February 22, 2022

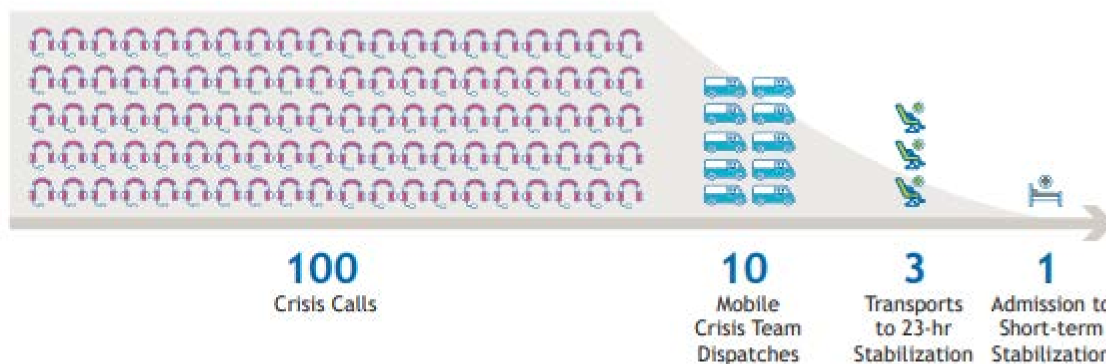
Senator David Wilson
Chair, Senate Health & Social Services Committee
State Capitol Room 121
Juneau AK, 99801

Representative. Matt Claman
Chair, House Judiciary Committee
State Capitol Room 118
Juneau AK, 99801

Re: SB124/HB172

Dear Sen. Wilson and Rep Claman:

These are my comments on SB124 & HB172 (Proposed Legislation) regarding amendments to Alaska's involuntary psychiatric procedures. As I understand it, the impetus for the Proposed Legislation is the meltdown of the Alaska Psychiatric Institute (API) resulting in people being illegally held in jail and other venues for long periods of time waiting for court ordered psychiatric evaluation. I also understand it is designed to mesh with the Crisis Now model being evaluated by the Alaska Mental Health Trust Authority (Trust) and the Department of Health & Social Services (DHSS) to dramatically decrease psychiatric hospitalizations through the use of mobile crisis teams and 23/120 hour short term crisis/residential centers.[1] The idea is to dramatically reduce the use of police and emergency medical services to address "behavioral health crises" as well as dramatically reduce psychiatric hospitalizations.



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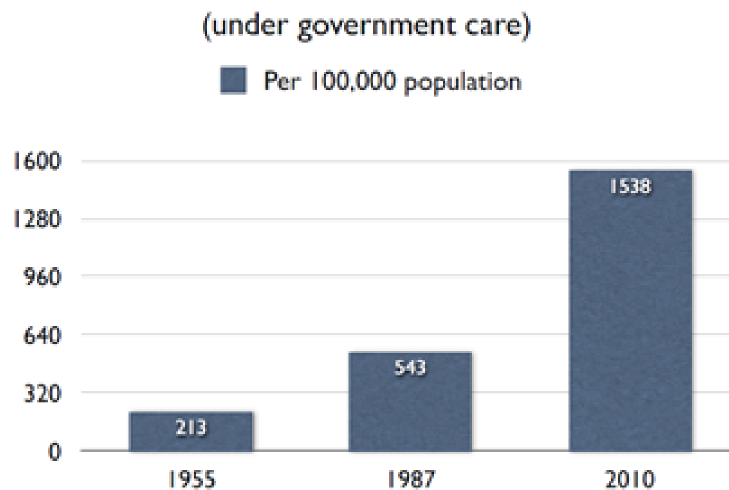
[1] See, https://alaskamentalhealthtrust.org/alaska-mental-health-trust-authority/what-we-do/crisis-continuum-of-care/.

The Trust and DHSS are to be commended for piloting the Crisis Now model, which has a lot of good elements to it. At the same time, the whole program as currently designed leads to perpetuating a system that is massively counterproductive and harmful. To the extent the Proposed Legislation facilitates this, it is also massively counterproductive and harmful. First, I will address the programmatic problem, which I call The Big Picture and then the specifics of the Proposed Legislation.

I. THE BIG PICTURE

It is fairly universally accepted that America's mental health system is a failure. Alaska's is no exception. At great public expense, our current mental health system's ubiquitous deployment of psychiatric drugs, including through court orders against unwilling patients, often by holding them down and injecting them against their will, or threatening to do so to obtain "compliance," dramatically worsens outcomes and suffering.

Since the introduction of the so-called miracle drug Thorazine in the mid-1950's the disability rate of people diagnosed with serious mental illness has increased more than seven-fold.[2]

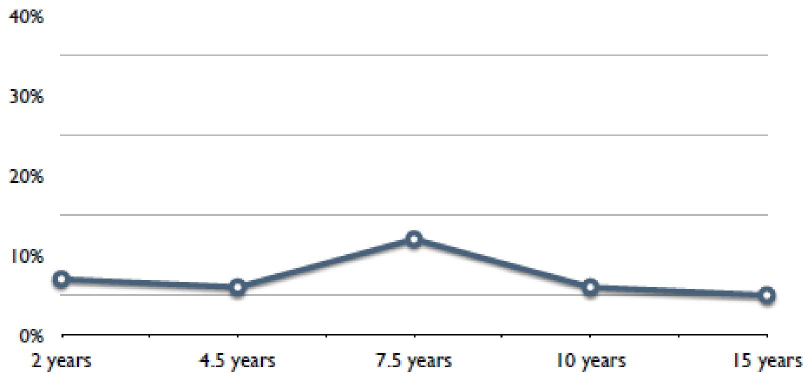


[2] The charts in this letter are from talks given by award winning journalist, Robert Whitaker, author of *Anatomy of an Epidemic* and *Mad in America*, including his July 16, 2021, talk to the Soteria Network in the UK, "Soteria Past, Present, and Future: The Evidence For This Model of Care," available on YouTube at https://youtu.be/UXe2dgBF70w. This one hour talk is highly recommended.

We now see a recovery rate of only 5% for those people who are maintained on neuroleptics.[3]

Long-term Recovery Rates for Schizophrenia Patients on Antipsychotics

(Martin Harrow's study)



Source: Harrow M. "Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications." *Journal of Nervous and Mental Disease* 195 (2007):406-14.

This is far worse than anything seen before the advent of the neuroleptics in the mid-1950's.

Outcomes in Select Studies from Pre-Antipsychotic Era

(Patients diagnosed as insane, schizophrenic or psychotic)

Study	Time	Good Outcome*
York Retreat	1796-1811	70%
Worcester Asylum	1833-1846	65%
Pennsylvania Hospital	1841-1882	45% to 70%
Warren State Hospital	1946-1950	73%
Delaware Hospital	1948-1950	70%
Boston Psychopathic Hospital	1947-1952	76%
Norway	1948-1952	63%
California FEP study	1956 (no neuroleptics)	88%

* Good outcome = discharge from hospital, or living in community at end of study period

[3] Marketed as "antipsychotics" even though they don't have anti-psychotic effects for most.

It has been shown, however, that if we try to avoid the use of neuroleptics when people experience their first psychotic break a nearly 80% recovery rate can be achieved. The below chart shows results from the "Open Dialogue" program in Northern Finland in which they avoid the use of neuroleptics if possible.

Open Dialogue in Northern Finland

(Results for First-Episode Patients at Five Years)

Patients (N = 75)	
Schizophrenia (N = 30) Other psychotic disorders (N = 45)	
Antipsychotic Use	
Never exposed to antipsychotics	67%
Occasional use during five years	33%
Ongoing use at end of five years	20%
Psychotic Symptoms	
Never relapsed during five years	67%
Asymptomatic at five-year followup	79%
Functional Outcomes at Five Years	
Working or in school	73%
Unemployed	7%
On disability	20%

Source: J. Seikkula. "Five-year experiences of first-episode nonaffective psychosis in open-dialogue approach." Psychotherapy Research 16 (2006): 214-28.

Similar results were achieved during the Soteria-House study in the 1970's conducted by Loren Mosher, MD, who was Chief of Schizophrenia Research at the National Institute of Mental Health (NIMH) at the time.

Soteria-House Study

First-episode schizophrenia patients treated conventionally in a hospital setting with drugs versus treatment in the Soteria House, which was staffed by non-professionals and involved no immediate use of antipsychotic medications. Results are from 1971-1983 cohorts, with 97 patients treated conventionally and 82 patients treated in Soteria House .

Results:

At end of six weeks, psychopathology reduced comparably in both groups.

At end of two years:

- Soteria patients had better psychopathology scores
- Soteria patients had fewer hospital readmissions
- Soteria patients had higher occupational levels

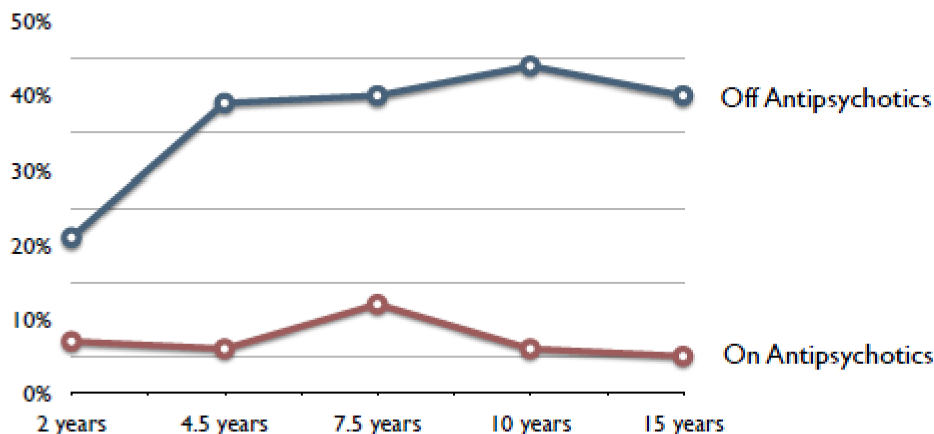
- Soteria patients were more often living independently or with peers

Antipsychotic Use in Soteria Patients:

- 76% did not use antipsychotic drugs during first six weeks
- 42% did not use any antipsychotic during two-year study
- Only 19 % regularly maintained on drugs during follow-up period

J Nerv Ment Dis 1999; 187:142-149
J Nerv Ment Dis 2003; 191: 219-229

What we find is the recovery rate of people who get off of neuroleptics after they have been on them for a while goes from 5% to 40%.



While this is 8 times better than staying on them (40% vs. 5%), it is half of what can be achieved by avoiding the use of neuroleptics in the first place as established by the Open Dialogue and Soteria House studies, both of which achieved close to an 80% recovery rate.[4] **This demonstrates the importance of avoiding the use of neuroleptics if at all possible.** In addition to their lives being so much better, allowing 16 times more people to recover not only saves a tremendous amount of treatment expense, it converts people who would otherwise be

[4] While there might not be a 100% overlap between the 80% who recovered and the 80% who were not taking the neuroleptics long term, clearly minimizing the use of the neuroleptics produce dramatically better outcomes.

receiving life-long publicly paid services and transfer payments into productive, taxpaying citizens. [5]

In addition to dramatically reducing the recovery rate, the ubiquitous use of psychiatric drugs reduce the lifespan of people diagnosed with serious mental illness in the public mental illness system by 20-25 years.[6]

To the extent the Crisis Now program and the Proposed Legislation further the ubiquitous use of psychiatric drugs they are driving a mental health system that achieves the 5% recovery rate, rather than the almost 80% recovery rate.

Chapter 9 of *Community Mental Health: A Practical Guide*, by Dr. Loren Mosher and Dr. Lorenzo Burti, lays out the details of an effective community mental health program. Published in 1994, it does not include some of the newer approaches described here, but it is still a valuable and, indeed, practical guide to this day. It should be Alaska's mental health program roadmap.

Dr. Mosher testified at the trial in *Myers v. Alaska Psychiatric Institute*,[7] in which I represented Faith Myers, and which resulted in the Alaska Supreme Court holding Alaska's current forced drugging statute unconstitutional. In addition to the negative impact of psychiatric drugs, Dr. Mosher testified involuntary treatment should be difficult to implement and used only in the direst of circumstances:

> [I]n the field of psychiatry, it is the therapeutic relationship which is the single most important thing. . . . Now, if because of some altered state of consciousness, somebody is about to do themselves grievous harm or someone else grievous harm, well then, I would stop them in whatever way I needed to. . . . In my career I have never committed anyone. . . . I make it my business to form the kind of relationship [through which the mentally ill person and I] can establish a[n] ongoing treatment plan that is acceptable to both of us.

The Crisis Now approach has elements consistent with what Dr. Mosher testified to, but the Proposed Legislation undermines that by making it easier rather than harder to lock people up by allowing people to be locked up for longer periods of time based only on probable cause, rather than clear and convincing evidence and, in some cases, for experiencing an "acute behavioral crisis," which is not defined, rather than being "gravely disabled or present a likelihood of serious harm," as will be discussed further below.[8]

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[5] The best book to understand the impact of psychiatric drugs in general, not just the neuroleptics, is *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*, by Robert Whitaker, from whose work the foregoing is largely drawn.

[6] See, various studies at http://psychrights.org/Research/Digest/NLPs/neuroleptics.htm and Morbidity and Mortality in People with Serious Mental Illness, by the National Association of State Mental Health Program Directors, October 2006.

[7] 138 P3d 238 (Alaska 2006).

[8] The as introduced version of the Proposed Legislation also made it far too easy to drug people against their will, but the February 16, 2022 House Judiciary Work Draft seems to back off of that. Perhaps because it would be unconstitutional as explained below.

In addition to the Open Dialogue and Soteria-House models, proven effective approaches that avoid the drugs, or at least allow choice, include peer respites and the Hearing Voices Network. These types of approaches should be the cornerstones of Alaska's mental health program.

I question the long term financial commitment to the Crisis Now approach. From what I can glean, the Alaska Mental Health Trust Authority (Trust) has invested start-up funding, primarily in Fairbanks. I don't know how well that is going, but the Trust has a history of abandoning its financial support for good programs on the faulty premise the State of Alaska is going to continue sufficient funding. For example, Soteria-Alaska, which I co-founded, modeled after Dr. Mosher's original Soteria-House, was granted startup funding by the Trust and the State picked up the funding for just a few years before it reduced it so much it closed. I wrote about this in Lessons from Soteria-Alaska.[9] The short funding of Soteria-Alaska and its resultant closure was a huge blunder and should be reversed. For these types of programs it is absolutely critical they be staffed by people who are invested in and knowledgeable about the approaches.

II. The Proposed Legislation

A. Statutes Held Unconstitutional Should Be Amended to be Constitutional.

First, if AS 47.30 relating to involuntary commitment and forced drugging is to be amended, the existing statutes should be conformed to constitutional requirements. I have won two Alaska Supreme Court cases declaring certain aspects of AS 47.30 unconstitutional and the statutes should be amended so as to be constitutional. Without that, people reading the statutes will be misled into thinking they state the law.

With respect to involuntary commitment, in *Wetherhorn v. Alaska Psychiatric Institute*, the Alaska Supreme Court held, "[T]he definition of 'gravely disabled' in AS 47.30.915(7)(B) is constitutional [only] if construed to require a level of incapacity so substantial that the respondent is incapable of surviving safely in freedom."[10] AS 47.30.915(7)(B) should be amended to reflect this. Frankly, subsection (B) should probably just be deleted.

With respect to forced drugging, in *Myers v. Alaska Psychiatric Institute*, interpreting AS 47.30.839, the Alaska Supreme Court held:

> [I]n future non-emergency cases a court may not permit a treatment facility to administer psychotropic drugs unless the court . . . expressly finds by clear and convincing evidence that the proposed treatment is in the patient's best interests and that no less intrusive alternative is available.[11]

In *Bigley v. Alaska Psychiatric Institute*, the Alaska Supreme Court followed up on the least intrusive alternative requirement of *Myers*, holding:

> If that *Myers* inquiry had lead us to conclude that API's proposed treatment was constitutionally barred . . . API could attempt to offer some other form of

[9] https://www.madinamerica.com/2015/06/lessons-from-soteria-alaska/.

[10] 156 P.3d 371, 384 (Alaska 2007).

[11] 138 P.3d 238, 254 (Alaska 2006).

> treatment that was not constitutionally invalid, or could simply release Bigley without treatment.[12]

AS 47.30.839 should be amended in the ways identified by the Alaska Supreme Court in *Myers* and *Bigley* to make it constitutional.

In my attached law review article, *Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course*,[13] I address these and other problematic ways in which involuntary commitment and forced drugging proceedings are administered in violation of patients' rights to their great detriment.

B. More Robust Grievance Procedures and Legitimate, Independent Oversight Should be Included.

One of the reasons psychiatric inmates' rights are violated as a matter of course is the AS 47.30.847 Grievance Procedure Statute has no teeth and there is no real oversight. Faith Myers, my client in *Myers v. Alaska Psychiatric Institute*, has been advocating for statutory changes to beef up AS 47.30.847 regarding grievances and she is right. One thing I would add is exempting anyone who might appeal an adverse determination on a grievance from a Civil Rule 82 attorney's fee award against them if they are not the prevailing party. I was prepared to take an appeal for Faith a number of years ago, but when I told her she could lose her Permanent Fund Dividend for many years if she lost, she decided she couldn't risk it. This amounts to a denial of access to the courts because one is not wealthy.[14]

There should also be legitimate, independent oversight of API and any other facilities where people can be held there against their will, including an enforcement mechanism, as Ms. Myers recently suggested. A potential model to look at is from Arizona, contained in ARS 41-3803 and ARS-41-3804. I recall that after settlement of the Alaska Mental Health Trust Lands Litigation, for a number of years API had a governing body that had oversight responsibilities, at least on paper, and former behavioral health patients were on it. API didn't like the oversight, however, and when a minority report outlining patient mistreatment was submitted, Commissioner Perdue gutted its authority and now it does not appear any behavioral health client or former client is on it.

I also agree with Ms. Myers recent comment that DHSS should be required to semi-annually report the number and type of patient complaints and injuries and the number and type of traumatic events experienced by patients within a psychiatric facility or unit as defined by being strapped to a gurney, placed in isolation, placed in restraints including handcuffs while being transported, or physically restrained.

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[12] 208 P.3d 168, 187-188 (Alaska 2009).

[13] 25 *Alaska L. Rev.* 51 (2008).

[14] The Alaska Department of Law has had a long-standing policy of always seeking attorney's fees when they are the prevailing party, no matter of the opposing party's financial situation. My belief this is deliberate to discourage people from trying to vindicate their rights in the courts.

C. HB172/SB124[15]

1. Overview

Crisis stabilization and residential centers should only be voluntary. As currently drafted the Proposed Legislation violates Dr. Mosher's testimony that involuntary treatment should be difficult to implement and used only in the direst of circumstances.[16]

2. "Acute Behavioral Crisis" is an Unconstitutional Basis for Psychiatric Confinement

It appears the term "acute behavioral crisis" was introduced into the Alaska Statutes by Ch. 28 SLA 2020, adding AS 47.30.031, allowing police officers alternatives to arrest for people in an acute behavioral crisis. While it may be an appropriate term in that context it is an improper basis for psychiatric confinement. I could not find any definition of it in the Alaska Statutes and, in addition to being bad policy, its use as a standard for locking people up and drugging them against their will is unconstitutional.

Under United States Supreme Court precedent, psychiatric confinement is only constitutional when (a) it takes place pursuant to proper procedures and evidentiary standards, (b) there is a finding of "dangerousness either to one's self or to others," and (c) proof of dangerousness is "coupled ... with the proof of some additional factor, such as a 'mental illness' or 'mental abnormality, *Kansas v. Crane*, 534 U.S. 407, 409-10, 122 S.Ct. 867, 869 (2002). With respect to harm to self, being unable to take care of oneself can constitute danger to self if the person is "incapable of surviving safely in freedom." *Cooper v. Oklahoma*, 517 U.S. 348, 116 S.Ct. 1373, 1383 (1996). As set forth above, in *Wetherhorn* the Alaska Supreme Court held exactly this under the Alaska Constitution in declaring the definition of "gravely disabled" in AS 47.30.915(7)(B) unconstitutional as written.

Currently, the standard for obtaining an *ex parté* order **for a psychiatric evaluation** is "probable cause to believe the respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others."[17] Under the Proposed Legislation, a person may be confined "to resolve an acute behavioral crisis." In some places it also requires the person to be gravely disabled or to present a likelihood of serious harm to self or others and in other places it doesn't. To be constitutional it must require the person to be gravely disabled or to present a likelihood of serious harm to self or others in all instances. However, better yet would be to make the crisis stabilization and residential centers to be completely voluntary. This requires more work with people in the beginning, but pays huge dividends in the long run.

To be specific, proposed new subsections AS 47.30.707 and AS 47.30.708 are unconstitutional where it allows the court to order people be confined if it finds probable cause the respondent's acute behavioral health crisis will be resolved during admission to a crisis center

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[15] Except as noted, these comments are addressed to the February 16, 2022, House Judiciary Work Draft, "W" version, Committee Substitute for HB172.

[16] Transcript p. 0176.

[17] AS 47.30.700(a).

without also requiring the person to be gravely disabled or to present a likelihood of serious harm to self or others.[18]

3. Except for Emergencies, a Court Finding that Forced Psychiatric Drugging is in the Person's Best Interest and There Is No Feasible Less Intrusive Alternative is Constitutionally Required to Psychiatrically Drug Someone Against Their Will.

The Alaska Supreme Court ruled in *Myers* and *Bigley* that, except in emergency situations, it is unconstitutional to psychiatrically drug someone against their will unless there is a court determination that in addition to (a) the person being found incompetent to decline the medication and (b) the patient made no previous statement about their preference while competent, (c) it is in the person's best interest, and (d) there is no less intrusive alternative that could be feasibly provided. The as introduced version of the Proposed Legislation explicitly violated *Myers* and *Bigley* by allowing people to be psychiatrically drugged against their will in crisis stabilization and residential centers without the protections in AS 47.30.839, *Myers* & *Bigley*. In other words, the originally introduced Proposed Legislation would be unconstitutional to the extent people could be psychiatrically drugged against their will without the full protections of AS 47.30.839, *Myers* & *Bigley*.

In proposed new subsection AS 47.30.709(d), a crisis stabilization or residential center may administer psychiatric drugs to involuntarily held people only through the emergency procedures contained in AS 47.30.838. THIS IS GOOD.[19] I will note there is no prohibition against administering psychiatric drugs voluntarily to voluntary residents. I do think people should be told the truth about the drugs.

4. There is a Constitutional Limit to How Long a Person Can be Confined Without Court Authorization

Finally, proposed new subsection AS 47.30.710(d) provides that a person shall be confined at an evaluation facility until the court issues a decision on the *ex parte* order. While the contours are not clearly defined as far as I know, there is no doubt a constitutional limit on how long someone can be confined without judicial authorization. A similar defect exists in AS 47.30.805(a)(1)—there is a constitutional limit to how long a person may be confined before a judicial determination that involuntary commitment is warranted.

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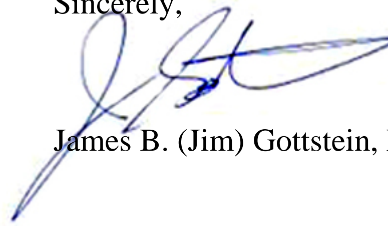
[18] "Probable cause" is also probably a constitutionally insufficient basis to confine someone for anything other than a short time for evaluation. Other than that the full due process protections outlined in *Kansas v. Crane* are required and the allegation the person is "mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others," must be proven by **clear and convincing evidence**. In particular, a decision under proposed subsection AS 47.30.708(g) to confine someone requires clear and convincing evidence.

[19] I will note, however, as relayed in Chapter 10 of my book *The Zyprexa Papers*, API staff have absolutely no idea of the requirements of AS 47.30.838 and violate its terms regularly. While this was 15 years ago I would be flabbergasted if people's rights under AS 47.30.838 are being respected.

Thank you for your consideration of these comments. I will be pleased to answer questions or otherwise assist as I can.

Sincerely,



James B. (Jim) Gottstein, Esq.

INVOLUNTARY COMMITMENT AND FORCED PSYCHIATRIC DRUGGING IN THE TRIAL COURTS: RIGHTS VIOLATIONS AS A MATTER OF COURSE

JAMES B. (JIM) GOTTSTEIN*

A commonly-held belief is that locking up and forcibly drugging people diagnosed with mental illness is in their best interests as well as society's as a whole. The truth is far different. Rather than protecting the public from harm, public safety is decreased. Rather than helping psychiatric respondents, many are greatly harmed. The evidence on this is clear. Constitutional, statutory, and judge-made law, if followed, would protect psychiatric respondents from being erroneously deprived of their freedom and right to decline psychiatric drugs.

However, lawyers representing psychiatric respondents, and judges hearing these cases uncritically reflect society's beliefs and do not engage in legitimate legal processes when conducting involuntarily commitment and forced drugging proceedings. By abandoning their core principle of zealous advocacy, lawyers representing psychiatric respondents interpose little, if any, defense and are not discovering and presenting to judges the evidence of the harm to their clients. By abandoning their core principle of being faithful to the law, judges have become instruments of oppression, rather than protectors of the rights of the downtrodden. While this Article focuses on Alaska, similar processes may be found in other United States' jurisdictions, with only the details differing.

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* J.D., Harvard Law School (1978), Cambridge, Massachusetts; B.S., Finance, University of Oregon (1974), Eugene, Oregon. The author is the founder and current President of Law Project for Psychiatric Rights (PsychRights), where he works on a pro bono basis.

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I. INTRODUCTION

The Law Project for Psychiatric Rights ("PsychRights")[1] was founded to mount a strategic litigation campaign against forced psychiatric drugging and electroshock in the United States.[2] The impetus was the book *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*, by Robert Whitaker.[3] PsychRights recognized this as a possible roadmap for demonstrating to the courts that forced psychiatric drugging is not achieving its objectives but is, instead, inflicting massive amounts of harm.

It appears that prior to PsychRights's efforts, no involuntary commitment or forced drugging order was ever appealed in Alaska. The failure to prosecute any appeals and the lack of vigorous representation at the trial court level has led to virtually uncontested proceedings that can properly be characterized as shams. However, within a seven-month span, in appeals prosecuted by PsychRights, the Alaska Supreme Court issued two landmark opinions, *Myers v. Alaska Psychiatric Institute*[4] and *Wetherhorn v. Alaska Psychiatric Institute*.[5] *Myers* and *Wetherhorn* should force the State of Alaska to change how it administers its forced drugging program and should compel advocates of forced drugging patients to defend vigorously their client's constitutional and statutory rights. However, unless these decisions are honored in practice, psychiatric respondents' statutory and constitutional rights will continue to be violated.

1. PsychRights was founded by the author in late 2002.

2. As far as the author is aware, forced electroshock is not mandated by courts in Alaska. In 2006, due to what can only be considered an emergency, PsychRights adopted strategic litigation against the enormous and increasing amount of psychiatric drugging of children as a priority. Neither forced electroshock nor child drugging are addressed in this Article.

3. ROBERT WHITAKER, MAD IN AMERICA: BAD SCIENCE, BAD MEDICINE AND THE ENDURING MISTREATMENT OF THE MENTALLY ILL (2002).

4. 138 P.3d 238 (Alaska 2006).

5. 156 P.3d 371 (Alaska 2007).

This Article presents the scientific evidence and clinical realities not being submitted to the courts and weaves into this presentation ways in which psychiatric rights are being violated in Alaska—in spite of *Myers* and *Wetherhorn*—as a matter of course. Part II introduces *Myers* and *Wetherhorn*, focusing specifically on the Alaska Supreme Court's recognition of the limitations on the State's power to involuntarily commit and force drugs upon people found to be mentally ill. Part II also discusses the importance of these cases, both within and without the state of Alaska, but notes that they must be implemented in practice to be meaningful.

Part III presents the scientific evidence regarding the drugs most often given to those who have been committed, showing that the drugs are far less effective and far more harmful than commonly believed and that people who are not given them, or who manage to get off them, are far more likely to recover after being diagnosed with a serious mental illness. Within this scientific presentation, Part III describes less intrusive alternatives than forced drugging that produce far better outcomes.

Part IV and Part V provide necessary background material to understand the current rights violations in Alaska. Part IV gives an overview of United States Supreme Court cases establishing constitutional limits on involuntary commitment and court-ordered psychiatric drugging, including the requirements of proper procedures and evidentiary standards with respect to involuntary commitment. Part V outlines Alaska's statutory framework for involuntary commitment and court ordered psychiatric medication.

Part VI is a critique and description of ways in which current procedures, in Anchorage at least, systematically deprive people of their legal rights during involuntary commitment and forced drugging proceedings, and Part VII discusses ways in which proper evidentiary standards are not being followed. Part VIII presents two additional key areas that are systematically depriving people of their rights: the State of Alaska's failure to provide available less restrictive and less intrusive alternatives and the current lack of zealous representation, which, if corrected, would presumably result in people's rights being honored.

Finally, Part IX presents policy reasons why the State of Alaska should embrace a modality that minimizes force and coercion and provides the types of less restrictive and less intrusive alternatives that have been shown to dramatically improve outcomes. According to the data presented in Part III, this would result in at least halving the number of people diagnosed with mental illness on the disability rolls.

II. *MYERS* AND *WETHERHORN*

A. *Myers v. Alaska Psychiatric Institute*

Section 47.30.839(g) of the Alaska Statutes provides, in part, that in a non-emergency, where a mental health treatment facility has petitioned for authorization to administer psychotropic drugs against a person's will, "[i]f 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."[6]

In her appeal from a superior court order approving the "nonconsensual administration of psychotropic drugs," Faith Myers asserted the State must prove, under the Alaska Constitution and United States Constitution, that the forced drugging was in her best interest and there were no less intrusive alternatives regardless of whether she was competent to decline the drugs or not.[7] She introduced compelling evidence regarding the harms and lack of effectiveness caused by the drugs that the Alaska Psychiatric Institute (API) was seeking to force upon her, as well as viable alternatives.[8] The Alaska Supreme Court described this evidence as follows:

> The first [expert psychiatrist] testified that psychotropic medication is not the only viable treatment for schizophrenia. While acknowledging that psychotropic medications played an accepted role in the "standard of care for [the] treatment of psychosis," he advised that, because such drugs "have so many problems," they should be used "in as small a dose for as short a period of time as possible." Myers's second expert offered more specific testimony that one of the drugs that API proposed to administer to Myers—Zyprexa—was, despite being "widely prescribed," a "very dangerous" drug of "dubious efficacy." He based this testimony on a "methodological analysis" of the studies that led the food and drug administration [sic] to approve Zyprexa for clinical use.[9]

Although the superior court found it "troubling" that the "statutory scheme prevented it from considering the merits of API's treatment plan, or [from] weighing the objections of Myers's experts," the court had

6. ALASKA STAT. § 47.30.839(g) (2006).
7. *Myers*, 138 P.3d at 240–41.
8. *Id.* at 240.
9. *Id.*

approved the forced medication "[b]ecause it believed that the statute unambiguously limited the superior court's role 'to deciding whether Ms. Myers [had] sufficient capacity to give informed consent.'"[10]

Myers's assertion that it was unconstitutional to force psychiatric drugs on her flowed from a reading of the Alaska Constitution that being free from unwanted psychiatric drugging is a fundamental right.[11] The Alaska Supreme Court agreed with Myers, holding that freedom from unwanted drugging implicates fundamental liberty and privacy interests.[12] The court went on to note that "[w]hen a law places substantial burdens on the exercise of a fundamental right, we require the state to 'articulate a compelling [state] interest' and to demonstrate 'the absence of a less restrictive means to advance [that] interest.'"[13] Finally, the *Myers* Court held that although the police power does not provide a compelling state interest under non-emergency forced drugging cases, the assertion that these non-emergency actions are in the patient's best interest under the *parens patriae* doctrine does create such an interest in some situations.[14]

After discussing the significant negative side effects of the drugs, the Alaska Supreme Court agreed that the right to be free from unwanted psychotropic medications was "fundamental" under the Alaska Constitution[15] and stated that "the truly intrusive nature of psychotropic drugs may be best understood by appreciating that they are literally intended to alter the mind. Recognizing that purpose, many states have equated the intrusiveness of psychotropic medication with the intrusiveness of electroconvulsive therapy and psychosurgery."[16] Thus, the court held:

> [I]n future non-emergency cases[17] a court may not permit a treatment facility to administer psychotropic drugs unless the court makes findings that comply with all applicable statutory requirements and, in addition, expressly finds by clear and convincing evidence that the proposed treatment is in the

10. *Id.*
11. *Id.*
12. *Id.* at 246–48.
13. *Id.* at 245–46.
14. *See id.* at 248–49.
15. *See id.* at 246.
16. *Id.* at 242 (footnote omitted).
17. *See* ALASKA STAT. § 47.30.838 (2006) (addressing emergency situations).

> patient's best interests and that no less intrusive alternative is available.[18]

This passage states the core holding of *Myers*, although by no means the only important one. Other aspects of the decision are discussed below.

B. *Wetherhorn v. Alaska Psychiatric Institute*

In *Wetherhorn*, Roslyn Wetherhorn was involuntarily committed for being "gravely disabled" and subjected to a forced drugging order after a hearing that lasted approximately fifteen minutes.[19] She appealed, asserting a number of errors, including that one of the statutory definitions of "gravely disabled"[20] was an unconstitutional basis for involuntary commitment.[21]

Basing its decision on the Alaska Constitution, but citing to the "repeated admonition" by the United States Supreme Court that, "given the importance of the liberty right involved, a person may not be involuntarily committed if they 'are dangerous to no one and can live safely in freedom,'"[22] the Alaska Supreme Court held that committing someone considered gravely disabled pursuant to section 47.30.915(7)(B) of the Alaska Statutes "is constitutional if construed to require a level of incapacity so substantial that the respondent is *incapable of surviving safely in freedom.*"[23] The court declined to decide whether the facts on the record satisfied this standard because the case was moot,[24] leaving development of the standard for a future case. The court also upheld a number of other lower court actions under the "plain error" standard of review applicable

18. *Myers*, 138 P.3d at 254 (footnote added).
19. *See* Wetherhorn v. Alaska Psychiatric Inst., 156 P.3d 371, 374–75 (Alaska 2007).
20. Under section 47.30.915(7)(B) of the Alaska Statutes:

> "[G]ravely disabled" means a condition in which a person as a result of mental illness . . . 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.*

ALASKA STAT. § 47.30.915(7)(B) (2006) (emphasis added).
21. *Wetherhorn*, 156 P.3d at 376.
22. *Id.* at 377 (citing O'Connor v. Donaldson, 422 U.S. 563, 575 n.9 (1975)).
23. *Id.* at 384 (emphasis added).
24. *Id.* at 373–74, 384.

when issues were not raised below,[25] but in doing so injected some troubling dicta that will be discussed below.[26]

C. The Importance and Potential Impact of *Myers* and *Wetherhorn*

In the preface of the 2007 pocket section of his five-volume treatise on mental health law, noted scholar Michael Perlin stated the following:

> *Wetherhorn . . .* reflects how seriously that state's Supreme Court takes mental disability law issues. Last year, we characterized its decision in *Myers v. Alaska Psychiatric Institute*, as "the most important State Supreme Court decision" on the question of the right to refuse treatment in, perhaps two decades. This year, again, the same court continues along the same path, in this case looking not only at the "grave disability issue," but also building on its *Myers* decision.[27]

Unfortunately, appellate decisions affirming rights in this area are often ignored in practice. In other works, Michael Perlin has also noted that "the mental disability law system often deprives individuals of liberty disingenuously and upon bases that have no relationship to case law or to statutes"[28] and that "[a] right without a remedy is no right at all; worse, a right without a remedy is meretricious and pretextual—it gives the illusion of a right without any legitimate expectation that the right will be honored."[29]

The challenge posed by this Article is whether what Professor Perlin described as "how seriously [Alaska]'s Supreme Court takes mental disability law issues" will or will not be realized in practice.[30] Discussed below are a number of ways in which the actuality of involuntary commitment and forced medication proceedings do not comport with statutory and constitutional requirements. Unless and until these defects are corrected, psychiatric respondents' rights will continue to be violated in

25. *Id.* at 379, 383.
26. *See infra* Part VI.D–E.
27. 1 MICHAEL L. PERLIN & HEATHER ELLIS CUCOLO, *Preface* to MENTAL DISABILITY LAW: CIVIL AND CRIMINAL, at iii (2d ed. Supp. 2007) (footnotes omitted).
28. Michael Perlin, *The ADA and Persons with Mental Disabilities: Can Sanist Attitudes Be Undone?*, 8 J.L. & HEALTH 15, 34 (1993).
29. Michael Perlin, *"And My Best Friend, My Doctor/Won't Even Say What It Is I've Got": The Role And Significance Of Counsel In Right To Refuse Treatment Cases*, 42 SAN DIEGO L. REV. 735, 745–46 (2005).
30. PERLIN & CUCOLO, *supra* note 27, at iii.

Alaska's trial courts. As will be discussed in the next Part, the forced administration of psychotropic drugs is causing great harm.

III. PSYCHIATRIC DRUGS ARE EFFECTIVE FOR FEWER PATIENTS AND ARE MORE HARMFUL THAN COMMONLY BELIEVED

In *Myers* and *Wetherhorn*, the Alaska Supreme Court recognized that the drugs forced on psychiatric respondents have been equated with the intrusiveness of lobotomy and electroshock.[31] The following is a description of what they feel like to many:

> These drugs, in this family, do not calm or sedate the nerves. They attack. They attack from so deep inside you, you cannot locate the source of the pain. . . .
>
> . . . .
>
> . . . The muscles of your jawbone go berserk, so that you bite the inside of your mouth and your jaw locks and the pain throbs. For hours every day this will occur. Your spinal column stiffens so that you can hardly move your head or your neck and sometimes your back bends like a bow and you cannot stand up. The pain grinds into your fiber . . . . You ache with restlessness, so you feel you have to walk, to pace. And then as soon as you start pacing, the opposite occurs to you: you must sit and rest. Back and forth, up and down you go in pain you cannot locate; in such wretched anxiety you are overwhelmed, because you cannot get relief even in breathing.[32]

This Part examines the long-term medical effects of these drugs. Drawing substantially from an affidavit by Robert Whitaker filed in a September 2007 forced medication case,[33] the following presents evidence that the drugs cause a host of debilitating side effects, including the increased likelihood that those administered them will become chronically ill. It also presents the evidence that the newer drugs are no safer and have no greater efficacy than the older drugs. In sum, patients resisting these drugs are not crazy for doing so.

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31. *See* Myers v. Alaska Psychiatric Inst., 138 P.3d 238, 242 (Alaska 2006); *see also* Wetherhorn v. Alaska Psychiatric Inst., 156 P.3d 371, 382 (Alaska 2007).

32. JACK HENRY ABBOTT, IN THE BELLY OF THE BEAST: LETTERS FROM PRISON, 35–36 (1991) (emphasis omitted).

33. *See* Affidavit of Robert Whitaker, *In re William S. Bigley*, No. 3AN 07-1064 P/S (Alaska Super. Ct. Sept. 28, 2007).

A. Long-Term Effects of Neuroleptic Medications

Scientific support for the use of neuroleptics,[34] which is the class of drugs typically forced upon unwilling patients,[35] stems from two sets of studies. First, research by the National Institute of Mental Health (NIMH) has shown that the drugs are more effective than a placebo in curbing psychotic symptoms within a short span of time (six weeks).[36] Second, researchers have found that the more abruptly patients withdraw from neuroleptic medication, the higher their risk of relapse.[37]

In the early 1960s, the NIMH conducted a six-week study of 344 patients at nine hospitals that documented the efficacy of neuroleptics in decreasing psychosis.[38] The drug-treated patients fared better than the placebo patients at the end of six weeks.[39] However, when the NIMH investigators followed up on the patients one year later, they found, much to their surprise, that the drug-treated patients were more likely to have been re-hospitalized than those receiving a placebo.[40] This development was the first evidence of a paradox: drugs that were effective in curbing psychosis over the short term were making patients more likely to have additional psychotic episodes over the long term.

In the 1970s, the NIMH conducted three studies that compared neuroleptic treatment with "environmental" care that minimized use of the drugs. In each instance, patients treated without drugs did better over the long term than those treated in a conventional manner.[41] Those findings led

34. This class of drugs is also commonly referred to as "antipsychotics." *See, e.g.*, Sutherland v. Estate of Ritter, 959 So.2d 1004, 1006 n.3 (Miss. 2007) (referring to "neuroleptic (antipsychotic) drug therapy").

35. *See, e.g.*, Grant Morris, *Pursuing Justice for the Mentally Disabled*, 42 SAN DIEGO L. REV. 757, 772–74 (2005).

36. *See* Jonathan O. Cole et al., *Phenothiazine Treatment in Acute Schizophrenia,* 10 ARCHIVES GEN. PSYCHIATRY 246, 259–60 (1964) (noting that "[n]inety-five per cent of drug-treated patients showed some degree of improvement within six weeks—over [seventy-five percent] showed marked to moderate degrees of improvement," but "only [twenty-three percent] of the placebo group were rated as showing marked to moderate improvement").

37. *See* Patricia L. Gilbert et al., *Neuroleptic Withdrawal in Schizophrenic Patients*, 52 ARCHIVES GEN. PSYCHIATRY 173, 184–85 (1995).

38. *See* Cole et al., *supra* note 36, at 259–60.

39. *See id.*

40. *See* Nina R. Schooler et al., *One Year After Discharge: Community Adjustment of Schizophrenic Patients*, 123 AM. J. PSYCHIATRY 986, 991 (1967).

41. *See generally* John R. Bola et al., *Treatment of Acute Psychosis Without Neuroleptics: Two-Year Outcomes from the Soteria Project*, 191 J. NERVOUS & MENTAL DISEASE 219, 224–25 (2003); William T. Carpenter et al., *The Treatment of Acute Schizophrenia Without Drugs: An Investigation of Some Current Assumptions*, 134 AM. J.

NIMH scientist William Carpenter to suggest "that antipsychotic medication may make some schizophrenic patients more vulnerable to future relapse than would be the case in the natural course of their illness."[42] Studies have shown that, by blocking the brain's dopamine receptors, neuroleptics cause the brain to develop super-sensitivity to dopamine and, thus, a tendency toward psychotic symptoms.[43] Furthermore, neuroleptics cause morphological changes in the brain that have been associated with psychotic symptoms.[44]

As a number of studies document, long-term recovery rates are higher for patients off neuroleptic medications than for those on such medications.

In 1994, Courtenay Harding at Boston University reported on the long-term outcomes of eighty-two "chronic schizophrenics" discharged from

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PSYCHIATRY 14, 17–19 (1977); Maurice Rappaport et al., *Are There Schizophrenics for Whom Drugs May Be Unnecessary or Contraindicated?*, 13 INT'L PHARMACOPSYCHIATRY 100 (1978).

42. *See* Carpenter et al., *supra* note 41, at 19.

43. *See* Guy Chouinard et al., *Neuroleptic-Induced Supersensitivity Psychosis*, 135 AM. J. PSYCHIATRY 1409, 1410 (1978) ("[N]euroleptics can produce a dopamine supersensitivity that leads to both [an impairment in the ability to control movements, characterized by spasmodic or repetitive motions or lack of coordination] and psychotic symptoms. An implication is that the tendency toward psychotic relapse in a patient who has developed such supersensitivity is determined by more than just the normal course of the illness."); *see also* Guy Chouinard et al., *Neuroleptic-Induced Supersensitivity Psychosis: Clinical and Pharmacologic Characteristics*, 137 AM. J. PSYCHIATRY 16 (1980).

44. Magnetic Resonance Imaging (MRI) studies have powerfully confirmed this hypothesis. During the 1990s, several research teams reported that neuroleptic drugs cause atrophy of the cerebral cortex and an enlargement of the basal ganglia. *See* A.L. Madsen et al., *Neuroleptics in Progressive Structural Brain Abnormalities in Psychiatric Illness*, 352 THE LANCET 784, 784–85 (1998) ("Our study showed an unexpected effect of neuroleptic medication on cerebral cortex, but our analysis suggests that the results cannot be taken as accidental."). *But see* Raquel E. Gur et al., *A Follow-Up Magnetic Resonance Imaging Study of Schizophrenia: Relationship of Neuroanatomical Changes to Clinical and Neurobiological Measures*, 55 ARCHIVES GEN. PSYCHIATRY 145 (1998) (noting that changes observed in the brain were correlated with neuroleptic dose, but concluding that those changes could also have been caused by progression of patients' illness); Miranda H. Chakos et al., *Increase in Caudate Nuclei Volumes of First-Episode Schizophrenic Patients Taking Antipsychotic Drugs*, 151 AM. J. PSYCHIATRY 1430 (1994) (concluding that striatal enlargement in patients may have been connected to neuroleptic treatment or may have been illness-related). In 1998, investigators at the University of Pennsylvania reported that the drug-induced enlargement of the basal ganglia is associated with greater "severity of both negative and positive symptoms." Raquel Gur et al., *Subcortical MRI Volumes in Neuroleptic-Naive and Treated Patients with Schizophrenia*, 155 AM. J. PSYCHIATRY 1711, 1716 (1998). While these articles may indicate these brain changes might be due to the person having mental illness, no study of which the author is aware has demonstrated these brain changes occur in un-medicated patients.

Vermont State Hospital in the late 1950s.[45] She found that sixty-eight percent of this cohort showed no signs of schizophrenia at follow-up[46] and that these patients shared one characteristic: they had all stopped taking neuroleptic medication.[47]

In studies conducted by the World Health Organization, sixty-three percent of the schizophrenia patients studied in poor countries were asymptomatic after five years and only twenty-four percent were still chronically ill.[48] In the United States and other developed countries, only thirty-eight percent of patients were in full remission and the remaining patients did not fare so well.[49] In the undeveloped countries studied, only sixteen percent of patients were maintained on neuroleptics over the five years, versus sixty-one percent of patients in the developed countries.[50]

In response to this body of literature, physicians in Switzerland, Sweden, and Finland developed programs that minimize use of neuroleptic drugs. These programs have reported much better results in terms of eliminating schizophrenia symptoms than what is seen in the United States.[51] In particular, Jaako Seikkula recently reported that, using the open-dialogue approach, five years after initial diagnosis, eighty-two

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45. Courtenay M. Harding et al., *The Vermont Longitudinal Study of Persons with Severe Mental Illness, II: Long-Term Outcome of Subjects Who Retrospectively Met* DSM-III *Criteria for Schizophrenia*, 144 AM. J. PSYCHIATRY 727, 730 (1987).

46. *Id.*

47. *See* Patrick McGuire, *New Hope for People with Schizophrenia,* 31 MONITOR ON PSYCHOL. (2000), *available at* http://www.apa.org/monitor/feb00/schizophrenia.html ("Harding . . . notes that all of those in her Maine and Vermont studies who had fully recovered, had long since stopped taking medications.").

48. *See* WHITAKER, *supra* note 3, at 226–32 (describing the World Health Organization studies).

49. *See id.* at 230 Table 9.1.

50. *Id.*

51. *See generally* Luc Ciompi et al., *The Pilot Project 'Soteria Berne': Clinical Experiences and Results*, 161 BRIT. J. PSYCHIATRY SUPPL. 145 (1992) (reporting positive results from an experimental project providing alternatives to standard pharmacotherapy); J. Cullberg, *One-Year Outcome in First Episode Psychosis Patients in the Swedish Parachute Project*, 106 ACTA PSYCHIATRICA SCANDINAVICA 276 (2002) (reporting that schizophrenics treated by a "parachute" method, which involved fewer drugs than a historic group, had better functioning after one year than patients in the historic group); V. Lehtinen et al., *Two-Year Outcome in First-Episode Psychosis According to an Integrated Model,* 15 EUR. PSYCHIATRY 312 (2000) (reporting that an experimental group of patients with first-episode functional non-affective psychosis who received fewer drugs than a control group showed outcomes that were just as good or better than those in the control group two years after treatment, as measured by total time spent in the hospital, occurrence of psychotic symptoms during the last follow-up year, employment, GAF score and the Grip on Life assessment).

percent of his psychotic patients were free of psychotic symptoms, eighty-six percent returned to their jobs or studies, and only twenty-nine percent of his patients had used neuroleptic medications during the course of treatment.[52]

In the spring of 2007, researchers at the University of Illinois College of Medicine reported on the long-term outcomes of schizophrenia patients in the Chicago area since 1990.[53] After administering five-year and fifteen-year follow-up exams, they found that forty percent of those who did not take neuroleptic medications had recovered versus only five percent of the medicated patients.[54]

B. Harmful Effects from Neuroleptic Medications

In addition to making patients chronically ill, standard neuroleptic medicines cause a wide range of debilitating side effects, including tardive dyskinesia, akathisia, and emotional and cognitive impairment.

Tardive dyskinesia, which is usually caused by the heavy, long-term use of neuroleptics, is a Parkinsonism especially prevalent in psychiatric hospitals.[55] People suffering from tardive dyskinesia may have trouble walking, sitting still, eating, and speaking.[56] In addition, people with tardive dyskinesia show impaired nonverbal function.[57] Akathisia, which can also be caused by the use of neuroleptics, is an inner restlessness and anxiety that many patients describe as extremely tormenting.[58] This side effect has been linked to suicide[59] and assaultive behavior, including murder.[60]

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52. Jaakko Seikkula et al., *Five-Year Experience of First-Episode Nonaffective Psychosis in Open-Dialogue Approach: Treatment Principles, Follow-Up Outcomes, and Two Case Studies*, 16 PSYCHOTHERAPY RES. 214, 220–24 (2006).

53. Martin Harrow & Thomas H. Jobe, *Factors Involved in Outcome and Recovery in Schizophrenia Patients Not on Antipsychotic Medications: A 15-Year Multifollow-Up Study*, 195 J. NERVOUS & MENTAL DISEASE 406 (2007).

54. *Id.* at 409.

55. OXFORD MEDICAL PUBLICATIONS, TEXTBOOK OF ADVERSE DRUG REACTIONS 542–43 (D. M. Davies ed., 4th ed. 1991).

56. R. Yassa, *Functional Impairment in Tardive Dyskinesia: Medical and Psychosocial Dimensions*, 80 ACTA PSYCHIATRICA SCANDINAVICA 64, 65–66 (1989).

57. James Wade et al., *Factors Related to the Severity of Tardive Dyskinesia,* 23 BRAIN & COGNITION 71, 75 (1993).

58. Theodore Van Putten, *The Many Faces of Akathisia*, 16 COMPREHENSIVE PSYCHIATRY 43, 43–45 (1975); ABBOTT, *supra* note 32, at 35–36; WHITAKER, *supra* note 3, at 186–89.

59. *See* M. Katherine Shear et al., *Suicide Associated with Akathisia and Deport Fluphenazine Treatment*, 3 J. CLINICAL PSYCHOPHARMACOLOGY 235 (1982) (reporting

Emotional and cognitive impairment have also been linked to the use of neuroleptics. Many patients describe having zombie-like feelings while on neuroleptic medications.[61] In 1979, University of California at Los Angeles (UCLA) psychiatrists Theodore van Putten and James E. Spar reported that most patients on neuroleptics were spending their lives in "virtual solitude, either staring vacantly at television . . . or wandering aimlessly around the neighborhood, sometimes stopping for a nap on a lawn or a park bench."[62] Moreover, studies have found that neuroleptics may reduce one's capacity to learn and retain information.[63] As Duke University scientist Richard Keefe said in 1999, "[t]he results of several studies may be interpreted to suggest that typical antipsychotic medications actually prevent adequate learning effects and worsen motor skills, memory function, and executive abilities, such as problem solving and performance assessment."[64]

Other negative effects of standard neuroleptics include an increased incidence of blindness, fatal blood clots, arrhythmia, heat stroke, swollen breasts, leaking breasts, obesity, sexual dysfunction, skin rashes, and seizures.[65] Use of multiple anti-psychotics is also associated with early death.[66]

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two suicides of men with akathisia); WHITAKER, *supra* note 3, at 186–88 (relating stories in which akathisia was a contributing factor in suicide or thoughts of suicide).

60. Theodore Van Putten, *Behavioral Toxicity of Antipsychotic Drugs*, 48 J. CLINICAL PSYCHIATRY 13, 14 (1987); Igor I. Galynker & Deborah Nazarian, *Letters to the Editor: Akathisia as Violence,* 58 J. CLINICAL PSYCHIATRY 16, 31–32 (1997); J.N. Herrera, *High Potency Neuroleptics and Violence in Schizophrenics*, 176 J. NERVOUS & MENTAL DISEASE 558, 560–61 (1988); *see* WHITAKER, *supra* note 3, at 188–89 (telling the story of a man's "murderous explosion" while on neuroleptic medication).

61. WHITAKER, *supra* note 3, at 189–90.

62. Theodore Van Putten & James E. Spar, *The Board and Care Home: Does It Deserve a Bad Press?*, 30 HOSP. & COMMUNITY PSYCHIATRY 461, 461–62 (1979).

63. Richard S. Keefe et al., *Do Novel Antipsychotics Improve Cognition? A Report of a Meta-Analysis*, 29 PSYCHIATRIC ANNALS 623, 626 (1999) (conducting meta-analysis of fifteen studies to show link between anti-psychotics and cognitive functioning).

64. *Id.*

65. George W. Arana, *An Overview of Side Effects Caused by Typical Antipsychotics*, 61 J. CLINICAL PSYCHIATRY SUPPL. 5, 5–8 (2000).

66. John L. Waddington et al., *Mortality in Schizophrenia: Antipsychotic Polypharmarcy and Absence of Adjunctive Anticholinergics over the Course of a 10-Year Prospective Study*, 173 BRIT. J. PSYCHIATRY 325, 325 (1998); Matti Joukamaa et al., *Schizophrenia, Neuroleptic Medication and Mortality*, 188 BRIT. J. PSYCHIATRY 122, 124–25 (2006).

C. Atypical Neuroleptics Do Not Provide a Safer Alternative

The conventional wisdom today is that the "atypical" neuroleptics[67] promise enhanced efficacy and safety compared to the older drugs, such as Haldol, Thorazine, and others.[68] However, the new drugs have no such advantage, and there is evidence suggesting they may be worse than the old ones.

Risperdal (risperidone), which is manufactured by Janssen, was approved in late 1993.[69] After risperidone was approved, independent physicians conducted studies of the drug. They concluded that risperidone, in comparison to Haldol, caused a higher incidence of Parkinsonian symptoms[70] and had a greater adverse effect on eye movement.[71] Additionally, many patients stopped taking the drug, most frequently because it failed to reduce their psychotic symptoms.[72] Jeffrey Mattes, director of the Psychopharmacology Research Association, concluded in 1997: "It is possible, based on the available studies, that risperidone is not as effective as standard neuroleptics for typical positive symptoms."[73] Letters in medical journals linked risperidone to neuroleptic malignant

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67. Examples of atypical neuroleptics include Risperdal, Abilify, Zyprexa, and Seroquel.

68. *See, e.g.*, Jeffrey A. Lieberman et al., *Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia*, 353 NEW ENG. J. MED. 1209, 1210 (2005).

69. FDA CENTER FOR DRUG EVALUATION & RESEARCH, APPROVED DRUG PRODUCTS WITH THERAPEUTIC EQUIVALENCE EVALUATIONS 344 (28th ed. 2008) [hereinafter FDA APPROVED DRUG PRODUCTS]. Although it was hailed in the press as a "breakthrough" medication, the FDA reviewed clinical trial data and concluded that there was no evidence that this drug was better or safer than Haldol (haloperidol). WHITAKER, *supra* note 3, at 274–77. The FDA told Janssen: "We would consider any advertisement or promotion labeling for RISPERDAL false, misleading, or lacking fair balance under section 501 (a) and 502 (n) of the ACT if there is presentation of data that conveys the impression that risperidone is superior to haloperidol or any other marketed neuroleptic drug product with regard to safety or effectiveness." Letter from Robert Temple, Director, FDA Office of Drug Evaluation, to Janssen Research Foundation (Dec. 29, 1993) (obtained by Freedom of Information Act request).

70. Michael B. Knable et al., *Extrapyramidal Side Effects with Risperidone and Haloperidol at Comparable D2 Receptor Levels*, 75 PSYCHIATRY RESEARCH 91, 98 (1997).

71. John A. Sweeney et al., *Adverse Effects of Risperidone on Eye Movement Activity*, 16 NEUROPSYCHOPHARMACOLOGY 217, 217 (1997).

72. Renee L. Binder et al., *A Naturalistic Study of Clinical use of Risperidone*, 49 PSYCHIATRIC SERVICES 524, 525 (1998), *available at* http://psychservices.psychiatryonline.org/cgi/content/full/49/4/524.

73. Jeffrey Mattes, *Risperidone: How Good is the Evidence for Efficacy?* 23 SCHIZOPHRENIA BULLETIN 155, 157 (1997).

syndrome,[74] tardive dyskinesia,[75] tardive dystonia,[76] liver toxicity,[77] mania,[78] and an unusual disorder of the mouth called "rabbit syndrome."[79]

Zyprexa (olanzapine), which is manufactured by Eli Lilly, was approved by the Food and Drug Administration (FDA) in 1996.[80] However, in its review of the trial data for Zyprexa, the FDA noted that Eli Lilly had designed its studies in ways that were "biased against haloperidol," such as comparing multiple doses of Zyprexa with one dose of Haldol and not using "equieffective doses."[81] Twenty-two percent of the Zyprexa patients suffered a "serious" adverse event, compared to eighteen percent of the Haldol patients.[82] The clinical trials also revealed that Zyprexa patients gained nearly a pound per week in the short term.[83] Other problems in the Zyprexa patients included Parkinson's, akathisia, dystonia, hypotension, constipation, tachycardia, seizures, liver abnormalities, white-blood-cell disorders, and diabetic complications.[84] Moreover, two-thirds of the Zyprexa patients did not successfully complete the trials.[85]

Today, scientific circles are increasingly recognizing that the atypical neuroleptics are no better than the old drugs and may in fact be worse. For example, in 2000, a team of English researchers led by John Geddes at the University of Oxford reviewed results from fifty-two studies and 12,649

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74. Iman Bajjoka et al., *Risperidone-Induced Neuroleptic Malignant Syndrome*, 30 ANNALS AM. MED. 698, 698–700 (1997); Steven Singer et al., Letter to the Editor, *Two Cases of Risperidone-Induced Neuroleptic Malignant Syndrome*, 152 AM. J. PSYCHIATRY 1234, 1234 (1995).

75. Kyung Sue Hong et al., Letter to the Editor, *Risperidone-Induced Tardive Dyskinesia*, 156 AM. J. PSYCHIATRY 1290, 1290 (1999).

76. *See, e.g.*, L. Vercueil & J. Foucher, Letter to the Editor, *Risperidone-Induced Tardive Dystonia and Psychosis*, 353 LANCET 981, 981 (1999); M.O. Krebs, Letter to the Editor, *Tardive Dystonia Induced by Risperidone*, 44 CAN. J. PSYCHIATRY 507 (1999).

77. Matthew A. Fuller et al., *Risperidone-Associated Hepatotoxicity*, 16 J. CLINICAL PSYCHOPHARMACOLOGY 84, 84–85 (1996).

78. W. Craig Tomlinson, Letter to the Editor, *Risperidone and Mania*, 153 AM. J. PSYCHIATRY 132, 132–33 (1996).

79. Tomar Levin & Uriel Heresco-Levy, *Risperidone-Induced Rabbit Syndrome*, 9 EUR. NEUROPSYCHOPHARMACOLOGY 137, 137 (1999). Rabbit syndrome is characterized by "rapid, fine, rhythmic movements of the mouth . . . that mimic the chewing actions of a rabbit." *Id.*

80. FDA APPROVED DRUG PRODUCTS, *supra* note 69, at 305.

81. WHITAKER, *supra* note 3, at 280. *See* GRACE E. JACKSON, RETHINKING PSYCHIATRIC DRUGS: A GUIDE TO INFORMED CONSENT 198–99 (2005); Affidavit of Grace E. Jackson, *In re* Myers v. Alaska Psychiatric Inst., No. 3AN 03-277 P/S (Alaska Super. Ct. 2003).

82. WHITAKER, *supra* note 3, at 281.

83. *Id.*

84. *Id.*

85. *Id.* at 281.

patients.[86] They concluded that "[t]here is no clear evidence that atypical antipsychotics are more effective or are better tolerated than conventional antipsychotics."[87] They further noted that Janssen, Eli Lilly, and other manufacturers of atypicals had administered higher-than-recommended average doses of the older drugs in their clinical trials.[88] More recent studies have come to similar conclusions.[89]

There is also growing evidence suggesting that the newer, "atypical" neuroleptics may be linked to early death in patients. In a 2003 study of Irish schizophrenia patients, twenty-five of seventy-two patients (thirty-five percent) died over a period of seven and a half years,[90] leading the researchers to conclude that the risk of death for people diagnosed with schizophrenia had doubled since the introduction of the atypical neuroleptics.[91] In 2006, in the United States, the National Association of State Mental Health Program Directors published a study revealing that people diagnosed with serious mental illness are now dying twenty-five years earlier than the general population.[92]

D. Summary of Data on Neuroleptics

In summary, the research literature supports the following conclusions: (1) neuroleptics increase the likelihood that a person will become chronically ill; (2) long-term recovery rates are higher for non-medicated patients than for those who are maintained on neuroleptic drugs; (3)

86. John Geddes et al., *Atypical Antipsychotics in the Treatment of Schizophrenia: Systematic Overview and Meta-Regression Analysis*, 321 BRIT. MED. J. 1371, 1371 (2000).

87. *Id.*

88. *Id.* at 1374.

89. In 2005, a National Institute of Mental Health study found that there were "no significant differences" between the old drugs and the atypicals studied in terms of their efficacy or how long patients could tolerate the drugs before terminating use. Lieberman et al., *supra* note 68, at 1218. The scientists studied olanzapine, perphenazine, quetiapine, risperidone, and ziprasidone, and found that seventy-four percent of the 1432 patients in the study were unable to stay on the neuroleptics for eighteen months owing to the drugs' "inefficacy or intolerable side effects or for other reasons." *Id.* at 1209. In 2007, a study by the British government found that schizophrenia patients had a better quality of life when using the old drugs than when taking the new ones. L.M. Davies et al., *Cost-Effectiveness of First- v. Second-Generation Antipsychotic Drugs*, 191 BRIT. J. PSYCHIATRY 14, 16–17 (2007).

90. Maria G. Morgan et al., *Prospective Analysis of Premature Morbidity in Schizophrenia in Relation to Health Service Engagement*, 117 PSYCHIATRY RESEARCH 127, 130 (2003).

91. *Id.* at 132.

92. MORBIDITY AND MORTALITY IN PEOPLE WITH SERIOUS MENTAL ILLNESS 110 (Joe Parks et al. eds., 2006).

neuroleptics cause a host of debilitating physical, emotional, and cognitive side effects, and lead to early death; and (4) the newer, so-called "atypical" neuroleptics are neither safer nor more effective than old ones.

This scientific evidence shows it is incorrect to assume psychiatric respondents who do not want to take these drugs are making bad decisions. At the same time, it is not suggested here that people be prevented from obtaining them because some people find these drugs helpful. However, all patients and the judges hearing forced drugging cases should be told the truth about the drugs' effects and informed of the fact that other approaches to treatment often result in a better outcome.[93]

IV. UNITED STATES CONSTITUTIONAL RIGHTS WITH RESPECT TO INVOLUNTARY COMMITMENT

The United States Supreme Court has unequivocally declared involuntary commitment a "massive curtailment of liberty" requiring due process protection.[94] While the government does not have to prove its case beyond a reasonable doubt, it does have to prove it with more than a preponderance of the evidence.[95] Further, involuntary commitments are constitutional only when: "(1) 'the confinement takes place pursuant to proper procedures and evidentiary standards;' (2) there is a finding of 'dangerousness either to one's self or to others;' and (3) proof of dangerousness is 'coupled . . . with the proof of some additional factor, such as a "mental illness" or "mental abnormality."'"[96]

The Court has suggested that the inability to take care of oneself cannot be considered a sufficient finding of dangerousness, unless survival is at stake: "a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[97] In addition, "although never specifically endorsed by the [United States] Supreme Court in a case involving persons with mental disabilities," it also seems people may not constitutionally be involuntarily committed if there is a less restrictive alternative.[98]

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93. *See, e.g.*, Seikkula, *supra* note 52 (suggesting that an open-dialogue approach is effective in treating schizophrenia).

94. Humphrey v. Cady, 405 U.S. 504, 509 (1972).

95. Addington v. Texas, 441 U.S. 418, 432–33 (1979).

96. Kansas v. Crane, 534 U.S. 407, 409–10 (2002) (quoting Kansas v. Hendricks, 521 U.S. 346, 357–58 (2002)).

97. O'Connor v. Donaldson, 422 U.S. 563, 575–76 (1975).

98. PERLIN & CUCOLO, *supra* note 27, at § 2C–5.3.

In *Wetherhorn*, the Alaska Supreme Court cited to this line of cases, adopting the same standard, which allows involuntary commitment for being gravely disabled only when a person is unable to survive safely in freedom, but resting its decision on the Alaska Constitution.[99]

V. ALASKA'S STATUTORY FRAMEWORK

As section 47.30.655 of the Alaska Statutes states, the purpose behind the 1981 revisions to Alaska's civil commitment statutes "is to more adequately protect the legal rights of persons suffering from mental illness."[100] In passing the revisions, "[t]he legislature . . . attempted to balance the individual's constitutional right to physical liberty and the state's interest in protecting society from persons who are dangerous to others and protecting persons who are dangerous to themselves by providing due process safeguards at all stages of commitment proceedings."[101] This Part gives a brief overview of relevant portions of Alaska's provisions on committing people alleged to have mental illnesses.

Section 47.30.700 of the Alaska Statutes authorizes "any adult" to file a petition to have someone screened for mental illness by alleging the person is mentally ill and as a result "gravely disabled or to present a likelihood of serious harm to self or others."[102] After the evaluation, if the court believes that there is probable cause that the person is mentally ill and a danger to

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99. Wetherhorn v. Alaska Psychiatric Inst., 156 P.3d 371, 378 (Alaska 2007).

100. ALASKA STAT. § 47.30.655 (2006).

101. *Id.* The statute goes on to outline the "principles of modern mental health care [which] have guided this revision":

> 1. that persons be given every reasonable opportunity to accept voluntary treatment before involvement with the judicial system;
> 2. that persons be treated in the least restrictive alternative environment consistent with their treatment needs;
> 3. that treatment occur as promptly as possible and as close to the individual's home as possible;
> 4. that a system of mental health community facilities and supports be available;
> 5. that patients be informed of their rights and be informed of and allowed to participate in their treatment program as much as possible;
> 6. that persons who are mentally ill but not dangerous to others be committed only if there is a reasonable expectation of improving their mental condition.

Id.

102. ALASKA STAT. § 47.30.700 (2006) (emphasis added).

self or others or gravely disabled, the judge *may* have the person taken into custody and delivered to a hospital[103] by issuing an *ex parte* order.[104]

Section 47.30.705 of the Alaska Statutes authorizes what is known as a Police Officer Application.[105] Under this provision, any peace officer, physician, psychiatrist, or licensed clinical psychologist may cause another person to be taken into custody and delivered to a hospital, *without any court involvement at all*, if he has "probable cause to believe [the] person is suffering from mental illness and is gravely disabled or is likely to cause serious harm to self or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures [under section] 47.30.700 [of the Alaska Statutes]."[106] It should be noted that this section explicitly bars taking the person to jail or another correctional facility, except for protective custody purposes.[107] If a person detained for evaluation is to be held involuntarily for more than seventy-two hours from the time of arrival at the hospital, he is entitled to a court hearing on whether there is cause for detention within seventy-two hours of first meeting with evaluation personnel.[108]

Section 47.30.730 of the Alaska Statutes sets forth the requirements for an initial commitment petition, which may not last more than thirty days ("Thirty-Day Commitment Petition").[109] Among other requirements, the petition must "allege that the respondent is mentally ill and as a result is likely to cause harm to self or others or is gravely disabled,"[110] "list the facts and specific behavior of the respondent supporting the allegation,"[111] and "list the prospective witnesses who will testify in support of commitment or involuntary treatment."[112]

If the Thirty-Day Commitment Petition is granted, a ninety-day commitment may follow under section 47.30.740 of the Alaska Statutes.[113] In seeking a ninety-day commitment, "the professional person in charge" or his "professional designee" must file a petition for ninety-day

103. "Hospital" within this Article refers to any mental health facility that can provide mental health evaluation and treatment.
104. ALASKA STAT. § 47.30.700.
105. *See* ALASKA STAT. § 47.30.705(a) (2006).
106. *Id.*
107. *Id.*
108. ALASKA STAT. § 47.30.725(b) (2006).
109. ALASKA STAT. § 47.30.730 (2006).
110. ALASKA STAT. § 47.30.730(a)(1) (2006).
111. ALASKA STAT. § 47.30.730(a)(7) (2006).
112. ALASKA STAT. § 47.30.730(a)(6) (2006).
113. ALASKA STAT. § 47.30.740(a) (2006).

commitment before the initial thirty days expire.[114] If a ninety-day commitment is granted, an additional 180-day commitment may follow.[115] Petitions for 180-day commitments may continue one after the other, keeping the respondent committed.[116]

Although there is no statutory right to a jury trial for the thirty-day commitment, there is such a right for the 90- and 180-day commitment hearings.[117] Further, the final decision on a 90- or 180-day commitment must be reached within twenty days of filing the petition, or else the respondent must be released.[118] The twenty-day deadline may be extended for no more than ten days upon the request of the respondent.[119]

Hospitals may give a committed patient psychotropic drugs in non-crisis situations only if the patient (1) has the capacity to give informed consent and does consent; (2) has authorized use of such medication in an advance health care directive, including authorizing a surrogate decision-maker to consent; or (3) lacks the capacity to give informed consent as determined by the court, and the court orders the use of psychotropic medication.[120] Section 47.30.837 of the Alaska Statutes sets forth the criteria for determining whether a person has the capacity to give informed consent to either accept or decline the drugs.[121]

In a crisis situation, hospitals are authorized to administer drugs under very specific criteria and procedural protections, including limits on how long and the number of times the hospital may administer medication as the result of an emergency.[122]

The court may order administration of medication under section 47.30.839 of the Alaska Statutes.[123] If the court finds that the respondent lacks capacity (i.e., is incompetent) and never previously made known his position on taking such medication while competent, the statute provides that "the court shall approve the facility's proposed use of psychotropic medication."[124] The court must review any information that the patient's desire had "been expressed in a power of attorney, a living will, an

114. *Id.*
115. ALASKA STAT. § 47.30.770(a) (2006).
116. ALASKA STAT. § 47.30.770(b) (2006).
117. ALASKA STAT. § 47.30.745(c) (2006); ALASKA STAT. § 47.30.770(b).
118. ALASKA STAT. § 47.30.745(g) (2006); ALASKA STAT. § 47.30.770(b).
119. ALASKA STAT. § 47.30.745(g).
120. ALASKA STAT. § 47.30.836 (2006).
121. ALASKA STAT. § 47.30.837(a) (2006).
122. ALASKA STAT. § 47.30.838 (2006).
123. ALASKA STAT. § 47.30.839 (2006).
124. ALASKA STAT. § 47.30.839(g) (2006).

advance health care directive . . . , or oral statements of the patient[.]"[125]Additionally, a court visitor is appointed to assist the court in determining the respondent's capacity when a hospital files a petition for court-ordered administration of medication,[126] and the respondent is entitled to his own attorney or an appointed public defender.[127] In *Myers*, the Alaska Supreme Court held that, under the Alaska Constitution, application of this statute required findings by the court that the proposed medication is in the respondent's best interest and that no less intrusive alternative is available.[128]

VI. CRITIQUE OF CERTAIN CURRENT PROCEDURES

As already noted, involuntary commitment is constitutionally permissible only if it takes place pursuant to proper procedures.[129] Presumably the same is true with respect to court-ordered drugging because it also involves infringement of a fundamental constitutional right.[130]

A. *Ex Parte* Orders: Ministerial-Like Issuance of *Ex Parte* Orders Violates Due Process and the Express Mandate of the Alaska Statutes

It is the author's experience that, at least in Anchorage, judges uniformly issue *ex parte* orders to have respondents taken into custody and delivered to the hospital solely upon the filing of petitions under section 47.30.700 of the Alaska Statutes. When such a petition is filed, *ex parte* orders are issued as a ministerial act, without any apparent inquiry as to the validity of the alleged facts or any apparent consideration of whether the alleged facts justify issuance. In doing so, a form is used which recites the statutory requirements as follows:

125. ALASKA STAT. § 47.30.839(d)(2) (2006).
126. ALASKA STAT. § 47.30.839(d).
127. ALASKA STAT. § 47.30.839(c) (2006).
128. Myers v. Alaska Psychiatric Inst., 138 P.3d 238, 254 (Alaska 2006).
129. *See supra* Part IV.
130. *See Myers*, 138 P.3d at 247 ("Because psychotropic medication can have profound and lasting negative effects on a patient's mind and body, we now similarly hold that Alaska's statutory provisions permitting nonconsensual treatment with psychotropic medications implicate fundamental liberty and privacy interests.").

> Having considered the allegations of the petition for initiation of involuntary commitment and the evidence presented, the court finds that there is probable cause to believe that the respondent is mentally ill and as a result of that condition is gravely disabled or presents a likelihood of causing serious harm to him/herself or others.[131]

This ministerial-like issuance of *ex parte* orders is disturbing because it violates due process, violates the express terms of the Alaska Statutes, and is counter-therapeutic.

First, meaningful notice and a meaningful opportunity to be heard are the hallmarks of procedural due process.[132] Thus, while emergency circumstances in specific cases may justify an *ex parte* order, *ex parte* orders under section 47.30.700 of the Alaska Statutes in non-emergency situations appear to be unconstitutional in Alaska.[133] The unconstitutionality of non-emergency *ex parte* orders was explicitly recognized by the Washington Supreme Court.[134]

The Alaska Supreme Court has held, with respect to property interests, that only when most or all of a class of cases involve exigent circumstances may the State always proceed *ex parte*.[135] Nothing justifies dispensing with notice and an opportunity to be heard in the whole class of cases in which a

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131. *See* Excerpt of Record at 4, Wetherhorn v. Alaska Psychiatric Inst., 156 P.3d 371 (Alaska 2007) (No. S-11939), *available at* http://psychrights.org/States/Alaska/CaseFour/Excerpt.pdf (including a copy of the *ex parte* order from the Wetherhorn case).

132. *See, e.g.*, Hamdi v. Rumsfeld, 542 U.S. 507, 533 (2004). The Court in *Hamdi* stated that:

> 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.'" (quoting Fuentes v. Shevin, 407 U.S. 67, 80 (1972) (other citations omitted)).

Id.

133. *See* Hoffman v. State, 834 P.2d 1218, 1219 (Alaska 1992) ("We have consistently held that, except in emergencies, due process requires the State to afford a person an opportunity for a hearing *before* the State deprives that person of a protected property interest." (citing Graham v. State, 633 P.2d 211, 216 (Alaska 1981))).

134. *In re* Harris, 654 P.2d 109, 113 (Wash. 1982) ("The danger must be impending to justify detention without prior process.").

135. Waiste v. State, 10 P.3d 1141, 1145–46 (Alaska 2000).

mental evaluation is sought.[136] Even if *ex parte* orders were to be permitted in this whole class of cases, the court must perform its adjudicatory duties—indeed it must do so with a heightened punctilio—because the respondent has no opportunity to contest the evidence. This heightened standard is analogous to the search warrant situation.[137]

Second, the issuance of *ex parte* orders prior to completion of the screening does not comport with the Alaska Statutes. Under the express language of section 47.30.700(a), a judge must immediately conduct a screening investigation after an application is filed: "Within 48 hours *after* the completion of the screening investigation," the court "*may* issue an *ex parte* order" and have the person taken into custody and delivered to an inpatient psychiatric facility.[138] To have the person taken into custody, the Alaska Statutes require the court to provide findings that the person is mentally ill and is either gravely disabled or likely to harm himself or others.[139] Under the *Waiste* and *Hoffman* rationales, there must be a particularized set of findings justifying the granting of an *ex parte* order based on the specific facts in each case. Presumably, these specific facts are those developed in the required screening investigation that must occur prior to any *ex parte* order being issued. Apart from failing to provide factual findings applicable to the petition, it is the author's experience that the *ex parte* orders being issued in Anchorage fail to give any justification for dispensing with notice and with an opportunity to be heard.

The issuance of *ex parte* orders is also harmful to respondents. When the police pick someone up on an *ex parte* order, they are usually, if not always, handcuffed, which is harmful in itself.[140] Often, these individuals are already experiencing great fear, and this exacerbates that feeling. Even if others believe the fears are unfounded (i.e., the person is labeled as paranoid), the fears are real to the people that are taken by the police.

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136. *Cf. id.*

137. *See, e.g.*, Keller v. State, 543 P.2d 1211, 1215 (Alaska 1975) ("It is imperative that a magistrate be presented with adequate supporting facts, rather than mere affirmations of suspicion or belief."); State v. Malkin, 772 P.2d 943, 947 (Alaska 1986) ("[J]udicial officer has the . . . duty to make a searching inquiry as to the validity of the facts."); State v. Davenport, 510 P.2d 78, 82 (Alaska 1973) ("[C]ourts must be willing to investigate the truthfulness of the material allegations of the underlying affidavit in order to protect against the issuance of search warrants based on conjured assertions of probable cause.").

138. ALASKA STAT. § 47.30.700(a) (2006) (emphasis added).

139. *Id.*

140. *See* Karen J. Cusack et al., *Trauma Within The Psychiatric Setting: A Preliminary Empirical Report*, 30 ADMIN. AND POL'Y IN MENTAL HEALTH 453, 457 (2003).

Without notice and other constitutionally required procedural protections, such procedures tend to reinforce the belief in the minds of many individuals with mental illnesses that others are "out to get them." Instead of automatically taking a person into custody through the use or display of force when there are concerns about their behavior, someone should go and talk to the person, explain the concerns, and work on de-escalating the situation. Inquiry should be made into what difficulties the person might be experiencing, and, if possible, assistance should be offered. Failing to do so is inconsistent with section 47.30.655 of the Alaska Statutes.[141]

Testimony of Dr. Loren Mosher in the *Myers* case supports the conclusion that judicial involvement should be limited to the absolute minimum possible. As Dr. Mosher explained, involuntary treatment should be "difficult to implement and used only in the direst of circumstances."[142] Rather than forcing patients to conform, the therapeutic imperative is that doctors must build trusting relationships with patients. To this end, Dr. Mosher testified that:

> [I]n the field of psychiatry, it is the therapeutic relationship which is the single most important thing. . . . Now, if because of some altered state of consciousness, somebody is about to do themselves grievous harm or someone else grievous harm, well then, I would stop them in whatever way I needed to. . . . In my career *I have never committed anyone*. . . . I make it my business to form the kind of relationship [through which the mentally ill person and I] can establish a [sic] ongoing treatment plan that is acceptable to both of us.[143]

Thus, in forty years of psychiatric practice working with the most psychotic patients, Dr. Mosher never had to commit anyone because he talked to his patients and established a relationship based on trust, rather than the

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141. *See* ALASKA STAT. § 47.30.655(1)–(6) (2006).

142. Transcript of Record at 176, *In re* Myers v. Alaska Psychiatric Inst., No. 3AN 03-277 P/S (Alaska Super. Ct. 2003), *available at* http://psychrights.org/States/Alaska/CaseOne/30-Day/3-5and10-03transcript.htm. Dr. Mosher is a board-certified psychiatrist who received his undergraduate degree from Stanford University, medical degree from Harvard University Medical School, and was the former Chief of the National Institute of Mental Health's Center for the Study of Schizophrenia. *Id.* at 171–72. When asked whether he had much experience with un-medicated people experiencing psychosis, he replied, "Oh, dear. I probably am 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." *Id.* at 178.

143. *Id.* at 177 (emphasis added).

power to force. Ordering a person to be taken into custody and admitted to a hospital through a ministerial-like entry also precludes the opportunity to defuse, de-escalate, and resolve the situation without resort to more judicial proceedings and force.

Ultimately, prospective hospital inmates[144] should have the opportunity to address people's concerns before being taken into custody. In addition to it being the right thing to do, providing the opportunity to be heard is required by the Due Process clauses of the United States and Alaska Constitutions.[145]

B. Examination

Section 47.30.710 of the Alaska Statutes pertains to the evaluation of persons already delivered to a hospital pursuant to subsections 700–705.[146] It includes a provision that directs the evaluator to apply for an *ex parte* order if the evaluator has reason to believe the person should be hospitalized on an emergency basis and there has not yet been a judicial order under subsection 700.[147] However, since the person is already in custody there is no exigency justifying *ex parte* proceedings and thus no reason why this section should pass constitutional muster under the Due Process Clause.[148]

C. Notice of Rights and Filing Petitions

Section 47.30.725(a) of the Alaska Statutes provides that "[w]hen a respondent is detained for evaluation under sections 47.30.660–47.30.915, the respondent shall be *immediately notified* orally and in writing of the rights under this section."[149] In the event a petition for commitment is subsequently filed, section 47.30.730(b) of the Alaska Statutes provides that "[a] copy of the petition shall be served on the respondent, the respondent's attorney, and the respondent's guardian, if any, before the 30-day commitment hearing."[150]

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144. "Inmate" 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." AMERICAN HERITAGE DICTIONARY (4th ed. 2000).
145. *See supra* Part IV.
146. ALASKA STAT. § 47.30.710 (2006).
147. ALASKA STAT. § 47.30.710(b) (2006).
148. *See* Hoffman v. State, 834 P.2d 1218, 1219 (Alaska 1992).
149. ALASKA STAT. § 47.30.725(a) (2006) (emphasis added).
150. ALASKA STAT. § 47.30.730(b) (2006).

It is not uncommon, if not standard practice, for the Alaska Psychiatric Institute (API) to wait until just before the involuntary commitment hearing to serve the respondent with either of these notices. The treatment of the appellant in *Wetherhorn* provides an example; she was brought to the hospital late on April 4, 2005, or early on April 5, 2005, and a petition for involuntary commitment was filed that same day.[151] However, she was served with neither the notice of rights required to be given "immediately" when brought to the hospital, nor the petition for commitment, until an hour before the scheduled hearing three days later.[152] By waiting to provide notice, respondents are denied a meaningful opportunity to prepare a defense and are effectively prevented from obtaining a non-public defender attorney.

D. List of Facts and Specific Behavior

The hallmark requirements of the Due Process Clause of the United States Constitution include the right to have "notice of the factual basis of claims" made against oneself and "a fair opportunity to rebut the Government's factual assertions before a neutral decisionmaker."[153] Section 47.30.730(a)(7) of the Alaska Statutes requires that a petition for involuntary commitment "list the facts and specific behavior of the respondent supporting the allegation" that "the respondent is mentally ill and as a result is likely to cause harm to self or others or is gravely disabled."[154]

In *Wetherhorn*, the only specific behavior cited to justify the petition was "[m]anic state homeless and non-medication compliant x 3 months."[155] Since these facts do not support the allegation that Ms. Wetherhorn was a

151. Excerpt of Record at 1–3, Wetherhorn v. Alaska Psychiatric Inst., 156 P.3d 371 (Alaska 2005) (No. S-11939), *available at* http://psychrights.org/States/Alaska/CaseFour/Excerpt.pdf.

152. *Id.* at 8–11. The hearing was ultimately continued for a week, but not because of any complaint about lack of notice by the assistant public defender assigned to represent Ms. Wetherhorn. It is the author's understanding that the assistant public defenders handling these cases are often served with the petitions the day of the hearing and that there is no preparation other than a brief conference with the respondent just prior to the hearing.

153. Hamdi v. Rumsfeld, 542 U.S. 507, 533 (2004) (citing Cleveland Bd. of Educ. v. Loudermill, 470 U.S. 532, 542 (1985) (other citations omitted)).

154. ALASKA STAT. § 47.30.730(a)(7) (2006).

155. Transcript of Record at 2, Wetherhorn v. Alaska Psychiatric Inst., 156 P.3d 371 (Alaska 2005) (No. S-11939), *available at* http://psychrights.org/States/Alaska/CaseFour/Excerpt.pdf.

threat to herself or others, or that she was gravely disabled, it does not appear these allegations were sufficient to support the petition.[156] The assistant public defender representing Wetherhorn at the hearing did not object to the insufficiency of the petition, but it was raised by PsychRights on appeal.[157] Because the issue was not raised below, the Supreme Court of Alaska applied the plain error standard, requiring a "high likelihood that injustice has resulted" in order to overturn the lower court's decision.[158] Unfortunately, the court went on to state in dicta:

> Wetherhorn's proposed requirements go far beyond what Alaska statutes require. Alaska Statute 47.30.730(a)(7) merely requires that the petition allege "facts and specific behavior" supporting the conclusion that the respondent meets the standards for commitment and does not articulate the standard by which the sufficiency of the facts and behavior listed is to be judged. And because whether a person is actually committed depends on the hearing, not on the petition standing alone, there is no reason to require that the petition summarize all the evidence or be sufficient in itself to entitle the petitioner to a grant of the petition as a matter of law.[159]

This dicta misses the point that failure to provide the factual assertions justifying commitment does not allow a psychiatric respondent a meaningful opportunity to defend against the petition. This conclusion is particularly true because of the extremely short time frame mandated.[160]

In other civil cases, the pleading must include allegations sufficient to state a claim upon which relief can be granted or be subject to dismissal.[161] The same is true for criminal cases: if a defendant is not arrested under warrant, a judicial officer must determine if the person was arrested with probable cause, as evidenced by the complaint, affidavits filed with the

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156. *See* ALASKA STAT. § 47.370.730(a) (requiring that a petition for commitment allege that a person is either a threat to self or others or is gravely disabled and that facts or specific behavior supporting that allegation be listed).

157. Wetherhorn v. Alaska Psychiatric Inst., 156 P.3d 371, 380 (Alaska 2007).

158. *Id.* at 379–80.

159. *Id.* (citing ALASKA STAT. § 47.30.735(c) (2006)).

160. *See* ALASKA STAT. § 47.30.725(b) (2006) (entitling respondent to a hearing in order to determine whether there is cause for detention within seventy-two hours); ALASKA STAT. § 47.30.725(f) (2006) (allowing a respondent, if represented by counsel, to waive the seventy-two hour limit and to set a hearing date for no more than seven calendar days after arrival at the hospital).

161. *See, e.g.*, ALASKA R. CIV. P. 12(b)(6).

complaint, oral statements from the arresting officer, or oral statements by another person recorded by the judicial officer.[162]

Similarly, a psychiatric respondent should be provided the alleged factual basis justifying his detention in order to have a meaningful opportunity to be heard. If involuntary commitment respondents are not entitled to know what alleged facts will be used to justify their confinement, the Alaska Supreme Court will have carved out an exception to the otherwise universal elimination of ambush litigation embraced in the United States after the promulgation of the Federal Rules of Civil Procedure in 1938. The "massive curtailment of liberty" represented by involuntary commitment,[163] and the short time frames involved, make the prejudice extreme if the petition does not provide factual allegations legally sufficient to justify the psychiatric incarceration requested. Therefore, it is suggested here that the Alaska Supreme Court's affirmance of the *Wetherhorn* petition can only be understood in the context of the failure to raise the issue at the trial court level and that, on appeal, Wetherhorn did not show that failure resulted in a high likelihood that injustice resulted under the plain error standard of review.

E. List of Prospective Witnesses

Section 47.30.730(a)(6) of the Alaska Statutes requires that the commitment petition list the prospective witnesses who will testify in support of commitment.[164] In the *Wetherhorn* case, no prospective witnesses were listed on the petition.[165] Again, this problem was raised for the first time on appeal.[166] After acknowledging that the failure to list witnesses was a clear violation of the statute, the court held that the failure did not amount to plain error:

> [I]t is unclear what prejudice resulted from the failure to list witnesses in this case. Here, the petition for thirty-day commitment was signed by two API physicians and the only witness testifying before the hearing was another API physician. As API puts it, "[t]hat a psychiatrist from API would testify in

162. ALASKA R. CRIM. P. 5(d)(1).
163. *Wetherhorn*, 156 P.3d at 378.
164. ALASKA STAT. § 47.30.730(a)(6) (2006).
165. Excerpt of Record at 6, Wetherhorn v. Alaska Psychiatric Inst., 156 P.3d 371 (Alaska 2005) (No. S-11939), *available at* http://psychrights.org/States/Alaska/CaseFour/Excerpt.pdf.
166. *Wetherhorn*, 156 P.3d at 379.

> support of a petition initiated by API could surprise no one." We therefore conclude that the failure to list witnesses in this case does not constitute plain error.[167]

Here, the court was more explicit that the basis for affirmance was the failure to meet the plain error standard. Even so, it is troubling that, in dicta, the court would agree with the hospital that respondents should know that a psychiatrist from API would testify.[168] The court, in fact, missed the point: respondents cannot adequately prepare if they must guess which psychiatrist is going to testify. It is also troubling if the court has blessed total non-compliance with the statutory requirement that the prospective witnesses be listed[169] by affirming the petition in *Wetherhorn* that listed no witnesses.[170] Thus, as with specifying the factual basis of the petition discussed in the previous section, it is suggested here that the Alaska Supreme Court's affirmance of the *Wetherhorn* petition's failure to list *any witnesses* can only be understood in the context of the failure to raise the issue at the trial court level, and that, on appeal, Wetherhorn did not show that failure resulted in a high likelihood that injustice had occurred under the plain error standard of review.

F. Court-Ordered Administration of Medication

1. Best Interests. In *Myers*, the Supreme Court of Alaska required the additional element that the proposed medication be in the best interest of the respondent.[171] However, almost two years later, the forced medication petitions that are filed fail to comply with this requirement.

In making the best interest determination, the court in *Myers* held that "[e]valuating whether a proposed course of psychotropic medication is in the best interests of a patient . . . at a minimum [requires] that courts should consider the information that our statutes direct the treatment facility to give to its patients in order to ensure the patient's ability to make an informed treatment choice."[172] The court then noted that it found

167. *Id.*
168. *See id.*
169. *See* ALASKA STAT. § 47.30.730(a)(6) (2006).
170. Excerpt of Record at 6, Wetherhorn v. Alaska Psychiatric Inst., 156 P.3d 371 (Alaska 2005) (No. S-11939), *available at* http://psychrights.org/States/Alaska/CaseFour/Excerpt.pdf.
171. Myers v. Alaska Psychiatric Inst., 138 P.3d 238, 254 (Alaska 2006).
172. *Id.* at 252. The court then recited that this included the following information under section 47.30.837(d)(2) of the Alaska Statutes:

helpful the Supreme Court of Minnesota's holding that courts must balance a "patient's need for treatment against the intrusiveness of the prescribed treatment" in order to determine whether a court should order the forced administration of medical treatment and its approach sensible.[173]

If requiring the trial court to find forced drugging to be in the respondent's best interest is to have any meaning, the hospital has to present evidence with respect to the foregoing and respondents have the right to a meaningful opportunity to contest it. Thus, petitions for forced medication should include sufficient factual allegations as to the respondent's best interests to justify the relief requested.

2. "Two-Step" Procedure Required by Myers & Wetherhorn. In *Myers*, the Alaska Supreme Court held that involuntary commitments and court-ordered forced medication are two separate steps: "To treat an unwilling and involuntarily committed mental patient with psychotropic medication, the state must initiate the second step of the process by filing a second

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

Id. (quoting ALASKA STAT. § 47.30.837(d)(2) (2006)).

173. *Myers*, 138 P.3d at 252 (quoting Price v. Sheppard, 239 N.W.2d 905, 913 (Minn. 1976)). The specific factors Minnesota courts consider, which the Alaska Supreme Court found sensible, are:

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

Meyers, 138 P.3d at 252.

petition, asking the court to approve the treatment it proposes to give."[174] This principle was reiterated and explained as follows in *Wetherhorn*:

> Unlike involuntary commitment petitions, there is no statutory requirement that a hearing be held on a petition for the involuntary administration of psychotropic drugs within seventy-two hours of a respondent's initial detention. The expedited process required for involuntary commitment proceedings is aimed at mitigating the infringement of the respondent's liberty rights that begins the moment the respondent is detained involuntarily. In contrast, so long as no drugs have been administered, the rights to liberty and privacy implicated by the right to refuse psychotropic medications remain intact. Therefore, in the absence of an emergency, *there is no reason why the statutory protections should be neglected in the interests of speed.*[175]

The supreme court's explicit direction was ignored in a September 2007 forced drugging case under section 47.30.839 of the Alaska Statutes. Both the hospital's attorney and the Probate Master to whom the case was referred through a standing order insisted that the proceeding be completed on an expedited basis.[176]

Not only is it mandatory that trial courts comply with the direction that careful consideration of court-ordered administration of medication not be compromised in the interest of speed, it is also very beneficial to respondents. Programs that medicate all patients immediately regardless of patient input are not optimal for treating people diagnosed with serious mental illness, nor are those that eschew drugs altogether; rather, the most successful treatment programs *selectively* use drugs on a voluntary basis after other efforts have failed.[177] In other words, the most successful programs first try non-drug approaches, giving the patient the opportunity to recover without resorting to use of these problematic drugs. Thus, not only is a more deliberate approach to deciding whether to authorize

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174. *Id.* at 242–43.

175. Wetherhorn v. Alaska Psychiatric Inst., 156 P.3d 371, 381 (Alaska 2007) (footnotes omitted) (emphasis added).

176. *See* Transcript of Proceedings, *In re* W.S.B., No. 3AN 07-1064 PR, p.14 (Aug. 31, 2007), *available at* http://psychrights.org/states/Alaska/CaseXX/3AN-07-1064PS/070831BBTranscript.pdf; Transcript of Proceedings, *In re* W.S.B., No. 3AN 07-1064 PR, pp 16–18, 23 (Sept. 5, 2007), *available at* http://psychrights.org/states/Alaska/CaseXX/3AN-07-1064PS/070905TBBTranscript.pdf.

177. *See supra* text accompanying notes 51–52.

administration of medication in the courts mandated by *Myers*, it also benefits many respondents by allowing those who may not need the drugs the opportunity to recover. The evidence suggests that if this procedure is followed with the employment of less intrusive alternatives, such as those exemplified in these programs, *chronicity could be at least halved*.[178]

G. Right to Have the Hearings and Court Records Open to the Public

Parties to civil proceedings have the constitutional free speech right to have the proceeding open to the public, and the public has its own free speech right of access to civil proceedings.[179] Like other fundamental constitutional rights, this free speech right of access can be overridden only by a showing of an important or compelling countervailing governmental interest and that there are no less restrictive alternatives.[180] There is also a common law right of public access to civil trials.[181] In short, "[a] trial is a public event. What transpires in the court room is public property."[182] However, these common law rights can also be overridden in certain circumstances, such as to protect privacy interests[183] and to ensure the integrity of the adjudicatory process.[184]

People who have jobs or go to school, have relationships and reputations to protect, etc., have good reason to want to keep involuntary commitment and forced drugging proceedings confidential. However, many other psychiatric respondents, especially those who no longer have any reputation to protect, want the world to know what is happening to them. That is their right.

Section 47.30.735(b)(3) of the Alaska Statutes provides that in commitment hearings, respondents have the right "to have the hearing open or closed to the public as the respondent elects."[185] There is no default provision that the hearing be either open or closed. Under the statute, the election is required to determine whether the commitment hearing is to be

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178. *See, e.g.*, Harrow & Jobe, *supra* note 53, at 409.
179. Westmoreland v. Columbia Broad. Sys., 752 F.2d 16, 21–22 (2d Cir. 1984).
180. Publicker Indus., Inc. v. Cohen, 733 F.2d 1059, 1070 (3d Cir. 1984).
181. Nixon v. Warner Communications, 435 U.S. 589, 597 (1978).
182. Craig v. Harney, 331 U.S. 367, 374 (1947).
183. North Jersey Media Group, Inc. v. Ashcroft, 308 F.3d 198, 224 n.10 (3d Cir. 2002) (Scirica, J., dissenting).
184. *See* Gentile v. State Bar of Nev., 501 U.S. 1030, 1075–76 (1991).
185. ALASKA STAT. § 47.30.735(b)(3) (2006). This right is incorporated into the 90- and 180-day commitment hearings pursuant to section 47.30.745(a) and section 47.20.770(b) of the Alaska Statutes.

open or closed.[186] However, until PsychRights began representing psychiatric respondents in involuntary commitment cases, the author knows of no case in which an involuntary commitment respondent was asked to make the required election and as far as the author knows all commitment hearings under the current statute have been closed to the public.[187]

It seems that to make an election to have the hearing open to the public meaningful: (1) the *required election* must be made sufficiently in advance of the hearing and (2) the hearing cannot be conducted behind the locked doors of API.

With respect to forced drugging hearings, there is no statutory authority to close them to the public. Any authority to do so must therefore derive from some other source. There are sound privacy reasons why a respondent's request to close a forced drugging hearing justifies an exception to the rule that court hearings are open to the public. By the same token, however, if a respondent desires to have a forced drugging proceeding open to the public, that seems virtually to be an absolute right. In involuntary commitment (and forced drugging) cases, the only cognizable interest in confidentiality is that of the psychiatric respondents. Therefore, if a respondent wants the court proceedings open to the public, this must be honored. One of the prime reasons for the right of public access is to "[keep] a watchful eye on the workings of public agencies," including the courts.[188] The conduct of these proceedings behind locked doors for almost fifty years is one of the reasons they have strayed so far from proper procedures, resulting in pervasive rights violations.

It seems self-evident that an election to have the "hearing" open to the public includes the court file. Towards this end, one of the cases cited with approval in *Nixon* is *State ex rel Williston Herald*, in which the court held the right to have a "hearing" open to the public necessarily includes access to the court file, subject to reasonable regulation.[189] However, in a

186. Circumstances can be conceived in which the public's constitutional and/or common law rights in having a commitment hearing open to the public may override the statutory right of a respondent to have it closed. While it seems relatively remote that a news organization would assert such a right over the objections of the respondent, it seems quite a bit more likely that family members might assert such a right.

187. The author's experience is in Anchorage, and it may be that respondents in other locations are asked to make the required election and some hearings have been open to the public.

188. Kamakana v. Honolulu, 447 F.3d 1172, 1178 (9th Cir. 2006).

189. 151 N.W.2d 758, 763 (N.D. 1967).

PsychRights September 2007 forced drugging case,[190] after the respondent elected to have the hearing open to the public, the Probate Master *sua sponte* issued an order that the file would be closed after a court clerk was informed that someone was likely to come to look at the file.[191]

H. Right to Have the Hearing in a Real Courtroom

As set forth above, the author suggests that to make the right to have the hearings open to the public meaningful, such "public" hearings cannot be held behind the locked doors of API. In addition, section 47.30.735(b) of the Alaska Statutes explicitly provides that "[t]he hearing shall be conducted in a physical setting least likely to have a harmful effect on the mental or physical health of the respondent, within practical limits."[192] PsychRights takes the position that this also means respondents normally have the right to elect to have the hearing held in a real courtroom at the courthouse.[193]

Currently, these "hearings" are conducted in a cramped conference room at API without the trappings of a legitimate legal proceeding. This leaves respondents feeling that they have not had their "day in court."[194] In

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190. *In re* W.S.B., No. 3AN 07-1064 P/R (Alaska Super. Ct. Jan. 21, 2008).

191. *Id.* The superior court approved this order without analysis, other than "for the reasons stated" in API's motion to strike, and this is currently on appeal in Bigley v. Alaska Psychiatric Inst., No. S-13015 (Alaska filed July 17, 2007). The rights violation was real. A reporter was interested in the case, and the Probate Master's *sua sponte* order closing the file precluded her access. Previously, at the main hearing in the case, even though the respondent had elected in open court to have the proceeding open to the public, the reporter found the courtroom locked and left before it was discovered the courtroom door was improperly locked. *Contra In re* William S. Bigley, No. 3AN 08-00247 P/R (Alaska Super. Ct. March 2008) (public hearing granted).

192. ALASKA STAT. § 47.30.735(b) (2006).

193. If a respondent's choice to have the commitment hearing in a real courtroom is contested, then a hearing must be held under section 47.30.735(b) of the Alaska Statutes to determine whether it is the "physical setting least likely to have a harmful effect on the mental or physical health of the respondent, within practical limits." *Id.*

194. In reality, they have not had a legitimate determination of their rights. That these hearings do not have the trappings of legitimate judicial proceedings may also contribute to the cavalier treatment of these proceedings by the other participants, such as the probate masters and lawyers. In contrast, in March of 2008, in *In re* William S. Bigley, No. 3AN 08-00247 P/R (Alaska Super. Ct. March 2008), the respondent, who had previously been involuntarily committed many times and was represented by the Alaska Public Defender Agency, elected to have his involuntary commitment hearing held publicly. This public hearing was held before a superior court judge, rather than in a closed proceeding before a master.

the author's experience, there are a host of negative consequences that flow from this. For one thing, it can exacerbate the perception of some respondents that people are out to get them.[195] Similarly, since they do not feel it was a legitimate judicial process, it can solidify their resistance to cooperating with hospital staff.

I. The Required Time Frame for Involuntary Commitment Precludes Proper Processing by Masters

In Anchorage, as of the date of writing, involuntary commitment and forced drugging cases are most often heard by probate masters, putatively under the authority granted in section 2(a) of the Alaska Rules of Probate Procedure allowing a standing referral. It is suggested here, however, that because of the extremely short time frames in which involuntary commitment decisions must be made,[196] especially for thirty-day commitments,[197] it is not possible for these cases to be handled properly in this way. Implicitly recognizing this, section 2(b)(3)(C) of the Alaska Rules of Probate Procedure provides that involuntary commitments are effective pending superior court review.[198] However, this is improper. Probate masters only have authority to make recommendations for court acceptance, modification, or rejection.[199] By making involuntary commitments effective pending review, section 2(b)(3)(C) of the Alaska Rules of Probate Procedure effectively eliminates the requirement of superior court approval.

One reason it is not possible to properly handle these cases in a timely manner by referrals to masters is that section 2(f)(1) of the Alaska Rules of Probate Procedure allows ten days to object to the master's report and a reply to such objections within 3 days of service of the objections.[200] This time frame renders meaningless respondents' right to have the superior court determine whether they should be committed. Indeed, half of the initial commitment period may have already expired before the question is

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The judge took the case very seriously, applied the law to the facts presented, and found the respondent to not be gravely disabled. *See id.*

195. In fact, the whole involuntary commitment and forced drugging process can legitimately be perceived that way.

196. *See* ALASKA STAT. § 47.30.725(b) (2006); ALASKA STAT. §§ 47.30.745(c),(d),(g) (2006); ALASKA STAT. § 47.30.770(b) (2006).

197. *See* ALASKA STAT. § 47.30.725(b).

198. ALASKA PROBATE R. 2(b)(3)(C) (2006).

199. *See* ALASKA PROBATE R. 2(e) (2006).

200. ALASKA PROBATE R. 2(f)(1) (2006).

even ripe for decision by the superior court. In a case brought at the end of February 2007, the superior court granted the commitment petition before the objections were filed, and the objections were not even ruled upon until the start of the ninety-day commitment hearing.[201]

Another reason it is not possible to properly handle these cases in a timely manner by referrals to masters is because section 53(d)(1) of the Alaska Rules of Civil Procedure requires that a transcript accompany the masters reports,[202] and this can not be done as a practical matter within the required timeframes. The requirement for a transcript has simply been ignored.[203]

J. Probate Rule 2(b)(3)(D) Is Invalid

Section 2(b)(3)(D) of the Alaska Rules of Probate Procedure provides that a probate master's recommendation that a forced drugging petition be granted is effective pending superior court review.[204] Whether or not this procedure was ever proper, *Myers* implicitly invalidates the practice. In *Myers*, the Supreme Court of Alaska was very explicit that no non-emergency forced drugging could occur without *court* approval after careful consideration of the fundamental liberty interests involved, including the constitutionally required best interests and no less intrusive alternative determinations.[205] There is no such court determination prior to a superior court decision.

VII. PROPER EVIDENTIARY STANDARDS

As previously set forth, the United States Supreme Court has unequivocally held that involuntary commitment may not constitutionally take place except pursuant to proper evidentiary standards.[206] There is every reason to believe the Alaska Supreme Court would hold at least as much under the Alaska Constitution with respect to involuntary commitment, as well as forced drugging proceedings. If so, the court

201. *In re* W.S.B., 3 AN 07-0247 (Alaska Superior Ct. 2007).
202. ALASKA R. CIV. P. 53(d)(1).
203. This was confirmed by the judge and assistant attorney general in March of 2007. *In re* W.S.B., No. 3AN 07-247 P/R (Alaska Super. Ct. 2007). This failure to comply with Civil Rule 53(d)(1) is on appeal in Bigley v. Alaska Psychiatric Inst., No. S-12677 (Alaska filed July 17, 2007).
204. *See* ALASKA PROBATE R. 2(b)(3)(D) (2006).
205. *See* Myers v. Alaska Psychiatric Inst., 138 P.3d 238, 243 (Alaska 2006).
206. *See supra* Part IV.

would presumably hold that proper evidentiary standards must be employed in presenting evidence with respect to such issues as the respondent's dangerousness and capacity to decline the drugs and whether the forced drugging is in the "best interests" of the respondent.

In *State v. Coon*, the Alaska Supreme Court adopted the United States Supreme Court's revised standard for expert scientific opinion testimony as laid out in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*[207] Under Alaska expert opinion testimony law, in order for "scientific" expert testimony to be admissible, the court must consider certain reliability factors prior to admitting the testimony. Factors to consider may include:

> (1) whether the proffered scientific theory or technique can be (and has been) empirically tested (i.e., whether the scientific method is falsifiable and refutable); (2) whether the theory or technique has been subject to peer review and publication; (3) whether the known or potential error rate of the theory or technique is acceptable, and whether the existence and maintenance of standards controls the technique's operation; and (4) whether the theory or technique has attained general acceptance.[208]

In *Marron v. Stromstad*, the Alaska Supreme Court rejected the United States Supreme Court's extension of the *Daubert* standard to all "'technical' or 'other specialized' knowledge" in *Kumho Tire Co. v. Carmichael*.[209] In rejecting a "*Coon-Daubert* analysis" for experience-based expert testimony, the Alaska Supreme Court held that other Alaska Rules of Evidence must be complied with to ensure reliability.[210] These include proper qualification[211] and that the type of data utilized must be reasonably relied upon.[212] In addition, the court relied on the following as "the basic pillars of the adversary system" to ensure reliability and proper consideration: "[v]igorous cross-examination, presentation of contrary evidence, and

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207. State v. Coon, 974 P.2d 386, 388 (Alaska 1999) (citing Daubert v. Merrell Dow Pharms., Inc., 509 U.S. 579 (1993)).
208. *Id.* at 395.
209. Marron v. Stromstad, 123 P.3d 992, 1004 (Alaska 2005) ("[W]e limit our application of *Daubert* to expert testimony based on scientific theory, as opposed to testimony based upon the expert's personal experience.") (referencing Kumho Tire Co. v. Carmichael, 526 U.S. 137, 147 (1999)).
210. *Id.* at 1007.
211. ALASKA R. EVID. 702(a).
212. ALASKA R. EVID. 703.

careful instruction on the burden of proof" as "the traditional and appropriate means of attacking shaky but admissible evidence."[213]

The distinction between scientific evidence requiring a "*Coon/Daubert* analysis" and experience-based expertise which does not is a critical one, because the psychiatrists called by the hospital in favor of involuntary commitment and forced drugging petitions are asked to provide expert opinions in both categories.[214] Instead of any recognition of the distinction, they are uniformly qualified as "experts in psychiatry" and allowed to testify with respect to scientific knowledge without compliance with *Coon*.[215]

To a large extent, involuntary commitment—explicitly—and forced drugging—in actuality—are fear-based proceedings. Some of this is based on legitimate fears regarding the person's safety, especially by family members. However, they are also very often based on the erroneous belief—fueled by tragic, well-publicized incidents—that people diagnosed with mental illness tend to be very dangerous, violent individuals. The scientific debate is over whether there is even a slight correlation between mental illness and violence[216] or whether there is only a greater-than-chance relationship between mental illness and violence.[217] With respect to the latter, since studies demonstrate that psychiatric drugs cause violence, it appears highly likely that any correlation between mental illness and commission of violent acts above the rate in the general population is a result of the psychiatric drugs, rather than any underlying mental illness.[218]

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213. *Marron*, 123 P.3d at 1007 (quoting Daubert v. Merrell Dow Pharms., Inc., 509 U.S. 579, 596 (1993)). However, the Alaska Supreme Court's reliance in *Marron* on these "basic pillars of the adversary system" is misplaced for involuntary commitment and forced drugging cases as they are currently conducted. It requires a truly adversarial process, which has not existed in these cases. This is, in truth, the place where the legal system in these cases is most broken. This is further addressed *infra* Part VIII.B.

214. One example is whether a respondent exhibits symptoms of Tardive Dyskinesia, as opposed to the rate at which Tardive Dyskinesia occurs.

215. *See generally* State v. Coon, 974 P.2d 386 (Alaska 1999) (involving a dispute over voice spectrographic analysis as evidence).

216. Bruce J. Ennis & Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693, 733 (1974).

217. *See* John Monahan, *The Scientific Status of Research on Clinical and Actuarial Predictions of Violence*, *in* 1 MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY 423, 441 (David L. Faigman et al. eds., 2002) ("[T]here appears to be a greater-than-chance relationship between mental disorder and violent behavior.").

218. *See supra* note 59 and accompanying text.

Rather than acceding to an irrational mob mentality to lock up and drug people found to be mentally ill, courts must insist that such deprivations of the fundamental right to liberty occur only when the legal predicates are truly met. This includes proper evidentiary gate-keeping to ensure reliability to guard against erroneous deprivations of liberty. Three key factual issues where improper and unreliable scientific opinion is regularly allowed are dangerousness, capacity (competency), and best interests.

A. Dangerousness

As previously set forth, under both the United States and Alaska constitutions, a person may not be committed unless he or she has been found by clear and convincing evidence to be dangerous to others or self (which includes being unable to survive safely in freedom).[219] Historically, psychiatrists' predictions of dangerousness have been recognized as totally unreliable:

> The voluminous literature as to the ability of psychiatrists (or other mental health professionals) to testify reliably as to an individual's dangerousness in the indeterminate future had been virtually unanimous: "psychiatrists have absolutely no expertise in predicting dangerous behavior—indeed, they may be *less* accurate predictors than laymen—and that they usually err by overpredicting violence.[220]

Some of the leading research was performed by Ennis and Litwick who concluded: "In summary, training and experience do not enable psychiatrists adequately to predict dangerous behavior."[221]

A tremendous amount of work and research was subsequently done to improve this dismal performance. In 2003, Professor Alexander Scherr of the University of Georgia School of Law reviewed the science behind predictions of dangerousness:

> The opinions of experts in prediction should help the courts in this task, but over thirty years of commentary, judicial opinion, and scientific review argue that predictions of danger lack scientific rigor. . . . The American Psychiatric Association has argued to the [United States Supreme] Court that "[t]he

219. *See supra* Parts II.B, V.
220. PERLIN & CUCOLO, *supra* note 27, § 2.A-4.3c, at 109.
221. Ennis & Litwack, *supra* note 216, at 733.

> professional literature uniformly establishes that such predictions are fundamentally of very low reliability." . . . The sharpest critique finds that mental health professionals perform no better than chance at predicting violence, and perhaps perform even worse.
>
> . . . .
>
> Clinical opinions have never received high marks for reliability. Early literature and studies almost completely discounted them, finding that clinicians did little better than chance. A 1981 study by John Monahan, an early critic of predictive accuracy, summarized these studies, and critiqued their methodological shortcomings, resulting in a "second generation" of research into the accuracy of clinical methods. Over the past decade, these second generation research methods have led to a conclusion that clinical methods perform somewhat better than random, but are still deeply imperfect. Assessments that incorporate actuarial data appear to have performed somewhat better than unguided and particularly unstructured assessments, increasing the rate of reliability from 1 in 3 to 1 in 2. Overall, Monahan concluded that "the sober conclusion that clinicians are 'modestly better than chance' at predicting violence appears to be becoming the consensus view." [222]

Whether proffered expert testimony on dangerousness is properly admitted under *Coon* and *Marron* should be tested by attorneys representing psychiatric respondents. Motions *in limine* should be filed in advance of the testimony being proffered. *Marron* made clear that even though the *Daubert* standards are not required for experience-based expert opinion testimony, the trial court is still obligated to "ensure that it is relevant and reliable."[223]

In *Samaniego v. City of Kodiak*, citing *Coon*, the Alaska Supreme Court affirmed the trial court's allowance of certain psychological testimony by taking judicial notice of its reliability as follows: "[P]sychological and psychiatric evaluations, including clinical interviews . . . are long-recognized techniques that have been empirically tested, subject[ed] to extensive peer review and publication, and generally accepted in the

222. Alexander Scherr, Daubert *& Danger: The "Fit" of Expert Predictions in Civil Commitments*, 55 HASTINGS L.J. 1, 2, 17–18 (2003).
223. Marron v. Stromstad, 123 P.3d 992, 1007 (Alaska 2005).

psychological community."[224] As the court further held, "A *bare claim* that psychiatric evidence is unreliable does not subject forensic psychiatry to a mini-trial in every case."[225]

In *Coon*, after authorizing judicial notice for expert testimony "when an area of expertise is well-known and has been fully considered by the courts," the Alaska Supreme Court noted that even this can be challenged by "affirmative evidence of unreliability."[226] Even if dangerousness testimony is "an area of expertise that is well-known and has been fully considered by the courts," a dubious proposition, just such affirmative evidence of unreliability as to such testimony is set forth above in this section.

As previously shown, clinical judgments, which might be authorized by *Marron*, are no better than chance.[227] Legitimate actuarial approaches perform somewhat better, but, at best, are wrong half the time.[228] It is difficult to see how even fifty percent reliability can meet the required clear and convincing proof standard of dangerousness—yet, as a result of this unreliable testimony, the courts commit people involuntarily on the grounds that they are dangerous. As Professor Perlin notes:

> [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 . . . 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

224. Samaniego v. City of Kodiak, 80 P.3d 216, 219–20 (Alaska 2003) (quoting the trial court).
225. *Id.* at 220 (emphasis added).
226. State v. Coon, 974 P.2d 386, 398 (Alaska 1999).
227. Scherr, *supra* note 222, at 2.
228. *Id.* at 17–18.

individuals of liberty disingenuously and upon bases that have no relationship to case law or to statutes.[229]

The logical conclusion, then, is that most psychiatric respondents are not being locked up because they are truly dangerous (or gravely disabled). Instead, many are being locked up because they are bothering people, because people disapprove of their lifestyles, or because the judicial system does not know what else to do with them. However, there are proven alternative approaches available for treating people experiencing these problems that result in much better outcomes overall.[230]

By engaging in the traditional adversarial process, the courts—and especially the lawyers representing psychiatric respondents—will be the instruments of justice they should be, and the mental health system will be encouraged to adopt an approach more like Dr. Mosher's, who in forty years of active psychiatric practice with countless un-medicated people experiencing psychosis, never had to commit even one of them.[231] It is suggested here that this is not only required from the legal perspective, but it is also the right thing therapeutically.

B. Capacity

Under section 47.30.839(g) of the Alaska Statutes, if the court determines by clear and convincing evidence that the patient does not have the capacity to provide informed consent to either accept or decline the recommended medication and "was not competent to provide informed consent at the time of previously expressed wishes," "the court shall approve the facility's proposed use of psychotropic medication."[232] Otherwise, under section 47.30.839(f) of the Alaska Statutes, the court must honor the patient's decision about the use of psychotropic medication.[233]

As with dangerousness, there is also a body of science surrounding the issue of capacity to decline or refuse psychotropic medications and validated instruments developed to assess it, which is most often referred

229. Perlin, *supra* note 28, at 32–34.

230. *See supra* Part III.A, C.

231. *Cf.* Transcript of Record at 178, *In re* Myers v. Alaska Psychiatric Inst., No. 3AN 03-277 P/S (Alaska Super. Ct. 2003), *available at* http://psychrights.org/States/Alaska/CaseOne/30-Day/3-5and10-03transcript.htm.

232. ALASKA STAT. § 47.30.839(g) (2006). In *Myers*, the Alaska Supreme Court additionally required findings that the forced drugging was in the patient's best interests and there is no less intrusive alternative in order for this statute to be constitutional. Myers v. Alaska Psychiatric Inst., 138 P.3d 238, 248 (Alaska 2006).

233. ALASKA STAT. § 47.30.839(f) (2006).

to as competency.[234] Professor Perlin summarized the scientific findings, noting, "mental patients . . . are not inherently more incompetent than nonmentally ill medical patients."[235]

Section 47.30.837 of the Alaska Statutes sets forth the statutory standard for competency, which it phrases as the capacity to provide informed consent.[236] A key point is that a person must be competent to accept the medication as well as decline it.[237] In practice, as admitted by Dr. Hanowell at his deposition in the *Myers* case, if the patient accepts the medication, the hospital deems her competent, but if the patient refuses, the hospital says she is incompetent.[238] In other words, disagreement with the psychiatrist's desire to administer the drugs gives rise to testimony that the person is incompetent, not any legitimate evaluation of competence.

Alaska law provides what is supposed to be a more neutral process. Under section 47.30.839(d) of the Alaska Statutes, the court is to direct the Office of Public Advocacy (OPA) to provide a visitor to, among other things, assist the court in investigating whether the respondent has capacity to give informed consent, including the patient's response to a capacity assessment instrument.[239] The Alaska Supreme Court in *Wetherhorn* found performance of these requirements to be "essential to the court's mandatory duty to determine whether the patient is presently competent to provide informed consent" and the failure to do so plain error.[240] Unfortunately, the author's experience has been that court visitors

234. However, a fundamental problem with even the scientific work around competency to decline psychotropic drugs is that it starts with the assumption that a decision to decline the medication is a bad decision and the question is thus when should a person be allowed to make a bad decision. As set forth in Part III.D, however, a decision to decline the drugs, especially without first trying other approaches can, in fact, be a very good one. Additionally, these instruments assume the doctor is providing accurate information, which is often not a valid assumption with respect to psychotropic medications.

235. Perlin, *supra* note 29, at 746–47.

236. ALASKA STAT. § 47.30.837 (2006).

237. ALASKA STAT. §§ 47.30.836(1), (3) (2006).

238. *See* Deposition of Robert Hanowell, MD at 36–43, *In re* Faith J. Myers, No. 3AN-03-277 P/S (Alaska Super. Ct. Feb. 27, 2003), *available at* http://psychrights.org/States/Alaska/CaseOne/30-Day/Hanowelldepo.htm. It is worth noting that many patients know from their own experience and research that the drugs are very harmful to them. When this is expressed, it is not only considered evidence of incompetence, but also cited as evidence of their mental illness.

239. ALASKA STAT. § 47.30.839(d) (2006).

240. Wetherhorn v. Alaska Psychiatric Inst., 156 P.3d 371, 382 (Alaska 2007).

do not execute their responsibilities in a valid manner.[241] The "capacity assessment instrument" being utilized was just made up by a court visitor and has never been validated.[242] The current competency determinations, at least in Anchorage, are therefore the product of testimony that has no evidentiary reliability. There are, however, capacity assessment instruments that have been developed for determination of competence to make treatment decisions that have been subjected to critical review as to their validity, strengths, and weaknesses.[243]

C. Best Interests

The best interests determination required by *Myers* directly presents the *Coon/ Marron* dichotomy between science-based testimony and experience-based testimony. For example, testimony about the effectiveness and negative effects of the neuroleptics is science-based and any such testimony on behalf of the hospital, or the respondent for that matter, is subject to a *Coon/Daubert* analysis. Testimony based on the experience of the witness does not require a *Coon/Daubert* analysis, but must still pass the reliability standards required in *Marron* and must be recognized by the court as restricted to the witness's experience.

Part III presents the scientific evidence regarding the neuroleptics. This evidence should be presented on behalf of forced drugging petition respondents and hospital psychiatrists required to address it with scientific evidence if they can. In doing that, respondents are entitled to know what scientific studies, etc., will be offered against them in order to be able to prepare—just as in all other proceedings.

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241. The author understands the reason why the court visitors had not complied with the statute in *Wetherhorn* is that the assistant public defenders had long before prohibited them from interviewing their psychiatric respondent clients because the assessments were considered biased. The court uniformly appointed court visitors to perform their statutory duties, this was uniformly ignored, the public defenders never noted the deficiency, and the court never did anything about it.

242. This "capacity assessment instrument" consists of questions ranging from "What is your name?" to "Do you take medications?" to "Have you ever heard of informed consent?"

243. *See* THOMAS GRISSO ET AL., EVALUATING COMPETENCIES: FORENSIC ASSESSMENTS AND INSTRUMENTS 404–50 (2d ed. 2003) (describing eight different capacity assessment instruments).

VIII. OTHER IMPORTANT RIGHTS VIOLATIONS

A. Failure to Provide Available Less Intrusive Alternatives

One of the core holdings of *Myers* is that the State may not forcibly drug someone with psychotropic medication(s) against their wishes unless "no less intrusive alternative treatment is available."[244] The word, "available," however, is ambiguous. Does it mean the State is required to fund a proven alternative, or does it mean the State may avoid providing a viable less intrusive alternative by deciding to not fund it? Based on the following analysis, the answer appears to be the former.

In *Wyatt v. Stickney*, a district court in Alabama required the State of Alabama to provide constitutionally required services to institutionalized persons, holding that "no default can be justified by a want of operating funds."[245] This was affirmed by the Court of Appeals for the Fifth Circuit in *Wyatt v. Anderholt*, which held that the state legislature is not free to provide social services in a way that denies constitutional rights.[246] In *Wyatt*, therefore, the federal courts required the State of Alabama to spend funds in specific ways to provide constitutionally adequate services.

In *Hootch v. Alaska State-Operated School System*, in considering an Equal Protection claim regarding the right to state funding of local schools, the Alaska Supreme Court held that resolution of the complex problems pertaining to the location and quality of secondary education are best determined by the legislative process, but went on to state: "We shall not, however, hesitate to intervene if a violation of the constitutional rights to equal treatment under either the Alaska or [United States] Constitutions is established."[247]

Presumably, the Alaska Supreme Court would also not hesitate to order the provision of an available less intrusive alternative to satisfy the constitutional due process right to a less intrusive alternative it required in *Myers*. There would likely be some limitation on the State's obligation to provide less intrusive alternatives, such as extreme cost, but if the State can reasonably provide a less intrusive alternative, it should not constitutionally forcibly drug the person instead.

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244. Myers v. Alaska Psychiatric Inst., 138 P.3d 238, 239 (Alaska 2006).
245. 344 F.Supp. 387, 392 (M.D. Ala. 1972).
246. 503 F.2d 1305, 1315 (5th Cir. 1974).
247. 536 P.2d 793, 808–09 (Alaska 1975).

B. Zealous Representation Should Be Provided to Psychiatric Respondents

The trial process relies on a truly adversarial system to function properly. The failure of psychiatric respondents to receive effective representation is where the legal process is most broken. If psychiatric respondents' rights were being zealously represented, which is their lawyers' ethical responsibility,[248] including thorough prosecution of appeals,[249] the above-described pervasive rights violations would presumably be corrected. Requiring proper representation was the main objective of the *Wetherhorn* appeal, but the Supreme Court of Alaska held that a challenge to effectiveness of counsel under state law must be made through a separate proceeding, such as section 60(b) of the Alaska Rules of Civil Procedure or habeas corpus, rather than through direct appeal.[250]

In *In re K.G.F.*, the Montana Supreme Court recognized and addressed the systemic failure of involuntary commitment respondents to receive effective assistance of counsel:

> As a starting point, it is safe to say that in purportedly protecting the due process rights of an individual subject to an involuntary commitment proceeding—whereby counsel typically has less than [twenty-four] hours to prepare for a hearing on a State petition that seeks to sever or infringe upon the individual's relations with family, friends, physicians, and employment for three months or longer—our *legal system of judges, lawyers, and clinicians has seemingly lost its way in vigilantly protecting the fundamental rights of such individuals.*[251]

The *K.G.F.* court then went on to articulate five specific, but not exclusive, requirements for effective representation: (1) *Appointment of Competent Counsel*, which requires that the attorney have an "understanding of the legal process of involuntary commitments, as well as the range of alternative, less-restrictive treatment and care options

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248. ALASKA R. OF PROF. CONDUCT pmbl. ("[A] lawyer zealously asserts the client's position under the rules of the adversary system.").

249. In briefing over attorneys' fees before the Alaska Supreme Court in *Wetherhorn*, the State conceded that it was obligated to pay for such appeals by the Public Defender Agency. *See* Responsive Supplemental Briefing Re: Application for Full Reasonable Fees at 12–13, Wetherhorn v. Alaska Psychiatric Inst., No. 3AN-05-0459 PR (Alaska June 29, 2007), *available at* http://psychrights.org/States/Alaska/CaseFour/AttysFees/StateResp2SuppMemo.pdf.

250. Wetherhorn v. Alaska Psychiatric Inst., 156 P.3d 371, 384 (Alaska 2007).

251. *In re* K.G.F., 29 P.3d 485, 492–93 (Mont. 2001) (emphasis added).

available;"[252] (2) *Initial Investigation*, which requires the attorney to, at minimum, acquire information about "the patient's prior medical history and treatment [if relevant] . . . , the patient's relationship to family and friends within the community, and the patient's relationship with all relevant medical professionals involved prior to and during the petition process;" [253] (3) *The Client Interview*, which "should be conducted in private and should be held ***sufficiently before any scheduled hearings*** to permit effective preparation and prehearing assistance to the client;"[254] (4) *The Right to Remain Silent*, which includes the basic requirement that "[a]ny waiver of right to remain silent to be interviewed by a hospital psychiatrist must be knowing and counsel is entitled to be at such an interview;"[255] and (5) *Counsel as an Advocate and Adversary*, which instructs that "the proper role of the attorney is to 'represent the perspective of the respondent and to serve as a vigorous advocate for the respondent's wishes.'"[256] In addition, "[i]n the courtroom, an attorney should engage in all aspects of advocacy and vigorously argue to the best of his or her ability for the ends desired by the client."[257]

Presumably, because Montana law provides psychiatric respondents with the right to have the state pay for an independent evaluation under section 53-21-118 of the Montana Code,[258] the Montana Supreme Court did not specifically identify it. In Alaska, an indigent does not have the right to such appointed expert at a thirty-day commitment hearing under section 47.30.735 of the Alaska Statutes,[259] but does have such a right for subsequent commitments under sections 47.30.745(e) and 47.30.770(b) of the Alaska Statutes.[260] However, it is absolutely critical that such an independent expert witness also be available to psychiatric respondents for the initial thirty-day commitment hearing, especially with respect to a 30-

252. *Id.* at 498.
253. *Id.* at 498–99. Additionally, "counsel should also attempt to interview all persons who have knowledge of the circumstances surrounding the commitment petition, including family members, acquaintances and any other persons identified by the client as having relevant information, and be prepared to call such persons as witnesses." *Id.*
254. *Id.* at 499 (citation omitted). Additionally, "counsel should also ascertain, if possible, a clear understanding of what the client would like to see happen in the forthcoming commitment proceedings." *Id.*
255. *Id.* at 499–500.
256. *Id.* at 500 (citation omitted).
257. *Id.*
258. MONT. CODE ANN. § 53-21-118(2) (2007).
259. *See* ALASKA STAT. § 47.30.735 (2006).
260. ALASKA STAT. § 47.30.745(e) (2006); *see* ALASKA STAT. § 47.30.770(b) (2006).

day forced drugging petition, because this is where many respondents are channeled into chronicity. As Professor Perlin notes, "attorneys will need to employ independent psychiatric (or other medical disability) experts in a significant percentage of such cases,"[261] and cites to *Practice Manual: Preparation and Trial of a Civil Commitment Case*[262] for the following proposition: "Such an expert will probably be '[t]he single most valuable person to testify on behalf of a client in a contested commitment hearing.'"[263]

Attorneys defending these cases should virtually always, if not always, have an expert, or experts, testify on behalf of psychiatric respondents. In *Marron*, the Alaska Supreme Court relied on the presentation of contrary expert testimony evidence as one of "the traditional and appropriate means of attacking shaky but admissible evidence" in holding a *Daubert/Coon* analysis was not required for expert opinion testimony based on experience. In the author's experience, such testimony is virtually never offered by the Public Defender Agency, even though, as set forth above, the validity of the hospital's testimony is often dubious at best. Experts should present evidence about these drugs' true rate of efficacy and potential harmfulness to rebut: (1) testimony of hospital psychiatrists generally; (2) testimony as to whether the respondent is properly diagnosed as mentally ill under the statute,[264] a danger to self or others, or gravely disabled; and (3) testimony as to whether the respondent has the capacity to decline medication. In addition, attorneys should be looking to have fact witnesses, such as friends, employers, family members, etc., called as witnesses when they will support their clients' cases. This requires investigational efforts prior to the hearing.

To the extent the assistant public defenders call no witnesses at all and cross-examination of the hospital's witness, or witnesses, is lackadaisical or worse, using the Alaska Supreme Court's words, these "pillars of the adversary system"[265] are absent. The result, as Professor Perlin puts it, is a system that "deprives individuals of liberty disingenuously and upon bases that have no relationship to case law or to statutes."[266]

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261. Michael L. Perlin, *"You Have Discussed Lepers and Crooks": Sanism in Clinical Teaching*, 9 CLINICAL L. REV. 683, 703 (2003).
262. Franklin J. Hickman et al., *Practice Manual: Preparation and Trial of a Civil Commitment Case*, 5 MENTAL DISABILITY L. REP. 281, 289 (1981).
263. Perlin, *supra* note 261, at 703 n.118 (alterations in the original).
264. *See* ALASKA STAT. § 47.30.915(12) (2006) (defining mental illness).
265. Marron v. Stromstad, 123 P.3d 992, 1007 (Alaska 2005).
266. Perlin, *supra* note 28, at 34.

IX. THE STATE OF ALASKA SHOULD EMBRACE THE CONCEPTS PRESENTED HERE

The State should implement the concepts set forth here, both as to the legal proceedings and its mental health program. Unfortunately, the State of Alaska's legislative and executive branches have refused to even discuss these rights violations, therefore leaving litigation as the only option thus far. Letters and e-mails have been sent to the Attorney General requesting substantive discussions and a briefing given to the Judiciary Committees of the Alaska Legislature along the same lines,[267] but the Attorney General has refused to respond as of the date of this writing.[268]

The current system is truly irrational. In addition to the tremendous amount of unnecessary suffering it creates, it reduces rather than increases public safety, increases chronicity, and imposes substantial unnecessary costs upon the government.

A. The Current Paradigm Increases Rather than Decreases Violence

As set forth above, the scientific evidence is clear that the drugs themselves increase, rather than reduce, violence.[269] In addition, psychiatric respondents experience unwarranted violence, such as being strapped down to a bed for hours and drugged against their will.[270] The police, pursuant to *ex parte* orders, show up without notice and usually handcuff the respondents for transport to the hospital. If any protest is made, as police are trained to do, the respondents are physically subdued,[271] sometimes with injuries.

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267. *See, e.g.*, Briefing Points from James B. Gottstein, to Jay Ramras, Chair, House Judiciary Comm.; Hollis French, Chair, Senate Judiciary Comm; and Talis Colberg, Attorney Gen. (February 7, 2007), *available at* http://psychrights.org/States/Alaska/Legislature/2-8-07JudiciaryBrfng.pdf.

268. Alaska Supreme Court Chief Justice Fabe, however, has recognized there are at least procedural issues to be addressed and, in June of 2007, appointed a Probate Rules Subcommittee on Involuntary Commitments and the Involuntary Administration of Psychotropic Medication to make recommendations with respect to revising the procedural rules governing these cases.

269. *See, e.g.*, Van Putten, *supra* note 58, at 43–46 (describing manifestations of akathisia and how neuroleptic drugs can be a cause); Herrera, *supra* note 60, at 558–61 (suggesting that haloperidol can increase violence in patients); Galynker & Nazarian, *supra* note 60, at 31–32.

270. *See* Cusack et al., *supra* note 140, at 456–57 (discussing results from a questionnaire about trauma and harm in psychiatric settings).

271. At the urging of the Anchorage chapter of the National Alliance on Mental Illness (NAMI), and with the financial support of the Alaska Mental Health Trust

Forced drugging is experienced as torture by those forced to endure it, and internationally, human rights activists assert it is a violation of the universal prohibition against torture.[272] When the former Soviet Union gave this class of drugs to political prisoners, the international community decried it as torture.[273] Being a mental patient does not change the experience of being on the sharp end of the hypodermic. If a patient does not take prescribed drugs, four or five staff members will physically subdue the person and inject him or her with drugs.[274] As noted above, the Alaska Supreme Court has equated forced medication with the intrusiveness of lobotomy and electroshock.[275] When one considers that this is experienced by psychiatric respondents as serious, unwarranted violence against them, it is understandable that physical resistance will sometimes result. This can be viewed as a "fight or flight" scenario in which the physical flight option has been taken away.[276]

B. A System that Maximizes Voluntariness Is Far More Successful

It is only natural that people who are forced to undergo these types of treatment will avoid them.[277] There are many people who choose

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Authority, the Anchorage Police Department, and other Alaska police departments are to be commended for instituting what is known as a "Crisis Intervention Team" (CIT). Under CIT, certain police officers are trained to de-escalate situations with people engaging in disturbing behavior attributed to symptoms of mental illness. These CIT officers are dispatched to applicable situations when available, and this approach has reduced the violence associated with police interactions. More information on the CIT approach, which was developed in Memphis after a mentally ill person was unnecessarily killed by police, can be found at Memphis Police Department, *The Crisis Intervention Team Model*, http://akmhcweb.org/docs/TheCrisisInterventionTeamModel.pdf.

272. *See* Tina Minkowitz, *The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free From Nonconsensual Psychiatric Interventions*, 34 SYRACUSE J. INT'L L. & COM. 405 (2007) (classifying forced psychiatric interventions as torture).

273. *See* Carl Gershman, *Psychiatric Abuse in the Soviet Union*, 21 SOCIETY 54, 57 (July 1984).

274. *See, e.g.*, Transcript of Deposition of William Worrall, M.D. at 9, *In re* W.S.B., No. 3AN 07-247 P/R, March 30, 2007.

275. *See supra* Part III.

276. Faced with this, it is not unusual for patients to withdraw into themselves as the only "flight" option. It seems worth noting that either response—i.e., (1) physical resistance or (2) withdrawal, an extreme form of which would be described as catatonia—will be labeled a symptom of mental illness.

277. This was recognized by the Washington Supreme Court in *In re* Harris, 654 P.2d 109, 115 (Wash. 1982) ("If commitment is always associated with force, those who need help may be diverted from seeking assistance. . . . Ms. Harris' only

homelessness over engagement with the mental health system.[278] In the PsychRights' September 2007 forced drugging case, Sarah Porter, an expert from New Zealand who brought an alternate approach to fruition there, happened to be in Anchorage and available to testify about the benefits of voluntariness:

> A. I've worked in the mental health [field] in New Zealand for the last [fifteen] years in a variety of roles. I'm currently employed as a strategic advisor by the Capital and Coast District Health Board.
> I also have . . .
> . . . set up and run a program in New Zealand which operates as an alternative to acute mental health services. . . . That's been operating since December last year, so it's a relatively new program, but our outcomes to date have been outstanding, and the funding body that provided . . . the resources to do the program is extremely excited about the results that we've been able to achieve, with people receiving the service and helping us to assist and [starting] out more similar programs in New Zealand.
> . . . .
> Q. Is there a philosophy that you might describe . . . that would go along with this kind of alternative approach?
> A. The way that I would describe that is that it's—it's really about relationships. It's about building a good therapeutic relationship with the person in distress and supporting that person to recognize and come to terms with the issues that are going on in their life, in such a way that builds a therapeutic alliance and is based on negotiation, rather than the use of force or coercion, primarily . . . because we recognize that the use of force and coercion actually undermines the therapeutic relationship and decreases the likelihood of compliance in the long term with whatever kinds of treatment or support has been implicated for the person. So we have created and set up our service along the lines of making relationship and negotiation the primary basis for working with the person and supporting the

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previous commitment experience was involuntary, and it left her with a lasting fear of commitment. It is not surprising that she became a fugitive when ordered to report to the hospital.").

278. Because of the extreme negatives of psychiatric imprisonment and forced drugging, this should not be assumed to be an irrational choice.

> person to reflect on and reconsider what's going on to create what might be defined as a crisis, and to devise strategies and plans for how the person might be with the issues and challenges that they face in their life.
>
> . . . .
>
> Q. Now, you mentioned—I think you said that coercion creates problems. Could you describe those kind of problems?
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> A. Well, that's really about the fact that [there is] growing recognition—I think worldwide, but particularly in New Zealand, that coercion, itself, creates trauma and further distress for the person, and that that, in itself, actually undermines the benefits of the treatment that is being provided in a forced context. And so our aiming and teaching is to be able to support the person to resolve the issues without actually having to trample . . . on the person's autonomy, or hound them physically or emotionally in doing so.
>
> . . . .
>
> Q. And—and have you seen success in that approach?
>
> A. We have. It's been phenomenal, actually. . . . I had high hopes that it would work, but I've . . . been really impressed how well, in fact, it has worked . . . .[279]

C. A System that Minimizes Force in Favor of Recovery Is Far Less Expensive Overall

As set forth above, if psychiatric drugs were used more selectively and the types of alternative approaches described above were used, it appears the chronicity rate would be at least halved.[280] Virtually all of the people who are involuntarily committed are put on psychiatric drugs and labeled as disabled, which ensures that they are able to receive medical, mental health, and social security benefits. Providing these benefits, not surprisingly, is very costly. Halving the number of people going down this route would result in substantial avoided costs. In its Budget Summit Report in August of 2003, the Alaska Mental Health Board acknowledged

279. Proceedings for 30-Day Commitment Hearing at 73–81, *In re* The Necessity for the Hospitalization of W.S.B., No. 3AN-07-1064 PR (D. Alaska Sept. 5, 2007), *available at* http://psychrights.org/states/Alaska/CaseXX/3AN-07-1064PS/070905TBBTranscript.pdf.

280. *See supra* Part III.C.

that psychiatric medications appeared to be increasing chronicity,[281] that "[i]t is being accepted around the country that recovery from mental illness is possible for many people that have previously been considered to be destined to a life of great disability,"[282] and

> [s]ince placement on SSDI and SSI are criterion for receiving Medicaid services, and . . . people have to be both disabled and very poor to be in these programs, the clear result of this funding mechanism is that *the Medicaid/SSDI/SSI eligibility and funding mechanism is . . . a one way ticket to permanent disability and poverty.* [283]

It need not be so. By implementing the types of programs described in Part III(C) of this Article, it appears at least half of the people who now are given this one way ticket to permanent disability and poverty could recover and change their life trajectory towards being productive citizens with meaningful, fulfilling lives. Thus, not only will there be substantial fiscal benefits to the State, but it is the right thing to do.

X. CONCLUSION

In *Myers* and *Wetherhorn*, the Alaska Supreme Court demonstrated how seriously it takes mental disability law issues. As shown above, for various reasons, the same cannot be said to be true in Alaska's trial courts. By abandoning the traditional adversarial approach in favor of a paternalistic one—where both the trial court judges and the lawyers assigned to represent psychiatric respondents assume what the State wants to do to psychiatric respondents is in their best interest—the State's proposed actions are not subjected to the normal litigation crucible. The critical evidence presented in this Article showing that oftentimes what the State wants to do is not in the person's best interest is not being presented to the courts. This is not a legitimate judicial process. The courts should not engage in what is essentially a mock judicial process. It discredits the judiciary and justifiably creates cynicism regarding the judicial system among psychiatric respondents. It also causes great harm.

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281. ALASKA MENTAL HEALTH BD. BUDGET COMM., REPORT BY THE ALASKA MENTAL HEALTH BOARD BUDGET COMMITTEE ON THE 2003 BUDGET SUMMIT WITH RECOMMENDATIONS 1 (2003), *available at* http://akmhcweb.org/Docs/AMHB/2003BudgetSummitReport.pdf.

282. *Id.* at 7.

283. *Id.* at 8.

Clearly, though, while the trial courts participate in the process, it is the failure of psychiatric respondents' counsel to raise the issues presented here (and others), to introduce the evidence discussed herein, and then, having done so, to prosecute appropriate appeals and other remedies, which is where the legal system is most broken. Judges normally only consider the issues and evidence presented to them by the parties' attorneys. Our judicial system is premised upon the respective parties' attorneys being zealous advocates for the ends desired by their clients. Where, as in these cases, this fundamental aspect of our judicial system is not employed for one side, the judicial process does not work properly. This should be remedied. The stakes are enormous for the lives of psychiatric respondents, for the public good, and for the integrity of the judiciary itself.