The Insider presents:

The Insider Outreach

Voices of California's Civil Detainees, Coalinga State Hospital

Issue 4 **June 2011**

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DSM-5 Rejects Coercive Paraphilia: Once Again Confirming That Rape Is Not A Mental Disorder

By Allen Frances, MD / Psychiatric Times, May 12, 2011

The proposal to include "coercive paraphilia" as an official diagnosis in the main body of t DSM-5 has been rejected. This sends a important message to everyone involved in approving psychiatric commitment under Sexually Violent Predator (SVP) statutes. The evaluators, prosecutors, Public defenders, judges and juries must all recognize that the act of being a rapist almost always is an indication of criminality, not of mental disorder. This now makes four DSM's (DSM-III, DSM-IIIR, DSM-IV, DSM-5) that has unanimously rejected the concept that rape is a mental illness. Rapists need to receive longer prison sentences, not psychiatric hospitalizations that are constitutionally quite questionable.

This DSM-5 rejection has huge consequences for forensic psychiatry and for the legal system. If "coercive paraphilia" had been included as a mental disorder in DSM-5, rapists would be routinely subjected to involuntary psychiatric commitment once their prison sentences had been completed. While such continued psychiatric incarceration makes sense from a public safety standpoint, misusing psychiatric diagnosis has given risk that greatly outweigh the gain. Mislabeling rape as mental disorder in SVP cases allows a form of double jeopardy, constitutes a civil rights violation, and is an unconstitutional deprivation of due process. Preventive psychiatric detention is a slope with possibly disastrous future consequences for both psychiatry and the law. If we ignore the civil rights of rapists today, we risk someday following the lead in other countries in abusing psychiatric commitment to punish political dissent and suppress individual difference.

This DSM-5 rejection of rape as mental disorder will hopefully call attention to, and further undercut, the widespread misuse in SVP hearings of the fake diagnosis "Paraphilia Not Otherwise Specified, non-consent." Mental health evaluators working for the state have badly misread the DSM definition of paraphilia and have misapplied it to rapists excluded as an example of paraphilia NOS in order to avoid such backdoor misuse. Not Otherwise Specified diagnoses are included in DSM only for clinical convenience and inherently too idiosyncratic and un reliable to be used in consequential forensic proceedings.

Which brings us to one continuing problem raised by the DSM-5 posting. The sexual disorders work group proposes placing "coercive paraphilia" in an appendix for disorders requiring further research. We created such an appendix for DSM-IV. It was meant as a replacement for proposed new mental disorders that were clearly not suitable for inclusion in the official body of the manual, but might nonetheless be of some interest to clinicians and researchers. In preparing DSM-IV, we had very strict rules and high hurdles for adding any new diagnosis – only a few suggestions made the cut, while close to 100 were rejected. Because it wass no more than an unofficial tag along, we had no similar qualms about the appendix and felt comfortable including numerous rejected diagnose in what seemed like a benignly obscure way that could do no harm.

If "coercive paraphilia" were like the average rejected DSM suggestion, it would simply make sense to park it in the appendix – as has been suggested by the DSM-5 sexual disorder

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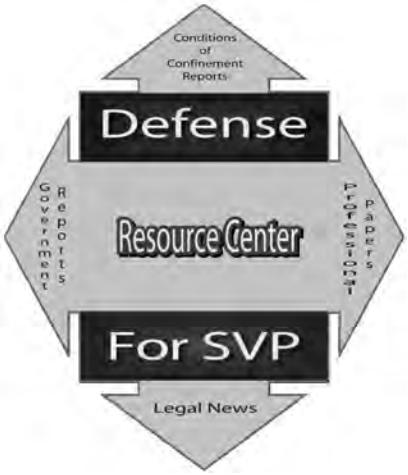

Good Cause and Individualized Treatment

Submitted by: Cory Hoch

The following is a compilation of law that expounds on the definition or better describes the process known as "individualized treatment" that is a crucial element for conditions of confinement for any person who is civilly confined.

Edward v. Lamkins (App. 1 Dist. 2002) 122 Cal.Rptr.2d 1, 24, 99 Cal.App.4th 516, 545 (showing of good cause is in effect an individualized showing of exigent circumstances in a particular case and a blanket statement of reasons offered as a matter of routine policy does not constitute good cause)

Norman v. Unemployment Ins. Appeals Bd. (Cal. 1983) 34 Cal.3d 1, 11-12, 192 Cal.Rptr. 134, 141 (term "good cause" is the kind of broad, open-ended language that the Legislature uses when it foregoes making specific rules in favor of individualized, case-by-case consideration)

Employment Div., Dept. of Human Resources of Oregon v. Smith (1990) 494 US 872, 110 S.Ct. 1595, 1603 ("good cause" standard created a mechanism for individualized exemptions)

W&IC § 5326 ("The professional person in charge of the facility or his or her designee may, for good cause,, deny a person any of the rights under Section 5325, except under subdivisions (g) and (h) and the rights under subdivision (f) may be denied only under the conditions specified in Section 5326.7. To ensure that these rights are denied only for good cause, the Director of Mental Health shall adopt regulations specifying the conditions under which they may be denied. Denial of a person's rights shall in all cases be entered into the person's treatment record.")

W&IC § 5327 ("Every person involuntarily detained under provisions of this part or under certification for intensive treatment or postcertification treatment in any public or private mental institution or hospital, including a conservatee placed in any medical, psychiatric or nursing facility, shall be entitled to all rights set forth in this part and shall retain all rights not specifically denied him under this part.

9 CCR § 881(w) ("'Safety' means protection of persons and property from potential danger, risk, injury, harm or damage.")

9 CCR § 881(x) ("'Security' means the measures necessary to achieve the management and accountability of patients of the facility, staff, and visitors, as well as property of the facility.")

9 CCR § 884(c) ("The rights specified in Subsection (b) of this Section shall be denied only for good cause. Good cause for denying a patient the exercise of a right exists when a facility director determines that: (1) The exercise of the specific right would be injurious to the patient; or (2) There is evidence that the specific right, if exercised, would seriously infringe on the rights of others; or (3) The facility would suffer serious damage if the specific right is not denied; or (4) The exercise of the right would compromise the safety and security of the facility and/or the safety of others; and (5) That there is no less restrictive way of protecting the interests specified in Subsections (c)(1) through (4) of this Section.")

9 CCR § 884(d) ("The reason for denial of a right under this Section must be related to the specific right denied. A right specified in this Section shall not be withheld or denied as a punitive measure, nor shall a right specified in this Section be considered a privilege to be earned. A denial of a right shall not exceed thirty days without additional staff review. Treatment plans shall not include denial of any right specified in Subsection (b) of this Section.")

Implementing the Right to Treatment

Submitted by: Larry Lowe

The following is an interesting excerpt out of **People v. Feagley** (Cal. 1975) 14 Cal.3d 338, 121 Cal.Rptr. 509, 525 fn. 19:

The uncertainty in the typical statutory definition and finding of dangerousness sufficient to warrant 'involuntary civil commitment' is tolerated on the rationalization that the person is not being imprisoned, but rather hospitalized for treatment. Of course when no treatment is forthcoming, we cluck sympathetically, but reluctantly refuse to release the individual because he is dangerous. This chicanery is intolerable. Courts cannot force legislators to provide adequate resources for treatment. But neither should they play handmaiden to the social hypocrisy which rationalizes confinement by a false premise of treatment. Quite the contrary, courts should, and must, reveal to society the reality that often festers behind the euphemism of hospitalization.

22 CCR §§ 71507(b) (rights may be denied except for those specified in subsection (7) and (9), whereas subsection (9) addresses all other rights as provided by law or regulation)

22 CCR § 73523(b) (patients' rights may only be denied or limited if such denial or limitation is otherwise authorized by law)

DMH Special Order 254.01, Section V-VI ("Good cause for the denial of a right exists when the Executive Director or designee has good reason to believe that: A. The exercise of the specific right would be injurious to the patient; or B. There is evidence that the specific right, if exercised would seriously infringe on the rights of others; or C. The state hospital would suffer serious damage if the specific right is not denied; D. The exercise of the right would compromise the safety and security of the facility and/or the safety of others; **and** E. There is no less restrictive way of protecting the interests specified in (A), (B) or (C). **VI. Criteria for All Good Cause Denials (all patients)** A. The reason used to justify the denial of a patient's right must be related to the specific right denied. B. A right shall not be withheld or denied as a punitive measure, nor shall a patient's right be considered a privilege to be earned. C. A patient's right denial can only be done on an individual basis. Rights may never be denied as a part of a policy or unit practice. D. Treatment modalities shall not include the denial of any rights specified in this policy. Waivers signed by the patient or by the conservator shall not be used as a basis for denying these rights in any treatment modality. E. Waivers signed by the patient or by the responsible person, guardian or conservator are not legal and shall not be used as a basis for denying any "non-deniable" right or any "deniable" right unless specifically granted by court order. F. Denial of a patient's right shall be done in the least restrictive manner. G. The patient must be informed of the reason why the right was denied, how long the right will be denied, and what action/behavior is necessary to have the right restored. H. If a patient is in seclusion and/or restraint, a denial of right(s) only occurs when the patient requests to exercise one or more rights and good cause exists for the denial.")

CSH Administrative Directive No. 604, Patient's Rights Advocacy Program, Sections IV.A-B and E ("The Executive Director or designee (Program Director or Program Officer of the Day (POD)) may for "good cause" deny an Individual any of the statutory rights listed in

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Section V, upon recommendations from the Individual's Interdisciplinary Team. The team must include the psychiatrist responsible for the Individual's treatment program...In emergencies, a right may be denied immediately by treatment staff; however, approval for continuation of the denial of a right shall be obtained as soon as possible or no longer than twenty-four (24) hours after the emergency action. A copy of all completed Denial of Rights forms shall be submitted to the Standards Compliance Department. **A.** Definition of "Good Cause" for Denial of Rights: "Good cause" for denying an Individual the exercise of a right exists when the Executive Director or designee has good reason to believe that: (1) The exercise of the specific right would be injurious to the Individual. (2) There is evidence that the specific right, if exercised, would seriously infringe on the rights of others. (3) The institution would suffer serious damage if the specific right isn't denied. (4) There is no less restrictive way of protecting the interests specified above. **B. Limitations on "Good Cause" Denial of Rights:** (1) The reason used to justify denying a right must be directly related to the specific right denied. A right shall not be withheld or denied as a punitive measure. A right shall not be considered as a privilege that is to be earned. A right cannot be denied as part of a treatment plan. (2) When a denial is in effect, a treatment plan must be instituted to assist the Individual in restoration of his rights...**E. Restoration of Rights:** Individuals' rights shall not continue to be denied when "good cause" for the denial no longer exists. When a right has been denied, staff shall employ the least restrictive means of managing the issues that led to the denial. Restrictions of Individuals' communication (visits, telephone calls, correspondence) shall be evaluated daily by unit staff and should be reviewed formally by the Interdisciplinary Team at least every seven (7) days. All other rights shall be formally reviewed every thirty (30) days. The Individual shall be informed of both the denial and the restoration of his right(s).

Additionally, the following should be noted:

Porter v. Superior Court (6th Dist. 2007) 56 Cal.Rptr.3d 240, 254, 148 Cal.App.4th 889, 909 (effective waiver of constitutional rights means it must not only be voluntary but also knowing, intelligent acts done with sufficient awareness of the relevant circumstances and likely consequences); **Burton v. Terrell** (5th Cir. 2009) 576 F.3d 268, 271 (same); **U.S. v. Ramirez** (9th Cir. 2003) 347 F.3d 792, 799 (same); **Sailer v. Gunn** (C.D.Cal. 1974) 387 F.Supp. 1367, 1372 (same)

In re Rosenkrantz (Cal. 2002) 128 Cal.Rptr.2d 104, 162, 29 Cal.4th 616, 59 P.3d 174, cert. den., 123 S.Ct. 1808, 538 U.S. 980, 155 L.Ed.2d 669, citing **In re Minnis**, 7 Cal.3d at p. 647, 102 Cal.Rptr. 639, 749, 498 P.2d 997 ("It is well established that a policy of rejecting parole solely on the basis of the type of offense, without individualized treatment and due consideration, deprives an inmate of due process of law."); **In re Lawrence** (Cal. 2008) 82 Cal.Rptr.3d 169, 44 Cal.4th 1181, 190 P.3d 535 (same)

Seling v. Young (2001) 531 U.S. 250, 121 S.Ct. 727, 729 (SVPs have a right to adequate care and individualized treatment)

Foy v. Greenblott (1st Dist. 1983) 190 Cal.Rptr. 84, 90 fn. 2, 141 Cal.App.3d 1 ("Congress has also declared that all state mental health programs should provide treatment in the least restrictive environment. (Mental Health Systems Act, 42 U.S.C. § 9501, subd. (1)(A), (F), (G), (J).) Numerous courts have found a federal constitutional right to the least restrictive conditions of institutional treatment. (See **Wyatt v. Stickney** (M.D.Ala. 1972) 344 F.Supp. 373, aff'd sub. Nom., **Wyatt v. Aderholt** (5th Cir. 1974) 503 F.2d 1305; **Davis v. Balson** (N.D.Ohio 1978) 461 F.Supp. 842; **Gary W. v. State of La.** (E.D.La. 1976) 437 F.Supp. 1209.) The Supreme Court has stated that "reasonably nonrestrictive confinement conditions" are constitutionally mandated. (**Youngberg v. Romeo**, supra, --US--, –, 102 S.Ct. 2452, 2463, 73 L.Ed.2d 28.)

THE TROUBLING ROLE OF PSYCHOLOGISTS IN SEXUAL PREDATOR LAWS

Paul Good, Ph.D. and Jules Burstein, Ph.D.

DUE TO THE LENGTH OF THIS ARTICLE, I AM UNABLE TO PRINT IT IN THIS EDITION.

THERE IS GREAT INFORMATION REGARDING THE IMPACT THAT PSYCHOLOGISTS HAVE HAD IN REGARDS TO THE SEXUALLY VIOLENT PREDATOR LAWS AND THE CREATION OF FICTICIOUS MENTAL ILLNESSES.

IT ALSO ADDRESSED THE COSTS INVLOVED IN THE OPERATION OF THE HOSPITAL UNDER THESE LAWS AND THE ADDITIONAL COSTS OF EVALUATIONS.

IF YOU WOULD LIKE A COPY OF THIS ARTICLE, PLEASE WRITE TO MYSELF (WILLIAM HESTER, EDITOR) OR TO MICHAEL ST. MARTIN AND REQUEST US TO SEND ONE TO YOU.

IF POSSIBLE, PLEASE INCLUDE A SELF-ADDRESSED STAMPED

RIGHTS OF THE MENTALLY ILL

(Includes patients involuntarily confined for mental health purposes in whatever stage of process or placement they may reside)

MINIMUM CONSTITUTIONAL STANDARDS FOR ADEQUATE TREATMENT OF THE MENTALLY ILL

(Wyatt Standards)

42 CFR §§ 483.70(d)(iv) (bedrooms must be designed or equipped to assure full visual privacy for each resident), 483.70(d)(v) (each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains)

The right to dignity. (**Wyatt v. Stickney** (M.D.Ala. 1972) 344 F.Supp. 373, 379 (Standard #1);); UN International Covenant on Civil and Political Rights (1966), Article 10, section 1 (all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person); Universal Declaration of Human Rights (1948), Article 1 (all human beings are born free and equal in dignity and rights); 42 CFR § 483.15 (facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality); W&IC §§ 5325.1(b), 5327; 9 CCR § 883(b)(1); 22 CCR § 73523(a)(11) (right to be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs))

PROVIDED AS A PUBLIC SERVICE ANNOUNCEMENT BY:

Civil Detainees' Advisory Council

with cooperation from

The Insider

Voices of California's Civil Detainees, Coalinga State Hospital

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The Insider Outreach is produced at Coalinga State Hospital, in Coalinga, California. Material published in this electronic paper is written, edited, and published entirely by hospital residents.

The ideas and opinions expressed herein do not reflect the opinions of the hospital's staff or its administration, unless otherwise noted.

The Insider, in all its incarnations, is dedicated to fair, unbiased and impartial reporting of information, current events, and news that is of interest to civil detainees and others who are interested in finding out about the real people here. Any questions and correspondence can be submitted by mail to:

William Hester
CO# 532-2 / Unit 4
P.O. Box 5003
Coalinga, CA 93210

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DSM-5 Rejects Coercive Paraphilia: Once Again Confirming That Rape Is Not A Mental Disorder—From Page 1

work group. This might facilitate the work of researching and also provide some guidance to clinicians in assessing the vanishingly rare "black swan" rapist who does have a paraphilia pattern of sexual arousal.

But "coercive paraphilia" is not the average rejected DSM diagnosis. It has been, and is continuing to be, badly misused to facilitate what amounts to an unconstitutional abuse of psychiatry. Whether naively or purposefully, many SVP evaluators continue to widely misapply the concept that rap signifies mental disorder and to inappropriately use NOS categories where they do not belong in forensic hearings.

Including "Coercive Paraphilia" in the DSM-5 appendix might confer some unintended and undeserved back-door legal legitimacy on a disavowed psychiatric construct. Little would be gained by such inclusion and the risk of promoting continued sloppy psychiatric diagnosis and questionable legal proceedings are simply not worth taking.

The rejection of rape as grounds for mental disorder must be unequivocal in order to eliminate any possible ambiguity and harmful confusion. We did not include any reference to "coercive paraphilia" in DSM-IV, and it should not find its way in any form, however humble and unofficial, into the DSM-5. The inclusion of "coercive paraphilia" in the DSM-5 appendix is a bad idea because the appearance of this white elephant anywhere in DSM-5 could be used to justify the Paraphilia NOS in SVP commitments.

Daily Life in Treatment Unit #2

Submitted by: Thomas A. Alexander

I requested a copy of my IDN (InterDisciplinary Note) dated 4/7/2011 from staff and I received it 5/7/2011. This document stated that I was verbally assaultive towards staff on that date. I asked Jerry Foster, Senior Psychiatric Technician, who was the Shift Lead that afternoon. He checked the Communications Log ("Comm Log") and also checked my chart to find out whose signature it was, and apparently none of the staff know.

The incident revolved around my telling Jack Sellick, Psychiatric Technician, "You were told to stay away from me and not to talk to me." Jack told me in a threatening manner that he will put me in seclusion if I didn't stop interfering with medical. I responded, "Go away, go away, I am helping McDonald with his wrist brace." RN Eric Njorge asked me and Mr. Profitt to help him with it because he was confused in how to put the wrist brace on. Eric asked us to help Mr. McDonald with it so the RN could attend to another patient in the Exam Room. We pushed him a little further down the hall from the Exam Room.

Jack then shoved me out of the way, and Mr. Profitt stepped in front of Mr. McDonald to protect him. Jack told Mr. Profitt, "If you don't move out of the way, I will have to push my red light." He did after Mr. Profitt told him, "I will not let you get to Mr. McDonald because he did nothing wrong and you (Jack) threatened to put all three of us in seclusion." I got pushed away from McDonald real hard after the staff and DPS showed up.

Then Jack got into Mr. McDonald's face. Mr. McDonald socked Jack on the side of the face because Jack violated his personal space, talking loud to him at the same time putting spittle on him. Jack then grabbed Mr. McDonald out of his wheelchair, placed him in a bear hug and carried him from the Exam Room to the Seclusion Room. All this while in front of staff and DPS who knew damn well that this was unethical and unprofessional. Jack has had a reputation here for coming to work drunk or nearly drunk and his actions showed that he was nearly drunk that night. One DPS officer told me in front of Cory Hoch that DPS was going to file a formal Dependent Adult Abuse report against Mr. Sellick for his behavior toward my peers.

I have been a Seventh Day Adventist for many years and as such have never used foul language, hurt people; nothing. I don't do these kinds of negative things.

Be Advised: Jack Sellick was walked out of the Hospital around two days after the April 7th incident. It is not known at this time whether a Dependent Adult Abuse report was actually filed against Mr. Sellick. The three Individuals involved have requested that charges be filed against Mr. Sellick on the grounds of Dependent Adult Abuse.