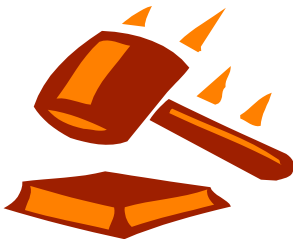
A Client Perspective of Mental Health Courts and the Use of Force and Coercion

A Compilation of Writings Addressing the Issue of Mental Health Courts, Coercion, and Recovery Approaches



2014

“Force and coercion drive people away from treatment,” said Jean Campbell, Ph.D., one of the nation’s leading mental health researchers. “In 1989, 47% of Californians with mental illnesses who participated in a consumer research project reported that they avoided treatment for fear of involuntary treatment; that increased to 55% for those who had been committed in the past.”

“No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his[/her] own person, free from all restraint or interference of others, unless by clear and unquestioned authority of law.”

— United States Supreme Court
(Union Pacific Railway Co. v. Botsford)

"Of all tyrannies a tyranny sincerely exercised for the good of its victims may be the most oppressive. It may be better to live under robber barons than under omnipotent, moral busybodies. The robber baron's cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience.... To be "cured" against one's will and cured of states which we may not regard as disease is to be put on a level with those who have not yet reached the age of reason."

-Lewis, C.S. "The Humanitarian Theory of Punishment," God in the Dock.
William B. Berdmans Publishing Company, Grand Rapids, MI, 1994.

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- Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial, by Tom Burns, Jorun Rugkåsa, Andrew Molodynski, John Dawson, Ksenija Yeeles, Maria Vazquez-Montes, Merryn Voysey, Julia Sinclair, and Stefan Priebe, *The Lancet*, Vol 381 (2013)
- Evidence Regarding OutPatient Commitment, by Toby T. Watson, Psy.D.
- The relationship between voluntary and involuntary outpatient commitment programs An Assessment of the Scientific Research on OPC Implementation, by Jasenn Zaejian, Ph.D. November 18, 2011.
- International experiences of using community treatment orders, by the Institute of Psychiatry at the Maudsley (UK), March 2007. This study, which says it is the most comprehensive and thorough review of outpatient commitment, concluded "it is not possible to state whether community treatments orders (CTOs) are beneficial or harmful to patients."
- Does compulsory or supervised community treatment reduce 'revolving door' care? Legislation is inconsistent with recent evidence, by Stephen Kisely and Leslie Anne Campbell, *British Journal of Psychiatry*, 197, 373-374 (2007)
- The Effectiveness of Involuntary Outpatient Treatment Empirical Evidence and the Experience of Eight States, by M. Susan Ridgely Randy Borum John Petrila, *The Rand Corporation*, 2001.
- Kisely S, Campbell LA, Preston N. 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. This study found little beneficial effect: "In 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."

INTRODUCTION

Mental health services in this country consist mainly of voluntary and involuntary inpatient stays, diagnosing, prescribing daily psychiatric drug regimens, day programs, entitlements, electroconvulsive therapy and "treatment" that is either forced or coerced. These therapies are driven by the idea that emotional distress can be reduced to an abnormality in the brain or the unproven theory that there is a chemical imbalance. This medical model approach of seeing symptoms as evidence of disease or pathology has perpetuated a reliance on medication and symptom management as adequate responses to mental illness. The system's biological approach reduces human distress to a brain disease, and recovery to taking a pill. The focus on drugs obscures issues such as housing and income support, vocational training, rehabilitation, and empowerment, all of which play a role in recovery.

Our entire system of care for people with emotional distress is built around illness. This is a negative approach. We diagnose illness. We complain of illness. We treat illness. We label illness. Even wellness means an absence of illness so we treat the symptoms of illness. Recovery means getting over illness. The person who is "well" is one who causes no community disturbance, no matter how disabled or incapacitated they may be (often as a result of "treatment").

The outcomes of this approach have resulted in a 25-year reduction in life span for people receiving public mental health services, according a study led by Dr. Joe Parks for the National Association of State Mental Health Program Directors. It has also significantly increased the number of people on Social Security Disability Insurance, the suicide rate, the incarceration rate and the homelessness rate, according to the National Association For Rights Protection And Advocacy and others who have studied results of mental health treatments. The most detrimental ramification of the current approaches to mental health services and treatment is that they tend to deprive hope.

Adherents to the medical model believe that a disabled person's problems are caused by the fact of his or her disability and thus the question is whether or not the disability can be alleviated. Advocates of the disability-rights model, on the other hand, believe that a person with a disability is limited more by society's prejudices than by the practical difficulties that may be created by the disability. Under this model, the salient issue is how to create conditions that will allow people to realize their potential.

We know outcomes improve if those seeking help from mental health facilities are aided by peers who have experienced firsthand comparable struggles and know the path to recovery. Such peer-to-peer relationships can provide critical mutual and empathetic support. Individuals in the peer role are ideally suited to facilitate the process of fellow consumers employing wellness tools such as yoga, meditation/mindfulness, movement and intentional exploration of the impacts of nutrition on states of mind.

Everyone working in the system needs to be educated to promote the belief that individuals labeled mentally ill will recover. They need to promote and encourage the creation of life goals and movement toward them. This creates a framework through which to direct one's treatment — rather than simply devoting time and effort toward analyzing, mitigating and correcting symptoms or problems.

We must reconsider relying on psychiatric-drugs as the first line of defense (particularly when treating children). Peer support — which offers self-disclosure as a tool that provides hope and suggested wellness tactics for individuals who welcome such information — must be available to every person entering any part of the mental health system. Support that is sensitive to trauma issues is necessary and creates places where people can feel safe to heal.

Mental Health Courts

(compiled and written by Pat Risser)

In advocating for mental health courts, Rusty Selix, the executive director of the Mental Health Association in California, wrote, "Unfortunately, across the United States, people with mental illnesses are overrepresented in prisons and jails. In California alone, it is estimated that between 20 percent and 25 percent of all California prisoners are afflicted with serious mental health problems such as schizophrenia and bipolar disorder." (http://www.nctimes.com/articles/2007/07/15/perspective/20_15_047_14_07.txt)

Mental illness is a concept subject to debate. There are no biochemical markers, no biological tests, no hard evidence at all, to "prove" the existence of "mental illness." Proof means the ability to demonstrate a reliable association between a clearly specified pattern of observables and other reliably measurable event(s) which operate as antecedents. (This is same level of proof used for TB, cancer, diabetes, etc.) In addition, it is not sound medical practice to label our thoughts, moods, feelings or emotions a disease, disorder or illness.

It is claimed by some that mental health courts will provide a stopgap to prevent mentally ill offenders from becoming part of the prison system. Part of my problem is that while we're allegedly seeking equality, we're also seeking "special" treatment. So SB 851 provides a stopgap for "mentally ill" offenders. What's next? A stopgap for offenders with blond hair and blue eyes? How about offenders who can wiggle their ears? Why should any "offender" be treated differently? Allegedly, mental health courts will offer alternatives to defendants with "mental illness." Isn't that everyone? Hasn't the DSM just about reached the point where we're all in there somewhere? Supposedly the law will target only those “most seriously ill,” those with bipolar or schizophrenia. But, there is no training to allow law enforcement or judges to diagnose.

Most legislation for mental health courts claim that they will, when appropriate, offer defendants an opportunity to participate in court-supervised, community-based treatment in place of typical criminal sanctions. What is "community-based" treatment and is it, in reality, anything but forced drugs administered by the decree of psychiatrists? It's a shame to surrender the criminal justice system to psychiatry. I believe our criminal justice system belongs to and should remain the purview of those who have been trained in the law. Lawyers, judges and other legal advocates have a much greater awareness of peoples' rights and their obligation to defend and protect those rights.

Setting aside the "mental illness" debate for a moment, there are at least two other obvious solutions. First, law enforcement can choose to not arrest folks. There would be fewer problems if they turned an unseeing eye toward minor offenses. Shoplifting a candy bar because you’re hungry or urinating behind a bush because you’re homeless won’t be solved by forcing people to be labeled and forcibly drugged. The other solution is that people (not just those labeled "mentally ill") should not break laws. Fewer broken laws equals fewer arrests equals fewer in jails and prisons. If people choose to break laws, perhaps they should heed the saying, "if you can't do the time, don't do the crime." We need outpatient services that include peer support and focus on recovery. With education, people can learn that there are alternatives to help get their needs met instead of breaking the law.

Another solution would be to have the police be able to call a peer case manager who could come to the scene and assess the situation. This peer could have the authority to release the officers back to patrol and save time, money, paperwork and efforts that tie up the officers. The peer could help deescalate the situation, calm the person and direct the person to aid and assistance that would not be coercive. The program has been highly successful in places where it's been tried (Citywide Case Management in Denver, Colorado, circa 1988).

Mr. Selix states that, "Effective mental health treatment is the missing element of corrections reform." The "system" has been working at getting better and more "effective" for many, many years. If their efforts are tied to the increase in prison population then I guess they haven't done a good job. The only folks I'm seeing get much better are those who are connected to solid peer supports and services. It seems a shame to refer people (or rather "sentence" them) to a system that the President's New Freedom Commission said is, "in a shambles." Of course, folks in California (like Mr. Selix) should be aware of that since Steve Mayberg (Mental Health Director of California) was on that Commission.

Psychiatry holds a legacy of over one-hundred years during which people identified as having serious mental illnesses were confined to institutions, often for the remainder of their adult lives. This period of institutionalization both gave birth to and perpetuated the belief that these illnesses were permanently disabling. As it turns out, what was permanently disabling was being confined to an institution, not the illnesses themselves. Since the end of that era, epidemiologic and longitudinal studies have found that many people do well over time, and that when they do well, they often see no reason to seek or utilize mental health services.

Mental health courts are segregationist apartheid. (I first heard this term used by Judi Chamberlin.) Any time we take one group and set them apart from everyone else, we are practicing discrimination. What's next? Separate drinking fountains and bathrooms and eating areas and then moving people into ghettos and then labor camps from which they are never heard from again? All done with the approval and acceptance of the law and respecting our 'rights.' What's needed is something where the treatment system is the one ordered to provide real supports to people to help them to live and thrive successfully in the community of their choice. (Federal definition of 'recovery' is, "a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.")

Mental health court should be the court of the mental health system and not the court of people being forced or coerced into treatment that doesn't work. It should not be the court of 'compliance.' Imagine jailing a diabetic for having dessert or incarcerating a person having chronic bronchitis for lighting up a cigarette or forgetting his/her inhaler. No one would find such a solution to public health problems acceptable because it violates people's right to choose their lifestyles and medical treatment. In virtually all other medical concerns, we have upheld individuals' rights in this regard irrespective of the possible risks to self or others. It is absurd to imagine jailing (or threatening to jail) someone for non-compliance with medical treatment. We wouldn't jail someone for not adhering to a diet and eating fast food. We don't treat people "for their own good" over their objections. If you have cancer, you have an absolute right to refuse treatment, even if it means you will die.

Mental health courts are courts of force and coercion and are indicative of treatment failure and should not be used. Force isn't treatment. A therapeutic alliance is impossible in the face of force/coercion. Force and coercion are abuse. MH Courts are solely designed to "force" medication "compliance." Sure, they claim to only be helping people to comply with "treatment" but in this day and age, "treatment" more and more consists solely of medication. People are just plain contrary and generally non-compliant. Most people don't take the full ten days of antibiotics as prescribed. They stop when they feel better. There are endless other examples and studies of non-compliance for heart patients and people with diabetes. However, compliance is the major concern of the mental illness system and families who expect those in the mental illness system to uphold a standard of compliance higher than everyone else.

While complying with 'treatment' consisting almost solely of medications, it's good to remember two particularly damning recent research studies. One found that mental patients in the United States are now living an average of 25 years less than those who escape notice by the psychiatric

system. The other study by the World Health Organization found that third-world countries that practice far less 'western medicine' actually have far higher 'recovery' rates. Perhaps less invasive 'treatments' should be emphasized. Perhaps mental health courts should consider that they might be sentencing people to a death sentence of a shortened life span. A life cut by one-third is not a satisfactory outcome to justify the use of force and coercion in a broken system.

Mental health courts create another 'entrance' door into the system yet the system is chronically overcrowded and without enough corresponding 'exit' doors. Our courts are equally overcrowded. It is not the job of the legal system to adjudicate 'treatment.' The legal system lacks the knowledge and expertise to dictate terms of 'treatment' for people and the legal system incorrectly relies upon the medical model of psychiatric care to help people. The medical model of psychiatric care is a failure. Mental health courts are a wasteful diversion of people and resources from the mental health system to a criminal justice system that also lacks resources and connections to the community. And, what about the people who, because they are difficult to treat, will get labeled as 'treatment resistant' or 'non-compliant' and it is due to the inadequacies of the mental health provider or the treatment program. It is claimed that mental health courts are necessary to stop the revolving door of the mental health system and the criminal justice system. Yet, there are no studies to indicate that using the coercion or force of a court system does anything to reduce recidivism. There is no proof that forcing people into "treatment" either reduces recidivism in the mental health system or the prison population.

Mental health courts are typically funded by mental health funds. How did that happen? Was it put to a vote? And, does the mental health system have any obligation to the criminal justice system or should the funds of the criminal justice system cover their own? The mental health system is for those who are psychiatrically labeled and the criminal justice system is for those incarcerated for breaking the law. The two aren't the same and certainly aren't funded the same. Do we want the funds of the mental health system diverted to criminal justice? Doesn't the criminal justice system have lots and lots of their own funds? Besides, there really isn't any mental health system. There's only a mental illness system. People are labeled as mentally ill, treated as mentally ill and given mental illness drugs. As a result, we die an average of over 25 years sooner but hey, aren't we mentally "healthier?"

Mental health courts need to assure that they don't blame the person for the failures of the mental health system. Instead of creating courts to force medication compliance, we should spend our valuable time, energy and resources creating true alternatives that work to divert people into proven successful self-help programs (that they will desire and therefore automatically 'comply' with). How do we get people 'out' from under the thumb of the mental health courts once they are in? In Oregon, people can remain under the PSRB (Psychiatric Services Review Board for following forensic patients after their release) system for far longer than necessary. People who are no longer considered a danger to themselves or others are often forced to continue to comply with 'treatment' (forced drugs) despite the known dangers of these drugs.

Most people who have been labeled with psychiatric disabilities have experienced abuse, neglect and trauma – it is wrong to label the result of those experiences as sickness or illness. It is also wrong in a similar way to label the control of the natural thoughts, feelings and emotions that result from abuse, neglect and trauma as healing, recovery or wellness and it is even worse to drug or shock those thoughts, feelings and emotions into control or submission. This IS the medical model and 'treatment' at it's worst. Mental health courts that force people into medication compliance do not consider the whole person and their background, history and other factors. Forcing someone into submission may cause him or her to no longer be a public nuisance, but there is no consideration of how miserable or incapacitated it may make him or her. There is likewise no consideration of how toxic his or her environment may be. Drugs do not help poverty, joblessness, homelessness, abuse and other social ills that contribute to the emotional distresses that cause people to come to the attention of the mental illness system.

The mental illness system deludes, diminishes, discounts and distorts the reality of consumer/survivors by diverting attention from abuse, neglect and trauma and victims' natural reactions. The mental health system shifts the focus to sickness/healing rather than remediation of injustice. While our children are locked in psychiatric units, the parents and other adults who abused, neglected and otherwise mistreated them are continuing their lives free of any consequences. While adults languish in hospitals or drug induced stupors in 'treatment' programs, those who originally abused, neglected or otherwise mistreated them are continuing their lives free of any consequences.

Part of the difficulty of coping with trauma issues can be an overwhelming sense of hopelessness, helplessness and powerlessness. It is impossible to learn how to cope with these issues while under a court ordered “treatment” that induces an overwhelming sense of hopelessness, helplessness and powerlessness.

The system blames the victim instead of seeking remediation and providing validation. The system often fails to acknowledge that the people it serves have usually been victims. The system 'treats' these victims by blaming them in the form of labeling them as 'mentally ill.' The system invalidates our experiences and us through the use of its language. Not only are the labels invalidating, so is much of the language. For example, the term 'side-effects' minimizes and trivializes the impact of the very real effects of medication and makes it easier to blame the person for non-compliance. Statements like, "Oh, it's just a side-effect," gloss over our very real suffering and refocus on coercing our compliance. It's tragic how often psychiatrists will dismiss tremors and other uncomfortable and even more serious maladies as "just a side-effect." Sometimes, even death is a "side-effect." In any other social structure, the use of seclusion and restraints would be considered torture and locking people up against their will would be called incarceration and not 'treatment.'

Family members also blame the victim and label behaviors as mental illness rather than face the fact that the family dynamic is broken. Perhaps the person was a victim of abuse, neglect or trauma but rather than admit responsibility, the family will relieve their guilt by labeling the victim as mentally ill. It attacks the credibility of the individual and if medications can be used, it can even mask the memories and further cloud the individual and make his or her to blame.

Drugs are not solutions. Psychiatric drugs need to be used with more caution and restraint. Underlying causes of people's distress needs to be addressed. We can't solve homelessness, poverty, joblessness, abuse and other social issues with a prescription pad. Drugs don't solve poverty issues and they don't heal emotional wounds. People who have poverty issues ought not have to be labeled mentally ill to get housing, meaningful employment, social opportunities, etc. Staff have been mis-trained to equate subduing a person with treatment; a quiet client who causes no community disturbance is deemed 'improved' no matter how miserable or incapacitated that person may feel as a result of the 'treatment.' Someone may go for years and years to a day treatment program where they live from cigarette to cigarette or measure time from Big Gulp to Big Gulp (a 7-11 soft drink) but they have no life. They are essentially 'soul dead' but as long as they stay out of the hospital and comply with taking their drugs, they are considered a success. We need to define success differently! Mental health courts contribute to the distress of people by becoming a 'compliance enforcement' branch of psychiatry. Mental health courts know little to nothing about how psychiatry contributes to peoples' misery. Re-traumatization is common.

*** POSITION OF THE NATIONAL MENTAL HEALTH ASSOCIATION ON MENTAL HEALTH COURTS:**

"Mental health courts, and all other courts dealing with mental health treatment issues, need to be vigilant to minimize the use of coercion to compel treatment. The danger is that in the hope of improving access to scarce treatment resources, mental health courts will, in the end, increase coercion and stigma. There is also the risk that they will fail to effectively triage available treatment resources to achieve the best overall public health outcomes. The basic problem is that the courts cannot run the mental health system from their limited vantage point and cannot provide the resources needed to fill the gaps. Therefore, mental health courts risk inappropriate intervention of the criminal justice system, with no real improvement in treatment outcomes. At best, they may effectively determine individual needs and advocate for good individual treatment. At worst, they risk further criminalizing people with mental illnesses and fragmenting the mental health and criminal justice systems."

Mental Health Courts don't really solve the criminalization of psychiatric disability. In many places, they are a well-meaning response to the discrimination and stigma of the regular court system, the lack of mental health care in the jails, and the tendency of police to arrest people with psychiatric disabilities in order to get them off the street. A better, although more difficult, solution is to educate judges and ensure that they do not treat people with psychiatric disabilities with contempt; make sure that jails provide adequate mental health care, and make clear to police that it is not their function to clear the streets of idiosyncratic people who make shopkeepers nervous. In other words, mental health courts don't solve the root problem. Part of the problem with the mental health system is that there is a lack of clarity regarding the product, goals, mission and purpose. It is unclear whether the primary task is to produce 'Medicaid billable units of service' or treatment hours or tenure in the community for the clients or cost savings for the agency. It is unclear for whom the clinicians work, whether it's on behalf of the clients or the agency or the system and whether their task is to help people improve their quality of life (as defined by the clients) with successful living in the community of their choice or whether it's to improve company profits.

The only way mental health courts might effectively work is if they became the court of the mental illness system. Rather than hold the individual to blame, courts should hold the system accountable. If a person is not getting their needs met by the system, it should rightfully be called a problem with the system. Mental illness courts might order the system to perform their duty and meet the needs of the person. Homelessness would be solved by finding the person a home. Poverty and unemployment can be solved by helping to set the person on a career path.

Mental health courts are usually only for misdemeanors, and minor ones at that. They basically use 'crimes' like loitering or shoplifting less than $5.00 worth of goods to sweep people into a treatment system. Some objections to mental health courts might be muted if they were only used for major (i.e. death penalty or life imprisonment) felonies.

People are not given much opportunity to exercise much in the way of informed consent over whether they will go to a mental health court or regular court. Additionally, mental health clients are not given the right to make mistakes (fail) without it being judged negatively. Thus, they are deprived of the growth opportunities that everyone else experiences through trial and error. People don't know when they 'consent' to mental health court that they may be caught in a web of force and coercion lasting many years longer than if they just dealt with the offense that brought them to the attention of the system. In addition, they may not realize that they might essentially be sentenced to a shorter life span by taking medications that can result in that shortened life span being filled with misery, pain and suffering.

The jurisdiction of mental health courts can go on much longer than a person would have served

for the misdemeanor for which he or she was arrested. If the court requires that a person be involved in mental health treatment for anytime longer than the time required for jail and probation/parole, then the court is participating in 'unnecessary' coercive treatment. Mental health treatment should be a choice. Just as some people choose to be treated or not treated for certain medical problems, they should have the same choice regarding mental health treatment. It is a fairness in sentencing issue (although it is at the opposite end of what is usually presented as fairness in sentencing). I do believe that people with mental health issues involved in the justice system should be able to access treatment if they so desire. There is no 'treatment alliance' (that which psychiatrists claim contributes to 'success' in the mental illness system) in the court system.

Having worked in community mental health programs and having been a client of community mental health programs, I am also concerned about the people who because they are difficult to treat will get labeled as 'treatment resistant' or 'non-compliant' due to the inadequacies of the mental health provider or the treatment program. A program that 'fails' the client will result in blame and 'punishment' directed toward the client. A provider who 'fails' in their job will be ignored while the client will be chastised, penalized or sentenced.

In Florida, the judge in the mental health court got state appropriations for specific mental health treatment units to which she sent people who came before her court. Legally that violates separation of powers doctrine. While many praised this judge for her kindness and creativity, there is no guarantee that other judges will be as kind or creative in their efforts.

The system needs to be completely revamped. Clients are trained to be "mentally ill" and not mentally healthy. Efforts are focused on disability instead of strengths and abilities. Dependency is maintained under the guise of good care. The system is staff-oriented as opposed to client-oriented. The system is still heavily biased in favor of institutional based containment rather than community based supports. Many within the treatment system believe recovery is an unattainable myth.

Criminal records keep people from getting housing in the community, employment, interfere with parental rights, and can seriously affect eligibility for many social programs. Rather than operating as diversion from the criminal justice system, the mental health system is increasingly serving as the gateway into the criminal justice system. More and more as seclusion and restraints are reduced on inpatient units, mental health staff call upon the police to arrest and control patients. Outpatient systems call upon police for everything from "welfare checks" to enforcement of outpatient commitment orders.

Compliance is an issue of control, not treatment. People in general don't 'comply.' Many who were prescribed 10 days of antibiotics stop after a few days when they feel better. Few actually 'comply' with diets. We're just generally ornery and contrary and to expect compliance is to deny our basic humanness.

The Communist Takeover Of America - 45 Declared Goals.

Communist Goals - Congressional Record - Appendix, pp. A34-A35 January 10, 1963.
(as read before Congress in 1963).

Current Communist Goals EXTENSION OF REMARKS OF HONORABLE A. S. HERLONG, JR. OF FLORIDA IN THE HOUSE OF REPRESENTATIVES Thursday, January 10, 1963.

#38) Transfer some of the powers of arrest from the police to social agencies. **Treat all behavioral problems as psychiatric disorders which no one but psychiatrists can understand or treat.**

#39) **Dominate the psychiatric profession and use mental health laws as a means of gaining coercive control over those who oppose Communist goals.**

Three Faulty Medication Compliance Assumptions:

1. Psychotropic medications are effective (not true for many)
2. Psychotropic medications are safe (tardive dyskinesia and other harmful effects are all too common)
3. People stop taking psychotropic medications for inappropriate reasons (as you know, this is nonsense)

There are serious concerns about the checks and balances of the system. Where are they? An attorney may represent the person in their defense, and if they determine the program is not beneficial for their client, they may not recommend it. However, for those people who do agree to the program, what happens if they later disagree with the treatment, or if they have a grievance? What rights do they have to disagree with their treatment protocol? To whom do they voice their concerns? What are the treatment options? Is it solely medication? Is therapy included? Will consumer-run and peer services be considered to be treatment or part of the treatment? Can the person change their mind? Is there room for alternative forms of 'treatment?'

There are no biochemical markers, no biological tests, no hard evidence at all, to 'prove' the existence of 'mental illness.' 'Proof' means the ability to demonstrate a reliable association between a clearly specified pattern of observables and other reliably measurable event(s) that operate as antecedents. (This is same level of proof used for TB, cancer, diabetes, etc.) Yet, the courts rely upon the opinions of voodoo practitioners (psychiatrists) who claim to be experts on 'mental illness.' I did a study back in the 1970's and found Christian Science hospitals to have as high a "healing" percentage or better than other medical facilities.

There are many ways to interact with people. We can treat them as 'patients' or we can try to understand and see their world through their eyes. We can weigh the 99+% of the positive or we can look only at the less than 1% negative. Using mental health courts enforces the view of the person as 'patient' and negates the person. People should not be defined by a system that labels them as 'illness', 'disease' or 'disorder.' Courts that are part of the psychiatric system don't ask: What happened to this person? What is this person's hopes and dreams? What are this person's loves? Who are the people (good and bad) with whom this person has interacted? What experiences (positive and negative) has this person had? Why did this person end up following one path rather than another? What motivates this person? Who are this person's role models? What drives this person to get out of bed every day and proceed through the day? What defines this person's 'spirit?'

Assisted Outpatient Treatment
Fact Sheet

How to create a Myth:

- **Capitalize on an episode of violence involving a person with a psychiatric disability by**
  - **Aligning with the victims**
  - **Publishing stats suggesting we're violent**
  - **Linking with local family groups**
  - **Indentifying State or City Administrative or Legislative champions**
  - **Identifying a reporter or two to carry their message**
- Even if every mentally ill person in the country were registered regarding firearms, the system isn't prepared to handle them—and only about half of the states require registration.
- Only about 10 percent of mentally ill people are registered—and these are people who have been committed, they've come to attention in a way that requires court intervention.
- Literature says the vast majority of people who do these kinds of shootings are not mentally ill—or it is recognized after the fact.
- The majority of mentally ill people aren't dangerous.
- Mentally ill people in a country with gun rights, still have rights.
- Mass shootings are not just an American phenomenon—they have and are occurring in countries that have strong gun control.

Myth 1. The Name: Assisted Outpatient Treatment
Fact: The term "Assisted Outpatient Treatment" sounds very humane and appealing, but it is neither assisted nor is it treatment. It is a court order to force people to undergo medical intervention, and primarily that means that they are **forcibly medicated**. It means that people will be subjected to drugs and procedures to which they object and that may be harmful.

Myth 2. The Popularity: 44 other states have outpatient commitment laws.
Fact: Very few states actually implement their outpatient commitment laws. There are many reasons for this. These laws are impractical, cumbersome for the judicial system and law enforcement, and they entail additional fiscal resources for court processes, court-ordered evaluation, and expert testimony. Enforcement of such laws pose difficult practical dilemmas of such magnitude that most states choose to ignore the law. For example, if an individual does not come to the clinic for his injection of medications, will police seek him out, apprehend him, and restrain him while he is brought to the clinic and forcibly injected with medications? Do our law enforcement agencies have the resources to assume additional responsibilities with respect to mental health treatment, or feel that it is an appropriate role for them to be essentially an arm of the mental health system? In most states, the answer has been "No." **"In only 12 states and the District of Columbia was use of outpatient commitment rated as very common or common."** *A National Survey of the Use of Outpatient Commitment,* E. Fuller Torrey, M.D. Robert J. Kaplan, J.D. Psychiatric Services August 1995
Other States:

- **Virginia 2008**

The Virginia Legislature rejected a Kendra's Law styled legislation, even in the wake of the Virginia Tech tragedies, favoring alternative solutions.

- **New Mexico 2007**

The New Mexico state legislature rejected mandated outpatient treatment legislation patterned on New York's Kendra's Law for the second year in a row. Instead, the legislature approved a measure which is intended to "streamline behavioral health services for adults…and open up more possibilities to maximize Medicaid funding for mental health and substance abuse services." This past summer, a New Mexico District Court judge rejected as unconstitutional a similar measure approved by the Albuquerque Town Council.

- **Connecticut 2000**

In the spring of 2000, the Connecticut state legislature rejected legislation creating a mandated mental health outpatient treatment order. Alternatively, they created a task force that, after months of study, recommended against the use of mandated outpatient treatment and instead urged the adoption of more active outreach and engagement services staffed by trained 'peers' (persons in recovery from psychiatric disabilities); it also successfully pushed for the increased use of advance directives.

- **Maryland 2000**

Due to strong opposition by leading state mental health advocacy groups, as well as the Department of Health and Mental Hygiene, Maryland's 1999 involuntary outpatient commitment measure failed to get out of committee. The state mental health agency then convened a task force of stakeholders that *met 12 times and concluded that legislation to mandate treatment would not be advisable and, in the alternative, recommended "enhanced" community services and psychiatric advance directives*.

Myth 3. It's effectiveness: outpatient commitment is effective.
FACT: The actual research in this area has very mixed results. Most studies do show that you can decrease the use of inpatient services and homelessness using outpatient commitment. But one has to ask – how does it do that? Is it because individuals are effectively treated, less symptomatic, healthier, and recovering? Consumers have been saying for years that this is not the case – that it is because they are overly sedated by medications, incapacitated, and therefore no longer perceived to be "a problem" to others. There are certainly research findings that support their observations – outpatient commitment has not been shown in any studies to improve social functioning or to increase employment, and some studies suggest that individuals who receive involuntary outpatient commitment are not even less symptomatic than others receiving voluntary services, even if their participation in treatment is sporadic. Outpatient commitment is a simplistic way to give the false impression of "doing something" to solve complex and disconcerting problems. The core clinical problem is simply that we don't have effective and easily tolerated cures for mental disorders. But neither will outpatient commitment address the prevailing social concerns surrounding mental health treatment.
In 1999, in New York, a legislatively authorized pilot study at Bellevue Hospital provided improved discharge planning and care management to two groups of individuals with psychiatric disabilities who were deemed at risk for relapse, providing court mandated care to one group in an effort to test whether such mandates provided superior results. **"The core finding of the study was that there were no statistically significant differences between the two groups on any outcome measure, including re-hospitalization."**[1]
The 2009 Duke University evaluation of "Kendra's" law demonstrated an array of positive outcomes commonly associated with improved access to and better coordination of community care, but **it clearly failed to provide the scientific comparison between voluntary and court mandated services required under the 2005 statute.**

Myth 4. Personal Experience: Some say it's been helpful.
FACT: I do not doubt that some citizens managed to derive benefit from having been forced into treatment (or felt that their family members did), much as some people manage to derive benefit from time in prison. However, I believe we all know that we should not enact law based upon anecdotal evidence, as it does not represent the full spectrum of the impact of such laws and is easily manipulated. Individuals who are harmed by such laws generally face severe barriers to being able to come forward to present testimony on their own behalf: they are often severely disabled, they are impoverished, they are not supported by such organizations as NAMI or the "Treatment Advocacy" groups, and sometimes they are simply incapacitated by the treatment they are being administered. I appreciate the personal experience of those who feel forced treatment was helpful to them; however, I can also say that I have personally known individuals who killed themselves rather than to continue to be forced to receive psychotropic medications in outpatient commitment, as well as many more individuals who felt that forced treatment was dehumanizing and decimated their motivation to pursue recovery due to the overwhelming sense of oppression they felt from being forcibly medicated.

Myth 5. Evidence regarding costs: Kendra's Law in New York is effective.
FACT: The key piece of information that proponents of outpatient commitment omit is that Kendra's law has shown some positive outcomes largely due to the fact that, at the time the law was enacted, the governor of New York pumped an additional $200 million into mental health services. In addition, New York's 'Assisted Outpatient Treatment' program is budgeted at $32 million a year, which is spent mainly on statewide and county based program coordination, on some jail re-entry services and a medication fund for those not yet on Medicaid. However, it costs untold millions more in time psychiatrists and clinicians are forced to spend in court, in developing and writing reports…and certainly a great deal more in Medicaid/state aid funds spent by providers who are a part of the mandated service plans.

[1] Policy Research Associates, *Research Study of the New York City Involuntary Outpatient Commitment Pilot Program*, December 1998

There is also an exceedingly high amount of time, effort, energy and resources spent on enforcement. We know from research that people participate more in treatment and need less acute hospitalization when consumers are offered expanded outpatient treatment options, so it is highly probable that New York could have achieved all these things without compromising the rights of its citizens.

- New York Court of Appeals recently ruled that sharing medical records of individuals under consideration for a Kendra's Law order is a violation of individuals' HIPPA privacy rights, unless their approval or a court order is obtained.
- Involves considerably more effort and costly time by local and court officials

Myth 6. AOT as a panacea: AOT works.
FACT: The National Association of State Mental Health Program Directors (NASMHPD) cautions against enacting outpatient commitment in an environment where there are not robust resources for community mental health treatment. So what does that mean for Ohio? We know that our mental health system has been stripped to the bare bones. We do not have sufficient resources to provide adequate mental health services to the many Ohioans who are voluntarily seeking treatment, so what are we really offering the individual who gets "assisted treatment"? I believe the answer is clear. Outpatient commitment will mean only one thing – they will be medicated excessively, against their will so that they no longer pose an inconvenience to the community.

Myth 7. Mental illness is a disease that keeps people from knowing they are ill.
FACT: Involuntary treatment in public health is generally reserved for situations in which the disease is common, communicable, and has a relatively high potential to be lethal, and in which the cause of the disease is known and the legally required treatment is associated with very low risk. An example would the tetanus or pertussus vaccines for children. Mental health diagnoses and treatments simply do not meet this profile. While many mental health professionals cite "chemical imbalances in the brain" as the cause for psychiatric disturbance and the justification for psychotropic medications, the fact is that such imbalances have never been consistently demonstrated by research. Most recently, E. Fuller Torrey (Treatment Advocacy Center) and others have put forward alternative theories that implicate viral genetic material and autoimmune reactions in the central nervous system in the etiology of mental illnesses including that it comes from feral cat urine. These novel models of mental illness are promising, but they also call our current treatment practices into question. The fact is, we don't know what causes mental health disorders, and as a result we don't know whether our treatments are scientifically justifiable or even relevant.

- There is a myth that **People go off psych meds because of bad brain chemistry (anosognosia).**
- 75% go off meds because they don't work or because of disturbing side effects **2005 National Institute of Mental Health 'CATIE' study**: A large (1,400 patients) study that concluded that the medications were….associated with high rates (75%) of discontinuation due to intolerable side effects or failure to adequately control symptoms."

Proponents use the term "anosognosia" in order to sound professional and scientific. Anosognosia means ignorance of the presence of disease, specifically of paralysis, most often seen in patients with non-dominant parietal lobe lesions, who deny their hemiparesis. This neurological condition only applies to psychiatric patients if the definition is twisted and distorted by those who seek to attempt to legitimize psychiatry by using neurological terms but really, it only demonstrates ignorance. I've spoken with many who have lived experience with psychiatric issues. Almost universally they will claim that one of the issues that professionals don't understand is: "Just because I'm banging my head on a table doesn't mean I don't know that I'm banging my head on a table." We have more awareness than is commonly believed. Even if anosognosia were to be applied to psychiatric issues, by fallacious reductio ad absurdum argument, we could argue that lack of insight into the status of your circumstances would mean that we should create mental hospitals for chronically obese folks, smokers, hang-gliders, surfers, etc. or anyone else who continues to indulge in risky or socially disapproved of behavior. Shall we create, "Eastern State Hospital for Hoarders."

- **Impact Of Accepting A Psychiatric Diagnosis And Tx**

Shame, Stigma and discrimination
Dehumanizing 'hopeless' care
Isolation; expectations of single, childless life
Idleness: Lack of social meaningful roles work, school.
Loss of rights and choices around where you live, with whom and around major life decisions

Poverty (reliance on entitlements)
Loss of personal and family relationships
Loss of sexuality (medication side effects)
Criminalization of emergency care: handcuffs, police, coercion

- **Many require more skilled, personalized voluntary engagement that builds on people's immediate needs and hopes**

Myth 8. The medications help people.
FACT: Medications do help some people. We must ensure that the full range of psychotropic medications is made available in the mental health armamentarium. However, we also need to acknowledge that, generally, the people who get a good response to medications are not the people who are targeted for outpatient commitment. About a third of people will have a significant improvement from medications. They tend to recover and are often highly motivated to continue treatment. Roughly another third may have a partial response but struggle with significant side effects, and they are understandably ambivalent about treatment. About a third have no significant reduction in their symptoms, though they frequently do have severe adverse effects, and their motivation to pursue treatment with medications is, not surprisingly, very low. Thus many people who are being forced to take medications are those who derive very little therapeutic benefit from them, though others may perceive them to be improved because they are more sedated or chemically restrained.

Myth 9. Medications are safe and effective.
FACT: Irrespective of whether one has a good or poor response to the medications, each individual needs to weigh the benefit of treatment against the adverse effects of these medications. Most people who take these medications experience some degree of fatigue, poor attention, flattened emotion, tremor or restlessness, and gastrointestinal side effects such as constipation and heartburn. More than half experience severe weight gain, which may be in excess of 50 pounds. For example, if an individual is forced to receive an antipsychotic that causes him to gain 50 pounds (which is very common), and he goes on to develop diabetes and hypertension (which is also very common), and he has no health care resources to treat his diabetes, and he cannot afford to eat a healthy, low-carbohydrate diet, and he does not have the appropriate support to check his blood sugars regularly, how is it acceptable to continue to force this treatment upon him knowing that the outcome is likely to be lethal? There are also other medically serious adverse effects such as seizures, permanent neurological problems, diabetes, heat stroke, heart failure, massive weight gain, and even abrupt onset of come or other potentially life threatening conditions. One injectable medication has been given special monitoring requirements by the FDA because it can cause sudden unexplained coma. We know that taking these medications over the long term, as many people having psychiatric disability do, erodes people's health. Due largely to the adverse effects of psychotropic medications, people having psychiatric disabilities have a life expectancy that is 25 years less than the average population.

Myth 10. Court mandated services will be effective.
FACT: A serious problem with involuntary commitment is the lack of provisions to ensure that the mandated services are effective and that risks are adequately managed. No safeguards are put in place to ensure that the individual receives quality treatment, rather than being indiscriminately subjected to chemical restraint for indefinite periods of time. To my knowledge, no outpatient commitment law includes a mandate for the treating facility to empirically document, using standardized rating tools, an improvement in symptoms and functioning, or to track and document the intensity of adverse effects. Nor do these laws mandate medical monitoring and treatment for the adverse effects of medications, or specify a threshold for risk. For example, if under involuntary treatment, an individual gains 100 pounds and develops diabetes, the "treating" facility is under no obligation to modify the "treatment" approach. Lastly, the proposed law gives no guarantee that the treatment that is forced upon the individual meets generally accepted standards of care. It only requires the individual to have a treatment plan that is approved by the court. Given that there are gaping deficiencies in the continuum of care, the law will force individuals to be subjected to substandard treatment. The bill does not ensure that care providers must assess the individual's therapeutic response to the forced treatment. This is essential because we should not be requiring a person to receive a potentially hazardous treatment if that treatment is not producing a clear benefit for the individual. The bill needs to protect individuals by ensuring that they are regularly assessed using *standardized rating scales* to fully evaluate the person's symptoms, quality of life, and adverse effects from medications. Even requiring a general assessment is not adequate, as, in the current system of care, that assessment is likely to

consist of a brief encounter with a temporary "locum tenens" psychiatrist who will form a very general impression of the person's status without rigorously determining the extent of their symptoms. The bill does not require care providers to fully screen for or treat the serious adverse effects of medications that place individuals at risk.

Myth 11. Without "treatment" these folks are dangerous.
FACT: We also need to critically examine our motivations in enacting outpatient commitment laws. Proponents often cite public safety issues and roll out the rare but dramatic examples of situations where individuals having psychiatric symptoms engaged in homicidal acts in response to psychotic beliefs. Such incidents are vanishingly rare though they receive a lot of publicity, and homicides precipitated by psychosis do not constitute a significant percentage of homicides in the US. Nor is it clear that forced treatment would have prevented these tragedies.

- **People with psychiatric diagnoses who are involved in violent episodes were actually compliant**
- Most of the individuals associated with acts of publicly covered violence by or towards them were in fact in treatment that failed them:

1999: Andrew Goldstein and Julio Perez
2007-8: Lee Coleman, David Kostovski, Khiel Coppin and David Tarloff

In some instances, these individuals were in fact mandated to receive outpatient psychiatric services, but this did not prevent the tragedy, as was the case for Seung Hui Cho at Virginia Tech in 2007. There are also cases where the individual was felt by others to be mentally ill but had refused contact with the mental health system. In these instances one would need to expand the law to mandate psychiatric treatment in response to the expressed concerns of other citizens in order to intervene to protect public safety. However, in concrete terms, if we allow forced psychiatric intervention based upon hearsay, this would then mean that a disgruntled neighbor could allege that someone is crazy, mandate that they are apprehended and assessed, then subject them to the consequences of having had a court-mandated psychiatric assessment. As it is currently structured, this proposed law will thankfully not make this sort of abuse possible; however, it should be obvious that outpatient commitment laws, no matter how they are worded, are ineffective tools for improving public safety and are fraught with opportunities for abuse. Public and media misconceptions to the contrary, people with psychiatric disabilities are no more violent than the general public and are, in fact, 11 times more likely to be victims of violence. We urge legislators to reject calls to expand outpatient civil commitment based upon false connections with violence that are stigmatizing and offensive to our community.

- **1998 McArthur Study** on "Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods" Steadman et al Archives of General Psychiatry 1998 "; People with psychiatric disabilities are no more violent than the general public and are far more likely to be victims of violence except when, like the general public, they abuse alcohol & drugs.
- **2011 study including Helsinki University** 'Homicide of Strangers by People with a Psychotic Illness ' published in Schizophrenia Bulletin estimated such instances occur at a rate of 1 in 14.3 million in Wales, Finland, Canada and the Netherlands.
- **2005 "Crime Victimization in Adults With Severe Mental Illness" study Teplin et al Archives of General Psychiatry**. "More than one quarter of persons with SMI had been victims of a violent crime in the past year, a rate more than 11 times higher than the general population rates."

Myth 12. It helps the high-users of services to not drop out of treatment.
FACT: Another common motivation for pursuing outpatient commitment is the belief that such laws reduce mental health expenditures for individuals who are frequent hospital recidivists or who otherwise consume a disproportionate amount of public mental health resources. However, when one examines the bigger picture, most studies have found that outpatient commitment drains funds from mental health to pay for court mandated evaluations, court process, expert testimony, and other expenses associated with the legal process.

Myth 13. We want to help those people.
FACT: We need to consider the devastating impact of involuntary outpatient commitment on our ability to serve people. The single most important therapeutic tool that mental health professionals have is the trusting relationships we have with our clients. People need to be able to tell us their innermost thoughts and fears, and trust that we will treat them in a fair and respectful manner. In my experience, the threat of involuntary outpatient commitment undermines that relationship and will deter people from seeking the help they need. The single

most important therapeutic tool that a clinician has is the trusting relationship with the client. If people know that mental health treatment can entail forced treatment, in which the law empowers police to hunt them down, apprehend them, and bring them in for forcible injections of medications, they are going to be much less likely to seek voluntary treatment. Except in cases of dire emergency, police action has no place in mental health treatment. Our clients are people seeking health care; they are not criminals. Forced outpatient treatment is never the short-cut to recovery that proponents claim it will be. Forcing someone to be injected with medications does not promote insight, improve functioning, improve quality of life, save money, or promote public safety. If we truly wish to assist citizens having refractory psychiatric concerns, we should fund mental health adequately, ensure that Ohio's mental health systems meet the prevailing standard of care, and encourage strengths-based, individualized approaches to recovery that de-stigmatize mental health concerns.

- **People diagnosed with 'serious and persistent' MH conditions do not require life long supervision.**
- Even people on backwards with severe disabilities can achieve significant levels of recovery, when they are offered the choice of the right kind and mix of modern services and medications (**1997 Maine-Vermont Comparison Study per British Journal of Psychiatry Dr. Courtenay Harding et al)**
- Most people still are not offered or can't get access to the right mix of the right services. "Fewer than Half of Schizophrenia Patients Get Proper Treatment" **1998 Patient Outcomes Research Team (PORT) Study, Agency for Health Care Policy and Research (AHCPR) and the National Institute of Mental Health (NIMH)**

Myth 14. The concerns of family members are legitimate.
FACT: I know you will hear from a number of family members who have suffered along side their loved ones and hope that having a law to force their family members into treatment will make them recover and give them insight about the benefits of treatment. In reality, forced outpatient treatment rarely results in such happy outcomes. The person who is forced to take medications usually focuses on the injustice of the situation, blames and mistrusts family and service providers, and does whatever he can to protest and subvert the forced treatment. Some individuals do this by using drugs and alcohol, some by engaging in high-risk behaviors. Many people lapse into despair in the face of their powerlessness, and some engage in self-harm or allow others to exploit them. Some people are just too incapacitated by the medications to do much of anything. In general, people only gain insight and recover when they have had the opportunity to struggle through their difficulties and then evaluate their successes and failures.

Myth 15. The law will be applied equitably.
FACT: Geographic Disparities
The most recent (New York) OMH data once again confirms that there continue to be great geographic disparities in the implementation of Kendra's Law, with **82% (7672) of the orders emanating from New York City and Long Island.** The 2009 Duke study found that "...**in other counties, largely outside of New York City, voluntary agreements are more frequently used before a...court order**." In fact, **most other counties have offered over 7,000 individuals a variety of voluntary service packages, with 28 upstate counties using 5 or less orders in total since the program's inception in November of 1999.** The study quoted a psychiatrist from an upstate county: "We don't do it like downstate...**We use the voluntary order first. We don't approach it in an adversarial way**."
High Racial Disparities
Troubled by the **disproportionate number of New Yorkers from communities of color who were receiving court ordered mental health care**, the NYS Legislature extended Kendra's Law for an additional five years and ordered independent research to look into these and other disparities in the law's implementation. The result?
The 2009 Duke study's results are identical with the most recent OMH data, finding **no change in the overrepresentation of African Americans and Hispanic New Yorkers in the group receiving court ordered care**. Just as in the 2005 and 2009 studies, **64% of involuntary orders are being levied at those groups.**
This striking imbalance continues to turn up **even in areas of the state where those groups are vastly outnumbered**. Examples include Rockland where African Americans and Hispanics receive 77% of the orders while they comprise only 20% of the population and Westchester where they get 52% of the orders as they comprise 29% of the population.

These findings continue to point to an unchecked systemic deficiency in providing effective outreach and engagement services to communities of color with psychiatric disabilities that remains unaddressed, even though these disparities were highlighted five years ago, leading Dr. Rosa Gil, Founder, President & CEO of Comunilife, Inc to assert that **"culturally-centered innovative strategies for outreach and engagement must be first used when addressing the needs of Hispanics and other underserved communities**."

Authors:
These facts were composed by Coni Kalinowski, M.D., a practicing psychiatrist who for 9 years, trained and worked in Wisconsin where involuntary outpatient commitment has been used to force people into treatment for over 30 years, and Patrick Risser, an advocate who has served on the National Advisory Council for the Substance Abuse and Mental Health Services Administrations Center for Mental Health Services, on the Board of the National Association for Rights Protection and Advocacy and is a fully recovered former mental patient. They can tell you first hand, forced treatment does far more harm than good to individuals, it is very expensive, and it does not address the public health and safety issues that people hope it will. Both are home owners, tax payers and registered voters.

* *

The Well Being Project, a research project supported by the California Department of Mental Health, found that 55 % of clients interviewed who had experienced forced treatment reported that fear of forced treatment caused them to avoid all treatment for psychological and emotional problems.

* *

Proponents use an interesting argument where they say there is a "black robe effect" that will result in compliance with court orders because a judge orders it. Hence, outpatient coercion doesn't cost anything.

I have always thought this "black robe effect" argument undermines their argument with regard to the need for IOC in the first place. They say that IOC is needed because some folks are supposedly so lacking in insight that they cannot make rational decisions that will prevent very bad things from happening. But according to them, if there is a court order, then suddenly these same folks will gain insight and be able to make rational judgments about the very same decisions that before they could not make. So people lack insight until some judge signs a piece of paper and then they gain back their insight. Judge signing equals medical miracle?

Force is not effective. Unfortunately, "treatment" almost always means, only medications. Often the medications do not work, and may have effects that are not only unpleasant but can be harmful and even result in death. No court order will be enough to make someone take drugs that are hurting them. Compliance should not be the issue; helping the individual is the issue. And, when someone doesn't comply and chooses to ignore the court-order, the consequences will be that the court will have to issue an order of contempt, mobilize law enforcement and bring the person to the court to then be sent to a hospital. All of this enforcement activity will incur significant costs. The model in New York only works because they throw hundreds of millions of dollars at the problem but without any real impact.

I was hospitalized over 20 times, including state hospital and together with over ten years of "treatment" I believe it cost the system well over $1 Million. That's just one person. And the ten years of "treatment" with drugs are, I believe, the direct cause for my subsequent heart problems (with additional cost). And, of course we're dying over 25-years too young which means that sentencing someone to "treatment" basically means they're being sentenced to an early death sentence. Can you say, eugenics?

The MacArthur Coercion Study

http://www.macarthur.virginia.edu/coercion.html

"The amount of coercion a patient experiences in the mental hospital admission process is strongly associated with the degree to which that process is seen to be characterized by "procedural justice." That is, patients who believe they have been allowed "voice" and treated by family and clinical staff with respect, concern, and good faith in the process of hospital admission report experiencing significantly less coercion than patients not so treated. This holds true even for legally "involuntary" patients and for patients who report being pressured to be hospitalized."

Involuntary Outpatient Commitment

- Often instituted in response to tragedies (sensationalism)
- Person alleged to have serious mental illness (scapegoating)
- Person has a history of not taking medications outside of hospital settings (non-compliance)
- Person has benefitted from medications in the past (mental health clinicians tend to equate subduing the person with treatment; a quiet client who causes no community disturbance is deemed "improved" no matter how miserable or incapacitated that person may feel as a result of the treatment.)
- Without medication, person is at risk of becoming incapacitated or dangerous (although risk early death with the medication)
- Person can be taken to mental health clinic for evaluation, but medication cannot be forced

IOC-Little Difference in Outcomes

- Coerced treatment for Substance Use Disorders may improve rates of retention in treatment, but ultimate outcomes are similar for individuals in coerced treatment and individuals in non-coerced treatment (IOM 2005).

- There is little difference in actual medication compliance between patients who perceived that medication was forced ("high perceived coercion") and those who did not feel that they were forced to take medication (TAC 2011; Rain et al. 2003).

- Cochrane of IOC review showed no significant differences in outcomes, except for rates of victimization

Outpatient Commitment Implementation?

CONCLUSIONS FROM BEHAVIORAL SCIENCE RESEARCH, NATIONAL DISABILITY AND MENTAL HEALTH ORGANIZATIONS

- A review of the studies on outpatient commitment finds benefit from the enhanced services with implementation. Although those studies allege to exhibit a benefit for involuntary outpatient treatment, they have been determined, by the Rand Corporation and other researchers, to have faulty research designs such that the conclusions drawn are not supported by the studies. (Rand, 2001. Steadman, et al, 2001, 2009).

- Acceptable scientifically controlled studies illustrated that the same benefits accrue with enhanced voluntary assisted community outpatient treatment services as with OPC. (Steadman, 2001, Cochrane Review, 2011)

- There is no relationship between dangerousness or violence and mental illness.
    - "The prevalence of violence among people who have been discharged from a hospital and who do not have symptoms of substance abuse is about the same as the prevalence of violence among other people living in their communities who do not have symptoms of substance abuse." (Steadman, Monahan, et al. (1998) The Macarthur Foundation Community Violence Study)

- While, according to SAMHSA, 20%-25% of the homeless population can be diagnosed as mentally ill, an unpublished randomized study, at NYU, found that a program permitting the tenants of subsidized housing to control whether or not they receive services, compared with a program that linked housing to treatment adherence, reduced homelessness without increasing psychiatric symptoms or substance abuse. (Shinn, M., et al, NYU (2003). Effects of housing first and continuum of care programs for homeless individuals with a psychiatric diagnosis)

- These National organizations strongly oppose implementation of OPC laws: The National Mental Health Association, the Judge David L. Bazelon Center for Mental Health Law, the California Network on Mental Health Clients (2001), the National Association for Rights Protection and Advocacy; and the National Council on Disability (2000) have all expressed strong negative opinions regarding OPC laws, as have a few professional associations, such as the International Association of Psychosocial Rehabilitation Services. (Geller J. (2006) International Journal of Law and Psychiatry, 29, 234-248.

Cochrane Review of All Randomized Clinical Trials of OPC programs through 2003

Compulsory community and involuntary outpatient treatment for people with severe mental disorders (Review)

Kisely S, Campbell LA, Preston N (2005)

"Cochrane Reviews are systematic reviews of primary research in human health care and health policy, and are internationally recognized as the highest standard in evidence-based health care."

- One research group found that, "although patients who received prolonged involuntary community treatment had reduced hospital readmissions and bed days, it was difficult to separate out how much of the improvement was due to compulsory treatment and how much to intensive community management." (North Carolina studies, Swartz 1999)

- The authors, "found little evidence to indicate that compulsory community treatment was effective in any of the main outcome indices…" including readmissions to a hospital or jail, quality of life, social functioning, mental state and homelessness. There may be a decrease in risk of victimization (Risk of the consumer being the victim of a crime), but it is difficult to discern if it is due to the OPC or enhanced services.

- "In 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."

- "It appears that compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care."

- These internationally recognized reviews argue against the need for Laura's law.

Cochrane Review of all scientifically acceptable studies through 2008

Wiley Online Library: Book Abstract
http://onlinelibrary.wiley.com/doi/10.1002/14651858. CD004408.pub3
Intervention Review

Compulsory community and involuntary outpatient treatment for people with severe mental disorders

Steve Kisley[1], Leslie Anne Campbell[2], Neil J Preston[3]

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Abstract

Background

There is controversy as to whether compulsory community treatment for people with severe mental illnesses reduces health service use, or improves clinical outcome and social functioning. Given the widespread use of such powers it is important to assess the effects of this type of legislation.

Objectives

To examine the clinical and cost effectiveness of compulsory community treatment for people with severe mental illness.

Search methods

We undertook searches of the Cochrane Schizophrenia Group Register 2003, 2008, and Science Citation Index. We obtained all references of identified studies and contacted authors of each included study.
We updated this search July 2012, five new studies added to awaiting classification section.

Selection criteria

All relevant randomised controlled clinical trials of compulsory community treatment compared with standard care for people with severe mental illness.

Data collection and analysis

We reliably selected and quality assessed studies and extracted data. For binary outcomes, we calculated a fixed effects risk ratio (RR), its 95% confidence interval (CI) and, where possible, the weighted number needed to treat/harm statistic (NNT/H).

Main results

We identified two randomized clinical trials (total n = 416) of court-ordered 'Outpatient Commitment' (OPC) from the USA. We found little evidence that compulsory community treatment was effective in any of the main outcome indices: health service use (2 RCTs, n = 416, RR for readmission to hospital by 11-12 months 0.98 CI 0.79 to 1.2); social functioning (2 RCTs, n = 416, RR for arrested at least once by 11-12 months 0.97 CI 0.62 to 1.52); mental state; quality of life (2 RCTs, n = 416, RR for homelessness 0.67 CI 0.39 to 1.15) or satisfaction with care (2 RCTs, n = 416, RR for perceived coercion 1.36 CI 0.97 to 1.89). However, risk of victimization may decrease with OPC (1 RCT, n = 264, RR 0.5 CI 0.31 to 0.8). In terms of numbers needed to treat (NNT), it would take 85 OPC orders to prevent one readmission, 27 to prevent one episode of homelessness and 238 to prevent one arrest. The NNT for the reduction of victimization was lower at six (CI 6 to 6.5). A new search for trials in 2008 did not find any new trials that were relevant to this review.

Authors' conclusions

Compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care. People receiving compulsory community treatment were, however, less likely to be victims of violent or

non-violent crime. It is unclear whether this benefit is due to the intensity of treatment or its compulsory nature. Evaluation of a wide range of outcomes should be considered when this type of legislation is introduced.

Plain language summary

Compulsory community and involuntary outpatient treatment for people with severe mental disorders

The evidence found in this review suggests that compulsory community treatment may not be an effective alternative to standard care.

We examined the effectiveness of compulsory community treatment for people with severe mental illness through a systematic review of all relevant randomised controlled clinical trials. Only two relevant trials were found and these provided little evidence of efficacy on any outcomes such as health service use, social functioning, mental state, quality of life or satisfaction with care. No data were available for cost and unclear presentation of data made it impossible to assess the effect on mental state and most aspects of satisfaction with care. In terms of numbers needed to treat, it would take 85 outpatient commitment orders to prevent one readmission, 27 to prevent one episode of homelessness and 238 to prevent one arrest.

"A research group found that although patients who received prolonged involuntary community treatment had reduced hospital readmissions and bed days, it was difficult to separate out how much of the improvement was due to compulsory treatment and how much to intensive community management (Swartz 1999)"

New England J. Criminal and Civil Confinement 2005

4740 Words.
31 N.E. J. on Crim. & Civ. Con. 109
OUTPATIENT COMMITMENT DEBATE: New Research Continues to Challenge the Need for Outpatient Commitment
NAME: Jennifer Honig, J.D.* &Susan Stefan, J.D.**
* Staff Attorney, Mental Health Legal Advisors Committee (MHLAC) of the Supreme Judicial Court, Boston, Massachusetts, since 1992.
** Attorney, Center for Public Representation, Newton, Massachusetts.

• LEXISNEXIS SUMMARY:

Outpatient Commitment ("OPC"), a mechanism to compel individuals with mental illness to comply with treatment in the community, has been analyzed repeatedly from many perspectives. Proponents argue that OPC keeps psychiatric patients on medication and thereby out of hospitals.

Since the RAND report was released, a 2004 Australian study of 754 subjects found that OPC alone failed to reduce psychiatric hospitalization admission rates in the first year after the introduction of community treatment orders.

Although one of the principal rationales for outpatient commitment is that it improves compliance with medications, "few previous studies have directly addressed the issue of whether OPC improves adherence with prescribed medications and scheduled mental health appointments.

A number of recent new studies examine the effects of involuntary outpatient commitment on the subjective quality of life experience in persons with severe mental illness, whether these individuals endorse OPC as a positive benefit in their lives and whether they perceive it as coercive.

Too often, the services absent from a community's mental health care continuum (e.g., incentivizing programs) are precisely those services that would most likely engage the consumer in voluntary treatment.

Conclusion

This article updates research into several frequently examined issues related to OPC. This research is important, but there are still further topics of research to be explored. As one observer has suggested, studies should evaluate the success of OPC as measured in ways other than reduction of [*121] hospital days, lengths of hospital stays, and number of arrests such as the impact of OPC on the individual's connection to community life, satisfaction with living arrangements, and feelings of empowerment.50

Researchers should examine potential harms as well. For example, new data suggests that racial bias may skew the implementation of OPC toward black individuals.[51] In the research underlying many of the studies cited in this article, over two thirds of the individuals under outpatient commitment were African-American.[52] Although this figure matches the proportion of severely mentally ill individuals in the state hospital, it is not clear whether the proportion holds true for the surrounding community population. Researchers also should evaluate the impact of OPC on the service delivery system; how using coercion affects service providers, the impact in terms of resource allocation, and the impact on consumer empowerment and anti-stigma campaigns.[53] Additionally, as OPC statutes age, researchers should evaluate their long-term impact.[54]

The fact that outpatient commitment appears to be of limited effectiveness should certainly give pause to policymakers. However, even effective strategies to induce desired social goals - confessions of [*122] criminals, for example - may sometimes bow to greater social values of privacy, liberty and independence. Social science researchers cannot make and do not pretend to make these judgments.

The Supreme Court did not strike down school segregation in Brown v. Board of Education because it was educationally ineffective but because it was unequal. Likewise, our drive to provide mental health treatment to people who do not want it must be constrained not only by concerns that to do so is ultimately ineffective, but also by the realization that to do so may violate their rights.

Budgetary Factors

Without the additional expense and DMH oversight, enhanced, effective services approximating those mandated by Laura's law can be delivered, voluntarily, for an additional budgetary expense of approximately 50% less than the costs incurred if Laura's law were to be implemented in Orange County.

If the County enhances Assertive Community Treatment team programs (ACT) by changing clinical staff/consumer ratios from the current 1:15 to 1:10 (Laura's law mandate) and standard care clinical staff ratios from the current 1:65 to 1:35, and enhances supportive housing and associated services it will, according to research, accomplish, the same effect as implementation of Laura's law. Of most importance is the development of a program of incentivizing consumers with effective, positive incentives to attend clinics and treatment appointments. This will likely result in less hospitalization, less dangerousness, less law enforcement involvement, increased positive staff/consumer relationships, increased compliance with treatment recommendations, and less homelessness.

The noted fiscal impact of this legislation has missed an important piece and that is with regard to enforcement. If a probate judge were to issue what would essentially be a judicial treatment plan and if the psychiatrically labeled person chose to not follow that plan, there is no method cited for enforcement. To force compliance, the judge would have to issue a bench warrant, presumably for contempt, and local law enforcement would have to be charged with picking the person up and arresting the person. All of that process costs time and money. And, even then, the law remains basically unenforceable. That's just a small piece of the fiscal impact.

* *

Bazelon on Forced Treatment

People with mental illnesses have the right to choose the care they receive. Forced treatment--including forced hospitalization, forced medication, restraint and seclusion, and stripping--is only appropriate in the rare circumstance when there is a serious and immediate safety threat. In general, circumstances that give rise to the use of force are not spontaneous and do not occur in isolation. Usually, there were multiple opportunities for earlier interventions that could have prevented the need for force. For this reason--and to counteract coercion that is too often routine in mental health systems--it is important to regard the use of forced treatment as reflecting a failure in service and to reform systems accordingly.

The Bazelon Center has a long history of opposing forced treatment. Not only is forced treatment a serious rights violation, it is counterproductive. Fear of being deprived of autonomy discourages people from seeking care. Coercion undermines therapeutic relationships and long term treatment. The reliance on forced treatment may confirm false stereotypes about people with mental illnesses being inherently dangerous. Moreover, the experience of forced treatment is traumatic and humiliating, often exacerbating a person's mental health condition.

Often, it is difficult to engage people in treatment. But service systems have developed effective techniques for doing so. Peer services, outreach, mobile outreach [such as assertive community treatment (ACT)], and supportive housing (Housing First) have proven success. All too often, systems turn to force and coercion because they lack such services.

The Bazelon Center advocates for self-determination in treatment decisions and works for service systems that avoid force and coercion. Such systems listen carefully to consumers and offer the type of services and supports that consumers prefer. Such systems do not simply respond to crises, but develop plans in partnership with the individuals they serve to avert crises. When treatment plans are imposed, it is not surprising that consumers may depart from the plan. Shared responsibility promotes "buy-in" and better treatment outcomes. In the long run, the best way to secure "treatment compliance" is to respect consumer choice.

Disability-rights model vs Medical model

The disability-rights activist, Carol Gill of the Chicago Institute of Disability Research, described the traditional forms of discrimination that disabled people have faced, as well as the progress toward social inclusion that has been made in the last two decades. She then explained the differences between the medical model of disability and the disability-rights model of disability. Adherents to the medical model believe that a disabled person's problems are caused by the fact of his or her disability and thus the question is whether or not the disability can be alleviated. Advocates of the disability-rights model, on the other hand, believe that a person with a disability is limited more by society's prejudices than by the practical difficulties that may be created by the disability. Under this model, the salient issue is how to create conditions that will allow people to realize their potential.

Characteristic assumptions of the Disease Model are:

- A primary focus on biological dysfunction, denying the consumer control over his or her disability;
- A belief that recovery from severe mental disorders is highly unlikely or impossible;
- Symptom reduction and remission are the best possible outcomes;
- Inflexible, time-limited services designed for provider convenience rather than consumer needs;
- A belief that the doctor or therapist is primarily responsible for the healing process;
- Lack of proactive outreach and ongoing support for consumers and family members.

Fundamental assertions of the Recovery Model are:

- A paradigm shift to a holistic (i.e., biological, psychological, social, and spiritual) view of mental illness;
- Recovery from severe psychiatric disabilities is achievable;
- Recovery can occur even though symptoms may reoccur;
- Recovery is not a single event or linear process—it involves periods of growth and setbacks, rapid change or little change;
- Individual responsibility for the solution, not the problem;
- Recovery is not a function of one's theory about the causes of mental illness;
- Recovery requires a well-organized support system;
- Consumer rights advocacy and social change;
- Flexibility to issues of human diversity.

Kendra's Law (New York) is Racially Biased

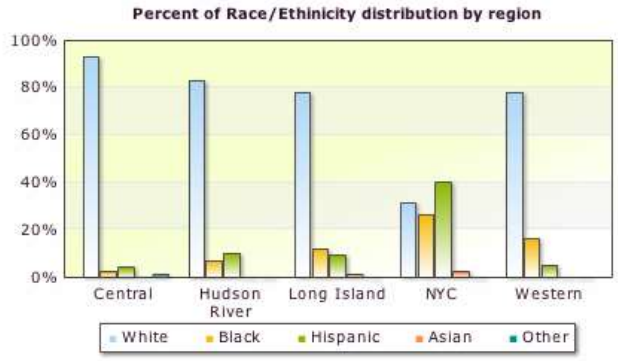
Characteristics of Recipients

Race: Race/Ethinicity distribution of AOT recipients since Nov.1999.

Race

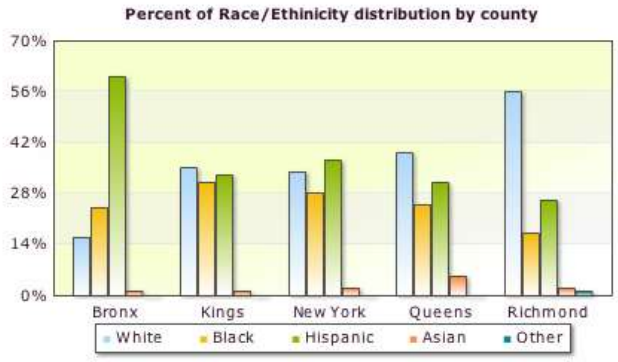
Statewide By Region

Region	White	Black	Hispanic	Asian	Other
Central	93%	2%	4%		1%
Hudson River	83%	7%	10%	0%	0%
Long Island	78%	12%	9%	1%	
NYC	31%	26%	40%	2%	0%
Western	78%	16%	5%		0%
Statewide	**48%**	**21%**	**30%**	**1%**	**0%**



Counties In NYC Region

County	White	Black	Hispanic	Asian	Other
Bronx	16%	24%	60%	1%	
Kings	35%	31%	33%	1%	0%
New York	34%	28%	37%	2%	0%
Queens	39%	25%	31%	5%	0%
Richmond	56%	17%	26%	2%	1%
Region Total	**31%**	**26%**	**40%**	**2%**	**0%**



* Areas where data represents fewer than 5 recipients are suppressed to protect confidentiality.

Last Refresh Date : January 25,2013

From: http://bi.omh.ny.gov/aot/characteristics?p=demographics-race on May 17, 2013

NYC Census
African-Americans = 15.9% r. White = 1::4
Latino(a) = 17.6% r. White = 1::3.7
Asian = 12.7 % r. White = 1::5
White = 65.7%

****

Contrary to what the NYS 2009 Program Evaluation Report of Kendra's law cites, a look at 10 years of statistics of racial characteristics, clearly indicate racial bias in application of the law. This will likely be the subject for constitutional challenges in the Federal Courts, representing an additional, unanticipated cost to the counties who choose to adopt Laura's law or Article 9 of WIC.

An Elephant in the Room – Editorial in Psychiatric Rehabilitation Journal, Winter 2006

The idiom that there is an elephant in the room is used to indicate that some issue, which is perfectly obvious to some people, is rarely talked about. Furthermore, the use of the expression refers to an issue that can't be avoided, much like an elephant in the room, but often is. This phrase implies a value judgment that the issue should be discussed openly.

I sense the elephant in the room whenever we talk about the importance and beauty of the recovery vision while accepting the incompatibility and ugliness of the use of force in a recovery oriented system. The danger in not openly discussing this incompatibility is that eliminating the use of force will never be critically examined as a necessary goal in a recovery oriented system. As a matter of fact phrases such as outpatient commitment and forced medication oftentimes are seemingly paired in a naïve and incongruous way with the pursuit of recovery-oriented systems.

I am not offering a single strategy as to how to get force out of the system. I don't know the most effective and efficient way to go about it. What I am proposing is that if we do not redouble our efforts to focus seriously on the incompatibility of force and recovery, we will never figure out ways of eliminating force from recovery oriented systems. Force elimination is both a necessary and reasonable goal as we move further down the path of recovery. Let us use our most creative minds to discuss this elephant in the room, rather than spend time trying to regulate or reduce the use of force in the hopes of making environments that use force more "humane". This incompatibility must see the light of day. There is no such thing as "forced recovery".

-- William A. Anthony, Ph.D.

Additional Thoughts From Pat Risser:

In 2002, Dan Fisher was serving on President Bush's New Freedom Commission on Mental Health and he was a member of the subcommittee on "Rights and Engagement" with a focus on coercive treatment. He invited me to represent the consumers/survivors side of the issue and provide testimony to the subcommittee.

I went to Washington to provide 'expert' testimony. Dan knew that I felt passionately about our rights and that I'd been to law school, was formerly director of Patients' Rights in a county in California and was President of NARPA (National Association for Rights Protection and Advocacy). The other members of the subcommittee were Ginger Lerner-Wren (Judge from the first Mental Health Court in the Country in Broward County Florida) and Henry Harbin, M.D. (Psychiatrist, CEO Magellan Behavioral Health and former Commissioner of Mental Health in Maryland). Providing testimony for the opposing viewpoint (in favor of "compassionate coercion") was Steve Sharfstein, M.D. who was the incoming Vice-President of the American Psychiatric Association.

Much of the original draft of this document opposing mental health courts was developed in preparation for providing my testimony. I knew I couldn't just come out in opposition with Judge Lerner-Wren but what I'd noticed was that she held the system accountable. Rather than 'sentence' people to the treatment that was available from the system, she determined what would help the person and 'ordered' the system to provide for those needs even if they had to create something that would work. She was also very understanding and compassionate. Essentially, she 'sentenced' the system to meet the needs of the person.

When I gave testimony, I credited her as the reason why Broward County Mental Health Court works. However I also pointed out that she could not be duplicated elsewhere so there was no way to assure that other mental health courts would be successful. At that point, Steve Sharfstein poo-poohed with his typical psychiatric arrogance and claimed I didn't know what I was talking about. Then, Judge Lerner-Wren proceeded to chew him out royally and stated I was right! It was quite a show.

In any case, there are a number of reasons why the mental illness system does not work. By extension, a court system that forces people into a broken system that the New Freedom Commission declared is in disarray, would be akin to asking people to drive safely in a broken car. It just doesn't make sense.

How and Why the System is Broken:

- Clients are trained to be "mentally ill" and not mentally healthy
- Efforts are focused on "disability" instead of strengths and abilities
- Dependency is maintained under the guise of good care
- The system creates a suffocating "safety net"
- Clients are not given the right to make mistakes (fail) without it being judged negatively
- The system is deaf, dumb and blind to research and ignores it's implications in practice
- The system is staff-oriented as opposed to client-oriented
- School-based inculcation is so strong as to be nearly totally immutable (people get stuck and stay stuck in what they learned from 20-year out-of-date textbooks)
- "Mental Illness" is perceived by staff to be an intractable condition (recovery not possible) for at least 75% of the clients
- Severe and persistent disabilities associated with "mental illness" are grounds for assuming clients are incapable of choice
- Pervasive belief that "treatment" (symptom control) must precede substantive rehabilitation efforts
- Belief that impairment in one life area affects all abilities
- Absence of clarity as to the product (what it is that the system is supposed to provide) precludes evaluation and effective management

* There is confusion about mission, purpose and goals; What is the desired product?
  - -Treatment hours?
  - -Tenure in the community?
  - -Quality of life? (as defined by whom?)
  - -Normalization? (as defined by whom?)
  - -Recovery? (as defined by whom?)

- Pay is too highly correlated with credentials that are not indicative of the skills required to do the job (academic degrees don't necessarily correlate to "people skills")
- Public dollars continue to subsidize the education and preparation of practitioners for the private sector with no pay back to the public sector despite some fairly massive workforce shortages
- Notable major advances are accomplished by rebels yet the system rewards conformity and punishes non-conformity
- The system subcomponents are underfunded and non-integrated
- The governor has minimal interest in mental health aside from cost-containment
- People argue about causes and attempt to make clients "compliant" instead of teaching them coping skills regardless of causes and in spite of them
- Legislators are naïve and pay more attention to providers' and family members' wants than to consumers' needs
- Provider Boards of Directors are inadequately trained to do their jobs. What little training they receive is generally done by staff within the agencies creating inbreeding that is not beneficial

Mental Health and Human Rights

(written by Sylvia Caras, Ph. D.)

There is no conflict between a position that generates the greatest good and at the same time does the least harm. Coercion does the least good, the most harm, and is disrespectful to human dignity.

Coercion deals with a social problem by punishing the victims.

By creating a sub-class, coercion readies the public mind for prejudice and discrimination.

Interventions without consent may ignore the problems of living that cause distress.

Disagreement with medical authority is not incapacity.

Self-management and personal responsibility save public money.

Governments have a responsibility to protect all their citizens. The way to do this is by strengthening self-definition and autonomy so we each define useful assistance and accommodation for ourselves.

Determining the needs of others by one's own needs is oppressive. The value "caring coercion" puts another's idea of what is good for me over what I would like for myself, whitewashes the violation of my personal integrity, dishonors my experience of my life.

The mental health system is a violent system, using force to impose its will, bullying patients by withholding privileges and threatening charting and isolation, subduing its subjects with leather and chemical restraints, and in general setting a harsh example of how humans should treat one another. What is needed is to overhaul a dishonest system.

Prompted by Sharfstein's title: Case for Caring Coercion, APHA 2006, Boston, and informed by internet exchanges with members of the WNUSP board and subscribers to ActMad.

Sylvia Caras, Ph.D., http://www.peoplewho.org

A Fairy Tale

Once upon a time in a land by the ocean, people lived in comfort and prosperity. Over time, they came to notice that some of the people among them had unusual experiences. Some heard voices, others saw things that other people couldn't see, others became very agitated or very sad, some became confused. At times these experiences caused people much pain, and they suffered and their families suffered with them.

The families went to the leaders of the people and cried, "Our sons and daughters are suffering. You must help us." and the leaders of the people saw the truth in what they said and undertook to find a cure for these ills. Whereupon they commanded wise and compassionate doctors and profitable pharmaceutical companies to bring before them new treatments - wondrous drugs that would heal people if taken regularly.

And so the drugs were administered to the sons and daughters who had these unusual experiences. But apparently an evil spell had been cast upon the medications, for they were far less effective and far more injurious than promised. Many sons and daughters were crippled by their effects. Many feared the medicine had been turned to poison. "This drug doesn't help me at all….it makes me too tired….it makes my muscles stiff…it makes me too jumpy…I gained 50 pounds on it…it makes me feel like a zombie," they were heard to say. The sons and daughters were frightened and disappointed, and they threw down the pills and returned to their unusual lives and unusual experiences.

Their families were enraged and returned to the leaders and the doctors. "You must help us," they said, "Our sons and daughters do not see how wonderful these medications are, and they will not take them."

"Never fear," said the leaders, "we will create a law that will compel your children to take the drugs they need, for it is clear that they do not have the insight and judgment to make this decision on their own."

And so a proclamation went throughout the land requiring people who were afflicted by visions and voices, mood swings and confusion to appear for their required medications. Thousands upon thousands of sons and daughters were forcibly, but compassionately injected and, Lo, they began to heal. Unburdened by their symptoms, the sons and daughters were able to keep their medication appointments and attend day treatment regularly.

And they all lived happily ever after, with minimal residual disability and fewer side effects than placebo.

The end.

Like I said….it's a fairy tale.

(by Coni Kalinowski, M.D.)

March 21, 2012

Subject: **Opposition to involuntary outpatient commitment** bill AB 1569 (Allen)(California)

We, the undersigned organizations and individuals, urge a "no" vote on AB 1569, currently pending before the Assembly Health Committee. AB 1569 would re-authorize involuntary outpatient commitment under AB 1421 ("Laura's law", referred to as "assisted outpatient treatment" by proponents) for six years and would eliminate all state oversight of such programs. Instead of extending AB 1421's sunset date, California should increase the availability of a full array of voluntary mental health services, expanding programs that have demonstrated success in saving lives and money.

We stand united in opposition to involuntary outpatient commitment (IOC) for the following reasons:

1. IOC violates or threatens to violate the fundamental human rights of a broad group of mental health clients who have a history of hospitalization or suicide attempts by forcing them to comply with court ordered treatment even though they are not currently a danger to themselves or others, and have not been found incompetent to make their own medical decisions.

2. IOC is inconsistent with mental health recovery principles of self-determination and empowerment.

3. The stereotypes, prejudices and irrational fears of "violent" mental health clients on which IOC is based are not consistent with the facts. Mental health clients without symptoms of substance abuse are no more prone to violence than others living in their communities who do not have symptoms of substance abuse. (MacArthur Violence Assessment Risk Study, 1999).

4. IOC under "Kendra's Law" in New York has targeted African Americans and Latinos in numbers disproportionate to their respective populations. African American clients are nearly five times as likely as whites, and Latinos twice as likely as whites, to be the subject of court-ordered treatment under "Kendra's Law" (NY Lawyers for the Public Interest, 2005).

5. IOC remains unproven. Nearly ten years after AB 1421 became law, no empirical evidence comparing court-ordered community mental health services and supports with comparable programs offered on a voluntary basis shows any difference in outcomes. (RAND Corp., 2000; Steadman et al., 2001; Swartz et al., 2009).

6. IOC's use of coercion risks re-traumatizing clients who already have a high prevalence of trauma (Muesar et al., 2004), and driving people away from treatment altogether (Campbell & Schraiber, 1989).

7. IOC threatens to divert scarce resources from voluntary mental health programs with proven track records such as Prop 63 (Millionaire Tax) full service partnerships (FSPs, a highly successful approach to voluntary treatment that includes community-based recovery services, housing, and 24-7 emergency response), psychological counseling, peer support, and subsidized and supportive housing and "Housing First" programs. Many people diagnosed with serious mental illnesses throughout the state are still being turned away from services they want and need. Increased investment in voluntary services is the most sensible approach to meeting this need.

California CARES Coalition

For every 100 who might get pushed to the head of the line for services because of a loud-mouthed family member pushing for IOC, 100 others will be pushed to the bottom of the line or out of the system where they will not receive services and will perhaps decompensate and create a greater problem.

EARLY DEATH

"What does it mean that the life expectancy of persons with serious mental illness in the United States is now shortening, in the context of longer life expectancy among others in our society? It is evidence of the gravest form of disparity and discrimination." --Kenneth J. Gill, Ph.D., CPRP

A series of recent studies consistently show that persons with serious mental illnesses in the public mental health system die sooner than other Americans, with an average age of death of 52.
(Colton, C.W., Manderscheid, R.W. (2006) Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States. *Preventing Chronic Disease*. Vol. 3(2).)

"Adults with serious mental illness treated in public systems die about 25 years earlier than Americans overall, a gap that's widened since the early '90s when major mental disorders cut life spans by 10 to 15 years."
Report from NASMHPD (National Association of State Mental Health Program Directors), May 7, 2007

Psychiatric Services 50:1036-1042, August 1999
Life Expectancy and Causes of Death in a Population Treated for Serious Mental Illness
Bruce P. Dembling, Ph.D., Donna T. Chen, M.D., M.P.H. and Louis Vachon, M.D.

OBJECTIVE: This cross-sectional mortality linkage study describes the prevalence of specific fatal disease and injury conditions in an adult population with serious mental illness. The large sample of decedents and the use of multiple-cause-of-death data yield new clinical details relevant to those caring for persons with serious mental illness.
METHODS: Age-adjusted frequency distributions and years of potential life lost were calculated by gender and causes of death for persons in the population of 43,274 adults served by the Massachusetts Department of Mental Health who died between 1989 and 1994. Means and frequencies of these variables were compared with those for persons in the general population of the state who did not receive departmental services and who died during the same period.
RESULTS: A total of 1,890 adult decedents served by the department of mental health were identified by electronic linkage of patient and state vital records. They had a significantly higher frequency of deaths from accidental and intentional injuries, particularly poisoning by psychotropic medications. Deaths from cancer, diabetes, and circulatory disorders were significantly less frequently reported. On average, decedents who had been served by the department of mental health lost 8.8 more years of potential life than decedents in the general population—a mean of 14.1 years for men and 5.7 for women. The differential was consistent across most causes of death.
CONCLUSIONS: Findings in this study are consistent with previous findings identifying excess mortality in a population with serious mental illness. The high rate of injury deaths, especially those due to psychotropic and other medications, should concern providers.

The World Health Organization (WHO) found that recovery from schizophrenia is at least 50% higher in emerging (third-world) countries that practice far less 'Western medicine' and there are almost no psychiatric services.

Two studies by the World Health Organization (WHO), one in 1979 and the second in 1992, compared the recovery rate, mostly from schizophrenia, in developing countries with the recovery rate in industrialized countries. In 1979, WHO had about 1800 cases validated by Western diagnostic criteria in developing counties matched with controls from industrialized countries, and they found that the recovery rate was roughly twice as high in the developing countries compared with the industrialized.[1] They were so surprised by this that they said, "Well, this must be a big mistake." So they repeated the study in 1992, and they got the same results.[2]
[1] World Health Organization. Schizophrenia: WHO study shows that patients fare better in developing countries. WHO Chron. 1979;33:428.
[2] Jablensky A, Sartorius N, Ernberg G, et al. Schizophrenia: manifestations, incidence and course in different cultures. A World Health Organization ten-country study. Psychol Med Monogr Suppl. 1992;20:1-97.

Compared to the general population, recipients of public mental health care:

- **Experience higher rates of medical disease**
- **Die in greater numbers each year (1 - 3.5% vs. 0.5 - 0.8%)**
- **Die 13 to 30 years earlier than expected**

*** * * * * * * * * * * * * * * * * ***

JAILS and the "Mentally Ill"

People go to jail because they break the law and get convicted, not because they are "mentally ill." On 02-09-14, Nicholas Kristof wrote a NY Times Opinion (http://www.nytimes.com/2014/02/09/opinion/sunday/inside-a-mental-hospital-called-jail.html?src=recg) in which he highlighted E. Fuller Torrey's narrative that the reason so many people with psych disabilities are in jails and prisons is that we've shut down all the hospitals, and intimating that what we need is a new Dorothea Dix to help us rebuild the old asylums since we've gone backward. He congratulates the Cook County Jail for doing a bang-up job of providing good mental health services to inmates, and fails to mention the Jail's systematic failure to offer anyone linkage to any kind of services if they want & need them when they leave - instead he blames the inmates, who, when they are released, "go off their medications and the cycle repeats."

There’s an elephant in the room …

The impact of psychiatric drugs upon morbidity (illness rates) and mortality (death rates) of recipients of public mental health care is usually ignored or minimized

U.S.A. = 4.5 % of world population

Although the U.S. population comprises only 4.5% of the planet's human inhabitants, Americans account for a disproportionate share of the world's pharmaceutical ***sales*****:**

90% of the world's stimulants
63% of the world's antipsychotics
51% of the world's antidepressants
41% of the world's anti-epileptics

[Source of sales data: IMS Health]

Heart Disease
#1 Cause of Death 2011

	APs	ADs
sudden death	↑2-4X	↑1.5-3.6X
heart attacks	↑5X	↑1.2-1.85X
		8-11%

Numerous epidemiological studies (population based studies of human patients) have documented increased risks of cardiac disease among the users of psychiatric drugs. These risks have not been explained by the presence of other variables, such as lifestyle or pre-existing health conditions.

In other words, even after “controlling for” mental illness severity and medical comorbidity,
and even after adjusting statistical equations for lifestyle factors (such as smoking, poverty, and/or lack of exercise), the use of psychiatric drugs has been a significant risk factor for sudden death and heart disease.

Antipsychotic drugs (APs) have been associated with a 100-300% increase in the risk of sudden cardiac death; and a 400% increase in the risk of heart attacks (myocardial infarction).

Antidepressant drugs (ADs) have been associated with a 50% to 260% increase in the risk of sudden cardiac death; and a 20-85% increase in the risk of heart attacks. (In some studies, as many as 8-11% of antidepressant drug users have experienced a heart attack during treatment.)

Stroke

#4 Cause of Death in 2011

APs	ADs	AEDs
↑1.4-3.5X	↑1.2-2X	↑2.5-3.7X
2-4%	2 to 10%	

Just as psychiatric drugs contribute to elevated rates of heart disease, these pharmaceuticals also elevate the risk of stroke (acute "brain attacks" > caused by impaired blood flow, bleeding, and/or changes in cell metabolism).

Antipsychotic drugs (APs) elevate the risk of stroke by 40-250%.

Antidepressant drugs (ADs) elevate the risk of stroke by 20-100%.

Antiepileptic drugs (AEDs) (aka, anticonvulsants) which are commonly used for "bipolar disorder" elevate the risk of stroke by 150-270%.

Diabetes Mellitus

#7 Cause of Death in 2011

APs	ADs	AEDs
↑7X	↑2X	↑2-3X

general population	9% (lifetime)
APs	≥ 20-30%
ADs	10-20%
AEDs	probably 15-25%

The term “diabetes” is taken from the Greek word, “diabainein” meaning siphon. The implication is a gushing or overflow of fluid > specifically, of urine. Historically, physicians have identified and treated two major kinds of diabetes: *diabetes mellitus* characterized by sugar in the urine (mellitus = honey sweet); and *diabetes insipidus*, characterized by excessive urination (insipidus = without taste).

The information above refers to the #7 leading cause of death in the USA: diabetes mellitus (Type I and Type II). Childhood onset or Type I diabetes mellitus, is caused by an autoimmune deficiency which impairs the body’s ability to make insulin. Type II diabetes mellitus refers to an *acquired disease* involving decreased insulin production and decreased insulin response (e.g., insulin resistance).

This information compares the rates of Type II Diabetes Mellitus in the general population of the USA (lifetime prevalence: 9%) versus psychiatric drug users:

At least 20-30% of antipsychotic drug (APs) users are developing Type II DM;

~10-20% of chronic antidepressant drug (ADs) users are developing Type II DM;

~30-50% of some anti-epileptic drug (AEDs) users are developing insulin resistance (pre-diabetes); of these, 1/2 are expected to progress to diabetes

Psychiatric Drugs and Death

Approximately 1% of the US population dies each year.

General population ~ 1% die per year
Public Mental Health System Recipients (1997-2000) up to 3.5% per year

Lithium 15% dead in 5 to 10 years
Anti-depressants 20% dead in 10 years
Anti-psychotics (in general) 20-33% dead in 10 years

Several studies of patients exposed to different classes of psychiatric drugs have shown high mortality rates: 15-33% of the patients have died within ten years.

 **ADVERSE EFFECTS** 

106,000 inpatient deaths
199,000 outpatient deaths

305,000 deaths from Rx

In 2000, the prestigious *Journal of the American Medical Association* (aka, JAMA) featured an article by Johns Hopkins University professor, Dr. Barbara Starfield. Using data culled from a variety of inpatient and outpatient investigations, Starfield's analysis estimated that adverse effects of medication (i.e., *"therapeutic" doses of prescription drugs taken exactly as prescribed*) account for approximately 305,000 deaths per year.

106,000 inpatient deaths due to pharmaceuticals
199,000 outpatient deaths due to pharmaceuticals

[Note: Given the fact that "adverse drug reactions" are rarely reported, and given the fact that drug-related heart attacks, strokes, pneumonias, and cancers are seldom attributed by physicians or governmental agencies to pharmaceuticals, these estimates were absurdly conservative.]

U.S.A.: Psychiatric Drugs 2009

[Source: Express Scripts 2009 Drug Trend Report]

Antidepressants	10%	31,000,000
Anticonvulsants	4%	12,300,000
Stimulants	2%	6,754,000
*Antipsychotics	2%	5,526,000

*part of Express Scripts' "mental/neurological" class: includes lithium, dementia drugs, substance abuse drugs

Express Scripts, a pharmaceutical benefits management company, produces annual drug trend reports. The information in this slide was obtained from the April 2010 Drug Trend Report. Approximately 10% of U.S. residents used an antidepressant at some time in 2009; 4% used anticonvulsants; 2% used stimulants; and approximately 2% used an antipsychotic.

These numbers exclude drug use by non-commercially insured patients, such as veterans and active duty military personnel; institutionalized patients (e.g., residents of nursing homes, prisons, jails, and state hospitals); and patients who rely upon publicly funded programs, such as Medicaid and Medicare.

How Did They Do It:

Prescription drug use was evaluated by examining pharmacy claims from two independent, random samples of approximately 3 million commercially insured individuals. The prevalence of use was calculated by dividing the # of insured members taking medications in a certain drug class by the total number of insured.

To place the aforementioned figures in context, the Express Scripts database revealed the following patterns of non-psychiatric drug use in 2009:

Pain killers	17.8%
Heart disease, hypertension	15.7%
High cholesterol drugs	12.1%
Asthma medications	8.7%
Ulcer disease (antacids)	8.2%
Diabetes	5.0%
Anti-virals	4.5%

Against Forced Treatment

Robert Whitaker

Are there sufficiently convincing arguments in favor of outpatient commitment laws and society's decision to force certain adults to take antipsychotics? The logic behind outpatient commitment laws is that antipsychotic medication is a necessary good for people with a diagnosis of severe mental illness. The medications are known to be helpful, but—or so the argument goes—people with "severe mental illness" lack insight into their disease and this is why they reject the medication.

However, if the history of science presented in "Anatomy of an Epidemic" is correct, antipsychotic medications, over the long term, worsen long-term outcomes in the aggregate, and thus a person refusing to take antipsychotic medications may, in fact, have good medical reason for doing so. And if that is so, the logic for forced treatment collapses.

In my foreword to *Anatomy of an Epidemic*, I told of how, when co-writing a series for the *Boston Globe* in 1998 on abuses of psychiatric patients in research settings, I stumbled upon two outcome studies that I found difficult to understand. The first such study was by Harvard researchers, who reported in 1994 that outcomes for schizophrenia patients had worsened during the past two decades and were now no better than they had been a century earlier. This outcome belied what I understood to be true at that time, which was that psychiatry had made great progress in treating schizophrenia.

Anosognosia

Anosognosia means ignorance of the presence of disease, specifically of paralysis. Most often seen in patients with nondominant parietal lobe lesions, who deny their hemiparesis. This neurological condition only applies to psychiatric patients if the definition is twisted and distorted by those who seek to attempt to legitimize psychiatry by using neurological terms but really, it only demonstrates ignorance.

I've spoken with many who have lived experience with psychiatric issues. Almost universally they will claim that one of the issues that professionals don't understand is: "Just because I'm banging my head on a table doesn't mean I don't know that I'm banging my head on a table." We have far more awareness than is commonly believed.

Even if anosognosia were to be applied to psychiatric issues, by fallacious reductio ad absurdum argument, we could argue that lack of insight into the status of your circumstances would mean that we should create mental hospitals for chronically obese folks, smokers, hang-gliders, surfers, etc. or anyone else who continues to indulge in risky or socially disapproved of behavior. Shall we create, "Eastern State Hospital for Hoarders." The reality is that anosognosia means that if you don't agree with your diagnosis you *lack insight t*hat the psychiatrist is right.

LETTER: Neurological Basis For Denying Mental Illness

April 30, 2013
In response to Dr. Larry Davidson's op-ed "Mental Illness Fallacies Counterproductive" [April 28, http://www.courantopinion.com], it is embarrassing that a professor of psychiatry at Yale University School of Medicine can publicly claim that "there are no data of which I am aware that indicate that persons with psychotic disorders refuse treatment because they have a neurological condition that makes them unaware that they are ill."

This condition, anosognosia, was described by neurologists more than a century ago and affects approximately half of individuals with schizophrenia. Dr. Davidson should be assigned to read Amador and David's "Insight and Psychosis," Prigatano and Schacter's "Awareness of Deficits after Brain Injury," or the 17 published studies showing anatomical brain differences between individuals with schizophrenia with and without anosognosia. One wonders what else his psychology training failed to cover.

E. Fuller Torrey, M.D., Arlington, Va.
The writer, a psychiatrist, is the founder of the Treatment Advocacy Center.

http://articles.courant.com/2013-04-30/news/hcrs-14690hc--20130429_1_schizophrenia-fuller-torrey-mental-illness

LETTER: Denial Of Mental Illness Not Neurological

May 03, 2013
http://articles.courant.com/2013-05-03/news/hcrs-14742hc--20130502_1_schizophrenia-fuller-torrey-condition-obscures-mental-illness#

I can reassure Drs. E. Fuller Torrey and Xavier Amador that I know of their theory linking anosognosia to schizophrenia. Anosognosia is a neurological condition in patients with nondominant parietal lobe lesions, who deny their partial paralysis. I can understand wanting to apply this notion to mentally ill persons who refuse treatment, but there are at least five reasons not to:
1) No such lesions have been found in schizophrenia, despite over 200 years of research looking for them. What Drs. Amador and Torrey have is a theory, not a fact. Other than justifying outpatient commitment, this theory has led to no breakthroughs in treatment.
Not only are such theories dangerous, but they 2) do not explain how so many people with schizophrenia gain insight and recover over time; 3) do not take into account the power of stigma, which persons with mental illnesses identify as the major barrier to accessing care; 4) do not take into account the limited effectiveness and responsiveness of much mental health care; and 5) do not support outpatient commitment because schizophrenia is the least likely condition among the mental illnesses to be implicated in the extremely rare acts of violence that occur.

Larry Davidson, Hamden
The writer is a psychiatry professor at Yale University.

Mental Illness Fallacies Counterproductive

By LARRY DAVIDSON | OP-ED
The Hartford Courant
6:11 PM EDT, April 26, 2013

Proponents of Connecticut establishing a law that would allow the involuntary treatment of people with mental illness in the community have recently used two misleading ideas to support their case.

They acknowledge that voluntary treatment is preferable, but point out it doesn't work for everyone. Among the reasons they give for the failure of voluntary treatment is that some people with mental illness have a condition that makes them unaware they are ill, or they don't like the side effects of medication. Both assertions are highly questionable and neither does justice to the seriousness of the issue.

It is misleading, for example, to refer to people with mental illnesses as either "treated" or "untreated." The medications we currently have for these conditions do not come close to resembling the effective use of insulin for diabetes, for example. Only seven out of 10 people with a serious mental illness will derive any benefit from medications, and these benefits will typically be modest.

For most people, medications do not eliminate the illness but only lessen some of its more intrusive features. At the same time, side effects are not merely unpleasant or annoying. They may make it difficult for people to function at all and may contribute to the loss of fully a third of the person's expected lifespan, as those with serious mental illnesses die 25 years sooner than the American average.

This leads to the second issue of refusing treatment. There are no data of which I am aware that indicate that persons with psychotic disorders refuse treatment because they have a neurological condition that makes them unaware that they are ill. This theory assumes that if people were aware of their symptoms, then they would know and accept that those symptoms were due to having a mental illness. But no one is born knowing what mental illnesses are or how to recognize when they begin to experience the symptoms of one. How, then, are people to know that what they have is a mental illness?

If the only things people are taught about mental illnesses are the negative stereotypes held by our society — such as being "mental defects" — we can assume that many people will continue to "deny" that they have a mental illness. From their perspective, they are not "crazy" or "insane," so they could not possibly have a mental illness. They are just like you and me (because they are, after all, you and me).

Many people choose not to follow through with outpatient care once discharged from a hospital because they do not see themselves as the "madmen" that society has painted persons with mental illnesses to be. Treating such people as dangerous thus accomplishes exactly the opposite of what we intend. This attitude drives people in need away from the care that would be effective in addressing their concerns.

No one would willingly choose to adopt the identity of a "mental patient." This is why it requires considerable courage for people to seek mental health care. One consequence of this attitude is the shocking statistic that recently came to light about the war in Afghanistan: More American soldiers died from suicide in 2012 than from combat.

I know about what it takes to accept having a mental illness. I am a highly trained mental health professional who suffered for 17 years with an undiagnosed mental illness before getting effective treatment because of my own deeply held beliefs that I was not one of "them." This is the false dichotomy that we must break down.

If we want to make mental health care accessible, then we should stop scapegoating people with mental illnesses and focus instead on fixing the society, and system, that marginalizes them. We need to educate the public and youth in particular about what mental illnesses are, including how common they are (one in four Americans will have one), and, important, how possible it is to recover.

There are effective treatments other than medication that we can make available, such as outreach and peer support. These invite, rather than coerce, people into care that is respectful and responsive to their needs, so they need not suffer alone in silence, and so that mental health care is no longer something of which people are ashamed.

Larry Davidson is a professor of psychiatry at the Yale University School of Medicine.
courant.com/news/opinion/hc-op-davidson-involuntary-treatment-of-mental-ill-20130426,0,3300501.story

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http://web.archive.org/web/19981205154708/http%3A//www.schizophrenia.com/ami/coping/911.html

How to prepare for an emergency

by
D.J. Jaffe (co-founder of Treatment Advocacy Center)

While AMI/FAMI is not suggesting you do this, the fact is that some families have learned to 'turn over the furniture' before calling the police. Many police require individuals with neurobiological disorders to be imminently dangerous before treating the person against their will. If the police see furniture disturbed they will usually conclude that the person is imminently dangerous.

A Discussion Paper on Policy Issues at the Intersection of the Mental Health System and the Prison System

by Daniel Hazen and Tina Minkowitz
Center for the Human Rights of Users and Survivors of Psychiatry

1. Debunking the Myth: Prevalence of Psychosocial Disability in Prison - What Does It Mean?

It has become a commonplace of mental health advocates and criminal justice advocates, often without lived experience of incarceration in either system, to point to high numbers of people with mental health problems[1] in prison, and argue for increasing transfer of direct control and supervision of such individuals to the mental health system.

We contest the implied assumption that the presence of people with mental health problems in prison is inherently shocking or problematic, as well as the recommendation of greater involvement of the medical-psychiatric system in social control as a response to this situation.

Given the traumatic backgrounds of people who end up in prison and the relationship of trauma to mental health problems, the prevalence of mental health problems by any measures should not be surprising. Trauma may be common among prisoners for reasons including discrimination in access to justice, discrimination in the definition of crime and in the establishment of penalties for different crimes, as well as factors influencing the commission of criminal acts.

The gathering of information on mental health problems, whether by self-reporting or diagnosis, may change over time for reasons unrelated to people's experience of distress. Diagnostic trends in particular change with the fluctuation of DSM/ ICD categories, and with the attention placed on mental health issues by authorities.

Given the traumatizing nature of prison – deprivation of freedom, toxic environment, bad food, strip searches, etc. – people inevitably experience distress and altered consciousness that can be labeled as mental health problems. The traumatizing nature of prison can be encapsulated in the degrading entry procedure, described from experience of a U.S. prison:

"Walking into a system where you are being given a number that becomes your identification. A barber shaves your head, they have you strip your clothes off and de-lice you, dropping this powder. There are 50 men in this line. It has a humiliating, degrading, punishing effect immediately. How trauma-insensitive that is, the anxiety that drives through your body is incredible. It reminded me of the concentration camps. They say that Germany was so bad but we're doing the same thing. They call it rehabilitation - they break you and rebuild you."

The number of people labeled with mental health problems in prison is sometimes compared with declining numbers in psychiatric institutions, as if to argue that the psychiatric system by failing to confine people with psychosocial disabilities is creating the conditions for these individuals to commit crimes and be incarcerated in the prison system. It is a tautology that incarceration of any demographic would stop those individuals from committing crimes. Human rights principles do not permit profiling and preventive detention based on psychosocial disability, any more than

they would permit profiling and preventive detention based on race, gender or age. To the extent that the mental health system has been placed in the role of public safety official, with legal duties to confine individuals based on risk assessment of any kind, this is incompatible with the duty to serve the individual client and must be removed in order that the mental health profession may be able to comply with its human rights obligations. Moreover, mental health treatment is far from being foolproof, reliable or safe. Expansion of mental health treatment, even when community-based, has not resulted in decrease of mental health problems, but rather in an upsurge, iatrogenic problems in both physical health and mental health, and enforced dependency on mental health providers for services that maintain individuals in poverty and segregation.

2. Mental Health System is Coerced Compliance – Not a True Alternative to Prison

A. Diversion into Coerced Medical Disablement is Not a Viable Alternative to Incarceration

Diversion from the court system to coerced mental health treatment is also proceeding apace. "Mental health courts" in the U.S., although participation in them is voluntary at the outset, induct individuals into coerced compliance with treatment, in exchange for suspension of prison sentence. A guilty plea is required, and compliance with treatment is supervised by the court, with the possibility of a prison/jail sentence being imposed if compliance is not deemed adequate.

In Japan, a preventive detention law for people with mental disabilities went into effect in 2005. Under this law, a person accused of a crime and deemed by the court to have a mental disability can be diverted from a trial of their guilt or innocence, to a hearing before a mental health tribunal to determine whether civil commitment should be imposed. This means that a person labeled with mental disability is denied the right to be considered innocent until proven guilty, and unlike all other criminal suspects can have detention imposed without proof of having committed the crime. Unlike the U.S. mental health courts, this diversion is not voluntary but is decided by the court.

The use of diversion schemes has been promoted as an alternative to the punitive sentences imposed by the "criminal justice" system, however we cannot consider it in any way an acceptable alternative, particularly when there are penalties for noncompliance with the prescribed treatment. Mental health treatment appears to many people to be beneficial to all concerned, to society as well as to the person accused of crime. But when the mental health system is made to do the duty of public safety official, it promotes neither public safety nor mental health. Irreparable harm is done by the coerced ingestion of mind-numbing drugs (the main modality of forced treatment), and by the narrative of incapability that removes a person from responsibility for, and confidence in, making deliberate choices to shape his/her own life.

Proponents of restorative justice, and of any theory of justice that supports reintegration, need to consider the implications of the social model of disability for their work, and to go deeper in imagining systems of accountability that respect human dignity. Coerced mental health treatment of people accused or convicted of crime is not restorative, and it does not contribute to meaningful re-integration. It is furthermore a form of discriminatory violence that fits the criteria for torture and ill-treatment.

B. Double Discrimination Against People with Psychosocial Disabilities in Prison

People with psychosocial disabilities in prison experience double discrimination. In some U.S. jurisdictions a person who has been given a psychiatric diagnosis is not eligible for programs with early leave such as work release and military style or modeled shock camps – 6 months of military style discipline and training after which the remainder is served on parole. (This blatant discrimination extends also to people with physical disabilities, for example if a person is unable to run with their legs.) Men and women with psychiatric diagnoses who have physical illnesses such as cancer or diabetes are often not treated for the physical illness which is explained as a psychiatric symptom.

In addition, state systems have access to past records. Due to having received a psychiatric label/diagnosis in the past, upon entry into the prison/penal system, a person can be placed in solitary confinement until being "seen" or evaluated by a mental health professional. This takes place in a segregated part of the prison, not the general population.

Forced drugging and confinement in a psychiatric unit within a prison can be similar to the way it's done in psychiatric institutions, but double discrimination emphasizes a person's status as being under the control of others.

"I felt, here I am a prisoner and mental patient. Those two things together left me with no liberty. I felt if I was captured by one, I could escape. Why would a judge listen to me not to medicate me, here I am a prisoner found guilty by judge and jury, there's no way I'm going to win a medication hearing or a retention hearing. The hearing was very short, about a minute. The psychiatrist said, "You need to take this," and that was it, bye, they send you back.

"There's no access to a lawyer in the penal system for psychiatric things. No access to a phone. The culture inside prison is often controlled by gang activity, underground crime. There are a lot less phones in the psychiatric piece than in regular prison - 120 prisoners inside the psych hospital in prison, and two phones. You can't get to the phone. And you have to be in programs all day.

"In the hospital they call you by name and not a number. You think you're a person again in the psych ward and not in prison. My thing was, you're getting out of one cage to be in another. This one's shinier, more buttons... but that doesn't make it not a cage."

3. Accountability

A. Insanity Defense is Counter-Productive

Behind the schemes to divert people from courts and prisons into the mental health system lies a belief that people with psychosocial disabilities do not belong in a penal system, but instead need medical treatment in order to not re-offend. The traditional penal system objectives of retribution and deterrence are seen as inapplicable to people with psychosocial disabilities, who are considered uniquely unable to control their actions. The remaining objectives of incapacitation and rehabilitation (primarily in the form of compulsory medication and other incapacitating treatments) are intensified.

This is seen most clearly in the operation of the insanity defense and its equivalents in every legal system. This defense - that a person is not guilty, or cannot have responsibility imputed for a crime, because of his/her mental state at the time the crime was committed - is considered a pillar of our legal systems and a sacred right of defendants. At some times and in some places, where the objectives of retribution

and deterrence were primary, it may have operated to allow people to avoid punishment that was seen as unfair given the circumstances.

However, ordinarily a verdict of insanity results in psychiatric rather than penal incarceration (and the Standard Minimum Rules on the Treatment of Prisoners so provide, in Rule 82). Whether it is labeled as punishment or treatment, the deprivation of liberty, lack of privacy, having one's daily life controlled by authorities, assaults on personal dignity and integrity from strip searches to forced medication have substantially similar effects on people in both institutions. Both institutions promote a negative self-image and submitting to authorities rather than seeking internal self-justification and conscience.

There is, furthermore, an overlap between the two systems that discloses their underlying unity. Despite the label of "treatment," the mental health system administers a wide range of punitive measures. These include "steps" or "levels" of increasing control, "privileges", and the imposition of coercive regimes in response to "failure to comply with prescribed treatment". Rehabilitation in prison, when imposed coercively, is substantially similar to forced mental health treatment (e.g. programs like "DARK", psychological intervention, coercion to attend self-help groups, and programs to "correct the personality").

The CRPD (United Nations Convention on the Rights of People with Disabilities: http://www.un.org/disabilities/default.asp?id=150) takes an opposite approach to responsibility of persons with disabilities for their own actions. Article 12, Equal Recognition Before the Law, provides that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. Legal capacity implies both rights and responsibilities, and "all aspects of life" can encompass criminal as well as civil matters. As the Office of the High Commissioner for Human Rights has said, this requires abolition of the insanity defense and its replacement by disability-neutral concepts such as the subjective element of a crime (mens rea).

B. Community Responsibility and Support

Article 12 also provides that States Parties must provide access to the support needed by persons with disabilities in exercising their legal capacity. The Committee on the Rights of Persons with Disabilities has clarified that support "respects the autonomy, will and preferences of the person," and that States Parties must replace all substituted decision-making schemes with support.

What might support look like in relation to crime and punishment?

It could start with community members taking responsibility to help avoid the commission of a crime and defuse conflict situations. Two examples:

"I was in the Apple Store and saw a kid bend down and take some hardware or software for IPad, he ripped open the box and put it in his sleeve. I had two choices - I could tell the staff, assumed he was going to steal, maybe he was testing the staff. I said to him, 'What you got there?' He put it back and didn't take it."

"One gentleman was camped out in his parents' backyard. The county mental health director called me [as head of a peer advocacy center], didn't want to call police, didn't want to go through routine, asked if we would go over. The guy didn't want respite, didn't want any government thing. He didn't get locked up that I know of, and moved off his parents' porch."

These examples might also be understood in a restorative justice framework, and there is a great deal of congruency between the values of restorative justice and the

social model of disability as enunciated in the CRPD. Both promote intersubjective and relational processes for arriving at decisions, respect for individual dignity and the equality of persons, autonomy, and reliance on community members rather than the state. Both encourage personal accountability and responsibility as a manifestation of mutual respect. Both encourage a holistic and big picture approach to justice, which is simultaneously grounded in lived experience: what do participants need, what is lacking (or over-present) in our social and economic system that impacts on the current situation, what is crime and what should be criminalized?

The prison reform and abolition movement, particularly including current and former prisoners, have a significant role to play in developing guidance and policy and in sharing their experience and wisdom with the community. Prisoners with psychosocial disabilities especially need to be consulted. This is a part of "reintegration" that is often overlooked.

The CRPD framework, restorative approaches to justice, and prison reform/abolition need to inform each other so as to transform our communities to promote social and individual healing, self-determination and mutual respect and accountability, for all people including people with disabilities. We need to reject one-sided approaches that either fail to address disability, or that address it from a medical model rather than social model perspective leading to increased discrimination. We need to fundamentally change both the legal framework for civil and criminal responsibility, and the relationship of responsibility to the law itself. We need to simultaneously build the capabilities of communities and ensure that the law reflects and enforces values of fairness, equality, freedom from torture and de-escalation of violence. The scope of the task should not overwhelm us, but inspire us to begin.

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Intentional Peer Support, www.mentalhealthpeers.com.

Center for the Human Rights of Users and Survivors of Psychiatry, www.chrusp.org

[1] We have used various terms in this paper reflecting diverse ways that our community talks about our experiences. Please see the WNUSP paper "Psychosocial Disability" explaining the meaning of this term as a preferred terminology. It is available at: http://www.chrusp.org/home/flyers

Psychosocial disability

The preferred terminology of “persons with psychosocial disabilities” should be used wherever relevant in legislation, to refer to persons who may define themselves in various ways: as users or consumers of mental health services; survivors of psychiatry; people who experience mood swings, fear, voices or visions; mad; people experiencing mental health problems, issues or crises. The term “psychosocial disability” is meant to express the following:

- a social rather than medical model of conditions and experiences labelled as “mental illness”.

- a recognition that both internal and external factors in a person’s life situation can affect a person’s need for support or accommodation beyond the ordinary.

- a recognition that punitive, pathologizing and paternalistic responses to a wide range of social, emotional, mental and spiritual conditions and experiences, not necessarily experienced as impairments, are disabling.

- a recognition that forced hospitalization or institutionalization, forced drugging, electroshock and psychosurgery, restraints, straitjackets, isolation, degrading practices such as forced nakedness or wearing of institutional clothing, are forms of violence and discrimination based on disability, and also cause physical and psychic injury resulting in secondary disability.

- inclusion of persons who do not identify as persons with disability but have been treated as such, e.g. by being labelled as mentally ill or with any specific psychiatric diagnosis.

It does not mean:

- an affiliation with psychosocial rehabilitation.

- acceptance of any label that an individual may not identify with.

- a category to be used in addition to “mental illness” or “mental disorder”.

- a belief in psychosocial “impairment”.

CRPD (United Nations Convention on the Rights of People with Disability) Article 1 refers to

“those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

In this context, the reference to persons with “mental” impairments includes persons with psychosocial disabilities. However, for the reasons given above, national legislation implementing the CRPD should use the preferred terminology of “persons with psychosocial disabilities,” which is in keeping with the social model of disability reflected throughout the CRPD, and the recognition that disability is an evolving concept as provided in CRPD preambular paragraph (e).

Given the fact that persons with psychosocial disabilities are included under CRPD Article 1, a provision that is linked to the purpose of the Convention and thus not subject to reservations of any kind, all legislation applicable generally to persons with disabilities must include this group, including anti-discrimination legislation (including reasonable accommodation); eligibility for subsidies, programs and services; and recognition of organizations of persons with disabilities for consultation purposes as required by CRPD Article 4.3.

NOTE: This position paper originally appeared as section 2.q in the IDA CRPD Forum Contribution to the OHCHR thematic study to enhance awareness and understanding of the CRPD, focusing on legal measures key for the ratification and effective implementation of the Convention, August 15, 2008

Involuntary Psych not Hippocratic

Ethical Human Sciences and Services, Vol. 2, No. 1, 2000

Involuntary Psychiatric Interventions: A Breach of the Hippocratic Oath?

Peter Stastny, MD
Albert Einstein College of Medicine
Bronx, New York

In this article the author argues that involuntary psychiatric interventions are inherently dangerous and potentially harmful to their subjects, thus challenging the Hippocratic ethical principle of "first do no harm." Damages arising from coercion in common clinical situations are analyzed, as well as the motives of psychiatrists for persistently promoting an expansion of involuntary interventions. Alternate strategies to coercion are explored.

The controversy over involuntary psychiatric interventions is usually presented as a conflict between civil libertarian interests to safeguard personal autonomy and concerns about individual health and public safety. However, this view is problematic. The actual conflict may be between two contrasting definitions of health: medical/authoritarian and subjective/empathic. The paternalistic view in which health status is determined "objectively" by a doctor conflicts with an empathic assessment based on collaboration between doctor and patient. Given that doctors in clinical practice remain primarily responsible for the health of individual patients and not of society as a whole, we should examine whether involuntary and coercive interventions by physicians are compatible with medical ethics as codified in the Hippocratic Oath. For the purpose of this article "coercive" and "involuntary" are used interchangeably, even though differences may exist between coercion as perceived by individuals and as sanctioned by law (see Monahan et al., 1995).

The relationship of involuntary intervention and medical ethics is becoming increasing relevant as, for instance, the power to impose psychiatric interventions is broadening under outpatient commitment laws, and patients who feel victimized are growing more insistent about having their damage recognized by the medical profession. This article argues that subjective and objective experiences of harm from coercive interventions challenge basic ethical principles of medicine. If coercive interventions indeed carry a significant risk of harm, then we must ask what alternate, non-authoritarian stance doctors could reasonably take when confronted with people in extreme emotional distress.

Discussions about involuntary interventions have been primarily legal or utilitarian, the former based on constitutional arguments, the latter on evaluations of outcomes (Chodoff, 1988; Wertheimer, 1993). These two approaches are insufficient to develop moral guidelines for psychiatric practice. Also, most studies of coercion ignore the issue of its concurrent or long-term effects on the health and well-being of patients (Blanch & Parrish, 1993). Even the well-publicized, recent studies on coercion supported by the McArthur Foundation have yielded only scant data on its actual effects (Lidz, 1998). Consequently, this article discusses how coercion and involuntary interventions may directly and indirectly cause harm.

THE CURRENT RELEVANCE OF THE HIPPOCRATIC OATH

The original, "pagan" Oath of Hippocrates (about 450 B.C.) aimed to supplant a shamanic tradition in which "doctors could as easily murder as cure, or could supply a potion for a man to murder his enemy" (Clements, 1992, p. 367). Undoubtedly, the Hippocratic tradition combined its ethical stance with a guild orientation aimed to enhance physicians' status in Greek society. By the Middle Ages, the Hippocratic tradition had been incorporated into the Roman Catholic medical ethic, as exemplified by the "Oath According to Hippocrates as a Christian May Swear It" (Leake, 1975). Greek and Christian versions of the oath were based on the argument that "expertise in knowing the good was possible, and the empirical world of natural events could be investigated to identify the good objectively" (Clements, 1992, p. 213). This tradition prevailed until the explosion of scientific knowledge of the 20th century: in 1966 about one fourth of American medical schools still administered versions of the oath to their graduates (Levine, 1971). However, by the early 1970s, as Clements (1992) argues, the Hippocratic principle of beneficence (which relied on paternalism and a fundamental trust in doctors to correctly diagnose and treat illnesses) was challenged by the principle of personal autonomy.

In recent years, social, political, legal, economical, and scientific forces have further impinged on doctors' ability to rely on their own judgments when prescribing treatments. Given this new complexity, in which some authors speak of "systems" or "health" ethics rather than medical ethics, one might question the relevance of ancient Hippocratic ethics to the issue of involuntary interventions (Clements, 1992). However, regardless of the number of systemic variables impacting medical decision-making, doctors should still be bound by a set of moral guidelines that govern their behavior toward patients, with the aim of eliminating to the greatest possible extent from their practice interventions that are harmful to patients.

INVOLUNTARY INTERVENTIONS CHALLENGE THE HIPPOCRATIC OATH

Paternalistic and self-serving as they may have been, Hippocratic ethics place important restrictions upon the behaviors of doctors. The famous section of the oath which admonishes doctors to refrain from harm, known in Latin as "*Primum non nocere*," reads in one translation as follows: "I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them" (Jones, cited in Leake, 1975, p. 213). Edelstein (cited in Temkin & Temkin, 1967, p. 6) translated the original Greek differently: "I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice." Despite differences, both translations concur that doctors have a responsibility to protect patients from harm stemming from their own treatment.

Further in the oath the doctor is again asked to foreswear injurious behavior: "Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both male and female persons, be they free or slaves" (Edelstein, in Temkin & Temkin, 1967, p. 214). Jones (in Leake, 1975; p. 213) substitutes "keeping myself free from intentional wrong-doing and harm . . . " for "remaining free of all intentional injustice." This dual admonition – to refrain from doing harm *and* to assure that no harm would occur from other sources – should be a key standard in assessing the impact of involuntary interventions. Hippocrates' writings apparently do not contain an explicit reference to the use of force by doctors in dispensing treatments.

The Hippocratic principle of "First do no harm" has received scant attention in the literature on involuntary interventions. Wettstein (1987) refers to the ethical theory of "non-maleficence," but fails to consider in what ways coercion itself might be considered "maleficence." Most other authors who are apparently attempting to justify involuntarism, ignore the issue of non-maleficence, putting the entire weight of their arguments on the notion of delayed and secondary benefit (see Chodoff,

1988). Incidentally, the theory that coercion is justified since patients will ultimately be thankful for having been forced into treatment (Stone, 1975) is not supported by evidence, which shows that only a small minority of involuntary patients exhibit this change of mind (Beck & Golowka, 1988; Gardner et at., 1999). Curtis and Diamond (1997) provide an exceptionally balanced discussion of the ethical quandary of coercive interventions.

Contemporary versions of a physician's oath exist, such as the 1948 Declaration of Geneva, which barely resembles its Hippocratic ancestor and no longer includes a specific reference to refraining from harm. Instead, it states that "the health of my patient will be my first consideration," and "I will not permit considerations of religion, nationality, race, party politics and social standing to intervene between my duty and my patient." This is supplemented by the pledge that: "even under threat, I will not use my medical knowledge contrary to the laws of humanity" (Leake, 1975, p. 277).

Crimes against humanity perpetrated by doctors in Nazi Germany made it clear that mere lip service to the Hippocratic tradition would not prevent medical atrocities (see, among many others, Breggin, 1993; Drobniewski, 1993). Indeed, it may be argued that leaving the definition of "good" and "health" to doctors can lead to medically sanctioned torture and murder. However, Cameron (1992) suggests that the Geneva revision lacks the religious and philosophical obligations which are central to the Hippocratic Oath, and is therefore even more vulnerable to infractions. In any case, the Geneva declaration mentions two instances when involuntary interventions run counter to their intended benefit:

1. whenever social forces outside the doctor-patient relationship intervene, and
2. whenever a doctor's intervention breaks with the "laws of humanity."

Outside forces and prejudice are almost always involved in involuntary interventions (e.g., pressures from police, family, community, etc.). For example, African American men are more frequently committed to psychiatric institutions than any other group, regardless of diagnostic and mental status variables (Chen, Harrison, & Standen, 1989; Tomelleri, Lakshmenarazanam, & Herjanic, 1977). Community sources of coercion have been identified as contributing more to perceived coercion than the behavior of hospital staff, including psychiatrists (Cascardi & Poythress, 1997; Pescosolido, Gardner, & Lubell, 1998). This suggests that doctors might be obligated to counterbalance the pressures stemming from community sources, instead of automatically acting on them. Furthermore, involuntary and coercive interventions might be considered human rights violations (Szasz, 1978). Indeed, in December 1991 the United Nations adopted a set of "Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care" limiting but not precluding involuntary interventions (see Rosenthal & Rubinstein, 1993). Of course, psychiatric interventions against political opponents are routinely considered human rights violations—unlike force used against persons with nonmainstream beliefs in psychiatric custody.

Clinical Harm From Involuntary Interventions

In reviewing studies that assess the short- and long-term impact of coercion on its subjects, it becomes apparent that virtually none address the interaction between coercive interventions and the emotional state of the coerced person. This omission is particularly significant given the assumption that a state of emotional or interpersonal crisis would increase vulnerability to harm from coercion. Investigators seem primarily interested in determining how various parties define coercion and what its victims think about it 30 minutes to 1 year later (Monahan et aI., 1993). While the John D. and Catherine MacArthur Foundation has funded a series of investigations on coercion, to date, these have focused on process variables leading

to coercion, methodological issues in measuring the nature and impact of coercion, and posthoc studies of attitudinal and perceptual variables (e.g., Bennett et al., 1993; Gardner et al., 1993; Hiday, Swartz, Swanson, & Wagner, 1997; Hoge et aI., 1993; Monahan et aI., 1993, 1995).

Even studies that do examine the outcomes of coercive interventions fail to consider specific interactions between psychological variables and the impact of coercion, particularly for individuals who report negative effects (Hiday, 1992). Instead of further exploring these negative effects, some researchers have attempted to show that negative attitudes about coercion correlate with certain "negativistic" dimensions of illness or personality (Hoge et aI, 1990; Schwartz, Vingiano, & Bezirganian-Perez, 1988). The first American study focusing on the relationship between coercion and hospitalization outcome (Nicholson, Ekenstam, & Norwood, 1996) reports finding "no evidence that outcomes for 'coerced' patients were worse than outcomes for patients whose hospital admission was characterized by minimal or no coercion" (p. 214). The authors arrive at this conclusion even though 50% of all involuntarily admitted patients in their sample were excluded from the analysis (p. 208). A Scandinavian study using measures of coercion that were developed in the MacArthur studies (Kjellin, Anderson, Candefjord, Palmstierna, & Wallsten, 1997) found that 67% of "committed" patients experienced "some" or "only ethical costs." This was also true for 47% of voluntarily admitted patients, indicating that the negative effects of coercion are experienced even among patients admitted under ostensibly voluntary procedures.

A small minority of researchers have looked at the psychological effects of coercion, but without taking into consideration the patient's prior state of mind. Another recent Scandinavian study has actually demonstrated unfavorable psychological treatment outcomes of coercive interventions (Kaltiala-Heino, Laippala, & Salokangas, 1997). These authors conclude that "coercive treatment arouses negative feelings in the patient, creates negative expectations about the outcome of treatment, and fails to result in a trusting relationship between the patient and the professionals" (p. 318). Two theoretical concepts have emerged over the years explaining the various negative responses to coercion:

1. "reactance," which includes anger toward the source of restriction, an effort to restore freedom, and an increased attractiveness of foreclosed options (Brehm, 1981) and
2. helplessness, which often goes along with depression, anxiety, and the cessation of efforts to alleviate the situation, leading to the long-term pattern of "learned helplessness" (Seligman, 1975).

Few will dispute that most people who are subject to coercion are experiencing some type of crisis. Frequently, a coercive intervention arises from others' perception of an undesirable change in the person's behavior or attitude, which seemingly require psychiatric intervention. At other times, the individual is overwhelmed by internal or external events. A great variety of personal, interpersonal, and social problems result in the final common pathway of involuntary intervention. One way to begin disentangling this complex set of factors is to distinguish between those developments that precede first-time psychiatric interventions and those that affect people who have already been exposed to voluntary or involuntary psychiatric intervention. Almost half of all involuntary admissions affect people who have never been hospitalized before, indicating that many initial psychiatric contacts lead to coercive measures (Hiday, 1988).

Adolescent Crises

Many first contacts with psychiatry occur during late adolescence, when children are expected to make steps toward adulthood, move out of the parental home, engage

in romantic and sexual relationships, and prepare for their careers. It is also a time when many young people struggle with their identities and face major personal crises. This can take the form of extreme confusion, a search for meaning, introversion, depression, and family conflict. Some people experience "psychotic" symptoms, ranging from the fragmentation of physical and psychological boundaries to extreme internal preoccupation and hallucinatory experiences. Such occurrences are often very frightening to someone already undergoing a difficult transition (Arieti, 1974). To be confronted by coercive psychiatric measures in the midst of such experiences is likely to aggravate and pathologize the confusion, raising the specter of mental illness in the midst of adolescent turmoil. Without a great deal of empathy, respect and understanding, a young person in such a situation is likely to resist any form of intervention, wanting to pursue his or her search for meaning and identity, rather than being forced into a depersonalizing mold (Gutstein, Rudd, Graham, & Raytha, 1988). Armstrong (1993) has pointed out that when adolescents are forced into psychiatric institutions, their crises, which may have been transitional, are likely to be prolonged and aggravated by this type of coercion.

Someone experiencing extreme alterations of perceptions and thinking for the first time is usually in a state of considerable terror and is not likely to understand why he or she is being forcibly held in an emergency room or injected with mind-altering drugs (Sullivan, 1974). Anger and flight might be sensible responses but will usually escalate the coercion and aggravate the emotional distress. Another response might be capitulation to perceived punishment for one's emotional experiences. Either response is likely to have a deleterious influence on the further course of events, often resulting in "chronicization" –a persistent cycle of institutionalization and trauma.

Melancholy

People who are extremely sad, beyond, for instance, what is culturally accepted after the loss of a loved one, to the point of having trouble conducting their usual activities, often feel guilty and responsible for their "failures." This can take extreme proportions, as when a person feels like he/she is carrying the burden of the entire world or is responsible for all evil (Wolfersdorf et aI., 1990). To coerce someone in this state of mind is likely to reinforce the expectation of punishment, potentially triggering a suicide attempt (De Jong & Roy, 1990). Marcia Hamilcar's 1910 personal account of being forcefully removed from her home (in Peterson, 1982) and institutionalized for depression is one of many examples. In these personal accounts the mental institution and its "treatment" methods are often seen as legitimate punishment for the wrongs a person in such a guilt-ridden state believes himself or herself to have committed.

Repetition of Trauma

A growing body of first-person accounts (e.g., Deegan, 1994; McKinnon, 1994; Sonn, 1977) and scholarly reviews including research studies (Craine, Henson, Colliver & McLean, 1988; Muenzenmaier, Meyer, Struening, & Ferber, 1993; Rose, Peabody, & Stratigeas, 1991; van der Kolk, 1987) are drawing our attention to the problem of women (and to some extent also of men) with a history of childhood or adult traumatization who are experiencing abuses in the mental health system. The notion that people who struggle with memories of physical and sexual abuse should be adversely affected by physically coercive psychiatric interventions seems self-evident (Stefan, 1994). In the literature on posttraumatic stress disorder there is much evidence that any situation bearing resemblance to the circumstances of the original/earlier traumata can trigger extreme fear (McFall, Nurburg, Ko, & Veith, 1990), and in women who experience multiple personality or other dissociative disorders, it can lead to fragmentation and self-destructive acts (Doob, 1992). Why this should not hold true for instances of forcible drugging, four-point restraint, the

process of seclusion which usually involves being taken down and stripped by male and female attendants, remains to be demonstrated by those who want to draw a line between "social and familial" traumatization and injuries inflicted in the name of "treatment" (Norris & Kennedy, 1992; Stefan, 1994).

Interestingly, coercion and institutionalization are not considered traumatic per se in the trauma literature, unless they are perpetrated for political reasons on persons not considered mentally ill (Chodoff, 1988; Koryagin, 1989; Stover & Nightingale, 1985). In fact, the possibility of traumatization by psychiatric interventions such as forced detention or drugging is not even mentioned in the most comprehensive, 800-page handbook on traumatic stress syndromes (Wilson & Raphael, 1993). Williams-Keeler, Milliken and Jones (1994) consider the experience of psychosis as one possible etiology for posttraumatic stress disorder. Forced psychiatric intervention, especially in someone with a history of significant earlier traumatization, can aggravate, unmask or even cause a form of iatrogenic post-traumatic stress disorder.

Fear of Persecution

Paranoia is the psychiatric term for the extreme fear of others, especially those in authority. This state of heightened alertness and sensitivity to danger, to the point of becoming convinced that sinister forces are scheming to inflict harm, can lead to withdrawal, sleeplessness, reluctance to eat and other potentially hazardous behaviors. Most individuals experiencing such fears are likely to stay away from psychiatric settings, shunning their intervention. This is precisely why they suffer incomparably when forcibly submitted to psychiatric intervention. Many, who are already terrified, are further panicked by physical restraint and forced drugging. Their worst nightmares come true when they are apprehended, restrained, and dragged into an emergency room where unfamiliar doctors ask them invasive questions, decide to keep them against their will, and place them in a ward full of other individuals in distress, many of whom could be perceived as threatening. Such perceptions often lead to altercations and further physical and chemical restraints. Numerous personal accounts of this type of experience corroborate its fundamentally traumatic nature (e.g., Cameron, 1979; Schreber, 1903; Trosse, 1741).

Panic and Mania

Another group of individuals who experience psychiatric coercion are those who suffer from extreme anxiety and panic states. They are likely to feel considerably worse when they realize that they are trapped. Finding themselves prevented from leaving until a psychiatrist has completed their evaluation, they easily become "agitated," thereby further aggravating their situation. Unfortunately, this outright consequence of coercion may be used retrospectively to justify the coercion which precipitated the behavior in the first place.

In the state of mind psychiatrically known as mania, the person is driven toward ever more daring acts in a kind of self-generated euphoria. Whenever such persons encounter obstacles, they tend to become irritable, even angry and possibly assaultive. Clearly, individuals in such states are highly challenging to their surroundings and to anyone trying to help. Not surprisingly, individuals diagnosed with bipolar disorder (mania and depression) tend to experience coercion more acutely than others (Pescosolido et aI., 1998). Intervention usually comes late and with extreme severity. These are the well known situations when a person is wrestled to the ground by a number of strong arms, tied down, and injected with large doses of tranquilizers. Many people have died during such psychiatrically sanctioned assaults (Appelbaum, 1999; Black, Winokur & Bell, 1988; O'Halloran & Lewman, 1993).

Suicide

Persons planning or attempting to commit suicide are often victims of coercive interventions. The coercion in this instance usually occurs either because a concerned friend or relative has notified the authorities, or because the individual has decided to seek help. In both instances suicidal persons are detained until they have successfully convinced the psychiatrist that they are not about to kill themselves. This is considered by many professionals as the only way to take suicidal threats and sentiments seriously and to prevent charges of negligence should someone actually commit suicide after an intervention by a mental health professional (Appelbaum, 1988). But in most cases someone discloses a suicidal preoccupation to a friend or a professional precisely because he or she is afraid of acting on this impulse, wants to talk about it, and seeks a better solution. If such a person encounters mistrust resulting in commitment, he or she is likely to conclude that the next time a suicidal feeling recurs it may be better to stay away from "helping" professionals. This decision can increase the chance of a completed suicide.

Having been told by a professional that the only way to avert suicide is by being locked up, rather than by seeking alternate life-affirming strategies, these persons are also likely to further loose confidence in themselves. Thus, instead of bolstering their inner strength and self-confidence, psychiatry gives the message that they lack control and must be under surveillance. Some evidence on detrimental aspects of involuntary hospitalization for suicidal individuals supports these intuitive conclusions (Litman, 1991). According to various authors, involuntary commitment might actually increase the risk for suicide in the period immediately after admission (Roy, 1985; Sundquist-Stensman, 1987; Tsuang, 1978).

Family Conflict

Many involuntary interventions occur when family members are in conflict. When coercion and commitment occur as a way of responding to family tensions and distress, including concerns about the well-being of the identified patient, family relations may suffer further. In the case of elderly family members placed in an institution against their will, severe depression and even suicide may result (Boucher & Tenette, 1989). The detrimental effect of commitment on family relations has been demonstrated by studies that provide evidence for the common occurrence of "closure," a regrouping of the family without the banished member, which renders the person homeless and without support, suddenly dependent on psychiatric institutions (Scott, 1967). When a family member petitions for commitment or signs consent for unwanted medications or procedures such as ECT, the coerced individual may react with great anger and long-term resentment. This can lead to irreversible family disruption, much pain and disappointment on both sides, and a downward social drift and loss of support for the new "ward of the state." This might also be a factor in precipitating violent acts toward family members that occur after forced treatment.

Forced Administration of Psychotropic Drugs

There is some evidence that the coercive intramuscular administration of psychotropic drugs is associated with a greater incidence of physical adverse effects, thus potentially endangering the life and health of the patient. Kjellin and associates (1993) report substantial differences in rates of adverse effects between committed and voluntary patients, as judged by psychiatrists (82% vs. 63%). Severe adverse effects were reported by 48% of the committed versus 30% of voluntary patients. "Rapid tranquilization"—the abrupt injection of large, toxic dosages of a potent neuroleptic drug, usually haloperidol—has caused serious concomitant side effects, including death from neuroleptic malignant syndrome (Lazarus, Dubin, & Jaffee, 1989). One possible mechanism for this drug-related toxicity is the massive rise of

creatinine phospho-kinase (CPK), an enzyme produced by the destruction of muscle tissue, which can lead to kidney failure and other deadly complications (Keshavan & Kennedy, 1992). There is no doubt that the physical restraint of an actively resisting individual, followed by deep intramuscular injections, has caused injuries and deaths (Robinson, Sucholeiki, & Schocken, 1993).

Most coercive interventions aim to achieve the administration of psychotropic drugs in the short term and to enhance "compliance" in the long term (Geller, 1995; Miller, 1999). However, it is likely that forced medication often has the opposite result, discouraging patients from accepting treatment while hospitalized, and leading to avoidance or cessation of treatment in the community (Curtis & Diamond, 1997; McPhillips & Sensky, 1998).

Long-Term Effects of Coercion

Initial responses to coercion, such as a fight-flight reaction, are repeatedly broken down by involuntary interventions and ensuing conventional treatment programs. When the same person is subjected to further coercion, even without exhibiting active resistance, the repetitive acts of domination may induce a learned helplessness, submission to coercion becomes accepted as an unavoidable part of life. This process will render it increasingly less likely for the person to emerge from the status of a chronic mental patient and to assume a meaningful role in society (Lauterbach & Stecher, 1988). Thus coercive interventions can be seen on a continuum from "early spirit breaking" to "lifelong patienthood."

Bill Nordahl, an advocate from New Jersey, describes this pattern succinctly:
> When I was involuntarily committed to a forensic psychiatric institution it was clear to me that the mental health system was saying to me in effect: 'You're crazy and you're dangerous.' When they offered no therapy that was helpful, they were saying in effect: 'Your situation is hopeless.' No matter how we fight against it, we all tend to believe what is said about us. To the extent that I internalized this message ... this was what I tended to create in my life. It is clear that this did not benefit me or society. (Blanch & Parrish, 1993, p. 14).

PSYCHIATRIC MOTIVES FOR COERCIVE INTERVENTIONS

Why do so many conscientious psychiatrists continue to practice coercive interventions rather than actively opposing them and searching for alternatives? Several possible factors, simultaneously present in various degrees, may account for this unique psychiatric persistence.

Promulgating the Medical Model

Consciously or unconsciously, psychiatrists may use coercion as a way to promulgate—indeed, to enforce—their view of the medical nature of the presenting problem (Chodoff, 1988). Without the power to enforce their interventions, psychiatrists might be less successful in convincing their patients and the public of the medical/biological nature of emotional distress. It is to be expected that the greater the level of uncertainty and complexity in psychiatry, the greater the degree of paternalism which underlies coercive interventions.

Psychiatry embodies medical uncertainty *par excellence*. It is the only medical specialty that has continuously suffered from the lack of a "substrate" or a clear biological basis for the conditions it has set itself up to treat. Ironically, whenever a bona fide substrate has been identified, as in the case of syphilitic encephalitis, psychiatry has had to forfeit the entire disease and its treatment to other medical specialties. Consequently, psychiatric practice currently rests—at the scientific level—

on uncertainty bolstered by the hope for irrefutable and yet "non-neurologic" substrates. Under these conditions of fundamental uncertainty and paradox, psychiatrists practice their particular brand of medicine, based on the ability to forcibly diagnose and treat (see Valenstein's 1986 discussion of psychiatry's perennial attempt to compensate for this dilemma with fantastic, often tormenting interventions).

Patients' Denial of Illness

Underlying many, if not most, coercive interventions is the premise that the person cannot or will not accept the idea of being ill as an explanation for his or her situation. "Denial," "lack of insight" and other such deficits are widely seen as features of the person's illness (especially psychosis). They are used to justify forceful interventions including the recent expansion of outpatient commitment laws (Cuesta & Peralta, 1994; Geller, 1999). Of course, whether actual deficits or alternate coping mechanisms are at work in the so-called denial, and whether coercion is likely to improve or worsen these ostensibly morbid processes, remains speculative.

In all of medicine there is not one example where force is justifiably used to help a patient accept a medical diagnosis and where such force is considered by doctors to be an essential element of treatment. One apparent exception is the threat of contagion from persons with infectious diseases who refuse treatment—but here the goal is not to develop insight: it is to protect the public from extremely communicable diseases, such as tuberculosis. So far this has only been applied to airborne pathogens (for a perspective on contagion which analogizes it to mental illness, see Wertheimer, 1993). In psychiatry we have no qualms about handcuffing someone to a chair without charging him or her with a crime and then, amid protests, injecting the person with an unfamiliar substance in order to combat the symptoms of a morbid condition the person probably does not appreciate, accept or interpret in pathological terms. Could this really be the only way to drive home that this person may be suffering from a "mental illness," or is this type of approach more likely to harden the resolve to keep things private, to distrust doctors, to fear for one's life, and to withdraw from society?

The Power to Control

It is of course true that some persons who come to the attention of psychiatrists have in one way or another challenged the authority of the state or the rules of civility. In our society, having made the distinction between those infractions that are punishable by law, and those that are attributable to psychiatric conditions, psychiatrists are charged with asserting the power of the state by enforcing treatment conditions. This power to control individuals who are perceived as out of control is a very formidable tool, which psychiatrists employ whenever they find justification in the person's behavior or in reports by others. We do not know whether the practice of psychiatry promotes authoritarianism or whether physicians inclined toward paternalism are more likely to choose the specialty of psychiatry. This is not a frivolous question. Whether the element of coercion in psychiatric practice is seen as part of the public health/*parens patriae* function, or rather as a gratuitous, if not sadistic trait, is an important question that needs to be seriously addressed, given the numerous perspectives of users who have poignantly expressed their extreme fear and rejection of involuntary treatment.

Fear of Legal Liability

A major constraint on psychiatrists to hold someone involuntarily is the fear of liability (discussed extensively by Appelbaum, 1988). Several successful lawsuits have charged psychiatrists with malpractice and negligence due to the release of a

patient who may have later committed suicide or harmed someone. More recently, however, a number of cases have been settled or adjudicated in favor of plaintiffs who felt they were being detained inappropriately and harmed by this intervention (Appelbaum, 1995). This may tip the balance of liability back toward less coercive interventions. On the other hand, it may simply lead psychiatrists to be more careful when justifying coercion (Miller, 1992).

A "Burning House"

The argument that certain conditions, in particular psychotic states, are inherently harmful to the person and the surroundings, has been put forth as a major and frequent justification for early, and if necessary, involuntary interventions (Wyatt, 1991). This recommendation rests on the assumption that if left "untreated," that is, not treated with neuroleptics, these conditions will invariably lead to deterioration and dangerous behavior, much as a burning house is likely to destroy itself and its neighborhood. This argument assumes that non-coercive methods are not likely to have beneficial effects in these situations. The work of Loren Mosher and others (Mathews, Roper, Mosher, & Menn, 1979) contradicts this point, as do studies looking at persons with schizophrenia who have survived with adequate support in the community without forced interventions (for example Gillis & Keet, 1965; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987).

Lack of Alternative Resources

A lack of adequate non-coercive resources, such as crisis services and assertive case managers, has been cited as a major rationale for the use of coercive interventions. This argument is ethically unacceptable. If psychiatrists are truly compromised in their ability to administer the appropriate non-coercive clinical treatments, they should refuse to work in such settings. Doctors working in medical emergency rooms that lack essential resources have had the courage to walk out of such untenable conditions. The Italian experience, where psychiatrists led the way toward abolishing dehumanizing long-term institutions including many coercive practices, is an example of doctors standing in the way of prevailing doctrine (Mosher & Burti, 1989). John Connolly's program of institutional treatment without mechanical restraints in the 1840s, when virtually no chemical methods were available, stands as a pioneering effort against psychiatric coercion (Connolly, 1973). More recently, Michael Ford and other psychiatric administrators in New York State have begun to regard the use of restraints and seclusion as an indicator of failed treatment (New York State Commission on Quality of Care, 1994). By doing so they succeeded in reducing these practices in their institutions dramatically in comparison to other facilities where the use of coercive interventions remained considerably higher for similar patient populations.

Peer Pressure

The prevailing doctrine of psychiatry fully authorizes and encourages the use of coercion whenever "clinically indicated." In fact, there is no mention of the Hippocratic principle—"first do no harm"—in the ethical guidelines promulgated by the American Psychiatric Association. Even a chapter dedicated to the topic of involuntary commitment in the authoritative volume on psychiatric ethics makes no mention of the possibility that coercion may be harmful and therefore unethical (Bloch, Chodoff, & Green, 1999). It is part of psychiatric lore, if not science, that one of three reasons to commit almost always exists—a potential for danger to self or others, a denial of illness, and a lack of capacity to consent voluntarily. Given these unswerving assumptions among their peers, it is not surprising that only a small minority of psychiatrists have taken an active stand against involuntarism and have searched for non-coercive alternatives.

Toward a Noncoercive, Hippocratic Psychiatry

Legal or programmatic alternatives outside of psychiatry that may ameliorate the situation described in this paper, and even result in virtually coercion-free systems of care, have been considered elsewhere (Blanch & Parrish 1994; Mazade, Blanch, & Petrila, 1994; Stroul, 1991; Sydeman, Cascardi, Poythress, & Ritterband, 1997). The primary concern in this article is what psychiatrists can do to reduce or eliminate the use of coercion.

The first and widest-reaching measure would be for psychiatrists to withdraw from front-line interventions where the temptation to use coercion is the greatest. In other words, psychiatrists could refuse to work in clinical settings where they are asked to utilize coercion, unless they are prepared and authorized to do everything within their power to prevent this. Psychiatric emergency rooms and triage units are basically unsuited for the practice of non-coercive psychiatry and should be eliminated from the panoply of mental health services. It may be ethically and clinically sounder to separate restrictive functions from therapeutic activities more clearly. In this case, actions which are punishable by law could be dealt with through the court system along with proper protection of due process, while voluntary treatment could be provided all along.

Psychiatrists could refuse to prescribe psychotropic medications to persons who are physically restrained. The combined experience of restraints and neuroleptization often results in severe muscular dysfunction and is among the more traumatizing medically sanctioned interventions. In addition, psychotropic drugs are often ineffective in restraining a highly agitated individual (Anderson & Reeves, 1991). Refraining from these practices would require that psychiatrists become familiar with nonviolent techniques to assist persons in extreme emotional distress, which could include non-coercive holding, talking down, creating a physical outlet, and the conflict resolution strategies. Soteria House is a good example of how such techniques can become an effective component of treatment for acutely psychotic individuals (Mosher & Vallone, 1992).

Lastly and most important, psychiatrists should be at the forefront in the search for non-coercive interventions. In fact, there is a small, but significant tradition of advocacy for non-coercive alternatives among psychiatrists, starting with the 18th century British hospital superintendent John Conolly who proved that his institution could run entirely without physical restraints (Connelly, 1973). Leonard Stein (1976) and Loren Mosher (1994) are two psychiatrists who made it their mission to provide non-coercive, non-institutional alternatives in crisis situations. Some lesser known pioneers are Edward Podvoll (1990) who initiated the Windhorse Project in Naropa, and Paul Polak, who proposed the use of foster-family crisis intervention as an alternative to hospitalization (Polak & Kirby, 1976). Thomas Szasz (1978) has devoted a great deal of his writings to arguments against coercive interventions by psychiatrists, as did Peter Breggin who proposes conflict resolution and empathic treatment as alternatives to coercion (Breggin, 1992, 1997).

Some of the most important lessons for psychiatry today come from different quarters—the movement of ex-patients and survivors of coercive interventions, who have made it their aim to prevent coercion for themselves and for their peers and who are in the process of developing non-hospital, non-coercive alternatives which merit our fullest support. Crisis-residential settings are being developed by survivors in California, New York, Connecticut, The Netherlands, and Germany, among others (Dumont, 1993; Wehde, 1991). Comprehensive community support alternatives are being designed and developed by survivors of coercive interventions (Chamberlin & Rogers, 1990). Various forms of advanced directives are being promoted and field-tested by survivors at risk for involuntary interventions (Lehmann, 1993; Rogers & Centifanti, 1991).

Considering this rich trove of alternatives to coercion, it is not acceptable for psychiatrists to claim that they can do nothing to change the system. Existing models have demonstrated significant success in this area (Breggin, 1991; Breggin & Stern, 1996; Neugeboren, 1999). New models need to be developed in collaboration with survivors of coercive interventions. Psychiatrists could be at the forefront of these alternatives instead of trailing behind as the principal advocates for increased coercion and outpatient commitment.

We now return to the Hippocratic Oath to present one interpretation of its controversial passage, "First do no harm." It would seem that as medical doctors, psychiatrists should be obliged to safeguard patients from damaging interventions that might be initiated by practitioners who do not subscribe to this oath. Whereas in the days of Hippocrates these might have been called shamans, today they are the public officials and mental health professionals who believe that forcing people into treatment "helps" them. Therefore, any physician wanting to observe the Hippocratic Oath must stand in the way of these practices and do the utmost to search for non-coercive solutions. Perhaps these "conscientious objectors" would then be considered, as Ron Thompson (1994) has suggested, "Hippocratic Oath Practitioners" in contrast to those who practice social control under the guise of psychiatric treatment.

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Offprints. Requests for offprints should be directed to Peter Stastny, MD, 75 Morton St., New York, NY 10014.

Should Forced Medication be a Treatment Option in Patients with Schizophrenia?

PRO

E. Fuller Torrey, MD

- President, Treatment Advocacy Center, Arlington, Virginia
- Professor of Psychiatry, Uniformed Services, University of Health Sciences, Bethesda, Maryland
- Executive Director, Stanley Foundation Research Programs, Bethesda, Maryland

There are scientific, humane, public protection, and practical reasons why the involuntary treatment of individuals with severe mental illness (SMI) is sometimes necessary. Scientifically, it has been shown in many recent studies that 40% to 50% of individuals with schizophrenia and bipolar disorder have an impaired awareness of their illness (also called impaired insight).[1] Their illness has impaired the function of the prefrontal cortex, which is the part of the brain that is used for self-reflection and to appreciate one's own needs. Thus, many people with SMI are similar to individuals who have suffered strokes that have impaired their self-awareness (e.g., denial that one leg is paralyzed) or individuals in the early stages of Alzheimer's disease.

On humane grounds, the failure to treat such individuals often leads to homelessness or incarceration on misdemeanor charges. The streets, public shelters, and jails are overflowing with such individuals. On humane grounds alone, is it fair to leave those who are not aware of their own illness living in the streets and eating out of garbage cans, as over 25% of the population with severe mental illness do?[2]

The issue of public protection arises because a small number of individuals with SMI who are not being treated

CON

Judi Chamberlin

- Senior Associate, National Empowerment Center, Lawrence, Massachusetts

The question posed in this debate is not purely a medical one; therefore, it is appropriate that one of the discussants is not a doctor, but a legal rights advocate. The issue here is not the use of psychiatric medications per se, but whether doctors should be permitted to force medications on unwilling recipients. Although the question refers to "patients," it is clear that the people under discussion have chose not to be patients. The question might better be framed as, "Should psychiatrists be able to define people as 'patients' against their will?" making it clearer that the issues under discussion are more about legal rights and ethics than about medicine.

There are no medical tests that clearly separate those with the diagnosis from those without it. Sarbin, in an analysis of 30 years of psychological research, concluded that it "has produced no marker that would establish the validity of the schizophrenia disorder."[1] "Schizophrenia" remains a clinical impression, and one that is heavily influenced by such non-medical factors as race and social class.[2] Again, these facts point to the necessity for enlarging this debate beyond purely medical considerations.

The question also contains certain assumptions that must be carefully scrutinized, specifically (1) that medication improves outcome, and (2) that force is an efficacious way of medicating objecting individuals.

With regard to outcome, there is little objective evidence that it is improved by

become dangerous, usually because of their delusions. There have been at least 25 studies in the past 15 years that have reported that untreated individuals with SMI are significantly more dangerous than the general population. A 1994 Department of Justice study reported that 4.3% of all homicides (approximately 1,000 per year) are committed by individuals with a history of mental illness;[3] most of these homicides would not happen if these individuals were being treated. In terms of public safety, an individual with schizophrenic or bipolar disorder who is not being treated is similar to a person with untreated epilepsy who is driving a car, or a person with untreated active tuberculosis who is sitting next to you in a movie theater; in both cases, we require that these individuals receive treatment.

Finally, involuntary treatment should be used when necessary because-on practical grounds-it works. In New Hampshire, for example, the use of conditional release was found to improve medication compliance by a factor of three and to reduce episodes of violence to one-third their previous level.[4] Outpatient commitment has similarly been shown to markedly reduce the readmission rates in studies in Ohio, Iowa, North Carolina, Arizona, and the District of Columbia.

Objections to involuntary treatment are ill-founded. It is claimed, for example, that if the mental health services are attractive enough, the patients will seek them out. Individuals with no awareness of their illness will never seek out services, because they do not believe they are sick.

Others claim that involuntary treatment drives patients away. in fact, studies have shown quite the opposite. In one study of patients who had been involuntarily medicated, 71% later agreed with the following statement: "If I become ill again and require medication, I believe it should be given to me even if I don't want it at the time."[5] In another study, 60% of

neuroleptic drugs. In fact, there has been little change in outcomes of people diagnosed with serious mental illness over the past 100 years, despite claims that neuroleptic drugs are specific treatments.[3] Further, there is growing evidence that neuroleptics themselves are responsible for brain changes that are often pointed to as evidence of schizophrenic deterioration.[4,5]

With regard to efficacy, the largest single study of out-patient commitment, the New York City Involuntary Out-Patient Commitment Program, found that there was no difference between groups that received enhanced out-patient services without compulsion, and the group that received such services under court order.[6] Both groups were equal in terms of rehospitalization, drop-out rates, and outcome measures. What this study indicates is that the key variable is enhanced services, not compulsion. Services like one-to-one counseling, support groups, and help in finding housing and jobs have been shown repeatedly[7] to benefit people diagnosed with serious mental illness. the irony is that every dollar spent on surveillance and control is a dollar that is not available to fund services that research shows really make a difference.

Campbell and Shraiber[8] found that slightly more than half of a group of Californians diagnosed with serious mental illness avoided voluntary treatment at times when they believed it might benefit them because of a fear of being subjected to involuntary treatment. Kasper, Hoge, Feucht-Haviar, Cortina, and Cohen[9] studied treatment refusers in Virginia and concluded that "these patients suffered more morbidity than compliant patients. This study suggests that the negative sequelae of of an in-hospital treatment refusal cannot be eliminated by rapid treatment." Further, "refusers were prescribed higher doses of anti-psychotic medications than were compliant patients," and were found to have "negative attitudes toward past, present, and future treatment at the time of admission," Coercive treatment thus creates a negative cycle, calling for the

patients who had been forcibly medicated agreed retrospectively that it was a good idea.[6]

Others oppose involuntary treatment because of its potential for abuse, evoking memories of Nazi Germany or Stalinist Russia. Of course, treatment can be abused; however, it need not be if a proper system of checks and balances are [sic] put in place. Given that the United States has over 900,000 lawyers, there is no reason that these precautions cannot be taken.

Finally, civil libertarians decry involuntary treatment as an infringement of the person's fundamental rights. One must ask, however, whether a person with schizophrenia or bipolar disorder who is living on the streets is truly free in any meaningful sense.

The final word on this belongs to Herschel Hardin, who for 9 years was a director of the British Columbia Civil Liberties Association:

"The opposition to involuntary committal and treatment betrays a profound understanding of the principle of civil liberties. Medication can free victims from their illness-free them from the Bastille of their psychoses-and restore their dignity, their free will, and the meaningful exercise of their liberties."[7]

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use of ever more coercion.

The usual justification for forced treatment is violence on the part of people with serious mental illness. However, not only is violence rare, but according to the American Psychiatric Association, "Psychiatrists have no special knowledge or ability with which to predict dangerous behavior." Studies have shown that "even with patients in which there is a history of violent acts, predictions of future violence will be wrong for two out of every three patients."[10] Further, although the usual justification for forced treatment is lack of insight and the unwillingness of subjects to seek treatment voluntarily, it is instructive to note that several of the individuals involved in recent highly publicized incidents of violence committed by former patients had been engaged in fruitless efforts to get treatment in the weeks preceding their criminal acts, visiting emergency rooms and clinics, and being repeatedly turned away. Rather than lacking insight, these individuals sensed their own emotional deterioration, which was apparently invisible to those clinicians that came into contact with.

Under all of these circumstances, it is clear that calls for expanded involuntary treatment benefit neither those who might be subjected to it, those who are traumatized and driven away from voluntary help, nor the public at large, whose safety is not improved, and whose tax dollars will go toward making the mental health system even less able to offer the kinds of voluntary programs that enhance community integration.

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Rebuttal to the Article by Ms. Chamberlin

By E. Fuller Torrey, MD

Ms. Chamberlin's contribution suggests that she may be woefully out of touch with scientific literature in this field.

1) "Schizophrenia" is more than a "clinical impression." It is a clearly established, biologically based brain dysfunction. There are literally hundreds of studies that have shown that individuals with schizophrenia differ from normal controls in both brain structure (e.g., ventricular enlargement, loss of hippocampal volume, decreased gray matter) and brain function (e.g., neurochemically, neurologically, neurophysically). Schizophrenia is no more a "clinical impression" than is Parkinson's disease.

2) She is also incorrect in stating that antipsychotic drugs may cause the brain changes cited. There are studies showing, for example, that ventricular enlargement,[1] loss of hippocampal volume[2] and decreased gray matter occur in individuals with schizophrenia who have never been treated.

3) She cites one non-peer-reviewed study alleging that "more than half" of patients "avoided voluntary treatment...because of a fear of being subjected to involuntary treatment." Almost every peer-reviewed article on this question has reported that the majority of involuntarily treated patients retrospectively acknowledge its necessity.

4) While ignoring multiple studies that have proven the efficacy of outpatient commitment, she cites the New York City Bellevue Hospital study as having found "no difference between the group that received enhanced outpatient services without compulsion, and the

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Rebuttal to the Article by Dr. Torrey

By Judi Chamberlin

The arguments raised by Dr. Torrey are primarily ethical and moral ones, in which he proposes that involuntary outpatient commitment (IOC) is humane to the individual and beneficial to society. In contrast, I believe that IOC would make society less humane and more unjust.

First, as I argued earlier, there is no reliable way to diagnose severe mental illness (SMI); therefore, people would lose their right to choose or refuse treatment based on vague diagnostic criteria. This would create a loosely defined group of citizens who have fewer rights than others. We know from both history and current public policy that little money or attention is given to people diagnosed as mentally ill. The deinstitutionalization decried by Dr. Torrey was fueled, in part, by repeated revelations of horrific conditions inside state mental institutions; there is no reason to believe that wide-scale IOC would be any less horrific.

Dr. Torrey also makes the logical mistake of generalizing from the minority of individuals with SMI who are lawbreakers, and extending his

group that received the services under court order." In fact, the group under court order was hospitalized for a median of 43 days in the following 11 months compared with 101 days for the group not under court order. This difference just missed being statistically significant at the P=0.05 level of significance but certainly supports the other studies that have proven the efficacy of outpatient commitment.

5) She alleges that episodes of violence by seriously mentally ill individuals are "rare." If the person is being treated, that is true. For those individuals who are not being treated, multiple studies have shown that this is not true. For example, the families of mentally ill individuals who reported that 11% of their seriously ill relatives had harmed another person in the preceding year do not consider this "rare."[4] And the relatives of 133 outpatients of which "13% of the study group were characteristically violent" do not consider this "rare."[5] I would suggest that Ms. Chamberlin spend some time in a public shelter filled with untreated seriously mentally ill individuals to establish for herself just how "rare" violent episodes are.

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draconian prescriptions to the much larger number of law-abiding, productive citizens who, despite their diagnoses, function well in society with the treatments and/or supports of their choice. By his logic, all members of racial minority groups, for example, should be subjected to restrictions on their freedom because some members of the group are lawbreakers. Such a policy would result in less freedom for all.

Another logical flaw in Dr. Torrey's argument is the claim that most murders committed by individuals with SMI would not happen if these individuals were receiving treatment, which is an unprovable assertion. Further, even the elimination of the 1,000 murders a year cited by Dr. Torrey would make barely a blip in crime statistics. The reasons why the United States has one of the highest murder rates in the world has far more to do with the easy availability of guns and other social factors than with mental illness.

I, too, will close with a quote and invite readers to reflect on society and morality:

"Of all tyrannies a tyranny sincerely exercised for the good of its victims may be the most oppressive. It may be better to live under robber barons than under omnipotent, moral busybodies. The robber baron's cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience.... To be "cured" against one's will and cured of states which we may not regard as disease is to be put on a level with those who have not yet reached the age of reason."[1]

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Uncivil Commitment: Mental Illness May Deprive You of Civil Rights
By Thea Amidov

Americans take considerable pride in our Constitutionally guaranteed civil liberties, yet our government and institutions often abridge or ignore those rights when it comes to certain classes of people.

According to a National Council on Disability report, people with psychiatric illnesses are routinely deprived of their civil rights in a way that no other people with disabilities are (2). This is particularly so in the case of people who are involuntarily committed to psychiatric wards.

Under present standards of most states, a person who is judged by a psychiatrist to be in imminent danger to self or others may be involuntarily committed to a locked psychiatric ward and detained there for a period of time (3). Some would argue that involuntary civil commitment is a necessary approach justified by safety and treatment concerns. Others would counter that it is an inhumane and unjustifiable curtailment of civil liberties.

Let's look at the example of recent suicide survivors in order to examine this debate in more depth.

On one side of this argument are the vast majority of mental health specialists and an uncertain percentage of former patients. They argue that forced confinement is, at times, justified by safety concerns and to ensure that proper treatment is administered. Psychiatrist E. Fuller Torrey, eminent advocate of greater use of coercive psychiatry, criticizes the reforms gained by civil rights advocates (4). He says that these reforms have made involuntary civil commitment and treatment too difficult and thus have increased the numbers of mentally ill people who are homeless, warehoused in jails, and doomed by self-destructive behavior to a tortured life.

D. J. Jaffe claims that the high-functioning "consumertocracy" anti-psychiatry people do not speak for the severely ill and homeless (5). If you are suffering from serious mental illness, "freedom," Torrey and Jaffe say, is a meaningless term. Many a family member has bemoaned the difficulty in getting a loved one committed and kept safe. Torrey pleads with passion that involuntary commitment should be facilitated and the time of commitment lengthened.

No one can contest the problems that Torrey describes, but a nation dedicated to civil liberties should question the solutions he advocates. Prominent critics of coercive psychiatry include early activist psychiatrist Loren Mosher and psychologist Leighten Whittaker, the consumer organization Mindfreedom.org, consumers (or service users) such as Judi Chamberlain, and civil rights attorneys.

In presenting counter-arguments against the use of involuntary commitment with suicide survivors, I consider here the interlinked issues of safety and science-based medicine, as well as civil liberties and justice. Here are my concerns:

- **There is no reliable methodology behind the decision of whom to commit.**

  Despite studies and innovative tests, doctors still cannot accurately predict who will make a suicide attempt even in the near future. As Dr. Igor Galynker, associate director of Beth Israel Department of Psychiatry said in 2011, it is amazing "how trivial the triggers may be and how helpless we are in predicting suicide." (6) In fact, an average of one out of every two private

psychiatrists loses a patient to suicide, blindsided by the action. (1)So how do hospital psychiatrists choose which people recovering from a suicide attempt they should commit? There are patient interviews and tests, but commitment is primarily based on the statistics that a serious recent suicide attempt, particularly a violent one, predicts a 20-40 percent risk of another attempt. (7) However, this statistics-based approach is akin to profiling. It means that those 60-80 percent who will not make another attempt will lose their liberty nonetheless. So should we accept locking up individuals when evaluation and prediction of "danger to self" is so uncertain?

- **Confinement does not offer effective treatment.**

  Erring on the side of caution and confining all people who have made a serious suicide attempt is particularly unjust and harmful because the vast majority of psychiatric wards do not offer effective stabilization and treatment. A report by the Suicide Prevention Resource Center (2011) found that there is no evidence whatsoever that psychiatric hospitalization prevents future suicides. (8) In fact, it is widely recognized that the highest risk of a repeat attempt is soon after release from a hospital. This is not surprising, given the limited therapeutic interventions usually available on wards beyond the blanket administration of anti-anxiety and psychotropic medications. What the hospital can do is reduce the risk of suicide for the period of strict confinement. Despite this data, in *Kansas v. Henricks*the U.S. Supreme Court found that involuntary commitment is legal even if there is an absence of treatment.

- **Involuntary psychiatric hospitalization is often a damaging experience.**

  Psychiatrist Dr. Richard Warner writes: "…we take our most frightened, most alienated, and most confused patients and place them in environments that increase fear, alienation, and confusion." (9) A psychiatrist who wishes to remain anonymous told me that voluntary psychiatric programs often see patients with post-traumatic stress from their stay on a locked inpatient ward. Imagine finding yourself surviving a suicide attempt, glad to be alive, but suddenly locked up like a convicted criminal with no privacy, control over your treatment, or freedom.

- **Involuntary confinement undermines the patient-doctor relationship.**

  The prison-like environment of a locked ward and the power dynamics it entails reinforces a person's sense of helplessness, increases distrust of the treatment process, reduces medication compliance, and encourages a mutually adversarial patient-doctor relationship. Hospital psychiatrist Paul Linde, in his book, *Danger to Self*, critically labels one of his chapters, "Jailer." (10) Yet, like some other hospital psychiatrists, he talks about the pleasure of winning cases 'against' his patients who go to mental health courts, seeking their release. The fact that judges almost always side with hospital psychiatrists undermines his victory and patient access to justice. (11)

- Finally, **coercive treatment of people with mental illness is discriminatory.**

> Doctors do not lock up those who neglect to take their heart medications, who keep smoking even with cancer, or are addicted to alcohol. We might bemoan these situations, but we are not ready to deprive such individuals of their liberty, privacy, and bodily integrity despite their "poor" judgment. People who suffer from mental illness also are due the respect and freedoms enjoyed by other human beings.

One might think from the widespread use of involuntary civil commitment that we have few alternatives. On the contrary, over the past decades, there have been several successful hospital diversion programs developed which use voluntary admission, peer counseling, homelike environment, and noncoercive consultative approaches, such as Soteria and Crossing Place. (12)

Community-based cognitive therapy has been fairly effective with suicide survivors at lower cost, yet we continue to spend 70 percent of government funds on inpatient settings. (13) Yes, many underfunded community clinics are in a disgraceful state, but the same may be said of some psychiatric hospitals.

For a nation that prides itself on its science, its innovation, and its civil rights, we have too often neglected all three in our treatment of those tormented by mental illness and despair who have tried to take their lives.

Endnotes

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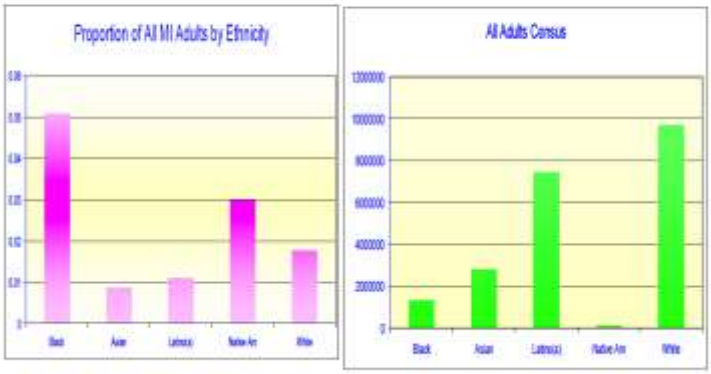
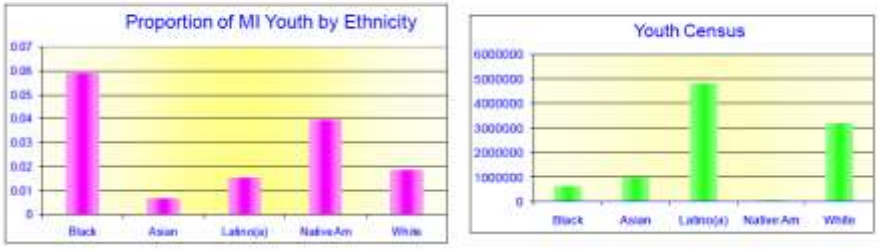
Proportion of Older Adults Diagnosed as "Mentally ILL" (MI) & Receiving Services in the DMH Community System For Fiscal Year 2006-2007

Proportion of All Adults Diagnosed as "Mentally ILL" (MI) & Receiving Services in the DMH Community System For Fiscal Year 2006-2007



Proportion of Youth Diagnosed as "Mentally ILL" (MI)& Receiving Services in the DMH Community System For Fiscal Year 2006-2007



Responding to the Challenge of Involuntary Outpatient Commitment

Harvey Rosenthal
New York Association of Psychiatric Rehabilitation Services
2013 MASSPRA Meeting

Forced Mental Health Treatment

The issue of choice and the threat of forced treatment is among the very top concerns for most consumers/survivors, closely related to the dehumanization, despair and emotional and physical damage experienced by many, due to stigma and discrimination and in many people's experience of 'traditional' mental health services.

Involuntary Outpatient or Civil Commitment

- "Assisted outpatient treatment is court-ordered treatment (including medication) for individuals who have a history of medication noncompliance, as a condition of remaining in the community.
- Typically, violation of the court-ordered conditions can result in the individual being hospitalized for further treatment."

Criminalization and Psychiatric Profiling

In the wake of several recent horrific tragedies, having a psychiatric diagnoses or getting mental health treatment has been criminalized due to defamatory unfounded linkages with violence

- state and federal gun law mental health reporting initiatives
- IOC passage or expansions

Forced Outpatient Treatment Has Been a Top Controversy in Mental Health Field

- A public safety measure?
- A 'compassionate' treatment intervention?
- A measure to offer 'true freedom'?

OR

- A violation of individual liberties, rights, respect and personal choice?
- A failure of state and local mental health systems to properly engage and service individuals in need, especially those who've had a poor past experience with treatment?
- A poor, unproven use of increasingly precious public dollars?

Why Does IOC Appeal to the Public and to Policymakers?

- Public fears that people with psychiatric disabilities are violent and a threat to their safety.
- Beliefs that medications are the primary treatment, that they're safe and effective and that overcoming people's 'denial' or reluctance to take them is a responsible compassionate policy.
- Public ignorance of the failings, ineffectiveness and poor effort of our public mental health systems.
- Poor understanding as to why people are reluctant to engage in services and are 'non compliant'
- Efforts by the Treatment Advocacy to play up rare episodes of violence to push this agenda

Treatment Advocacy Center

- "A national nonprofit organization dedicated to eliminating legal and clinical barriers to timely and humane treatment for millions of Americans with severe brain disorders who are not receiving appropriate medical care."
- "Founded in 1998, TAC serves as a catalyst to achieve proper balance in judicial and legislative decisions that affect the lives of persons with serious brain disorders." http://www.treatmentadvocacycenter.org/

TAC: Why Forced Treatment?

- 'Their brain disease has impaired their brain function, and since they do not think they are sick, many of them do not actively seek treatment and often refuse it.'
    - Anosognosia is the single largest reason why individuals with schizophrenia and bipolar disorder do not take their medications. This impaired awareness of illness is caused by damage to specific parts of the brain, and affects approximately 50 percent of individuals with schizophrenia and 40 percent of individuals with bipolar disorder. Medications can improve awareness in some patients.
    - TAC says that IOC reduces:
        - hospitalization
        - homelessness
        - arrests
        - violence
        - victimization
    - TAC says that IOC improves:
        - mental health treatment compliance
        - substance abuse treatment

The TAC Playbook

- Capitalize on an episode of violence involving a person with a psychiatric disability by
    - Aligning with the victims
    - Publishing stats suggesting we're violent
    - Linking with local family groups
    - Indentifying State or City Administrative or Legislative champions
    - Identifying a reporter or two to carry their message

TAC on IOC in America

'In only 12 states and the District of Columbia was use of outpatient commitment rated as very common or common' (TAC '99).

The states that currently do not have assisted outpatient treatment are Connecticut, Maine, Maryland, Massachusetts, New Mexico, Nevada and Tennessee.

9 Responses to IOC Proposals

- Address The Myth Of Violence
- Educate Around Recovery
- Med Noncompliance in Perspective
- Deconstructing 'Noncompliance'
- System Failure Not Person Failure
- IOC Research Findings

- Ethnic, Geographic Disparities
- Cost of IOC
- Alternative Voluntary Strategies

Address The Myth of Violence

People with psychiatric disabilities are no more violent than the general public and are far more likely to be victims of violence except when, like the general public, they abuse alcohol & drugs.

- **1998 McArthur Study** on "Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods" *Steadman et al Archives of General Psychiatry 1998* http://archpsyc.ama-assn.org/cgi/content/abstract/55/5/393?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=Steadman&searchid=1139212828284_30&FIRSTINDEX=0&journalcode=archpsyc
- **2005 "Crime Victimization in Adults With Severe Mental Illness" study** "More than one quarter of persons with SMI had been victims of a violent crime in the past year, a rate more than 11 times higher than the general population rates." *Teplin et al Archives of General Psychiatry.* http://archpsyc.ama-assn.org/cgi/content/abstract/62/8/911
- **Risk of people with mental illnesses dying by homicide** "people with any mental disorder were at a five-fold increased risk of homicidal death, relative to people without mental disorders" *British Medical Journal March 2013* http://www.bmj.com/content/346/bmj.f1336

Recovery Education

- Even people on back wards with severe disabilities can achieve significant levels of recovery, when they are offered the choice of the right kind and mix of modern services and medications. *1997 Maine-Vermont Comparison Study per British Journal of Psychiatry Dr Courtenay Harding et al* http://akmhcweb.org/ncarticles/Vocational%20Rehab.htm
- Most people still are not offered or can't get access to the right mix of the right services. *1998 Patient Outcomes Research Team (PORT) Study, Agency for Health Care Policy and Research (AHCPR) and the National Institute of Mental Health (NIMH)*
- "Fewer than Half of Schizophrenia Patients Get Proper Treatment" http://www.ahrq.gov/news/press/schizpr4.htm

Put Med Noncompliance in Perspective

- 75% go off meds because they don't work or because of disturbing side effects **2005 National Institute of Mental Health 'CATIE' study**: A large (1,400 patients) study that concluded that the medications were….associated with high rates (75%) of discontinuation due to intolerable side effects or failure to adequately control symptoms." http://www.nimh.nih.gov/healthinformation/catie.cfm
- Antipsychotic drugs cause brain atrophy over time, especially at high dosages. **Dr. Nancy C. Andreasen Study (Unpublished, NY Times)**

Deconstruct 'Noncompliance"

- **Impact Of Accepting A Psychiatric Diagnosis And Tx**
  - Shame, Stigma and discrimination
  - Dehumanizing 'hopeless' care

- Isolation; expectations of single, childless life
- Idleness: Lack of social meaningful roles work, school.
- Loss of rights and choices around where you live, with whom and around major life decisions
- Poverty (reliance on entitlements)
- Loss of personal and family relationships
- Loss of sexuality (medication side effects)
- Criminalization of emergency care: handcuffs, police, coercion

- **For many, resisting a blind acceptance of care as it is now, is actually an act of courage and sanity**

Noncompliant?

- Most of the individuals associated with acts of publicly covered violence by or towards them were in fact in treatment that failed them:
  - Andrew Goldstein (pushed Kendra Webdale in front of an oncoming subway)
  - Julio Perez (hired murder of wife; http://www.truecrimereport.com/2011/04/rev_julio_cesar_perez_paid_130.php)
  - Lee Coleman (Motel murders; http://www.wcjb.com/local-news/2013/03/motel-murder)
  - David Kostovski (cut up roommate)
  - Khiel Coppin (Mother claims domestic abuse; http://www.nytimes.com/2007/11/13/nyregion/13domestic.html)
  - David Tarloff (Killed psychologist; http://topics.nytimes.com/top/reference/timestopics/people/t/david_tarloff/)

IOC Research Findings

- **2001 "Assessing the New York City Involuntary Outpatient Commitment Pilot Program" Steadman et al Psychiatric Services"** A 3-year study at Bellevue Hospital compared the impact of providing an enhanced, better-coordinated package of services both with and without the use of a court order. Results: "On all major outcome measures, no statistically significant differences were found between the two groups" yielding the conclusion that people do better when they are offered better services, not because they are forced to accept them. http://ps.psychiatryonline.org/cgi/content/short/52/3/330
- **2000 NYOMH Data**: No scientific comparison and control group; program evaluation data only; Legislature rejected Kendra's Law permanence, mandated study comparing involuntary and voluntary measures
- **2005 Duke Study**: No scientific comparison to show cause of improved outcomes, despite 7,000 voluntary service enhancements and 8,000 court orders. "Available data allow only a limited assessment of whether voluntary agreements are effective alternatives to initiating or continuing court orders."
- There's plenty of evidence to show that improved discharge planning, patient engagement and accountable provider follow-up gets the kind of results that are cited. But there is no study to show that court treatment orders made the difference.
- In fact, the only study that did a direct comparison of enhanced services provided to groups with and without court orders found no statistically significant differences, and that the two groups were similarly compliant with

their treatment plans

Cultural Competence?

- Black people were almost five times as likely as White people to be subjected to Kendra's Law– which dramatically reduces freedom of choice over their treatment and their lives - and Hispanic people were two and a half times as likely as non-Hispanic White people. (systemic lack of cultural competence)
- **2005 Report "Implementation of "Kendra's Law" Is Severely Biased" New York Lawyers for the Public Interest**

Geographic Disparities

- ***82% (8,275) of the orders emanated from New York City and Long Island. The study found that*** "...***in other counties, largely outside of New York City, voluntary agreements are more frequently used before a…court order***."
- ***Most other counties offered almost 7,000 individuals a variety of voluntary service packages, with 24 upstate counties using 5 or less orders in total since the program's inception in November of 1999.***
- The study quoted a psychiatrist from an upstate county: "We don't do it like downstate...***We use the voluntary order first. We don't approach it in an adversarial way***."

Cost of IOC

- On its own, Kendra's Law Cost $32 Million in 2000 to boost the bureaucracy of additional state and local overseers the program required.
- An often overlooked allocation was the $125 million then Governor Pataki used to fund 60+ ACT Teams and 2,000 supported housing beds.

System Failure Not Person Failure

- President's Mental Health Commission 2003
    - "America's mental health service delivery system is in shambles."
    - "For too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today's mental health care system is a patchwork relic."

"The Broken System" Systems Level

- **No outcomes expected:** if no progress is expected; 'it's the illness'
- **Chronic Condition = Lifelong Services**, whether you want or need them or not (Hotel California)
- **Deficit based** not skills based
- **Power not partnership**
- **Fragmentation**: within mental health system, between MH, addiction and medical services
- **Lack of accountability**
- **Reactive vs. preventive**
- **Passive, office or site based vs. mobile**

HEALTHCARE REFORM: Major federal drivers

- **Triple Aim**: improve **outcomes/quality, reduce $**

- Medicaid/managed care **expansion**, BH parity
- Focus on **better coordinated, accountable and integrated** physical and behavioral health care
- Major emphasis on **home and community based services** and less reliance on institutional care
- Promoting **wellness, preventing** relapses **upstream**
- **Person centered individualized care**

HEALTHCARE REFORM: Major state initiatives

- Health Homes: accountable coordinated integrated provider networks of care
  - Focus on engagement and outreach, prevention, support and diversion
  - Single unified plan and electronic record
  - 24-7 response
- Managed Care Expansion
  - Integrating funding streams, outcome not visits, wellness based, **broader more flexible benefit package**
  - Medical necessity expansion: social determinants

Some Data on Peer Services Effectiveness

Peer Bridger

- Tennessee: reduced average number of hospital days per month from **7.42 to 1.98**, a **73.3% decrease**.
- Wisconsin: reduced average number of hospital days from **86 to 48**, **a 44.1% decrease.**
- New York/NYAPRS: reduced the number of people who were rehospitalized and days in hospital by 50%

PEOPLe Inc Peer Crisis Diversion Services Continuum

- Hospital Diversion House
  - 90% of Rose House residents were supported to not return to the hospital in the following year.
- Crisis Warm Line
- In-Home Peer Companionship
- Emergency Department Advocacy

Housing

- 90%: less need for crisis intervention
- 99%: housing stability has improved
- 94%: improved daily living skills;
- 90%: improved social and personal relationships.
- More than 70% of the individuals that have transitioned by Housing Options from state psychiatric centers to the community have remained there for over one year.

NYAPRS Peer Wellness Coaching

- Clean for 1 year
- Relapsed 1 year post rehab-went back to rehab-now clean
- 2009-prior to enrollment**: 7 inpt stays** (4 different facilities) **$52,282**
- 2010-1 detox, 1 rehab (referred by the CIDP team) **$20,650.**
- 2011-1 relapse with detox/rehab no claim yet.

Peer Employment Coaching

- 2010: Mental Health Peer Connection's Life Coaches helped 53% of individuals with employment goals to successfully return to work

ACT/Supported Housing

- **2000 "Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals With Psychiatric Disabilities" Psychiatric Services Tsemberis and Eisenberg** An innovative 'harm reduction' housing and support program model was able to achieve an 88% service retention rate and general stability among a group of primarily young men of color with psychotic disorders and previous histories of homelessness and non-participation with services http://ps.psychiatryonline.org/cgi/content/abstract/51/4/487
- **This is the very same group** of those who have been "incapable of living and maintaining treatment in the community" that Kendra's Law proponents would have us believe can only be served via court order. PTH does this without mandating treatment adherence or abstinence but by offering 'housing first' via a model that merges supported housing and ACT team services.

Westchester County Care Coordination Project 2007-10

- Intensive program consisting of care manager, peer mentor and self directed budget
- Total local funds: $176 million for 48 people
- Reductions
    - Medicaid services: 35%
    - Incarceration: 53%
    - State hospital: 78%
    - Total: 53% $2.3 million down to $1.2 million

More Bytes

- IOC is more often used to get people to the 'front of the line' to under-resourced or under-responsive systems; why drag people into the criminal justice system to accomplish this?
- Why force people into the same system that failed them? Fix the systems!
- IOC drains precious MH dollars and transfer the burden for system reform to the courts and cops

Strategies to Oppose IOC

- Focus on system failures and fixes not rights issues…especially improved outreach and engagement, crisis support
- Give policy makers alternatives for which they can take credit: pilots, studies, task force, care monitoring initiatives….demonstrate how healthcare reform offers true solutions in ways that improve outcomes , save lives and $
- Don't just react or play defense…lead with solutions…we're here all year, we offer real solutions vs false solutions and reassurances
- Fight flawed findings and assumptions
- Attack defamation and discrimination, psychiatric profiling
- Develop talking points and fact sheets that inform news releases, letters, opinion pieces and legislative flyers
- Build diverse coalitions of peers, providers, county officials……and families
- Align with family movement's experience, frustrations with the system…we agree with the problem, offer different solutions
- Pursue the 'art of the possible': e.g. we supported an extension to defeat an expansion and permanence

Fixing Not Forcing Services: Hartford Courant Letter 3/29/13

Connecticut policy-makers should not buy letter writer DJ Jaffe's analysis [March 29, http://www.courant.com/letters, "Forced Meds Law Working In NY"] regarding New York's experience with court-ordered outpatient treatment associated with Kendra's Law.

- There's plenty of evidence to show that improved discharge planning, patient engagement and accountable provider follow-up gets the kind of results he cited. But there is no study to show that court treatment orders made the difference.
- In fact, the only study that did a direct comparison of enhanced services provided to groups with and without court orders found no statistically significant differences, and that the two groups were similarly compliant with their treatment plans.
- One other correction: More than 15 New York mental health advocacy groups have consistently opposed expanding Kendra's Law and the state legislature has consistently refused to make the controversial program permanent.
- Similar to many other states, we are instead engaged in a complete systemic overhaul that is already showing impressive results in engaging and serving at-risk individuals, without bringing in the courts and the cops.

Op Ed: Kendra's Law Expansion is Wrong Answer for New York: Binghamton Press and Sun-Bulletin, May 25, 2012

All across the nation, state and local systems of mental health care have been wrestling with how to best get timely help to people with challenging conditions and lives who are prone to relapse, crisis and avoidable hospital admissions and contacts with the criminal justice system…. Here in New York, several recent initiatives proposed by Gov. Andrew Cuomo's Medicaid Redesign Team and approved by legislative stalwarts are showing impressive results in helping to fill the cracks in these systems.

We deserve more and better-directed treatment, not more involvement with judges and police who are already overburdened with their primary duties.

We hope that lawmakers will withhold support for Kendra's Law expansion and instead continue to focus on smarter, stronger solutions.

Mental Health Advocates Decry Defamatory Media Coverage, Call For Advances In State's Community Service System, January 3, 2013

A group representing New Yorkers with psychiatric disabilities and mental health advocacy groups came to Albany today to express their outrage at defamatory media depictions of people with mental illnesses. "We join all Americans in sharing our profound grief and horror at the fatal shootings in Newtown and the subway pusher deaths in New York City…"At the same time, we are horrified and outraged at recent statements and media coverage that rushes to judgment and viciously attacks people with mental illnesses here in New York and across the country," Rosenthal said.

Fighting Fear

- Most powerful tool is demonstrating who and how we really are just like everyone else
- Message: 'you don't need protection from us….but we are needing protection from defamation and discrimination and the policies of profiling'
- Emphasize and demonstrate that we are talking about people with serious needs not the 'worried well'

Final Words

Someday we'll look back and recall a time when 'we were so ineffective in engaging and helping people in need that we resorted to using the courts and police to force people into flawed, antiquated ineffective systems of care"

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EDITORIAL

Alternatives to Outpatient Commitment

Michael Rowe, PhD

Dr. Rowe is Associate Professor, Program for Recovery and Community Health, Department of Psychiatry, Yale School of Medicine, New Haven, CT. Address correspondence to: Michael Rowe, PhD, Associate Professor, Yale School of Medicine, Department of Psychiatry, Program for Recovery and Community Health, 319 Peck Street, Building 1, New Haven, CT 06513. E-mail: michael.rowe@yale.edu.

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The killing of 26 students and teachers in Newtown, Connecticut last year was committed by a young man, Adam Lanza, who took his own life before police could apprehend him. Investigative news reports and articles have stated that Lanza had received a diagnosis of Asperger's syndrome with sensory integration disorder.[1] Even before significant investigation into Lanza's past was conducted, however, the tragedy at Newtown rekindled the debate on legal commitment to outpatient treatment (outpatient commitment) for persons with disabling psychiatric disorders who refuse voluntary treatment. In this editorial, I review both pro and con arguments regarding outpatient commitment and the research conducted on it and discuss alternative approaches to addressing the objectives of assuring public safety and providing care for persons at risk of violence to self or others who are not engaged in mental health treatment.

Outpatient Commitment as Public Policy and Practice

The concept and practice of outpatient commitment has been a divisive subject in mental health care in the United States for at least two decades. Currently, 44 of 50 states have laws that provide for some form of outpatient commitment.[2,3] Mental health professionals and others have argued that the practice, including commitment to taking prescribed psychiatric medications, can:

> Be an effective means of providing care to persons with mental illness who refuse mental health treatment,[4] including those who lack insight into the fact that they have a mental illness.[5]
>
> Spur efforts to identify persons at risk of violence against self or others and, by providing treatment to them, reduce acts of violence committed by members of this group.[6]
>
> Reduce the risk of incarceration of mandated persons. [7]

Encourage persons who have previously refused treatment to enter treatment willingly.[7] For example, a colleague worked with homeless persons in New York City when they were notified of their eligibility to receive mandated outpatient commitment after Kendra's Law went into effect. He stated that a female client, after receiving notification, began to take her prescribed medications immediately, and her thinking and functioning improved (personal communication from Charles Barber, February 7, 2013). (Kendra's Law, ironically, was passed in New York State after a man with mental illness, who had repeatedly sought treatment but was turned away, pushed a woman in front of an oncoming subway train in New York City.[4])

Encourage clinicians to provide coordinated and attentive care to mandated clients.[6]

Provide a less restrictive alternative to inpatient commitment for those who refuse outpatient treatment,[8] and help prevent episodes of deterioration and negative outcomes, such as arrest or violence.[9]

Other mental health experts and advocates oppose outpatient commitment laws and practices, arguing that they may:

Unfairly target persons with mental illnesses, as most of this group does not commit acts of violence,[4] whereas a strong majority (80%) of mass or serial killings is committed by persons seeking revenge, not persons with histories of mental illness.[10]

Wrongly assess individuals as being, or not being, at imminent risk of violence toward others, as psychiatrists have poor track records of predicting violence in their patients.[4]

Drive people away from treatment.[8] The colleague noted earlier (personal communication from Charles Barber, February 7, 2013), whose client began to take her prescribed medication after Kendra's Law was passed, observed different responses among his male shelter clients: when informed of their potential eligibility for outpatient commitment, almost all fled the shelter and were not seen again.[7,11]

Draw attention and resources away from the most significant challenges of mental health care in the United States: lack of access to care due to stigma and misconceptions about mental illness and violence (including ignorance of the fact that persons with mental illness are far more likely to be victims of violence than to commit it)[4,12] and underfunded systems of care.[7]

Target African Americans, who were overrepresented in New York State among recipients of outpatient commitment after passage of Kendra's Law.[13–15] The possible role of bias in this regard is unclear, as African Americans are overrepresented among the target group for outpatient commitment. Even so, the coercive nature of mandated mental health treatment, considered in the context of African Americans' over-representation in U.S. jails and prisons,[16] should give

us pause. It would be ironic, to say the least, if addressing the inequity in receipt of mental health care among African Americans[17] were to be accomplished, in part, through forcing some members of this population to accept outpatient treatment.

Research on Outpatient Commitment

Regarding research on outpatient commitment, two randomized controlled studies, one in New York and one in North Carolina, have been conducted in the United States. The New York study found no statistically significant differences in rehospitalization rates, arrests, homelessness, or other outcomes between participants randomized to receive involuntary outpatient care and those randomized to intensive outpatient care without outpatient commit-ment.[18] The weaknesses of the study were small sample size, some differences in the two comparison groups, and problems with enforcement of court orders among the commitment group.[19]

In the North Carolina study, participants being discharged from psychiatric hospitalization were randomly assigned to outpatient commitment or standard release. Participants with outpatient commitment who also received intensive outpatient care had fewer hospital admissions and fewer days in the hospital, were more likely to adhere to community care, and were less likely to be violent or to be victimized than were participants in the standard release condition.[20] A weakness of this study is that the impact of outpatient commitment could not be distinguished from the impact of intensive outpatient care.[19]

Two systematic reviews of studies of outpatient commitment have been published by the Rand Corporation and the Cochrane Collaborative. The authors of the Rand report wrote of the findings in the North Carolina study: "[O]utcomes were only improved for those under court order who received intensive mental health services. *Whether court orders without intensive treatment have any effect is an unanswered question*" (Ref. 19, p99; italics in original). A later Cochrane Collaborative review of outpatient commitment studies, including the New York and North Carolina studies and subsequent research, concluded: "The evidence found in this review suggests that compulsory community treatment may not be an effective alternative to standard care" (Ref. 21, p2). The authors recommended further research on outpatient commitment and consideration of alternative approaches with stronger evidence of effectiveness.

Finally, a 2013 article in *The Lancet* reported on a randomized, controlled U.K. study of persons with psychosis discharged from psychiatric hospitalization under community treatment orders (CTOs) or §17 leave. Participants randomized to CTO were subject to clinical monitoring and rapid recall assessment, whereas participants randomized to §17 leave were subject to recall for assessment, but received significantly less extensive monitoring and for shorter times. Findings on the primary study outcome, rehospitalization over a 12-month period, were that there was no difference in readmission rates between the two groups. The authors concluded: "In well coordinated mental health services the imposition of compulsory supervision does not reduce the rate of readmission of psychosis patients. We found no support in terms of any reduction in overall hospital admission to justify curtailment of patients' personal liberty" (Ref. 22, p 1).

Alternatives to Outpatient Commitment

Coercive treatment should be undertaken with reluctance, with protections against abuse, and only when there is clear evidence of benefit to the individual, to society, or to both.[23,24] Evidence of the effectiveness of outpatient commitment is not robust, even under the most generous reading. Evidence-based alternatives for engaging people with serious mental illness in care, which may be effective with the target group for outpatient commitment, are available. In the following sections, I will briefly discuss three alternatives that my colleagues and I have studied: peer engagement, mental health outreach to people who are homeless, and citizenship interventions.

Peer Engagement

In 2000, the Connecticut General Assembly, considering passage of an outpatient commitment law, responded positively to advocates' proposed alternative approach by allocating funds for a statewide community-based intervention, the Peer Engagement Specialist Project. For this program, peers (persons with lived experience of mental illness) were hired and trained to provide support and engagement services to persons who would have been subject to outpatient commitment had it been enacted in Connecticut. Included were persons with serious mental illnesses who had histories of violence or the threat of violence and who were not engaged in treatment. A randomized, controlled study of this four-site project compared persons receiving peer specialist services with persons receiving current community-based case management services. Findings were that participants in the peer engagement condition had greater satisfaction with care and perceived higher positive regard, understanding, and acceptance from peer engagement specialists than did participants in the comparison condition from their case managers. In addition, positive regard from peer specialists in the early stages of enrollment was associated with participants' future motivation to receive care for psychiatric, alcohol, and drug use problems and attendance at Alcoholics and Narcotics Anonymous meetings.[25] Finally, for participants in the peer specialist condition, even negative feedback from their peer specialists regarding their behavior was linked to improved quality of life and fewer obstacles to recovery.[26] These findings suggest that peer providers can quickly forge therapeutic connections with and motivate to accept treatment those persons who are among the most disconnected from mental health care.[25]

Citizenship Interventions

Citizenship-based approaches are designed to support the recovery of persons with serious mental illnesses through efforts to enhance their sense of belonging and attainment of valued roles in their communities. A citizenship-based intervention, including community-oriented classes, valued role and giving-back community projects, and wraparound peer support, was evaluated through a randomized, controlled trial. Participants with serious mental illness and criminal justice charges were randomized to the citizenship-based intervention plus current community mental health services or to current services. Citizenship intervention participants had statistically significant reductions in substance and alcohol use and increased quality of life on some subscales, compared with current service participants. In addition, arrests decreased significantly for both groups, perhaps suggesting that engagement in treatment, which occurred without outpatient commitment in this study, supported decreased criminal justice contacts for the target group.[27]

Mental Health Outreach

Mental health outreach was developed as a means of finding mentally ill homeless people who are not engaged in care, building their trust, and providing care, including mental health, housing, and rehabilitation services.[28,29] Research on a nine-state, 18-site national study of services for this group found that mental health outreach engages the most severely psychiatrically impaired among persons living on the streets and that those engaged through street outreach showed significant improvements in several domains.[30]

These three interventions directly target persons who, otherwise, would be subject to outpatient commitment (peer engagement); persons who would be subject to outpatient commitment and others with serious mental illness and criminal justice charges (the citizenship intervention); or persons who are homeless and are equally marginalized and hard to reach (mental health outreach). In addition to these potential alternatives to outpatient commitment, initiatives involving coordination of care, ongoing assessment, stigma reduction, mental health public education activities, and ongoing consultation from experts in forensic psychiatry should be regarded as part of a comprehensive alternative approach to work with the target group for outpatient commitment.

Regarding coordination of care, an advance in community mental health care since the early 1980s has been the development of local mental health authorities (LMHAs) to oversee and provide quality assurance for integrated clinical care and rehabilitation services.[31] In addition, enhanced coordination of care between mental health and criminal justice systems can be built on current initiatives and coordinating mechanisms related to the reentry of persons to their communities following incarceration.[32]

Ongoing assessment can be accomplished by building on current evaluation structures in LMHAs and other service systems and through statewide reporting requirements for monitoring program outcomes. Stigma reduction and mental health public education activities to enhance early intervention efforts in mental illness and encourage individuals to seek care can support the alternative intervention approaches just described. Ongoing consultation from experts in forensic psychiatry is available in many local systems of care and should be enhanced in others for work with this target group. Specific objectives, action steps, and target dates for these recommended initiatives must be developed. The capacities and means for carrying these recommendations forward, however, are largely in place at present.

Conclusion

The topic of outpatient commitment engenders strong emotions on both sides of the debate. Those in favor express outrage over leaving to their own devices persons with disabling psychiatric disorders who refuse treatment and who, they argue, represent a potential danger to the public. Those opposed express outrage over the threat to the civil rights of persons with mental illness who are highly unlikely to commit acts of violence and are already subject to coercive practices such as forced treatment compliance to remain in some housing programs and representative payees who control their money. Mental health policy-making, as with other public policy-making, must consider individual and societal needs, ethics-related and constitutional demands, and evidence. Outpatient commitment is likely to help some

persons, such as the female client mentioned earlier who enrolled in treatment after being informed of her eligibility for outpatient commitment under Kendra's Law. This person, one might guess, would support the ethics component of Kendra's Law, at least in her own case, along with testifying to its practical benefit for her.

(As this editorial goes to press, a cost-effectiveness study of New York's Kendra's Law has been published. Costs of care for 634 persons enrolled in court-ordered outpatient treatment within 30 days of discharge from psychiatric hospitalization between January 2004 and December 2005 were compared for the year before and the first and second years after enrollment. The study found reduced psychiatric hospitalization and arrests, increased use of outpatient treatment and psychiatric medications, and overall significantly decreased mental health system and Medicaid costs for patients during the first year, with less dramatic but still decreased costs, during the second year after enrollment. Costs of care for a comparison group of persons enrolled voluntarily in intensive outpatient care also declined, but less significantly than for the court-ordered treatment[33] group. While this study warrants, and will no doubt foster, renewed discussion of the effectiveness and advisability of outpatient commitment, it lacks randomization or a true matched sample, and thus can offer only a qualified comparison to the New York and North Carolina studies discussed above. In addition, its findings do not address the argument in this editorial regarding the potential alternatives to outpatient commitment of peer engagement, citizenship interventions, and mental health outreach.)

On balance, after more than 20 years of mandates and programs, outpatient commitment remains a costly, coercive, and unproven approach. More promising, and proven, practices are available. Through building on such practices and increasing the availability of services, effective mental health care can be provided to persons with serious mental illness who are not presently receiving care, including the very small percentage of those among this group who are at risk of violence toward others.

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The Truth About Kendra's Law: Let's Make Policy on Facts Not Fear

Harvey Rosenthal
New York Association of Psychiatric Rehabilitation Services
www.nyaprs.org
February 6, 2006

MYTH: Many with psychiatric disabilities are just too sick to get well, will never work, marry or have good judgment and will always need custodial forms of care like Kendra's Law that direct their care for them.

FACT: Even the most disabled can achieve significant levels of recovery, when they are offered the choice of the right kind and mix of modern services and medications.

EVIDENCE: 1997 Maine-Vermont Comparison Study per British Journal of Psychiatry, Dr. Courtenay Harding et. al., http://akmhcweb.org/ncarticles/Vocational%20Rehab.htm

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MYTH: People with psychiatric disabilities typically refuse good services. (The individual who pushed Kendra Webdale to her tragic death (Andrew Goldstein) refused care and required forced outpatient treatment.)

FACT: Despite research indicating highly successful service and medication models of care, most people still are not offered or can't get access to the right mix of the right services. (Like so many Americans with psychiatric disabilities, Andrew Goldstein sought care that was repeatedly denied or unavailable.)

EVIDENCE: 1998 Patient Outcomes Research Team (PORT) Study, Agency for Health Care Policy and Research (AHCPR) and the National Institute of Mental Health (NIMH): "Fewer than Half of Schizophrenia Patients Get Proper Treatment," http://www.ahrq.gov/news/press/schizpr4.htm

1999 NYS Commission on Quality of Care for the Mentally Disabled Review, Andrew Goldstein repeatedly sought care which nonetheless failed to adequately respond to help him. "This fragmented series of services was insufficient to meet the complex needs of Mr. (Goldstein) and to protect those around him." "As indicated in the findings, Mr. (Goldstein) would often present himself for treatment — complaining that he was anxious, hearing voices and unable to control himself — and ask to be helped, at times requesting supervised housing."

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MYTH: People with psychiatric disabilities won't take their medications because they have a "brain deficit" that renders them unable to perceive that they are ill. TAC (Treatment Advocacy Center) has even come up with a name for this new condition they have come up with, "anosognosia." Psychiatric News, September 7, 2001

FACT: 75% go off meds because they don't work or because of disturbing side effects.

EVIDENCE: 2005 National Institute of Mental Health 'CATIE' study: A large (1,400 patients) study that provides, for the first time, detailed information comparing the effectiveness and side effects of five medications that are currently used to treat people with schizophrenia. Overall, the medications were associated with high rates (75%) of discontinuation due to intolerable side effects or failure to adequately control symptoms. http://www.nimh.nih.gov/healthinformation/catie.cfm

Heather Laney, a recovering individual who works for the Western NY Independent Living Center in Buffalo, NY in remarks at a 2005 Albany news conference: "Who would want to accept a diagnosis of mental illness, and the often poor help that such an acceptance brings, if he or she believes that the result will be a life of poverty, isolation, broken relationships, and general stigma. How can we really be surprised that people reject the system as it is now? How can we not conclude that the solution is not more coercion but instead more compassion, understanding, integration, and dignity for all involved? Kendra's law is an easy answer. But it is an unjust and in the long run an ineffective one."

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MYTH: People with psychiatric disabilities are dangerous and pose a major threat to public safety.

FACT: People with psychiatric disabilities are no more violent than the general public and are far more likely to be victims of violence.

EVIDENCE: 1998 McArthur Study on "Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods," Steadman. et. al., Archives of General Psychiatry, 1998. "There was no significant difference between the prevalence of violence by (mental) patients without symptoms of substance abuse and the prevalence of violence by others living in the same neighborhoods who were also without symptoms of substance abuse." http://archpsyc.ama-assn.org/cgi/content/abstract/55/5/393?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=Steadman&searchid=1139212828284_30&FIRSTINDEX=0&journalcode=archpsyc

2005 "Crime Victimization in Adults With Severe Mental Illness" study, Teplin, et. al., Archives of General Psychiatry. "More than one quarter of persons with Serious Mental Illness (SMI) had been victims of a violent crime in the past year, a rate more than 11 times higher than the general population rates." http://archpsyc.ama-assn.org/cgi/content/abstract/62/8/911

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MYTH: Forced outpatient treatment measures are needed to achieve better results with 'at risk' groups.

FACT: Better services, and not court mandates, work best.

EVIDENCE: 2001 "Assessing the New York City Involuntary Outpatient Commitment Pilot Program," Steadman, et. al., Psychiatric Services. A three-year study at Bellevue Hospital of a program similar to one later mandated by Kendra's Law, compared the impact of providing an enhanced, better-coordinated package of services both with and without the use of a court order. Results: On all major outcome measures, no statistically significant differences were found between the two groups yielding the conclusion that people do better when they are offered better services, not because they are forced to accept them.
http://ps.psychiatryonline.org/cgi/content/short/52/3/330

2001 Rand study: Proponents of Kendra's Law like to dismiss the Bellevue study's findings and to cite a Duke University they believe found involuntary outpatient commitment an effective intervention. Yet, a 2001 prestigious Rand study concluded that "the Duke study does not prove that treatment works better in the presence of coercion or that treatment will not work in the absence of coercion."
http://www.rand.org/pubs/research_briefs/RB4537/index1.html

2005 "Compulsory community and involuntary outpatient treatment for people with serious mental disorders," Kisely, et. al., The Cochrane Library. "It appears that compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care. There is currently no evidence of cost effectiveness.

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MYTH: The forced outpatient mechanism in New York's Kendra's Law is responsible for any of the good outcomes reported in a recent evaluation conducted by the NYS Office of Mental Health.

FACT: The OMH research design was flawed in that, unlike the Bellevue study and other scientific evaluations, it has no comparative 'control' group and, hence, can't prove that the improved outcomes were not due to improved services access, funding, coordination & accountability, rather than to the forced outpatient treatment mechanism.

EVIDENCE: 2005 Report "Implementation of 'Kendra's Law' Is Severely Biased," New York Lawyers for the Public Interest. "While it claims many apparent benefits for those subjected to court orders, it is impossible to tell from OMH's data what is accomplished by compulsion and what by enhanced access to services." The OMH research is based almost entirely on the opinions of case managers and, unlike the Bellevue Study, fails to provide a comparison with a control group of those who received a voluntary package of similarly improved, well-coordinated services, including housing and case management.
http://www.nylpi.org/pub/Kendras_Law_04-07-05.pdf

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MYTH: Only force can work for some groups.

FACT: Good voluntary services get very good outcomes with same population as Kendra.

EVIDENCE: 2000 "Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals With Psychiatric Disabilities" Psychiatric Services, Tsemberis and Eisenberg. An innovative 'harm reduction' housing and support program model was able to achieve an 88% service retention rate and general stability among a group of primarily young men of color with psychotic disorders and previous histories of homelessness and non-participation with services - the very same group of those who have been "incapable of living and maintaining treatment in the community" that Kendra's Law proponents would have us believe can only be served via court order. And he does this without mandating treatment adherence or abstinence but by offering 'housing first' via a model that merges supported housing and ACT team services. http://ps.psychiatryonline.org/cgi/content/abstract/51/4/487

Shelly Nortz, Coalition for the Homeless. An innovative voluntary community housing initiative, 'New York/New York,' has achieved an 88% compliance level and an average 83% reduction in re-hospitalization, incarceration and homelessness for over 10,000 homeless seriously mentally ill adults, rivaling if not exceeding corresponding rates for those ordered into treatment under Kendra's Law. We strongly advise against extending the period of the initial court order to one year. (Assembly Public Hearing)

2003 "Public Service Reductions Associated with Placement of Homeless Person with Severe Mental Illness in Supportive Housing," Culhane, et. al., Housing Policy Debate. The study by Penn Center for Mental Health Policy and Services Research concludes that, on average, the homeless mentally ill use $40,500 a year in public funds for shelter, jail and hospital services. But providing them with supportive housing would cost the same amount while also providing them with comprehensive health support and employment services.
http://www.upenn.edu/pennnews/article.php?id=376

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MYTH: Forced treatment measures get potentially violent individuals into care.

FACT: In truth, the Kendra's Law mandate program is used by counties, families and even the patients to 'get to the front of the line' and gain access to preciously scant local service systems and housing.

EVIDENCE: John Gresham, New York Lawyers for the Public Interest: "Most court orders have been used to link nonviolent individuals with priority access to scant services. Must we rely on courts and cops to make our system more responsive and more accountable? Localities that are turning to court orders are using them primarily to get individuals with 'high needs' to the 'front of the line' for scarce services and housing. Only 15 percent of those under court orders have done any physical harm.

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MYTH: Court ordered care under Kendra's Law has had a major statewide impact.

FACT: Court orders have been concentrated in 8 counties and New York City, with the remaining 49 counties using few to none.

EVIDENCE: Nassau County Mental Health Commissioner Howard Sovronsky: "We must not lose sight of the fact that it is largely the availability and access to community-based services that has the greatest impact on our most needy citizens. It is the support and encouragement we provide that is the most valuable aid. It is compassion not coercion that must drive our system." (NYS Assembly Public Hearing).

Harvey Rosenthal, NYAPRS 2005 Assembly Hearing: "Once you take out New York City's 3,000+ court orders (which represent over ¾ of all court orders statewide), most counties have been far more successful in engaging individuals with serious psychiatric conditions without the use of forced treatment. For example, 13 counties have not produced even 1 court order; 12 counties have produced 2 or less forced treatment orders: Also, NYC has sought court orders for 3 out of every 5 investigations; in contrast, Onondaga Co. (Syracuse), has only sought court order for 1 out of every 12."

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MYTH: Most advocates support forced outpatient treatment.

FACT: Quite the opposite.

EVIDENCE: Every single mental health advocacy group in NYS opposed the passage of Kendra's Law in 2000, except for the National Alliance for the Mentally Ill-NYS and the American Psychiatric Association. The APA did not back the bill in 2005.

Nationally, many leading mental health advocacy groups oppose forced outpatient treatment, most notably the National Mental Health Association and the United States Psychiatric Rehabilitation Association.

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MYTH: The NYS legislature strongly supports Kendra's Law.

FACT: Quite the opposite.

EVIDENCE: "In 2005, the NYS Legislature was so troubled by the program, by its questionable research and by a host of unanswered questions about the program's implementation...that it refused to relinquish its oversight role, refused to make it permanent, rejected efforts to expand the use of forced outpatient treatment and at the same time, required that an independent body conduct a more trustworthy evaluation." (Harvey Rosenthal, news release}

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There is simply no proof to make Kendra's Law permanent or, worse, to strengthen its reliance on coercive outpatient treatment. There is no proof that people with psychiatric disabilities are more violent or to suggest that this initiative is an effective public safety measure, no proof that court orders, rather than more responsive, accountable, better coordinated and funded services, have created the improved

outcomes OMH reports and no proof that counties that have favored improved voluntary care are 'negligent.'

There is proof, however, that innovative service models can successfully and cost-effectively engage 'hard to serve' individuals without the use of any force - but by simply responding to people's actual stated needs - a safe place to live, some decent food to eat, and some friendly people to provide some comfort and support.

In truth, in our understandable grief and fear, we must not rush to embrace the false beliefs that forced outpatient treatment programs will prevent violence. The research shows that good services that are adequately funded, accessible, coordinated and accountable will best help reduce incidents. The sad and plain truth also is that despite all of our best efforts, some random tragedies will occur - and frankly far more often at the hands of someone without a psychiatric disability.

Someday, people will look back at our use of forced outpatient treatment and will wonder why we were so incapable of providing the right kind and level of accountable, appealing and effective services that we fell prey to the desperation that is driving the use of involuntary outpatient treatment.

Let's instead devote ourselves to committing the state's political will, wisdom and funding - and committing our state and local governments and community providers to provide the range of services that science tells us will surely engage those most in need, even those at risk of coming to and/or causing harm before we talk about committing innocent non-violent individuals to forced outpatient treatment orders.

NON VIOLENT ON THE FACTS

"Most people should have little reason to fear violence from those with mental illness, even in its most serious forms."
Mental Health: A Report of the US Surgeon General, 1999

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"The prevalence of violence among (mental) patients without substance abuse was statistically indistinct from the prevalence of violence among non-mentally ill residents without substance use living in the same neighborhoods."
Steadman, H. J., et. al., MacArthur Study, 1998

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"From this exhaustive review of the literature, the authors concluded that 'as yet, there is no compelling scientific evidence to suggest that mental illness causes violence'."
Mental Illness and Violence; J. Arboleda-Fl'rez, Heather Holley, Annette Crisanti, University of Calgary

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"It is generally accepted that the public perceives the mentally ill as substantially more violent than the general population. This perception is perpetuated through the media, and is a source of major stigma for mentally ill persons. The relationship between mental illness and violence continues to be addressed through new

research, which clearly indicates that substance use, not mental illness, is a risk factor more closely associated with violence."
Current Opinion in Psychiatry: Volume 12(6) November 1999
Violence and mental illness; Noffsinger, Stephen G.; Resnick, Phillip J.

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"From a marketing perspective, it may be necessary to capitalize on the fear of violence to get the law passed."
D. J. Jaffe, an advertising executive associated with the Treatment Advocacy Center, a national organization dedicated to passing outpatient commitment laws in every state.

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Laura's Law (California) Research Update 2014

Current Research On Outpatient Commitment Laws (Laura's Law)

Jasenn Zaejian, Ph.D.

February 1, 2014

Outpatient commitment laws, passed by a number of states, permit forced commitment to treatment by mental health professionals of those whom a psychiatrist, psychologist, or mental health official deems in need of treatment. The majority of this "treatment," while not specifically written in the law, results in coercive tactics to pressure agreement to take pharmaceutical preparations of limited to no effectiveness, but, as shown in early research, with massive side effects on cognitive functions and subsequent decision making ability, not to mention a long term or lifelong diminished quality of life and ability to function as a productive member of society (cf: Brown Library). Lately, however, such research has been defunded, given the prevalence of pharmaceutical industry dominance in antipsychotic research.

When a mandated outpatient commitment is scientifically justified, that is one thing. However, numerous research studies, over the past 60 years, have established that an enhanced voluntary services program for those diagnosed as mentally ill, including sufficient financial incentive programs for those resisting attendance and housing programs, are far more effective, economically efficient, and consistent with social justice concerns than an involuntary commitment program. (British Medical Journal).

New York State instituted an outpatient commitment law, "Kendra's law," about 15 years ago. While the NYS Office of Mental Health, in an assessment of the law's effectiveness, specifies there is no racial disparity in its application, one only need look at the statistical database to see that there is certainly racial disparity. An analysis of NYC outpatient commitments by Kendra's law between1999-2010, presented in the following table, clearly indicates prima facie racial discrimination:

Racial Characteristics	**Current NYC Census Data**	**Kendra NYC Commitments**
African Americans	15.9%	36%
Latino (a)	17.6%	38%
Asian	12.7%	3%
White	65.7%	23%

In California, the Orange County (O.C.) Board of Supervisors are now preparing to adopt “Laura’s law,” identical to New York’s Kendra’s law in its emphasis on legal outpatient commitment. The Board of Supervisors have been presented with Research data clearly indicating that legal forced commitment to treatment is less effective than voluntary enhanced treatment.

The Psychiatric Rehabilitation Association has repeatedly stated its strong opposition to involuntary outpatient commitment as presented in the association’s recent 2013 statement:

“Recovery is possible when the individual in treatment acts in partnership with the rehabilitation workforce and strengthens integration into their community; coercion is not an incentive to recover and all too frequently may be implemented where other treatment and community support options could achieve a better result”

However, most recently following the reaction, covered in the O. C. press, of the killing of a young, supposedly mentally ill individual who was beaten to death by police (currently under review by the US Dept. of Justice), the false conflation of violence and mental illness has reemerged, resulting in legislative officials ignoring the worldwide research on the ineffectiveness of legal outpatient involuntary commitment when compared to the effectiveness of a less expensive increased funding for enhanced voluntary mental health services. It is not too far of a reach to hypothesize that the real problem, in the killing of the young man, was the ineffective training of the police in dealing with a supposedly mentally ill individual who was sitting at a bus stop when confronted, and repeatedly stated he was doing nothing wrong. He was badly beaten and died of his injuries. What would have likely saved him was a liaison from the local mental health with the Fullerton Police, on call for every encounter with a potentially mentally ill individual. We had this in the 70’s when I worked as a young clinical psychology post-doc intern at a California Community Mental Health Clinic. I recall going out in the middle of the night with Sheriff’s deputies. In other major metropolitan areas I have participated in training sessions with SWAT team members and other police, on how to relate to a disturbed person. One has to wonder what happened with this system. A legal outpatient commitment would not have saved this person from being beaten to death by police, yet the public and the O.C. Board of Supervisors are supporting outpatient commitment as a reaction, not based on reason, but on the public’s unwarranted fears and basic ignorance of those who are diagnosed as mentally ill.

Parents dealing with disturbed young adults, as well as parent groups embrace the false belief that a legal outpatient commitment to treatment will provide a solution. This is compounded by the well funded and nationally organized distortions of research presented by the Treatment Advocacy Center (TAC) to governments, mental health professionals, and organizations. TAC is an organization created after the National Alliance For Mentally Ill (NAMI), posing as a parent advocate group, was discovered by Senator Grassley’s group and investigative reporters to be covertly funded by the pharmaceutical industry. TAC was formed by a psychiatrist, a former NAMI creator, and his associate from the advertising industry, to distance themselves from NAMI. TAC receives much of its funds from a foundation associated with the Stanley Medical Research Institute (of which the psychiatrist is cited as Executive Director), an organization that has pursued pharmaceutical research on schizophrenia and related disorders. This particular psychiatrist has been active for decades, in promoting strategies to enforce mandated medical treatment on those deemed mentally ill, but who are resistant to taking anti-psychotic medication, most of which research has established is minimally effective, compared to non-medical treatments (Soteria) and creates deleterious life-long risks to an individuals health, not to mention early death. Soon after TAC’s formation, the former advertising industry person reportedly suggested they falsely conflate mental illness with violence to elevate the public fears so that laws will be passed to promote their views and manipulate the mental health industry to succumb to their unscientific beliefs (Stigmanet). Sound research repeatedly proves most of their assumptions, beliefs, and proclamations are in serious error, sadly laughable to those professionals who are cognizant of the research. Yet their target audience is to the general public

for purposes of generating fear. The public does not follow the scientific research on these issues.

Not many citizens are aware of the serious detriments to an individual's mental and physical health, and the financial implications of implementing a law requiring involuntary commitment. If such a law proved scientifically valid, the effort might be justified. But, studies, including those conducted by the Rand Corp, cited below, proves that it has little if any scientific support. In fact, a far less costly enhanced voluntary services program has proven, in numerous international studies, to be far more effective.

Counties will incur significant unanticipated court and legal costs if it implements an outpatient commitment law. The O.C. County Behavioral Mental Health Director, supportive of the law, recently indicated, as reported in the local press, that it would apply to "120" clients. While the state will provide some funds if the county implements the law, the costs for those 120 could well exceed $50 Million to the county, over what will be provided from the state, including court operating costs, attorney fees, salaries for involved police and sheriff deputies, salaries for mental health officials and expert witnesses involved, state mandated enhanced services, and oversight. The conclusion of the recent study on the matter, updated November, 2012, is quoted below from the Rand Corp.

"A RAND team led by Susan Ridgely reviewed the available studies, interviewed stakeholders in eight states, and analyzed administrative data on services provided by California's county mental health contract agencies. Their conclusions:

There is no evidence that a court order is necessary to achieve compliance and good outcomes, or that a court order, in and of itself, has any independent effect on outcomes."

The social consequences of implementing such a coercive law extend into unanticipated realms. As we know, Martin Luther King's dream of a post-racial America has not been achieved, regardless of popular rhetoric. This fact is clearly reflected in the racial disparity in our major institutions, corrections, and mental health. Significant evidence has accumulated that the local, state, county, and federal mental health systems and agencies engage in racially biased practices, albeit subtly but denied in most cases (cf. California Mental Health statistics for one example, NY state Kendra's law statistics for another).

Since at least the 1960's, diagnostic research has portrayed a racial bias in psychiatric diagnosing where major mental illnesses are over diagnosed in ethnic populations.

Prompted by my curiosity why the hospitalized population represented a far greater proportion of African Americans, I once did a study of race-based diagnoses at a major metropolitan forensic hospital where I was the director of program evaluation. An African-American, Haitian-American or other black person on admission, had (if memory serves) a 70% chance of receiving a schizophrenic diagnosis compared to less than a 50% chance of a white person or Asian person walking through the door. Latino chances for a diagnoses of schizophrenia was around 60%. Many studies confirmed similar racial disparities (cf: Racial Bias In Psychiatric Diagnosis).

The psychiatrist and scholar Jonathan Metzl, in his 2010 book, Protest Psychosis) presents confirming data that the diagnosis of schizophrenia has become racialized, a "black disease," as many activists and civil rights protesters have fallen under the eye of the mostly white psychiatric system run by white-privileged psychiatrists, psychologists, and other white mental health professionals. Experience as well as research informs that people of different ethnicities who present anger and opposition at being institutionalized or forced to be evaluated by professionals are labeled with one of the variants of "schizophrenia," most commonly paranoid schizophrenia, by opinion, not science. (cf: Black Men and Schizophrenia).

The same diagnostic bias is true for professionals of different ethnicites who subscribe to the mainstream mental health model.

How does this racial diagnostic disparity bear on the implementation of Laura's law in California? One need only to look above at the NYC statistics on racial disparity on the implementation of Kendra's law to see how it will apply if Laura's law is implemented. Based on solid research over the past 15 years of similar laws put into effect, the implementation of Laura's law will necessarily result in racial disparities, opening Orange County, once again, to civil rights lawsuits, judgments, and other unanticipated expense to taxpayers.

Having worked in the state and county mental health systems, I can say from experience that California counties need an enhanced mental health program that transcends the rigidly uncreative operation that it now is, not another law based on a knee jerk reaction, as was done with New York's Kendra's law. NYS Mental Health officials continue a strategy to obfuscate it's true ineffectiveness and social consequences. Kendra's law has resulted in oppressive practices, based on opinion, naiveté, knowledge deficits and ignorance of what really does work, while ignoring more than 60 years of worldwide research that mostly opposes it. The people of California need a mental health system, reorganized in a creative fashion, utilizing positive incentives to induce those reluctant to accept treatment to attend programs. They certainly do not need another law, costly to the taxpayers with little if any benefit, that harms the public welfare, only to benefit political agendas while creating more pain, suffering, and alienation to those most needy in our society.

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Psychiatry and Social Control

Introduction

Community Treatment Orders were introduced in November 2008, by new sections 17A-G being inserted into the Mental Health Act 1983 by the Mental Health Act 2007. In the Code of Practice it is called Supervised Community Treatment; in the Act those subject to CTOs are called community patients.

The 2007 amendment to the 1983 MHA allows Supervised Community Treatment (CTO) where community patients have to comply with a number of conditions. The powers only apply to discharged detained patients and the main condition is usually to comply with a depot neuroleptic as a way of preventing relapse. However, failure to comply with such a condition is not in itself enough to justify a recall and there must be a risk to the health or safety of the patient or others. The NIHME guide to the act states:

The RC can recall the patient if he breaches a mandatory condition (s17E(2))(namely being available for examination to consider renewal or by a second opinion doctor) or if in his opinion (s17E(1)):

> *(a) the patient requires medical treatment in hospital for his mental disorder; and*
> *(b) there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled to hospital for that purpose.*

The government predicted that they would be used for 200 to 400 patients a year but there were over 2000 CTOs in the first year and since then around 4000 per year. There is often pressure on community psychiatrist from inpatient services and from MHA Tribunals to accept patients on CTOs.

Dilemma

Two clients who were recently discharged on CTOs. I think they illustrate a lot about the social control function of psychiatry, and they are not atypical of the patients in our service.

Should we ignore the risk to the public, and simply try and do what is best for the patient? Or should we accept some role in social control, but maybe campaign for it to be more explicit, democratically instigated and better scrutinized.

Case 1:
A client who has episodes of psychosis characterized by religious thinking and paranoid ideas, recently set a fire in the house, putting
themselves and neighbors life at risk while being acutely unwell. I think that antipsychotic medication suppresses the symptoms, and then the client improves naturally. The client then usually stops medication, remains well for some time but then has another episode. Ongoing antipsychotic might plausibly prevent another episode- since it seems to improve her acute symptoms- but the client dislikes it intensely. They were discharged on a CTO (while not being completely stable, due to pressure on beds and client wishes). The client would rather stop medication and take the risk of another relapse, but there are neighbors to consider, and the client is difficult to engage while unwell, and becoming unwell.

Case 2:
A client who has a history of paranoid ideas, and possibly hallucinations, recently attacked a MH professional while paranoid, and has previous charges of criminal damage. The client had spent some time in prison, but was then transferred to hospital without any criminal justice system restrictions. The client was treated with antipsychotics, and the psychotic symptoms appear to have settled, but was reluctant to continue medication, and has a history of non-engagement with services, so was placed on a CTO. The client was acutely Parkinsonian (on a small dose of depot), and complaining that the medication made them sleep all day, and feel extremely depressed. Do we take the view that the client is dangerous and therefore has to put up with the side effects, or do we take a risk with public safety?

Background Thoughts

1. For me, the problem is not *coercion* in itself, but who controls this and according to what justification. There have always been 'awkward' people who cause problems for themselves and others. What happened in the asylum era was that these people were placed in institutions that eventually came to be run by psychiatry. In the 19th century (with minimal 'scientific' justification), psychiatry was given legal powers to make decisions about such people. These powers have come down to us over time and, in many ways, have been a corrupting influence on our discipline. We still practice in the shadow of the asylum every time we use the Mental Health Act.

2. I think we need to be clear that although some form of 'socialized coercion' might be needed to deal with 'awkward' people and the risks that they generate, there is no justification for psychiatry to have the power to control this. While there may be a medical dimension to some of the problems, there is no real reason why one professional group, with a set of dubious theories and treatments, should be the only ones with decision-making powers.

3. Most of the situations in which coercion is seen as necessary are complex and multi-dimensional involving ethical dilemmas, hermeneutic challenges and practical difficulties. There may be a technical/medical aspect but this is often not of great importance. However, there is a constant push to 'medicalize' such crises.

4. In arguing for a post-technological psychiatry, I am arguing that we should situate these ethical, hermeneutic and practical issues in the foreground. For me, critical psychiatry is about doing just this. It is the refusal to render problems of
values/meanings/relationship/economics/culture in the narrow biomedical idiom that is at the heart of the current technological paradigm.

5. The challenge for us is not to walk away from problems (even those where coercion might

be necessary) but to deconstruct the medical/technological framing of such situations and to push ourselves and others to find different, more democratic, more transparent, ways of framing and intervening.

6. I have no doubt that one implication of a move beyond the technical framing of mental health problems will be that service users are seen as being more responsible for themselves. While this might be seen as a disadvantage by some, I believe that most service users would welcome such a move. Unlike Szasz, I do not see this as a yes/no, black/white situation. There often is a medical dimension, even if not dominant, and a role for doctors to advise, investigate, treat. But I agree with him that the medical profession cannot justify its current primary role in the use of 'social coercion'.

7. I am not against the concept of 'mental illness' and the idea that, at times, people are 'unwell' and that this manifests in altered behavior. However, we need a different, more thoughtful notion of illness, one that does justice to the complex, multi dimensional nature of the 'mental' aspect of human life.

8. The traditional medical model was born in the asylum. It should have been replaced as mental health care moved out of the asylum and into the community. Tragically, this happened just at the moment Big Pharma was getting into gear. They, and their allies, have worked hard to prevent the development of an adequate discourse of mental health/illness. This is what we are struggling against.

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I think this is a helpful statement of the core argument in critical psychiatry. The daily problem is how much to compromise with the views of others while attempting to do what you say at point 5.

On which point, while we certainly have some dubious theories and treatments for awkward behavior, the criminal justice system seems to have some worse ones (and the benefits system has some confused underpinnings also), which is why in practice I'm reluctant to leave all management of such behavior to the police.

I would not accept that it is impossible to act with integrity while trying to mediate between the various imperfect systems we, and our patients, have to struggle with.

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I agree that our lives are shaped by compromise. The world of mental health is, by its very nature, messy. I take that as a fact. The technological (or modernist) dream is that if we can just get the science right, if we can just do more studies, organize more interventions and service models, give people more training etc, then we can turn this messy field of weeds into a neat and organized garden. To me, this is a dangerous agenda. Our world is a meadow, not a garden, and some of the weeds are beautiful!

But critical thought (questioning assumptions, histories, agendas and practices) is not just for psychiatry. All professionals who have powers to describe, classify and intervene in the lives of ordinary people need a critical dimension.

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Having fought my way through the wording of "Madness and Civilization", in English, I am comfortable with the fact that I operate (work, practice) in a context that I have little control over. Discourses that shape that context can be challenged, and competing discourses developed. As a result how "mental illness" is viewed and how institutional responses to "it" are formed and function will continue to change and evolve but the utopian view, that somewhere out there is a tidy solution and all we have to do is identify and implement it is, to my mind, naive.

I would share with Foucault that we have had provision for "the mad" throughout history because their presence amongst us is a reminder of how frail "sanity" and reason actually are. In one way or another "madness" has been banished or alienated from time immemorial. Identifying it as "illness to be treated by doctors and nurses" is but the contemporary metaphor.

A criticism of Szasz, however is that it doesn't feel right just chucking the despairing, anxious or the confused to the wolves, to be prosecuted if they break the law but left to fend for themselves otherwise. The physical presence of a disturbed person evokes strong, visceral feelings which demand a response … barely surprising in a species so socially attuned, and the compunction to "do something" generally means "do something to stop this spectacle hurting me". Result, historically, alienation and/or one form or another of incarceration, and currently, treat the distress so that it stops or goes away. Actually embracing disturbed, distressing or frightening people as fully signed up members of the human race is emotionally difficult and challenges what is meant by "human race".

There is precedent. The characteristic response to physical disability once generally included stigma and social marginalization. In a few weeks time we will have the para-olympics. The achievements of the disability rights movement … recognition, ramps, lifts and the rest are the result of at least a century's hard work … The Secret Garden was published in 1911.

When a problem in living is construed "illness to be treated" and the suffering marginalized or even coerced the "doctor" accepts and is handed responsibility for the outcome. Responsibility is power and of course it justifies salaries and status. Perhaps more importantly the same process disenfranchises others who might have a part to play in resolving the particular problems of living. It is interesting that a couple of the contributions to this thread have focused upon getting others involved in the "patients" difficulties to participate in efforts to resolve them. This tacitly acknowledges that "patients" can be considered troublesome as much for how others experience them, and the expectations others have or our collective ability and assumed responsibility to "do something", as they are for what they actually do. I like Rethink's recent slogan "My problem is schizophrenia, what's yours? It is time to rethink mental illness" carries an interesting message if read appropriately.

So, ditching the illness model only needs to be more coercive if there is no other channel for the imperative to "do something" when confronted with a distressed or anxiety provoking person. What the disability rights movement has been able to do is carve out social territory which accepts disability but which doesn't accept the sick role with its dominance of medical authority and assumptions of lost autonomy. What I find most helpful in practice is focusing primarily upon what is actually happening, as a set of human problems afflicting the "patient" and those around them … doing what wise physicians once taught me when I used to wear a white coat … seeing the problem in terms of disturbances of normal function rather than importing foreign (alien??) concepts. Bad things do happen, sadly. Children are abused and grow up impaired in their ability to relate to others, vulnerable people are exploited, tragic deaths and injuries do occur, and the rest. These take their toll upon people's ability to live quietly and tolerantly, and so conflict and social extrusion do happen. What we aren't very good at is accepting these inconvenient truths, and the implications they have for how we view the way we organize our world … and so we deny their contribution when things go socially wrong, and call it "illness to be treated".

Practicalities

The RMO can discharge a CTO by filling out the s23 form. I have done this several times because I felt that the reasoning about why the CTO would reduce risk was unclear. They were mostly rather low risk patients, though I did have one who was likely to assault when unwell- but he refused to leave hospital if he was put on a CTO, undermining the purpose rather neatly and ensuring it was not used! And another who said he would (and had) disregard the authority of the order, making it very unclear how it could really make a difference (given that he was not immediately recalled).

With your cases, you are suggesting a mechanism by which the CTO does possibly reduce risk to others. So it is the usual problem of balancing the risks and restriction of liberty. I do see that as part of psychiatrists' role, yes, just as it is in every public job from police to noise abatement officer or dog or traffic warden. It would be nice
if one could use Tribunals as a way of scrutinizing and democratizing that decision, but ultimately if you feel they are not carrying out that role properly it is up to you to discharge the CTO if you aren't happy with enforcing it.

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I agree that mental health services, like some other public services, are not simply there to serve patients, and that there is a duty to consider public safety and balance the interests of different parties. But how does this sit with our ethos of service user collaboration and involvement? Is it simply that there can be collaboration and choice but within tightly defined boundaries of acceptable behavior- and if so who defines those boundaries and on what criteria? Should there not be some more public and democratic way of doing this? Or are we arguing, as Szasz would, that service users should be able to behave in any way they chose with the criminal justice system dealing with all legal infractions and that services should only concern themselves with purely voluntary treatment.

Many if not all of my patients behave in ways that upset, disturb, sometimes threaten and almost always burden some other people and it feels like the majority of my job is trying to persuade and sometimes coerce people to behave in ways that are less troublesome to others. It is rare, among my patients at least – for people to turn round after recovery and say that they recognize the troublesome nature of their previous behavior. The emphasis on service user collaboration in some ways assumes that the only person involved is the user themselves- and this mirrors the medical or technological model that locates the problem within the individual not the system or society as a whole (although I recognize that in some ways this simply balances out their previous exclusion from consideration). If we accept that mental health care is part of a wider social response to some sorts of disturbing behavior, then maybe this means less collaboration not more!

I suppose what I am raising is that if you ditch the illness/medical/technological model of mental disturbance (and I know that not everyone on this list would wish to do so), maybe you are left with a service that looks more coercive not less so. I think that this is a dilemma for Critical Psychiatrists, since most of us, including myself, would wish to be less coercive.

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For me the starting point of this discussion is the capacity of the two individuals to take responsibility for their actions. If you believe they have sufficient understanding and judgment to take responsibility for their actions, they should be responsible for the consequences and able to make choices about treatment.

However if you believe their actions arose out of a distorted view of reality then they were not responsible for their actions. If they cannot appreciate that their actions occurred because of a distortion of reality then they cannot be competent to make a decision to accept or decline the treatment that you believe may reduce the likelihood of recurrence. This does not mean it SHOULD be coerced but rather the
decision to coerce is a best interest decision by you and others rather than an autonomous decision by the user.

However the scope of a best interest decision clearly is wider than simply the interests of the individual patient. We would not be quibbling about being agents of social control if the victim of the fire or the assault was their child or their elderly mother- we would be right in there making sure they were safe. Our duties to our patients may be central but they do not exclude duties to their relatives, neighbors and carers (even if it is a lesser duty).

It has been said that the object of any therapeutic intervention should be to maximize autonomy- to optimize a person's ability to lead the life they would wish to lead. My experience of CTOs is that they can offer a platform of stability upon which one can grow a therapeutic relationship and bring people to a point where they can make informed choices about medication, which, in some cases has been continuation and in others, cessation.

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I agree, but this makes decisions about capacity central, and potentially very contentious- as contentious, although I agree more transparent, than decisions about the presence or otherwise of mental illness. Whose 'reality' are we to go by, for example? Also, when different parties 'best interests' conflict, how are these conflicts to be resolved?

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There is no objective evidence so far about whether CTOs as used in the UK have any positive impact or not so most discussion so far is based on hunch and speculation.

I wanted to point out to people that there has been a multicenter randomized control trial of CTO versus standard care undertaken by the team in Oxford (it is called the Octet Trial). It will be interesting to see what it shows and it may help our reflections on when to coerce and when not to.

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These are issues we need to address as working critical psychiatrists. There are pressures to use CTOs. Many of us work in services where there is a separation between inpatient and community psychiatrists and the CTO will be instigated by the inpatient consultant and the community consultant can be under real pressure to comply.

I believe that the evidence for CTOs being effective either clinically or even as a means of social control is not that robust and so it needs to be looked at on a case by case basis as to whether the powers can be of benefit to the individual. I can't see how people can be coerced into 'recovery' so any benefits are either in terms of preventing distressing relapses or purely for social control.

I believe that the use of the MHA should be done in the least restrictive way so I expect anyone who is being considered for a CTO to have had a period of Assertive Outreach (for which we have a separate team) as well as some psychological input.

Regarding the cases above: If case 1 was transferred to my care on a CTO, I would keep it for a year and then review whether to continue with it - this decision would relate to the yearly CPA particularly engagement with the key worker. I would have told the patient this at the start. If there was a risky relapse and she went back on a CTO I'd follow the same process but I guess I'd be a bit more wary about discharge. Case 2 is different in that there are side effects, which means that we are harming the patient by our actions. In this case I would consider changing the medication to low dose oral neuroleptics but initially maintaining the CTO. If there were signs of relapse she could be recalled to hospital and given medication without having to be admitted. However it’s likely that this would lead to an admission so in reality the CTO isn't of great help as it would be easier to complete a section 2 or 3.

IV. UNITED STATES CONSTITUTIONAL RIGHTS WITH RESPECT TO INVOLUNTARY COMMITMENT

http://psychrights.org/Research/Legal/25AkLRev51Gottstein2008.pdf

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]

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.

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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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.

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 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 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
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 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 . . . . . Youache 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.

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 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 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 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]

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]

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 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 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 (thirtyfive 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) 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]

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 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 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 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:

> 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 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. 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 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]

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 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 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 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 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 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 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 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 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 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 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 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 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]

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 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 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 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 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 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.

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.

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 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-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]

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.

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 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 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?
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 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.

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.

References:

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

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. 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.

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 DSMIII 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).
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 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).

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.psychiatry online.org/cgi/content/full/49/4/524.
73. Jeffrey Mattes, *Risperidone: How Good is the Evidence for Efficacy?* 23 SCHIZOPHRENIA BULLETIN 155, 157 (1997).
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.
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).
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.
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).
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).
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).
118. ALASKA STAT. § 47.30.745(g) (2006).
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).

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.").
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).
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).
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).
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).
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.
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).
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.
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:
    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.

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.
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.
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).
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 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).
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.

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.
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.
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.

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).
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.

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).
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).
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).
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).
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).
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).
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.
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 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 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.
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.
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.

* 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.