**
 - **Enormous logistical problems created by witness location and transportation, and follow-up investigation.**
 - **Bethel Trooper Post and Bethel Police Department chronically understaffed.**
 - **Tribal police officers and Village police officers are often ill-trained and often unable to complete police reports acceptable for court use.**
 - **The Bethel office has more referred felony sexual assault cases and Sexual abuse of Minor cases referrals -- in absolute, not *per capita* numbers -- than does Anchorage.**

Regional DAOs - Juneau

Juneau DAO staffing

- **three prosecutors**
- **one paralegal**
- **three admin support assistants**

•Judicial staffing

- **Three Superior Court judges,**
- **one district Court judge**
- **six magistrates**

•Case load:

- **312 felony referrals in 2003**
- **405 felony referrals in 2004**
- **414 felony referrals in 2005**
- **336 felony referrals in 2006**

•Outlying communities

- **Juneau, Haines, Skagway, Hoonah and Yakutat and Wrangell, Pelican, Elfin Cove, Tenakee Springs and Gustavus**

Regional DAOs - Ketchikan

Ketchikan DAO staffing

- **three prosecutors**
- **one paralegal**
- **two admin support assistants**

•Judicial staffing

- Two Superior Court judges,**
- One District Court judges**
- two magistrates (Ketchikan, Craig)**

•Case load increase:

- 221 felony referrals in 2003**
- 303 felony referrals in 2004**
- 285 felony referrals in 2005**
- 225 felony referrals in 2006**

•Outlying communities

- **Craig, Klawock, Hydaburg, Thorne Bay, Metlakatla, Hyder**

Regional DAOs - Nome

Nome DAO staffing

- **two prosecutors**
- **one paralegal**
- **one admin support assistant**

•Judicial staffing

- **One Nome Superior Court judge,**
- **two magistrates (Nome, Unalakleet)**

•Case load:

- **191 felony referrals in 2003**
- **162 felony referrals in 2006**

•Outlying communities

- **Little Diomedede, Wales, Shishmaref, Brevig Mission, Teller, Gambell, Savoonga, White Mountain, Golovin, Elim, Koyuk, Shaktoolik, Unalakleet, Stebbins and St. Michael**

•Unique problems

- **AST, Nome Police Department, Unalakleet Police Department, some villages have VPSOs, some villages have VPOs. Some at times have neither VPOs or VPSOs.**
- **Over 1,000 criminal cases last year, not including PTRPs, almost all alcohol-related.**

Regional DAOs - Kodiak

Kodiak DAO staffing

- two prosecutors
- one paralegal
- one admin support assistant

•Judicial staffing

- One Superior Court judge,
- one magistrate

•Case load increase:

- 131 felony referrals in 2003
- 163 felony referrals in 2004
- 156 felony referrals in 2005
- 130 felony referrals in 2006

•Outlying communities

- Akhiok, Chiniak, Karluk, Larsen Bay, Old Harbor, Ouzinkie, and Port Lions

•Unique problems

- Routinely DOL Civil Division work; represent DHHS/Office of Children's Services on child-in-need-of-aid cases and parental rights termination cases

Regional DAOs - Sitka

- **Sitka DAO staffing:**

- **one prosecutor**
- **one paralegal**
- **one admin support assistant**

- **Judicial staffing**

- **Sitka has a resident Superior Court judge and a full-time magistrate**
- **Petersburg has one full-time magistrate**
- **Kake and Angoon both have resident magistrates**

- **Outlying communities**

- **Petersburg, Kake, Angoon, Pelican, Port Protection, Port Alexander, Point Baker**

- **Traveling calendars**

- **A Superior Court judge travels to Petersburg monthly. The Sitka DA travels to Petersburg every month**

- **Case load increase:**

- **80 felony referrals in 2003**
- **124 felony referrals in 2006**

Regional DAOs - Kotzebue

Kotzebue DAO staffing

- 1 prosecutor
- 1 paralegal
- 1 administrative support assistant

• **Judicial staffing**

- 1 Superior Court judge
- 1 magistrate

• **Case load increase:**

- 166 felony referrals in 2003
- 190 felony referrals in 2006

• **Outlying communities**

- Point Hope, Kivalina, Noatak, Noorvik, Kiana, Shungnak, Selawik, Buckland, Deering, Ambler, Kobuk

• **Service area**

- The Kotzebue DAO services an area the size of Indiana.

• **Unique problems**

- Only one prosecutor to screen/prosecute 850-1000+ cases annually,
- The Kotzebue DA covers all daily district court, superior court, and juvenile delinquency hearings

Regional DAOs - Dillingham

Dillingham DAO staffing

- **one prosecutor**
- **one paralegal**
- **one admin support assistant**

Judicial staffing

- **One Superior Court judge,**
- **two magistrates (Dillingham, Naknek)**

Case load:

- **137 felony referrals in 2003**
- **122 felony referrals in 2006**

Outlying communities

- **Togiak, Twin Hills, Manokotak, Clark's Point, Portage Creek, Ekwok, New Stuyahok, Koliganek, Aleknagik, Naknek, King Salmon, Iliamna, New Halen, Kokhanok, Egegik, Port Heiden, Port Alsworth, Pedro Bay, Pilot Point, Perryville, Levelock, Nondalton**



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Stan Hubbard

Signature of Camera Operator

6-1-2009

Date

2/8/07

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

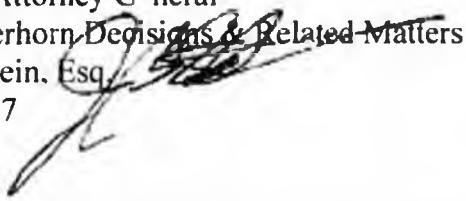
PsychRights[®]

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
James B. (Jim) Gottstein, Esq.

of

PsychRights[®]

**Law Project for
Psychiatric Rights**
<http://PsychRights.Org>

Presented at

Alternatives 2005
Leading the Transformation to Recovery
Phoenix, Arizona, October 28, 2005

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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

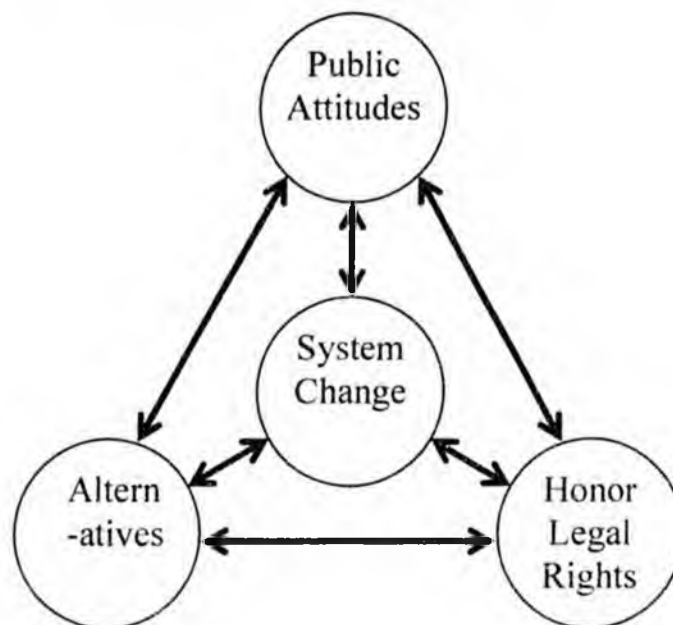
[http://psychrights.org/Articles/EHPPPsychDrugEpidemic\(Whitaker\).pdf](http://psychrights.org/Articles/EHPPPsychDrugEpidemic(Whitaker).pdf), Robert Whitaker demonstrates the rate of disability has increased six fold since the introduction of Thorazine in the mid '50s. The Michigan State Psychotherapy 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.

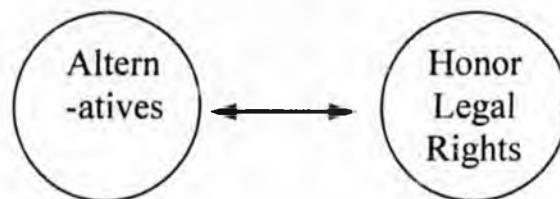
More legal trouble for the system comes in if people were to have Advance Directives that were made when they were certifiably (I would even suggest certified) competent at the time they made them. The system still doesn't know what to do with them, so it has to come with some way to ignore them, but 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.

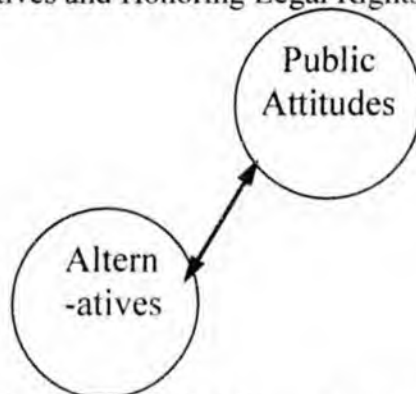
⁵⁶ See, Effective Non-Drug Treatments, which can be found on the Internet at <http://psychrights.org/Research/Digest/Effective/effective.htm>, for some specific examples.

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:

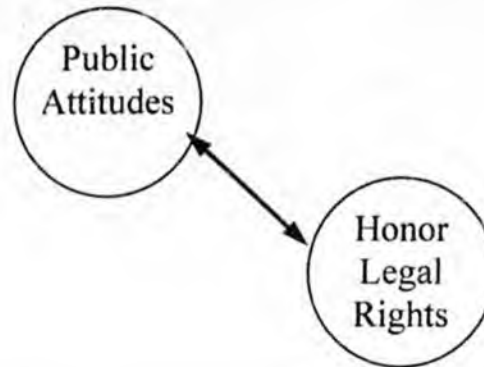


VI. Interplay Between Public Education and Honoring Legal Rights

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

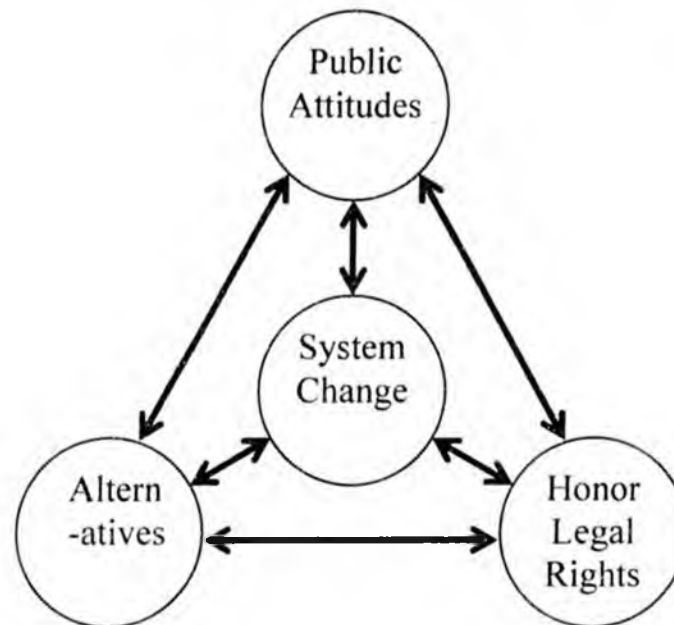
⁵⁷ U.S. 294, 75 S.Ct. 753, 99 L.Ed. 1083 (1955).

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>.