James B. Gottstein, Esq.
Law Project for Psychiatric Rights, Inc.
406 G Street, Suite 206
Anchorage, AK 99501
907-274-7686 phone
907-274-9493 fax

Attorney for Roslyn Wetherhorn, Respondent

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT, AT ANCHORAGE

In The Matter of the Necessity for the Hospitalization of:	)	
Roslyn Wetherhorn, Respondent.	)	
	)	Case No. 3AN 05-459 P/R

REPLY Re: MOTION FOR ATTORNEY'S FEES

In its Opposition to Ms. Wetherhorn's Motion for Attorney's Fees (Opposition), the State asserts:

A. AS 47.30.905(b),
B. *Crittel v. Bingo*, 83 P.3d 532 (Alaska 2004),
C. Probate Rule 1(b) & (e), and
D. Administrative Rule 12(e)(1)A)(vi) & (5),

preclude the requested award. The State, as will be shown, is clearly in error in all respects. In addition, the State having eliminated the reason for not doing so, Ms. Wetherhorn also reinforces footnote 5 of her Memorandum in Support of Motion for Attorney's Fees (Memorandum) with respect to the reasons why she is entitled to enhanced or full fees.

I. Ms. Wetherhorn is Entitled to a Rule 82 Award of Attorney's Fees.

(A) Involuntary Mental Health Actions Under AS 47.30 Are Civil Actions.

The State asserts at page 2, citing Probate Rule 1(b), that "A civil commitment proceeding is a probate matter, which are governed first by the probate rules." While it is true that Probate Rule 1(b) states that the Probate Rules govern mental health commitments under AS 47.30, that does not make them "probate matters." Nowhere in Title 47 does the word "probate" appear.[1] In other words, the Legislature did not designate these proceedings as "probate" actions. Instead, the Legislature required the Superior Court to authorize any involuntary commitment or forced drugging orders. That the Probate Rules may have been made applicable to AS 47.30 involuntary mental health actions in order to subject AS 47.30 psychiatric respondents to summary proceedings does not make them "probate matters."[2] Even if they were/are "probate matters," they are still civil actions. *Crittell, supra.*, 83 P.3d at 535 (Civil action encompasses probate action"). And, as acknowledged by the State, even though the Probate Rules may apply,

[1] This is based on counsel being unable to find the word, including using a Westlaw search.

[2] *Black's Law Dictionary*, Seventh Edition, as applicable defines probate as "1. To admit (a will) to proof. 2. To administer (a decedent's estate)." The American Heritage Dictionary defies probate as: "1. The process of legally establishing the validity of a will before a judicial authority. 2. Judicial certification of the validity of a will. 3. An authenticated copy of a will so certified." That is clearly not the case here.

they are governed by the Civil Rules "where no specific procedure is prescribed" by the Probate Rules.[3]

(B) Civil Rule 82 Applies to this Action.

The State also argues Civil Rule 82 does not apply because AS 47.30905(b) does. However, by its clear and unambiguous terms AS 47.30.905(b) only applies to counsel appointed to represent a respondent in involuntary mental health proceedings under AS 47.30.660--915. Thus, it does not cover this situation. *Crittel*, 83 P.3d at 536, cited by the State, actually confirms this analysis by making it clear that Rule 82 applies when such other attorney fee provision does not. More specifically, in *Crittell,* the Alaska Supreme Court responded to the argument that AS 13.16.435 controls the award of fees rather than Civil Rule 82 as follows:

> But here, section .435 did not apply to the interested parties' request for fees, since they did not bring their case as personal representatives and did not claim to be persons nominated as personal representatives under either of Violet's wills. . . . [S]ection .435 could not apply to the Crittells, since Edmond Crittell failed to meet that provision's first requirement: he was neither the personal representative of the estate nor a person nominated as the personal representative. Because section .435 did not apply in this case, it follows that the superior court properly concluded that Civil Rule 82 governed the interested parties' right to recover fees.

83 P.3d at 536, emphasis added. AS 47.30.905(b) is simply inapplicable here;[4] Civil Rule 82 is applicable here, just as it was in *Crittell*.[5]

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[3] Probate Rule 1(b)(e).

[4] Thus, the rate of compensation and ceiling under Administrative Rule 12 are also inapplicable. It should be noted, however, that the State makes a misstatement when it says at page 4, that "Administrative Rule 12 specifically contemplates the court

II. Enhanced or Full Attorney's Fees Should Be Awarded Here

Footnote 5 of Ms. Wetherhorn's Memorandum in Support of Motion for Attorney's Fees (Memorandum), states:

> For various reasons, Ms. Wetherhorn believes it is appropriate to award full attorney's fees under Civil Rule 82(b)(3) (E), (G),(H) or (K), or any combination thereof, but since the effort in demonstrating both that full fees should be awarded under such subsections and that §2, Ch. 86 SLA 2003, potentially prohibiting such an award, is invalid for failure to be approved by a two-thirds majority (or otherwise), would likely greatly exceed the amount at stake, has elected not to move for full fees at this time. However, the court may take into account these factors and award more than 20%.

At page 5 of the State's Opposition, it asserts *Crittell* holds Civil Rule 82 is only available for "fraud upon the court." This misstates *Crittell*, which as set forth above, clearly holds Civil Rule 82 is generally available in all non-criminal actions. Moreover, *Crittell* actually specifically holds enhanced fees may be awarded in probate matters under Civil Rule 82.[6]

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appointing counsel in proceedings under AS 47.30," citing to Administrative Rule 12(e)(1)(A)(vi). Administrative Rule 12(e)(1)(A)(vi) actually only applies to "involuntary alcohol commitments brought pursuant to AS 47.37," not mental health commitments under AS 47.30.

[5] Moreover, AS 47.30.905(b) requires payment to appointed counsel whether the prevailing party or not, while Civil Rule 82 is a fee shifting provision and is only awarded to the prevailing party. Thus, there very well may be situations where both AS 47.30.905(b) and Civil Rule 82 would apply.

[6] Contrary to the State's assertion at page 5 of its Opposition that Civil Rule 82 fees may only be awarded in probate matters for "fraud on the court," the Alaska Supreme Court merely restated that full fees are normally not awarded unless there is "bad faith or vexatious conduct." 83 P.3d at 536-7 and n. 20. The requirement of "bad faith or vexatious conduct" only applies to awards of 90% or more of actual fees. *See*, e.g., *Crook v. Mortenson-Neal*, 727 P.2d 297, 306 (Alaska 1986), which holds only an award

Here, for the reasons stated below, the State's cavalier disregard for Ms. Wetherhorn's statutory rights, enabled and emboldened by the Public Defender Agency's complete abdication of its responsibility to protect the rights of its AS 47.30 clients, fully justifies awarding her enhanced, if not full attorney's fees.

(A) The State Flouted the Requirements of AS 47.30.

(1) The Petition for Initiation of Involuntary Commitment Does Not Comply with the Law.

The Petition initiating involuntary commitment (Initiation Petition)[7] does not comply with AS 47.30.700. More specifically, AS 47.30.700(b) provides:

> (b) The petition required in (a) of this section must allege that the respondent is reasonably believed to present a likelihood of serious harm to self or others or is gravely disabled as a result of mental illness and must specify the factual information on which that belief is based including the names and addresses of all persons known to the petitioner who have knowledge of those facts through personal observation.

(emphasis added).

AS 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

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of 90% or more of actual fees triggers the necessity that the conduct be in bad faith or vexatious. *See*, also, *State v. University of Alaska*, 624 P.2d 807, 818 (Alaska 1981). The State seriously misrepresents *Crittell* throughout its Opposition.

[7] Exhibit A. This predates the Law Project for Psychiatric Rights (PsychRights) entry into this case, but is part of the State's pervasive practice of violating the law relating to civil commitments under AS 47.30 and is presented as part of the entire picture.

> (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.

With respect to the requirement to specify the factual information on which the allegation that Ms. Wetherhorn is mentally ill and as a result gravely disabled or presents a likelihood of causing serious harm to herself or others, the Initiation Petition states:

"Manic state homeless and non medications compliant 2 months"

First, no names and addresses of persons having personal knowledge, as is required by statute, are included. Second, being manic, homeless and non medications compliant are not adequate grounds for commitment, i.e., they do not support "likelihood of serious harm" nor "gravely disabled" under either prong of the AS 47.30.915(7) definition.[8] The Initiation Petition thus manifestly fails to comply with AS 47.30.700.[9] In addition, there is no indication that the mental health professional who caused Ms. Wetherhorn to be

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[8] It is highly likely the (B) prong of the definition of gravely disabled is unconstitutional. Standards for commitment to mental institutions are constitutional only if they require a finding of dangerousness to others or to self. *Kansas v. Crane*, 534 U.S. 407, 409, 122 S.Ct. 867, 869 (2002); *Foucha v.Louisiana*, 504 U.S. 71, 112 S.Ct. 1780 (1992); *Addington v. Texas*, 441 U.S. 418, 99 S.Ct. 1804, 60 L.Ed.2d 323 (1979); *Suzuki v. Alba*, 617 F.2d 173 (CA9 1980); *Doremus v. Farrell*, 407 F.Supp. 509, 514- 15 (D.Neb.1975). See also *O'Connor v. Donaldson*, 422 U.S. 563, 95 S.Ct. 2486, 45 L.Ed.2d 396 (1975); Colyar v. Third Judicial District, 469 F.Supp. 424 (D.Utah 1979)*Doe v. Gallinot*, 486 F. Supp. 983 (C.D. California 1979); and *Stamus v. Leonhardt*, 494 F. Supp. 439, 451 ((S.D. Iowa 1976), citing *Doremus v. Farrell*, 407 F.Supp. 509 (D. Neb. 1975).

[9] In spite of this manifest failure to comply with the law, the Superior Court, Judge Philip Volland, issued an *Ex Parte* Order granting temporary custody for emergency examination/treatment. Exhibit B.

transferred to API, Dr. Lee,[10] was "interviewed by a mental health professional at [API]" as required by AS 47.30.705(a).

Non-compliance with statutory directions is fatal. Statutes authorizing involuntary commitment to a mental hospital must be strictly interpreted. *Humphrey v. Cady*, 405 U.S. 504, 509, 92 S.Ct. 1048, 1052 (1972). See, e.g., *Covington v. Harris*, 419 F.2d 617, 623 (U.S.App.D.C. 1969) (statutes "sanctioning such a drastic curtailment of the rights of citizens must be narrowly, even grudgingly, construed in order to avoid deprivations of liberty without due process of law."); *In re Elkow*, 521 N.E.2d 290 (Ill.App. 1988) (any noncompliance with a statutory procedure for involuntary admission renders the judgment in the case erroneous and of no effect."); *In re Wahlquist*, 585 P.2d 437, 439 (Utah 1978) ("However well intended, the confinement of a person in an institution for mental health treatment is just as effective a restraint on personal liberty as confinement in a prison and may, in some instances, be even more trying or burdensome. It is therefore essential that the rights of one so confined be treated with the same degree of respect as are the rights of persons deprived of their liberty upon accusation or conviction of criminal conduct. Consistent with that principle, it is important that there be full compliance with statutes setting forth the procedures for commencing and continuing such involuntary hospitalization."); *In re Morlock*, 862 P.2d 415 (Mont. 1993) (civil commitment laws are to be strictly followed so state's failure to comply with statutory time requirements for filing recommitment petition deprived trial court of authority to

[10] *See*, Exhibit C.

recommit.); *In re Cross*, 662 P.2d 828 (Wash. 1983) (involuntary commitment statutes allow for deprivation of liberty interest so must be strictly construed.); *People in Interest of Dveirin*, 755 P.2d 1207, 1209 (Colo. 1988) ("because of the curtailment of personal liberty which results from certification of mental illness, strict adherence to the procedural requirements of the civil commitment statutes is required.").

(2) The 30-Day Commitment Petition Does Not Comply With the Law.

The Petition for 30-Day Commitment (30-Day Commitment Petition)[11] also fails to comply with AS 47.30.730. For purposes here, AS 47.30.730 provides:

> (a) The petition must
>
> (1) allege that the respondent is mentally ill and as a result is likely to cause harm to self or others or is gravely disabled;
>
> * * *
>
> (6) list the prospective witnesses who will testify in support of commitment or involuntary treatment; and
>
> (7) list the facts and specific behavior of the respondent supporting the allegation in (1) of this subsection.

(emphasis added).

The 30 Day Commitment Petition fails to list any witnesses as required in AS 47.30.730, which in itself, makes it fatally defective. With respect to the facts and specific behavior of the respondent supporting the allegation that Ms. Wetherhorn is

[11] Exhibit D.

mentally ill and as a result is likely to cause harm to herself or others and gravely disabled,[12] the 30-Day Commitment Petition states:

"Manic state homeless and no insight and non med compliant [?] 3 months"

Being manic, homeless, lacking insight, and non medication compliant are totally insufficient grounds under AS 47.30.730 to justify commitment.[13] Thus, as the Initiation Petition, the 30-Day Commitment Petition manifestly fails to comply with the statutory requirements.

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[12] The failure to list witnesses and the specific facts and circumstances are due process violations as well as violations of the statute because in light of the short time frames involved in these proceedings, it is the only way to have have meaningful notice and a meaningful opportunity to be heard, which are the hallmarks of due process.

> "For more than a century the central meaning of procedural due process has been clear: 'Parties whose rights are to be affected are entitled to be heard; and in order that they may enjoy that right they must first be notified.' It is equally fundamental that the right to notice and an opportunity to be heard 'must be granted at a meaningful time and in a meaningful manner.' " *Fuentes v. Shevin*, 407 U.S. 67, 80, 92 S.Ct. 1983, 32 L.Ed.2d 556 (1972) (quoting *Baldwin v. Hale*, 1 Wall. 223, 233, 17 L.Ed. 531 (1864); *Armstrong v. Manzo*, 380 U.S. 545, 552, 85 S.Ct. 1187, 14 L.Ed.2d 62 (1965)

Hamdi v. Rumsfeld, 542 U.S. 507, 124 S.Ct. 2633, 2648-9 (2004) ("a citizen-detainee . . . must receive notice of the factual basis . . . and a fair opportunity to rebut the Government's factual assertions before a neutral decisionmaker.")

[13] As set forth above, they are also constitutionally insufficient.

(3) The 30-Day Forced Drugging Petition Does Not Comply with the Law.

A Petition for Court Approval of Administration of Psychotropic Medication (30 Day Forced Drugging Petition) was filed April 15, 2005, 10 days after the 30-Day Commitment Petition was filed.[14] Under AS 47.30.839(e):

> (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.

As relevant here, AS 47.30.837(c) provides:

> (c) If an evaluation facility or designated treatment facility has provided to the patient the information necessary for the patient's consent to be informed and the patient voluntarily consents, the facility may administer psychotropic medication to the patient unless the facility has reason to believe that the patient is not competent to make medical or mental health treatment decisions. 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 the procedures of AS 47.30.839.

Thus, the State has to seek a court order to administer psychotropic drugs to someone that is incompetent to provide informed consent <u>whether or not the person agrees to take the medication</u>.

The 30-Day Forced Drugging Petition, however, does not check either box as to whether the patient has or has not refused the medication. This is fatally defective because it doesn't specify the grounds for seeking the court order. That the form is set up

[14] Exhibit E. The hearing on both the 30-Day Commitment Petition and 30-Day Forced Drugging Petition were held April 15, 2005, which was the same day the 30-Day Forced Drugging Petition was filed.

to indicate this makes clear it is a required element. The failure to specify whether Ms. Wetherhorn refused or did not refuse the medication does not appear to be an oversight because at the April 15, 2005, hearing, Dr. Kiele testified that sometimes Ms. Wetherhorn agreed to take the medication and sometimes she declined the medication. This presented a conundrum in filling out the form because if Ms. Wetherhorn was competent to give consent, she was competent to decline.[15] If Dr. Kiele had checked both boxes, it would have been obvious (a) that psychotropic medications were either being illegally administered because Ms. Wetherhorn lacked competence to give informed consent to accept the medications or (b) Ms. Wetherhorn was competent to decline the medication.[16] Leaving both boxes unchecked was far less likely to bring the illegal nature of what was going on to light. In any event, whatever the reason for failure to comply with the requirements of AS 47.30.839, the 30-Day Forced Drugging Petition is fatally defective in this regard.

[15] This is made clear in AS 47.30.839 (f), which 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."

[16] This illegal practice of deeming someone competent to accept the medications by virtue of agreeing to it and deeming someone incompetent to decline the medication by virtue of not agreeing to take it appears common at API. For example, in the *Myers* case discussed below, the treating psychiatrist admitted in his deposition that this was his practice. *See*, Exhibit U.-2., pages 48-55.

(4) The 90-Day Commitment Petition Does Not Comply With AS 47.30.740.

A Petition for 90-Day Commitment was filed April 27, 2005, pursuant to AS 47.30.740 (90-Day Commitment Petition).[17] As pertinent to the argument here, AS 47.30.740 provides:

> (a) At any time during the respondent's 30-day commitment, the professional person in charge, or that person's professional designee, may file with the court a petition for a 90-day commitment of that respondent. The petition must include all material required under AS 47.30.730(a) except that references to "30 days" shall be read as "90 days"; and
>
> (1) allege that the respondent has attempted to inflict or has inflicted serious bodily harm upon the respondent or another since the respondent's acceptance for evaluation, or that the respondent was committed initially as a result of conduct in which the respondent attempted or inflicted serious bodily harm upon the respondent or another, or that the respondent continues to be gravely disabled, or that the respondent demonstrates a current intent to carry out plans of serious harm to the respondent or another;

(emphasis added).

In the "facts and specific behavior" section of the 90-Day Commitment required of a legally sufficient petition, Dr. Kiele, testifies (*via* verification):

> Irritability, confusion, agitation, threatening demeanor, delusional thinking (believes she owns the hospital, that staff are racially discriminating against her, etc.). Poorly cooperative with any oral medications which has greatly complicated treatment and lengthened her hospital stay.

While more specific than both the Initiation Petition and the 30-Day Commitment Petition, this also utterly fails to satisfy the requirements of AS 47.30.740 (and AS

[17] Exhibit F.

47.30.730, incorporated therein) because it does not recite "specific facts and circumstances" supporting the likelihood of serious harm nor grave disability.

The foregoing demonstrates a cavalier disregard of Ms. Wetherhorn's legal rights, through utilization of the courts, whereby the full force of the State has been brought to bear against her, including being incarcerated[18] at API and forcibly injected with powerful mind-numbing, dangerous drugs of dubious, at best, efficacy.[19] For the reasons stated below, this justifies award of enhanced or full attorney's fees.

(B) The Rights of Ms. Wetherhorn Flouted by the State are Important Statutory and Constitutional Ones.

It is well settled that involuntary civil commitment is a massive curtailment of liberty requiring strict due process protections. *See,* e.g., *Vitek v. Jones*, 445 US 480, 491, 100 S.Ct. 1254, 1263 (1980)("commitment to a mental hospital produces 'a massive curtailment of liberty'"); *Humphrey v. Cady*, 405 U.S. 504, 509, 92 S.Ct. 1048, 1052, 31 L.Ed.2d 394 (1972); *Addington*, *supra*.; *O'Connor v. Donaldson*, 422 U.S. 563, 580, 95 S.Ct. 2486, 2496, 45 L.Ed.2d 396 (1975).

Similarly, with respect to forced drugging, in *Washington v. Harper*, 494 U.S. 210, 221, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990) the United States Supreme Court "recognized that an individual has a 'significant' constitutionally protected 'liberty

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[18] The American Heritage Dictionary, 4th Ed.'s definition of "incarcerate" includes " 2. To shut in; confine." Similarly, "inmate" (used below) is defined 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." (emphasis added)

[19] These attributes of the drugs are discussed below.

interest' in "avoiding the unwanted administration of antipsychotic drugs." *United States v. Sell*, 539 U.S. 166, 178, 123 S.Ct. 2174, 2183, 156 L.Ed.2d 197 (2003).

While there are no Alaska Supreme Court cases directly on point,[20] there seems little doubt the same is true under the Alaska Constitution. For example, the Alaska Supreme Court has held Alaska's constitutional right to privacy "clearly . . . shields the ingestion of food, beverages or other substances." *Gray v. State*, 525 P.2d 524, 528 (Alaska 1974)

In *Valley Hosp. Ass'n, Inc. v. Mat-Su Coalition for Choice*, 948 P.2d 963, 969 (Alaska,1997), the Alaska Supreme Court ruled:

> [W]e are of the view that reproductive rights are fundamental, and that they are encompassed within the right to privacy expressed in article I, section 22 of the Alaska Constitution. These rights may be legally constrained only when the constraints are justified by a compelling state interest, and no less restrictive means could advance that interest.

In *Breese v. Smith*, 501 P.2d 159 (Alaska 1972), the Alaska Supreme Court held the Alaska Constitution's right to privacy included a student's right to wear his hair the way he wanted to. In the instant case, Ms. Wetherhorn's interest in preventing the mental and bodily intrusion of unwanted psychotropic medication is a much more serious invasion of rights than the haircut preference ruled constitutionally protected by the Alaska Supreme

[20] One reason why there are no Alaska Supreme Court cases on point is because the Alaska Public Defender Agency, which is uniformly appointed to represent AS 47.30 psychiatric respondents, has never appealed any involuntary commitment or order authorizing forced drugging.

Court in *Breese* and, Ms. Wetherhorn suggests, at least equals the liberty interest in reproductive rights addressed in *Valley Hospital*.

Unfortunately, as set forth above and will be set forth below, these rights are uniformly ignored in the administration of AS 47.30.

(C) The Current Representation Regime is Broken.

(1) AS 47.30 Psychiatric Respondents Uniformly Receive Inadequate Assistance of Counsel.

"Noted scholar,"[21] Professor of Law, New York Law School, Michael L. Perlin, author of the five volume treatise, *Mental Health Disability Law*, 2nd Ed. (1998), Lexis Law Publishing, *The Hidden Prejudice: Mental Disability on Trial* (2000), and of over 150 scholarly articles on mental disability law,[22] states the obvious:

> Traditionally, lawyers assigned to represent state hospital patients have failed miserably in their mission.[23]

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

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[21] *See*, *Martin v. Taft*, 222 F.Supp.2d 940, 965 (S.D. Ohio 2002), where the court referred to Prof. Perlin as such.

[22] New York Law School's web page on Prof. Perlin, http://www.nyls.edu/pages/389.asp, accessed July 28, 2005.

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

> dangerousness of a mentally ill person's behavior to obtain a judicial order for commitment.[24]

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."

The consequence of this meretricious testimony, enabled by the wholesale failure of lawyers assigned to represent psychiatric respondents to do so adequately has been described by Professor Perlin as follows:

> [C]ourts accept . . . testimonial dishonesty, . . . specifically where witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends." . . .
>
> Experts frequently . . . and openly subvert statutory and case law criteria that impose rigorous behavioral standards as predicates for commitment . . .
>
> This combination . . . helps define a system in which (1) dishonest testimony is often regularly (and unthinkingly) accepted; (2) statutory and case law standards are frequently subverted; and (3) insurmountable barriers are raised to insure that the allegedly "therapeutically correct" social end is met . . .. In short, the mental disability law system often deprives individuals of liberty disingenuously and upon bases that have no relationship to case law or to statutes.[25]

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

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

That this holds true in Alaska is starkly proven above where it is clear manifestly insufficient pleadings are not challenged by counsel, nor critically reviewed by the court. It is only by there being a consistent practice of the Public Defender Agency allowing its clients to be subjected to the "massive curtailment of liberty" that is civil commitment and the deprivation of the "significant constitutionally protected liberty interest in avoiding the unwanted administration of antipsychotic drugs" with barely a *pro forma* defense that such a series of manifestly defective pleadings would have been filed.

(2) Ms. Wetherhorn Received Inadequate Assistance of Counsel in the 30-Day Proceedings.

That legally insufficient petitions went unchallenged by the Public Defender Agency resulting in Ms. Wetherhorn's incarceration and forced drugging, alone demonstrates inadequate assistance of counsel in this case. In addition to the failure to challenge the fatal defects in the petitions, there were many other deficiencies in representation. The Public Defender Agency should have challenged the constitutionality of committing someone as gravely disabled under the AS 47.30.915(7)(B) definition. The Public Defender Agency should have challenged the basis of Dr. Kiele's expert opinion testimony.[26] In Ms. Wetherhorn's view, at a minimum, Dr. Kiele's deposition

[26] It was totally improper for Dr. Kiele's qualification as an expert witness to have been carried over from another case. In addition, Dr. Kiele's opinion testimony should have been challenged under *State v. Coon*, 974 P.2d 386 (Alaska 1999). There was absolutely no foundation laid, nor a sufficient basis presented for his opinions, yet no objection was interposed.

should have been taken.[27] The Public Defender Agency should have objected to the Master's recommendations under Probate Rule 2(f).[28]

It should go without saying that Psychiatric Respondents' rights ought to be protected regardless of the perceived benefit of the unwanted interventions (*i.e.*, incarceration and forced drugging).[29] However, as will be shown next, the fact is these court authorized invasions of fundamental rights are causing great harm.

(D) The Failure of the Current Representation Regime is Resulting In Great Harm to AS 47.30 Psychiatric Respondents.

The issue of the harmfulness of the current forced drugging regime was directly litigated by PsychRights in the Alaska Superior Court, Third Judicial District at

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[27] In addition, potentially other staff members, Dr. Lee and other possible witnesses should have had their depositions taken.

[28] Attached as Exhibit G are notes that were handed out and discussed at a June 10, 2004, meeting between counsel here, the Public Defender and the Assistant Public Defenders who typically handled AS 47.30 involuntary proceedings at that time (the names of two inmates at API have been redacted to just reveal initials). As is apparent, the Public Defender Agency was made aware that all of these steps (and more) to adequately represent their clients should be taken. Thus, the failure of the Public Defender Agency to present any defense (in this case or any other case), let alone an adequate one, is in the face of being informed its performance was viewed as inadequate.

[29] The failure of the attorneys at the Public Defender Agency handling these cases to

(1) "zealously represent" their clients, as required in the Preamble, and

(2) "to use legal procedure for the fullest benefit of their clients' cause," as required by the Comment to Rule 3.1,

of the Alaska Rules of Professional Conduct are clearly violating their professional ethical obligations.

Anchorage in 2003 in *In re: Myers*, 3AN 03-277 P/R.[30] There, after expert opinion testimony from both sides, the Superior Court found:

> [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.[31]

The evidence upon which this factual finding was based included the following.[32]

- "An Approach to the Effect of Ataraxic Drugs on Hospital Release Rates,"

  American Journal of Psychiatry, 119 (1962), 36-47 (Release Rates Study)

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[30] In addition to the harmfulness of the drugs being forcibly administered, the use of force itself, including incarceration at API is harmful. Loren R. Mosher, M.D., the former Chief of Schizophrenia Studies at the National Institute of Mental Health testified in an affidavit that "Involuntary treatment should be difficult to implement and used only in the direst of circumstances." (Exhibit H, emphasis in original). This was followed up in his testimony where he explained establishing a "therapeutic relationship" in which the patient trusts the therapist is the most important thing and that forcing a patient prevents the establishment of such a relationship ("it is the therapeutic relationship which is the single most important thing.") Exhibit I, page 5. Dr. Mosher further testified that while he could envision circumstances where it might be indicated, he had never found it necessary to commit anyone during his (40 year) career. Exhibit I, page 4.

[31] Exhibit W, pages 8, 13. The *Myers* case is currently before the Alaska Supreme Court under Case No. S-11021.

[32] Many of these studies were of people diagnosed with and given drugs for schizophrenia, but they are essentially the same drugs the State sought to subject Ms. Wetherhorn to in this case and the studies are thus applicable to her situation.

which found that "drug treated patients tend to have longer periods of hospitalization."[33]

- "Relapse in Chronic Schizophrenics Following Abrupt Withdrawal of Tranquillizing Medication," *British Journal of Psychiatry*, 115 (1968), 679-86 (Relapse Study) by the National Institute of Mental Health, which found relapse rates rose in direct relation to neuroleptic dosage -- the higher the dosage patients were on before the drugs were withdrawn, the greater the relapse rates.[34]
- "Comparison of Two Five-Year Follow-Up Studies: 1947 to 1952 and 1967 to 1972," *American Journal of Psychiatry*, 132 (1975), 796-801 (Comparison Study), which "unexpectedly" found psychotropic drugs did not appear indispensable and the data suggests neuroleptics prolong social dependency."[35]
- "Dopaminergic Supersensitivity after Neuroleptics: Time-Course and Specificity, *Psychopharmacology* 60 (1978), 1-11 (Supersensitivity I) which reported prolonged use of all of the neuroleptics studied, except clozapine, cause an increase in dopamine receptors in the brain which results in a supersensitivity.[36]

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[33] Exhibit J.
[34] Exhibit K.
[35] Exhibit L.
[36] Exhibit M.

- "Neuroleptic-induced Supersensitivity Psychosis," *American Journal of Psychiatry*, 135 (1978), 1409-1410 (Supersensitivity II), which found that the "tendency toward psychotic relapse" is caused by the medication itself and that this and other deleterious effects could be permanent.[37]
- "Neuroleptic-induced Supersensitivity Psychosis: Clinical and Pharmacologic Characteristics," *American Journal of Psychiatry*, 137 (1980), 16-20 (Supersensitivity III) confirmed that neuroleptic use leads to psychotic relapse when it is discontinued.[38]
- "The International Pilot Study of Schizophrenia: Five-Year Follow-up Findings," *Psychological Medicine*, 22 (1992), 131-145, conducted by the World Health Organization (WHO I), compared outcomes between patients with schizophrenia in developed and poor countries and found that that patients in the poor countries (where neuroleptic use was uncommon) "had a considerably better course and outcome than [patients] in . . . developed countries and this remained true whether clinical outcomes, social outcomes, or a combination of the two was considered." [39]
- "Schizophrenia: Manifestations, Incidence and Course in Different Cultures, A World Health Organization Ten-Country Study," *Psychological Medicine*, suppl. 20 (1992), 1-95 (WHO II) confirmed WHO I's finding and concluded

[37] Exhibit N.
[38] Exhibit O.
[39] Exhibit P.

"being in a developed country was a strong predictor of not attaining a complete remission."[40]

- "Empirical Correction of Seven Myths About Schizophrenia with Implications for Treatment," *ACTA Psyciatrica Scandinava*, 1994: 90 (suppl 384): 140-146 (Schizophrenia Myths)[41] reviewed the evidence and concluded in its abstract:

> This paper presents empirical evidence accumulated across the last two decades to challenge seven long-held myths in psychiatry about schizophrenia which impinge upon the perception and thus the treatment of patients. Such myths have been perpetuated across generations of trainees in each of the mental health disciplines. These myths limit the scope and effectiveness of treatment offered. These myths maintain the pessimism about outcome for these patients thus significantly reducing their opportunities for improvement and/or recovery. Counter evidence is provided with implications for new treatment strategies.

Myth Number One in Schizophrenia Myths is "Once a schizophrenic always a schizophrenic:"

> *Evidence*: Recent worldwide studies have . . . consistently found that half to two thirds of patients significantly improved or recovered, including some cohorts of very chronic cases. The universal criteria for recovery have been defined as no current signs and symptoms of any mental illness, no current medications, working, relating well to family and friends, integrated into the community, and behaving in such a way as to not being able to detect having ever been hospitalized for any kind of psychiatric problems.

[40] Exhibit Q.
[41] Exhibit R.

Myth Number 5 in Schizophrenia Myths is "Patients must be on medication all their lives. Reality: It may be a small percentage who need medication indefinitely . . . Evidence: There are no data existing which support this myth."

- "A Critique of the Use of Neuroleptic Drugs" by David Cohen, Ph.D., in *From Placebo to Panacea, Putting Psychiatric Drugs to the Test*, edited by Seymour Fisher and Roger Greenburg, John Wiley and Sons, 1997, a comprehensive review of the scientific evidence regarding the safety and efficacy of neuroleptics (Cohen Critique).[42] The Cohen Critique's summary of the scientific efficacy evidence included:

  > *The ability of neuroleptics (NLPs)*[43] *to reduce "relapse" in schizophrenia affects only one in three medicated patients.*
  >
  > *The overall usefulness of NLPs in the treatment of schizophrenia is far from established.*

  The Cohen Critique also discusses an analysis of 1,300 published studies which found neuroleptics were no more effective than sedatives.[44] The side effects of these drugs are also addressed:

  > *[T]he negative parts [the side effects] are perceived as quite often worse than the illness itself. . . . even the most deluded person is often extraordinarily articulate and lucid on the subject of their*

[42] Exhibit S.
[43] This class of drugs is commonly known by a number of names, including "neuroleptics" and "anti-psychotics."
[44] Exhibit S, Page 22.

> *medication. . . . their senses are numbed, their willpower drained and their lives meaningless.*[45]

Concluding, Dr. Cohen states:

> Forty-five years of NLP use and evaluation have not produced a treatment scene suggesting the steady march of scientific or clinical progress. . . . Unquestionably, NLPs frequently exert a tranquillizing and subduing action on persons episodically manifesting agitated, aggressive, or disturbed behavior. This unique capacity to swiftly dampen patients' emotional reactivity should once and for all be recognized to account for NLPs' impact on acute psychosis. Yet only a modestly critical look at the evidence on short-term response to NLPs will suggest that this often does not produce an abatement of psychosis. And in the long-run, this outstanding NLP effect probably does little to help people diagnosed with schizophrenia remain stable enough to be rated as "improved" -- whereas it is amply sufficient to produce disabling toxicity.
>
> A probable response to this line of argument is that despite the obvious drawbacks, NLPs remain the most effective of all available alternatives in preventing relapse in schizophrenia. However, existing data on the effectiveness of psychotherapy or intensive interpersonal treatment in structured residential settings contradicts this. Systematic disregard for patients' own accounts of the benefits and disadvantages of NLP treatment also denigrates much scientific justification for continued drug-treatment, given patients' near-unanimous dislike for NLPs. Finally, when social and interpersonal functioning are included as important outcome variables, the limitations of NLPs become even more evident . . .
>
> The positive consensus about NLPs cannot resist a critical, scientific appraisal.[46]

Loren R. Mosher, M.D., the former Chief of Schizophrenia Studies at the National Institute of Mental Health, after being qualified as an expert on psychiatry,[47] testified on

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[45] Exhibit S, p.23.
[46] Exhibit S, pages 33-35. [Exc. 205-7].
[47] Exhibit I, Page 4.

cross-examination by the State, when challenged that his views about the use of psychotropic drugs were contrary to the current standard of care, that his opinion was based on the evidence:

> Q Dr. Mosher, is it not your understanding that the use of anti-psychotic medications is the standard of care for treatment of psychosis in the United States, presently?
>
> A Yes, that's true.
>
> * * *
>
> Q Would you say that your viewpoint presented today falls within the minority of the psychiatric community?
>
> A Yes, but I would just like to say that my viewpoint is supported by research evidence. And so, that being the case, it's a matter of who judges the evidence as being stronger, or whatever. So, I'm not speaking just opinion, I'm speaking from a body of evidence.[48]

As indicated above, based on this and other evidence presented in the *Myers* case, the Superior Court found there was a viable debate over whether the drugs the State wanted to force Ms. Myers to take should be the standard of care[49] and whether they would ultimately help or hurt her.[50]

Since then, additional studies and articles have confirmed this. Perhaps the most alarming is "Prospective analysis of premature mortality in schizophrenia in relation to

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[48] Exhibit I, Page 6. Dr. Mosher also testified he is "probably . . . the person on the planet who has seen more acutely psychotic people off of medication, without any medications, than anyone else on the face of the planet today." Exhibit I, Page 5. Dr. Mosher passed away in July of 2004, to the great sorrow of thousands of victims of psychiatry around the world to whom he was a true hero.

[49] Of course, just because some intervention might be the "standard of care" does not allow a doctor to force it on a patient.

[50] Exhibit W, pages 8 and 13.

health service engagement: a 7.5-year study within an epidemiologically complete, homogeneous population in rural Ireland," *Psychiatry Research*, 117 (2003) 127–135, which 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."[51] In other words, rather than the newer drugs being safer than the older ones, they doubled the already elevated death rate of people subjected to psychiatric "treatment."[52]

(E) The Civil Rule 82 Enhanced Fee Criteria Support Award of Enhanced or Full Attorney's Fees.

In her Memorandum, Ms. Wetherhorn specified that it was appropriate to award full attorney's fees under Civil Rule 82(b)(3) (E), (G),(H) or (K), or any combination thereof.[53] These provisions state:

> (3) The court may vary an attorney's fee award calculated under subparagraph (b)(1) or (2) of this rule if, upon consideration of the factors listed below, the court determines a variation is warranted: . . .
>
> (E) the attorneys' efforts to minimize fees; . . .
> (G) vexatious or bad faith conduct;
> (H) the relationship between the amount of work performed and the significance of the matters at stake;

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[51] Exhibit T.
[52] In light of the evidence presented here (and in the *Myers* case) that psychiatry's interventions inhibit and often prevent people from recovering from a diagnosis of serious mental illness and their extreme harm, including causing death, "treatment" is put in quotes.
[53] Footnote 5 to the Memorandum.

(I) the extent to which a given fee award may be so onerous to the non-prevailing party that it would deter similarly situated litigants from the voluntary use of the courts; . . . and

(K) other equitable factors deemed relevant.

If the court varies an award, the court shall explain the reasons for the variation.

(1) Attorney's Efforts to Minimize Fees

With respect to Civil Rule 82(b)(3)(E), the attorneys' efforts to minimize fees, there is no legitimate question but that the 90-day petitions were abandoned due to PsychRights entry into the case, including the demand for jury trial. API had experienced what it was like to prosecute petitions for commitment and forced drugging against a vigorous defense in the *Myers* case and decided two things: first, it wasn't worth it,[54] and second, that Ms. Wetherhorn didn't meet commitment criteria, which would be revealed if a real challenge was made. The dismissal[55] was therefore achieved with a minimum of fees.

(2) Vexatious or Bad Faith Conduct

With respect to Civil Rule 82(b)(3)(G), vexatious or bad faith conduct, the above recitation of the cavalier disregard of Ms. Wetherhorn's rights through gross violations of the explicit statutory requirements of AS 47.30 described above establish vexatious and

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[54] For example, attached hereto as Exhibit U are copies of some of the legal pleadings filed by PsychRights in the *Myers* case.

[55] At page 2 of its Opposition, the State erroneously recites this matter was dismissed without prejudice. After contested a straight dismissal without prejudice, it was dismissed "without prejudice against a new petition pursuant to AS 47.30.730," which is essentially the same thing as being dismissed with prejudice because any new petition would have to start all over from the beginning based on subsequent events.

bad faith conduct amply justifying a full award of the modest fees in the amount of $2,623.50.

(3) Relationship Between Work Performed and Interests at Stake

With respect to Civil Rule 82(b)(3)(H), the relationship between the amount of work performed and the significance of the matters at stake, as set forth above, the stakes for Ms. Wetherhorn were nothing less than the most important fundamental constitutional rights to be free of confinement and the forcible administration of unwanted, mind-altering and harmful drugs. To have achieved this for $2,623.50 is a bargain.

(4) Extent to Which Fee Would Deter Use of the Courts

With respect to Civil Rule 82(b)(3)(I), the extent to which a given fee award may be so onerous to the non-prevailing party that it would deter similarly situated litigants from the voluntary use of the courts, normally the court would view deterring voluntary use of the courts as a negative. However, the rule doesn't say that and here it is suggested the State should be deterred from its voluntary use of the court because it has proven to be abusive. In other words, because of the complete abdication by the Public Defender Agency from any real defense of these cases, it has been so easy for the State to file and obtain unwarranted involuntary commitment and forced drugging orders that it is doing so without legal justification and to the great detriment of people it is purporting to help. Awarding enhanced or full fees here can serve to discourage the State from filing petitions that are not warranted by the law and facts.

(5) Other Factors

With respect to Civil Rule 82(b)(3)(K), other equitable factors deemed relevant, even if awarding enhanced or full fees to discourage the State from its pervasive practice of filing for unwarranted involuntary commitment and forced drugging petitions does not qualify under Civil Rule 82(b)(3)(I), it certainly qualifies under this subsection. Moreover, if the State has the obligation to provide representation to indigent AS 47.30 psychiatric respondents, which it does, it has the obligation to provide adequate representation. The current regime is clearly illegal in this regard and thus some other mechanism must be pursued. Awarding full fees can encourage other attorneys to take on these cases.

III. Conclusion

Even though the Memorandum included a request for enhanced or full attorney's fees ("the court may take into account [the Civil Rule 82 enhancement factors] and award more than 20%"), the precise basis for such an award has primarily been fleshed out in this Reply. Therefore, Ms. Wetherhorn will not object to the State filing a response to

this reply. Whether or not the State files such a response, for the foregoing reasons, this court should award enhanced or full attorney's fees in Ms. Wetherhorn's favor.[56]

DATED: August 1, 2005.

Law Project for Psychiatric Rights, Inc.

By: _____
James B. Gottstein,
ABA # 7811100

[56] Footnote 5 in the Memorandum mentions §2, Ch. 86 SLA 2003, which was codified at AS 09.60.010(b)-(e). It is unclear to what extent this legislation might have impacted the arguments made here, but since it is obviously invalid for failure to garner the two-thirds vote required under Art. 4, § 15 of the Alaska Constitution, which the State did not dispute, it is unnecessary to address this question. *See*, Exhibit V.

EXHIBITS TO
REPLY Re: MOTION FOR ATTORNEY'S FEES

A. Petition for Initiation of Involuntary Commitment (Initiation Petition).
B. *Ex Parte* Order (Temporary Custody For Emergency Examination/Treatment)(*Ex Parte* Order).
C. Peace Officer/Mental Health Professional Application for Examination. (POA).
D. Petition for 30-Day Commitment (30-Day Commitment Petition).
E. Petition for Court Approval of Administration of Psychotropic Medication [AS 47.30.839] (30-Day Forced Drugging Petition).
F. Petition for 90-Day Commitment (90 Day Commitment Petition.
G. Notes for June 10, 2004 Meeting with Public Defender Agency.
H. Affidavit of Loren R. Mosher, M.D.
I. Pages from March 5, 2003, transcript of trial in *In re: Myers*, 3AN 05 277 PR.
J. "An Approach to the Effect of Ataraxic Drugs on Hospital Release Rates," American Journal of Psychiatry, 119 (1962), 36-47 (Release Rates Study).
K. "Relapse in Chronic Schizophrenics Following Abrupt Withdrawal of Tranquillizing Medication," *British Journal of Psychiatry*, 115 (1968), 679-86 (Relapse Study).
L. "Comparison of Two Five-Year Follow-Up Studies: 1947 to 1952 and 1967 to 1972," *American Journal of Psychiatry*, 132 (1975), 796-801 (Comparison Study)
M. "Dopaminergic Supersensitivity after Neuroleptics: Time-Course and Specificity," *Psychopharmacology* 60 (1978), 1-11 (Supersensitivity I)
N. "Neuroleptic-Induced Supersensitivity Psychosis," *American Journal of Psychiatry*, 135 (1978), 1409-1410 (Supersensitivity II)
O. "Neuroleptic-Induced Supersensitivity Psychosis: Clinical and Pharmacologic Characteristics," *American Journal of Psychiatry*, 137 (1980), 16-20 (Supersensitivity III) confirmed that neuroleptic use leads to psychotic relapse when it is discontinued.
P. "The International Pilot Study of Schizophrenia: Five-Year Follow-up Findings," *Psychological Medicine*, 22 (1992), 131-145, conducted by the World Health Organization (WHO I).
Q. "Schizophrenia: Manifestations, Incidence and Course in Different Cultures, A World Health Organization Ten-Country Study," *Psychological Medicine*, suppl. 20 (1992), 1-95 (WHO II).
R. "Empirical Correction of Seven Myths About Schizophrenia with Implications for Treatment," *ACTA Psyciatrica Scandinava*, 1994: 90 (suppl 384): 140-146 (Schizophrenia Myths).

S. "A Critique of the Use of Neuroleptic Drugs," David Cohen, Ph.D., in *From Placebo to Panacea, Putting Psychiatric Drugs to the Test*, edited by Seymour Fisher and Roger Greenburg, John Wiley and Sons, 1997 (Cohen Critique).

T. "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.

U. Various Pleadings from *In re: Myers*, 3AN 05 277 PR:
    1. Memorandum In Support Of Motion To Dismiss And Pre-Hearing Brief.
    2. Memorandum in Support of Motion in Limine to Exclude Psychiatric Testimony.
    3. Memorandum In Support Of Motion To Dismiss Re: Time.
    4. Motion And Supporting Memorandum To Dismiss Based On The Inadequacy Of The Commitment Petition.
    5. Motion And Supporting Memorandum For Appointment Of An Independent Medical Exam.
    6. Opposition To Second Amended 90-Day Commitment Petition. And Reply To Opposition To Motions To Dismiss Re: Time And Inadequacy Of The Petition.
    7. Pre-Trial Motions and Brief.

V. Journal Text for HB145 in the 23rd Legislature.

W. Order in *In re: Myers.*