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

BRIEF OF APPELLANT

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Filed in the Supreme Court of
the State of Alaska, this _____
day of _____, 2003

Marilyn May, Clerk

By: _____
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CONSTITUTIONAL PROVISIONS

Constitutional Provisions, Statutes and Court Rules Principally Relied Upon

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

AK CONST. ART. 1, § 1

Section 1 Inherent Rights.

This constitution is dedicated to the principles that all persons have a natural right to life, liberty, the pursuit of happiness, and the enjoyment of the rewards of their own industry; that all persons are equal and entitled to equal rights, opportunities, and protection under the law; and that all persons have corresponding obligations to the people and to the State.

AK CONST. ART. 1, § 7

Section 7 Due Process.

No person shall be deprived of life, liberty, or property, without due process of law. The right of all persons to fair and just treatment in the course of legislative and executive investigations shall not be **INFRINGED.**

AK CONST. ART. 1, § 22

Section 22 Right of Privacy.

The right of the people to privacy is recognized and shall not be infringed. The legislature shall implement this section.

AS 47.30.837

Sec. 47.30.837 Informed consent.

(a) A patient has the capacity to give informed consent for purposes of AS 47.30.836 if the patient is competent to make mental health or medical treatment decisions and the consent is voluntary and informed.

(b) When seeking a patient's informed consent under this section, the evaluation facility or designated treatment facility shall give the patient information that is necessary for informed consent in a manner that ensures maximum possible comprehension by the patient.

(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.

(d) In this section,

(1) "competent" means that the patient

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

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

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

(D) is able to articulate reasonable objections to using the offered medication;

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

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

(B) information about the proposed medication, its purpose, the method of its administration, the recommended ranges of dosages,

possible side effects and benefits, ways to treat side effects, and risks of other conditions, such as tardive dyskinesia;

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

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

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

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

(3) "voluntary" means having genuine freedom of choice; a choice may be encouraged and remain voluntary, but consent obtained by using force, threats, or direct or indirect coercion is not voluntary.

AS 47.30.838

Sec. 47.30.838 Psychotropic medication in emergencies.

(a) Except as provided in (c) and (d) of this section, an evaluation facility or designated treatment facility may administer psychotropic medication to a patient without the patient's informed consent, regardless of whether the patient is capable of giving informed consent, only if

(1) there is a crisis situation, or an impending crisis situation, that requires immediate use of the medication to preserve the life of, or prevent significant physical harm to, the patient or another person, as determined by a licensed physician or a registered nurse; the behavior or condition of the patient giving rise to a crisis under this paragraph and the staff's response to the behavior or condition must be documented in the patient's medical record; the documentation must include an explanation of alternative responses to the crisis that were considered or attempted by the staff and why those responses were not sufficient; and

(2) the medication is ordered by a licensed physician; the order

(A) may be written or oral and may be received by telephone, facsimile machine, or in person;

(B) may include an initial dosage and may authorize additional, as needed, doses; if additional, as needed, doses are authorized, the order must specify the medication, the quantity of each authorized dose, the method of administering the medication, the maximum frequency of administration, the specific conditions under which the medication may be given, and the maximum amount of medication that may be administered to the patient in a 24-hour period;

(C) is valid for only 24 hours and may be renewed by a physician for a total of 72 hours, including the initial 24 hours, only after a personal assessment of the patient's status and a determination that there is still a crisis situation as described in (1) of this subsection; upon renewal of an order under this subparagraph, the facts supporting the renewal shall be written into the patient's medical record.

(b) When a patient is no longer in the crisis situation that lead to the use of psychotropic medication without consent under (a) of this section, an appropriate health care professional shall discuss the crisis with the patient, including precursors to the crisis, in order to increase the patient's and the professional's understanding of the episode and to discuss prevention of future crises. The professional shall seek and consider the patient's recommendations for managing potential future crises.

(c) If crisis situations as described in (a)(1) of this section occur repeatedly, or if it appears that they may occur repeatedly, the evaluation facility or designated treatment facility may administer psychotropic medication during no more than three crisis periods without the patient's informed consent only with court approval under AS 47.30.839.

(d) An evaluation facility or designated treatment facility may administer psychotropic medication to a patient without the patient's informed consent if the patient is unable to give informed consent but has authorized the use of psychotropic medication in a declaration properly executed under AS 47.30.950 -- 47.30.980 or has authorized an attorney-in-fact to consent to this form of treatment for the patient and the attorney-in-fact does consent.

Sec. 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.

Jurisdictional Statement

This appeal is brought by Faith J. Myers, Respondent below in a court ordered medication proceeding under AS 47.30.839. Ms. Myers appeals to the Alaska Supreme Court from the final judgment issued through two orders, one dated March 14, 2003, and the other March 21, 2003, by Judge Morgan Christen, sitting in the Superior Court in Anchorage. [Exc. 292-305 and 306-313]. Notice of Appeal was timely filed on March 21, 2003. This court has jurisdiction over this appeal pursuant to AS 22.05.010(a).

Parties

All of the parties are listed in the caption, to wit: the Appellant is Faith J. Myers (Ms. Myers) and the Appellee is the State of Alaska's Alaska Psychiatric Institute (State).

Statement of Issues Presented

1. May the state of Alaska, relying on AS 47.30.839(g), constitutionally force a patient to take psychotropic medications against her will solely on a finding of incompetence to refuse the medication?

2. When seeking to obtain a court order to force a patient to take psychotropic medications against her will, is the state of Alaska exempt from the reliability standards for expert opinion testimony under *State v. Coon*, 974 P.2d 386 (Alaska 1999)?

Statement of the Case

I. Facts

February 25, 2003: Petition Filed, First Hearing

On February 25, 2003, Dr. Robert Hanowell, a staff psychiatrist for Appellee, the state of Alaska's Alaska Psychiatric Institute (State), filed a Petition for Court Approval of Administration of Psychotropic Medication (Forced Medication Petition) against Appellant, Faith J. Myers (Ms. Myers).[1] [Exc. 1]. The grounds for seeking the forced medication order under AS 47.30.839 was:

> Petitioner has reason to believe the patient is incapable of giving or withholding informed consent. The facility wishes to use psychotropic medication in a noncrisis situation.

[Exc. 1].

The Public Defender Agency was appointed to represent Ms. Myers and a hearing to approve the forced medication was set for 1:30, p.m., February 25, 2003, the same day the Forced Medication Petition was filed. [Exc. 2] Instead, Ms. Myers obtained private *pro bono* counsel and the hearing was postponed for three days over the State's objection in order to allow counsel to prepare.[2] [Tr. 1 (February 28, 2003)]

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[1] A contemporaneous petition for involuntary commitment was also filed, but is not the subject of this or any other appeal or appellate proceeding.

[2] The court system was not able to produce a tape recording of this hearing so there is no transcript of it. This reference is to the transcript of the hearing on February 28, 2003, where the Probate Master recites the reasons for the postponement on February 25th. The transcript of the February 28, 2003 hearing was prepared and numbered separately and the few references to this transcript herein note the February 28th date. All other references to the Transcript will use the standard "TR __" form and are to the March 5 and 10, 2003 hearings.

February 27, 2003; Hanowell Deposition

Dr. Hanowell's deposition was taken February 27, 2003. Dr. Hanowell testified he was unaware of studies indicating very few patients should be maintained on medications for the rest of their lives. [Exc. 143]. Dr. Hanowell further testified at his deposition that even though he had recently heard a presentation on this and related topics, it had not caused him to review any such research. [Exc. 142].

February 28, 2003; Pre-Trial Motions, Second Hearing.

In the morning of February 28, 2003, Ms. Myers filed two motions: (i) Motion to Dismiss (Exc. 3] and (ii) Motion *in Limine* to Exclude Psychiatric Testimony. [Exc. 103]. The memoranda in both of these motions argued the State's proffered expert testimony did not satisfy the reliability standards contained in *State v. Coon*, 974 P.2d 386 (Alaska 1999) and disputed the safety and efficacy of the proposed drug treatment as contradicted by the scientific evidence. [Exc. 4-19, 104-112] The Probate Master, John Duggan, after noting the "extensive motions with lots of attachments," continued the hearing set for that afternoon and recommended the Superior Court hear the case directly. [Tr. 5-6 (February 28, 2003)].

Relevant Studies Presented in Support of Motion to Dismiss.

The Memorandum in Support of Motion to Dismiss[3] included as attachments a number of relevant scientific studies: [Exc. 19A-102]

[3] This was also denominated a "pre-trial brief." [Exc. 4].

(A) "An Approach to the Effect of Ataraxic Drugs on Hospital Release Rates," *American Journal of Psychiatry*, 119 (1962), 36-47 (Release Rates Study) was attached as Exhibit A to the Motion to Dismiss. [Exc. 19A-L] The Release Rates Study found that "drug treated patients tend to have longer periods of hospitalization." [Exc.19G]

(B) "Relapse in Chronic Schizophrenics Following Abrupt Withdrawal of Tranquillizing Medication," *British Journal of Psychiatry*, 115 (1968), 679-86 (Relapse Study) was attached as Exhibit C to the Motion to Dismiss. [Exc. 20-6] This National Institute of Mental Health study 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. [Exc. 25].

(C) "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), was attached as Exhibit E to the Motion to Dismiss. [Exc. 27-32]. The Comparison Study "unexpectedly" found that psychotropic drugs did not appear indispensable and the data suggests neuroleptics prolong social dependency." [Exc. 32].

(D) "Dopaminergic Supersensitivity after Neuroleptics: Time-Course and Specificity, *Psychopharmacology* 60 (1978), 1-11 (Supersensitivity I) was attached as Exhibit G to the Motion to Dismiss. [Exc. 33-40]. Supersensitivity I reports that prolonged use all of the neuroleptics studied, except clozapine, cause an increase in dopamine receptors in the brain) which results in a supersensitivity. [Exc. 36].

(E) "Neuroleptic-induced supersensitivity psychosis," *American Journal of Psychiatry*, 135 (1978), 1409-1410 (Supersensitivity II) was attached as Exhibit H to the

Motion to Dismiss. [Exc. 41-2]. Supersensitivity II found that the "tendency toward psychotic relapse" is caused by the medication itself and that this and other deleterious effects could be permanent. [Exc. 42]

(F) "Neuroleptic-induced supersensitivity psychosis: clinical and pharmacologic characteristics," *American Journal of Psychiatry*, 137 (1980), 16-20 (Supersensitivity III) was attached as Exhibit I to the Motion to Dismiss. [Exc. 43-8], Supersensitivity III confirmed that neuroleptic use leads to psychotic relapse when it is discontinued. [Exc. 43].

(G) "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) was attached as Exhibit K to the Motion to Dismiss. [Exc. 49-63] 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. This remained true whether clinical outcomes, social outcomes, or a combination of the two was considered." [Exc. 50].

(H) "Schizophrenia: manifestations, incidence and course in different cultures, A World Health Organization ten-country study," *Psychological Medicine*, suppl. 20 (1992), 1-95 (WHO II) was attached as Exhibit L to the Motion to Dismiss. [Exc. 64-87]. WHO II confirmed WHO I's finding and concluded "being in a developed country was a strong predictor of not attaining a complete remission." [Exc. 84].

(I) "Empirical Correction of Seven Myths About Schizophrenia with Implications for Treatment," *ACTA Psyciatrica Scandinava*, 1994: 90 (suppl 384): 140-146 (Schizophrenia Myths) was attached as Exhibit O to the Motion to Dismiss. [Exc. 88-94]. Schizophrenia Myths states 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.

[Exc. 88].

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.

[Exc. 88].

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. " [Exc. 91].

Research Presented in Support of Motion *In Limine*

The Memorandum in Support of Motion *in Limine* to Exclude Psychiatric Testimony also argued that the scientific evidence did not support the proposed treatment and that Dr. Hanowell was unqualified to give expert opinion testimony under *State v. Coon, supra.*, because of his lack knowledge regarding the scientific evidence. [104-112] Attached thereto were the Hanowell deposition transcript and exhibits, including "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). [Exc. 113-221].

The Cohen Critique's summary of the scientific efficacy evidence included:

- The ability of neuroleptics (NLPs)[4] 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.

[Exc. 188].

The Cohen Critique also discusses an analysis of 1,300 published studies which found neuroleptics were no more effective than sedatives. [Exc. 187]. 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 medication. . . .

[4] This class of drugs is commonly known by a number of names, including "neuroleptics" and "anti-psychotics."

> their senses are numbed, their willpower drained and their lives meaningless.

[Exc. 195].

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.

[Exc. 205-7].

March 5, 2003; Hearing on Forced Medication Petition

An evidentiary hearing was held on March 5, 2003. [Tr.1-198]. Dr. Robert Hanowell, the State's main witness, was ruled qualified as an expert witness on psychiatry, including the use of psychiatric drugs. [Tr. 70]. In connection with this

qualification, the Superior Court refused to allow Ms. Myers to inquire into his knowledge of the efficacy of the psychiatric drugs he was proposing the court order Ms. Myers to take:

> MR. GOTTSTEIN: . . . [I]t seems to me, Your Honor, that knowledge about the efficacy is part of his qualifications.
>
> THE COURT: I don't agree. I'm not going to allow him to answer this question.

[Tr. 63].

Later in the voir dire, Dr. Hanowell testified he could not cite to any specific studies on long-term outcomes under the drugs he was proposing Ms. Myers be forced to take. [Tr. 69].

Dr. Nicholas Kletti, who was the Medical Director at API at that time was also offered as an expert witness, and testified the proposed medication was the standard of care for someone with Ms. Myers' diagnosis. [Tr. 104-5]. Dr. Kletti also testified no one knows why the proposed drugs work [Tr. 107], the newer drugs, such as the one proposed for Ms Myers were safer than the older drugs [Tr. 110-11], and were extremely safe medications. [Tr. 111].

Dr. Loren Mosher testified on behalf of Ms. Myers and was qualified as an expert on psychiatry, especially schizophrenia,[5] with the following background:

> I graduated from Stanford as an undergraduate, Harvard Medical School, Harvard psychiatric training, more training at the National Institute of Mental Health, post-doctoral fellowship in England, professor -- assistant professor of psychiatry at Yale -- I'm sort of going chronologically -- from '68 to '80 I was the chief for the Center for Studies of Schizophrenia, at the

[5] [Tr. 172, 174].

> National Institute of Mental Health from 1980 to '88 I was professor of psychiatry at the Uniform Services University of the Health Sciences in Bethesda, Maryland. That's a full-time, tenured, academic position. '88 to '96 I was the chief medical director of the Montgomery County Maryland Public Mental Health System. That's a bedroom community to Washington, D.C. From '96 to '98 I was clinical director of the San Diego County Public Mental Health System. Since November of '98 I have been the director and principle in Satiria (ph) Associates, a private consulting firm that I formed, and I also hold clinical professorships at the University of California San Diego School of Medicine, and at the Uniform Services University of the Health Sciences in Bethesda, Maryland. So that's briefly my credentials.

[Tr. 171-2].[6]

Dr. Mosher testified the current psychiatric thinking that schizophrenia is a brain disease which forms the basis for the current standard of care is completely unsupported by any scientific evidence -- that a hypothesis has been converted to belief in the absence of supporting evidence. [Tr. 174]. Dr. Mosher also testified anti-psychotic medication should not be the preferred method of treatment for schizophrenia:

> Q . . . Now, in your opinion, is medication the only viable treatment for schizophrenia paranoid type?
>
> A Well, no, it's not the only viable treatment. It is one that will reduce the so-called positive symptoms, the symptoms that are expressed outwardly for those kinds of folks. And that way they may seem better, but in the long run, the drugs have so many problems, that in my view, if you have to use them, you should use them in as small a dose for as short a period of time as possible. And if you can supply some other form of social environmental treatment -- family therapy, psychotherapy, and a bunch of other things, then you can probably get along without using them at all, or, if at all, for a very brief period of time. . . .

[Tr. 174-5].

In answering a hypothetical question involving the facts pertaining to Ms. Myers' psychotropic drug history, Dr. Mosher strongly recommended she not be placed back on the medications. [Tr. 175-6]

On cross-examination by the State, when challenged that his views about the use of psychotropic drugs were contrary to the current standard of care, Dr. Mosher testified 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.

[Tr. 179-80]

Dr. Mosher testified he knew psychiatrist Grace Jackson, M.D., who was Ms. Myers' next expert witness and that Dr. Jackson knows more about the mechanisms of actions of the various psychotropic medications than any clinician he was aware of. [Tr. 179].

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[6] Later, Dr. Mosher 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." [Tr. 178]

Dr. Jackson was qualified as an expert on psychopharmacology. [Tr. 165, 168]. Dr. Jackson testified the published research regarding neuroleptics has become tainted and unreliable because of the pharmaceutical companies' monetary influence over the process, including paying doctors to submit ghost written articles -- that clinicians are not getting accurate information. [Tr. 186-8, Exc. 274-288].

Dr. Jackson then testified the drug manufacturer of Zyprexa (Olanzapine), the drug the State proposed forcing Ms. Myers to take in this case, utilized such "ghost writing" mechanism to make claims that Zyprexa was safer and more efficacious than the older drugs -- claims which the FDA had specifically prohibited the manufacturer from making. [Tr. 188, Exc. 222-248]

Dr. Jackson, contradicting Dr. Kletti's assertions, also testified Zyprexa (Olanzapine) was a very dangerous drug whose efficacy has not been demonstrated. [Tr. 188-189]. This was supported by an extensive study by Dr. Jackson of the actual data in the clinical trials and submitted as an affidavit, admitted at the hearing as Exhibit C, entitled An Analysis of the Olanzapine Clinical Trials – Dangerous Drug, Dubious Efficacy," (Olanzapine Analysis). [Tr. 191, Exc. 249-273]]

Among the things the Olanzapine Analysis reveals are:

1. The FDA refused to approve olanzapine (Zyprexa) as a maintenance therapy for schizophrenia because its long term effectiveness had not been demonstrated [Exc.266]; and
2. The dosing methods in the trials were biased in favor of Olanzapine. [Exc. 269]

The March 5, 2003, hearing concluded with the Superior Court taking the Forced Medication Petition under advisement. [Tr. 197]

March 10, 2003; Post-Hearing Conference

On March 10, 2003, the Superior Court held a telephonic conference to address outstanding post-hearing issues. [Tr. 199-224] In response to Ms. Myers' request to finish presenting the scientific evidence regarding the safety and efficacy of the proposed medication, the Superior Court stated such evidence was irrelevant to her decision whether or not to grant the Forced Medication Petition. [Tr. 204-5] In response, Ms. Myers argued again that it was constitutionally impermissible to force her to take the medication without finding that it was in her best interest and make a substitute decision for her. [Tr. 206-7] The Superior Court replied that even though Ms. Myers had established there is a legitimate ongoing debate among qualified experts about the safety and efficacy of the proposed medication, the court was only going to consider the statutory criteria of competence (and not the constitutional arguments raised):

> I think that that is not an issue that the statute allows me to take up, given the context of this proceeding. And this is a proceeding where the State has initiated, pursuant to the statute -- is seeking an . . . order for the administration of the medication. And the statute sets out a standard that I'm to apply, and it requires that I make the finding regarding your client's capacity to make an informed consent, or not. That's the reason for my decision. . . . I can tell you that I've reviewed most of the materials that you've both submitted, and it strikes me that there is a legitimate ongoing debate among qualified experts on this question.

[Tr. 208-9]

March 14, 2003; Reply Re; Stay, Order Issued

On March 14, in her Reply Re: Stay, Ms. Myers reiterated her position that because the constitution requires the inquiry into the safety and efficacy of the medication it was part of the case:

> As asserted previously by Respondent, she respectfully suggests that the State must prove with scientifically valid evidence that the proposed treatment is both efficacious and safe before it may constitutionally override Respondent's wishes. The litany of harmful psychiatric treatments that were accepted by the psychiatric establishment over time reads like a horror story. As Robert Whitaker, the award winning science writer, states in the very last sentence (p. 290) of *Mad in America: Bad Science, Bad Medicine and the Enduring Mistreatment of the Mentall Ill*:
>
> > In fact, if the past is any guide to the future, today we can be certain of only one thing. The day will come when people will look back at our current medicines for schizophrenia and the stories we tell to patients about their abnormal brain chemistry, and they will shake their heads in utter disbelief.
>
> The issue is before the court in this case.

[Exc. 290-1].

Later that day, March 14, 2003, the Superior Court issued an Order approving the Forced Medication Petition (March 14th Order). [Exc. 292-305] In the March 14th Order, the court stated:

> Ms. Myers [Appellant] offered the testimony of two experts in the field of psychiatry: Dr. Loren Mosher and Dr. Grace Jackson. I find both to be qualified experts in this field. Dr. Mosher's credentials and experience in the area of schizophrenia are particularly impressive. The testimony of these experts and the articles they offered forcefully present their differing views on the advisability of administering anti-psychotic medications to patients suffering from schizophrenia. . . . Dr. Mosher testified that anti-psychotic medications should be avoided and that counseling and other supports should be used to assist Ms. Myers through her psychotic episodes. . . .

> The relevant conclusion that I draw from them is that there is a real and viable debate among qualified experts in the psychiatric community regarding whether the standard of care for treating schizophrenic patients should be the administration of anti-psychotic medication.
>
> * * *
>
> [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 court found "this case troubling," in light of the "real debate about the advisability of following the treatment path recommended by the psychiatrists" in this case, but granted the Forced Medication Petition solely on the grounds that Ms. Myers was not competent to refuse the medication under AS 47.30.839(g). [Exc. 304-5].

March 21, 2003; March 21st Order

By Order dated March 21, 2003, the Superior Court issued another Order (March 21st Order), ruling on the contentions contained in the Motion to Dismiss and Motion in Limine, which had not addressed in the March 14th Order. [Exc. 306-13]. In the March 21st Order, the Superior Court rejected Ms Myers' argument that the State had to support its proffered expert opinion evidence with reliable and competent scientific evidence, ruling, "when an area of scientific expertise is well known and has been fully considered by the court, a trial court may take notice of its admissibility." [Exc. 307].

The Superior Court also held in the March 21st Order:

> Where . . . a valid debate exists in the medical/psychiatric community as to the safety and effectiveness of the proposed treatment plan, it is troubling that the statutory scheme apparently does not provide a mechanism for presenting scientific evidence challenging the proposed treatment plan.

> The decision to grant the State's Petitions was made based upon the express language in the statute, which I do not find to be ambiguous. The superior court's role appears to be limited to deciding whether Ms. Myers has sufficient capacity to give informed consent, as defined by AS 47.30.839.

[Exc. 312-313].

II. Proceedings

The Forced Medication Petition was filed February 25, 2003. [Exc. 1]. The hearing set for that same day to approve the Forced Medication Petition [Exc. 2] was continued until February 28, 2003. [Tr. 1 (February 28, 2003)]. The February 28, 2003 hearing was further continued until March 5, 2003. [Tr. 5-6 (February 28, 2003)] An evidentiary hearing was held before Judge Christen on March 5, 2003. [Tr. 1-198]. A post hearing conference was held March 10, 2003. [Tr. 198-223]. Judge Christen issued an Order on March 14, 2003, granting the Forced Medication Petition. [Exc. 292-305]. On March 21, 2003, an additional Order was issued addressing certain issues not previously addressed. [Exc. 306-313]. Notice of Appeal was filed March 21, 2003.

Standard of Review

Issues of constitutional interpretation are questions of law this court reviews *de novo*, *State v. Alaska Civil Liberties Union*, 978 P.2d 597, 603 (Alaska, 1999) or, expressed differently, the constitutionality of a statute and matters of constitutional or statutory interpretation are questions of law to which this court applies its independent judgment. *State Commercial Fisheries Entry Com'n v. Carlson*, 65 P.3d 851, 858 (Alaska 2003).

This court reviews *de novo* questions of law presented by the trial court's evidentiary rulings. *M.R.S. v. State*, 897 P.2d 63, 66 (Alaska 1995).[7]

[7] "The admissibility of evidence is largely within the trial court's discretion and its rulings will not be overturned on appeal in the absence of an abuse of discretion." *Id*. However, Appellant believes only questions of law pertaining to the evidentiary issues in this case are at issue in this appeal.

Argument

I. Summary of Argument

Under AS 47.30.839(g) the State may obtain a court order to force a person to take psychotropic medication against their will if the person is found to be incompetent to refuse the medication under AS 47.30.837. The Superior Court ruled this precluded any other inquiry. [e.g., Exc. 313].

The question presented in this case is whether the State is constitutionally permitted to drug someone against their will without also showing the necessity, safety and efficacy of doing so, i.e., whether it is in the person's best interest ("Best Interests") and without a finding that if competent, the person would decide to take the medication ("Substituted Judgment"). Ms. Myers submits it is not.

The United States Supreme Court has held a person has United States Constitutional protection against forced psychiatric drugging under the Due Process Clause of the United States Constitution, U.S. Const.. amend. XIV §1, although the exact extent of these protections are intertwined with state law. *Mills v. Rogers*, 457 U.S. 291, 299, 102 S.Ct. 2442, 2448, 73 L.Ed.2d 16 (1982). Other courts have held before anyone can be medicated against their will, in addition to a proper finding that a person is incompetent to refuse the medication, a State must either prove the medication is objectively in the person's best interests or the person would decide to take the medication if he or she was competent. For the reasons stated below, Ms. Myers believes this court should require both.

II. Proving a Compelling State Interest and the Absence of a Less Restrictive Means is Required Before the State May Subject Someone to Unwanted Psychiatric Medication.

In *Breese v. Smith*, 501 P.2d 159, 171 (Alaska 1972), this court held the State must have a compelling governmental interest to impair a person's constitutionally protected right. In *Sampson v. State*, 31 P.3d 88, 91 (Alaska 2001) this court held, "When the state encroaches on fundamental aspects of the rights to privacy or liberty, it must demonstrate a compelling governmental interest and the absence of a less restrictive means to advance that interest." Ms Myers submits these general constitutional provisions apply with undiminished force to people the State is seeking to force to take psychotropic medications against their will.

Other courts have so held. In *Rivers v. Katz*, 495 N.E.2d 337, 341-3 (NY 1986), decided strictly on common law and constitutional due process grounds, New York's highest court held a person's right to be free from unwanted antipsychotic medication is a constitutionally protected liberty interest:

> "[i]f the law recognizes the right of an individual to make decisions about * * * life out of respect for the dignity and autonomy of the individual, that interest is no less significant when the individual is mentally or physically ill"
>
> * * *
>
> We reject any argument that the mere fact that appellants are mentally ill reduces in any manner their fundamental liberty interest to reject antipsychotic medication. We likewise reject any argument that involuntarily committed patients lose their liberty interest in avoiding the unwanted administration of antipsychotic medication.

In the relatively recent case of *Steele v. Hamilton County Community Mental Health Board*, , 736 N.E.2d 10, 16 (Ohio 2000), the Ohio Supreme Court confirmed

"persons suffering from a mental illness have a 'significant liberty interest' in avoiding the unwanted administration of antipsychotic drugs" protected by the due process clauses of both the Fourteenth Amendment of the U.S. Constitution and the Ohio Constitution.

> The liberty interests infringed upon when a person is medicated against his or her wishes are significant. "The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty." This type of intrusion clearly compromises one's liberty interests in personal security, bodily integrity, and autonomy.
>
> The intrusion is "particularly severe" when the medications administered by force are antipsychotic drugs because of the effect of the drugs on the human body. Antipsychotic drugs alter the chemical balance in a patient's brain producing changes in his or her cognitive processes. . . .
>
> The interference with one's liberty interest is further magnified by the negative side effects that often accompany antipsychotic drugs, some of which can be severe and/or permanent.

Id, at 16-17, citations omitted.

The *Rivers* court specifically held at n6, that the only permissible state interests were "the patient's well-being or those around him." Thus, the court, at 343, held:

> Where the patient presents a danger to himself or other members of society or engages in dangerous or potentially destructive conduct within the institution, the State may be warranted, in the exercise of its police power, in administering antipsychotic medication over the patient's objections.

The only other circumstance that gives rise to a sufficient compelling state interest in forcing someone to take these types of drugs in the civil context is if it is for the "patients well-being" under the *Parens Patriae"* doctrine:

> There is no doubt that the State may have a compelling interest, under its *parens patriae* power, in providing care to its citizens who are unable to care for themselves because of mental illness

Id. These two permissible grounds for forcibly medicating someone can be characterized as (a) "Police Power" and (b) "*Parens Patriae*."

In the recent case of *Sell v. U.S.*, __ U.S. __, 71 USLW 4456, 123 S.Ct. 2174, 2185 (June 16, 2003), the United States Supreme Court addressed the potential compelling governmental interest in making a criminal defendant competent to stand trial. The Court specifically contrasted the considerations there with those in the civil context, where it recognized the (i) *parens patriae* basis ("when in the best interests of a patient who lacks the mental competence to make such a decision") and (ii) police power interest ("courts, in civil proceedings, may authorize involuntary medication where the patient's failure to accept treatment threatens injury to the patient or others"). *Id*, 123 S.Ct. at 2185.

The Alaska Statutes also make the *Parens Patriae* and Police Power distinction for civil forced medication proceedings. The provisions for forcibly medicating someone under the Police Power basis is found at AS 47.30.838 and AS 47.30.839(a)(1), while provisions utilizing the *Parens Patriae* basis are found in other sections of AS 47.30.839 and AS 47.30.837(d). AS 47.30.839(g), the key provision relating to this appeal relied upon by the court below, provides:

> (g) If the court determines that the patient is not competent to provide informed consent . . . the court shall approve the facility's proposed use of psychotropic medication.[8]

[8] AS 47.30.837(d) is the definition of competence in the backwards way it is done there (informed consent).

This was the basis relied upon by the State in seeking the forced medication of Ms. Myers [Exc. 1] and was the basis for the Superior Court's decision that incompetence to make the decision alone was sufficient for forcing someone to take psychotropic medications against their will. [Exc. 312-13].

However, forcibly medicating a patient for incapacity alone as provided in AS 47.30.839(g) is constitutionally impermissible. In *Rivers v. Katz, supra.,* New York's highest court held while a proper judicial finding of incompetence was a necessary predicate to such a governmental intrusion, standing alone, it was not constitutionally sufficient:

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

(Rivers v. Katz, supra, at 344, footnote omitted).

Steele v. Hamilton County, supra., also holds a finding of incompetence, while a necessary element to force a patient to take psychiatric medication against their will is, standing alone, insufficient. In addition to a finding of incompetence, the Ohio Supreme Court required both that the proposed medication be in the patient's best interest and that no less intrusive treatment is available:

> [A] court may issue an order permitting hospital employees to administer antipsychotic drugs against the wishes of an involuntarily committed mentally ill person [only] if it finds, by clear and convincing evidence, that (1) the patient does not have the capacity to give or withhold informed consent regarding his/her treatment, (2) it is in the patient's best interest to take the medication, i.e., the benefits of the medication outweigh the side effects, and (3) no less intrusive treatment will be as effective in treating the mental illness.

Steele at 20-21.

In *Sell, supra,* 123 S.Ct. at 2183 and 2185 the United States Supreme Court said there must be no less restrictive alternative before forced administration of psychotropic medication is permissible.

As set forth above, this court has also held as a general constitutional principle that when a fundamental constitutional right is sought to be encroached upon by the State it must be done through the least restrictive means. In this case, the unrebutted testimony of Dr. Mosher established there was such a less restrictive means. [Tr. 174-5]

Ms. Myers submits that because AS 47.30.839(g) subjects people to forced medication solely upon a finding of incompetence, which is an insufficient state interest in and of itself, and because it does not employ the least restrictive means, it is constitutionally infirm under the general principles of constitutional law enunciated by this court.

III. Due Process Requires a Finding that the Forced Psychiatric Drugging Is In Ms. Myers Best Interests.

As set forth above, the United States Supreme Court in *Mills v. Roger* recognized a right to refuse psychiatric medications under the due process clause of the 14th Amendment to the United States Constitution, although the exact extent of these

protections are intertwined with state law. In the very recent *Sell,* case, *supra*, 123 S.Ct. at 2183, 2185 and 2186, the United States Supreme Court held the proposed medication had to be medically appropriate, including considerations of efficacy and side effects.

Also as set forth above, in *Rivers v. Katz,* at 343-4, New York's highest court held in addition to a proper finding of incompetence, before forcibly medicating someone was constitutional:

> [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.

In other words, additional requirements under *Rivers v. Katz* are:

1. the best interests of the patient,
2. the benefits of the treatment
3. the adverse side effects associated with the treatment, and
4. the absence of any less intrusive alternative.

As set forth above, *Steele v. Hamilton County, supra,* at 20-21, is in accord that a finding of incompetence, while necessary to force someone to take psychiatric medication against their will is, standing alone, constitutionally insufficient -- it also has to be in the person's best interest.

Similarly, *In Re: M.P.*, 510 N.E.2d 645, 646-7 (Indiana 1987), after recognizing the constitutional right to be free of forced psychiatric drugging under *Mills v. Rogers, supra*., the Indiana Supreme Court held before the state could constitutionally force psychiatric drug anyone, the state had to show the medication will be of substantial benefit in treating the condition and not just in controlling the behavior of the individual,

and "the probable benefits from the proposed treatment outweigh the risk of harm to, and personal concerns of, the patient." In addition, the Indiana Supreme Court held the court must determine that,

> there has been an evaluation of each and every other form of treatment and that each and every alternative form of treatment as been specifically rejected. It must be plain that there exists no less restrictive alternative treatment and that the treatment selected is reasonable and is the one which restricts the patient's liberty the least degree possible.

Ms. Myers submits this court should apply these same requirements from other jurisdictions that due process requires the State to prove both (1) that the proposed medication is in the patient's best interest, and (2) that no less restrictive alternative is available. The constitutional principles involved find ample support in the decisions of this court, as set forth above, and should be applied here.

IV. Ms. Myers Privacy Rights Require a Judicial Substituted Judgment Decision Before Forced Psychiatric Drugging.

This court has also held where a law impinges upon the right of privacy under Alaska's Constitutional Right to Privacy, AK Const. Art. 1, § 22, the statute may be upheld only if it is necessary to further a compelling state interest. *Gray v. State*, 525 P.2d 524, 527 (Alaska 1974). *Gray*, at 528, specifically holds Alaska's constitutional right to privacy "clearly . . . shields the ingestion of food, beverages or other substances."

In *Valley Hosp. Ass'n, Inc. v. Mat-Su Coalition for Choice*, 948 P.2d 963, 969 (Alaska,1997), this 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 the instant case, Ms. Myers' interest in preventing the mental and bodily intrusion of unwanted psychotropic medication is a much more serious invasion of rights than the haircut issue ruled constitutionally protected by this Court in *Breese* and, Ms. Myers submits, at least equals the liberty interest in reproductive rights addressed in *Valley Hospital*.

The Massachusetts Supreme Court, in *Guardianship of Roe*, 421 N.E.2d 40, 52-3 (Mass 1981), in an instructive observation, held:

> We can identify few legitimate medical procedures which are more intrusive than the forcible injection of antipsychotic medication. "In general, the drugs influence chemical transmissions to the brain, affecting both activatory and inhibitory functions. Because the drugs' purpose is to reduce the level of psychotic thinking, it is virtually undisputed that they are mind-altering. . . . The drugs are powerful enough to immobilize mind and body. Because of both the profound effect that these drugs have on the thought processes of an individual and the well-established likelihood of severe and irreversible adverse side effects, see Part II A(2) infra, we treat these drugs in the same manner we would treat psychosurgery or electroconvulsive therapy.

(footnote and citations omitted). The Massachusetts Supreme Court found that a non-institutionalized person the state wanted to subject to forced medication had a constitutional right of privacy that could only be overridden if the person was both incompetent and the court made a substituted judgment decision involving at least six factors. *Id*. at 56-59.

In *Rogers*, 458 N.E. 2d 308, 318-19 (Mass 1983),[9] the Massachusetts Supreme Court ruled the same requirements attach to someone who is institutionalized and a patient adjudicated as incompetent can not be medicated against his or her will except by a court made Substituted Judgment Decision that includes the following factors:

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

The *Rogers* court specifically re-affirmed *Guardianship of Roe's* holding that "No medical expertise is required [for making the substituted judgment decision], although medical advice and opinion is to be used for the same purposes and sought to the same extent that the incompetent individual would, if he were competent." The Massachusetts Supreme Court also held because of the inherent conflicts in interest, the doctors should not be allowed to make this decision.

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

Rogers at 382-3, citation omitted.

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[9] This opinion is the Supreme Court of Massachusetts' response to the questions certified to it from the First Circuit Court of Appeals in the *Mills v. Rogers* remand from the United States Supreme Court.

The court also found additional sources of conflicts of interest between the patient and doctors:

> Economic considerations may also create conflicts between doctors and patients. Because medication with antipsychotic drugs "saves time, money, and people," Zander, Prolixin Decanoate: Big Brother by Injection? 5 J. Psychiatry & Law 55, 56 (1977)
>
> * * *
>
> [T]he temptation to engage in blanket prescription of such drugs to maintain order and compensate for personnel shortages may be irresistible. See Guardianship of Roe, supra, 383 Mass. at ---, Mass.Adv.Sh. (1981) at 1004 n. 11, 421 N.E.2d 40 (citation to literature documenting "abuses of antipsychotic medication by those claiming to act in an incompetent's best interests").

Rogers, *supra.*, n. 19.

Ms. Myers respectfully submits her right to be free of unwanted mind-altering and dangerous drugs is protected under the privacy clause of the Alaska Constitution and, in addition to a proper finding of incompetence, can only be overridden by a proper Substituted Judgment Decision.

V. The Inherent Rights Clause of the Alaska Constitution Requires a Finding that Forced Psychiatric Drugging is In Ms. Myers Best Interests and a Judicial Substituted Judgment Decision.

In *Breese*, at 168, citing to Article 1, Section 1 of the Alaska Constitution (Inherent Rights), this Court held that a student's right to choose his hairstyle was a fundamental right under the Alaska Constitution and, at 171, that right could only be abridged by showing a compelling state interest.

As demonstrated by the authority cited above under the due process and privacy clauses, contrary to AS 47.30.839(g), mere incompetence to refuse the medication is a

constitutionally insufficient reason to force someone to take these medications. It appears these courts require either a "best interests" finding or a "substituted judgment" determination. However, Ms. Myers respectfully suggests constitutional doctrine and logic require both be satisfied. Can it be constitutionally permissible to force someone to take these medications, where the asserted compelling state interest is the treatment is in the person's best interest, without requiring the proposed treatment be, in fact, in the person's best interest? Ms. Myers suggests the answer is clearly no.

Similarly, if a competent person has the right to refuse treatment that may be objectively in his or her best interest for any number of reasons, shouldn't the state be required to prove she would consent to the medication if she were competent? Ms. Myers submits the answer to this should be yes. Otherwise, the constitutional right to refuse medication that may be in a person's medical best interest is taken away from someone merely because they have been determined incompetent to make that decision.

In light of the authority and constitutional principles cited herein, Ms. Myers respectfully suggests the following as being constitutionally required before a person's right to refuse psychotropic medication can be overridden on a *parens patriae* justification:

(a) the person is incompetent to refuse such medication, and
(b) the proposed medication is objectively in the person's long-term best interests, and
(c) the person would make a decision to accept the medication if he or she were competent, and
(d) there is no less restrictive alternative.

As will be discussed in the next section, Ms. Myers submits all of these determinations must be made under proper evidentiary standards.

VI. The Required Determinations Must Be Made Under Proper Evidentiary Standards.

In *Breese* at 172, this court held in order to meet the school board's "substantial burden" to show the compelling interest in regulating students' hair length, it had to present valid scientific evidence supporting the justification.

In response to Ms. Myers' evidence that the medications the State was seeking to force her to take would be both counterproductive on a long-term basis and harmful to her, the State repeatedly asserted all they were seeking was standard practice in psychiatry and this was all they needed to show. The history of the practice of medicine, and particularly psychiatry, is rife with standard practices that have been abandoned for being ineffective and/or harmful. Dr. Jackson testified about two medications, for example, Thalidomide and Diethylstilbestrol (DES), that are no longer allowed for safety reasons. [Tr. 190-1]. In psychiatry, (1) Metrazol induced convulsive seizures, (2) Insulin induced comas, (3) Electroshock, and (4) Lobotomy were not so long ago touted as great psychiatric treatments and were the standard of care in succeeding waves of enthusiasm that faded as claims for their efficacy and safety were disproven.

Ms. Myers submits any showing the State is required to make justifying its encroachment on a person's vital liberty interest in being free from these drugs must be made under proper evidentiary standards, including reliable and competent medical opinion testimony. This is especially true where, as here, it has been shown that the

practitioners attempting to force these medications on their patients have been misled by research that has been biased by pharmaceutical company manipulations.

Fortunately, the evidentiary standards laid down by this court specifically address how to deal with such issues. In *State v. Coon*, 974 P.2d 386, 393 (Alaska 1999), this court held Alaska's rules of evidence allow, "a proponent to establish admissibility even if general acceptance is absent, and allowing an opponent to challenge admissibility even if general acceptance is present."

In this case, the State's expert witnesses were unable to cite to any scientific evidence to support their opinions,[10] while Ms. Myers and her witnesses cited numerous studies contradicting the State's position. With respect to the scientific validity of the State's expert witnesses' testimony that their opinions were based on the current standard of care, Dr. Mosher, the former Chief of Schizophrenia Studies at the National Institute of Mental Health testified this current standard of care is based on converting a hypothesis into a belief in the absence of any evidence supporting it. [Tr. 174].

Ms. Myers submits *Breese's* holding that the failure to provide proper scientific evidence was fatal in that case, necessarily requires that in this case, the state must prove all of the elements required to justify forcible medication under proper evidentiary standards for scientific opinion testimony. *See*, e.g., *Steele v. Hamilton County, supra.*, at 20-21, quoted in Section II, above.

[10] The State's attorney and main witness even expressed incredulity that Ms. Myers expected the State's proffered expert to be able to support his opinion with scientific evidence. [Exc. 161-2].

Without the right to enforce constitutional protections against the State's attempt to force psychotropic medications upon people against their will through resort to normal evidentiary standards, such constitutional protections are illusory.

Conclusion

For the foregoing reasons, Ms. Myers requests this court REVERSE the Superior Court and hold when the State seeks to obtain a court order authorizing the administration of psychiatric medication against a person's will, the State must prove under proper evidentiary standards for scientific expert opinion testimony, i.e., *State v. Coon*, *supra*., that:

(a) the person is incompetent to refuse such medication, and

(b) the proposed medication is objectively in the person's long-term best interests, including (i) consideration of probable benefits, (ii) potential side effects, and (iii) the long term prognosis with and without the proposed medication, and

(c) the person would make a decision to accept the medication if he or she were competent, and

(d) there is no less restrictive alternative.

RESPECTFULLY SUBMITTED this 13th day of August, 2003.

LAW PROJECT FOR PSYCHIATRIC RIGHTS, INC

By: _____
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