IN THE SUPREME COURT OF THE STATE OF ALASKA

M.A., Appellant, v. Jennifer Winkelman, Timothy Ballard, and James Milburn, in their official capacities for the State of Alaska, Department of Corrections, Appellees.	)	Supreme Court No. **S-19453**

Trial Court Case No. **3AN-23-05725 CI**

APPEAL FROM THE SUPERIOR COURT
THIRD JUDICIAL DISTRICT AT ANCHORAGE
THE HONORABLE DANI CROSBY, JUDGE

BRIEF OF APPELLEES STATE OF ALASKA DOC OFFICIALS JENNIFER WINKELMAN, TIMOTHY BALLARD, AND JAMES MILBURN

STEPHEN J. COX
ATTORNEY GENERAL

/s/ Kimber Rodgers
Kimberly D. Rodgers (0605024)
Assistant Attorney General
Department of Law
1031 West Fourth Avenue, Suite 200
Anchorage, AK 99501
(907) 269-6612
kimber.rodgers@alaska.gov

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AUTHORITIES PRINCIPALLY RELIED UPON

ALASKA CONSTITUTION

Art. I, § 7. Due Process.

No person shall be deprived of life, liberty, or property, without due process of law.

ALASKA REGULATIONS

22 AAC 50.122. Involuntary administration of psychotropic medication.

(a) Except as provided in (b)–(d) of this section, unless treatment or medication has been ordered by a court a prisoner retains the right to informed consent and to refuse psychological or psychiatric treatment including the administration of psychotropic medication.

(b) If facility health care personnel diagnose a prisoner as being in imminent danger of harming himself or herself, or others, as a result of illness, and the prisoner has refused to make an informed consent for treatment, psychotropic medication may be involuntarily administered in accordance with procedures established by the commissioner, if the prisoner

> (1) has been evaluated by a physician who has reviewed pertinent records and information regarding the prisoner and has prescribed the psychotropic medication as part of a therapeutic medical treatment plan;
>
> (2) is apparently capable of, but refuses to give informed consent after being advised of the elements of informed consent;
>
> (3) has had less restrictive alternative forms of treatment such as soft restraints or housing in a restrictive setting applied, without satisfactory therapeutic result;
>
> (4) continues to manifest symptoms that indicate that treatment is necessary to prevent the prisoner from endangering himself or herself, or others; and
>
> (5) has been evaluated by a second physician who concurs in the involuntary administration of psychotropic medication.

(c) Notwithstanding (b) of this section, if, in the opinion of the facility physician, a prisoner presents such an immediate danger to himself or herself, or others, that the informed consent process under (a) of this section, or the informed consent review process under (b) of this section cannot be completed in a timely fashion, the prisoner

may be involuntarily administered psychotropic medication. The involuntary administration must be followed by

(1) a medical review as set out in (b) of this section within 72 hours after the emergency administration of medication; and

(2) regular and timely follow-up monitoring by the prescribing physician, incorporating safeguards consistent with prudent standards of medical care.

(d) If, in the opinion of facility health care personnel, a prisoner requires the administration of psychotropic medication as part of the therapeutic medical treatment plan but is not capable of giving informed consent, the following standards apply:

(1) emergency cases must be treated as set out in (c) of this section; and

(2) non-emergency cases must be considered for transfer to a psychiatric facility under 22 AAC 05.253 or referred to the Department of Law for assistance in seeking a court order for treatment.

PARTIES

Martin Adam, who is serving a life sentence in state prison, is the appellant.[1] The appellees are Jennifer Winkelman, commissioner of the Department of Corrections; Timothy Ballard, DOC's chief medical officer; and James Milburn, the superintendent of Spring Creek Correctional Center, where Adam was incarcerated for most of this case.

ISSUE PRESENTED

Whether due process requires a judicial hearing and a right to counsel before DOC may involuntarily medicate a mentally ill convict who is dangerous to himself or others.

INTRODUCTION

Whether due process is violated depends on the interests at stake and the value of proposed alternative procedures.[2] Here, due process does not require a judicial hearing before DOC may involuntarily medicate an inmate whose mental illness endangers himself and others. Instead, DOC's administrative hearing process strikes the right balance between the inmate's diminished (but still substantial) interest in refusing medication and the State's interest in treating him to reduce the long-term dangers he poses to himself and prison security. Like another state's procedures upheld as satisfying federal due process,[3] DOC's policy affords the inmate many ways to have his views on medication heard and creates a record sufficient for judicial review. This Court should conclude DOC's involuntary medication procedures satisfy due process.

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1 This is a pseudonym to protect the confidentiality of medical information.

2 *Bigley v. Alaska Psychiatric Inst.*, 208 P.3d 168, 181 (Alaska 2009).

3 *Washington v. Harper*, 494 U.S. 210 (1990).

STATEMENT OF THE CASE

I. Adam, who has schizoaffective disorder, has a history of cutting himself and assaulting others, declining to take psychotropic medications, and refusing to eat due to paranoid delusions.

Adam, who is serving a life sentence for murder, robbery, burglary, and two counts of theft, has schizoaffective disorder. [Exc. 127; Tr. 6, 23[4]] He has a long history of harming himself and others in prison and damaging prison property:

- **October 2000:** Adam hit a correctional officer in the chest and fought being handcuffed after the assault. [R. 886 (Exh. P at SOA 2580[5])]
- **2001-2008:** In 2001, Adam repeatedly tried to commit suicide. [R. 886 (Exh. P at SOA 2521, 2722–93)] Multiple times, he reopened wounds on his wrists and wrote on walls with his own blood, and a toothbrush whittled to make a shank was found in his cell. [R. 886 (Exh. P at SOA 2498, 2521, 2722–70)] He also climbed on the sink in his cell and dove off, landing on his head and shoulder and knocking himself out. [R. 886 (Exh. P at SOA 2793)] As part of these incidents, Adam flooded his cell multiple times, tampered with a smoke detector, and threatened staff. [R. 886 (Exh. P at SOA 2498, 2521, 2723–70)] Until about 2008, he continued to cut himself. [Exc. 11, 325]
- **2003-2013:** Over this decade, Adam had multiple write-ups for violence and was in and out of segregation, including for assaulting another inmate with a sock containing multiple locks in February 2011. [Tr. 10, 30; Exc. 15, 325] That assault resulted in his admission to the acute mental health unit and placement on suicide precautions. [Tr. 10, 30]
- **2016:** Adam complained that a correctional officer was harassing him, but another officer investigated, found no basis, and attributed his paranoia to his mental illness, referring him for treatment. [R. 886 (Exh. P at SOA 3148–52)] Later that same year, Adam required suicide precautions. [R. 886 (Exh. P at SOA at 3135); *see* Exc. 209–10]

As a result of this behavior, DOC admitted Adam for treatment to the acute mental health

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[4] Tr. refers to DOC's involuntary medication hearings, not the oral argument on the motion and cross-motion for summary judgment in superior court.

[5] Three exhibits cited in this brief—State's K, N, and P—are on a DVD at R. 886.

unit eight times over the 13 years before 2018. [Tr. 30, Exc. 11, *see* Exc. 325]

In about 2017, Adam began refusing to take psychotropic medication, and his condition deteriorated. [Exc. 128, 207] He complained of stomach pain, diarrhea, and lethargy, and he blamed the medication, but medical staff attributed his symptoms to a viral illness and an antibiotic. [Exc. 208, 212] A few months later, staff noted that Adam did not believe medical staff and had fixed beliefs about his gastrointestinal issues. [Exc. 207] That same year, DOC put Adam in segregation twice after he reported feeling like he was going to explode and hurt someone. [R. 886 (Exh. P. at SOA 3467, 3510)]

By September 2018, Adam was having delusions and resisting medical care, claiming that staff had inserted microchips in his stomach and were trying to kill him. [Exc. 231, 324; R. 886 (Exh. K at 392, 401)] He avoided his bunk, believing that it would electrocute him, and would not shower. [Tr. 7] He stopped eating, lost 50 pounds in a few months, and became increasingly weak, spending so much time lying in one position that he developed an ulcer on his skin. [Tr. 7; R. 886 (Exh. K at 313, 345–402)] Adam was admitted to the acute mental health unit for the ninth time. [Tr. 30]

II. When Adam's hunger strike threatens his life, a DOC committee authorizes involuntary medication; he improves on medication, but his paranoia persists over the next several years.

Due to Adam's deterioration, his treating psychiatrist asked for non-emergency authorization to involuntarily administer psychotropic medication, and a three-member review committee granted the authorization in mid-October 2018. [Exc. 171, 225, 293] The committee found that Adam suffered from a mental illness, that involuntary medication was in his best interest for medical reasons, and that he was gravely disabled

and a danger to himself. [Exc. 225, *see* Exc. 28–35] Adam began to improve within days of starting to take Zyprexa and Celexa—eating more, becoming more physically active, and communicating with staff. [R. 886 (Exh. K. at 313, 319, 323–25, 329–34, 340)] DOC administered the medication via injections for a few days but then Adam began taking the pills when provided. [Exc. 290–91; R. 886 (Exh. K at 323–25, 333, 340)]

The policy in place at the time required six-month reviews to continue involuntary medication. [Exc. 35] A different committee with more members reviewed Adam's medications twice in both 2019 and 2020 and renewed the authorization.[6] [Exc. 294–97] The committee based the renewals on grave disability and danger to self, noting Adam's continued lack of insight into his mental illness and ongoing delusions. [Exc. 294–97]

Even with the consistent medication, Adam was paranoid and sometimes became agitated and threatening. [R. 886 (Exh. K at 272–81, 285, 297)] In December 2019, he was disciplined for fighting with another inmate. [*Id.* (Exh. K at 63), Tr. 29]

Around this same time, DOC tried to address Adam's complaints of stomach pain. [Exc. 226–30] Adam filed grievances claiming that the psychotropic medication was causing stomach pain.[7] [Exc. 226–30] But he also said that his stomach had microchips

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[6] The record contains no documentation about whether or not hearings were held. [*See* At. Br. 6 n.7, Exc. 189] But a DOC committee reviewed the authorization four times (every six months over these two years) and renewed it each time. [Exc. 294–97]

[7] The record does not include the full history of Adam's medical treatment because he agreed that whether the psychotropic drugs were causing side effects was irrelevant to the legal question at issue and the court permitted him to refile for summary judgment without mentioning an expert report so finding. [Exc. 318–19, At. Br. 18] This brief draws the facts only from the attachments to the summary judgment briefing.

[R. 886 (Exh. K at 301)], and routinely denied any side effects from the medication. [*Id.* (Exh. K at 249–52, 257, 260, 266, 270, 288, 294, 298)] Medical staff tried to persuade Adam that he had acid reflux and show him that his stomach did not have any metal objects by waving a metal-detecting wand over it, but he was unconvinced and declined to take acid reflux medication. [*Id.* (Exh. K at 301–02, 307)] On another occasion when he told his psychiatrist that the medication hurt his stomach, the psychiatrist decreased his dosage of Celexa and recommended taking it with food. [*Id.* (Exh. K at 308–10)]

In 2020, Adam challenged DOC's practice of involuntary medication by moving to enforce the *Cleary v. Smith* settlement agreement, which addresses prison conditions.[8] [R. 1361, 1372–76] Representing himself, Adam alleged that medicating him without his consent and a chance to challenge the basis violated the constitutions and other state laws. [R. 1372–76] Adam said he had side effects and had no way to challenge the medication because DOC's committee was not staffed and functioning. [R. 1373–75] He asked the superior court to order DOC to cease the involuntary medication of mentally ill inmates unless it established that an inmate was dangerous and provided for an appeal. [R. 1375] Ultimately, Adam got an attorney, who moved to sever his claim from *Cleary*. [R. 1177, 1258, 1269] The court granted that motion in April 2023. [R. 1177–79]

In the meantime, Adam's psychiatrist changed his medication. [Exc. 223] In March 2021, Adam refused to consent to bloodwork, which was needed so that he could safely take Zyprexa, and his psychiatrist requested authorization for involuntary blood

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[8] *See Smith v. Cleary*, 24 P.3d 1245, 1246–47 (Alaska 2001).

draws. [Exc. 302–03] The review committee denied the request and suggested a different medication, Abilify (aripiprazole), which was less likely to cause weight gain and metabolic changes that required monitoring with blood tests. [Exc. 223, *see* Tr. 27] The psychiatrist made the change. [Exc. 223] That year and the next, 2022, Adam repeatedly denied having any side effects from Abilify and Celexa (citalopram). [R. 886 (Exh. K at 182, 195, 208–09, 214, 217, 220–26, 229, 231–33, 238–39)]

In 2021, Adam refused treatment for hypertension after an elevated reading. [R. 886 (Exh. K at 1, 227, 246)] He rejected increased blood pressure checks, would not take medication, and did not want information on ways to reduce blood pressure. [R. 886 (Exh. K at 1, 227)] He distrusted staff and said he would lower his stress by skipping DOC activities. [*Id.*] After that, Adam did not allow staff to check his blood pressure for years. [Tr. 9, 13–14; R. 886 (Exh. K at 41, 43, 200, 411–13); Exc. 213–14]

III. Beginning in 2022, DOC reviews (and renews) the involuntary administration of Adam's medication by conducting hearings under a new policy.

In July 2022, DOC adopted a new involuntary medication policy.[9] [Exc. 37–51, 310–17] The policy authorizes DOC to involuntarily administer psychotropic

[9] Adam does not claim that applying the new policy to him is inconsistent with 22 AAC 05.122(d)(2), which requires court orders to medicate those "not capable of giving informed consent," so this appeal does not present that issue and this Court should not decide it. [*See* At. Br. 3–4] But even if 22 AAC 05.122(d)(2) applies, rather than the law used here (22 AAC 05.122(b) and the policy), section (d)(2) does not give Adam a right to counsel, leaving unresolved whether that is available or required. Plus, this Court should decide whether due process requires a pre-medication judicial hearing and a right to counsel because the superior court decided these issues, they are fully briefed, and without a contrary constitutional ruling, DOC could amend the regulation and apply the policy to all requests to authorize involuntary medication.

medications in an emergency for up to three consecutive or separate 72-hour periods, excluding weekends and holidays.[10] [Exc. 41–42] To continue involuntary administration beyond those periods, the policy requires three findings: (1) the inmate is at imminent risk of harming himself or others due to mental illness or at imminent risk of harm due to "grave disability"[11]; (2) the inmate "refused to make an informed consent for treatment"; and (3) less restrictive alternatives for treatment have failed. [Exc. 43]

Under the policy, the treating psychiatrist must request a hearing before an involuntary medication committee composed of three non-treating mental health professionals, including a psychiatrist.[12] [Exc. 40, 43–44, 310–11] Before the hearing, a third-party psychiatrist evaluates the inmate face to face to offer a second opinion.[13] [Exc. 44, 312–13] The inmate receives notice of the hearing at least 24 hours in advance, may attend and present evidence or remain silent, and may be assisted by a trained staff advisor. [Exc. 44–46, 314] The inmate may choose not to attend the hearing and may be excluded if his attendance "poses a substantial risk of harm to self and/or others" or he is

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10 Adam does not challenge these emergency provisions. [At. Br. 4 n.4, 7]

11 "Grave disability" is a "condition in which a person, as a result of mental illness" is "in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken" or will, "if not treated, suffer, or continue to suffer severe and abnormal . . . 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." [Exc. 39]

12 A non-treating professional is someone "who has not provided any service to the prisoner beyond routine coverage for another provider within the last month." [Exc. 40]

13 DOC contracts with outside psychiatrists to provide this opinion. [Exc. 39]

"so disruptive it is not possible to proceed." [Exc. 45–46] Moreover, among other rights, the policy permits the inmate to refuse all mental health treatment for 24 hours before the hearing (barring an emergency) and to be informed of the evidence relied on for the proposed involuntary treatment. [Exc. 45–46] The hearing is recorded. [Exc. 47, 49]

After the hearing, the committee deliberates and reaches a decision based on the hearing record and review of the inmate's medical records. [Exc. 48] The decision is by majority vote except that the committee may approve involuntary medication only if the committee psychiatrist votes in favor. [Exc. 48] The committee documents its decision in writing, including stating the inmate's appeal rights. [Exc. 48–49, 315]

The inmate may appeal an unfavorable decision in writing within 48 hours to a different committee, the Medical Advisory Committee. [Exc. 49, 316] This committee is composed of DOC medical professionals, including the chief medical and mental health officers, and selected collaborating and consulting doctors. [Exc. 40] Within five working days of an appeal, the committee must decide whether to uphold or reject the initial decision or, if required procedures were not followed, order a new hearing. [Exc. 49, 317] The inmate gets a copy of this decision. [Exc. 49–50, 316–17]

The authorization to administer medication involuntarily must be renewed every 180 days unless the treating psychiatrist discontinues the medication or the inmate begins to regularly and voluntarily take it. [Exc. 50–51] Subsequent renewal hearings follow the same procedure as the initial hearing. [Exc. 51]

In August 2022, Adam had his first hearing under the new policy.[14] [Tr. 4–20] At Adam's regular appointment about a week before, the treating psychiatrist, Dr. Dwight Stallman, documented "[s]ome generalized paranoia," observing that "tends to be [Adam's] baseline." [Exc. 326, 329] Although Adam reported doing well with no side effects, he denied having a mental illness and would stop taking medication if he could. [Exc. 329] The psychiatrist noted that Adam would not allow staff to check his weight or treat his hypertension. [Exc. 326] Due to Adam's lack of insight and history of grave disability, Dr. Stallman asked for authorization for involuntary medication. [Exc. 330]

As the policy required, a third-party psychiatrist, Dr. William Worrall, provided a second opinion. [Exc. 331–34] At the evaluation, Adam was minimally cooperative. [Exc. 331] He asked to talk to his lawyer and initially refused to discuss whether he had side effects or why he did not want to take the medication. [Exc. 332] Later, Adam stated that he did not want the medication because he did not have a mental illness and it was inconvenient, complaining about having to wake up early and miss activities while waiting in the medication line. [Exc. 332] Adam also distrusted and had paranoid beliefs about DOC staff. [Exc. 332–33] Dr. Worrall recommended that the committee continue to authorize the involuntary medication because Adam would become more delusional,

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[14] The record lacks documentation of DOC's review of the involuntary medication in the preceding year and a half (since the March 2021 denial of forced blood draws [Exc. 223]), but apparently no injections were needed in this period. [R. 886 (Exh. K at 195, 199, 201, 205, 208–09, 214–23); Exc. 223–24; Tr. 6; *see* Exc. 35 (former policy, stating that absent another review hearing, "a prisoner may not be involuntarily administered psychotropic medication after a six-month period has expired")]

unstable, and threatening to others otherwise, and he did not appreciate the nature of his illness or the risk of harm. [Exc. 333] Reviewing Adam's records, Dr. Worrall noted Adam's history of cutting himself and the 2011 assault. [Exc. 332–33]

Two days before the hearing, Adam's staff advisor gave him formal notice. [Exc. 222] At the start of the hearing, the committee chair told Adam he could ask questions or make a statement at the end. [Tr. 5] The three-member committee heard from Dr. Stallman, two other providers, Adam's staff advisor, and Adam. [Tr. 4–17]

Dr. Stallman recommended that the involuntary medication authorization continue because the benefits outweighed the risk of side effects, and Adam would stop his medications, decompensate, and become gravely disabled otherwise. [Tr. 8] Dr. Stallman reported that Adam was tolerating Abilify (aripiprazole) and Celexa (citalopram) well and had not complained of side effects. [Tr. 6, 9] He said that Adam had no insight into his mental illness, did not believe he needed medication, and would stop taking it if allowed to do so. [Tr. 6] Dr. Stallman explained that when Adam was last off medication in 2018, he had delusions that staff was trying to poison him and that his bed was electrified. [Tr. 7] He spent almost all his time on the floor, would not eat or shower, lost 50 pounds, and became very weak. [Tr. 7] Dr. Stallman said if involuntary medication had not been authorized then, Adam "may have in fact died, because he was very, very debilitated." [Tr. 7] Even on medication, Adam continued to be distrustful of medical staff and minimally cooperative, refusing routine health checks. [Tr. 6–8]

Mental health clinician Tiffany Hendricks Becker agreed with Dr. Stallman's recommendation. [Tr. 9–12, Exc. 335–43] She described Adam's history as "a well-

defined recurrent pattern of aggressive and assaultive behaviors" before he was on involuntary medication. [Tr. 10] For a decade, he was in and out of segregation for violence, including the 2011 assault that she attributed to his mental illness. [Tr. 10] She said the "dramatic drop in security incidents" since then showed that the medication helped. [Tr. 10] Without it, she said, Adam "displays increased paranoia and delusions, resulting in both the neglect of his [activities of daily living] and hostility" toward others. [Tr. 10] Becker identified and rejected segregation as an alternative because prolonged segregation "could be considered more restrictive than taking psychiatric medications," particularly when Adam had not reported side effects. [Tr. 11] She echoed Dr. Stallman's views about Adam's lack of insight into his needs and distrust of staff. [Tr. 9, 11–12]

Adam's staff advisor reported that he had not had any disciplinary action since 2019 and he was pleasant but did not say much to her. [Tr. 15] At his request, she looked into whether his attorney could attend the hearing, which was denied. [Tr. 14]

Adam did not want to make a statement without his lawyer but agreed to answer questions. [Tr. 15] He said that if the authorization ended, he would stop taking the medication because he did not want it and did not have a mental illness. [Tr. 16] The chair then told Adam that the committee would go off record to deliberate and that he could appeal an unfavorable decision. [Tr. 16–17]

After Adam left, the committee went back on record to read the report and recommendations of Dr. Worrall, the third-party psychiatrist. [Tr. 17–20] Dr. Worrall did not attend the hearing, and his opinion did not provide any new information about Adam's need for involuntary medication beyond what the committee had already heard.

[Tr. 17–20] Dr. Worrall's recommendations differed from Dr. Stallman's by suggesting changes to the dosage and type of psychotropic medications to try to reduce Adam's psychosis and resistance to medical treatment. [Tr. 19–20]

The committee authorized continuing involuntary medication because Adam was a danger to others without it. [Exc. 305] The committee relied on the testimony that Adam would discontinue the medication if given the choice and decompensate, resulting in threatening and assaultive behavior and weight loss. [Exc. 305]

Adam appealed. [Exc. 220–21] He contended that the decision failed to address his changed circumstances—that he had no current reports of violence. [Exc. 220–21] He also objected to his attorney's absence from the hearing and repeated that he did not want to take the medication without explaining why. [Exc. 220–21]

In September 2022, an eight-member appellate committee upheld the authorization based on Adam's risk of harm to others when off medication, as documented by his history. [Exc. 298] The committee also noted his history of refusing to eat due to his mental illness when not taking his medication. [Exc. 298]

Over the next eight months, Adam reported doing well and not having any side effects. [R. 886 (Exh. K at 36–41, 44, 113, 119, 126, 132, 138, 150)] In December, he moved to the general prison population. [R. 886 (Exh. K at 44)] His appetite, sleep, and energy levels were good. [R. 886 (Exh. K at 36, 113, 132, 150)] In April, he said he was enjoying participating in a club. [R. 886 (Exh. K at 37)] But he continued to distrust and act hostile toward medical staff. [R. 886 (Exh. K at 40–41, 44, 46–48)]

IV. Adam sues, alleging that the policy violates procedural due process, while DOC follows the policy a second time to authorize his involuntary medication.

In March 2023, Adam filed an amended complaint seeking a declaratory judgment in his newly opened case severed from *Cleary*. [Exc. 1–26, *see* R. 1179] The complaint, which was brought against three DOC officials in their official capacities, narrowed his allegations to one count—that DOC violated his state procedural due process rights because the policy did not provide for a judicial hearing and a right to counsel. [Exc. 4, 18–23] Adam asked the court to strike the policy and require a judicial hearing with a right to counsel before any further involuntary medication. [Exc. 23–24]

While Adam's suit was pending, DOC held three more involuntary medication hearings in 2023 and 2024. [Tr. 21–70] Adam's staff advisor gave him formal notice of the hearings three days or more in advance, met with him beforehand, and attended the hearings.[15] [Exc. 304, 351, 358–59; Tr. 23–24, 41, 60–61] At each hearing, Dr. Gerardo Olivera, Adam's new treating psychiatrist, recommended the involuntary administration of Adam's currently prescribed medications. [Tr. 25–27, 42–43, 62–63]

For the May 2023 review, Dr. Stallman, who had not been Adam's treating psychiatrist for more than six months, evaluated him as the third-party psychiatrist. [Exc. 344–45; R. 886 (Exh. K at 144, 150)] Dr. Stallman summarized Adam's history, including his delusions resulting in a hunger strike when he was last off his medication, earlier incidents of cutting himself and requiring suicide precautions, and his ongoing

[15] One hearing did not proceed as originally scheduled, and Adam received a second, updated notice of that hearing a day before. [Tr. 41; Exc. 204, 351]

paranoia on medication resulting in refusals of vitals checks and blood work. [Exc. 344] Dr. Stallman stated that Adam's insight into his illness and need for medication was poor. [Exc. 344–45] He recommended that the authorization continue so that Adam would keep taking medication and his "reasonable functioning in corrections" would continue. [Exc. 345] Without medication, Dr. Stallman stated: "[I]nmate would decompensate and become a danger to himself due to self-harm and/or neglect of food and fluid intake as he did in the past and become a great danger to his health." [Exc. 345]

During the hearing, Dr. Olivera recommended that Adam remain on Abilify (aripiprazole) and Celexa (citalopram) and said he would not take the medication if given the choice. [Tr. 25–27] He explained that Adam was "quite paranoid, suspicious, and guarded," "appear[ed] to be hearing voices," and did not believe he needed medication. [Tr. 25–26] Dr. Olivera stated that if Adam stopped the medication, he would present a risk of harm to himself and others because he was psychotic—a state in which he could "become aggressive and hurt somebody else or somebody else hurt him." [Tr. 26–27] Dr. Olivera also believed he could become gravely disabled. [Tr. 27]

Mental health clinician Becker said that without the authorization, Adam was likely to become gravely disabled and dangerous because he denied having a mental illness and would stop the medication. [Tr. 28–29] She based her opinion on Adam's hunger strike and history of assaultive behavior, including fighting in 2019 and attacking another inmate in 2011. [Tr. 29–30] Becker said Adam still displayed extreme distrust and paranoia with staff, refusing checks of his vitals and barely participating in groups, but since the 2018 medication authorization, Adam had not been admitted to the acute

mental health unit and was now in the general population. [Tr. 28–30, 32–33] Becker also said Adam had not reported any side effects at his monthly appointments. [Tr. 29, 33]

A nurse agreed with Becker's testimony about Adam's need for the medication and unwillingness to take it without an order. [Tr. 31–32]

During the hearing, the chair invited Adam to question witnesses, and Adam addressed the three-member committee.[16] [Tr. 27–28, 30, 32, 33] After Dr. Olivera spoke, Adam stated, "I don't hear voices. I never heard voices."[17] [Tr. 28] Adam also said he had completed most of the mental health programs but did not think he needed them. [Tr. 33] In response to questions, he said he did not have a mental illness, did not need to take psychotropic medication, and did not know why others believed that he had a mental illness requiring medication. [Tr. 33] He would not answer a question about his assaultive and paranoid behavior off medication, stating, "I have a case against this right now," and that his attorneys told him not to say anything. [Tr. 33–34]

The chair read Dr. Stallman's report into the record. [Tr. 34–35, Exc. 344–45]

The committee deliberated and re-authorized involuntary medication. [Tr. 37, Exc. 346] Although the order was based on the risk of harm to others, the findings encompassed Adam's risk of self-harm, including by becoming gravely disabled. [Exc. 346] The committee relied on Adam's history—the hunger strike and assaultive behavior—and his ongoing paranoia about medical care. [Exc. 346] In the committee's

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16 Adam apparently did not have help from his staff advisor because he refused to talk to him before the hearing. [Tr. 23]

17 In 2016, Adam admitted hearing voices but being in control of them. [Exc. 209]

view, this exemplified the risks if Adam was off medication. [Exc. 346] The committee found that the medication helped Adam, noting that he had not been admitted to the acute mental health unit since involuntary medication was first authorized in 2018. [Exc. 346]

Adam claimed that he filed an appeal by sliding the form under his probation officer's door, but DOC had no record of this appeal. [Exc. 134, 308] DOC later double-checked and did not locate an appeal in Adam's records, and the probation officer confirmed that he did not receive one. [Exc. 308]

At most of his mental health appointments over the next six months, Adam reported no side effects. [R. 886 (Exh. K at 71, 88, 93, 102); Exc. 213–14] In July 2023, he said the medication helped. [R. 886 (Exh. K at 93)] In September, he reported vomiting after his morning medication, but the issue did not continue, and when staff pressed for more information, he became hostile. [*Id.* (Exh. K at 25–28)] Also in September, a provider saw Adam making involuntary mouth movements, but Adam would not discuss it, denied it was a side effect, and declined screening for tardive dyskinesia, a potential side effect of psychotropic medication. [Exc. 213–14, 216]

That fall, Adam refused a recommended colonoscopy. [R. 886 (Exh. K at 23, 29, 32)] Adam said he would see only "his own doctor," apparently a provider who evaluated him for his lawsuit. [R. 45, 886 (Exh. K at 23, 29, 32)] Staff encouraged Adam to reconsider, pointing out that a provider outside of DOC would do the procedure. [R. 886 (Exh. K at 23)] But Adam still declined and waived treatment. [*Id.* (Exh. K at 22)]

V. DOC reviews and renews Adam's involuntary medication for the third time under the new policy.

DOC next reviewed and renewed the authorization to involuntarily medicate Adam in December 2023. [Tr. 40; Exc. 203, 205]

At the hearing, Dr. Olivera recommended that Adam remain on involuntary medication based on grave disability and danger to himself and others. [Tr. 42–43] Dr. Olivera stated, "He does have a extensive history of schizoaffective disorder and a need of medications at this time and indefinitely."[18] [R. 886 (Exh. N at 3:10–3:19)] He said Adam remained "quite delusional, suspicious, paranoid," and was guarded and evasive at his last appointment. [Tr. 42] Dr. Olivera observed Adam appearing to respond to internal stimuli, but Adam denied hearing voices. [Tr. 42] Dr. Olivera explained that Adam continued to have no insight into his needs. [Tr. 42] Adam was still taking the same medications, Abilify (aripiprazole) and Celexa (citalopram). [Tr. 57]

A mental health clinician, Kristopher Staples, reported that he, too, had observed Adam's paranoid, cagey behavior. [Tr. 44] As an example, Staples said that when he asked Adam about side effects from the medication, Adam referred him to his lawyer. [Tr. 44] While Staples acknowledged that this could be viewed as following legal advice, his opinion was that this response "seemed a bit paranoid." [Tr. 44] Staples agreed with the recommendation that Adam stay on involuntary medication for his own safety and the safety of others to prevent Adam from engaging in threatening or assaultive behavior or

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[18] This sentence was transcribed inaccurately, reading that Dr. Olivera said Adam "does have a sense of his schizoaffective disorder." [Tr. 42:13–14]

from missing social cues that could lead to a fight.[19] [Tr. 44–45]

The chair then read the third-party psychiatrist's report. [Tr. 47–56, Exc. 347–50] Dr. Worrall reviewed Adam's history, observing that he was "extremely paranoid of staff on and off medications, but gets much more upset about his paranoia when on less or no meds." [Exc. 347–48] At the evaluation, Adam was largely uncooperative and responded to questions by telling Dr. Worrall to ask his attorney. [Exc. 347, 349] Adam also denied having a mental illness, became irritated, and demanded to leave. [Exc. 349] Dr. Worrall saw mouth movements, but Adam declined screening for tardive dyskinesia. [Exc. 349]

Dr. Worrall concluded that if Adam stopped taking psychotropic medication, he would present a risk of harm to himself and others within weeks to months. [Exc. 349] He also concluded Adam was gravely disabled and did not appreciate the nature of his illness. [Exc. 349] Dr. Worrall recommended "more aggressive psychiatric management with the backing of an involuntary med order." [Exc. 350] He suggested placing Adam on a combination of clozapine and another antipsychotic medication because clozapine may work better at reducing Adam's paranoia. [Exc. 350] Dr. Worrall also said Adam's apparent tardive dyskinesia should improve on clozapine. [Exc. 350]

Dr. Olivera responded to Dr. Worrall's suggestion of medication changes. [Tr. 56]

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[19] Although Staples was incorrect that Adam went on involuntary medication in 2018 due to assaultive behavior, Adam was "in and out of segregation" for violence for over a decade before he was on involuntary medication, including attacking another inmate with a lock-filled sock in 2011. [Tr. 10, 45; Exc. 325; *see* At. Br. 14] Also, Adam was convicted of murder and robbery, and in prison, he assaulted an officer in 2000 and fought another inmate in 2019. [Tr. 23, 29; R. 886 (Exh. K at 63, Exh. P at SOA 2580)]

Dr. Olivera said Adam was stable enough on Abilify and Celexa, and might regress with changes. [Tr. 56] Dr. Olivera also explained that administering clozapine (Clozaril) and another antipsychotic medication would be difficult because of Adam's resistance to treatment and the need for weekly blood tests for patients on clozapine. [Tr. 56–57]

During the hearing, Adam had opportunities to address the committee. [Tr. 43, 46, 57] The chair asked Adam if he had questions after each witness and at the end of the hearing, the chair explained the next procedural steps and again asked Adam if he had questions. [Tr. 43, 46, 57] Each time, Adam responded "nope," and did not indicate that he wanted to make a statement. [Tr. 43, 57; R. 886 (Exh. N at 9:25–9:32)]

After deliberating, the three-member committee renewed the authorization on the grounds of grave disability and danger to others. [Exc. 203, 205[20]] The hearing testimony and Dr. Worrall's report supported these grounds. [Tr. 42–57, Exc. 347–50]

Adam appealed, stating that he wanted to be taken off the medication because it was not helping and he did not need it. [Exc. 299–300] He said he did not hear voices and did "not want your pills because they are hurting my stomach and intestines." [Exc. 300] Adam also complained that his attorney was excluded from the hearing. [Exc. 300]

In January 2024, an 11-member appellate committee considered Adam's appeal and upheld the involuntary medication authorization based on grave disability.[21]

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[20] The second page of the decision is out of order, appearing after the hearing notice.

[21] Adam is incorrect that this was the first time since the original authorization that DOC justified the decision based on grave disability. [At. Br. 15] The four 2019–20 reviews under the old policy based the order on "grave disability and danger to self." [Exc. 294–97] Moreover, although the August 2022 and May 2023 decisions under the

[Exc. 301] The committee found that the evidence was insufficient to support involuntary medication based on a danger to others. [Exc. 301] The committee also suggested that the mental health team try Dr. Worrall's approach. [Exc. 301]

Over the next four months, Dr. Olivera did not change Adam's medication. [R. 886 (Exh. K at 454); Tr. 59, 64] In March, Adam reported feeling better taking the medication but would not discuss his care any further without his lawyer. [R. 886 (Exh. K at 454)] In April, he was angry and wanted to leave an appointment, saying, "My lawyer told me not to speak with you because I should not take meds." [*Id.* (Exh. K at 447, 452)] At two other appointments, he reported no side effects. [*Id.* (Exh. K at 440, 461)]

Meanwhile, Adam was evaluated for chest pain that came on suddenly one day in February. [R. 886 (Exh. K at 419–23)] He reluctantly allowed DOC to take his blood pressure, which was high, and do an EKG, which was abnormal. [*Id.* (Exh. K at 420–21, 423)] Adam would not go to an emergency room. [*Id.* (Exh. K at 417–18, 420–21)] After this, however, he allowed staff to routinely check his blood pressure and in April, he agreed to take hypertension medication. [*Id.* (Exh. K at 410, 412–13)]

VI. DOC reviews and renews Adam's involuntary medication for a fourth time but discontinues medicating him after failing to timely consider his appeal.

In June 2024, mental health clinician Staples reviewed Adam's condition over the prior 90 days. [Exc. 354–57] He documented that Adam was stable without any recent outbursts. [Exc. 355] But Staples could not get "a read on" Adam's symptoms because he

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new policy were based on danger to others, they also relied on Adam's hunger strike and weight loss due to paranoia when he was off medication. [Exc. 298, 305, 346]

would not answer questions; Adam's engagement with treatment had plummeted in the last six months. [Exc. 355–56] He mostly refused to see mental health staff or when he did, he referred them to his lawyer. [Exc. 356] Staples could not tell whether Adam's resistance was due to legal strategy or paranoia induced by his mental illness. [Exc. 357]

That same month, DOC reviewed the medication authorization. [Tr. 59–70] At the hearing, the committee chair explained that Adam could ask witnesses questions and respond to the information they provided. [Tr. 61] During the hearing, the chair repeatedly invited Adam to ask questions or respond to witnesses. [Tr. 64–65, 68, 69]

Dr. Olivera said the involuntary medication authorization was needed so that Adam would not stop the medication, decompensate, and become dangerous due to his schizoaffective disorder. [Tr. 62–63] Dr. Olivera explained that Adam's insight into his mental illness and need for medication was very poor, and he was paranoid and evasive. [Tr. 62–63] Adam was taking Abilify (aripiprazole) and Celexa (citalopram). [Tr. 64]

Next, Adam spoke, blaming the medication for side effects: "[A]ccording to my lawyers and the doctor that they hired that examined me, these pills, these psychotropic pills are hurting my stomach and my intestines, and I have high blood pressure because of these pills. And I'm at high risk of cancer."[22] [Tr. 64] He refused to say anything more, stating, "You want to know anything else, talk to my lawyers." [Tr. 65, *see* Tr. 69]

Staples provided his assessment next, explaining that Adam was stable and had

[22] Whether DOC then possessed this undated report is unclear. Adam's attorneys attached it to a motion filed in court a month after the hearing. [R. 55, 606, 630, 951–54]

not had any recent write-ups. [Tr. 65] Staples agreed with Dr. Olivera's recommendation that the medication authorization should continue so that Adam's dangerous behaviors, including cutting himself and assaulting others, would not reoccur—an outcome that Staples believed was likely especially since Adam's paranoia was ongoing. [Tr. 65–67]

Dr. Aaron Edwards gave a second opinion, which was read into the record. [Tr. 68–69] Adam would not meet with the psychiatrist, so the evaluation was a review of the last seven months of Adam's medical records. [Tr. 68, Exc. 352, R. 886 (Exh. K at 409)] Dr. Edwards recommended that the involuntary medication authorization continue because Adam was paranoid and delusional with "extremely limited insight into his mental health condition and need for medication." [Tr. 69, Exc. 353]

The hearing committee agreed with Dr. Olivera and authorized involuntary medication based on Adam's danger to himself and others. [Exc. 307, 360] Staples's comments about Adam's history of cutting himself and assaulting others supported the finding. [Exc. 307, Tr. 65–67] The committee was not required to view as dispositive the appellate committee's January decision that the information from an earlier hearing was insufficient to support a danger-to-others finding. [*See* At. Br. 16, 36; Exc. 301]

Adam appealed one day later, but his appeal went missing. [Exc. 307, 309] Three months later, while compiling records for Adam's lawsuit, DOC's chief mental health officer found the unreviewed appeal in a former employee's email. [Exc. 309]

Because the appellate committee did not timely consider the appeal, DOC discontinued involuntary medication in early October 2024. [Exc. 49, 309] Adam stopped

taking psychotropic medication and Dr. Olivera did not request another hearing.[23] [R. 364–69] A few months later, DOC transferred Adam to a different prison. [Oral Argument Tr. 4–5] Adam says this was a lower security facility, implying that the transfer reduced his custody status. [At. Br. 17, 36–37] That is not the case. Albeit not in the record, Adam's custody status—medium—was unchanged.

VII. The superior court upholds DOC's involuntary medication policy as consistent with procedural due process.

Meanwhile, Adam's court case proceeded. In early 2023, the superior court granted his request for a medical examination to assess whether his medication caused or exacerbated ailments that he claimed he was experiencing, including stomach pain, chest tightness, and fatigue. [R. 309–10, 1180–81] In June 2023, Dr. Sriharsha Gowtham examined Adam and asked for further evaluation by a specialist before formulating his opinions. [R. 45, 262–63] In February 2024, the court authorized the additional tests. [R. 45, 54–55] Dr. Gowtham then finished his undated report. [R. 951–54]

In July 2024, Adam moved for summary judgment on his state due process claim. [R. 574–75] He argued that procedural due process requires a judicial hearing before DOC could involuntarily administer psychotropic medication to a mentally ill convict. [R. 629–30] Adam cited Dr. Gowtham's report to support his claim that the medication

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[23] Even if this appeal is moot, the Court should consider it under the public interest exception. [*See* At. Br. 37 n.70] The appeal meets all the exception's factors. The issue—the scope of the right to due process—is important to the public interest and the facts are likely to reoccur and become moot before the issue can be decided. *In re Hosp. of Naomi B.*, 435 P.3d 918, 927–29 (Alaska 2019) (categorically applying the exception to civilly committed patients' appeals of medication orders). In late November 2025, the hearing committee authorized involuntary medication for Adam again and his appeal is pending.

caused his gastrointestinal issues. [R. 586–87, 604–07]

The DOC officials sought more time to oppose summary judgment to depose Dr. Gowtham. [Exc. 318] DOC disputed that the medications caused or exacerbated Adam's other medical issues. [R. 155–60] In opposing Dr. Gowtham's earlier request for more tests, DOC's chief medical officer described other potential causes, tests already done to evaluate Adam's abdominal pain, and DOC's proposed treatment, including medication and a colonoscopy, which were declined by Adam. [R. 157–60]

Adam opposed DOC's extension, arguing that Dr. Gowtham's findings were not relevant to summary judgment on his due process claim, and the superior court allowed him to refile without relying on the report. [Exc. 318–19, 70–125] DOC opposed Adam's motion on the merits and cross-moved for summary judgment. [Exc. 233–89]

In April 2025, the superior court decided that DOC's policy satisfied due process and granted summary judgment to the DOC officials. [Exc. 187–200] Adam appeals.

STANDARDS OF REVIEW

The Court reviews summary judgment rulings and constitutional claims de novo.[24] The Court affirms a grant of summary judgment "if the record presents no genuine issue of material fact and if the movant is entitled to judgment as a matter of law."[25] The Court interprets the Alaska Constitution by "adopting the rule of law that is most persuasive in light of precedent, reason, and policy."[26]

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24 *Sitka Tribe of Alaska v. Dep't of Fish & Game*, 540 P.3d 893, 899 (Alaska 2023).

25 *Stefano v. State, Dep't of Corr.*, 539 P.3d 497, 501 n.12 (Alaska 2023).

26 *Bigley v. Alaska Psychiatric Inst.*, 208 P.3d 168, 178–79 (Alaska 2009).

ARGUMENT

Procedural due process does not require a pre-medication judicial hearing and right to counsel before involuntarily medicating a mentally ill convicted inmate.

"No person shall be deprived of life, liberty, or property, without due process of law."[27] In determining what process is due, the Court weighs three factors addressing the interests at stake and the value of the proposed procedures:

(1) "the private interest that will be affected by the official action;"

(2) "the risk of an erroneous deprivation of such interest through the procedures used and the probable value, if any, of additional or substitute procedural safeguards;" and

(3) "the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail."[28]

Here, as the superior court found, these factors do not require a judicial hearing with a right to counsel before a mentally ill convict may be involuntarily medicated. [Exc. 198] Instead, DOC's policy adequately safeguards convicts' interest in refusing psychotropic medication, taking into account their "greatly diminished liberty interest," the "extraordinary security risks" inherent in managing incarcerated criminals that bolsters the State's interests, the low risk of an erroneous deprivation, and the burdens of Adam's preferred process.[29] The Court should affirm the superior court's decision that DOC's involuntary medication policy satisfies procedural due process. [Exc. 187–200]

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[27] Alaska Const. art. I, § 7.

[28] *Bigley v. Alaska Psychiatric Inst.*, 208 P.3d 168, 181 (Alaska 2009) (quoting *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976)).

[29] *Myers v. Alaska Psychiatric Inst.*, 138 P.3d 238, 246 n.56 (Alaska 2006).

A. The State's interest in medicating mentally ill inmates is stronger and the inmates' liberty interest weaker than the interests involved in medicating civilly committed patients.

Adam relies heavily throughout his briefing on *Myers v. Alaska Psychiatric Institute*, but that case expressly noted the constitutional analysis would be different for prisons versus state psychiatric hospitals.[30] [At. Br. 24–29, 31–32, 43–47] *Myers* held that the Alaska Constitution requires judges to independently evaluate the rationale for the involuntary administration of psychotropic medication before the State may medicate a civilly committed patient.[31] But "[w]hat procedural due process may require under any particular set of circumstances depends on the nature of the governmental function involved and the private interest affected by the governmental action."[32] *Myers* expressly rejected the idea that the nature of the governmental function and private interests at stake are the same for mentally ill inmates and civilly committed patients.[33]

In evaluating whether a judge must conclude that psychotropic medication is in a non-consenting person's best interests before authorizing it, *Myers* distinguished the situation of mentally ill convicts from civilly committed patients.[34] Unlike psychiatric patients involuntarily held because of mental illness, convicts have "greatly diminished liberty interests" because they are incarcerated for committing crimes.[35] At the same

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30 *Id.*

31 *Id.* at 239.

32 *In re K.L.J.*, 813 P.2d 276, 278 (Alaska 1991).

33 138 P.3d at 246 n.56.

34 *Id.*

35 *Id.*

time, "the extraordinary security risks . . . greatly increase[] the strength of the government's administrative and institutional interests" in effectively treating inmates.[36] In fact, the *Myers* Court observed that the prison security risks may justify forcing an inmate to take medication even when he is competent to refuse.[37] In contrast, the State's interests for civilly committed patients were not as strong because the *Myers* Court rejected danger to self and others as a justification for involuntarily medicating them.[38] The Court held that the civil commitment itself already addressed that risk.[39] And psychiatric hospitals must honor the medication refusals of civilly committed patients who are competent.[40] For these reasons, *Myers* is not particularly helpful here.

DOC's policy is designed to address the security risks posed by unmedicated and mentally ill inmates as well as its obligation to provide them with medical treatment.[41] Unlike the standard for involuntarily medicating a civilly committed patient—a showing

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36 *Id.*; *see Washington v. Harper*, 494 U.S. 210, 225 (1990) ("There are few cases in which the State's interest in combating the danger posed by a person both to himself or others is greater than in the prison environment, which, by definition, is made up of persons with a demonstrated proclivity for antisocial criminal, and often violent, conduct." (citations and internal punctuation omitted)).

37 138 P.3d at 246 n.56 (citing *In re Qawi*, 81 P.3d 224, 232 (Cal. 2004)).

38 *Id.* at 248–49.

39 *Id.*

40 AS 47.30.839(g) (requiring a finding of incompetency for an involuntary medication order in cases of civilly committed patients).

41 AS 33.30.011(a)(4) (requiring DOC to provide necessary medical care, including psychological or psychiatric treatment); *see Harper*, 494 U.S. at 225–26 (recognizing a state's duties to ensure facility security as well as "to take reasonable measures for the prisoners' own safety" in making involuntary medication decisions).

of incompetency, best interests, and "no feasible less intrusive alternative"[42]—DOC's policy focuses on the threats that the inmate presents to his own well-being and prison security. [Exc. 43] The policy permits involuntary medication when an inmate is dangerous or gravely disabled due to mental illness, the inmate refuses medication, and less restrictive alternatives for treatment have failed.[43] [Exc. 43]

Adam's case amply demonstrates the State's need to involuntarily medicate mentally ill inmates who endanger themselves or others.[44] Before Adam was forced to take medication for his schizoaffective disorder, he cut his wrists and engaged in other suicidal behavior, committed assaults, and risked death with a hunger strike caused by his delusions. [Tr. 7, 10–11; Exc. 11, 324, 344] Aside from the obvious dangers to himself and others in the prison, these behaviors undermined facility security more generally. [Exc. 324–25] DOC, which is "best equipped to make difficult decisions regarding prison administration," manages security through the direct supervision model, which places officers in housing modules as much as possible to manage inmates and build rapport with them.[45] [Exc. 324–25] To address Adam's mental health crises, DOC had to redirect

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42 AS 47.30.839(g).

43 Adam challenges solely procedures, not these substantive standards.

44 *See Bigley v. Alaska Psychiatric Inst.*, 208 P.3d 168, 181 (Alaska 2009) (noting that one of due process factors is the State's interest, including the function involved).

45 *Harper*, 494 U.S. at 223–24; *see Valoaga v. State, Dep't of Corr.*, 563 P.3d 42, 48 (Alaska 2025) (recognizing "the importance of giving prison administrators wide-ranging deference in the adoption and execution of policies and practices that in their judgment are needed to preserve internal order . . . and to maintain institutional security." (internal punctuation and citations omitted)).

staff, leaving other housing modules more vulnerable to security risks. [Exc. 324–25]

Moreover, managing incarcerated criminals safely and in furtherance of their rehabilitation requires them to function reasonably well in prison.[46] [Exc. 324–25] Before being involuntarily medicated, Adam required admission to the acute mental health unit nine times and was segregated at times. [Tr. 10, 30; Exc. 325] Segregation and acute units require more intensive staff oversight; for example, staff must restrain and escort inmates housed there whenever they leave their cells and must deliver meals, medication, and mail to the cells. [Exc. 325] Moreover, such segregated inmates do not contribute to the facility's functioning or further their own rehabilitation by working or engaging in programming.[47] When Adam's mental illness was better controlled with medication, he was housed in the general population, worked prison jobs, and participated in activities. [Tr. 30; Exc. 228, 332] This benefited both Adam and prison security.

Adam's case also exemplifies the diminished liberty and privacy interests of convicted inmates.[48] Adam's freedom to live as he chooses is severely limited because he is serving a life sentence for his crimes. [Exc. 127, Tr. 23] Even though the involuntary administration of psychotropic medication is an added infringement,[49] the impact on

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46 *See* Alaska Const. art. I, § 12 (requiring criminal administration to be based in part on "the principle of reformation"); AS 33.30.011 (listing the duties of the Corrections commissioner); AS 33.30.191(a) ("It is the policy of the state that prisoners be productively employed for as many hours each day as feasible.").

47 *See* AS 33.30.191(a) (stating policy that prisoners should engage in work).

48 *See Bigley*, 208 P.3d at 181 (citing *Mathews* due process factors, 424 U.S. at 335).

49 *E.g., Myers*, 138 P.3d at 246; *Harper*, 494 U.S. at 229–30.

inmates' liberty interests is not as great as for someone outside of prison.[50] Adam and other inmates do not have the same rights as civilly committed patients to refuse psychotropic medication. Even if an inmate is competent to decline psychotropic medication or has expressed a desire to refuse such medications when competent in the past, he could still be required to take the medication if he is dangerous to himself or others without it and it serves his medical interests.[51]

The interests on both sides led the U.S. Supreme Court to conclude that another state's involuntary medication procedures—similar to DOC's—satisfied federal due process.[52] That decision, *Washington v. Harper*, is persuasive, and this Court should follow it.[53] *Harper* rejected requiring a pre-medication judicial hearing with "the full panoply of adversarial procedural protections," including a right to counsel for a convicted inmate.[54] Instead, Washington's administrative hearing process struck the right

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50 *See McGinnis v. Stevens*, 543 P.2d 1221, 1226 (Alaska 1975) (holding that an inmate in a major prison disciplinary proceeding "is not entitled to the full panoply of rights due an accused in a criminal proceedings" because "the inmate's liberty as a free citizen [is not] threatened by potential curtailment").

51 *Myers*, 138 P.3d at 246 n.56 (citing *Qawi*, 81 P.3d at 232); 22 AAC 05.122(a)–(b) (providing that prisoners may refuse psychological or psychiatric treatment, including psychotropic medication, only if they are not a danger to themselves or others due to mental illness); *see Harper*, 494 U.S. at 226–27 (rejecting that federal due process permits involuntary psychotropic medication only if an inmate is incompetent).

52 *Harper*, 494 U.S. at 215–16, 228–36 (applying *Mathews* test, 424 U.S. at 335).

53 *Id.*; *see Native Vill. of Kwinhagak v. DHSS, OCS*, 542 P.3d 1099, 1120, 1123 (Alaska 2024) (stating that a federal due process decision offered guidance for a state due process claim and ultimately agreeing with the federal decision in part).

54 494 U.S. at 218, 235–36; *see United States v. Loughner*, 672 F.3d 731, 754–56 (9th Cir. 2012) (extending *Harper* as a matter of federal due process to pretrial detainees requiring involuntary psychotropic medication due to dangerousness).

balance between inmates' substantial liberty interests in refusing psychotropic drugs and the state's interests in treating mentally ill inmates to reduce the dangers they pose to themselves and prison security.[55] Moreover, *Harper* concluded that "only by permitting persons connected with the institution" to make involuntary medication decisions through an administrative process (with an opportunity for later judicial review) are "courts . . . able to avoid 'unnecessary intrusion into either medical or correctional judgments.'"[56]

Adam argues that this Court should not follow *Harper* because the Alaska Constitution's guarantee of due process is often more protective than the federal constitution.[57] [At. Br. 30, 44–47] But the Court nevertheless may agree with and adopt federal due process decisions when interpreting the Alaska Constitution.[58] This is especially appropriate for procedural due process claims because the balancing test is identical under federal and state law.[59] In applying that test recently, the Court agreed with a U.S. Supreme Court decision to the extent that it held that a "court need not hold a

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55 *Harper*, 494 U.S. at 229, 236.

56 *Id.* at 235 (quoting *Vitek v. Jones*, 445 U.S. 480, 496 (1980) (holding the state could not transfer an inmate to a mental hospital without notice and a hearing)). Under Alaska law, inmates medicated under the DOC policy may appeal to court. *See Brandon v. State, Dep't of Corr.*, 938 P.2d 1029, 1031–32 (Alaska 1997).

57 Adam misleadingly suggests the Court interpreted the right to refuse psychotropic medication more expansively than the right under federal law in *Myers*, 138 P.3d at 245. [At. Br. 45–46] Although *Myers* stated the principle that the Alaska Constitution may be more protective, the only federal case it distinguished in evaluating a civilly committed patient's right to refuse medication was *Harper*, 494 U.S. at 210, and that was due to the prison context, not because state law is more expansive. 138 P.3d at 245, 246 n.56.

58 *Kwinhagak*, 542 P.3d at 1123; *see McGinnis*, 543 P.2d at 1227, 1236–37 (agreeing with federal analysis of due process for some aspects of prisoner disciplinary decisions).

59 *Bigley*, 208 P.3d at 181 (quoting *Mathews*, 424 U.S. at 335).

hearing *before* a child can be admitted to the hospital for psychiatric care."[60] And for some aspects of prisoner discipline, the Court held that "the Alaska Constitution affords an inmate of our penal system no greater protection than the [U.S.] Constitution."[61] Specifically, the Court agreed that Alaska's due process guarantee, like the federal clause, does not require a right to judicial review of all prison disciplinary decisions, does not set the standard of proof for discipline at "beyond a reasonable doubt," and does not mandate that prison staff cannot conduct hearings and make disciplinary decisions.[62] The Court should not reject *Harper* just because it is federal law.[63]

As *Harper* shows, due process is flexible and should apply in a way that suits the interests and governmental function at issue.[64] The intricate balancing of prison management concerns with convicted inmates' reduced liberty and privacy interests weighs in favor of the constitutional sufficiency of DOC's policy.

B. The risk of an erroneous deprivation of an inmate's right to refuse psychotropic medication is low under the DOC policy.

The DOC policy is sufficiently protective of a convicted inmate's right to refuse psychotropic medication, making the risk of a mistake low.[65] "The crux of due process is

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60 *Kwinhagak*, 542 P.3d at 1123 & n.123 (citing *Parham v. J.R.*, 442 U.S. 584, 620–21 (1979) (holding that federal due process did not require a judicial-type hearing at all for a child's admission to a psychiatric hospital, much less a pre-admission hearing)).

61 *McGinnis*, 543 P.2d at 1236–37 (citing *Wolff v. McDonnell*, 418 U.S. 539 (1974)).

62 *Id.*

63 494 U.S. at 210.

64 *Sarah A. v. State, DHSS, OCS*, 427 P.3d 771, 778 (Alaska 2018).

65 *See Bigley*, 208 P.3d at 181 (stating due process balancing test).

[having the] opportunity to be heard and the right to adequately represent one's interests."[66] Unlike *Myers*, where the state psychiatric hospital had no formal system of independent administrative review,[67] DOC's policy gives inmates an adequate opportunity to be heard in a pre-medication hearing and through appeals, and provides rights to notice, assistance, and participation that allow inmates to adequately represent their interests. [Exc. 43–51] This leads to well-supported decisions, resulting in a low risk of wrongful deprivations. That is all due process requires.

Harper found that Washington's procedures were adequate for federal due process,[68] and because DOC's policy is substantially the same, it should pass muster. [Exc. 43–51] Like DOC's policy, the Washington policy required a committee of three adjudicators, including a non-treating psychiatrist, to hold a hearing and find that a non-consenting inmate was mentally ill and gravely disabled or a risk to himself or others before the long-term administration of involuntary medication.[69] [Exc. 40, 43–45] The adjudicators' independence—they were not involved in the inmate's treatment at the time of the hearing—and the lack of any evidence of institutional bias affecting the decision-making was key.[70] Like DOC's policy, the Washington policy gave inmates the right (1) to a day's notice; (2) to attend the hearing, present evidence, and cross-examine

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66 *Sarah A. v. State, DHSS, OCS*, 427 P.3d 771, 778 (Alaska 2018).

67 138 P.3d 238, 251 (Alaska 2006).

68 494 U.S. 210, 215–16, 233–36 (1990).

69 *Id.* at 215–16.

70 *Id.* at 233–34.

witnesses; (3) to representation by a lay advisor trained in psychiatric issues; (4) to appeal an adverse decision internally; and (5) to periodic review.[71] [Exc. 45–46, 49–51] And like the law in Alaska, Washington law had ways to obtain judicial review of medication decisions.[72] *Harper* approved this as satisfying federal due process.[73] Following *Harper*, this Court should decide DOC's policy is sufficient for state due process.

Alaska's seminal decision on the due process required for major disciplinary proceedings also supports that DOC's medication policy is sufficient to protect inmates' liberty interests.[74] In disciplinary proceedings, an inmate "is not entitled to the full panoply of rights due an accused in a criminal proceedings" because there is no threat to the inmate's liberty as a free citizen.[75] But in major disciplinary cases, prisoners have rights to a day's notice of the hearing, to counsel when felony prosecution may result, to a staff advisor in complex cases or if the inmate is illiterate, to call witnesses and produce

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71 *Id.* at 216 & n.4.

72 *Id.* at 216; *Brandon v. State, Dep't of Corr.*, 938 P.2d 1029, 1031–32 (Alaska 1997) (allowing—even when not authorized by statute—superior court review of DOC decisions "where there is an alleged violation of fundamental constitutional rights in an adjudicative proceeding producing a record capable of review"); *Hertz v. Carothers*, 784 P.2d 659, 660 (Alaska 1990) (interpreting AS 22.10.020(d) as giving the superior court jurisdiction over administrative appeals when provided by common law); *State, Dep't of Corr. v. Kraus*, 759 P.2d 539, 540 (Alaska 1988) (preferring administrative appeals when available). If an administrative appeal is not available, inmates likely could sue for declaratory and injunctive relief under AS 22.10.020(g) to address alleged violations of their constitutional right to refuse psychotropic medication, like Adam did here. [Exc. 3]

73 494 U.S. at 236.

74 *McGinnis v. Stevens*, 543 P.2d 1221, 1236–37 (Alaska 1975).

75 *Id.* at 1226.

evidence subject to some limits, to cross-examine witnesses, to a recorded hearing, to get a written decision, and to appeal into court decisions that raise constitutional issues.[76] DOC's medication policy mirrors these rules, which satisfy due process.[77] [Exc. 45–50]

The practices of most other states also reflect a widespread judgment that a *Harper*-style process is adequate for inmates. Two-thirds of states and D.C. use a *Harper*-style process to involuntarily medicate dangerous mentally ill inmates.[78] And of the minority of states that require judicial hearings for medication instead, none appear to require that to comply with their state's due process clause. The California Court of Appeal case quoted by Adam required pre-medication judicial hearings for inmates as a matter of statutory interpretation, not state constitutional law.[79] [At. Br. 21 n.23, 42]

1. Shifting decision-making from medical professionals to judges would not reduce the risk of unwarranted medication.

Relying heavily on *Myers*, Adam argues a pre-medication judicial hearing is necessary for inmates because staff decision-makers cannot be sufficiently neutral and

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76 *Id.* at 1225–26, 1236, & n.45.

77 *Id.* at 1236–37; *see Brandon,* 938 P.2d at 1031–33 (right of appeal to court).

78 E. Fuller Torrey et al., *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey* (Apr. 2014) at 22 (stating that 31 states use a *Harper*-style process), https://www.tac.org/wp-content/uploads/2023/11/Treatment-Behind-Bars.pdf. Arkansas, which did not respond to Torrey's survey, does too. *Id.*; *Singleton v. Norris*, 992 S.W.2d 768, 769 (Ark. 1999). Maryland and D.C., two jurisdictions not included in Torrey's total because they require that mentally ill inmates transfer to a state psychiatric hospital, also use a *Harper*-style process to authorize involuntary medication for inmates once they are committed to the hospital. Torrey, at 22; *In re Taylor*, 241 A.3d 287, 296, 300–01 (D.C. 2020); *Allmond v. Dep't of Health & Mental Hygiene*, 141 A.3d 57, 60 (Md. 2016). Altogether that equals 34 U.S. jurisdictions—two-thirds of states and D.C.

79 *Keyhea v. Rushen*, 223 Cal. Rptr. 746, 747, 755–56 (Cal. App. 1986).

unbiased because of institutional pressures.[80] [At. Br. 27–32] But *Myers* tied its concern about institutional pressures to "the inherent risk of procedural unfairness that inevitably arises when a public treatment facility possesses *unreviewable power* to determine its own patients' best interests."[81] In *Myers*, there was no formal system for independent administrative review, and a statute did not allow courts to review doctors' decisions that involuntary psychotropic medication was in non-consenting patients' best interests.[82] In this case, DOC's providers do not have unchecked power to involuntarily administer psychotropic medication. DOC has a formal system for independent administrative review, including an outside psychiatrist's evaluation, and the superior court may review its final decisions on appeal.[83] [Exc. 43–51] *Myers* is not controlling or persuasive.

Concluding that DOC's administrative review is biased would call into question longstanding precedent allowing agency personnel to serve as adjudicators.[84] Although due process requires impartial tribunals, agency personnel "are presumed to be honest and impartial until a party shows actual bias or prejudgment."[85] The standard of actual

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80 *Myers*, 138 P.3d at 250–51.

81 *Id.* at 250 (emphasis added).

82 *Id.* at 244, 251.

83 *See Brandon*, 938 P.2d at 1031–32.

84 *Alaska Pub. Offs. Comm'n v. Not Tammie*, 482 P.3d 386, 389 (Alaska 2021); *Amerada Hess Pipeline Corp. v. Alaska Pub. Utils. Comm'n*, 711 P.2d 1170, 1180 (Alaska 1986); *McGinnis*, 543 P.2d at 1228.

85 *Griswold v. City of Homer*, 556 P.3d 252, 270 (Alaska 2024); *see Calvert v. State, Dep't of Labor & Workforce Dev., Emp't Sec. Div.*, 251 P.3d 990, 1006 (Alaska 2011) (proving bias requires showing the adjudicator "had a predisposition to find against a party" or "interfered with the orderly presentation of the evidence").

bias is demanding and not satisfied merely by affiliation with the agency involved in the hearing.[86] In prison disciplinary proceedings, for example, this Court held that the committee composition—DOC employees and sometimes inmates—did not evince a lack of neutrality violative of due process.[87] The same is true here. Due process does not require judges to make medication decisions, rather than committees of DOC medical professionals, out of concerns about institutional pressures.[88]

Showing actual bias requires evidence, not speculation.[89] Adam speculates that DOC staff have "a strong incentive" to sedate inmates out of convenience. [At. Br. 28–29] But the policy provides that medication is not to be used for that purpose. [Exc. 38] And the hearings and decisions in Adam's case show consideration of relevant factors.[90] [*See* Tr. 4–70; Exc. 305, 298, 346, 203, 205, 301, 307, 360, 309] Plus, Adam was less sedated when taking medication than when he was unmedicated, gravely disabled, and

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[86] *Calvert*, 251 P.3d at 1006 (calling standard "demanding"); *Not Tammie*, 482 P.3d at 389 (rejecting that commissioners were inherently biased by their agency affiliation, precluding them from acting as hearing officers in agency cases); *Amerada Hess Pipeline*, 711 P.2d at 1180 (merging investigative and executive duties with adjudication does not violate due process "if institutional safeguards exist against the abuse of unchecked administrative discretion" (citing *Withrow v. Larkin*, 421 U.S. 35, 52 (1975)).

[87] *McGinnis*, 543 P.2d at 1228.

[88] *See Harper*, 494 U.S. at 233 ("In the absence of record evidence to the contrary, we are not willing to presume that members of the staff lack the necessary independence to provide an inmate with a full and fair hearing.").

[89] *Griswold*, 556 P.3d at 271 (rejecting bias claim due to a lack of evidence that the adjudicator prejudged the case or disfavored party); *Calvert*, 251 P.3d at 1006–07 (same); *Harper*, 494 U.S. at 233 (requiring evidence in the record to show partiality).

[90] *See Harper*, 494 U.S. at 222 n.8 ("[W]e will not assume that physicians will prescribe these drugs for reasons unrelated to the medical needs of the patients; indeed the ethics of the medical profession are to the contrary.").

moving so little that he had bed sores. [Tr. 7; R. 886 (Exh. K at 313, 375)] Adam also asserts that DOC staff may take old incidents out of context, pointing to the reliance on a 2011 assault in his case. [*See* At. Br. 28 n.47] But the assault was tied to Adam's mental illness; it resulted in his admission to the acute mental health unit. [Tr. 10, 30]

Adam's concerns about DOC decisionmakers are unfounded because the policy provides adequate procedural safeguards against "the abuse of unchecked administrative discretion."[91] [Exc. 37–51] These safeguards include:

- The treating psychiatrist must request authorization for involuntary medication, has an ethical duty to act in his patient's medical interests, and explains the need for involuntary medication.[92] [Exc. 43–44; Tr. 5–9, 25–27, 42–43, 56–57, 62–64]
- A psychiatrist outside DOC gives a second opinion after a face-to-face evaluation with the inmate. [Exc. 44] In Adam's case, the third-party psychiatrist's treatment recommendations sometimes differed from the treating psychiatrist's. [Exc. 350; Tr. 6, 19–20, 56–57]
- Hearings are recorded, helping ensure fairness.[93] [Exc. 47]
- At least three medical professionals—more if there is an internal appeal—decide whether to authorize the request. [Exc. 40, 44, 49] In Adam's case, they did not always agree with the treating provider and hearing committee. [Exc. 301; *see* Exc. 203, Tr. 43] And when DOC failed to timely consider a lost appeal, it promptly took Adam off the medication to correct the prejudicial error. [Exc. 309]
- An inmate may appeal a final administrative decision that raises constitutional issues into superior court.[94]

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91 *Amerada Hess Pipeline*, 711 P.2d at 1180.

92 *See Harper*, 494 U.S. at 222 n.8.

93 *McGinnis*, 543 P.2d at 1236 ("[T]he requirement of a verbatim record will help insure that administrators . . . will act fairly.").

94 *Brandon*, 938 P.2d at 1031–32.

In fact, as the Supreme Court recognized in *Harper*, a system of robust agency decision-making may be better than a judicial hearing at reducing the risk of unwarranted medication.[95] *Harper* observed that states could reasonably conclude "that a judicial hearing will not be as effective, as continuous, or as probing as administrative review using medical decisionmakers," who have the benefit of frequent and ongoing clinical observation to evaluate mentally ill inmates.[96] Here, DOC medical professionals are best positioned to assess the inmate's ongoing condition and functioning, the medication benefits and risks, and the risks he poses to prison security and himself.[97] This is a factual and medical determination that psychiatrists are as capable of addressing as judges.[98]

Adam is also wrong that due process requires only courts to make involuntary medication decisions because they implicate the constitutional right to refuse medication and interpreting the Alaska Constitution is the purview of the courts. [At. Br. 31–33] Even though agencies do not have jurisdiction to decide constitutional issues,[99] courts do not claim exclusive jurisdiction over any and every case that may raise such issues. For

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95 494 U.S. at 231–33.

96 *Id.* at 232–33; *see McGinnis*, 543 P.2d at 1228 ("Insofar as knowledge of the conditions of the prison environment is important to an understanding of the significance of events which occur therein, prison officials and offenders theoretically comprise an ideal disciplinary hearing committee.").

97 *Harper*, 494 U.S. at 233 ("The risks associated with antipsychotic drugs are for the most part medical ones, best assessed by medical professionals.").

98 *See United States v. Loughner*, 672 F.3d 731, 758 (9th Cir. 2012) ("When an inmate is involuntarily medicated because he is a danger to himself or others, he is being treated for reasons that are in his and the institution's best interests; the concern is primarily penological and medical, and only secondarily legal.").

99 *Alaska Pub. Int. Rsch. Grp. v. State*, 167 P.3d 27, 36 (Alaska 2007).

example, DOC may make disciplinary decisions through an administrative process even though those decisions may implicate liberty interests.[100] And a party challenging an administrative agency's action ordinarily must pursue available administrative remedies before suing in court.[101] Even if a claim raises solely constitutional issues, a court may require exhaustion of administrative remedies to provide "a factual context within which to review a case."[102] Here, the facts are essential to deciding whether an involuntary medication decision violates an inmate's constitutional right to refuse medication.

What is crucial is the opportunity for judicial review on constitutional issues. Depending on the interests and governmental function involved, it does not offend due process if that judicial review comes *after* a treatment, medication, or disciplinary decision is made.[103] Adams relies heavily on *Myers* to support his argument that constitutional claims require pre-medication judicial hearings, but that case should be limited to its facts.[104] [At. Br. 31–32] Recall that the statute in *Myers* did not allow *any* judicial review of decisions that involuntary psychotropic medication was in patients'

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100 *McGinnis*, 543 P.2d at 1227–28, 1235–36 & n.45.

101 *Nunamta Aulukestai v. State, Dep't of Nat. Res.*, 351 P.3d 1041, 1053 (Alaska 2015) (stating that the rule's purpose is to allow an agency "to perform functions within its special competence—to make a factual record, to apply its expertise, and to correct its own errors so as to moot judicial controversies").

102 *Id.*; *cf. Walker v. State, Dep't of Corr.*, 421 P.3d 74, 81 (Alaska 2018) (holding that an inmate did not forfeit a due process issue he raised at his disciplinary hearing but not on appeal internally to DOC, and not deciding whether issue exhaustion would apply to an inmate who failed to raise the issue altogether in the administrative process).

103 *Native Vill. of Kwinhagak v. DHSS, OCS*, 542 P.3d 1099, 1122–23; *Harper*, 494 U.S. at 235; *Kraus*, 759 P.2d at 540 (citing *McGinnis*, 543 P.2d at 1236 n.45).

104 138 P.3d at 250–51.

best interests.[105] Here, the DOC policy does not intrude on courts' prerogative to decide constitutional claims because judges may review DOC's decisions.[106]

For these reasons, the risk of authorizing unwarranted medication under the DOC policy is low, and a pre-medication judicial hearing would provide little to no value.

2. The right to counsel would make medical decisions more adversarial with little benefit to accurate decision-making.

Adam argues that due process also requires a right to counsel for involuntary medication proceedings because of the liberty interest at stake and the need for an inmate, alleged to be seriously mentally ill, to have assistance understanding and presenting their case. [At. Br. 47–48] But inmates have the assistance of a trained staff advisor, who must have knowledge of the psychiatric issues, and involving attorneys in the process would make the decision-making process more adversarial with little benefit. [Exc. 44–46]

Given the medical nature of the decision, *Harper* decided that offering an inmate the help of a lay advisor with knowledge of psychiatric issues was sufficient to satisfy due process.[107] "[I]t is less than crystal clear why *lawyers* must be available to identify possible errors in *medical* judgment."[108] The same is true here, particularly where inmates

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105 *Id.* at 244.

106 *Brandon*, 938 P.2d at 1031–32.

107 494 U.S. 210, 236 (1990). Only four U.S. Supreme Court justices, not a majority, agreed with Adam's quoted *Vitek v. Jones* language [At. Br. 48], which concluded that a right to counsel was required in an administrative hearing held before transferring an inmate to a psychiatric hospital. 445 U.S. 480, 496–97 (1980). A fifth justice rejected that a right to counsel was required, and the other four declined to reach the merits based on mootness and/or ripeness. *Id.* at 497–506.

108 *Harper*, 494 U.S. at 236; *Loughner*, 672 F.3d at 757 ("The decision to medicate

have many ways to communicate their views on medication, and the hearing is informal. Inmates may discuss concerns with the treating psychiatrist or other mental health staff at regular appointments, the outside evaluating psychiatrist when a hearing is requested, and their staff advisor, who helps the inmate prepare and present his views at the hearing and on appeal internally. [Exc. 43–46, 49; *see, e.g.,* Exc. 326–45, 347–50, 352–57] At the hearing, inmates may question witnesses and address the committee, and formal rules of evidence and procedure do not apply. [Exc. 45–47, *see* Tr. 3–70] The provision of a trained staff advisor satisfies due process in this situation.

In fact, lawyers would raise the level of confrontation between inmates and their treating providers, harming ongoing medical relationships and adding little benefit to ascertaining whether involuntary medication is necessary.[109] This is evident from Adam's case. The fact that he had a pending lawsuit about involuntary medication worsened his distrust of DOC staff such that he became increasingly difficult for staff and the outside psychiatrist to evaluate. [Exc. 349, 352, 355–56] Because Adam did not discuss side effects with the providers or raise the issue at a hearing until June 2024, the testifying providers, third-party psychiatrist, and hearing committee did not know that Adam believed the medication was causing persistent gastrointestinal side effects and could not

involuntarily based on dangerousness grounds is a quintessential medical judgment.").

[109] *See McGinnis*, 543 P.2d at 1227, 1231–35 (stating that "adversary proceedings typical of the criminal trial" would "very likely raise the level of confrontation between staff and inmate" in disciplinary cases, and rejecting a right to counsel unless the inmate is charged with felony-level misconduct, which would implicate the constitutional right to avoid self-incrimination in a criminal case).

consider that in their decision-making.[110] [*See* supra pp. 9–23]

For these reasons, the value of requiring counsel for inmates at involuntary medication hearings is low.[111]

3. Harmless or corrected flaws in DOC's proceedings do not support the conclusion that pre-medication judicial hearings are necessary.

Adam argues that flaws in his hearings show that DOC cannot be trusted to follow procedures that adequately safeguard constitutional rights. [At. Br. 33–37] But Adam's argument does not undermine the constitutionality of DOC's policy. Mistakes in one individual's case are not a reason to shift the initial decision-making to judges. Trial courts are not perfect, either. And this Court disregards as harmless any error that "does not affect the substantial rights of the parties," acting "only when the result is otherwise 'inconsistent with substantial justice.'"[112] The availability of judicial review is sufficient to correct prejudicial errors and provide guidance to DOC. At worst, Adam points out harmless or corrected errors—scant support for the claim that DOC's process has too

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110 In a December 2023 appeal, Adam said that the medication hurt his stomach, but he had not said that or anything else at the earlier hearing. [Exc. 300; Tr. 43, 46, 57]

111 Adam has not filed a 601 appeal of any medication decision, nor alleged that the lack of an attorney prevents him from doing so; thus, whether he would have a right to counsel for such an appeal is not ripe and DOC does not concede this issue by failing to brief it here. *Eng v. State, Dep't of Pub. Safety*, 557 P.3d 1198, 1206 (Alaska 2021); AS 22.10.020(g) (requiring "actual controversy" for a declaratory judgment).

112 *In re Hosp. of Rabi R.*, 468 P.3d 721, 732 (Alaska 2020) (quoting Civil Rule 61); *see Simmons v. State, Dep't of Corr.*, 426 P.3d 1011, 1020–21 (Alaska 2018) (holding that the failure to provide an inmate with counsel was harmless when the facts were undisputed); *Brandon v. State, Dep't of Corr.*, 73 P.3d 1230, 1235–36 (Alaska 2003) (holding that DOC's error of using a single adjudicator, rather than a committee, in violation of a regulation was harmless because the inmate did not dispute the facts).

high a risk of unwarranted medication.

The sole time a prejudicial error occurred, DOC promptly corrected it. Adam appealed the June 2024 decision authorizing involuntary medication, but the appellate committee did not consider his appeal within five working days as the policy requires. [Exc. 49, 307, 309] When DOC found the appeal in a former employee's email a few months later, DOC immediately discontinued the authorization for involuntary medication and Adam stopped taking it. [Exc. 309, R. 369] Adam was still not taking any psychotropic medication four months later.[113] [Oral Argument Tr. 4–5]

Adam does not explain how any of the other purported errors he points out prejudiced the outcome of the hearings held in 2022 through 2024.[114] Adam knew what the facts were and largely did not dispute them. He consistently denied that he had a mental illness, believed that he did not need medication, and did not report side effects.[115]

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[113] Contrary to Adam's position, the Court should not draw the inference that because Adam was not immediately put back on involuntary medication, the earlier medication was unwarranted. [At. Br. 36–37] The record has no facts about Adam's mental health after this discontinuation of psychotropic medication. But in late November 2025, the hearing committee authorized involuntary medication again; Adam's appeal is pending.

[114] Any arguments about deficiencies in DOC's process before July 2022 are moot because DOC implemented a new policy that month. [Exc. 37] *Young v. State*, 502 P.3d 964, 969 (Alaska 2022) (stating that "[m]ootness is particularly important in a case seeking a declaratory judgment" because of the "added risk that the party is seeking an advisory opinion"). Nevertheless, Adam overstates the extent of the pre-2022 defects—DOC reviewed the authorization four times from 2019 through 2020 before an apparent gap in 2021. [Exc. 294–97; *see supra* p. 4 note 6, p. 9 note 14]

[115] There were three exceptions to Adam's usual denial of side effects. In September 2023, he reported vomiting after his morning medication, but the issue quickly resolved. [R. 886 (Exh. K at 25–28)] In his December 2023 appeal, but not at the hearing or to medical staff, he said the pills were "hurting my stomach and intestines." [Exc. 300] And finally, at the June 2024 hearing, Adam complained of gastrointestinal side effects;

[*E.g.,* Tr. 6, 16, 28–29, 33, 52; Exc. 349] When he was not on involuntary medication, Adam required nine admissions to the acute mental health unit, had self-harm behaviors for at least eight years, was on suicide precautions many times, was in and out of segregation for over a decade due to violent behavior, including an assault on another inmate in 2011, and went on a life-threatening hunger strike in 2018. [Tr. 6–7, 9–10, 30; Exc. 11, 15, 324–25, 344] Adam has never disputed any of that history. Even on involuntary medication, Adam remained paranoid about staff and medical care, and he was disciplined for fighting with another inmate in 2019. [*E.g.,* Exc. 326, 332, 347–48; Tr. 11, 32–33] Because of this undisputed evidence of the dangers Adam poses when unmedicated, any procedural mistakes did not prejudice him.

In terms of Adam's specifically listed errors [At. Br. 34–37], many were not errors at all, but to the extent that any of them were, they were harmless:

- Purported denial of opportunity to make a statement: At one hearing, the chair did not invite Adam to make a statement but asked him twice if he had questions of a witness and asked at the end if he had any questions "before we finish the hearing." [Tr. 43, 46, 57] Adam said no each time. [Tr. 43, 46, 57] This gave him plenty of openings to speak, particularly when Adam knew he could interject with statements because he had done so at the immediately preceding hearing. [Tr. 27–28, 33]
- Allegation about the independence of third-party psychiatrist: Once, Adam's former treating psychiatrist, Dr. Stallman, provided the second opinion. [Exc. 344–45] He had not treated Adam for more than six months and so was sufficiently independent to provide the evaluation under the policy. [Exc. 39–40; R. 886 (Exh. K at 144, 150)] Moreover, what's crucial to satisfying due process is that the adjudicators—not the witnesses—not be currently involved in Adam's treatment.[116]

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that authorization decision was reversed due to the lost appeal. [Tr. 64, Exc. 309]

[116] *Harper*, 494 U.S. at 229, 233 (affirming committee make-up where members could not be involved in the inmate's current treatment); *McGinnis*, 543 P.2d at 1228

- Allegation of too much or too little reliance on prior decisions: On the one hand, Adam claims that the hearing committee improperly relied on prior conclusions; on the other, he contends the committee failed to follow a prior appellate committee's conclusion at a later hearing. [At. Br. 36–37] The sufficiency of the information at each hearing stood alone.[117] [*See* Exc. 48] To the extent that the information and third-party evaluation at each hearing varied, it makes sense that the basis for authorizing involuntary medication changed, too. And the committee was not required to view as dispositive an earlier appellate conclusion when the information at a later hearing was different.[118]
- Purportedly inadequate assistance by staff advisor: The staff advisor met with Adam beforehand and attended the hearings, but Adam was not obligated to use the assistance. [Exc. 45–46; Tr. 14, 23, 41, 60] One advisor helped Adam by checking on whether his attorney could attend. [Tr. 14] Given Adam's distrust of DOC staff, including his refusal to talk to his advisor at all before another hearing, it seems likely that he did not want help. [Tr. 23–24; *e.g.,* Exc. 344] But even if he did, he does not explain what he wanted and how this prejudiced him. [Exc. 132–33]
- Decisions purportedly not thorough enough: The hearing committee provided thorough written decisions for the first two hearings. [Exc. 305, 346] Although the third decision falls short of the policy by not explaining what evidence supported the conclusions, due process is satisfied when a written decision, recording, or both provide "information about the evidence relied on and the reasons for the decision."[119] [Exc. 48, 203, 205] Here, the evidence relied on by the committee was the undisputed facts at the recorded hearing: Two psychiatrists and a clinician agreed that the authorization should continue, and Adam said nothing. [Tr. 40–57] Moreover, Adam does

(approving of composition where officials on hearing committee were not involved in the disciplinary incident at issue).

117 *See State, Dep't of Corr. v. Kraus*, 759 P.2d 539, 541 (Alaska 1988) ("Agency reliance on evidence not in the record is a fundamental defect amounting to a failure of due process."); *Mona J. v. DHSS, OCS*, 511 P.3d 553, 567 n.52 (Alaska 2022) (requiring admitted evidence from earlier hearings in the same case to be expressly admitted at a later trial to become part of the trial record); *cf.* AS 47.30.740(c) (expressly incorporating the factual findings from an earlier commitment hearing as evidence at a later hearing).

118 *See supra* p. 22 for more details.

119 *Huber v. State, Dep't of Corr.*, 426 P.3d 969, 973 (Alaska 2018) (explaining due process requirements governing the adequacy of a prison disciplinary decision).

not explain how this prejudiced his appeal. [Exc. 299–300] The appellate committee reviewed the record for sufficiency and limited the grounds for that authorization to grave disability.[120] [Exc. 301]

- Reading the third-party opinion into the record after Adam left the hearing: If this one-time occurrence amounts to a due process violation, it did not prejudice Adam because he did not dispute any facts at that hearing and the report provided substantially the same information about his need for involuntary medication as the testimony of his treating psychiatrist and a clinician. [Tr. 17–20; *see* Tr. 5–12]
- Inadequate hearing notices: Although some notices did not precisely conform to the policy, they were sufficient to meet due process because they were "appropriate to the occasion and reasonably calculated to inform [Adam] of the nature of the proceedings," so he could prepare.[121] [Exc. 44–45, 222, 304, 351, 358–59] The notices informed Adam of the date, time, and subject matter (the administration of psychotropic medication without his consent), the requesting psychiatrist, and the diagnosis. [Exc. 222, 304, 351, 358–59] The first notice listed the psychotropic medication, which did not change. [Exc. 222] Given the informal nature of the process and the fact that Adam knew his own current condition and history of past behaviors and had recently seen the requesting and third-party psychiatrists, these notices were adequate.

As the superior court did, this Court should reject Adam's argument that imperfect administrative proceedings in one person's case mean that due process requires supplanting that process with evidentiary hearings in court for all cases. [Exc. 195–96]

C. Adam's desired procedures could cause security-threatening delays, and the balancing comes out in favor of DOC's existing process.

Pre-medication judicial hearings with a right to counsel or a right to counsel in the administrative process would result in longer decision-making timeframes, threatening prison security if lapses in treatment occur. Moreover, "requiring judicial hearings will

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120 The fourth decision's reversal due to the DOC's failure to timely consider the appeal mooted—and corrected—any inadequacies there. [Exc. 309]

121 *Bigley v. Alaska Psychiatric Inst.*, 208 P.3d 168, 181 (Alaska 2009).

divert scarce prison resources, both money and the staff's time, from the care and treatment of mentally ill inmates."[122] Measuring these costs against the low risk of the error in the existing procedures comes out in favor of DOC's existing process.[123]

Adam argues that the emergency medication procedures are sufficient to mitigate the security risks if delays occur. [At. Br. 38] But scheduling court hearings could easily stretch beyond the roughly 11 days that involuntary medication may be administered on an emergency basis. [Exc. 41–42] A treating psychiatrist may wait to ask for a hearing with good reason—hoping that the inmate will stabilize and either not need long-term psychotropic medication or consent.[124] If a hearing is requested late during the emergency authorization window, it may be scheduled too late to avoid a medication lapse.

Even if a hearing is requested soon after emergency medication begins, court schedules and the provision of a right to counsel are likely to delay hearings more than DOC's current process. While trial courts can act fast,[125] the schedules of attorneys, witnesses, and courts fill up. As the superior court recognized, the process for appointing attorneys for indigent litigants is time-consuming.[126] [Exc. 197] And if DOC must provide attorneys for administrative hearings, it has no process to identify and assign attorneys to indigent inmates, and such appointments will take time. Once retained,

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122 *Harper*, 494 U.S. at 232.

123 *See Bigley*, 208 P.3d at 181 (quoting test from *Mathews*, 424 U.S. at 335).

124 The policy understandably prefers obtaining consent. [Exc. 37–38]

125 *See* AS 47.30.715(g) (requiring the holding of initial civil commitment hearings in three days).

126 Administrative Rule 12(e).

attorneys may require more time to provide competent representation at a hearing even under an expedited schedule, may want to hire experts who will need time to prepare, and may ask that inmates come to court.[127] DOC would need to arrange access to inmates' medical records for their attorneys[128] and allow inmates to meet with their counsel. All this would take more time and cost more than the existing process. Pre-medication court hearings and/or a right to counsel also would add to the security risks—dangerous inmates could remain untreated for longer *and* require transportation to court or to medical appointments with experts.[129]

Adam speculates about ways to lessen the delays and ensure security, but this fails to account for the burdens and risks that would immediately arise with his desired procedures. He points out that videoconference participation by inmates and witnesses is possible, and that the legislature may amend the Public Defender Agency's and Office of Public Advocacy's enabling statutes to provide experienced attorneys for indigent inmates. [At. Br. 39, 50] But what courts may allow or require in response to requests by inmates' attorneys, and what the legislature may do is unclear.

Adam also argues that the practices in a minority of states show that pre-

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127 *See* AS 33.30.081(f) (requiring a court to order DOC to transport an inmate who is a party to court or another place when the inmate's "personal appearance is essential to the just disposition of the [civil] action"); *Alex H. v. State, DHSS, OCS*, 389 P.3d 35, 49 (Alaska 2017) (stating that due process does not require transporting an incarcerated parent to a termination trial, but the Court still applies the *Mathews* test to each case).

128 22 AAC 05.095.

129 AS 33.30.081(f) (addressing prisoner transportation for civil lawsuits).

medication judicial hearings are feasible without overly affecting prison security.[130] [At. Br. 39–40] But the mere fact that a state uses a different process does not mean that it has had no negative effects. Because every state has different levels of resources and ways of running correctional facilities, the experience of other states is not necessarily predictive.

This Court should follow *Washington v. Harper* and uphold DOC's policy as consistent with due process under the Alaska Constitution.[131] Even though the right to refuse psychotropic medication is entitled to significant procedural safeguards,[132] Adam has not established that his desired procedures would meaningfully reduce the risk of unwarranted medication compared to the existing practice of administrative hearings with appeal rights, including post-hearing judicial review.[133] Meanwhile, the treatment delays likely to occur if pre-medication judicial hearings and a right to counsel are required would add to the already "extraordinary security risks" inherent in managing incarcerated criminals and intrude on the "wide-ranging deference" due to prison administrators in the execution of policies and practices that preserve institutional security.[134]

CONCLUSION

The DOC officials ask the Court to affirm the superior court's decision.

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130 Torrey, *supra* p. 35 note 78, at 22 (stating that 13 states require a pre-medication judicial process for inmates while five others and D.C. require hospital transfers first).

131 494 U.S. 210 (1990).

132 *Id.* at 229–30; *Myers v. Alaska Psychiatric Inst.*, 138 P.3d 238, 246–48 (Alaska 2006).

133 *See Harper*, 494 U.S. at 231–36.

134 *Myers*, 138 P.3d at 246 n.56 (first quote); *Valoaga v. State, Dep't of Corr.*, 563 P.3d 42, 48 (Alaska 2025) (second quote).