12139 HOUSE JUDICIARY

C. Minnesota

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

D. New York

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

E. Other States

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

XI. Public Attitudes

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

A. An Effective Public Relations Campaign

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

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

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

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

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

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

B. Potential Talking Heads

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

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

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

C. Promoting and Making Stories

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

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

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

XII. Alternatives

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

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

- INTAR[77]
- Action Conference[78]
- Alaska -- Soteria-Alaska, CHOICES, Peer Properties[79]

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[71] *See*, http://mindfreedom.org/mindfreedom/hungerstrike.shtml.
[72] *See*, http://www.mindfreedom.org/mindfreedom/hungerstrike22.shtml.
[73] *See*, http://mindfreedom.org/mindfreedom/hungerstrike1.shtml.
[74] This is not a criticism at all. From my perspective the Hunger Strike was wildly successful.
[75] However, I am also in favor of non-system alternatives and especially "Underground Railroad" and "Safe Houses" types of efforts to which people facing involuntary commitment and forced drugging can escape.
[76] *See*, Anatomy of an Epidemic: Psychiatric Drugs and the Astonishing Rise of Mental Illness in America, which is available at http://psychrights.org/Articles/EHPPPsychDrugEpidemic(Whitaker).pdf.
[77] *See*, http://intar.org/
[78] *See*, Choices Track at http://psychrights.org/Education/2005ActionConference/FinalReport.pdf
[79] http://akmhcweb.org/News/AKEfforts.pdf.

- Arizona -- Meta Services[80]
- California -- Golden State Psychological Health Center[81]
- Illinois -- Associated Psychological Health Services[82]
- Massachusetts -- Freedom Center -- Soteria-New England, Zuzu's Place[83]
- New Hampshire -- The Cypress Center[84]
- Washington -- Ani'sahoni Consulting (Dr. David Walker)[85]
- Wisconsin -- Associated Psychological Health Services[86]

XIII. Conclusion

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

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[80] *See*, http://metaservices.com/. They have done a lot of very interesting things, although at this point a lot of their clients are medicated.
[81] *See*, http://www.gsphc.net/.
[82] *See*, http://www.abcmedsfree.com/.
[83] *See*, http://www.freedom-center.org/.
[84] *See*, http://psychrights.org/States/NewHampshire/NewHampshire.htm.
[85] *See*, http://www.anisahoni.com/about/.
[86] *See*, http://www.abcmedsfree.com/.

REPORT

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

by

Jim Gottstein

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

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

I. TABLE OF CONTENTS

II. INTRODUCTION

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

The four non-profits serve complementary roles in the effort to create alternatives to our mental illness system's[3] virtually exclusive focus on the administration of psychiatric drugs for "treatment" of people diagnosed with serious mental illness. The drugs are of dubious, at best, over all effectiveness, are extremely harmful, and are at least halving the number of people who recover from a diagnosis of serious mental illness. Another way to put it is our system is creating large numbers of people[4] who become seriously and persistently mentally ill,[5] most of whom become permanent burdens on government financial resources. More importantly from my perspective, they lead much less satisfying, shorter, and less fulfilling lives than they otherwise could.

There is a huge debate over this assertion and it is not my purpose to engage in that debate here[6] because the efforts described here are to allow choice. I know people who find the drugs helpful and some who feel they saved their lives. I think people who want the drugs should have access to them.[7] By the same token, those who do not want the drugs should be given the choice to decline them. And they should have support for this choice. Each of the four non-profits is designed to play a role in this, although one of them, Soteria-Alaska, could be rolled into CHOICES, Inc., depending on timing and funding.

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

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

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

[4] At least doubling.

[5] Also known as "chronically mentally ill."

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

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

The purpose of this Report then is to describe the strategy, history, progress to date and current prospects for this effort in Alaska[8] to improve the outcomes of people diagnosed with serious mental illness by making available alternatives to the coercive, substantially illegal, essentially exclusive, over-medication regime now in effect.

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

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

II. BACKGROUND

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

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

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

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

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

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

essentially a sham[13] and the lack of efficacy and the serious harm caused by the medications (and other treatments, such as electroshock) eliminate the justification for the prevailing paternalistic attitude that "we can't let these pesky rights get in the way of what we know is in the person's best interests."

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

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

IV. ALASKA ATTRIBUTES

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

A. Small Population

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

B. Alaska Mental Health Trust Authority

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

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[13] *See*, Section VI. D(3) below.

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

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

C. Alaska Mental Health Board

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

D. Consumers Consortium

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

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

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

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

[17] *See*, AS 47.30.662(b), which can be accessed at http://www.touchngo.com/lglcntr/akstats/Statutes/Title47/Chapter30/Section662.htm

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

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

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

From 2002 until 2005, the Consortium's members were able to reach a consensus on how available funds for Consumer run programs should be allocated. However, for the state fiscal year starting in July, 2005, funding was cut so much[20] this was no longer possible, which resulted in the more typical free-for-all competition process with winners and losers.

E. Ionia

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

V. Genesis of Effort

While I have been involved in mental health policy in Alaska for quite a long time in various capacities[22] and had a pretty good sense of the failure of the mental illness system to truly help most people diagnosed with serious mental illness, this particular effort arose out of my reading *Mad in America* in late 2002. It is an excellent, very readable and enjoyable, yet extremely alarming book in that it revealed vast numbers of people are being greatly harmed by the current "treatment" paradigm.[23] Of course, there have actually been many books documenting the same thing, including Dr. Peter Breggin's seminal book *Toxic Psychiatry*. *Toxic Psychiatry* is also a compelling and well documented indictment of the current system, but I found it was when people read *Mad in America* that they really "got" on an almost visceral level the scientific and moral bankruptcy of the current system and the scope of the harm being done.

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

[21] *See*, http://akmhcweb.org/recovery/ioniaadn.html and http://ionia.org/.

[22] A brief bio can be found at http://psychrights.org/about/Gottstein.htm.

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

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

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

> There were discussions of . . . whether it was clear enough from the data that the current reliance on psychiatric medications substantially increases chronicity. These and similar items are referred to the full Board/Planning Committee for further development and consideration. (p.1)
>
> The Mental Health System currently relies heavily on psychiatric medications. It is recommended that further research on how the use of these medications impact desired results should be conducted. (p.10)

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

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

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[24] The transmittal to the members of the Alaska Mental Health Board can be found at http://psychrights.org/states/alaska/2002/MadInAmericatxtoMHBltr4Web.pdf. In March of 2003, I also transmitted a copy of *Mad in America* and other materials to the Commissioner of the Alaska Department of Health and Social Services exhorting him to address the situation. This transmittal letter can be found at http://psychrights.org/alaska/DMHDD/3-24-03jgtogilbertson.pdf.

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

VI. SPECIFIC EFFORTS: STATUS & PROSPECTS

A. Acute Care: Soteria-Alaska

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a full business plan presentation to the Trust in September, 2006.[40] Susan Musante was hired as the Project Manager[41] and the Business Plan was submitted on August 4, 2006.[42] Because the long-term viability of Soteria-Alaska depends on State of Alaska financial participation an ' there are a number of other hurdles, making it hard to determine when Soteria-Alaska might be ready to open, the Trust staff recommended the Trust fund continued planning and pre-development efforts with the idea that it will fund the start-up when all of the pieces are in place, including inclusion in the state's budget. This recommendation was accepted and on September 6, 2006, the Trust passed a motion approving the following:

Fiscal Year 2007 (ending June 30, 2007)

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

Fiscal Year 2008 (ending June 30, 2008)

$160,000 in Trust Funds.
Recommendation that $220,000 in State of Alaska General Fund/Mental Health (GF/MH) be appropriated for Soteria-Alaska operations.

Fiscal Year 2009 (ending June 30, 2009)

$160,000 in Trust Funds.
It doesn't appear the Trust actually passed a motion regarding FY 2009 GF/MH, but it is understood the plan is if the State does appropriate the $220,000 in FY 2008, that it would go up to $470,000 in FY 2009

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

B. Community Based Services: CHOICES, Inc.

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

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

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

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

[43] *See*, http://choices-ak.org/.

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

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

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

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

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

(1) Helping people (and parents of younger children) get what they want.

(2) Providing the types of services Loren Mosher describes in Chapter 9 of his and Lorenzo Burti's excellent book, Community Mental Health: A Practical Guide, which can be found at http://choices-ak.org/grants/05TBGIOperating/Ch9.pdf (9 Megabytes).

(3) Being a conduit for pass-through grants for consumer run programs that have not obtained 501(c)(3) status.

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

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

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

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

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

C. Housing: Peer Properties

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

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

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

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

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

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

[48] *See*, http://peerproperties.org/Properties/outside.jpg

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

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

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

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

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

(1) Development

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

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

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

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

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

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

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

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

(2) Finances

PsychRights has a general policy against taking government funding because it is felt one can not seriously challenge what the government is doing with its money. This has certainly proven to be true with respect to other government funded attorneys in the arena. However, because of the unique nature of the Trust Authority, $5,000 in funding has been accepted from it to help present a seminar on Mental Health Disability Law in September of 2003 by Professor Perlin and Robert Whitaker[58] and a $10,000 Small Project grant for representation expenses, such as filing fees, deposition costs, expert witness fees, etc. Otherwise, PsychRights is entirely sustained by private donations.[59] PsychRights submitted a TBGI systems change grant application to fund one attorney and assistant, which was not awarded.[60] PsychRights' finances are completely transparent, with financial information being posted at http://psychrights.org/about.htm.

(3) The Role of Litigation for System Change

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

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[54] http://psychrights.org/calltoaction.htm.

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

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

[57] http://psychrights.org/Research/Digest/Chronicity/NeurolepticResearch.htm

[58] *See*, http://psychrights.org/Education/ak03CLE/Brochure.htm.

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

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

The Introduction mentic ..s that Forced "Treatment" proceedings are essentially a sham. This is well known to those involved. Psychiatrists, with the full understanding and tacit permission of the trial judges, regularly lie in court[61] to obtain involuntary commitment and forced medication orders:

> [C]ourts accept . . . testimonial dishonesty, . . . specifically where witnesses, especially expert witnesses, show a "high propensity to purp..sely 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 barrie..s are raised to insure that the allegedly "therapeutically correct" social end is met . . .. In short, the mental disability law system often deprives individuals of liberty disingenuously and upon bases that have no relationship to case law or to statutes.[62]

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

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

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

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[61] This is perjury, a crime.

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

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

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

It is also well known that:

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

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

Of course, to the extent the system recognizes people have the right to decline medication[68] and provides the choices to which they are entitled before they can legally be forced to take these drugs, litigation would/will not be necessary. In the absence of this, however, there has been some litigation already undertaken and other contemplated.

(4) Undertaken Litigation

(a) Myers -- Forced Drugging

PsychRights' first case, *Myers v. Alaska Psychiatric Institute*,[69] directly challenging Alaska's Forced Drugging procedures, was decided by the Alaska Supreme Court on June 30, 2006.[70] In *Myers*, the trial court, after receiving expert testimony from Dr. Loren Mosher and Grace Jackson, as well as the State's psychiatrists, found as a factual matter:

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

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

[67] *See*, http://psychrights.org/States/Alaska/CaseOne/30-Day/ExhibitRLRMosherAff.htm.

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

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

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

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

and

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

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

The Alaska Supreme Court agreed, holding:

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

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

(b) Wetherhorn -- Ineffective Assistance of Counsel

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

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[71] *See*, http://psychrights.org/States/Alaska/CaseOne/30-Day/Order.pdf, pages 8 and 13.
[72] 138 P.3d at 250.
[73] More information on this case can be found at http://psychrights.org/States/Alaska/CaseFour.htm.

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

(c) Bavilla -- Forced Drugging in Prison

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

(5) Prospective Litigation

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

(a) Kids in Custody/Out of State Placements

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

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

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

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

(b) In-State Residential Treatment Centers

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

(c) Elder Drugging Abuses

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

(d) Informed Consent

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

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

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

(7) Ethics Complaints.

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

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[77] *See*, AS 47.30.837, which can be accessed at http://touchngo.com/lglcntr/akstats/Statutes/Title47/Chapter30/Section837.htm.

[78] *See*, http://psychrights.org/States/Alaska/CaseTwo/draftInformedConsentComplaint.htm.

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

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

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

(8) Strategy/Attorney Recruitment

The cases described above are designed to set precedent and consequently be system changing in that way. In addition to this, however, just having one serious representation of an API inmate[81] per week, or even per month will substantially increase demands on state resources to involuntarily commit and Force Drug its inmates. In other words, make Forced "Treatment" not necessarily the path of least resistance. Serious representations involve depositions of the psychiatrist(s) and other treating personnel as well as potentially other witnesses, filing motions, etc. I make it a practice to elect the hearing be held in a real courtroom under AS 47.30.735(b)[82] and, in my view, a jury trial should be demanded under AS 47.30.745(c)[83] for every 90-day commitment petition. The trials should last at least hours, if not days, rather than the approximately 15 minutes they do now. Objections should be made to unfavorable Probate Master recommendations.[84] Requests for emergency stays against Forced Drugging should be made.[85] Appeals should be taken when appropriate.[86] In 2004, I met with the Public Defender and the Assistant Public Defenders who normally handle these cases.[87] I gave them copies of *Mad in America* and informed them what I thought it took to adequately represent psychiatric defendants. It does not appear anything changed and when the opportunity arose, PsychRights appealed an involuntary commitment and Forced Drugging Order to try and obtain more than sham representation.[88]

I think it is fair to say the all-out, four month legal battle that was the *Myers* case at the trial court[89] has had at least a minor impact. I have gotten people out or stopped Forced Drugging with a phone call or an e-mail in a few situations since then by suggesting the person

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

[82] *See*, http://www.touchngo.com/lglcntr/akstats/Statutes/Title47/Chapter30/Section735.htm.

[83] *See*, http://www.touchngo.com/lglcntr/akstats/Statutes/Title47/Chapter30/Section745.htm.

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

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

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

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

[88] *See*, http://psychrights.org/States/Alaska/CaseFour.htm.

[89] *See*, http://psychrights.org/States/Alaska/CaseOne.htm.

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

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

(a) Alaska *Pro Bono* Program

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

(b) Private Bar

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

(c) Attorney's Fees.

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

(9) Educational Programs

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

(a) Website

PsychRights' website is very deep with information, including posting full articles and studies for use by attorneys and other people. Its Scientific Research by Topic[91] and Articles[92] web pages are particularly replete with important information from accepted sources. There are many other sections of the website, which is hopefully organized in a user-friendly manner and includes a section with information about various states.[93]

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[90] *See*, http://psychrights.org/states/Alaska/CaseFour/FeeAppeal/Brief.pdf.
[91] http://psychrights.org/Research/Digest/Researchbytopic.htm.
[92] http://psychrights.org/Articles/articles.htm.
[93] http://psychrights.org/States/States.htm.

(b) Mental Health Disability Law Conference

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

VII. FINAL THOUGHTS, ACKNOWLEDGMENTS, AND PERSONAL NOTES

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

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

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

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[94] *See*, http://psychrights.org/Education/ak03CLE/Brochure.htm.

VIII. GLOSSARY

- "ACMHS" stands for Anchorage Community Mental Health Services, also known as Southcentral Counseling Center.

- "AHFC" stands for the Alaska Housing Finance Corporation.

- "Alaska Mental Health Board" is "the planning and coordinating agency for the purposes of federal and state laws relating to the mental health program of the state of Alaska. The purpose of the board is to assist the state in ensuring an integrated comprehensive mental health program." *See*, AS 47.30.661, which can be accessed at http://www.touchngo.com/lglcntr/akstats/Statutes/Title47/Chapter30/Section661.htm. The Alaska Mental Health Board is one of the four boards which provide funding recommendations to the Alaska Mental Health Trust Authority. *See*, AS 47.30.666, which can be accessed at http://www.touchngo.com/lglcntr/akstats/Statutes/Title47/Chapter30/Section666.htm.

- "Alaska Mental Health Trust Authority" *See* "Trust Authority" below.

- "API" stands for the Alaska Psychiatric Institute, which is the sole state psychiatric hospital.[95]

- "Beneficiaries" means the beneficiaries of the Mental Health Lands Trust, which include (1) the mentally ill, (2) the mentally defective and retarded, (3) chronic alcoholics suffering from psychoses, and (4) senile people who as a result of their senility suffer major mental illness.[96]

- "Budget Summit Report" is the report by the Budget Committee of the Alaska Mental Health Board, adopted by the full board in August of 2003. *See*, http://akmhcweb.org/Docs/AMHB/2003BudgetSummitReport.pdf.

- "Consumer" means someone who is or has received mental health services, normally after being diagnosed with a serious mental illness.

- "Consumers Consortium" is the statewide group consisting of all Consumer run programs in the state. *See*, http://akmhcweb.org/Announcements/2002rfr/consortiumproposals.htm for its initial set of proposals to the Alaska Mental Health Board.

- "Corpus" as employed herein is the principal amount of the Trust's endowment, as contrasted to the earnings or income. The corpus is not to be spent.

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

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

- "C/S/X" stands for **C**onsumers of mental health services, **S**urvivors of Psychiatry and e**X**-psychiatric patients and refers to people who have received mental health treatment. There has never been a consensus on what term should be used. Other terms that have been used include "users," "recipients," "patients," and "psychiatrized." In Alaska, because of the Mental Health Lands Trust, they are often called "beneficiaries."

- "Department" means the Alaska Department of Health and Social Services.

- "Mental Health Board." *See* Alaska Mental Health Board.

- " Mental Health Lands Trust Litigation" refers to the 15 year long litigation over the state of Alaska's "redesignation" (theft) of the one million acres of land granted to it in trust for Alaska's mental health program. http://www.touchngo.com/lglcntr/spclint/mht.htm.

- "MHAAK" stands for Mental Health Advocates of Alaska, a new member organization for Consumers intended to have substantial statewide membership.

- "NAMI" stands for the National Association for the Mentally Ill, which touts itself as "the Nation's Voice on Mental Illness." NAMI was founded by parents of people diagnosed with serious mental illness, is heavily financed by the pharmaceutical industry and vigorously pushes for more Forced Drugging.

- "NAMI-Alaska" is the statewide Alaska affiliate of NAMI. A majority of its board is currently Consumers, which allows it to access funding for Consumer run programs. NAMI-Alaska, as most of NAMI's affiliates, does not understand the extent to which NAMI is controlled by pharmaceutical funding nor the extent to which NAMI pushes Forced Drugging.

- "NARPA" stands for National Association of Rights Protection and Advocacy. *See*, http://www.narpa.org/.

- "Polypharmacy" is defined as the use of several drugs or medicines together in the treatment of disease, suggesting indiscriminate, unscientific, or excessive prescription. *See*, http://classes.kumc.edu/som/amed900/polypharmcay/polypharmdrug.htm.

- "Rasmuson Foundation" is the largest private foundation in Alaska and has made a number of mental health related grants. *See*, http://rasmuson.org/.

- "RECA" stands for Recovery Education Center for Alaska, which was formed to teach Mary Ellen Copeland's WRAP (Wellness Recovery Action Plan) program in Alaska. *See*, http://copelandcenter.com/whatiswrap.html.

- "RFP" means Request for Proposal, which is a notice of opportunity to apply for a grant.

- "Section 8 Vouchers" are United States Department of Housing and Urban Development low income housing subsidies.

- "SNHG" stands for Special Needs Housing Grant, which is funded by the Trust Authority and administered by the Alaska Housing Finance Administration.

- "Trust Authority" stands for the Alaska Mental Health Trust Authority, which was created in the settlement of the litigation over the Alaska Mental Health Lands Trust. *See*, http://mhtrust.org/.

- "TBGI" stands for Trust Beneficiary Group Initiative, which is an expansion by the Trust Authority of eligibility for funding of Consumer run programs formerly restricted to beneficiaries classified as mentally ill.

- "Trust Settlement" refers to the settlement of the litigation over the state of Alaska "redesignating" (i.e., "stealing") the one million acres of land granted in trust to Alaska's mental health program by the federal government. *See*, http://www.touchngo.com/lglcntr/spclint/mht.htm.

Westlaw.

--- P.3d ----, 2007 WL 80490 (Alaska)
(Cite as: --- P.3d ----)

Briefs and Other Related Documents
Wetherhorn v. Alaska Psychiatric Institute Alaska,2007.Only the Westlaw citation is currently available.

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

Jan. 12, 2007.

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

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

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

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

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

Affirmed in part and vacated in part.

[1] Appeal and Error 30 ⚿842(1)

30 Appeal and Error
30XVI Review
30XVI(A) Scope, Standards, and Extent, in General
30k838 Questions Considered
30k842 Review Dependent on Whether Questions Are of Law or of Fact
30k842(1) k. In General. Most Cited Cases
The Supreme Court applies its independent judgment to interpretation of the state constitution and statutes, adopting the rule of law that is most persuasive in light of precedent, reason, and policy.

[2] Mental Health 257A ⚿45

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

Mental Health 257A ⚿51.20

257A Mental Health
257AII Care and Support of Mentally Disordered Persons
257AII(A) Custody and Cure
257Ak51 Restraint or Treatment
257Ak51.20 k. Actions and Proceedings. Most Cited Cases
Factual findings in involuntary commitment or medication proceedings are reviewed for clear error, and the Supreme Court reverses only if its review of the record leaves us with a definite and firm conviction that a mistake has been made.

[3] Appeal and Error 30 ⚿970(2)

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

Appeal and Error 30 ⇐971(2)

30 Appeal and Error
30XVI Review
30XVI(H) Discretion of Lower Court
30k971 Examination of Witnesses
30k971(2) k. Competency of Witness. Most Cited Cases
The superior court's decisions regarding the admissibility of evidence, including expert testimony, are generally reviewed for abuse of discretion.

|4| Appeal and Error 30 ⇐842(6)

30 Appeal and Error
30XVI Review
30XVI(A) Scope, Standards, and Extent, in General
30k838 Questions Considered
30k842 Review Dependent on Whether Questions Are of Law or of Fact
30k842(6) k. Admissibility and Reception of Evidence. Most Cited Cases
If admissibility of evidence turns on a question of law, the Supreme Court applies its independent judgment.

|5| Mental Health 257A ⇐36

257A Mental Health
257AII Care and Support of Mentally Disordered Persons
257AII(A) Custody and Cure
257Ak36 k. Persons Subject to Control or Treatment. Most Cited Cases
Although state has a legitimate interest in providing care to those who represent a threat to themselves or the community, or who are unable to care for themselves, mental illness alone is insufficient to form a constitutionally adequate basis for involuntary commitment.

|6| Mental Health 257A ⇐32

257A Mental Health
257AII Care and Support of Mentally Disordered Persons
257AII(A) Custody and Cure
257Ak32 k. Constitutional and Statutory Provisions. Most Cited Cases
Commitment statute was constitutional if construed to require level of incapacity so substantial that alleged mentally ill individual could not live safely outside of a controlled environment. AS 47.30.915(7)(B).

|7| Constitutional Law 92 ⇐255(5)

92 Constitutional Law
92XII Due Process of Law
92k255 Deprivation of Life or Liberty in General
92k255(5) k. Diseased and Mentally Disordered Persons; Addicts. Most Cited Cases
Involuntary commitment implicates state's constitutional guarantees of individual liberty and privacy and therefore entitles alleged mentally ill individual to due process protections. U.S.C.A. Const.Amend. 14; Const. Art. I, § 7.

|8| Appeal and Error 30 ⇐181

30 Appeal and Error
30V Presentation and Reservation in Lower Court of Grounds of Review
30V(B) Objections and Motions, and Rulings Thereon
30k181 k. Necessity of Objections in General. Most Cited Cases
The Supreme Court will find plain error when there is a high likelihood that injustice has resulted.

|9| Mental Health 257A ⇐45

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

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

|10| Mental Health 257A ⇐38

257A Mental Health
257AII Care and Support of Mentally Disordered Persons
257AII(A) Custody and Cure
257Ak37 Admission or Commitment Procedure
257Ak38 k. Parties and Application. Most Cited Cases
Petition for 30-day involuntary commitment, which described alleged mentally ill person as being in a " manic state, homeless and no insight and non med compliant," complied with statute requiring that petition allege "facts and specific behavior" supporting conclusion that alleged mentally ill individual met standards for commitment; statute did not articulate standard by which sufficiency of facts and behavior listed was to be judged. AS 47.30.730(a)(7).

|11| Constitutional Law 92 ⇐255(5)

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

Mental Health 257A ⇐38

257A Mental Health
257AII Care and Support of Mentally Disordered Persons
257AII(A) Custody and Cure
257Ak37 Admission or Commitment Procedure
257Ak38 k. Parties and Application. Most Cited Cases
Factual allegations listed on petition for 30-day involuntary commitment, listing alleged mentally ill individual's current manic state, state of homelessness, lack of insight, and failure to take her prescribed medication for last three months, were sufficient to afford notice as required by due process; petition and notice of hearing were reasonably calculated to inform individual of nature and purpose of commitment hearing, petition listed " facts and specific behavior" to be raised at hearing, and information was sufficiently detailed to allow individual to prepare for hearing. U.S.C.A. Const.Amend. 14; Const. Art. 1, § 7; AS 47.30.730(a)(7).

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

|12| Constitutional Law 92 ⇐251.6

92 Constitutional Law
92XII Due Process of Law
92k251.6 k. Notice and Hearing. Most Cited Cases
As a general principle, due process requires that the notice of a hearing must be appropriate to the occasion and reasonably calculated to inform the person to whom it is directed of the nature of the proceedings. U.S.C.A. Const.Amend. 14; Const. Art. 1, § 7.

|13| Constitutional Law 92 ⇐255(5)

92 Constitutional Law
92XII Due Process of Law
92k255 Deprivation of Life or Liberty in General
92k255(5) k. Diseased and Mentally

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

[14] Action 13 ⇐6

13 Action
13I Grounds and Conditions Precedent
13k6 k. Moot, Hypothetical or Abstract Questions. Most Cited Cases
A claim is moot if it is no longer a present, live controversy, and the party bringing the action would not be entitled to relief, even if it prevails.

[15] Action 13 ⇐6

13 Action
13I Grounds and Conditions Precedent
13k6 k. Moot, Hypothetical or Abstract Questions. Most Cited Cases
Three factors in determining whether public interest exception to mootness doctrine applies are: (1) whether the disputed issues are capable of repetition; (2) whether the mootness doctrine, if applied, may cause review of the issues to be repeatedly circumvented; and (3) whether the issues presented are so important to the public interest as to justify overriding the mootness doctrine.

[16] Mental Health 257A ⇐45

257A Mental Health
257AII Care and Support of Mentally Disordered Persons
257AII(A) Custody and Cure
257Ak37 Admission or Commitment Procedure
257Ak45 k. Review. Most Cited Cases
Supreme Court would not consider, pursuant to public interest exception to mootness doctrine, claim by alleged mentally ill individual, who was involuntarily committed for 30 days, that evidence presented at hearing was insufficient to establish that she met standards for commitment; facts supporting commitment were all specific to individual's condition immediately before and at time of hearing, and if it were to become necessary to seek individual's commitment again, hearing would be based on different set of facts specific to different circumstances, and thus, issue was not capable of repetition. AS 47.30.735(c).

[17] Mental Health 257A ⇐51.20

257A Mental Health
257AII Care and Support of Mentally Disordered Persons
257AII(A) Custody and Cure
257Ak51 Restraint or Treatment
257Ak51.20 k. Actions and Proceedings. Most Cited Cases
Failure to provide visitor's report during hearing on petition for involuntary administration of psychotropic medication was plain error, thus requiring vacating of order approving non-consensual administration of psychotropic medication; since situation was non-emergency situation, there was no reason to neglect statutory protections in interests of speed, and visitor's report was essential to court's mandatory duty to determine whether individual was presently competent to provide informed consent or, if not competent, to decide whether individual was competent to provide informed consent at time of previously expressed wishes to refuse medication. AS 47.30.839(d).

[18] Mental Health 257A ⇐51.20

257A Mental Health
257AII Care and Support of Mentally Disordered Persons
257AII(A) Custody and Cure
257Ak51 Restraint or Treatment
257Ak51.20 k. Actions and Proceedings. Most Cited Cases
For purposes of involuntary administration of psychotropic medication, court must in non-emergency cases make specific findings: (1) that patient is incapable of giving or withholding informed consent and has not made a previous statement while competent expressing a choice; (2) that the proposed treatment is in patient's best interest; and (3) that no less intrusive alternative is available. AS 47.30.839(d).

[19] Mental Health 257A ⇐51.20

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

[20] Mental Health 257A ⇐45

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

Mental Health 257A ⇐51.20

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

[21] Constitutional Law 92 ⇐255(5)

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

Mental Health 257A ⇐41

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

Mental Health 257A ⇐51.20

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

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

[22] Trial 388 ⇐107

388 Trial
388V Arguments and Conduct of Counsel
388k107 k. Representation of Party by Counsel. Most Cited Cases
Whenever the right to counsel is constitutionally guaranteed in a particular proceeding, the effective assistance of counsel is also constitutionally required. U.S.C.A. Const.Amend. 6.

James B. Gottstein, Law Project for Psychiatric Rights, Inc., Anchorage, for Appellant.
Laura C. Bottger, Assistant Attorney General, Anchorage, and David W. Márquez, Attorney General, Juneau, for Appellee.

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

OPINION

FABE, Justice.

I. INTRODUCTION

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

II. FACTS AND PROCEEDINGS

On April 4, 2005 Dr. M. Lee of Valley Hospital initiated an application for the examination of Wetherhorn pursuant to AS 47.30.705. Alaska Statute 47.30.705 allows a person to be taken into custody and delivered to the nearest evaluation facility.[FN1] Dr. Lee's application stated that Wetherhorn was mentally ill and gravely disabled and that considerations of safety did not allow the initiation of involuntary commitment proceedings.

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

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

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

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

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

III. STANDARD OF REVIEW

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

IV. DISCUSSION

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

A. The Petition for Thirty-Day Commitment

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

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

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

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

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

Alaska Statute 47.30.915(7) defines "gravely disabled" as follows:
(7) "gravely disabled" means a condition in which a person as a result of mental illness
(A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or
(B) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently[.]

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

Subsection B was added to AS 47.30.915(7) by the legislature in 1984. [FN19] The addition was part of a major revision of the civil commitment statutes undertaken "to more adequately protect the legal rights of persons suffering from mental illness." [FN20] In testimony before the House Health, Education and Social Services Standing Committee discussion on the revisions, the Director of the Division of Mental Health and Developmental Disabilities of the Department of Health and Social Services explained that the then-current law only allowed Alaska Psychiatric Institute (API) to hold people with violent tendencies and that the addition of the "gravely disabled" language would allow API "to hold people that need to [be held], but haven't shown a violent tendency enough to hold them. There is a very significant number who don't fit into [the] present standard, but can walk out." [FN21] The expert concluded, "[o]ur hands are tied behind our back, when [a] patient walks out. We only attempt to hold people who are gravely in danger." [FN22] The committee discussion reveals that the gravely disabled language was added "so that a person can be committed before it's too late." [FN23] The addition of subsection B was thus intended to broaden the scope of civil commitment standards in order to reach those persons in need of treatment who did not fit within the pre-1984 statutory criteria, which required a showing of violent tendencies before a person could be held involuntarily.[FN24]

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

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

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

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

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

2. Procedural due process concerns

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

has resulted." [FN50]

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

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

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

[10][11] In her challenge to the sufficiency of the language on the petition, Wetherhorn argues that the list of facts and specific behaviors on the petition must: "(1) be sufficient, without supplementation, to entitle the petitioner to the granting of the petition as a matter of law, and (2) to at least summarize all of the evidence the state intends to put on in its case in chief." But Wetherhorn's proposed requirements go far beyond what Alaska statutes require. Alaska Statute 47.30.730(a)(7) merely requires that the petition allege "facts and specific behavior" supporting the conclusion that the respondent meets the standards for commitment and does not articulate the standard by which the sufficiency of the facts and behavior listed is to be judged. And because whether a person is actually committed depends on the hearing, not on the petition standing alone,[FN51] there is no reason to require that the petition summarize all the evidence or be sufficient in itself to entitle the petitioner to a grant of the petition as a matter of law.

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

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

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

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

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

B. The Petition for Administration of Psychotropic Medication

Wetherhorn raises two challenges specific to the petition for the administration of psychotropic medication. Both of these challenges are affected by our decision in *Myers v. **Alaska Psychiatric Institute***,[FN56] which had not yet been decided at the time of **Wetherhorn's** hearing.

1. The failure to submit a visitor's report

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

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

report.

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

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

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

C. Remaining Procedural Challenges

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

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

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

Alaska Evidence Rule 603 requires every witness

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

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

2. Ineffective assistance of counsel

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

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

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

V. CONCLUSION

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

FN1. AS 47.30.705, "Emergency detention for evaluation," provides:
(a) A peace officer, a psychiatrist or physician who is licensed to practice in this state or employed by the federal government, or a clinical psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners who has probable cause to believe that a person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to self or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700, may cause the person to be taken into custody and delivered to the nearest evaluation facility. A person taken into custody for emergency evaluation may not be placed in a jail or other correctional facility except for protective custody purposes and only while awaiting transportation to a treatment facility. However, emergency protective custody under this section may not include placement of a minor in a jail or secure facility. The peace officer or mental health professional shall complete an application for examination of the person in custody and be interviewed by a mental health professional at the facility.
(b) In this section, "minor" means an individual who is under 18 years of age.

FN2. AS 47.30.710 provides:
(a) A respondent who is delivered under AS 47.30.700-47.30.705 to an evaluation facility for emergency examination and treatment shall be examined and evaluated as to mental and physical condition by a mental health professional and by a physician within 24 hours after arrival at the facility.
(b) If the mental health professional who performs the emergency examination has reason to believe that the respondent is (1) mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others, and (2) is in need of care or treatment, the mental health professional may hospitalize the respondent, or arrange for hospitalization, on an emergency basis. If a judicial order has not been obtained under AS 47.30.700, the mental health professional shall apply for an ex parte order authorizing hospitalization for evaluation.

FN3. AS 47.30.839, "Court-ordered administration of medication," states in relevant part:
(d) Upon the filing of a petition under (b) of this section, the court shall direct the office of public advocacy to provide a visitor to assist the court in investigating the issue of whether the patient has the capacity to give or withhold informed consent to the administration of psychotropic medication. The visitor shall gather pertinent information and present it to the court in written or oral form at the hearing. The information must include documentation of the following:

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

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

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

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

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

FN8. *Id.*

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

FN10. *Id.*

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

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

FN13. *Rust v. State*, 582 P.2d 134, 139 n. 16 (Alaska 1978) ("A person who presents a danger to others is committed under the state's police power. A person who requires care and treatment is committed through exercise of the state's *parens patriae* power. One who poses a danger to himself is committed under a combination of both powers."); *see also Addington*, 441 U.S. at 426, 99 S.Ct. 1804.

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

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

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

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

FN18. *Id.*

FN19. Ch. 142, § 27, SLA 1984.

FN20. AS 47.30.655.

FN21. *Act Relating to the Treatment of Mentally Ill Persons: Before the Standing and Special Comm. of the M. Health, Educ. & Soc. Servs. Standing 13th Comm.*, Leg.2d Sess. HHES 84/04/24 1342 (Alaska 1984) (statement of Dr. Shapiro, Dir. of Mental Health & Developmental Disabilities, Dep't of Health & Soc. Servs.).

FN22. *Id.*

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

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

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

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

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

FN27. *O'Connor*, 422 U.S. at 575, 95 S.Ct. 2486; *see also id.*, 422 U.S. at 574 n. 9, 95 S.Ct. 2486 ("Of course, even if there is no foreseeable risk of self-injury or suicide, a person is literally 'dangerous to himself' if for physical or other reasons he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends."). In 1996 the Supreme Court noted that " [a]lthough we have not had the opportunity to consider the outer limits of a State's authority to civilly commit an unwilling individual, our decision in [*O'Connor*] makes clear that due process requires at a minimum a showing that the person is mentally ill and either poses a danger to himself or others or is incapable of ' surviving safely in freedom.' " *Cooper*, 517 U.S. at 368, 116 S.Ct. 1373 (citations omitted).

FN28. AS 47.30.915(7)(B).

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

FN30. AS 47.30.915(7)(B).

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

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

FN33. AS 47.30.730(a)(2).

FN34. AS 47.30.730(a)(3).

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

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

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

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

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

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

omitted).

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

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

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

FN44. *Id.*

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

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

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

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

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

FN50. *Id.*

FN51. AS 47.30.735(c).

FN52. *Huntley v. N.Carolina State Bd. of Ed.*, 493 F.2d 1016, 1019 (4th Cir.1974) (citing *Mullane v. Cent. Hanover Bank & Trust Co.*, 339 U.S. 306, 313, 70 S.Ct. 652, 94 L.Ed. 865 (1950)).

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

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

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

FN56. 138 P.3d at 238.

FN57. AS 47.30.725(b).

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

FN59. *Id.* at 242.

FN60. *Id.*

FN61. AS 47.30.700-.815.

FN62. AS 47.30.836(3); AS 47.30.839.

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

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

FN65. AS 47.30.839(d)(1).

FN66. AS 47.30.839(d)(2).

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

FN68. AS 47.30.839(g) provides in

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

FN69. 138 P.3d at 254.

FN70. Alaska R. Evid. 603.

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

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

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

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

FN75. *Id.*

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

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

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Wetherhorn v. Alaska Psychiatric Institute

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Briefs and Other Related Documents (Back to top)

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

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C
Briefs and Other Related Documents
Myers v. Alaska Psychiatric InstituteAlaska,2006.
Supreme Court of Alaska.
Faith J. MYERS, Appellant,
v.
ALASKA PSYCHIATRIC INSTITUTE, Appellee.
No. S-11021.

June 30, 2006.

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

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

Order vacated.
West Headnotes
[1] Mental Health 257A ⇐51.20

257A Mental Health
257AII Care and Support of Mentally Disordered Persons
257AII(A) Custody and Cure
257Ak51 Restraint or Treatment
257Ak51.20 k. Actions and Proceedings. Most Cited Cases
Supreme Court would adjudicate, pursuant to public interest exception to moot cases, the claim by patient involuntarily committed to state mental hospital that the nonconsensual administration of psychotropic drugs violated her constitutional rights to privacy and liberty, notwithstanding that patient was released without administration of drugs soon after trial court's order; given the importance of the issues raised by patient, their likelihood of recurring, and their ability to evade timely appellate review, the public exception applied.

[2] Appeal and Error 30 ⇐781(1)

30 Appeal and Error
30XIII Dismissal, Withdrawal, or Abandonment
30k779 Grounds for Dismissal
30k781 Want of Actual Controversy
30k781(1) k. In General. Most Cited Cases
Although appellate courts generally refrain from deciding issues where the facts have rendered the legal issues moot, an exception applies when a potentially moot case raises a matter of grave public concern that is recurrent but capable of evading review.

[3] Constitutional Law 92 ⇐82(7)

92 Constitutional Law
92V Personal, Civil and Political Rights
92k82 Constitutional Guaranties in General
92k82(6) Particular Rights, Limitations, and Applications
92k82(7) k. Privacy in General. Most Cited Cases

Constitutional Law 92 ⇐83(1)

92 Constitutional Law
92V Personal, Civil and Political Rights
92k83 Personal Liberty and Security
92k83(1) k. In General. Most Cited Cases

Constitutional Law 92 ⇐255(5)

92 Constitutional Law
92XII Due Process of Law

92k255 Deprivation of Life or Liberty in General
92k255(5) k. Diseased and Mentally Disordered Persons; Addic Most Cited Cases

Mental Health 257A ⚖51.15

257A Mental Health
257AII Care and Support of Mentally Disordered Persons
257AII(A) Custody and Cure
257Ak51 Restraint or Treatment
257Ak51.15 k. Involuntary Treatment or Medication. Most Cited Cases
Statutory provisions governing authorization of nonconsensual treatment with psychotropic medications violated patient's state constitutional guarantees of liberty and privacy; in the absence of emergency, court could not authorize the state to administer psychotropic drugs to non-consenting mental patient unless court determined that the medication was in the best interests of the patient and that no less intrusive alternative treatment was available. Const. Art. 1, §§ 1, 7, 22; AS 47.30.836, 47.30.839.

[4] Constitutional Law 92 ⚖82(7)

92 Constitutional Law
92V Personal, Civil and Political Rights
92k82 Constitutional Guaranties in General
92k82(6) Particular Rights, Limitations, and Applications
92k82(7) k. Privacy in General. Most Cited Cases

Constitutional Law 92 ⚖83(1)

92 Constitutional Law
92V Personal, Civil and Political Rights
92k83 Personal Liberty and Security
92k83(1) k. In General. Most Cited Cases
Alaska's guarantees of privacy and individual liberty are broader than the federal constitution's. Const. Art. 1, §§ 1, 7, 22.

[5] Constitutional Law 92 ⚖82(1)

92 Constitutional Law
92V Personal, Civil and Political Rights
92k82 Constitutional Guaranties in General
92k82(1) k. In General. Most Cited Cases
Courts determine the boundaries of individual rights guaranteed under the Alaska Constitution by balancing the importance of the right at issue against the state's interest in imposing the disputed limitation.

[6] Constitutional Law 92 ⚖82(1)

92 Constitutional Law
92V Personal, Civil and Political Rights
92k82 Constitutional Guaranties in General
92k82(1) k. In General. Most Cited Cases
When a law places substantial burdens on the exercise of a fundamental right, courts require the state to articulate a compelling state interest and to demonstrate the absence of a less restrictive means to advance that interest.

[7] Constitutional Law 92 ⚖82(1)

92 Constitutional Law
92V Personal, Civil and Political Rights
92k82 Constitutional Guaranties in General
92k82(1) k. In General. Most Cited Cases
When the law interferes with an individual's freedom in an area that is not characterized as fundamental, courts require the state to show a legitimate interest and a close and substantial relationship between its interest and its chosen means of advancing that interest.

[8] Constitutional Law 92 ⚖82(6.1)

92 Constitutional Law
92V Personal, Civil and Political Rights
92k82 Constitutional Guaranties in General
92k82(6) Particular Rights, Limitations, and Applications
92k82(6.1) k. In General. Most Cited Cases
Given that the right to refuse to take psychotropic drugs is fundamental, when no emergency exists, the state may override a mental patient's right to refuse psychotropic medication only when necessary to advance a compelling state interest and only if no less intrusive alternative exists. Const.

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Art. 1, §§ 1, 7, 22.

|9| Constitutional Law 92 ⇐12

92 Constitutional Law
92II Construction, Operation, and Enforcement of Constitutional Provisions
92k11 General Rules of Construction
92k12 k. In General. Most Cited Cases
Constitutional provisions should be given a reasonable and practical interpretation in accordance with common sense.

|10| Mental Health 257A ⇐51.15

257A Mental Health
257AII Care and Support of Mentally Disordered Persons
257AII(A) Custody and Cure
257Ak51 Restraint or Treatment
257Ak51.15 k. Involuntary Treatment or Medication. Most Cited Cases
In evaluating whether a proposed course of psychotropic medication is in the best interests of a patient, courts should consider the information that state statutes direct the treatment facility to give to its patients in order to ensure the patient's ability to make an informed treatment choice. AS 47.30.837(d)(2).

|11| Mental Health 257A ⇐51.20

257A Mental Health
257AII Care and Support of Mentally Disordered Persons
257AII(A) Custody and Cure
257Ak51 Restraint or Treatment
257Ak51.20 k. Actions and Proceedings. Most Cited Cases
The standard of proof that the state should be required to meet in establishing the patient's best interests, for purposes of determining whether nonconsensual administration of psychotropic drugs is appropriate, is the clear and convincing evidence standard.
West CodenotesUnconstitutional as AppliedAS 47.30.836, 47.30.839

***239** James B. Gottstein, Law Project for Psychiatric Rights, Inc., Anchorage, for Appellant.
Michael G. Hotchkin, Assistant Attorney General, Anchorage, and Gregg D. Renkes, Attorney General, Juneau, for Appellee.

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

OPINION

BRYNER, Chief Justice.

I. INTRODUCTION

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

II. FACTS AND PROCEEDINGS

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

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

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

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

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

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

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

During **Myers's** hearing on **API's** petition, two institute psychiatrists testified that, in their opinion, administering psychotropic medication to **Myers** would be appropriate. **Myers** countered with testimony from two expert psychiatrists who " forcefully present[ed] their differing views on the advisability of administering [psychotropic] medications to patients suffering from schizophrenia." The first testified that psychotropic medication is not the only viable treatment for schizophrenia. While acknowledging that psychotropic medications played an accepted role in the "standard of care for [the] treatment of psychosis," he advised that, because such drugs " have so many problems," they should be used "in as small a dose for as short a period of time as possible. " Myers's second expert offered more specific testimony that one of the drugs that API proposed to administer to Myers-Zyprexa-was, despite being " widely prescribed," a "very dangerous" drug of " dubious efficacy." He based this testimony on a " methodological analysis" of the studies that led the food and drug administration to approve Zyprexa for clinical use.

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

The court nevertheless noted that it found **Myers's** case "troubling"-so much so that it issued an additional order addressing in detail the arguments presented in the parties' pre-hearing briefs. In the order, the court found it troubling that Alaska's statutory scheme prevented it from considering the merits of API's treatment plan, or weighing the objections of Myers's experts. Because it believed that the statute unambiguously limited the superior court's role "to deciding whether Ms. Myers has sufficient capacity to give informed consent," the court felt constrained to adhere to its literal meaning. Yet the court nevertheless emphasized that it found this limitation to be problematic:
Where a patient, such as Ms. Myers, has a history of undergoing a medical treatment she found to be harmful, where she is found to lack capacity to make her own medical decisions and a valid debate exists in the medical/psychiatric community as to the safety and effectiveness of the proposed

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

Myers now appeals.

III. DISCUSSION

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

FN2. Alaska Const. art. I, § 7.

FN3. Alaska Const. art. I, § 22.

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

In response, **API** initially contends that this appeal should be dismissed as moot because **Myers** was released from **API** soon after the superior court issued its ruling, so she never actually received the authorized course of treatment. As to the merits of **Myers's** constitutional claim, **API** denies that **Myers's** interest in refusing unwanted psychotropic medication is fundamental. Because **Myers** has been judged unable to make informed decisions about her mental health condition, **API** analogizes her status to the status of minors, who, **API** claims, generally receive "a different level of constitutional protection." Therefore, **API** argues, in order to justify medicating **Myers** without her consent, the state needs only to show that this treatment would advance something "less than a compelling state interest." **API** further contends that, "as a committed mental patient," **Myers** "has a competing constitutional interest in receiving treatment for her illness." [FN4] It asserts that the state's "duty to provide **[Myers]** with treatment" amounts to a legitimate state interest-one that we should deem sufficient to overcome **Myers's** objections.

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

A. Alaska's Current Statutory Provisions

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

FN5. *See* AS 47.30.836; AS 47.30.838.

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

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

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

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

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

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

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

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

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

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

FN13. *Id.* (quoting Winick, The Right to Refuse Mental Health Treatment 72-73 (1997)).

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

FN14. *Riggins v. Nevada*, 504 U.S. 127, 134, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992) ("The purpose of the drugs is to alter the chemical balance in a patient's brain, leading to changes, intended to be beneficial, in his or her cognitive processes.").

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

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

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

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

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

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

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

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

FN20. AS 47.30.915(7) defines "gravely disabled" to mean "a condition in which a person as a result of mental illness"
(A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or
(B) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of the person's previous ability to function independently.

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

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

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

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

FN24. *See* AS 47.30.839(g).

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

FN25. AS 47.30.837(d)(2) provides:
"informed" means that the evaluation facility or designated treatment facility has given the patient all information that is material to the patient's decision to give or withhold consent, including
(A) an explanation of the patient's diagnosis and prognosis, or their predominant symptoms, with and without the medication;
(B) information about the proposed medication, its purpose, the method of its administration, the recommended ranges of dosages, possible side effects and benefits, ways to treat side effects, and risks of other conditions, such as tardive dyskinesia;
(C) a review of the patient's history, including medication history and previous side effects from medication;
(D) an explanation of interactions with other drugs, including over-the-counter drugs, street drugs, and alcohol;
(E) information about alternative treatments and their risks, side effects, and benefits, including the risks of nontreatment; and
(F) a statement describing the patient's right to give or withhold consent to the administration of psychotropic medications in nonemergency situations, the procedure for withdrawing consent, and notification that a court may override the patient's refusal[.]

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

FN26. AS 47.30.837 provides, in relevant part:
(c) ... If the facility has reason to believe that the patient is not competent to make medical or mental health treatment decisions and the facility wishes to administer psychotropic medication to the patient, the facility shall follow procedures of AS 47.30.839.
(d) In this section,
(1) "competent" means that the patient
(A) has the capacity to assimilate relevant facts and to appreciate and understand the patient's situation with regard to those facts, including the information described in (2) of this subsection;
(B) appreciates that the patient has a mental disorder or impairment, if the evidence so indicates; denial of a significantly disabling disorder or impairment, when faced with substantial evidence of its existence, constitutes evidence that the patient lacks the capability to make mental health treatment decisions;
(C) has the capacity to participate in treatment decisions by means of a rational thought process; and
(D) is able to articulate reasonable objections to using the offered medication[.]

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

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

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

FN29. AS 47.30.839(d).

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

FN30. *Id.*

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

FN31. *See* AS 47.30.839(e).

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

FN32. AS 47.30.839(f).

But if the court finds that the patient is presently incapable of giving or withholding informed consent, *and* further determines that the patient was also incompetent at the time of any previously expressed wishes not to be medicated, then the statute directs that the court "*shall* " authorize treatment:
If the court determines that the patient is not competent to provide informed consent and, by clear and convincing evidence, was not competent to provide informed consent at the time of previously expressed wishes documented under [the visitor's report], the court shall approve the facility's proposed use of psychotropic medication.[FN33]

FN33. AS 47.30.839(g).

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

B. Mootness

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Myers's Constitutional Challenge

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

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

FN40. Alaska Const. art. I, § 1.

FN41. Alaska Const. art. I, § 7.

FN42. Alaska Const. art. I, § 22.

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

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

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

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

We have similarly declared Alaska's constitutional guarantee of individual liberty to be more protective.[FN45]

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

[5][6][7] We determine the boundaries of individual rights guaranteed under the Alaska Constitution by balancing the importance of the right at issue against the state's interest in imposing the disputed limitation.[FN46] When a law places substantial burdens on the exercise of a fundamental right, we require the ***246** state to "articulate a compelling [state] interest" [FN47] and to demonstrate "the absence of a less restrictive means to advance [that] interest." [FN48] But when the law "interferes with an individual's freedom in an area that is not characterized as fundamental," we require the state to "show a legitimate interest and a close and substantial relationship between its interest and its chosen means of advancing that interest." [FN49]

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

FN47. *Ranney v. Whitewater Eng'g*, 122 P.3d 214, 222 (Alaska 2005).

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

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

1. Importance of right to choose or reject medication

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

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

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

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

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

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

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

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

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

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

FN56. In addressing the importance of a committed patient's right to choose or refuse psychotropic medications, API's briefing relies heavily on United States Supreme Court cases dealing with the forced medication of mentally ill prisoners. *See Sell v. United States,* 539 U.S. 166, 123 S.Ct. 2174, 156 L.Ed.2d 197 (2003) (defendant awaiting federal criminal trial); *Riggins v. Nevada,* 504 U.S. 127, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992) (defendant awaiting state criminal trial); *Washington v. Harper,* 494 U.S. 210, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990) (convicted state prisoner). In contrast to the state cases we rely on, which deal with civilly committed patients, the federal cases cited by API have little value here because prisoners' rights differ markedly from the rights of civilly committed mental patients. The prisoners involved in most of those cases had greatly diminished liberty interests because they had been convicted and incarcerated for criminal offenses, not because they were mentally ill. Further, in all of those prisoner cases-even *Sell v. United States,* which involved a mentally ill prisoner awaiting trial-the extraordinary security risks inherent in managing incarcerated criminal defendants greatly increased the strength of the government's administrative and institutional interests in providing mentally ill prisoners with medical treatment. *Cf. In re Qawi,* 32 Cal.4th 1, 7 Cal.Rptr.3d 780, 81 P.3d 224, 232 (2004) (even competent prison inmate can be forcibly medicated if he is a danger to himself and others and treatment is in his best medical interest). Here, API has never asserted that Myers posed an imminent threat of danger to any of API's patients or staff, and it has never suggested that its institutional or administrative interests compelled it to treat her with psychotropic drugs.

In *Rogers v. Commissioner of the Department of Mental Health,* the Supreme Judicial Court of Massachusetts held that a committed mental patient could not be forcibly medicated with antipsychotic drugs unless a court determined both that he was incompetent and that he would have consented to the administration of the drugs if he was competent. [FN57] Although the court's opinion relied on ***247** Massachusetts's statutory and common law, rather than on interpretation of the state constitution, the court emphasized the "constitutional and common law origins" of "[e]very competent adult['s] ... right 'to [forgo] treatment, or even cure, if it entails what for him are intolerable consequences or risks however unwise his sense of values may be in the eyes of the medical profession.' " [FN58] The court further emphasized that mentally ill patients have dignity and worth equal to other individuals; on this basis, the court held that a committed mental patient is entitled to an independent judicial determination of whether the patient would have consented to treatment with psychotropic drugs. [FN59] And the court explicitly rejected the argument that a "substituted judgment determination " of this kind could safely be left to the treating doctors rather than the courts.[FN60]

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

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

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

> incompetent person within its power, the State must recognize the dignity and worth of such a person and afford to that person the same panoply of rights and choices it recognizes in competent persons.").
>
> FN60. *See id.* at 317.

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

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

> In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires[.] [FN62]
>
> FN62. *Id.*

While acknowledging the state's police power to forcibly medicate mental patients in emergency situations-a situation not at issue in the case before us-the court held that in New York, decisions to forcibly medicate persons in all other circumstances must be made by the courts.[FN63] If "the court concludes that the patient lacks the capacity to determine the course of his own treatment, the court must [then] determine whether the proposed treatment is narrowly tailored to give substantive effect to the patient's liberty interest, taking into consideration all relevant circumstances, including the patient's best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments." [FN64]

> FN63. *Id.* at 343-44.
>
> FN64. *Id.* at 344.

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

> FN65. *Jarvis v. Levine*, 418 N.W.2d 139 (Minn.1988).
>
> FN66. *Id.* at 148.
>
> FN67. *Id.* at 148 n. 7.

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

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

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

FN69. *Id.* at 15.

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

FN70. See above, part III.A.

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

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

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

2. Importance of countervailing state interests

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

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

a. Police power

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

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

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

police power can serve as a compelling justification).

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

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

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

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

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

FN78. *See* AS 47.30.836, .839.

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

b. Parens patriae

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

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

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

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

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

3. Least intrusive means requirement

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

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

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

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

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

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

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

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

FN84. *Id.* at 320-21 *See, e.g., Rennie v. Klein*, 476 F.Supp. 1294, 1299 (D.N.J.1979) (the medical director of the Marlboro New Jersey State Hospital stated in an office memorandum that the hospital "uses medication as a form of control and as a substitute for treatment"); *Halderman v. Pennhurst State Sch. & Hosp.*, 446 F.Supp. 1295, 1307 (E.D.Pa.1977) (dangerous psychotropic drugs were used on mentally retarded persons "for purposes of behavior control and staff convenience, rather than for legitimate treatment needs"); *Clites v. State*, 322 N.W.2d 917, 921 (Iowa App.1982) (damages awarded where major tranquilizers used on mentally retarded child "as a convenience or expediency program rather than a therapeutic program"); Jessica Litman, Note, *A Common Law Remedy For Forcible Medication of the Institutionalized Mentally Ill*, 82 Colum. L.Rev. 1720, 1721 n. 9 (1982) (describing cases in which psychotropic drugs were found to be used "for the convenience of the staff and for punishment of patients"); Alexander D. Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 Bull. Am. Acad. of Psychiatry and Law 179, 206 (1980) ("staff too often abuses the management function of medications and slips into the use of medications for its own convenience"); Edward Opton, *Psychiatric Violence Against Prisoners: When Therapy Is Punishment*, 45 Miss. L.J. 605, 623 (1974) ("[I]n mental institutions the bureaucratic needs of the institution for passivity, obedience and submission take precedence over the therapeutic needs of the patients for development of autonomy, initiative, and self-control"); George E. Crane, *Clinical Psychopharmacology in Its 20th Year*, 181 Science 124, 125 (1973) ("drugs are prescribed to solve all types of management problems").

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

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

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

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

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

(original emphasis).

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

The defendants argue that they, as doctors, should be responsible for making treatment decisions for involuntarily committed patients, whether competent or not. We do not agree. Every competent adult has a right to '[forgo] treatment, or even cure, if it entails what for him are intolerable consequences or risks however unwise his sense of values may be in the eyes of the medical profession. ' " [FN88]

FN88. *Rogers*, 458 N.E.2d at 314 (citing *Harnish v. Children's Hosp. Med. Ctr.*, 387 Mass. 152, 439 N.E.2d 240, 242 (1982)); *cf. Rivers v. Katz*, 67 N.Y.2d 485, 504 N.Y.S.2d 74, 495 N.E.2d 337, 341 (1986) ("a patient's right to determine the course of his medical treatment [is] paramount ... and [ ] the right of a competent adult to refuse medical treatment must be honored, even though the recommended treatment may be beneficial, or even necessary to preserve the patient's life"); *Steele*, 736 N.E.2d at 20 ("the patient's wishes ... will be honored, no matter how foolish some may perceive that decision to be").

And Ohio's Supreme Court has similarly described the task of deciding "an involuntarily committed mentally ill person's interest in refusing [psychotropic] medication" as "a uniquely judicial function." [FN89]

FN89. *Steele*, 736 N.E.2d at 22. *Cf. Price v. Sheppard*, 307 Minn. 250, 239 N.W.2d 905, 912-13 (1976) ("Because the potential impact of the more intrusive forms of treatment is so great, we are reluctant in those cases where the patient or guardian refuse their consent, to leave the imposition of the more intrusive forms of treatment solely within the discretion of medical personnel at our state hospitals."); *Jarvis*, 418 N.W.2d at 148 ("[w]hen intrusive treatment is proposed, the ' professional judgment' of medical personnel insufficiently protects this basic human right").

The Minnesota Supreme Court aptly underscored the constitutional underpinnings for its decision that this issue must be directed to the courts:

The court's responsibility for the patient does not end at commitment. Commitment to an institution does not deprive an individual of all legal rights, ... especially fundamental rights guaranteed by our Constitution. It would be both unreasonable and unnecessary for the courts to become involved in every post-commitment treatment decision; [but] it is equally clear that the courts cannot abdicate *all* responsibility for protecting a committed person's fundamental rights merely because some degree of medical judgment is implicated.[FN90]

FN90. *Jarvis*, 418 N.W.2d at 147 (original emphasis).

We agree with these decisions and join them in concluding that the right to refuse psychotropic medication is a fundamental ***252** right, though not an absolute one; that the ultimate responsibility for providing adequate protection of that right rests with the courts; and that adequate protection of that right can only be ensured by an independent judicial determination of the patient's best interests considered in light of any available less intrusive treatments.[FN91]

FN91. *Cf. Steele*, 736 N.E.2d at 21 (the state can forcibly medicate a mental patient under its *parens patriae* authority only after a court finds, "by clear and convincing evidence, that (1) the patient does not have the capacity to give or

withhold informed consent regarding his/her treatment, (2) it is in the patient's best interest to take the medication, *i.e.*, the benefits of the medication outweigh the side effects, and (3) no less intrusive treatment will be as effective in treating the mental illness"); and *Rivers v. Katz*, 67 N.Y.2d 485, 504 N.Y.S.2d 74, 495 N.E.2d 337, 344 (1986) (if a "court concludes that the patient lacks the capacity to determine the course of his own treatment," the court must then "determine whether the proposed treatment is narrowly tailored to give substantive effect to the patient's liberty interest, taking into consideration all relevant circumstances, including the patient's best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments").

4. Best-interests criteria

Having determined that courts must engage in best-interest inquiries, we believe that some discussion is in order concerning appropriate criteria to guide courts on this issue.

[10] Evaluating whether a proposed course of psychotropic medication is in the best interests of a patient will inevitably be a fact-specific endeavor. At a minimum, we think that courts should consider the information that our statutes direct the treatment facility to give to its patients in order to ensure the patient's ability to make an informed treatment choice.[FN92] As codified in AS 47.30.837(d)(2), these items include:

FN92. AS 47.30.837(d)(2).

(A) an explanation of the patient's diagnosis and prognosis, or their predominant symptoms, with and without the medication;
(B) information about the proposed medication, its purpose, the method of its administration, the recommended ranges of dosages, possible side effects and benefits, ways to treat side effects, and risks of other conditions, such as tardive dyskinesia;
(C) a review of the patient's history, including medication history and previous side effects from medication;
(D) an explanation of interactions with other drugs, including over-the-counter drugs, street drugs, and alcohol; and
(E) information about alternative treatments and their risks, side effects, and benefits, including the risks of nontreatment[.] [FN93]

FN93. *Id.*

Considering these factors will be crucial in establishing the patient's best interests as well as in illuminating the existence of alternative treatments. FN94

FN94. *See id.*, subsection (d)(2)(E).

And here, too, we find the work of other state courts to be helpful. The Supreme Court of Minnesota has held that in order to determine the "necessity and reasonableness" of a treatment, "courts should balance [a] patient's need for treatment against the intrusiveness of the prescribed treatment." FN95 Factors that the Minnesota court believed should be considered included:

FN95. *Price*, 239 N.W.2d at 913.

(1) the extent and duration of changes in behavior patterns and mental activity effected by the treatment;
(2) the risks of adverse side effects;
(3) the experimental nature of the treatment;
(4) its acceptance by the medical community of the state; and
(5) the extent of intrusion into the patient's body and the pain connected with the treatment.[FN96]

FN96. *See id.*

We find these approaches to be sensible.

***253** [11] Finally, we note that the parties have disputed the standard of proof that the state should be required to meet in establishing the patient's best interests. API argues for a preponderance of the evidence standard, but it offers no legal authority to support that position. Other courts that have required best-interests determinations in this area have uniformly adopted the clear and convincing standard.[FN97] Moreover, our existing statutory scheme already adopts this standard for findings required to authorize psychotropic medication.[FN98] We see no reason to dilute the standard governing the best-interests determination, and hold that the clear and convincing evidence standard controls the issue.

FN97. *See, e.g., Steele,* 736 N.E.2d at 20; *In re M.P.,* 510 N.E.2d 645, 647 (Ind.1987); *People v. Medina,* 705 P.2d 961, 973 (Colo.1985).

FN98. *See* AS 47.30.839(g).

5. Substituted-judgment standard

Myers separately argues that we should follow the example of the Supreme Judicial Court of Massachusetts and require courts authorizing medication to make an additional finding applying the "substituted judgment" approach.[FN99] The substituted-judgment approach would require courts to attempt to determine what course of treatment an incompetent patient would likely choose if currently capable of making an informed decision.

FN99. *See Rogers,* 458 N.E.2d at 323.

But unlike the statutory scheme at issue in Massachusetts cases, our own statutes incorporate provisions designed to achieve the same goals as the substituted-judgment approach, but by a slightly different path. As already mentioned above, when a treatment facility files a petition for authorization to treat a mentally ill patient with psychotropic drugs, Alaska law requires the appointment of a "visitor" to help gather relevant information for the hearing. One of the two core duties assigned to the visitor under AS 47.30.839(d) is to investigate, document, and report any prior statements-oral or written-that the patient might have made while competent that expressed wishes regarding medication.[FN100] Moreover, as also described above, if the information gathered and documented by the visitor enables the court to find that the patient has expressed a prior competent desire not to be medicated, then the court may not authorize treatment; this emerges from the language of AS 47.30.839(g), which requires the court to order treatment only if it finds that a patient is presently incompetent *and* that the patient was incompetent at the time of any previously expressed wishes reported by the visitor:

FN100. In relevant part, AS 47.30.839(d) says:

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

....

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

(g) *If the court determines that the patient is not competent* to provide informed consent *and,* by clear and convincing evidence, *was not competent*

to provide informed consent at the time of previously expressed wishes documented [by the visitor] under (d)(2) of this section, *the court shall approve the facility's proposed use of psychotropic medication.*[FN101]

FN101. (Emphasis added.)

Because neither party has briefed or addressed this provision on appeal, and because Myers did not attempt to rely on it below,[FN102] ***254** we need not decide its exact scope and meaning, and express no opinion on the point here. At least arguably, though, it might be read to give courts authority to deny a petition if the patient made prior competent statements expressing a desire not to be medicated; and if so, it would seem to serve a similar purpose to that of the substituted-judgment approach advocated by Myers. Since the meaning of this provision is not at issue here and remains open for future consideration, and since the provision may ultimately be interpreted as performing many of the same functions as the substituted-judgment approach, we see no present need to decide Myers's argument urging us to adopt that approach.

FN102. In fact it appears that the visitor in this case was unable to submit a complete report. Myers voiced no objection, did not ask for a more complete investigation of prior expressed wishes, and did not ask for a ruling addressing the point. The superior court's decision made no finding on the issue of prior expressed wishes, and Myers has not pursued that point on appeal.

IV. CONCLUSION

We conclude that the Alaska Constitution's guarantees of liberty and privacy require an independent judicial determination of an incompetent mental patient's best interests before the superior court may authorize a facility like API to treat the patient with psychotropic drugs. Because the superior court did not determine Myers's best interest before authorizing psychotropic medications, we VACATE its involuntary treatment order. Although no further proceedings are needed here because Myers's case is now technically moot, we hold that in future non-emergency cases a court may not permit a treatment facility to administer psychotropic drugs unless the court makes findings that comply with all applicable statutory requirements and, in addition, expressly finds by clear and convincing evidence that the proposed treatment is in the patient's best interests and that no less intrusive alternative is available.

Alaska,2006.
Myers v. Alaska Psychiatric Institute
138 P.3d 238

Briefs and Other Related Documents (Back to top)

- 2004 WL 4908681 (Appellate Brief) Appellant's Supplemental Reply Brief (Sep. 23, 2004)
- 2004 WL 4908682 (Appellate Brief) Appellant's Opening Supplemental Brief (Jul. 26, 2004)
- 2003 WL 25257579 (Appellate Brief) Reply Brief (Dec. 17, 2003)
- 2003 WL 25257580 (Appellate Brief) Brief of Appellee (Dec. 1, 2003)
- 2003 WL 25257581 (Appellate Brief) Brief of Appellant (Aug. 13, 2003)

END OF DOCUMENT

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OVERVIEW: THERA-PUTIC COURTS

Partners For Progress

Supporting.....

Justice that Protects and Heals

Therapeutic Justice
Testimony to Joint Senate and House Judiciary Committees
Janet McCabe, Chair/CEO Partners for Progress
March 7, 2007

Good afternoon Chairman French, Chairman Ramras, members of the Senate and House Judiciary Committees and guests. For the record, I am Janet McCabe, speaking for Partners for Progress. Partners is a non-profit organization that focuses on supporting therapeutic justice statewide. I have been involved with the program since 1999 when I worked with Judge Wanamaker and the Municipality of Anchorage to start the Anchorage Wellness Court.

I want to thank you for this opportunity to speak today, and, especially, to thank you and your legislative colleagues for all you have done for in the past six years for therapeutic justice in Alaska. You took a major step in 2001 with House Bill 172 that set up the pilot felony therapeutic courts in Bethel and Anchorage. Larry Cohn has just given you results of that wise decision. In the intervening years, you have also established provisions that provided important incentives bringing offenders into the rigorous Anchorage Wellness Court for alcoholic misdemeanants.

Last year you added to this legacy by passing HB 441 that gave the Bethel and Anchorage courts ongoing status in codified law, established a consistent statewide sentencing system for all the addiction courts, included felony drug and DUI cases, and put annual funding for the Bethel and Anchorage therapeutic courts on a sustainable basis as part of the state operating budget. We added HB 441 to your packet because it is a very important milestone in the development of therapeutic justice.

My assignment is to tell you about costs and benefits of therapeutic courts. I will also suggest a couple of legislative actions, and I want you to hear from a therapeutic court graduate who has graciously agreed to speak today.

There are two ways of evaluating costs and benefits – social and budgetary. The first views the courts in terms of public protection and harm reduction, and the second looks at the cost-effectiveness of public expenditure. I will give you a few examples to illustrate how Alaska's therapeutic courts perform under each form of evaluation.

From the social point of view, most benefits are things that do not happen - drunk driving that does not occur, property that is not destroyed, people not injured or killed, and

families that are not stressed or broken. The opening sentence of the Alaska Judicial Council report sums it up well, "Graduates of the three courts were rearrested and re-convicted far less frequently than comparison offenders.[1]" By now, data from both Alaska and from national sources leave no doubt that therapeutic courts are a powerful method of reducing repeat crime.

The biggest public benefit of harm reduction is for individuals and society, but there is also a cost dimension. For example, recently the Anchorage Wellness Court graduated a young woman who had a baby that was conceived and born while she was in the program. She had a dreadful record of prior alcoholism, but the baby was not affected by fetal alcohol syndrome. Another young woman, also pregnant, has been in the program 10 months and is staying drug and alcohol-free, protecting her unborn child from harm. These mothers and their children will have vastly better futures because of the therapeutic court. The savings of public money by preventing two cases of fetal alcohol syndrome are also enormous.

The second form of evaluation measures cost efficiency and asks: "Is the program designed to maximize return on dollars spent?" In answer, therapeutic courts are very carefully focused so resources are placed where there is most potential for public benefit. To give you an example I ask you to look at page 3 on the right hand side of your packet for a cross-section of the Anchorage Wellness Court participants last month. The addiction courts are highly selective, focusing on "churners", people who have a pattern of multiple addiction-based offense, but who can become responsible, productive members of society given the "treatment plus" that Wellness Court offers. Violent offenders and sex offenders are not included, nor does the court generally admit first-time DWI offenders. People at the first-DWI end of the crime spectrum usually self-correct. Only a small fraction of first DWI offenders go on to commit a second DWI, so why spend the resources of the court on them? Instead, the Wellness Court focuses on people who are trapped in the revolving door, people so addicted that they repeatedly do illegal and destructive things while under the influence, sometimes at great harm to themselves and others.

Without "treatment plus" in a therapeutic court, the repeat addicted offender would probably serve another term in prison. About 60 percent of those with more than one DWI conviction are re-arrested for another driving offense within 3 years of release from custody. The court may order them into a treatment program, but only half ever show up to the first treatment appointment and retention is very low. Instead, "treatment plus" in a therapeutic court provides a whole packet of addiction-fighting tools combining the coercive power of the court with cognitive-behavioral treatment, medicine that blocks the craving, safe and sober housing, AA meetings, mandatory employment, employment assistance and much more. This tough, integrated program provides the ingredients for

[1] Alaska Judicial Council, February 2007, *Recidivism in Alaska's Felony Therapeutic Courts*, Executive Summary.

positive results with a severely addicted population. It is very hard work for both the participant and the team of people involved, but the rewards are in lives changed, harm avoided, families reunited – basically in seeing people become responsible, law abiding members of our community.

Several years ago the Washington State Legislature, looking at the same set of issues you are considering today, included an appropriation and a clause in the capital budget bill "to study options to stabilize future prison populations." The resulting report[2] is truly impressive. The Washington State Institute for Public Policy reviewed 571 evaluations of prevention and corrections programs. They looked nationwide for sound, evidence-based research and summed it up. Among the findings was a well-documented conclusion that adult drug courts and treatment, as well as cognitive-behavioral therapy for drug and alcohol abusers in prison or community reduced crime, and saved taxpayers and crime victims money.

I would like to conclude by suggesting a couple of action items for your consideration:

First, Partners for Progress urges you to continue your support of the therapeutic courts for addicted offenders by maintaining the existing ongoing operational budgets for the Bethel and Anchorage therapeutic courts. In addition, we ask that you lay the groundwork for comprehensive planning to put the existing and new therapeutic courts for repeat addicted offenders on a sustainable basis. We have given the Chairmen of the two Judiciary Committees a suggested draft resolution that asks the several state and non-profit entities involved in therapeutic courts to collaborate and develop a proposal to the Legislature for cost-effective funding to continue therapeutic courts when grant funding runs out. Grants have demonstrated the benefits of the program. Now the Administration, the Court System, and the non-profits need to develop a post-grant plan.

Second, we recommend that you look at the State of Washington study and consider something similar for Alaska. The savings and benefits could be large. In the meantime, there is value in selecting some of the most cost-effective therapeutic programs identified by Washington's study of nationwide programs, and seeing if they could be adapted to fit the needs of Alaska's correctional system.

And now, I want you to hear directly from a person who really knows the costs and benefits of therapeutic courts. Doreen Shenkenberger graduated from the Anchorage Municipal Court in May 2005. Like many other therapeutic court graduates, she wants to give back to the program that made such a difference in her life. So here is Doreen.

---

[2] Steve Aos, Marna Miller, and Elizabeth Drake. (2006). *Evidence Based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates.* Olympia: Washington State Institute for Public Policy.

Representative Jay Ramras
Chair, Judiciary
House Labor & Commerce
House Oil & Gas
House Military & Veteran Affairs
1292 Sadler Way, Suite 324
Fairbanks, Alaska 99701
Phone: (907) 452-1088
Fax: (907) 452-1146

Alaska State Legislature

While in Session
State Capitol, Room 118
Juneau, Alaska 99801-1182
(907) 465- 3004
Fax: 465-2070
Toll Free: (877) 465-3004

House District 10

House of Representatives

Memo

To: Members of the House Judiciary Committee

From: Representative Ramras

Date: March 7, 2007

Re: Therapeutic Courts Resolution

Please review the attached resolution which was authored by Janet McCabe, Chair & CEO of Partners for Progress. The resolution asks for the development of a plan to sustain and expand therapeutic courts for mentally ill and substance-abusing offenders.

Representative_Jay_Ramras@legis.state.ak.us

Draft 2/17/07
RESOLUTION NO __

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE – FIRST SESSION

BY

A RESOLUTION

Relating to a plan to sustain Alaska's therapeutic courts.

BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

WHEREAS therapeutic courts combine the coercive power of the court with monitoring, case management, medical and psychosocial treatment; and

WHEREAS recidivism data indicates that the therapeutic court program of coercive treatment is more effective and less expensive for reducing crime by mentally ill and addicted offenders than repeated incarcerations; and

WHEREAS reduction of recidivism by mentally ill and addicted offenders saves lives, reduces public harm, and reduces costs of recycling offenders through the judicial and correctional systems; and

WHEREAS reduction of recidivism by mentally ill and addicted offenders also reduces costs and harm to employers, families and communities; and

WHEREAS courts in Anchorage, Bethel, Palmer, Juneau, Ketchikan, Barrow and Fa banks are currently applying the therapeutic court model to some of the offenders in those communities; and

WHEREAS existing therapeutic courts in Anchorage, Juneau, Ketchikan, Barrow and Fairbanks are supported in part by grant funds that can not be sustained on a long-term basis; and

WHEREAS past legislatures have supported development of Alaska's therapeutic courts; and

WHEREAS the continuing success of the therapeutic courts requires the support of the legislature and the continuing collaboration of the judicial and executive branches, and

WHEREAS the Alaska Mental Health Trust Authority, Partners for Progress, and the Juneau Office of the National Council on Alcoholism and Drug Dependence have all contributed significantly to funding and development of therapeutic courts in Alaska and are knowledgeable about the structure, operations and financial needs of these courts; Dana Fabe, Chief Justice, Alaska Supreme Court

(1) the legislature supports the development of a plan to sustain and expand therapeutic courts for mentally ill and substance-abusing offenders;

(2) the legislature recommends that this plan be developed by a nine-person committee comprised of a representative designated by each of the following parties: Deputy Attorney General, Criminal Division, Department of Law; Director, Public Defender Agency; Director, Office of Public Advocacy; Director, Division of Behavioral Health; Chief Justice, Alaska Supreme Court; Administrative Director, Alaska Court System; Chief Executive Officer of the Alaska Mental Health Trust; Executive Director, Partners for Progress; and the Director, Juneau Office of the National Council on Alcoholism and Drug Dependence;

(3) the legislature recommends that the nine committee members elect one of their members to chair the committee and lead the planning process;

(4) the legislature encourages this planning committee to consult with others in the Administration and Court System and to access public information within State government that will be useful in preparing a plan to sustain and expand therapeutic courts for mentally ill and substance-abusing offenders;

(5) the legislature requests that this plan be submitted to the Governor of Alaska, the Chief Justice of the Alaska Court System and to members of the legislature in a time for consideration in the development of the Governor's FY 2009 operating budget proposal.

COPIES of this resolution shall be submitted to the Honorable Sarah Palin, Governor of Alaska; the Honorable Dana Fabe, Chief Justice, Alaska Supreme Court; Talis Colberg, Attorney General; Annette Kreitzer, Commissioner of Administration; Karleen Jackson, Commissioner of Health and Social Services; and to all parties holding the positions listed in (2) above.

alaska judicial council

1029 W. Third Avenue, Suite 201, Anchorage, Alaska 99501-1969 (907) 279-2526 FAX (907) 276-5046
http://www.ajc.state.ak.us E-Mail: postmaster@ajc.state.ak.us

EXECUTIVE DIRECTOR
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Susan Orlansky

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Dana Fabe
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Supreme Court

Recidivism in Alaska's Felony Therapeutic Courts

Presentation to Senate and House Judiciary Committees

March 7, 2007

Scope of Report:

The Alaska legislature asked the Alaska Judicial Council to evaluate the Anchorage Felony Driving Under the Influence and the Bethel Therapeutic Courts. The Council examined recidivism rates for these courts and the Anchorage Felony Drug Court. The Council's report *Recidivism in Alaska's Felony Therapeutic Courts* was published in February 2007.

The Council compared the recidivism rates of 117 offenders who participated in these three therapeutic courts to the recidivism rates of 97 matched offenders who did not participate in the therapeutic courts but who had similar characteristics as the participants, including substance abuse and/or alcohol problems. The Council also compared the recidivism rates of these groups to the baseline recidivism rates of about two thousand offenders charged with felonies in 1999 and convicted of some offense. The recidivism rates of these baseline offenders are the subject of the Council's companion report *Criminal Recidivism in Alaska* published in January 2007.

The Council followed the therapeutic court participants for one year after they graduated or otherwise terminated their participation in the program. The Council followed comparison offenders for one year after they were released from incarceration. Using data from the Alaska Department of Public Safety, the Council compiled the number of new arrests and convictions for each of the offenders who participated in one of these therapeutic courts and for the comparison offenders. Funding for this report came from the Alaska Department of Health and Social Services.

Findings:

- The longer the participants stayed in the program, the less likely they were to recidivate even if they did not graduate.
- 54% of the participants in these projects graduated.
- 13% of graduates were re-arrested within one year after completing a therapeutic court program compared to a 32% re-arrest rate for comparison offenders and a 38% re-arrest rate for offenders charged with felonies in 1999.
- The combined group of graduates and participants had slightly lower recidivism rates than the comparison offenders, but the differences were not statistically significant.
- Older participants were less likely to be re-arrested than younger participants.
- Participants in the Anchorage Felony DUI Court were less likely to be re-arrested than those in the Anchorage Felony Drug Court and the Bethel Therapeutic Court.
- No participants in the programs who were re-convicted within the first year were convicted of an offense at a more serious level than the one on which they entered the therapeutic courts. None were convicted of a Drug or Sexual offense. In contrast, 3% of the comparison offenders were convicted of offenses at a more serious level. In the Council's companion report on recidivism among 1999 offenders, about 15% of most types of offenders were convicted of offenses at a more serious level.
- Native participants responded as well to the therapeutic court programs as did Caucasian participants. Blacks and other ethnicities did not do as well as Caucasian participants.
- The Council recommended that the state should develop further information about the costs and benefits of therapeutic court programs; should explore the reasons for the relative success of Native participants in the programs; and should determine why ethnic groups other than Natives and Caucasians did not do as well in the programs.

Agenda
Therapeutic Justice
Presentation to the Joint House and Senate Judiciary Committees
March 7, 2007

Michelle Bartley, Therapeutic Court Program Coordinator, Alaska Court System
Alaska's Existing Therapeutic Courts: Location, Type and Capacity

Larry Cohn, Executive Director, Alaska Judicial Council
Recidivism in Alaska's Felony Therapeutic Courts, February 2007 Evaluation

Judge Keith Levy, Juneau Therapeutic Court
Juneau Therapeutic Court: Changing Lives of Addiction and Crime

Janet McCabe, Chair/CEO, Partners for Progress
Costs and Benefits of Therapeutic Justice including presentation by Doreen Schenkenberger, a 2005 graduate for the Anchorage Wellness Court

Summary of Existing Therapeutic Courts

Location	Type of Court	Assigned Judge	Capacity	Target Population	Month/Year Court Began
Anchorage	Anchorage Coordinated Resources Project	Rhoades/ Lohff	80	Misdemeanor offenders with mental illness, co-occurring disorders, developmental disabilities & other related disorders	July 1998
Anchorage	Municipal Wellness Court	Morse/ Nolan	40	People convicted of DUI and alcohol related Municipal misdemeanor offenses	August 1999
Anchorage	Felony Drug Court	Morse/ Nolan	20	People convicted of non-violent drug and drug related felony offenses	June 2001
Anchorage	Felony DUI Court	Morse/ Nolan	80	People convicted of felony DUI offenses	December 2001
Anchorage	State Wellness Court	Morse/ Nolan	40	People convicted of DUI and alcohol related State misdemeanor offenses	April 2004
Anchorage	Family CARE Court	Rindner/Tan	12	Parents with CINA cases Primarily mothers with alcohol related substance abuse problems	September 2002
Bethel	Therapeutic Court	Devaney	45	People convicted of DUI and alcohol related misdemeanor and felony offenses	June 2002
Palmer	Palmer Coordinated Resources Project	Heath/ Estelle	40	Misdemeanor offenders with mental illness, co-occurring disorders, developmental disabilities & other related disorders	March 2005
Ketchikan	Wellness Court	Miller	16	People convicted of DUI and alcohol related misdemeanor and felony offenses	May 2005
Juneau	Wellness Court	Levy	15	People convicted of DUI and alcohol related misdemeanor and felony offenses	June 2005

❖ **Highlighted courts began as separate courts, but were recently combined and are now collectively referred to as the Anchorage Wellness Court.**

Veteran's CT - ANC.

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Veteran's CT - ANC.

Summary of Therapeutic Courts in Planning Process

Location	Type of Court	Assigned Judge	Projected Capacity	Target Population	Projected Opening Date
Barrow	FAS/FASD Case Management Project	Jeffrey	Not yet determined	Misdemeanor offenders diagnosed with or suspected of having FAS/FASD	March 2007
Fairbanks	Wellness Court	Funk	20	People convicted of DUI and alcohol-related misdemeanor and felony offenses	May 2007
Fairbanks	Juvenile Mental Health Court	Steinkruger	Not yet determined	Youth offenders with mental illness, co-occurring disorders, and developmental disabilities such as FAS/FASD	October 2007
Bethel	Family CARE Court	Devaney	Not yet determined	Parents, primarily mothers, with CINA cases resulting from alcohol-related substance abuse	Not yet determined

February 2007
Anchorage Wellness Court Participants

Felony DWI, State And Municipal Misdemeanor Courts

No.	Description	Current Offense	Total Prior Convictions	Months in Wellness Court
1	33 yr. old male	3rd DWI	11	5
2	46 yr. old male	8th DWI	23	3
3	39 yr. old female	5thDWI	9	2
4	25 yr. old male	3rd DWI	5	8
5	37 yr. old female	3rd DWI	3	3
6	43 yr. old female	3rd DWI	6	1
7	53 yr. old female	5thDWI	5	7
8	44 yr. old male	4thDWI	4	3
9	36 yr. ld male	5th DWI	7	6
10	45 yr. old female	4th DWI	7	1
11	62 yr. old male	4th DWI	10	11
12	39 yr. old male	3rd DWI	3	14
13	44 yr. old female	2nd DWI	1	15
14	46 yr. old male	2nd DWI	3	12
15	47 yr. old male	10th DWI	23	42
16	51 yr. old male	5th DWI	10	1
17	40 yr. old male	2nd DWI	8	12
18	51 yr. old male	4th DWI	10	14
19	52 yr. old male	4th DWI	28	15
20	25 yr. old female	1st DWI	1	10
21	52 yr. old female	7th DWI	17	5
22	56 yr. old female	Assault 4th degree Alcohol related	4	18 graduated
23	39 yr. old male	2nd DWI	20	5
24	28 yr. old male	2nd DWI	5	15