IN THE SUPREME COURT FOR THE STATE OF ALASKA

FAITH J. MYERS, Appellant, vs. ALASKA PSYCHIATRIC INSTITUTE Appellee.	))))))))	 Supreme Court No. S-11021 Superior Court No. 3AN 03-00277 PR

APPEAL FROM THE SUPERIOR COURT
THIRD JUDICIAL DISTRICT AT ANCHORAGE
THE HONORABLE MORGAN CHRISTEN, PRESIDING

APPELLANT'S SUPPLEMENTAL REPLY BRIEF

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U.S. CONST. amend. XIV §1

Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

AS 47.30.839 Court-ordered administration of medication.

(a) An evaluation facility or designated treatment facility may use the procedures described in this section to obtain court approval of administration of psychotropic medication if

(1) there have been, or it appears that there will be, repeated crisis situations as described in AS 47.30.838(a)(1) and the facility wishes to use psychotropic medication in future crisis situations; or

(2) the facility wishes to use psychotropic medication in a noncrisis situation and has reason to believe the patient is incapable of giving informed consent.

(b) An evaluation facility or designated treatment facility may seek court approval for administration of psychotropic medication to a patient by filing a petition with the court, requesting a hearing on the capacity of the person to give informed consent.

(c) A patient who is the subject of a petition under (b) of this section is entitled to an attorney to represent the patient at the hearing. If the patient cannot afford an attorney, the court shall direct the Public Defender Agency to provide an attorney. The court may, upon request of the patient's attorney, direct the office of public advocacy to provide a guardian ad litem for the patient.

(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, 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.

(e) Within 72 hours after the filing of a petition under (b) of this section, the court shall hold a hearing to determine the patient's capacity to give or withhold informed consent as described in AS 47.30.837 and the patient's capacity to give or withhold informed consent at the time of previously expressed wishes regarding medication if previously expressed wishes are documented under (d)(2) of this section. The court shall consider all evidence presented at the hearing, including evidence presented by the guardian ad litem, the petitioner, the visitor, and the patient. The patient's attorney may cross-examine any witness, including the guardian ad litem and the visitor.

(f) 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.

(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 under (d)(2) of this section, the court shall approve the facility's proposed use of psychotropic medication. The court's approval under this subsection applies to the patient's initial period of commitment if the decision is made during that time period. If the decision is made during a period for which the initial commitment has been extended, the court's approval under this subsection applies to the period for which commitment is extended.

(h) If an evaluation facility or designated treatment facility wishes to continue the use of psychotropic medication without the patient's consent during a period of commitment that occurs after the period in which the court's approval was obtained, the facility shall file a request to continue the medication when it files the petition to continue the patient's commitment. The court that determines whether commitment shall continue shall also determine whether the patient continues to lack the capacity to give or withhold informed consent by following the procedures described in (b) -- (e) of this section. The reports prepared for a previous hearing under (e) of this section are admissible in the hearing held for purposes of this subsection, except that they must be updated by the visitor and the guardian ad litem.

(i) If a patient for whom a court has approved medication under this section regains competency at any time during the period of the patient's commitment and gives informed consent to the continuation of medication, the evaluation facility or designated treatment facility shall document the patient's consent in the patient's file in writing.

42 U.S.C. § 1983. CIVIL ACTION FOR DEPRIVATION OF RIGHTS

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

N.Y. Mental Hygiene Law § 80.03(d)

(d) "Best interests" means promoting personal well-being by the assessment of the risks, benefits and alternatives to the patient of a proposed major medical treatment, taking into account factors including the relief of suffering, the preservation or restoration of functioning, improvement in the quality of the patient's life with and without the proposed major medical treatment and consistency with the personal beliefs and values known to be held by the patient.

A. The Parties Agree a *De Novo* trial is Required In Response to Question 1.a.

Ms. Myers and the State agree that the answer to Question 1.a., is an original Superior Court factual determination is required, i.e. a *de novo* trial. Opening Supplemental Brief, § II.A., Appellee's Supplemental Brief, pp 2, 3-4.

B. In Order to Justify the Forcible Administration of Psychiatric Medication Based on Best Interests the State Must Prove the Likelihood of a Significantly Better Quality of Life with the Drugs than Without.

The State at §I.a., of its Supplemental Brief argues for the "promote and protect the well-being of the person," standard for best interest found in the guardianship statute, while Ms. Myers asserts "the person's quality of life will be significantly better with the court ordered psychiatric drugging than without it." Opening Supplemental Brief at 12.

Even though the State argues against the "quality of life" standard suggested by Ms. Myers, the New York statute cited by the State requires "improvement in the quality of the patient's life with and without the proposed [treatment]." N.Y. Mental Hygiene Law § 80.03(d), cited at pp 7-8 of Appellee's Supplemental Brief.

The State finds it remarkable at page 5 of its brief that Ms. Myers disputes "aspiring to restore a gravely disabled mental patient to an independent life in the community is a legitimate goal," but Ms. Myers asserted no such thing. Ms. Myers merely pointed out that forcing someone to take drugs so they can be discharged quickly to live a zonked out, zombie like existence on welfare for the rest of their life, rather than giving them a chance to recover is not in the person's best interest.

Moreover, the question isn't whether it is a "legitimate goal," but whether it overrides the fundamental right involved. The Supreme Judicial Court of Massachusetts has squarely rejected this as sufficient justification:

> In the present case the judge found that the State had a vital interest in seeing that its residents function at the maximum level of their capacity and that this interest outweighed the rights of the individual. We disagree. While the State, in certain circumstances, might have a generalized parens patriae interest in removing obstacles to individual development, this general interest does not outweigh the fundamental individual rights here asserted.

Guardianship of Roe, 421 N.E.2d 40, 59 (Mass. 1981).

The State also mischaracterizes Ms. Myers' position with respect to incorporating the statutory requirements for obtaining informed consent. Contrary to the State's characterization at page 5 of its Supplemental Brief, Ms. Myers did not assert the court was "limited to the factors enumerated in the informed consent statute," but instead asserted, "this same information should be explicitly considered as part of any best interest determination." Opening Supplemental Brief, p. 11, emphasis added. The State explicitly agrees this is so at p. 5 of its Supplemental Brief.

Ultimately, the question is what level of purported benefit(s) justifies the forcible injection of psychotropic drugs into an unwilling patient. Under both U.S. Constitutional law (*Sell v. United States*, 539 U.S. 166, 123 S.Ct. 2174 (2003)) and Alaska's (*e.g. Ravin v. State*, 537 P.2d 494 (Alaska 1975)) the government must achieve the justification for its intrusion of a fundamental right. Thus, since the State justifies the intrusion as being in the patient's best interests the State must prove her quality of life will likely be significantly better.

C. Forced Psychiatric Drugging Based on Best Interests Should Be Determined by Clear and Convincing Evidence

The State asserts that when a patient declines medication, only a preponderance of the evidence standard for determining best interests should be required to override the fundamental right to decline the medication. In support of this proposition, the State cites two of the Rogers cases arising in Massachusetts, *Rogers v. Okin,* 634 F.2d 650 (1st. Cir. 1980) and *Rogers*,[1] 458 N.E.2d 308 (Mass 1983) and the Illinois case of *In Re C.E.*, 641 N.E.2d 345 (Ill. 1994).[2] Appellee's Supplemental Brief, pp 9-10. First, *Rogers v. Okin* was vacated by the United States Supreme Court in *Mills v. Rogers,* 457 U.S. 291, 102 S.Ct. 2442 (1982). Even so, *Rogers v. Okin* was discussing the situation where "the administration of drugs to an individual is clearly in his best interests." (emphasis added).

In *In Re C.E.*, 641 N.E.2d at 353, the Illinois Supreme Court specifically noted in finding its statute constitutional that all of the elements (including that the benefits outweighed the harm) had to be proven by clear and convincing evidence.

Rogers does not address the standard of proof issue. However, the Supreme Judicial Court of Massachusetts did address the issue in the situation involving a non-committed person in *Guardianship of Roe,* 421 N.E.2d 40, 45-7 (Mass. 1981).

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[1] Note: The state incorrectly titles this case as "*Rogers v. Comm'r of Dep't of Mental Health."*

[2] The State also relies on *U.S. v Weston*, 134 F. Supp. 115 (D.D.C. 2001) (p. 13), yet at 134 F. Supp. 121, the court held the government must prove the justifications for forced drugging by clear and convincing evidence.

Massachusetts, perhaps uniquely, disfavors the clear and convincing standard of proof ("we doubt the utility of employing three standards of proof when two seem quite enough.") 421 N.E. 2d at 46. Instead it has required an extra measure of protection, allowing the court to allow forced medication "only after carefully considering the evidence and entering specific findings indicating those factors that persuade him that a guardian is needed." 421 N.E.2d at 47. *See*, also, *Doe v. Sex Offender Registry Bd.*, 697 N.E.2d 512, 519 (Mass. 1998) ("extra measure of protection" required under *Roe*).

In *Steele v. Hamilton County*, 736 N.E.2d 10, 20 (Ohio 2000), the Ohio Supreme Court also unequivocally required the best interest element be determined by clear and convincing evidence:

> When, in addition, the court also finds by clear and convincing evidence that the benefits of the antipsychotic medication outweigh the side effects, and that there is no less intrusive treatment that will be as effective in treating the illness, then it may issue an order permitting forced medication of the patient.

In *In Re: M.P.*, 510 N.E.2d 645, 647 (Indiana 1987), the Indiana Supreme Court held:

> [T]he State must demonstrate by clear and convincing evidence that . . . the probable benefits from the proposed treatment outweigh the risk of harm to, and personal concerns of, the patient.

See, also *Rivers v. Katz*, 495 N.E.2nd 337, 344 (NY 1986) (all elements, including best interests must be found by clear and convincing evidence); *People v. Medina*, 705 P2d 961, 973 (Colo. 1985) (Clear and convincing required for all elements); and *In the Interest of J.S.*, 530 N.W.2d 331, 333 (N.D. 1995).

The State also argues against the clear and convincing standard by citing to *Washington v. Harper*, 494 U.S. 210, 110 S. Ct. 1028 (1990), which was a prisoner case. Appellee's Supplemental Brief, p. 11, n 19. The Supreme Court of *Hawai'i v. Kotis*, 984 P.2d 78, 94-99 (Hawaii 1999), in a lengthy discussion that included *Washington v. Harper*, found that the Hawaiian Constitution requires clear and convincing evidence to support all of the findings of fact in proceedings concerning involuntary medication. Ms. Myers respectfully suggests this well-thought out opinion and the other authority cited herein are persuasive.

Ms. Myers also suggests again here, as she did at oral argument, that the Court ought not view the decision that a person is incompetent to decline the medication means that the person should have no input into the decision.[3]

Finally, the State, after admitting it failed to introduce adequate counter scientific evidence, cites to literature it says shows newer drugs have fewer problems than the older ones and this purported fact should change the constitutional legal principles

[3] Counsel misspoke at oral argument when he said the issue of Ms. Myers competence was not in the appeal because she had been found incompetent; in actuality, because incompetence is such a fact specific issue, Ms. Myers dismissed the points on appeal relating to incompetency after the petitions for commitment and forced drugging were dismissed with prejudice by agreement during the jury trial for the 180 day commitment and forced drugging petitions. *See*, Partial Dismissal, filed July 11, 2003. Counsel, however, again urges the Court to review Ms. Myers testimony regarding her very cogent reasons for declining the medications to gain an appreciation that a determination of incompetence may not be the complete lack of reasoning one might assume it is and how high a hurdle she faced. [Tr. 114-147]

protecting people's rights. Even if this purported fact were true, it should not operate to diminish people's constitutional rights.

But, this purported fact turns out to be false. During the hearing, Drs. Loren Mosher and Grace Jackson testified to the lack of efficacy and extreme danger of even the newer drugs as well as how the published medical literature had become unreliable because of improper pharmaceutical company influence.[4] [TR. 164-189]. This testimony has been completely borne out by subsequent disclosures. For example, contrary to the testimony of Dr. Kletti [Tr 108-111], API's Medical Director at the time,

[4] The media has recently been filled with the revelations that the drug companies hid data demonstrating the new drugs for treating depression, called Selective Serotonin Re-uptake Inhibitors (SSRIs) are ineffective and greatly increase suicidality and violence in children. *See*, e.g., "Information Is the Best Medicine," (Op Ed), by Dr. John Abramson, Harvard Medical School, *New York Times*, September 18, 2004 ("Findings that support drug sales tend to get published in medical journals, and become accepted as fact. Unfavorable findings often don't see the light of day."); "Medicine's Data Gap: Results of Drug Trials Can Mystify Doctors Through Omission," *New York Times*, July 21, 2004. The selective reporting of data was also testified to by Dr. Jackson and articles introduced at the Superior Court trial [Tr.185-187, Exc. 274-288] and the professional literature has recently highlighted the problem. *See*, eg Clinical Trials Controversy Spotlights Flawed System," by Jim Rosack, *Psychiatric News*, July 16, 2004 Volume 39 Number 14. In "Trial Registration:A Great Idea Switches From Ignored to Irresistible," by Drummond Rennie, MD, *Journal of the American Medical Association* (JAMA), September 15, 2004—Vol 292, No. 11 1359, Dr. Rennie, JAMA's Deputy editor reiterated:

> One consequence of this lack of reporting is a persistent bias in favor of positive results and therefore in favor of the newer and more expensive treatments. Another consequence is that harmful effects found in unpublished trials disappear without a trace, since the US Food and Drug Administration (FDA) has no mandate to report them to the public. The bad news about new drugs is disseminated later than the good news or not at all, resulting in widespread publication and outcome bias and in direct and widespread harm to patients.

that these medications were extremely safe, numerous warnings about serious side effects such as diabetes, and even death, have been ordered by the FDA since the March, 2003, hearing in this matter.[5] Thus, Dr. Jackson' written testimony [Exc. 249-273] and oral testimony [Tr 180-192] about the serious problems with these newer drugs and lack of efficacy have been completely borne out. In addition, a number of studies since then have debunked the State's thesis that the newer drugs don't have serious problems and are more effective than the older drugs.

For example, in "Effectiveness and Cost of Olanzapine and Haloperidol in the Treatment of Schizophrenia: A Randomized Controlled Trial," in the *Journal of the American Medical Association*, November 26, 2003, 290:2693-2702, it was found that Olanzapine (Zyprexa) does not demonstrate advantages compared with Haldol in compliance, symptoms, extrapyramidal symptoms (involuntary movements), or overall quality of life.

Other studies have concluded there is no real evidence supporting the use of these drugs. In "Happy birthday neuroleptics! 50 year later: la folie du doute," *European*

[5] *See*, e.g., the "Dear Health Care Provider" letters regarding Olanzapine (Zyprexa) and Risperidone (Risperdal), the two drugs that API wanted to force drug Ms. Myers with that can be accessed from the Food and Drug Administration's website at http://www.fda.gov/medwatch/SAFETY/2004/safety04.htm. The one for Olanzapine, states " Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics including Zyprexa." The same warning was issued about Risperdal. Olanzapine and Risperidone are the two drugs the State principally intended to force Ms. Myers to take.

Psychiatry 2002 ; 17 : 1-5, Dr. Stip asks and answers the following questions:

> After 50 year of neuroleptic drugs, are we able to answer the following simple questions: Are neuroleptics effective in treating schizophrenia? Is there a difference between atypical and conventional neuroleptics? How do the efficacy and safety of newer antipsychotic drugs compare with that of clozapine? . . . At this point in time, responsibility and honesty suggest we accept that a large number of our therapeutic tools have yet to be proven effective in treating patients with schizophrenia. . . . One thing is certain: if we wish to base psychiatry on EBM [Evidence Based Medicine], we run the genuine risk of taking a closer look at what has long been considered fact.

In "Atypical antipsychotics in the treatment of schizophrenia: systematic overview and meta-regression analysis," *British Medical Journal*, 2000 Dec 2;321(7273):1371-6, after a systematic and rigorous statistical analysis, it was found that "There is no clear evidence that atypical antipsychotics are more effective or are better tolerated than conventional antipsychotics."[6]

And, of course, the Superior Court found as a factual matter in this case that:

> [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.
>
> * * *
>
> [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.

[Exc. 299, 304]. The State did not appeal this factual finding and should not be allowed to try and contradict it by inserting new material on appeal.

[6] Thus, the Mossman article relied upon by the State at n. 24 is not persuasive because it relies on the disproven premise that the newer drugs are safer than the older drugs.

The State also asserts this Court can rely on the institutional psychiatrists to make sure only the patients' interests are considered, but the falsity of this is now well known and documented.[7] It has even been demonstrated in this case where the Medical Director of API was proud he declined to read critiques of the current practices of psychiatry and equated such critics to people who dispute evolution and the earth is round. TR. 104, 109-10. Dr. Hanowell, the treating psychiatrist in this case, testified in his deposition that while he had become aware of research disputing the validity of the current standard of care, it didn't cause him to look into the issue or change his practices. Exc. 140-3.

It seems clear that a patient's constitutional rights to challenge the forcible administration of psychiatric drugs should not vary based on an ever changing debate over the safety and efficacy of proposed drugs. This is particularly true in light of the continuing cycle of announced improved treatments for mental illness, which turn out to be no better or safer than the discredited treatments that were once so touted. This cycle is now playing out as usual with respect to these newer drugs to treat schizophrenia, just

[7] *See*, e.g., Opening Brief, pp. 27-28 and the further discussion in the case cited therein. *See*, also, "Psychiatric Ethics," by Jennifer Radden, *Bioethics*, 2002 Sep;16(5):397-411 ("A primary ethical concern is that these drugs are over-prescribed in . . . institutions to solve management problems") and "Extremely Unbalanced: Interest Divergence and Power Disparities Between Clients and Psychiatry," *International Journal of Law and Psychiatry*, Vol. 19, No. 1, pp 1-25, 1996 ("T]here are ample reasons to reject the general assumption that psychiatrists can be counted upon to ascertain the best interests of the client").

as it has with respect to such mental health "treatments" as Lobotomies, Insulin Coma, Metrozal Shock, Electroshock, and the older neuroleptics.

D. <u>Each Proposed Drug Must Be Considered.</u>

In its Supplemental Brief, the State seizes on the words "kinds of drugs" in *Sell*, to assert that means classes of drugs not individual medications. Ms. Myers suggests this is a strained reading of even that particular phrase. However, elsewhere in the Opinion the United States Supreme Court made clear it was talking about individual drugs.

> Has the Government, in light of the efficacy, the side effects, the possible alternatives, and the medical appropriateness of a **<u>particular course of antipsychotic drug treatment</u>**, shown a need for that treatment sufficiently important to overcome the individual's protected interest in refusing it?

Sell, supra., 123 S. Ct. at 2186, emphasis added. *See*, also *In re: Kness*, 661 N.E.2d 394, 399 (Ill. App. 1996) (Specific medication required to determine best interests). There is no legitimate doubt but that *Sell* requires an analysis of the potential benefits and risks of each drug proposed to be forced on the unwilling patient.

E. <u>Clear Procedural Rules and Substantive Guidelines do Not Obviate the Requirement of a *De Novo* Judicial Determination of Best Interests</u>.

The Court's Question 1.b., poses the question of whether the requirement for a judicial determination of best interests would change if clear procedural rules and substantive standards were adopted to guide the treatment facility in determining best interest. Ms. Myers asserts there must still be a *de novo* judicial determination, Appellant's Opening Supplemental Brief, pp 7-10, while the State asserts that an

arbitrary and capricious standard should apply. Appellee's Supplemental Brief at 30-31. The State's proposal devalues the fundamental right involved beyond recognition and can not be relied upon to protect people's rights.

The State relies heavily on *Jurasek v. Utah State Hospital*, 158 F.3d 506 (10th Cir. 1998) and *Washington v. Harper* in support of its contention. However the court in *Washington v. Harper* specifically limited its holding to the convicted prisoner situation where it is permissible to restrict fundamental rights when such restrictions are "reasonably related to legitimate penological interests," and explicitly stated that outside of such prison context, the government "would have been required to satisfy a more rigorous standard of review." 110 S.Ct. at 1038. Moreover, notwithstanding the state's protestations, as set forth in Ms. Myers prior briefing, there is grave doubt whether even that core holding survives *Sell*.

The State also asserts at p. 20 of its supplemental brief that because there is a discussion in *Sell* that other justifications for forced psychiatric drugging may obviate the need to conduct a *Sell* type analysis with respect to competency to stand trial the constitutional protections surrounding the best interest determination required in *Sell* do not apply in the civil commitment context. In order for this to be true, the state must prove to a court that the drug is in the person's best interest before it can force the person to take it to make him competent to stand trial, but is not required to do so when it wants to force drug a civilly committed patient in the patient's best interest. This seems inconceivable, as does the general idea that a civilly committed patient has fewer rights against forced drugging than a criminal defendant.

Jurasek is simply wrong, is an unconvincing interpretation of state law by a federal court, and has never been relied upon by any other court for the proposition asserted by the State as far as Ms. Myers has ascertained.

The State's reliance on the denial of certiorari as an affirmance of *U.S. v. Charters*, 863 F.2d 302 (CA4 1988) (*en banc), certiorari denied,* 494 U.S. 1016, 110 S.Ct. 1317, is curious in light of the repeated warnings from the U.S. Supreme Court that a "denial of *certiorari* does not constitute a ruling on the merits."[8] More substantively, the State's reliance on *Charters* is unfathomable since *Sell* overrules *Charters*.

The State also cites at n. 39 to *Morgan v. Rabun*, 128 F.3d 694 (CA8 1997) and *Noble v. Schmitt*, 87 F.3d 157 (CA6 1996) for the proposition that they extend the *Washington v. Harper* reduced procedural rights for prisoners situation to civilly committed patients. However, the forced drugging permitted in *Morgan* was based on dangerousness where the "'primary intent' of the injections was to restrain Morgan if he got out of hand." 128 F.3d 694 at 697, n. 5. *Noble* is also a dangerousness case and the court held Mr. Noble had a 42 USC § 1983 claim against hospital employees.

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[8] *Barber v. Tennesee*, 513 U.S. 1184, 115 S.Ct. 1177 (1995), citing to *United States v. Carver*, 260 U.S. 482, 43 S.Ct. 181 (1923)(" The denial of a writ of certiorari imports no expression of opinion upon the merits of the case, as the bar has been told many times."). The 4th Circuit indeed made this elementary error in *Hogan v. Carter*, 85 F.3d 1113, 1118 (CA 4 1996) (*on rehearing*) when it relied on the U.S. Supreme Court's failure to grant *certiorari* as an affirmance and reversed its own panel's determination that *Charters* had been overruled by *Washington v. Harper*.

Similarly, the State's reliance on the older cases of *Dautremont v. Broadlawns Hosp.*, 827 F.2d 291 (CA8 1987), and *Lappe v. Loeffelholz*, 815 F.2d 1173 (CA8 1987) is curious inasmuch as the state conceded at oral argument that obtaining a civil commitment was insufficient to forcibly medicate someone. Citing to *Richard B.*, 71 P.3d 811 (Alaska 2003), the state at p. 26 and n. 60, also argues that the cost of judicial hearings to vindicate someone's fundamental right against forcible medication is a sufficient basis not to require them. However, it is hard to see how ruling telephonic testimony was constitutionally sufficient in that case justifies dispensing with a judicial hearing altogether.

In *Medina*, *supra.*, 705 P.2d at 971, the Colorado Supreme Court rejected the argument that institution rules and regulations with appellate review was adequate to protect the fundamental right involved.

> The People argue that once the patient has been involuntarily committed and found to be incompetent, the patient's right to refuse treatment is adequately protected by the rules and regulations of the institution and the opportunity of the patient to seek post-treatment judicial review of the treatment decision. We find no merit whatever in this argument. Relegating the patient to a post-treatment hearing, in addition to requiring the forfeiture of the patient's interest in bodily integrity as related to the initial treatment, would compel a patient to submit to the very risks to which his refusal was most likely directed in the first instance. Such a remedy hardly comports with the importance that the law has long accorded to a patient's right to participate in treatment decisions affecting his own body.

As a practical matter, relegating a person to appealing an agency determination leads to one of two inherent problems. First, if a stay of the forced drugging is not automatic, then as the *Medina* court acknowledges, there is no way that the courts can

effectively protect the person's rights. If stays are granted or the administrative decision to medicate someone is not effective until after review, then the State's avowed desire to drug someone quickly will not be achieved. Moreover, since the State conceded at oral argument that the competency determination must be made *de novo* by a court there seems little additional burden to include the best interest determination. The State's suggested procedure would add two additional proceedings -- the administrative proceeding and then an appeal of that.

This is, however, exactly what is required under the New York constitution.

> The determination should be made at a hearing following exhaustion of the administrative review procedures provided for in 14 NCYRR 27.8. The hearing should be de novo, and the patient should be afforded representation by counsel. . . . [T]he court must determine whether the proposed treatment is narrowly tailored to give substantive effect to the patient's liberty interest, taking into consideration all relevant circumstances, including the patient's best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments. The State would bear the burden to establish by clear and convincing evidence that the proposed treatment meets these criteria.

Rivers v. Katz, 495 at 343-4, citations and footnotes omitted.

In Massachusetts, which requires a determination of what decision the person would make if competent, (substituted judgment), the Supreme Judicial Court held as a matter of its constitutional law:

> We conclude that, if a patient is declared incompetent, a court must make the original substituted judgment treatment decision and should approve a substituted judgment treatment plan.

Rogers, supra., 458 N.E.2d at 318.

Alaska's constitution certainly requires at least as much as New York's and Massachusetts'.

F. The U.S. Constitution Requires a *de novo* Judicial Finding of Best Interests Before a Civilly Committed Patient May be Involuntarily Administered Psychiatric Medication under the *Parens Patriae* Doctrine.

In §II.A., of the State's Supplemental Brief, the State asserts the federal constitution does not require a court determination of best interests. While the United States Supreme Court has never directly ruled on this precise issue, only if a civilly committed patient has fewer rights than a criminal defendant whom the government desires to force drug to make competent to stand trial can the State's position be correct. Ms. Myers suggests this can not be the case.

There is only one United States Supreme Court case that squarely addresses the constitutional right of a civilly committed patient to decline psychiatric medications, *Mills v. Rogers*, *supra*. The Supreme Court, as did the parties, assumed involuntarily committed mental patients have a federal constitutional right to refuse psychiatric medication, 102 S. Ct. at n. 16, but declined to delineate the parameters of such federal right because, "as a practical matter both the substantive and procedural issues are intertwined with questions of state law," 102 S.Ct. at 2448, and that since the federal due process clause requires the states to protect state created rights, "the minimal requirements of the Federal Constitution would not be controlling, and would not need

to be identified in order to determine the legal rights and duties of persons within that State."[9]

Earlier in the same year *Mills v. Rogers* was decided, the Court remanded *Rennie v. Klein*, 458 U.S. 1119, 102 S.Ct. 3506 (1982), to the Third Circuit "for further consideration in light of *Youngberg v. Romeo*, 457 U.S. 307, 102 S. Ct. 2452 (1982)." In *Youngberg*, a severely retarded man was being improperly treated in an institution through the excessive use of restraints and the lack of any training or habilitation (which resulted in the excessive use of restraints). Everyone, including all of the professionals agreed that his care did not comport with professional standards. There, the U.S. Supreme Court found that Romeo was "entitled to minimally adequate training . . . as may be reasonable in light of respondent's liberty interests in safety and freedom from unreasonable restraints." 102 S. Ct. at 2461. The Court concluded, "the Constitution only requires that the courts make certain that professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made." *Id.*

Thus, *Youngberg*, itself, is a right to treatment case, not a right to decline treatment case and the Court held *Youngberg* was entitled to the minimum treatment professional judgment requires. However, the remand of the *Rennie* right to decline

[9] 102 S.Ct. at 2449. The Supreme Court then remanded the case to the 1st Circuit, which certified nine questions to the Massachusetts Supreme Judicial Court, resulting in the 1983 *Rogers* case discussed throughout the briefing in this case requiring a judicial decision of "substituted judgment."

psychiatric drugs case "in light of" *Youngberg* made *Youngberg* seem at least relevant to the forced psychiatric drugging issue, and *Youngberg* is mentioned a number of times in *Mills v. Rogers*, including language suggesting treatment decisions should be left to the professionals. Nevertheless, as set forth above, the later case of *Mills v. Rogers*, while acknowledging due process protection, explicitly declined to rule on its extent and it is clear the U.S. Supreme Court has never defined the minimum substantive or procedural federal constitutional requirements before a civilly committed patient may be forcibly administered psychiatric drugs against their will. Nor has it ever held, even in the prison context, that the exercise of professional judgment overcomes the fundamental right to be free of unwanted psychiatric drugs. In fact, when presented with the issue in other contexts, it has always required more.

Washington v. Harper, supra, involved a convicted prisoner, while *Riggins v. Nevada*, 504 U.S. 127, 112 S.Ct. 1810 (1992) and *Sell, supra* involve criminal defendants whom the government desired to forcibly drug to render competent to stand trial. As discussed previously, the administrative procedures were found adequate in *Washington v. Harper* solely because of prisoners' reduced due process rights. It also was based on the State's police power interest in maintaining order in the prisons, rather than the *parens patriae* basis asserted here, and even there the U.S. Supreme Court required the medication be "in the inmate's medical interest." 110 S. Ct. at 1040.

In *Riggins*,[10] the U.S. Supreme Court held:

> [O]nce Riggins moved to terminate administration of antipsychotic medication, the State became obligated to establish the need for Mellaril and the medical appropriateness of the drug.

112 S.Ct. at 1815. The context makes clear it is the court that must make this determination. The Court declined to define the standards for "establishing the need" for the medication and "medical appropriateness," which Justice Kennedy, in his concurrence, felt should have been done. Of course, most recently, in *Sell*, the court did just exactly that and laid out the standards required before a criminal defendant could be forcibly administered psychiatric drugs in order to make him competent to stand trial. This included: "the court must conclude that administration of the drugs is *medically appropriate, i.e.*, in the patient's best medical interest in light of his medical condition." 123 S.Ct. 2185, italics in original, underlining added.

Thus, while the U.S. Supreme Court has not explicitly ruled on the minimum federal constitutional substantive and procedural requirements before a civilly committed patient may be forcibly administered psychiatric drugs, two things are clear. First, substantively, in every circumstance, even the reduced rights in prison context, the

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[10] In *Riggins*, 112 S.Ct. at 1815, the Court discussed its *Washington v. Harper* holding as follows:

> Taking account of the unique circumstances of penal confinement, however, we determined that due process allows a mentally ill inmate to be treated involuntarily with antipsychotic drugs where there is a determination that "the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest."

State must establish the medication is medically appropriate. As to procedural rights regarding best interests, since *Sell* requires a judicial determination of best interests, only if a civilly committed patient who has not been charged with any crime has fewer rights as to the determination of best interests than a criminal defendant, may a *de novo* judicial determination of best interests be dispensed with. It seems inconceivable that this can be so, particularly when as here the sole justification for the forced drugging is that it is in the person's best interest (*parens patriae* justification).

G. **Alaska's Constitution Requires a Judicial Determination of Best Interests**.

As set forth in the previous section, in *Mills v Rogers,* the U.S. Supreme Court held that as a practical matter it is state law which will most often define a civilly committed patient's substantive and procedural rights to decline psychiatric drugs. In Section III, of its Supplemental Brief, the State spends a considerable amount of space on the proposition that the Legislature's determinations should prevail. However, this Court "cannot defer to the legislature when infringement of a constitutional right results from legislative action." *Valley Hospital Ass'n. v. Mat-Su Coalition for Choice*, 948 P.2d 963, 972 (Alaska 1997).

In this case, the State has failed to cite to a single state high court decision supporting its views under their respective state constitutions. This is in stark contrast to Ms. Myers, who has cited to the high courts in several states, including, New York (*Rivers v. Katz*), Massachusetts (*Rogers* and *Roe*), Ohio (*Steele*), Illinois (*C.E.*), Colorado (*Medina*), Indiana (*M.P.*), Hawaii (*Kotis*) and North Dakota (*J.S.*), all of which support her arguments here. The Alaska constitutional principles enunciated by Ms.

Myers in her previous briefing demonstrate Alaska's constitution provides at least as much protection.

H. <u>Other Issues</u>

Ms. Myers will rely on her Opening Supplemental Brief for the other issues addressed in the State's Supplemental Brief, such as that AS 47.30.839 violates both the Equal Protection Clause and the Americans with Disabilities Act, except to correct one other mischaracterization. Contrary to the statement at p. 29 of the State's Supplemental Brief that Ms. Myers argues "Alaska's statutes violate the Americans with Disabilities Act because the statutes invalidate mental patients' durable powers of attorney," she, in fact, argued:

> [I]t is a violation of the Americans with Disabilities Act because AS 47.30.839 treats people diagnosed with mental[] illness differently than it treats people who have not been so diagnosed with respect to taking away their decision making authority.

Opening Supplemental Brief at 20.

RESPECTFULLY SUBMITTED this 23rd day of September, 2004.

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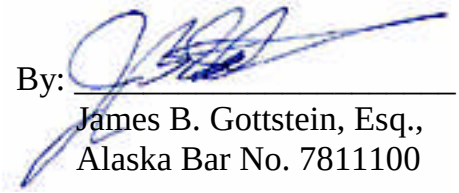
By: 

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