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Law Project for
Psychiatric Rights, Inc.

MEMORANDUM

TO: Alison Hymes
FROM: James B. Gottstein, Esq.
RE: Mental Health Commission Proposals
DATE: August 5, 2007

Introduction

You have asked me to review certain aspects of the Virginia Commission on Mental Health Law Reform, Task Force on Commitment's draft proposals. In connection therewith, I have reviewed:

1. June 22, 2007 (second) Report of the Subcommittee on Policies and Procedures;
2. July 26, 2007, Draft Report to the Commission on Inpatient Commitment Criteria;
3. [undated] Procedures for Involuntary Outpatient Commitment; and
4. [undated] Draft Criteria for Mandatory Outpatient Treatment.

Before addressing some of the specifics of the proposals, it seems helpful to review some broad principles, both clinically and legally.

Clinical Realities

There is an assumption that current modes of mental health treatment increase safety and improve the lives of patients. Unfortunately, this is not true. The rate of disability attributed to mental illness has increased six-fold since the introduction of Thorazine in the mid 1950's.[1] Despite all the marketing hype, the second generation of neuroleptics,[2] often termed "atypical" for supposedly being more effective and less harmful, have now been shown to be of the same extremely limited effectiveness as the first generation neuroleptics,[3] and even more harmful.[4]

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[1] Anatomy of an Epidemic: Psychiatric Drugs and the Astonishing Rise of Mental Illness in America, by Robert Whitaker, *Ethical Human Psychology and Psychiatry*, Volume 7, Number I: 23-35 Spring 2005.
[2] Such as Risperdal, Seroquel, Zyprexa, Abilify.
[3] Such as Thorazine, Haldol, Mellaril, Stelazine.
[4] Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia, by Jeffrey A. Lieberman, M.D., T. Scott Stroup, M.D., M.P.H., Joseph P. McEvoy, M.D., Marvin S. Swartz, M.D., Robert A. Rosenheck, M.D., Diana O. Perkins, M.D., M.P.H., Richard S.E. Keefe, Ph.D., Sonia M. Davis, Dr.P.H., Clarence E. Davis, Ph.D., Barry D. Lebowitz, Ph.D., Joanne Severe, M.S., and John K. Hsiao, M.D., for the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) Investigators, *New England Journal of Medicine*, N Engl J Med 2005;353:1209-23; Randomized Controlled Trial of the Effect on Quality of Life of Second- vs First-Generation Antipsychotic Drugs in Schizophrenia: Cost Utility of the Latest Antipsychotic Drugs in Schizophrenia Study (CUtLASS 1), by Peter B. Jones, MD, PhD; Thomas R. E. Barnes, MD, DSc; Linda Davies, MSc; Graham Dunn, PhD; Helen Lloyd, BA; Karen P. Hayhurst, MSc; Robin M. Murray, MD, DSc; Alison Markwick, BA; Shoˆn W. Lewis, MD, *Archives of General Psychiatry*, 2006;63:1079-1087; Lifetime suicide rates in treated schizophrenia: 1875-1924 and 1994-1998 cohorts compared, by D. Healy, M. Harris, R. Tranter, P. Gutting, R. Austin, G. Jones-Edwards, and A.P. Roberts, *British Journal of Psychiatry*, (2006), 188 , 223 -228; Prospective analysis of premature

This harm includes much lowered life expectancies, with the second generation of neuroleptics reducing life spans an additional ten years to 25 year shorter life spans.[5]

This is in sharp contrast to what could be achieved if a non-coercive, participatory approach, allowing people to choose non-drug approaches were utilized.[6] In Finland, such an approach resulted in the following outcomes: 82% did not have psychotic symptoms at the end of five years, 86% had returned to their studies or jobs, and only 14% were on disability allowance. Only 29% had ever been exposed to a neuroleptic medication at all during the five years, and only 17% were on neuroleptics at the end of five years.[7] The second generation of neuroleptics, as did the first generation, cause akathisia, an inner restlessness that causes certain people to commit suicide or become violent.[8] The same is true of the benzodiazpines[9] and Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants.[10,11]

It is important to keep this data in mind when considering not only the legal issues, but the larger policy issues. As will be discussed next, constitutional requirements, often reflected in statutory enactments, require not only a high showing to lock up people who are diagnosed with mental illness and forcibly drug them, but that it can be done only if there are no less restrictive alternatives. For involuntary medication there is the requirement that it be in the person's best interests. It is thus very relevant to the legal discussion that the data shows (i) there are such less restrictive alternatives that could be made available and, (ii) if properly presented, it would be rare if ever, that involuntary medication could properly be shown to be in someone's best interest. With respect to the policy issues, even leaving aside the huge amount of unnecessary suffering that results from the current system, it is clear it greatly increases the cost to at least double the number of people who become permanently disabled and on welfare.

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mortality in schizophrenia in relation to health service engagement: a 7.5-year study within an epidemiologically complete, homogeneous population in rural Ireland, by Maria G. Morgan , Paul J. Scully , Hanafy A. Youssef, Anthony Kinsellac, John M. Owensa, and John L. Waddington, *Psychiatry Research* 117 (2003) 127–135; and other studies posted at http://psychrights.org/Research/Digest/NLPs/neuroleptics.htm.

[5] Morbidity and Mortality in People with Serious Mental Illness, by National Association of State Mental Health Program, October 2006.

[6] *See*, e.g., Full Disclosure: Toward a Participatory and Risk-Limiting Approach to Neuroleptic Drugs, by Volkmar Aderhold, MD, and Peter Stastny, MD, *Ethical Human Psychology & Psychiatry*, Vol 9, No. 1: 35-61, 2007.

[7] Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies, by Jaakko Seikkula1, Jukka Aaltonen, Birgittu Alakare, Kauko Haarakangas, Jyrki Kera¨Nen, & Klaus Lehtinen, *Psychotherapy Research*, March 2006; 16(2): 214/228.

[8] Behavioral toxicity of antipsychotic drugs, T. van Putten & S. Marder, *Journal of Clinical Psychiatry*, 48 (Supp.), 13-19, 1987.

[9] Such as Xanax, Restoril, Halcion, Klonopin.

[10] Such as Paxil, Prozac, Zoloft.

[11] G. Jackson, Rethinking Psychiatric Drugs: A Guide to Informed Consent, *Author House*, 2005, 72, 112-129.

Legal Principles

Involuntary Commitment

The United States Supreme Court has unequivocally declared that involuntary commitment is a "massive curtailment of liberty" requiring extensive due process protection.[12] In consideration of this, it has ruled that while the government does not have to prove its case "beyond a reasonable doubt," it does have to prove it by "clear and convincing evidence."[13] It has held that involuntary commitments is 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.'"[14]

The United States Supreme Court has made it clear that the inability to take care of one's self can be considered a sufficient finding of "dangerousness" only when survival is at stake.

> In short, 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.[15]

In addition, "although never specifically endorsed by the U.S. Supreme Court in a case involving persons with mental disabilities," it is also clear that people may not be involuntarily committed unless there is no less restrictive alternative.[16]

This is the basic United States Constitutional setting for involuntary commitment with which Virginia's statutes must comply.

Court Ordered Psychiatric Drugging

When considering court ordered psychiatric drugging, it is useful to recognize that it comes up in different legal contexts. The most often are in connections with (1) inpatient commitment, (2) outpatient commitment, (3) competence to stand trial, and (4) prisoners, ie., after someone has been convicted of a crime.

The United States Supreme Court has held that the right to be free from unwanted psychiatric medication is a fundamental right, which requires due process protection.[17] In *Sell*, *supra*, which was a case in which the government wanted to force psychotropic drugs on Dr. Sell to make him competent to stand trial, it ruled the government could only do so on the following conditions:

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[12] *Humphrey v. Cady*, 405 U.S. 504, 509, 92 S.Ct. 1048 (1972).
[13] *Addington v.Texas*, 441 U.S. 418, 425, 99 S.Ct. 1804 (1979).
[14] *Kansas v. Crane*, 534 U.S. 407, 409, 122 S.Ct. 867, 869 (2002).
[15] *O'Connor v. Donaldson*, 422 U.S. 563, 575-76, 95 S.Ct. 2486, 2494 (1975).
[16] M. Perlin, Mental Disability Law: Civil and Criminal, 2nd. Ed. , §2.C-5.3, *Lexis Law Publishing*, 1998.
[17] *Sell v. United States*, 539 U.S. 166, 123, S.Ct. 2174, (2003); *Riggins v. Nevada*, 504 U.S. 127, 112 S.Ct. 1810, (1992); *Washington v. Harper*, 494 U.S. 210, 110 S.Ct. 1028 (1990).

> First, a court must find that *important* governmental interests are at stake.
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> Second, the court must conclude that involuntary medication will *significantly further* those concomitant state interests.
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> Third, the court must conclude that involuntary medication is *necessary* to further those interests. The court must find that any alternative, less intrusive treatments are unlikely to achieve substantially the same results.
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> Fourth, as we have said, the court must conclude that administration of the drugs is *medically appropriate*, i.e., in the patient's best medical interest in light of his medical condition. The specific kinds of drugs at issue may matter here as elsewhere. Different kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success.[18]

While *Sell* is a competence to stand trial case, it is based on well-established constitutional principles and should be equally applicable to the civil context. In fact, the Alaska Supreme Court recently utilized a similar analysis in the civil context, even though it was based on the Alaska constitution.[19] *Sell* explicitly forbids forced drugging if there is a less intrusive means to accomplish the governmental interests.

In light of the poor efficacy and extreme harm caused by the psychotropic drugs most often given involuntarily, if properly considered, it would be rare, if ever that the courts could constitutionally order people to be administered such drugs against their will.

Proposed Changes to Involuntary Commitment

The July 26, 2007, Draft Report to the Commission on Inpatient Commitment Criteria proposes the Virginia statute on involuntary commitment be changed to the following:

> Definition: Involuntary admission to a psychiatric inpatient facility refers to the admission of a person who has refused voluntary admission after sufficient explanation of the purpose of admission, or to the admission of a person who lacks the capacity to consent to voluntary admission.
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> A person may be involuntarily admitted to a psychiatric inpatient facility for treatment upon a finding of the court by clear and convincing evidence that:
>
> 1) He or she has a mental illness and as a result of such mental illness:
>
> a. there is a substantial likelihood that in the near future he or she will cause serious physical harm to himself to herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; or
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> b. there is a substantial likelihood in the near future that he or she will suffer serious harm due to substantial deterioration of his or her capacity to

[18] *Sell v. United States*, 539 U.S. 166, 180-1, 123, S.Ct. 2174, 2184-5 (2003).
[19] *Myers v. Alaska Psychiatric Institute*, 138 P.3d 238 (Alaska 2006).

protect himself or herself from such harm or to provide for his or her basic human needs; [or

c. he or she is unable to comprehend the nature of his or her illness or the need for treatment, is experiencing a substantial impairment of his or her judgment, reasoning, or behavior, and will, if not treated, suffer or continue to, suffer a substantial deterioration in his or her previous ability to function in the community;] and

2) All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been investigated and judged to be inappropriate.

Voluntary Admissions/Capacity to Consent

It is agreed it is very important that people be given the opportunity to sign themselves in voluntarily. However, trying to make determinations regarding capacity to consent to voluntary admission is rife with problems. The real issue to be addressed is whether the admission is truly voluntary, including that the person understands he or she can not necessarily leave if he or she doesn't like being at the hospital. While it is true *Zinermon v. Burch*[20] ruled that hospital personnel can be sued under the federal civil rights statute, 42 USC § 1983, for improperly admitting a person voluntarily, in *O'Connor v. Donaldson*,[21] the U.S. Supreme Court held hospital personnel were liable under 42 USC §1983 for involuntarily committing someone in violation of their constitutional rights. In both cases, the violation occurred because the person was locked up in violation of their rights.[22] People who are admitted voluntarily should be allowed to leave when they want to.

"Substantial Likelihood"

As set forth above, in *Addington*, the United States Supreme Court held that because of the massive curtailment of liberty represented by involuntary commitment, a state must prove its entitlement thereto by "clear and convincing evidence." Also as set forth above, in *Kansas v. Crane*, the US Supreme Court held that it is only permissible to involuntarily commit someone if he or she is dangerous to one's self or others. Thus, the proposal's allowance of commitment based on "clear and convincing" evidence that something has a "substantial likelihood" does not appear to be constitutionally permissible. In other words, it does not require clear and convincing evidence of dangerousness. It only requires clear and convincing evidence of a substantial likelihood of dangerousness which is a substantially lesser standard.

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[20] 494 U.S. 113 (1990).

[21] *O'Connor v. Donaldson*, 422 U.S. 563, 575-76, 95 S.Ct. 2486, (1975).

[22] My experience is that people's rights are violated as matter of course. It is the violation of people's rights under color of state law that gives rise to §1983 liability and if Virginia truly wants to avoid this liability, it should establish a system in which rights are honored. This requires serious legal representation such as was required by the Montana Supreme Court in *In re: K.G.F* 29 P.3d 485 (Mont. 2001).

Imminent versus Near Future

While at least one court has required imminence,[23] it is certainly not universal. "Near future" is probably sufficient, depending on what that means.

Substantial Deterioration

In *O'Connor*, the US Supreme Court considered whether the more passive harm of not taking care of one's self might be grounds for commitment. The Court noted that someone is dangerous to himself if he is "helpless to avoid the hazards of freedom"[24] and then went on to hold the state may not constitutionally lock someone up if he or she is "capable of surviving safely in freedom, on their own or with the help of family or friends."[25]

In proposed section 1)b., one can be locked up for being in danger of serious financial harm. This appears to be unconstitutional under *O'Connor*.

In proposed section 1)c., which the author calls a "Third Standard," someone can be committed based on a prediction the person will suffer substantial deterioration of his or her previous ability to function in the community. This also appears to be unconstitutional under *O'Connor*. This is precisely what the Alaska Supreme Court ruled unconstitutional earlier this year in *Wetherhorn v. Alaska Psychiatric Institute*.[26] The Alaska Supreme Court based its decision on the Alaska Constitution, but acknowledged it was also true under the United States Constitution.

Involuntary Medication

In the June 22, 2007, Second Report of the Subcommittee on Policies and Procedures, it is suggested that "best interests" be changed to "substituted judgment." As set forth above, *Sell* requires that "the court must conclude that administration of the drugs is *medically appropriate*, i.e., in the patient's best medical interest in light of his medical condition."[27] In *Myers v. Alaska Psychiatric Institute*,[28] the Alaska Supreme Court recently used struck down Alaska's statute as unconstitutional under the Alaska Constitution for failing to require the court to find it is in the person's best interest.

In doing so, the 2006 *Myers* case recognized the extreme intrusiveness of psychiatric drugs:

> [T]he truly intrusive nature of psychotropic drugs may be best understood by appreciating that they are literally intended to alter the mind. Recognizing that

[23] *See*, e.g., *Suzuki v. Yuen*, 617 F.2d 173, 178 (CA9 1980).
[24] 422 US at 574, 95 S.Ct. at 2493.
[25] 422 US at 575, 95 S.Ct. at 2494.
[26] 156 P.3d 371 (Alaska 2007).
[27] *Sell v. United States*, 539 U.S. 166, 181, 123, S.Ct. 2174, 2185 (2003).
[28] 138 P.3d 238 (Alaska 2006).

> purpose, many states have equated the intrusiveness of psychotropic medication with the intrusiveness of electroconvulsive therapy and psychosurgery.[29]

In Massachusetts, which uses the substituted judgment test, a best interests determination is a required element of substituted judgment that must consider the following elements:

1. The patient's expressed preferences regarding treatment.
2. The strength of the incompetent patient's religious convictions, to the extent that they may contribute to his refusal of treatment.
3. The impact of the decision on the ward's family -- this factor being primarily relevant when the patient is part of a closely knit family.
4. The probability of adverse side effects.
5. The prognosis without treatment.
6. The prognosis with treatment.
7. Any other factors which appear relevant.[30]

Thus, substituted judgment is really only allowed to overrule best interests when it would result in honoring the person's desire to avoid the drugs. If instead it is intended here to relax the standard, it appears to be unconstitutional.

Counsel

The June 22, 2007, Second Report of the Subcommittee on Policies and Procedures proposes changes for minor enhancements to representation. The failure of counsel appointed to represent psychiatric defendants to adequately represent their clients is where the legal system is most broken. As Professor Perlin has stated, "Traditionally, lawyers assigned to represent state hospital patients have failed miserably in their mission."[31] More recently, he has written:[32]

> The assumption that individuals facing involuntary civil commitment are globally represented by adequate counsel is an assumption of a fact not in evidence. The data suggests that, in many jurisdictions, such counsel is woefully inadequate—disinterested, uninformed, roleless, and often hostile. A model of "paternalism/best interests" is substituted for a traditional legal advocacy position, and this substitution is rarely questioned. (at 738, footnotes omitted)
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> * * *
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> The track record of lawyers representing persons with mental disabilities has ranged from indifferent to wretched; in one famous survey, lawyers were so bad that a patient had a better chance of being released at a commitment hearing if he appeared pro se. (at 743, footnote omitted)

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[29] 138 P.3d at 242.
[30] *Rogers*, 458 N.E. 2d 308, 318-19 (Mass 1983).
[31] Perlin, "Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization," Houston Law Review, 28 Hous. L. Rev. 63 (1991).
[32] 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 Law Review 735 (2005).

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> 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. . . . "Empirical surveys consistently demonstrate that the quality of counsel 'remains the single most important factor in the disposition of involuntary civil commitment cases." (at 745-6, footnotes omitted)

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> Without such [adequate] counsel, it is likely that there will be no meaningful counterbalance to the hospital's "script," and the patient's articulated constitutional rights will evaporate. (at 749)

This was also recognized by the Montana Supreme Court in *K.G.F*:

> "Reasonable professional assistance" cannot be presumed in a proceeding that routinely accepts—and even requires—an unreasonably low standard of legal assistance and generally disdains zealous, adversarial confrontation.

* * *

> 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 24 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.[33]

The Montana Supreme Court then went on to require the following minimum standards for the performance of counsel.[34]

1. Appointment of Competent Counsel, including understanding of the legal process of involuntary commitments, as well as the range of alternative, less-restrictive treatment and care options available. ¶71.

2. Initial Investigation that, at a minimum, includes: the patient's prior medical history and treatment, if and to what extent medication has played a role in the petition for commitment, 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. ¶74. . . 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

[33] 29 P.3d at 492-3, emphasis added.
[34] The "¶" references are to the paragraph numbers in the opinion.

by the client as having relevant information, and be prepared to call such persons as witnesses.[35] ¶76

3. The Client Interview. The initial client interview should be conducted in private and should be held *sufficiently before any scheduled hearings* to permit effective preparation and prehearing assistance to the client. ¶78 Counsel should also ascertain, if possible, a clear understanding of what the client would like to see happen in the forthcoming commitment proceedings. ¶79

4. The Right to Remain Silent. Any waiver of right to remain silent to be interviewed by hospital psychiatrist must be knowing and counsel is entitled to be at such an interview. ¶83

5. Counsel as an Advocate and Adversary. 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." In 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. ¶86

These are the types of standards that are necessary.

Outpatient Commitment

The undated draft titled "Criteria for Mandatory Outpatient Treatment" proposes extensive use of outpatient commitments. Proposals to increase outpatient commitment are irrational. After an extremely comprehensive and thorough evaluation of outpatient commitment, a UK government report conluded that "[i]t is not possible to state whether community treatments orders (CTOs) are beneficial or harmful to patients."[36] Another review of the effectiveness of outpatient commitment found that "[i]n terms of numbers needed to treat, it would take 85 OPC orders to prevent one readmission, 27 to prevent one episode of homelessness and 238 to prevent one arrest."[37]

These sorts of proposals as contained in the draft reviewed get enacted due to well-publicized tragedies, but end up doing nothing for public safety. The Treatment Advocacy Center, based in Virginia, is well known for exploiting tragic events to promote such legislative enactments:

> Advocates of reinvigorated commitment statutes--many of them family members of people with serious mental illness--have sold their approach to state legislatures by playing on already exaggerated public fears of violence committed

[35] It is my belief the attorneys should take depositions of the most important witness(es) against their clients for the same reasons they are taken in normal civil cases.
[36] Department of Health (UK), Institute of Psychiatry (2007), "International experiences of using community treatment orders."
[37] "Compulsory community and involuntary outpatient treatment for people with severe mental disorders," *The Cochrane Database of Systematic Reviews* 2005, Issue 3. Art. No.: CD004408.pub2. DOI: 10.1002/14651858.CD004408.pub2.

by people with a mental disorder. As stated by one of the most visible figures in the treatment advocacy movement,

> Laws change for a single reason, in reaction to highly publicized incidents of violence. People care about public safety. I am not saying it is right, I am saying this is the reality. . . . So if you're changing your [civil commitment] laws in your states, you have to understand that.[38]

In New York, which enacted its outpatient commitment statute, known as "Kendra's Law," in response to a tragic situation, its highest court found the statute constitutional only because it did not actually require the person to take the drugs and "simply triggers heightened scrutiny on the part of the physician, who must then determine whether the patient may be in need of involuntary hospitalization."[39] However, the New York Court was apparently not presented with the evidence that outpatient commitment simply does not work and the result might be different if/when such evidence is presented in a different case.

Conclusion

If Virginia truly wants to increase public safety and improve the lives of people who are diagnosed with serious mental illness, the answer is to fund the types of approaches that have been demonstrated to dramatically improve outcomes. This would pay a big dividend because it would cut at least in half the number of people who end up permanently disabled and thus on the government fisc. Enacting laws the evidence shows will be counterproductive and constitutionally infirm is not the answer.

As you know, the mission of the Law Project for Psychiatric Rights (PsychRights®) is to mount a strategic litigation campaign against unwarranted court ordered psychiatric medication around the country.[40] It has had some considerable success in Alaska[41] and has started to work on mounting campaigns in other states upon the invitation of local Consumers/Survivors/eX-patients (C/S/X). Especially if some of the proposals which seem obviously unconstitutional are enacted, and PsychRights is invited by local C/S/X to do so, we would be please to see how we might assist. I will be in Washington, DC, October 13-15, and could probably swing down to your neck of the woods for a day or so after that if that is desired.

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[38] *See*, J. Monahan, A Jurisprudence of Risk Assessment: Forecasting Harm Among Prisoners, Predators, and Patienst, 92 *Virginia Law Review* 391, 400-1, n. 35 & 36, (2006), footnotes omitted, but footnote 36 cites to such statements by E. Fuller Torrey and Mary Zdanowicz of the Treatment Advocacy Center appearing in the Wall Street Journal.

[39] *In the Matter of K.L.*, 806 N.E. 2d 480, 486 (NY 2004)

[40] *See*, How the Legal System Can Help Create a Recovery Culture in Mental Health Systems, available on the Internet at http://psychrights.org/Education/Alternatives05/RoleofLitigation.pdf.

[41] *See*, Report on Multi-Faceted Grass-Roots Efforts To Bring About Meaningful Change To Alaska's Mental Health Program available on the Internet at http://psychrights.org/Articles/AKEffortsRevMar07.pdf.